Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **THURSDAY, 23 AUGUST 2018**
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, Cleaver, Dr Moore, Pantling, and Dr 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

For Monitoring Officer

Officer contacts:
Julie Harget (Democratic Support Officer):
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Tel: 0116 454 6344, e-mail: Kalvaran.Sandhul@leicester.gov.uk)
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 Julie Harget**, Democratic Support on (0116) 454 6357 or email julie.harget@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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USEFUL ACRONYMS RELATING TO
HEALTH AND WELLBEING SCRUTINY COMMISSION

Acronym	Meaning
AEDB	Accident and Emergency Delivery Board
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
CCG LCCCG	Clinical Commissioning Group Leicester City Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
DTOC	Delayed Transfers of Care
ED	Emergency Department
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
GPAU	General Practitioner Assessment Unit
HALO	Hospital Ambulance Liaison Officer
JHWBS	Joint Health and Wellbeing Strategy
JHWBSAP	Joint Health and Wellbeing Strategy and Action Plan
JSNA	Joint Strategic Needs Assessment
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
RSE	Relationship and Sex Education
STP	Sustainability Transformation Plan
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

FIRE / EMERGENCY EVACUATION

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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 5 July 2018 have been circulated and the Commission is asked to confirm them as a correct record.

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

To receive updates on the following 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.

The following question has been submitted from Mr Robert Ball:

Moving the Intensive Care Unit from the Leicester General Hospital to the LRI

University Hospital Leicester (UHL) presented a case to the Scrutiny Commission stating that the intensive care unit (ICU) needed to be closed down at the Leicester General Hospital and moved to the Leicester Royal Infirmary and Glenfield Hospital. Because this was considered an urgent matter with closure required within months for reasons of patient safety, the scrutiny commission at the time approved the move without public consultation.

Clearly, however, closure was not urgent nor required in 2015 as the ICU at the General Hospital continues in place. As its governing body's approval of the full business case indicates (Ref 1), UHL appear to be assuming they can proceed three years later (commencement of construction by October 2018) with no public consultation, despite the fact that this represents a major change in service delivery.

This is a question for the Health and Wellbeing Scrutiny Commission: what action will the scrutiny commission be taking to ensure this does not occur?

The effective closure of ICU at LGH will require the removal of other services, making the long-promised STP consultation on the three to two strategy virtually a meaningless exercise.

The following question has been received from Mr Stephen Score:

University hospitals of Leicester want to close the General as an acute hospital and concentrate their services onto two sites only (the Royal Infirmary and the Glenfield). However, there has been no public consultation on this. Despite that, they are planning to move ITU out of the General, which will make it very difficult to keep other services there. Effectively they are moving from three to two hospitals by stealth and without public consultation. Will the Scrutiny Commission ensure consultation happens?

The following question has been received from Mr Peter Worrall:

It's my understanding the Scrutiny Committee approved the closure of intensive care at the General Hospital in 2015 without formal public consultation because it was informed by University Hospitals of Leicester that the matter was urgent and needed to be dealt with swiftly for patient safety reasons. As ITU still functions at the General can we assume that formal consultation will now be required? And furthermore will the Scrutiny Committee make clear whether it ***wishes*** *to see proper consultation now take place?*

7. INTEGRATED LIFESTYLE SERVICES REVIEW - FINAL PROPOSALS **Appendix A (Pages 1 - 74)**

The Director of Public Health submits a report that presents a final proposal for a new model of delivery for lifestyle services in Leicester City. Scrutiny Commission members are asked to note the recommended new model and

feedback comments on the proposed model to the Executive.

Members of the Heritage, Culture, Leisure and Sport Scrutiny Commission have received an invitation to attend and participate in the consideration of this item.

8. LEICESTER CITY, LEICESTERSHIRE AND RUTLAND URGENT AND EMERGENCY CARE RESILIENCE PLANNING FOR WINTER 2018/19 **Appendix B (Pages 75 - 82)**

The Director of Urgent and Emergency Care, submits a report that provides an overview of the ongoing work to prepare for the 2018/19 winter period across the Leicester City, Leicestershire and Rutland (LLR) Urgent and Emergency Care system. The Commission is asked to note and comment on the report as it sees fit.

9. PROPOSED CHANGES TO THE PRESCRIBING OF MEDICINES FOR MINOR AILMENTS **Appendix C (Pages 83 - 90)**

The Head of Medicines Optimisation, Leicester City Clinical Commissioning Group (CCG) submits a report that relates to the proposed changes to the prescribing of medicines for minor ailments. The Commission is asked to note and comment on the proposed changes as it sees fit.

10. REVISED JOINT HEALTH AND WELLBEING STRATEGY **Appendix D (Pages 91 - 116)**

The Director of Public Health presents the draft Joint Health and Wellbeing Strategy. The Commission is asked to note the content of the proposed strategy and feed in any additional comments on it as part of the consultation process.

11. INTEGRATED SEXUAL HEALTH SERVICES

The Commission will receive a verbal update on the new Integrated Sexual Health Services.

12. ITEMS FOR INFORMATION / NOTING ONLY **Appendix F (Pages 117 - 154)**

The following items are not for discussion in the meeting but for the Commission to consider if further information is required.

1. To note that the Leicestershire Partnership NHS Trust has requested a letter of support relating to the re-location of the Child and Adolescent Mental Health (CAMHS) in-patient facility.

2. To note a briefing paper from the University Hospitals Leicester, NHS Trust that provides information on the process and service development to re-provide and expand renal dialysis services for the population of Lincolnshire and Leicestershire and Rutland (LLR).

3. To note the Annual Report 2017/18 Healthwatch, Leicester

4. To note an update report on oral health in Leicester.

13. WORK PROGRAMME **Appendix E (Pages 155 - 160)**

The Scrutiny Policy Officer submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme for 2018/19. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

14. ANY OTHER URGENT BUSINESS

Appendix A

Health and Wellbeing Scrutiny Commission

Date: 23rd August 2018

Title: Integrated Lifestyles Services- Final proposals

Lead director: Ruth Tennant

Useful information

- Ward(s) affected: all
- Report author: Ryan Swiers/Jo Atkinson
- Author contact details: ryan.swiers@leciester.gov.uk / jo.atkinson@leicester.gov.uk

0116 4542032

- Report version number: 2

1. Summary

This report presents a final proposal for a new model of delivery for lifestyle services in Leicester City. This follows an extensive programme of work looking at the continued need for such services, performance of current services, evidence of alternative models, required efficiency savings as a result of reductions in the national public health grant and the views of staff and the general public.

In February this year the Executive approved outline proposals to develop a new integrated lifestyle service following a period of review and a number of earlier papers on these services. These proposals were also shared with an informal meeting for members of the Health and Wellbeing Scrutiny Commission and Heritage, Culture, Leisure and Sports Scrutiny Commissions in March 2018. Key dates in the development of these proposals are shown below (previous papers and slides attached as appendix A);

21st June 2017 – Paper presented to Health and Wellbeing Scrutiny Commission meeting with an explanation of the current services and need to review this offer.

8th February 2018- Paper presented to Executive outlining initial proposals for an integrated service and plan for public consultation.

7th March 2018 – verbal update at the commission meeting to explain there will be an informal meeting later that month.

21st March 2018 – Informal briefing session for Health and Wellbeing Scrutiny Commission and Heritage, Culture, Leisure and Sport Scrutiny Commission members outlining the proposed model going out to public consultation.

City Mayor

21st June- Consultation feedback presented and proposals for model and next steps approved by Executive.

5th July 2018 – Paper brought to Health and Wellbeing Scrutiny Commission meeting following the consultation. Content largely deferred until August meeting.

A period of public consultation which lasted for 8 weeks and was supported by focus groups specifically looking at areas of the proposal which it was felt would benefit from more in-depth insight (weight management, volunteer role and digital services) took place in summer 2018.

The response to the public consultation is detailed in this paper. This response has informed the final proposal for Integrated Lifestyle Services. These proposals which have been endorsed by the Executive are presented here for feedback from Health and Wellbeing Scrutiny Commission along with a final delivery model.

Key themes emerging from the consultation were;

- Support for a shift to integrated lifestyle services with a single booking function
- Support for retaining some specialist staff within this model
- Support for volunteers to be involved in services, as long as sufficient training and support is in place
- Support for greater use of digital services to be developed as long as face to face help continues to be available for people who need it most.

In light of this the proposed new model will;

- Bring staff from a range of existing services (stop smoking service, active lifestyle scheme, healthy lifestyle hub) together in an integrated team with single point of access
- Train all staff to deliver brief advice around a range of healthy lifestyles topics but retain subject level expertise
- Develop a comprehensive volunteer training package with sufficient support to ensure the development of this aspect of the service where it is appropriate
- Digital services- utilise existing resources such as 'One You' (https://www.nhs.uk/oneyou/) tools and monitor the reach of these services in relation to inequalities ensuring that we maximise the potential benefits whilst maintaining face-face services for those that need it most

2. Recommendations

Scrutiny Commission members are asked:

- To note the recommended new model
- To feedback comments on the proposed model to the Executive

It is proposed that regular updates on the development and implementation of an integrated service will be shared with the health scrutiny commission.

3.

3.1 Background

LIFESTYLE SERVICES – THE CURRENT PICTURE

The city council is currently responsible for a number of lifestyle services (see below) at a total cost of £1.8m in 2017/18. These aim to reduce preventable ill-health in adults, particularly cardio-vascular disease and preventable diabetes, by acting early to support people to make lifestyle changes which will reduce the risk of them going on to develop these conditions.

Since 2015, there have been a number of changes made to our lifestyle services. This has included:

- Focusing weight management on highest risk groups and ceasing funding for the universal Weight Watchers service
- Reducing expenditure on smoking, reflecting reductions in demand for the service predominately as a result of increased use of e-cigarettes
- Reducing waiting times for the Active Lifestyle scheme.

These changes have reduced overall expenditure on these services from £2.2 million in 2015/16 to £1.8 million in 2017/18.

Below is a summary of current services and their performance (more detail is available in appendix B).

Current services			
Service	**Need**	**Cost**	**Local uptake & impact**
Smoking cessation	21% smoking prevalence	£972k	Approx. 1,500 smokers quit each year with the service, including 175 pregnant women. Overall quit rate of 54% (higher than national rate and comparators) Decline in numbers largely as a result of e-cigarettes. Service focuses on 1-1 support.
Healthy lifestyles hub	31% of adults physically inactive *(higher than national rate)* 55% adults obese or overweight (20% obese)	Up to £300k (+£100k NHS)	c 5000 referrals each year from GPs 80% referred to at least one lifestyle service
Health trainer service			c 900 clients per year set a personal health plan. 80% of clients fully or partially achieve their health plan
Active lifestyle scheme (exercise referral)	31% of adults physically inactive (higher amongst those with long-term conditions)	£175k	c. 1,800 attend programme.

City Mayor

Weight management – targeted BME/ long-term conditions	See above	Up to £229k (payment per case)	450 clients per year complete programmes. 1 in 4 achieve and maintain clinically significant weight loss (5%) up to at least 12 months.
Total		£1.7million	

5

A review of existing services was accompanied by public engagement in 2016. This involved community development staff engaging with 290 people. A high response was received from east Leicester, particularly the Belgrave area. 57% of responders were "White British" and 27% Asian. There was a good mix of age groups responding and 60% of responses came from females.

Main findings from the review included;

- Lack of integration and fragmentation between the different lifestyle services
- 'Gold-standard' but high-cost 1-1 support in several of these services
- Lack of on-line or digital provision resulting in high referrals to 1-1 services
- Under-utilisation of other local resources such as existing volunteering schemes, outdoor gyms, community exercise programmes provided by professional sports clubs.
- Potential for improved integration with other council services, particularly adult social care
- Strong support for a single integrated lifestyle where people can tell their story once and which offers an easy point of referral for GPs and other health/ care professionals.
- Continued need for early intervention to reduce high levels of preventable heart disease, diabetes in working-aged adults in the city, particularly in the most deprived parts of the city as identified by measures included in Leicester's health profile around smoking, diabetes etc
- Significant scope to develop existing lifestyle services to also tackle low level mental health and social isolation which are addressed by services beyond those which explicitly focus on these issues[1][2]. This approach supports work taking place across Leicester in relation to Making Every Contact Count (MECC) and the potential for services such as those within the proposed model to have a positive impact on low level mental health and social isolation
- Under-utilised potential to increase referrals to specialist alcohol treatment services (Turning Point)
- Potential to introduce charging for elements of the service in line with leisure centre pricing.
- Emerging evidence from other parts of the country which have already moved to integrated services of good outcomes

Some key themes emerged from the public engagement which informed current proposals;

- When people were asked how the services should be delivered, a key finding was that people want local people to get involved and lead. It was suggested that local people need to be involved in running groups in local areas as they identify with them and a local person is likely to understand the needs of the community.
  "Letting local people step forward to get the qualifications to lead the groups. They are known in the community and get people into the building; they also have an understanding of the people."
  "Local people being given the chance and up skill them and professional support. Local people can sometimes relate better to people in the community as they are on the same page"
- Some people said they preferred groups as 1-1 is either *"too embarrassing"* or they

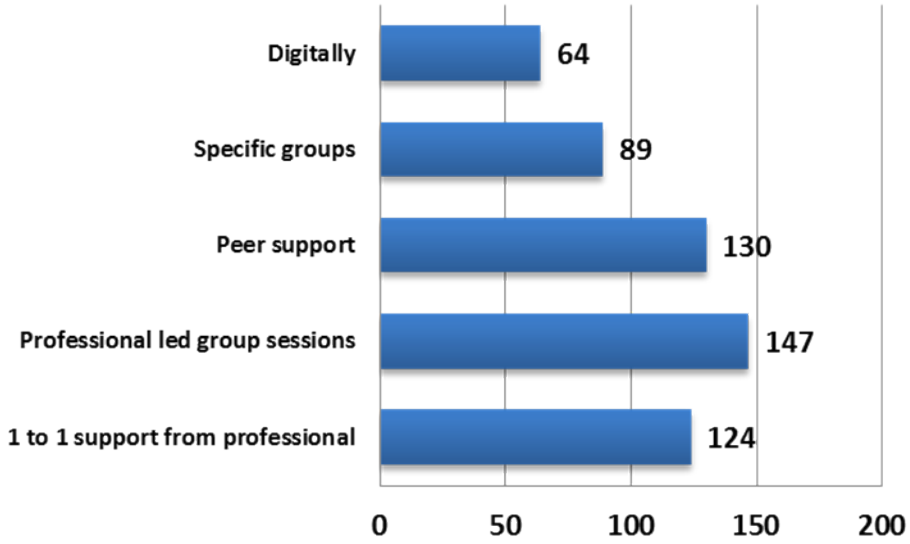
[1] https://www.scie.org.uk/publications/briefings/briefing39/index.asp

[2] https://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true

enjoy the social side of groups. However, some preferred 1-1 as they would be reluctant to speak in a group.

- Both peer support and professionally-led groups were most popular options for delivery of lifestyle services.
- Overall people want a range of channels for the service to be delivered through for different aspects e.g. groups for physical activity and internet for advice and food information.

The chart below shows the way in which people indicated they would like to receive services;



This earlier work informed proposals for changes to lifestyle services which are underpinned by two primary drivers namely a desire to ensure services are continually improving and keeping up to date with emerging evidence along with a necessity make further efficiencies as a result of year-on-year reductions in the nationally-allocated public health grant.

A number of options were considered when looking at service changes within lifestyle services although they are essentially variations on 4 available options which are briefly discussed below;

- Cessation of all services
- Cessation of some services
- Reduction of existing services
- Shift to an integrated model

Cessation of some or all services

The local authority is responsible for improving the health of the local population and evidence based lifestyle interventions play a key role in meeting this responsibility. The cessation of some/all services would allow the council to meet short-term efficiencies but would risk long term negative health impacts. These impacts would be felt across the health

and social care system and because of this cessation of services was deemed an unacceptable option by the Executive.

Positives	*Negatives*
Achieves additional savings	Long term negative health impacts
	System wide consequences
	Reputational damage

Reduction of all services within existing model

Efficiency savings made in recent years have already seen the existing services make changes to their offer to reduce costs whilst still delivering a population based approach. A reduction across all services as they currently operate would enable teams to continue to focus on their area of expertise but would not improve integration across these services.

Positives	*Negatives*
Achieves savings targets	Considerable reduction in frontline services
Provides a degree of continuity	Challenging to address multiple behaviours and provide a holistic service
	Limited scope for innovation
	No reduction of management costs achievable through integration

Shift to an integrated model

The shift to an integrated model would enable efficiency targets to be met but beyond this it also allows a holistic approach to improving people's health. Removing duplication of some functions such as admin and management provides clear savings whilst forging a single team who will, over time, become upskilled to provide a more comprehensive and rounded support package.

Positives	*Negatives*
Allow the council to meet efficiency targets	More 'change' for staff than other options, including potential reductions in staffing
Facilitate a holistic approach to providing support	Requires new systems to be trialled and embedded
Allows more sophisticated analysis of effectiveness	Period of inevitable transition and some reduction in frontline services

Adopting the proposed model of an integrated service will see lifestyle services meet a cumulative target of £1.35 million since 2015/16. This level of saving cannot be achieved without significant changes to services and whilst this presents opportunities for greater integration and more innovative working there are inevitably challenges in ensuring services continue to deliver high quality and achieve positive health outcomes.

Proposed changes are part of a broader ongoing piece of work across the division of Public Health and Sports Services to transform services to be focussed on health and wellbeing. This work includes a programme of activities around developing the council's leisure centre offer to improve and modernise leisure services to ensure they are inclusive and well utilised. The integrated lifestyle service will also support work aimed at utilising community assets such as parks, outdoor gyms and walking/cycling to increase physical activity and support positive mental wellbeing.

Consultation has taken place to gain the views of staff and the public on the proposals for lifestyle services in order to help refine proposals aimed at improving quality and reducing costs. This builds on previous engagement carried out in 2016.

3.2 Consultation feedback

171 people completed the consultation (online and paper) over an 8 week period between April and June 18. The consultation was promoted via Citizenspace and the standard council media channels. In addition the Clinical Commissioning Group, Voluntary Action Leicester and a wide range of community groups were proactively contacted and encouraged to participate. Costs of the consultation included £35 for printing of plus the associated staffing costs. The main staffing resource was a public health speciality registrar who is funded nationally by the NHS.

It should be noted that whilst 171 people responded to the consultation many questions were answered by low numbers of people. It is not possible to draw conclusions about the representativeness of those who completed the consultation or participated in focus groups. It is also important to note that over 50% of responses came from staff/people in a professional capacity. A breakdown of response rate by question is available.

In addition to the online consultation a number of focus groups were held during the consultation period with a specific focus on exploring the issues of weight management services, the role of digital resources and the involvement of volunteers in a new service. Below is a brief summary of the consultation and focus groups responses; more detail is available in appendix C and the final consultation summary is included as appendix D.

- Overall support for a shift towards integrated services with responses suggesting this would make services more user friendly
- A single booking system was well received
- There was support for group based sessions with people seeing this as a means of extra support. Whilst most people did not respond to this question (<30%) there was less support for stop smoking services than weight management, diet/physical activity
- A recognition that there was not a ‘one size fits all’ and that 1:1, group based and online had a role to play
- The key features affecting sessions included time location and cost. Friendly staff was cited as the biggest factor determining how successful sessions would be
- People expressed a desire for sessions to be offered at evenings and weekends
- A wide range of settings were seen as suitable with leisure centres (61), community centres (41), parks and outdoor (38) spaces being most popular
- Strong support for developing a more extensive walking programme with people suggesting guided and group walks as a good idea
- The increased use of volunteering was generally supported although there were concerns that this should not be used a mean to replace qualified staff
- There were concerns about an integrated service having a generic member of staff and responses were in favour of retaining specialist staff
- Regarding online services there was some concern via the consultation and focus groups about a complete shift to digital services and potential risks of exclusion
- Whilst there were limited responses to questions relating to wider services such as housing and debt management there was generally support for this especially as a signposting function
- Greater use of community assets was also mentioned
- There was a number of comments relating to the role of wider determinants such as

takeaways, advertising and sustainable travel*

*Factors beyond the scope of lifestyle services but related to the wider determinants of health including sustainable travel and takeaways have been shared across the public health team to ensure they are considered in the relevant areas of work; specifically the healthy places team.

3.3 Impact of the consultation

Many of the themes emerging from this consultation support the earlier public engagement and offer a degree of confidence in the validity of these responses for example around the use of volunteers and the need to offer both group and 1:1 support. Based on the consultation feedback including areas of concern for those responding, the following considerations will be reflected in the final model for integrated lifestyle services.

Retention of specialist staff

A clear message emerged that people valued the role of the specialist advisor. The proposed new model will retain specialist staff but seek to ensure all staff are trained to provide low level brief advice across a range of healthy lifestyle topics. A more holistic service will be achieved through the introduction of a single 'front door' and case management system alongside the numerous benefits both to services and efficiencies of bringing staff together in a single team.

Group based sessions to be introduced alongside continued 1:1 sessions

Differences existed in people's views of group based sessions. Many feeling that groups were appropriate, especially for some activities such as weight management, but there was a recognition that this wouldn't be appropriate for everyone and as such the new service will continue to offer 1:1 support for some people alongside more group, phone and online services. The introduction of group based sessions will be gradual and accompanied by a comparative evaluation to understand effectiveness and efficiency compared to 1:1 sessions.

Digital services

Similarly there were positive views in relation to digital services and an acknowledgement that this was very much the direction of travel for many services. There was however some concern around a 'digital divide' and the potential for a wholesale shift to online services to disadvantage particular groups. It is not the intention of the new service to make a wholesale shift online but rather to ensure the council is utilising the potential for digital services to support self-care.

The new service will ensure that digital services help to effectively manage demand without marginalising those with limited access/capability. Digital services will become more prominent in our lifestyle services without replacing a face to face offer. Initially the digital offer will provide a safe and trustworthy source of information on healthy lifestyles with details of accredited apps and resources. Digital services will also explore 'light touch' interventions for those with capacity to enable better use of resources. A text reminder service will also be investigated. Any use of digital services will pay due regard to their impact on inequalities.

Volunteering to be developed alongside the new model

Volunteering was another area where people were supportive as long as this was not a

means of replacing qualified and experienced staff. Volunteering within the new service will be well supported by a volunteer co-ordinator and comprehensive training package. Furthermore the nature of volunteering will vary across behaviour change topic, for example volunteers may be more active in a walking programme than stop smoking services. Volunteers are actively engaged by the council at present in a variety of means including within parks and museums. There are further opportunities within services to promote healthy lifestyles including those around food growing. A focus on volunteering is intended to both support lifestyle services and provide opportunities for local people rather than to replace staff. A dedicated resource will be required within the new structure to support volunteers and develop long term sustainability as well as exploring where volunteers can support healthy lifestyle services such as acting as a role model within weight management or a peer mentor when using outdoor gyms.

One size doesn't fit all

Whilst the proposed new service will standardise a great deal in terms of service access, delivery and monitoring it was clear from the consultation feedback that a single, uniform offer across the city would be sub-optimal. As such the new service will seek to explore how best to deliver service in individual communities and reflect the different assets across different areas. Working with communities will be essential in ensuring this is effective.

Access

Service users currently access lifestyle services via health professionals and are contacted by phone to conduct assessments and make appointments etc. This will continue although health professionals will now have a single service to refer into and clients will have additional options in terms of self-referral by phone/online.

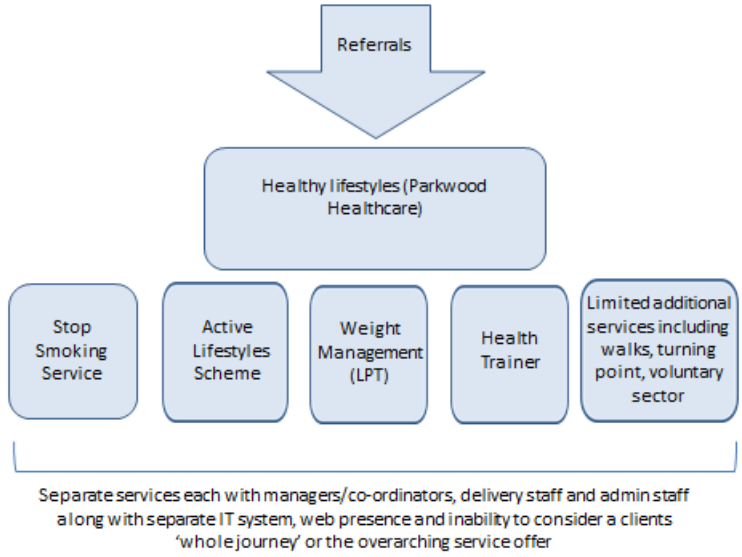
Below is shown an example of the existing model and the proposed new model for lifestyle services which should be viewed in light of the comments above relating to the impact of public consultation on delivery.

Weight management

Feedback in relation to weight management services was broadly similar to that regarding other aspects of the proposed model. Respondents favoured group sessions and recognised that online support could be helpful as could volunteers to support sessions.

Targeted weight management services will continue within the integrated lifestyle service from April 2019 although the provider will continue to be externally commissioned. At present these services are provided via the Diet, Health and Activity in Leicester (DHAL) and Lifestyle, Eating and Activity Programme (LEAP) groups. The consultation has supported the existing view that some groups derive significant benefit from bespoke services above and beyond commercial weight management programmes.

Current model:



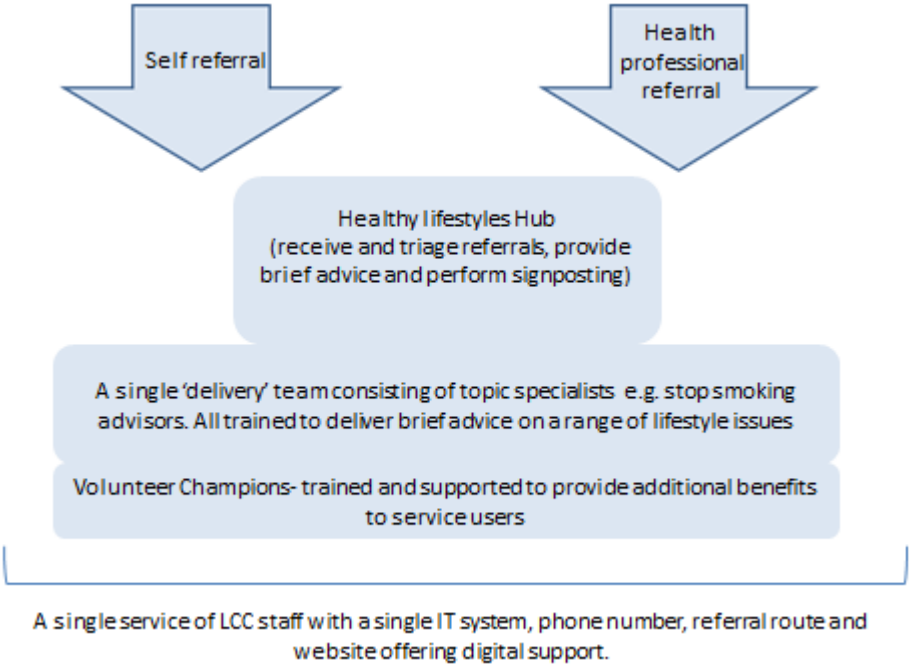
THE PROPOSED NEW SERVICE

Over the next 2 years, the proposed new service would replace our current services with a single integrated service, provided in-house.

The new service will:

- Provide access to good quality on-line information, using existing accredited websites as a first point of contact
- Provide phone-based support for people who cannot access information on-line or who need more specific support
- Sign-post people to a range of local facilities including outdoor gyms, community sports activities, including community activities run by partners such as LCFC and volunteering opportunities
- Provide a reduced level of group-based and 1-1 support for people with higher levels of health need

Future model:



3.4 How the new service will work

The integrated lifestyle service will have a single manager responsible for all staff although co-ordinator posts will be required to provide support around specific aspects of the service. A central pool of hub staff will form part of a multidisciplinary delivery team.

Single point of entry and hub function
The integrated model will consist of a single point of entry which can be accessed by either web or phone and enable referrers, including GPs and other health and care professionals, and potential clients to gain swift, easy access to lifestyle services. This retains the existing means of accessing the services but enhances the self-referral options.

Step 1: Digital Component

The new integrated service will have a significant shift in focus to enable maximisation of digital and web based support. This is not a shift of face to face services on line but a recognition that digital services do offer potential support to some clients which we should seek to embed as part of a wider offer. Digital services will give people personalised advice based on information that they submit and will become the default option for clients who have the means and capacity to utilise this medium. It is envisaged that the service will feature an attractive and easy to use public facing website with excellent functionality, including a secure access route for clinicians. This will allow a universal offer utilising NHS endorsed digital content such as the Public Health England 'One You' resource sand the

couch to 5k initiatives (https://www.nhs.uk/Livewell/c25k/Pages/couch-to-5k.aspx) and accredited sources of advice to support people to quit, including using e-cigarettes.

This will be supported by a case management system for people who need a higher level of support or advice. The digital package will be developed through the digital transformation board to ensure that this is effectively coordinated with the council's wider digital platforms including the current Liquid Logic system, MyChoice (adult social care portal).

The digital portal will also make it easier for a wider range of staff, including staff in housing, adult social care and the customer service centre to give basic health messages and point residents towards health advice and support. Basic training has already been given to some front-line staff but this would be accelerated as part of our proposals.

Step 2: Phone support & advice

For clients referred into the service (for example through the council's NHS Health-checks programme) an initial phone assessment would be undertaken. At this point, clients would be offered a range of options and motivational support to enable them to start to make changes to their lifestyle. All clients referred into the service will be followed up at 6 weeks and the case management approach adopted will allow longer term follow up.

A key element of the hub function will be assessing readiness to change using well established techniques in order to best support residents to access services which suit their needs. These skills will form part of a comprehensive staff training package which will also include ensuring staff are equipped to provide brief advice on onward referrals in relation to alcohol and mental health. Alongside staff training there will be period of engagement with partners including local GPs to ensure key stakeholders understand the importance of appropriate referral for residents who wish to make a change to unhealthy behaviours. By effectively screening people at the start of their journey, it is expected that uptake, retention, outcomes and customer satisfaction will be improved.

Clients will be referred into a wide range of services and initiatives within and beyond the in house lifestyle services. This will include existing initiatives in the community such as those provided by the voluntary sector e.g. Age UK programmes, conservation work, food growing programmes and community sports activities including community programmes provided by the community arms of the professional sports clubs as well as promoting outdoor gyms and LCC walking and cycling schemes.

The whole service will have a greater focus on mental wellbeing with all staff trained in mental health e.g. mental health first aid training. The service will also develop greater links with mental health organisations such as Leicestershire Action for Mental Health Project (LAMP) and establish referral/ signposting pathways.

Step 3: Lifestyle services

Following triage by the hub team clients either group or 1-1 support will be offered where appropriate:

Smoking Cessation support
The new service will promote accredited on-line resources to support people to quit smoking and offer phone based support. 1:1 and group sessions will be offered with evaluation undertaken to understand the effectiveness and efficiency of these different methods of delivery. The service will:

- Continue to provide 1-1 support for pregnant women, supporting wider objectives around reducing low birth weight babies and infant mortality.

- Provide group-based support and 1-1 support for vulnerable clients such a people with significant health problems or drug & alcohol dependency.

Group-Based Lifestyle Sessions
A team of lifestyle advisors will run group-based physical activity sessions incorporating healthy eating advice, motivational support and goal setting. Staff will work across leisure and community groups and facilities. The majority of individuals referred to this service, for example through an NHS health check, will either have a long term condition or be at increased risk of developing one. Targeted sessions for the inactive (with and without medical conditions) will also run in areas of highest need.

This will incorporate the existing Active Lifestyle Scheme that runs in the city's leisure centres. After a free introductory period of 12 weeks, charging will be introduced for this element of the service in line with existing leisure centre pricing structures and concessionary rates. This has been projected to reduce the revenue costs of the integrated lifestyle service over time.

Volunteering
Evidence supports the role of volunteering to reduce social isolation, promote community cohesion and improve both physical and mental health. The lifestyle service will coordinate a community activators programme, coordinated with existing council volunteer schemes such as the conservation and neighbourhood volunteering within parks and volunteering in museums.
This programme will:

- Deliver walking groups – this will enable the evidence based "walking for health" programme to continue in targeted areas of the city. Volunteers will be trained to run 12 week walking programmes and be supported by a volunteer co-ordinator to run weekly walking groups in 10 areas of the city (including the parks).
- Support volunteers to get basic qualifications in public health and physical activity plus training around services available across Leicester to enable effective signposting and support a holistic offer to residents
- Provide 1-1 buddying support to people attending group lifestyle sessions including weight management where the role of positive peer advocates has been recognised.

SERVICE LOCATION

The integrated service will operate across the city with a clear plan to deliver services in those areas where need is greatest. Whilst the hub team will be largely a 'back office' function there will be a digital and phone based 'front door' plus a range of access points in other setting such as leisure centres and GP practices. Group-based activities will operate in existing leisure centres, parks, outdoor gyms alongside classes in community venues with walking programmes offered across Leicester.

SERVICE IMPACT & EVALUATION

The new service model and associated costs are based on achieving the following high level outputs and outcomes: these will be subject to further development/ quantification.

Outputs

- 8000 referrals to service (via direct referral, community settings and digital component)
- 2000 users accessing digital support only
- 2000 given smoking support
- 3500 attending lifestyle group-based sessions in leisure centres and community

venues
- 500 residents taking part in a walking programme
- Minimum of 25 volunteers trained as walk leaders
- Volunteers trained as "activators" in the community
- Number of clients signposted to opportunities in the community

Outcomes
- 1000 4 week smoking quits including;
- 200 4 week smoking quits in pregnancy
- 2000 residents moving from inactive to active at 3 months
- 2000 residents measurably improving their diet e.g. increase in fruit and veg consumption

The service will also monitor:
- Weight loss at 3, 6 and 12 months
- Improvement in levels of mental wellbeing (measured using the validated WEMWBS tool)
- Improved client satisfaction
- Increased referrals into support services including alcohol and mental health services

All of the above will be quantified in total but also broken down by postcode so that services can be focused on areas with the poorest health outcomes. For example the service will aim to ensure 80% of those completing a health assessment will be from deprivation quintiles 1 and 2 (e.g. Eyres Monsell, New Parks, Saffron) along with the majority of those training as volunteers coming from these areas.

Lifestyle services have been criticised across England for a failure to provide robust, long term data on outcomes and supporting evaluation. The integrated service will address this by aligning the service to national guidelines on effective evaluation of integrated lifestyle services which is due to be released by Public Health England (PHE) in summer 2018.

Evaluation will consider two main priorities. Firstly the effectiveness of the various support interventions such as smoking cessation using validated smoking quits or physical activity interventions measuring change from inactive to active in line with national guidelines. Secondly ongoing evaluation will consider the effectiveness of integrating services. A single database will support this comprehensive evaluation.

3.5 Next steps

Public consultation has shown support for proposals to shift lifestyle services towards an integrated model with a single hub function and booking system whilst retaining professional expertise in different topic areas. A single hub, contact number and case management system will allow more holistic support for clients and reduce the opportunities for duplication and/or gaps between services.

An increased role for volunteers and an extended programme of walking will be included as will a shift to support more community based activities including existing sessions and outdoor gyms. Group and phone based services will be developed but face to face and 1:1 services will remain. As part of a shift to maximise digital services an online platform will bring together safe and reliable health information and existing apps and online support such as the One You resource. Digital services will compliment rather than replace services.

Discussions have taken place with local NHS partners to ensure services are embedded in clinical pathways and health professionals make appropriate referrals. This work will

continue to ensure a joined-up approach to supporting healthy lifestyles in Leicester City.

A comprehensive evaluation will accompany the new service to consider the effectiveness of the model overall and the separate elements within in.

The proposed new service has a 'go-live' date of April 2019.

4. Financial, legal and other implications

4.1 Financial implications

By 2019/20 the Lifestyle Services will achieve their full savings target although this will require use of reserves for a short period until the plans are fully implemented.

Rohit Rughani
Principal Accountant

4.2 Legal implications

The preferred option is to integrate the Lifestyle services. Under the preferred option – there are no proposed decommissioning but a reduction to some of the services for which a consultation has taken place.

Following consultation, the product of the consultation must be taken into account in the final decision and the responses need to be fed into the decision making process.

In relation to the recommissioning of these services, the design and the running of any procurement should be in accordance and compliance with the Council's Contract Procedure Rules and the Public Contracts Regulations 2015.

Assistance must be sought from and work directly with the Council's procurement team(s) in consultation with legal services to drive the procurement process in compliance with the regulations, internal rules and in order to ensure the desired outcomes are achieved in the most efficient way.

There is mention of a Digital Offer – this may also require input from IT/Procurement team.

Any reduction to any of the current arrangements should be in accordance with the provisions of the contracts to ensure smooth terminations and in alignment with the proposed procurement of the new Integrated Service.

Previous legal advice has been provided but it is re-iterated that the
the Council must comply with Statutory Best Value Guidance
(https://www.gov.uk/government/publications/consultation-principles-guidance) which means that the where there is an SME organisation (which may be the case in smaller services) then the guidance requires the Council to give 3 months' notice to terminate the current contracts, this is regardless of the contractual provisions.

The implications arising from this report are based on the preferred option as suggested within the report should the option change, legal services will need to be consulted to identify associated legal risks. Ongoing support should be sought from legal services as and when required.

Mannah Begum, Solicitor (Senior) - (Commercial Property and Planning Team
Legal Services)

A number of changes are envisaged in the report which have potential staffing implications.

Where staff are employed by the Council and it is proposed that there will be an organisational review the Council's organisational review policy should be followed.

If there is a decision to out-source any of the services going forward, there is the potential for the TUPE Regulations to apply. The TUPE Regulations are also likely to apply should there be a decision to bring any of the services back in-house.

Further employment legal advice should be sought once a decision on the model for service delivery has been made.

Paul Atreides
Head of Law

4.3 Climate Change and Carbon Reduction implications

A key element of the integrated lifestyle service will be to encourage physical activity and promote walking and cycling which will positively impact on climate change and carbon reduction. Fewer 1:1 sessions is also likely to lead to a reduction in travel, including single occupancy car journeys, for staff and residents

The reduction in 1:1 sessions and greater focus on group sessions, held in local venues, is likely to reduce travel by both clients and council staff, leading to a reduction in city-wide and council carbon emissions.

In addition, a key element of the integrated lifestyle service will be to encourage physical activity and to promote walking and cycling. This may lead to some clients adopting these active travel options for regular journeys previously made by car or bus – again contributing to reduced city-wide carbon emissions.

Duncan Bell, Senior Environmental Consultant.

4.4 Equality Implications

When making decisions, the Council must comply with the Public Sector Equality Duty (PSED) (Equality Act 2010) by paying due regard, when carrying out their functions, to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people who share a 'protected characteristic' and those who do not.

In doing so, the council must consider the possible impact on those who are likely to be affected by the recommendation and their protected characteristics.

Protected groups under the Equality Act 2010 are age, disability, gender re-assignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, sex and sexual orientation.

The report outlines proposals to bring existing lifestyle services together into one integrated service.

The key changes which are likely to have an impact on those who use the services are potential changes to the time and location of sessions, a shift towards group sessions as opposed to 1-1s and the provision of a digital platform. An Equality Impact Assessment has

been completed to explore the impacts of the proposal in greater detail and will be reviewed and updated as required. The initial assessment of the potential equalities impacts identified that changes could have a disproportionate negative impact on particular protected characteristic groups such as age, disability, race, pregnancy and maternity and gender reassignment. Therefore, in the equalities impact assessment, it has been identified that this disproportionate negative impact will be reduced or removed by ensuring that face to face, 1-1 and phone provision, for those who require it, is maintained. This has been built into the proposal.

Although mitigating actions have been identified, there are some benefits gained from group work and online provision in terms of peer support, socialisation and ease of access which should be accessible to and inclusive of people with protected characteristics. The ways in which group sessions and the digital platform can be made as accessible and inclusive as possible, will require consideration throughout the future development of the proposals. In particular, engagement with service user groups will be key to ensuring that the digital offer is accessible.

The equality impact assessment, consultation results, further engagement with service users and equality monitoring information should continue to be used in the decision making process, in the further development of the proposals and their implementation and in order to identify any unexpected equalities implications which arise and mitigate for these.
The implications arising from this report are based on the preferred option. Should the option change, the equalities implications of the alternative proposal will need to be considered. Ongoing support should be sought from the equalities team as and when required.

The report also suggests that implementing the proposals will require an organisational review of certain services. Where staff are employed by the Council and it is proposed that there will be an organisational review, the Council's organisational review policy should be followed in order to ensure that equalities implications of the review are fully taken into account.

Hannah Watkins Equalities Manager ext. 37 5811

Appendix A- Previous reports/slides

Paper from scrutiny committee June 2017

Health and Wellbeing Scrutiny Commission

Date:

21st June 2017

Title: Lifestyle Services Review: Background

Lead director: Ruth Tennant Director of Public Health

Useful information

- Ward(s) affected: All
- Report author: Jo Atkinson, Public Health Consultant
- Author contact details: Jo.Atkinson@leicester.gov.uk
- Report version number: 1

1. Summary

The city council funds a range of public health services as part of its responsibility to improve health in the city. This includes a number of lifestyle services, including stop smoking, weight management and physical activity programmes. These services account for around 11% of divisional spend or £2 million each year. A rolling programme of review of public health services is underway. This includes a review of lifestyle services which is the focus of this paper.

Leicester has high levels of disease related to lifestyle factors e.g. cardiovascular

disease and respiratory disease. Levels of smoking, physical inactivity and poor diet are also high. There is clear evidence that outlines the health (and other) benefits of stopping smoking, increasing physical activity, eating healthily and losing weight. There is also research evidence behind many interventions aimed at supporting people to stop smoking, lose weight and increase physical activity levels.

A range of lifestyle services are commissioned or provided by public health in the city. Nationally there is a drive towards developing integrated lifestyle services or wellness services. This is recognition of the fact that many people do not have only one risk factor for developing poor health but have multiple risk factors. In addition, integrated services are expected to be more efficient.

A further context for the discussion regarding lifestyle services is the need to make significant savings to this budget by 2019/20. Debate is therefore needed to inform the decision making about where savings are made, the scope of the new integrated service and prevention priorities.

2. Recommendations

To consider the information presented about the current lifestyle services provided in the city and the savings to be made by 2019/20.

To consider the questions posed at the end of the report regarding the future direction of lifestyle services and prevention priorities.

3. Supporting information

3.1 Background

3.1.1 Context

Since 2012 local councils have had a responsibility to take steps to improve and protect public health with a grant given to all upper tier councils to support this. Certain responsibilities are mandated:

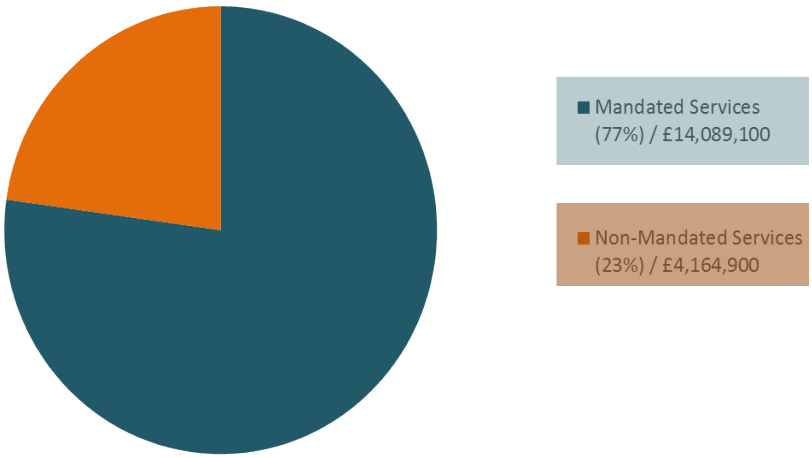
- Open access sexual health services, including contraception
- Elements of the 0-19 Healthy Child Programme, which includes the city's health visiting & school nursing service and the national child weight management programme.
- The NHS Health-checks programme which screens adults for preventable illnesses including heart disease and diabetes.
- Oral health prevention and promotion
- Taking steps to protect the health of the public

Other services are not mandated but councils are expected to demonstrate how they are using the grant to improve health outcomes locally and to report spend against a

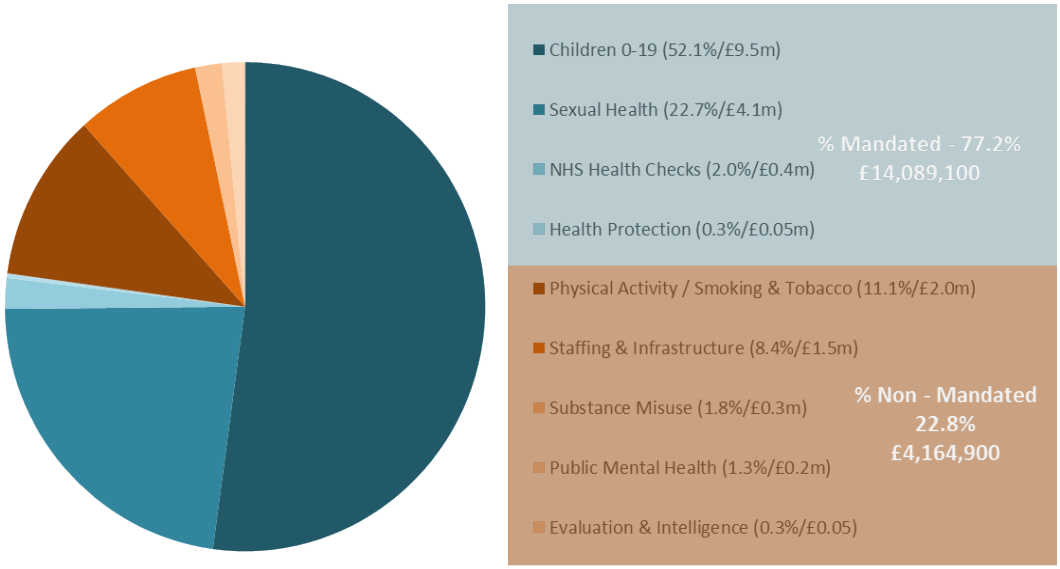
number of key areas including physical activity, obesity, smoking and mental health. Drug and alcohol treatment services are not mandated but councils are expected to consider the number of people using these services and local recovery rates in determining how the grant is used.

In 2016/17, mandated services accounted for 77% of divisional spend, or £15.3 million with non-mandated services costing £4.5 million (see table below). The council also spends a further £5.2 million on drugs and alcohol services (within Adult Social Care) and £3.4 million on sports and leisure service which has recently been brought under the Division of Public Health.

Mandated and non-mandated service spend



Spend by service area



This chart shows how spend is allocated to specific services. Lifestyle services (which includes services to reduce obesity, smoking and increase physical activity) accounts for 11% of divisional spend or just over £2 million each year in 2017/18.

Public Health Spending Reviews

Since May 2015, when in-year cuts to the public health grant were announced, there has been an annual reduction in the grant allocation. To meet this, there has been a rolling programme of spending reviews of public health services to achieve efficiencies (see below) across these services and to make sure that money is spent in a way that reflects the specific health challenges in the city and complies with statutory responsibilities.

Service area	Review
NHS Health-checks	Reviewed in 2017
Children's 0-19 services	Review in 2016: new service goes live July 2017
Drugs and alcohol (ASC)	Reviewed in 2015. New service went live in 2016.
Organisational Review of divisional staffing	Completed in March 2017
Sexual Health services	Review underway: new service to be recommissioned in January 2018.
Lifestyle services	Review underway

The rest of this paper focuses on our current lifestyle services.

3.1.1 Lifestyle services: the case for investment

Life expectancy, in particular, healthy life expectancy is significantly lower in

Leicester than in England. Overall life expectancy for women is 81.8 years but only 57.8 years are spent in good health, compared with 64 years in England. Men live on average 77.3 years with 58.5 years spent in good health, compared with 63.4 years nationally.

Leicester has high levels of disease related to lifestyle factors e.g. cardiovascular disease, respiratory disease and diabetes[i]. Estimates of the number of Leicester residents who have unhealthy lifestyle behaviours suggest that the situation is worse in Leicester compared to the national average for England. 21.5% of adults in Leicester smoke, 20% are obese and over 30% are inactive[ii] [iii].

Tobacco use is the single greatest cause of preventable deaths in England[iv] [v]. Half of regular smokers are killed by tobacco and half of these will die before the age of 70, losing an average 10 years of life[vi]. Obesity is a major public health issue and is associated with a range of health problems including type 2 diabetes, cardiovascular disease and cancer. Diet has a wider impact on health than the link with obesity. Even in the absence of obesity a poor diet is linked with a range of diseases including heart disease, strokes and some cancers. Oral health is also associated with diet. Physical inactivity is known to be the fourth leading cause of global mortality. In the UK, physical inactivity has been attributed to 11% of coronary heart disease cases, 19% of colon cancer cases, 18% of breast cancer cases, 13% of type 2 diabetes cases and 17% of premature all-cause mortality [vii](Lee, 2012).

There are significant health inequalities in relation to smoking, obesity, physical inactivity and diet according to age, gender, ethnicity and socio-economic status [viii] [ix] [x] [xi]. In particular, those living in the most disadvantaged areas have higher levels of smoking and obesity, are more likely to be inactive and have poorer diets [xii].

There is a clear evidence base that outlines the health and wider benefits of stopping smoking, increasing physical activity, eating healthily and losing weight. There is also research evidence behind many interventions aimed at supporting people to stop smoking, lose weight and increase physical activity levels[xiii] [xiv] [xv] [xvi].

Poor health resulting from smoking, obesity and inactivity impacts not only on length of life but also length of healthy life. This translates into costs not only for the NHS but also ultimately for adult social care. Leicester has a younger care home population than in the rest of the country and preventable long-term conditions such as diabetes, COPD and CVD are more common in care home residents.

Lifestyle services are just one part of a complex picture about what needs to be done to improve people's health. National policy (such as the Sugar Tax, plain packaging for cigarettes and fiscal policy such as alcohol duty or taxes on cigarettes) is key. Patterns laid down at home or at school in the early years are also crucial. Making environments healthy – for example, through smoke-free hospitals, promoting healthier schools or encouraging people to use parks and open spaces to get more active is crucial and is an important part of the division's work programme, working with other parts of the council. People are aware of the health risks of smoking, obesity and physical inactivity, and many will make positive changes without external support.

But we also know that healthy behaviours tend to get picked up quicker by people in more affluent areas. For example, smoking rates have dropped faster in higher social groups and have remained much more static in lower socio-economic groups. The effect of this is to widen the health gap between social classes, placing further strains on other services including social care.

To address this, the lifestyle services and programmes that the city currently provides focus on people who need this support most and are, in most cases, heavily targeted on people living in the more deprived parts of the city.

3.1.2 Lifestyle Services: what do we provide?

Our lifestyle services include smoking cessation, weight management, an exercise referral scheme, health trainer services and a healthy lifestyle hub. Although there is communication and some referral between services, integration is fairly limited. The first stage to address this has been the development of the healthy lifestyles hub which started delivering fully in April 2015. Nationally there is a drive towards developing integrated lifestyle services or wellness services. This is recognition of the fact that many people do not have only one risk factor for developing poor health but have multiple risk factors e.g. they smoke, drink excessively, have a poor diet and are inactive.

The review of lifestyle services needs to be considered within the context of a significant savings targets across the council and within the division. This includes a spending review target against these services of around half the current budget.

3.2 Current performance of lifestyle services

Smoking Cessation Services (Stop) (provider- public health, LCC)
(£970k, year)

The service

The service focuses on the following:

- providing an effective smoking cessation service particularly targeting those from disadvantaged communities, pregnant women and other vulnerable groups
- protecting children and young people from the impact of smoking through its smoke free homes work
- providing leadership to the tobacco control agenda in the city

The Stop Smoking Service offers proven behavioural support and medication to help smokers quit smoking. The length of treatment is 12 weeks and clients are encouraged to attend weekly/ fortnightly appointments with a specialist advisor for the duration of their treatment. This service is also offered by16 pharmacies and 6 practice nurses that are trained and supported by the Stop Smoking Service.

A new less intensive service has been piloted in workplaces whereby clients are seen face to face at the assessment and offered nicotine replacement therapy or other support and then followed up at 4 weeks. This is working well particularly

amongst those using e-cigarettes as their chosen aid to quitting.

Tobacco Control

The service carries out work with a wide range of settings and staffing groups to support them to reduce smoking rates. For example, stop smoking advisors support many settings e.g. UHL, LPT and care homes to develop smoking policies and become smokefree. Training is provided to help staff to give brief advice to smokers that they come into contact with and encourage them to stop and to accept referral into smoking cessation services.

A comprehensive smokefree homes programme has been developed in the city, led by the smoking cessation team, with a range of partners involved e.g. children's centres, midwives, health visitors and the neonatal unit. The programme aims to raise awareness about the dangers of second hand smoke and to encourage people to sign up to a 'Step Right Out' pledge to keep their home smokefree for the benefit of family health.

The team carry out extensive marketing and awareness-raising regarding the consequences of smoking and offer support for smokers who wish to quit.

Performance

3718 smokers in Leicester set a quit date with Stop in 2015/16. Numbers using the service have risen from around 4,200 in 2006/07 to a peak of nearly 6,200 in 2011/12 but there has been a decline more recently primarily as a result of the increased use of e-cigarettes. Leicester achieves higher quit rates than many of our comparator authorities with 52% quitting at 4 weeks.

Smoking services have differing approaches to engagement. Leicester's service aims to engage as many smokers as possible even if a proportion of them do not seem highly motivated to quit initially. A high number of people set a quit date per 100,000 population and the number of successful quitters per 100,000 population is the highest amongst our comparator authorities. Some other smoking cessation services will only engage with clients that are very highly motivated to quit and may therefore achieve high quit rates but do not achieve as high number of quitters per 100,000 population. It is estimated that the service engages nearly 7% of Leicester smokers per year to set a quit date, anything over 5% is considered good penetration of the smoking population.

A Health Equity Audit of the smoking cessation service is undertaken regularly, this enables the service to review how effectively they are reaching their target population. The last audit has shown that the service is successfully targeting the most deprived areas of the city with the majority (87%) of clients coming from the most deprived areas of the city. The white population have the highest uptake of the service with 8% of white smokers setting a quit date. The lowest uptake of the service is found in Mixed and Black ethnic groups. The 4 week quit rate amongst BME groups however has increased considerably between 2014/15 and 2015/16 from 49% to 56%.

The smoking service sees over 200 pregnant women per year and achieves a quit rate of nearly 45%, comparable to the national average.

Leicester's service costs approximately £409 per quitter, which is lower than the East Midlands and national average[xvii].

The Stop Service has been accredited by the NCSCT (National Centre for Smoking Cessation and Training) which is a marker of quality. This confirms that interventions offered are based on the current evidence base and that staff are appropriately trained and supervised.

The service is providing leadership to other smoking cessation services on the use of e-cigarettes, including an understanding that e-cigarettes can be used both for harm reduction and abstention. Stop is currently one of three services involved in a research trial of e-cigarettes, with more participation in research planned.

In relation to the Smokefree Homes programme, nearly 9000 people have pledged to make their homes smokefree and nearly 1800 frontline staff have been trained to deliver the message. An independent evaluation was carried out which reported that the Step Right Out campaign was achievable for those signing up and motivated the majority of individuals (over 80%) who previously allowed smoking in their home, to stick to the pledge to keep them smokefree[xviii].

Healthy Lifestyles Hub (provider – Parkwood Healthcare Ltd)
(up to 400k/ year)

The service

The Healthy Lifestyle Hub consists of telephone-based assessment and advice from which clients can then be referred on to the appropriate lifestyle support service. Clients in need of support to address lifestyle risk factors (including smoking, poor diet, physical inactivity, alcohol misuse and obesity) will be referred to the hub by GPs, and other health and social care professionals. Appropriately trained staff assess the needs of each client, provide motivational support, identify key health goals and refer/ signpost clients into relevant lifestyle services. The hub has been running fully for nearly 2 years, but ran as a pilot for over a year prior to this. The hub is partly funded by the local NHS.

Performance

Over 5000 referrals per year are made to the healthy lifestyles hub, the majority of which are made by practice nurses in GP practices. Since the contract started in April 2015 the service has worked hard to engage with GPs and other relevant organisations in order to ensure appropriate referrals. The service has ensured appropriate uptake of the service from clients in the most disadvantaged areas, BME groups and men. The hub refers over 80% of clients to at least one lifestyle service.

Health trainer service – (provider – Parkwood Healthcare Ltd)

The Health Trainer service provides a more intensive support service for clients who need additional help to achieve and support behavioural change. If it is apparent during the initial contact, or at the 6 week follow up, that the client requires additional support, a referral to the Health Trainer service can be made for those clients that meet the eligibility criteria. In order to be eligible people must come from one of the most disadvantaged areas of the city and have multiple and complex risk factors that

require more intensive support to address. Health trainers should come from the local communities, they are “lay workers” often without qualifications but are trained for approximately 6 months in order to carry out the role.

Health Trainers take their clients through a staged process: lifestyle assessment, decision making and goal setting, personal health planning, referral and review. The minimum period of contact agreed with an individual client will be three months and the maximum period should be 12 months. A maximum of 6 ‘contacts’ per client is recommended as the purpose of the health Trainer Service is to encourage independence. The most common reasons for accessing the service are to improve diet, increase physical activity and lose weight.

Performance

The health trainer service has been running in Leicester since 2010 and was formally evaluated in 2013[xix]. The service was meeting its targets and out-performing the national data set. Economic analysis of the service suggested that the service was cost-effective. Over 900 clients set a personal health plan per year. During 2016/17, over 60% of clients achieved/ partially achieved their personal health plan.

The service is accessing the appropriate clients i.e. those from the most disadvantaged areas and BME groups. Targets relating to weight loss, increasing fruit and vegetable consumption and increasing physical activity levels have also been achieved. User satisfaction with the service is good, with 94% of those completing surveys rating the service as very good or good.

Probation Health Trainer Service (provider – Inclusion Healthcare)
(75k/ year)

The service

The Probation Health Trainer service follows a similar model to the community health trainer service described above. However, the health trainers are all ex-offenders who consequently have a clear understanding of the needs of the offenders that they support. Health trainers often start as volunteers in order to gain experience, then get the opportunity to apply for paid positions.

Probation Health Trainers take their clients through the same staged process as community health trainers i.e. lifestyle assessment, decision making and goal setting, personal health planning, referral and review. Clients accessing the service commonly receive support with registering with GPs and dentists, accessing drug, alcohol and mental health services, accessing benefits and housing advice and are provided with advice and support to stop smoking, eat more healthily and become more physically active.

Performance

Initial assessments were carried out for 536 clients in the city in 2015/16. Nearly 400 clients developed a personal health plan with nearly 90% achieving their targets. 56 clients were supported to register with GPs and 69 to register with dentists.

Adult weight management
Targeted and enhanced service (provider - Leicestershire Partnership Trust)
(up to 230k per year)

The targeted weight management service is aimed at those who do not normally engage with commercial weight management services e.g. Weightwatchers/ Slimming World e.g. men, some BME populations, people with mental health conditions and people with learning difficulties. The service operates in a range of settings that are accessible to the targeted client groups.

The enhanced service is dietician-led and supports people with a BMI of 30+ (obese) or (BMI 28+ for South Asians) with significant health issues(e.g. heart disease, diabetes and those that are morbidly obese (BMI 40+).

Both programmes are 12 weeks long and include healthy eating advice and physical activity interventions. It is based on a behaviour change model and includes motivational support and support to maintain weight loss long term.

Performance

In 2015/16, 439 people attended the weight management programmes, with over 80% completing the programmes. 60% achieved a weight loss of at least 3% of their body weight by the end of the 12 week programme, with over 20% achieving a 5% weight loss. The appropriate groups i.e. BME groups and men are being successfully targeted. Rates of weight loss are good compared to national rates and satisfaction levels with the service are high.

Active Lifestyle Scheme (provider – Sports Services, LCC)
(175k/ year)

The service

The exercise referral scheme is for Leicester City residents, with specific health problems, who need a GP referral qualified exercise instructor to undertake an assessment and recommend a personalised exercise plan. Clients are followed up at 6 weeks, 3, 6 and 12 months and offered further assessment and support. The service has been redesigned during 2016 and in collaboration with the CCG the referral criteria have been refined, so those with multiple risk factors for heart disease, stroke and type 2 diabetes are prioritised. Patients with a lower level of risk or who are sedentary and inactive but otherwise in good health are directed to universal provision.

The separate Heart Smart group is the end stage of the cardiac rehabilitation pathway, and is operated as a closed group just for people who have had a cardiac event. The main referral route is from the UHL cardiac rehabilitation pathway.

Performance

The service receives approximately 4000 referrals per year, plus 200 referrals per year for Heart Smart. Retention rates on the programme have increased dramatically with 70% of those referred attending their first appointment. 82% of these attended the subsequent appointment. Increasing numbers of clients are also attending group-

based sessions such as walking football, group circuit sessions and other classes for Active Lifestyle Scheme clients.

Food for Life Programme in schools - (provider – Soil Association)
(75k in 2017/18)

The service

Food for Life Programme has been running in schools since April 2015. All schools in the city will be offered the opportunity to take part in the programme over the 3 year contract period. This offers face to face support to schools to adopt a whole school approach and create a positive food culture. Training courses are provided to give teachers the confidence and capacity to offer practical cooking, food growing and develop farm links. Training supports the curriculum and helps promote knowledge of healthy eating amongst pupils, parents and the wider community. Other courses are designed to support school cooks and lunchtime supervisors and develop the pupil voice.

Schools work towards Food for Life awards which are an independent endorsement for schools that serve nutritious, fresh, sustainably sourced food and support pupils to eat well and enhance their learning with cooking, food growing and farm links.

Performance

There are nearly 70 schools enrolled onto the Food for Life programme currently, 6 have already achieved the bronze award. Food for Life has supported the City Catering service to achieve the Bronze Catering Mark Award for school meals and are working towards the Silver award. City Catering supply bronze standard meals to 79 schools in Leicester City.

Food for Life in the City work in partnership with the Leicestershire Nutrition and Dietetics Service. They work with schools and parents to improve lunch boxes. They have also run cook and eat programmes in schools targeted at those most in need and involve both pupils and parents. In the previous academic year, 151 teachers and support staff received training from Food for Life.

Food for life have a clear evidence base regarding their impact e.g. they can demonstrate:
- an average increase in uptake of school meals of 13% after 2 years
- pupils in food for life schools are twice as likely to eat 5 or more portions of fruit or vegetables per day
- there is a £3 social return on investment for every £1 invested
- FFL catering mark Gold menus have up to 47% lower climate impact than standard school menus
- research evidence points towards FFL's potential to contribute helping close the gap for disadvantaged children in terms of their health and academic attainment[xx] (NFER, 2011)

Evaluation is currently being carried out to ensure that these outcomes have also been demonstrated locally.

School-based physical activity programme - (provider - School Sport and

Physical Activity Network)
(67k/ year)

The service

The aim of the commissioned service is to target inactive children in primary schools and encourage them to become more active. The team deliver a range of physical activity sessions and training for school staff. Delivery includes: physical literacy sessions in primary schools, physical activity sessions within Change4Life clubs, balanceability (balance bike training), extension of the WISPA project to target year 5 and 6 girls and whole school training on Klmbles (a music and movement programme) and physical literacy and training on playground supervision for lunchtime supervisors and young leaders.

In addition the service works with schools and offers advice and support regarding how best to increase physical activity levels, meeting Ofsted requirements and best use of the school sport premium.

Performance

There is a clear set of performance targets and the service is delivering on all of these.

Satisfaction amongst those attending training is high, both school staff and pupils attending young leaders training.

Contribution to Leicestershire and Rutland County Sports Partnership (LRS)
(45k/ year)

The service

The council has a partnership agreement with the County Sports Partnership which outlines the support and priorities which are key to ensuring that the Sport and Physical Activity offer across the city is cohesive and robust and that the work that LRS do is in keeping with the identified priorities as determined by City colleagues.

County Sports Partnerships (CSPs) work across the sporting landscape, actively supporting partners to increase participation in sport and physical activity. LRS brings additional strategic support and expertise to Leicester. LRS have led and supported the development of successful bids bringing additional resource, introductions to other partners and their projects such as Street Games and The Dame Kelly Homes Trust. LRS have built on the early years physical activity research previously undertaken in Leicester, and supported the production of resources and training for purposeful physical play in early years settings.

Performance

A detailed action plan is reported against to the LeicesterShire and Rutland Sport board quarterly. Leicester City Council is represented on the board by the Sports Development manager.

Nationally LRS is considered to be a high performing CSP and many of its initiatives, products and services are now being rolled out nationally.

The effectiveness of CSP can be considered in relation to some of the projects it has led on and/or delivered. One local example is Get Healthy, Get into Sport, a Sport England funded project aimed at getting inactive people more active. The local project in New Parks and Greenhill (in Coalville, Leicestershire) has achieved targets, within budget.

LRS bring additional resource through externally funded programmes, partnership projects and contribution in kind. LRS calculate that for every pound invested in LRS by Leicester City Council there has been a minimum of £17 partner funding.

Support to Food Growing Projects - (providers - Saffron Acres and British Trust of Conservation Volunteers (BTCV))
(20k/ year)

The Service

A food growing support programme has run for the past 2 years and has been extended for a further year. The two voluntary sector organisations commissioned support small scale growing projects in schools, early years' settings and in the wider community. The aim is to develop knowledge, skills and resilience in new and existing groups.

Additionally for the past 2 years £1000 grant per ward has been available to small groups to bid for to enable them to start growing. Further grants will be available in 2017/18. Additional grants have also been awarded to schools, early years' settings and other community growing projects to fund equipment and other growing resources.

Performance

Over 90 packages of support have been provided. The Get Growing Grant scheme has funded over 30 community groups and an evaluation process is being developed to identify value and benefit of this programme.

Food growing courses and bespoke training has been offered and delivered to community groups. Over a quarter of food growing projects funded by the Get Growing grant programme are now part of the It's Your Neighbourhood award scheme.

3.3 Next Steps

Workshops, one of which is focussed on prevention and lifestyle services, are being conducted during June/ July to engage with key stakeholders in discussions about the future shape of our lifestyle services before proposed options are taken to the Executive in the Autumn.

Scrutiny members are requested to consider the following questions which will also be discussed at the workshops this summer:

- What is the role of the public sector in prevention? To what extent should the state intervene?

- In the context of a reducing budget for prevention, what are the priorities? Should the public sector pay for people to be supported to e.g. stop smoking or lose weight or should individuals have to pay?
- Should we prioritise early years investment over support for adults?
- Should individual support only be available to certain disadvantaged or high risk groups? If so, which groups should we focus on?
- Should we continue to develop more integrated lifestyle services so that people can access advice and support in one place?

4. Details of Scrutiny

21st June meeting

5. Financial, legal and other implications

5.1 Financial implications

None yet – to be considered when preparing options for the future of lifestyle services

5.2 Legal implications

None yet – to be considered when preparing options for the future of lifestyle services

5.3 Climate Change and Carbon Reduction implications

None yet – to be considered when preparing options for the future of lifestyle services

5.4 Equality Impact Assessment

N/A

5.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

N/A

6. Background information and other papers:

None

7. Summary of appendices:

None

8. Is this a private report (If so, please indicated the reasons and state why it is not in the public interest to be dealt with publicly)?

No

9. Is this a "key decision"?

No

Slides from informal scrutiny committee briefing March 2018

The need for redesigned lifestyles services are driven by savings targets and the desire to offer Leicester residents a more integrated service.

Spending on lifestyle services (obesity, smoking, diet and physical activity) was £2.2 million in 2016/17 and the proposals here see that reduce to £760,000 by 2019/20

It is recognised that residents want to 'tell their story' once, services will be integrated and designed to be more effective for people who have multiple lifestyle issues.

New services will be better targeted according to need, will be community based but shift to a 'digital by default' model with a reduction in 1:1 programmes.

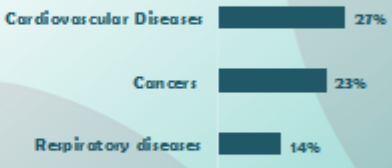
Significantly lower life and healthy life expectancy in Leicester shows a continued need for lifestyle services in the city.

Smoking & Alcohol

Sedentary lives

Unhealthy food

Main causes of death account for 2 out of every 3 deaths in Leicester



These poor lifestyle choices are linked to cardiovascular disease, cancers, respiratory diseases and other ill health.

Life expectancy differs across the city and is linked to inequality and deprivation.

What people die of has remained similar in Leicester for a number of years.

These conditions are responsible for the majority of deaths in under 75 year olds

The proposed new model will integrate services to promote and support healthy behaviours. The following 5 themes summarise the new service.

Targeted approach	Increased digital capacity	Group based activity	Community based	Supporting volunteers
To those in greatest need and least capacity to self help	Embracing the 'digital by default' approach to benefit most residents	A shift from intensive 1-1 support to more group/ peer based activities	More use of community centres, outdoor gyms and park/ local walks	Emphasis on developing community activators to support elements of the service.

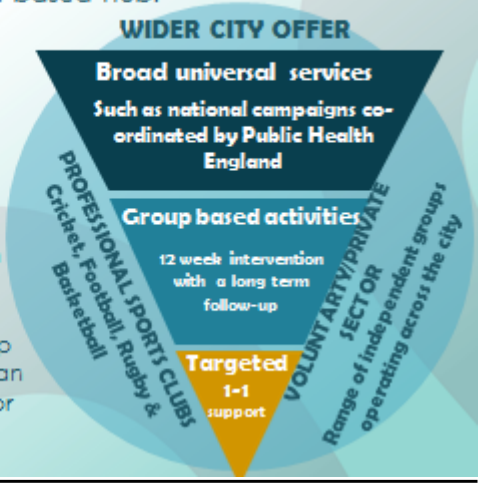
A single point of access to healthy lifestyle services will operate via a online/phone based hub.

Referrals to the hub will be accepted from partners such as GPs.

Self-referrals will also be accepted.

The hub team aim to understand the individuals needs and direct them to an appropriate service.

Group based and 1-1 support will last up to 12 weeks and following this clients can continue on a subsidised paid service or other free community scheme.



This approach is based on the best evidence following engagement with Public Health England and other local authority colleagues.

Local Authority integrated lifestyle services are found in areas such as Southampton, Derby and Coventry.

https://www.nhs.uk/oneyou/#S2uMlxTe88cX0E6v.97

Example journeys showing possible routes to integrated lifestyle services.

Following an NHS health check a client is referred to the hub.

Triage by the hub identifies that he resides in a deprived area and is currently unemployed. He would like to stop smoking and be more active

Client attends group based activities to help increase physical activity and receives phone based smoking cessation support.

Clients journey is monitored by the hub who help make a long term plan for maintaining healthy behaviours

Client is referred to the Couch to 5k scheme for further support and will receive a long term follow up at 6 and 12 months.

Example journeys showing possible routes to integrated lifestyle services.

A mother with three children would like to be more physically active.

During a visit to a leisure centre a member of staff informs the client of support offered via the hub.

Client is referred to a programme where there are child minding facilities during the exercise class.

Follow up from the hub discusses the session and signposts to other family friendly activity sessions.

At 12 months client is followed up to ensure programme is still meeting the families needs.

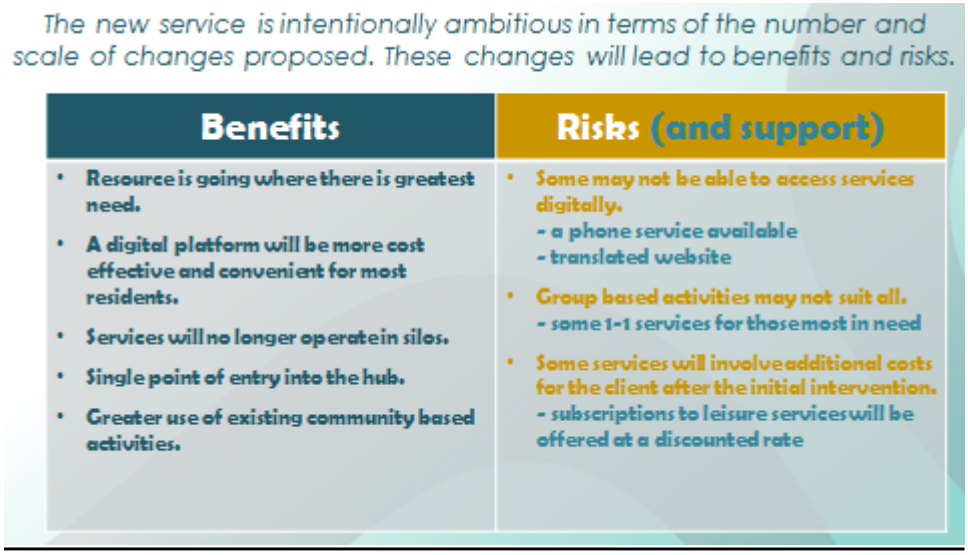
Example journeys below show possible routes to integrated lifestyle services.

A woman who wants to get more active and has been feeling isolated and lonely contacts the service.

Hub triage identifies that client is employed and lives alone in an area of low deprivation. She is keen to access physical activity and meet new people.

Client is directed to local community walks and supported to attend volunteer training.

Long term follow up shows that client has trained as a 'community activator' and is leading walking groups in her local area.



Appendix B- Current services and feedback

Smoking Cessation Services (Stop) (provider- public health, LCC)
The service

The service focuses on the following:

- providing an effective smoking cessation service particularly targeting those from disadvantaged communities, pregnant women and other vulnerable groups
- protecting children and young people from the impact of smoking through its smoke free homes work
- providing leadership to the tobacco control agenda in the city

The Stop Smoking Service offers proven behavioural support and medication to help smokers quit smoking. The length of treatment is 12 weeks and clients are encouraged to attend weekly/ fortnightly appointments with a specialist advisor for the duration of their treatment. This service is also offered by16 pharmacies and 6 practice nurses that are trained and supported by the Stop Smoking Service.

A new less intensive service has been piloted in workplaces whereby clients are seen face to face at the assessment and offered nicotine replacement therapy or other support and then followed up at 4 weeks. This is working well particularly amongst those using e-cigarettes as their chosen aid to quitting.

Tobacco Control

The service carries out work with a wide range of settings and staffing groups to support them to reduce smoking rates. For example, stop smoking advisors support many settings e.g. UHL, LPT and care homes to develop smoking policies and become smokefree. Training is provided to help staff to give brief advice to smokers that they come into contact with and encourage them to stop and to accept referral into smoking cessation services.

The team carry out extensive marketing and awareness-raising regarding the consequences of smoking and offer support for smokers who wish to quit.

Performance

2753 smokers in Leicester set a quit date with Stop in 2017/18. Numbers using the service have risen from around 4,200 in 2006/07 to a peak of nearly 6,200 in 2011/12 but there has been a decline more recently primarily as a result of the increased use of e-cigarettes. Leicester achieves higher quit rates than many of our comparator authorities with 54% quitting at 4 weeks.

Smoking services have differing approaches to engagement. Leicester's service aims to engage as many smokers as possible even if a proportion of them do not seem highly motivated to quit initially. A high number of people set a quit date per 100,000 population and the number of successful quitters per 100,000 population is the highest amongst our comparator authorities. Some other smoking cessation services will only engage with clients that are very highly motivated to quit and may therefore achieve high quit rates but do not achieve as high number of quitters per 100,000 population.

A Health Equity Audit of the smoking cessation service is undertaken regularly, this enables the service to review how effectively they are reaching their target population. The last audit has shown that the service is successfully targeting the most deprived areas of the city with the majority (87%) of clients coming from the most deprived areas of the city. The white population have the highest uptake of the service with 8% of white smokers setting a quit date. The lowest uptake of the service is found in Mixed and Black ethnic groups. The 4 week quit rate amongst BME groups however has increased considerably between 2014/15 and 2015/16 from 49% to 56%.

The smoking service sees almost 200 pregnant women per year and achieves a quit rate of nearly 45%, comparable to the national average.

The Stop Service has been accredited by the NCSCT (National Centre for Smoking Cessation and Training) which is a marker of quality. This confirms that interventions offered are based on the current evidence base and that staff are appropriately trained and supervised.

The service is providing leadership to other smoking cessation services on the use of e-cigarettes, including an understanding that e-cigarettes can be used both for harm reduction and abstention. Stop is currently one of three services involved in a research trial of e-cigarettes, with more participation in research planned.

In relation to the Smokefree Homes programme, nearly 9000 people have pledged to make their homes smokefree and nearly 1800 frontline staff have been trained to deliver the message. An independent evaluation was carried out which reported that the Step Right Out

campaign was achievable for those signing up and motivated the majority of individuals (over 80%) who previously allowed smoking in their home, to stick to the pledge to keep them smokefree[xxi].

Healthy Lifestyles Hub (provider – Parkwood Healthcare Ltd)
The service

The Healthy Lifestyle Hub consists of telephone-based assessment and advice from which clients can then be referred on to the appropriate lifestyle support service. Clients in need of support to address lifestyle risk factors (including smoking, poor diet, physical inactivity, alcohol misuse and obesity) will be referred to the hub by GPs, and other health and social care professionals. Appropriately trained staff assess the needs of each client, provide motivational support, identify key health goals and refer/ signpost clients into relevant lifestyle services. The hub is partly funded by the local NHS (100k through the Better Care Fund).

Performance

Over 5000 referrals per year are made to the healthy lifestyles hub, the majority of which are made by practice nurses in GP practices. Since the contract started in April 2015 the service has worked hard to engage with GPs and other relevant organisations in order to ensure appropriate referrals. The service has ensured appropriate uptake of the service from clients in the most disadvantaged areas, BME groups and men. The hub refers over 85% of clients to at least one lifestyle service.

Health trainer service – (provider – Parkwood Healthcare Ltd)

The Health Trainer service provides a more intensive support service for clients who need additional help to achieve and support behavioural change. If it is apparent during the initial contact, or at the 6 week follow up, that the client requires additional support, a referral to the Health Trainer service can be made for those clients that meet the eligibility criteria. In order to be eligible people must come from one of the most disadvantaged areas of the city and have multiple and complex risk factors that require more intensive support to address. Health trainers should come from the local communities, they are “lay workers” often without qualifications but are trained for approximately 6 months in order to carry out the role.

Health Trainers take their clients through a staged process: lifestyle assessment, decision making and goal setting, personal health planning, referral and review. The minimum period of contact agreed with an individual client will be three months and the maximum period should be 12 months. A maximum of 6 ‘contacts’ per client is recommended as the purpose of the health Trainer Service is to encourage independence. The most common reasons for accessing the service are to improve diet, increase physical activity and lose weight.

Performance

The health trainer service has been running in Leicester since 2010 and was formally evaluated in 2013[xxii]. The service was meeting its targets and out-performing the national data set. Economic analysis of the service suggested that the service was cost-effective. Over 900 clients set a personal health plan per year. During 2017/18, over 65% of clients achieved/ partially achieved their personal health plan.

The service is accessing the appropriate clients i.e. those from the most disadvantaged areas and BME groups. Targets relating to weight loss, increasing fruit and vegetable consumption and increasing physical activity levels have also been achieved.

Adult weight management

Targeted and enhanced service (provider - Leicestershire Partnership Trust)

The targeted weight management service is aimed at those who do not normally engage with commercial weight management services e.g. Weightwatchers/ Slimming World e.g. men, some BME populations, people with mental health conditions and people with learning difficulties. The service operates in a range of settings that are accessible to the targeted client groups.

The enhanced service is dietician-led and supports people with a BMI of 30+ (obese) or (BMI 28+ for South Asians) with significant health issues(e.g. heart disease, diabetes and those that are morbidly obese (BMI 40+).

Both programmes are 12 weeks long and include healthy eating advice and physical activity interventions. It is based on a behaviour change model and includes motivational support and support to maintain weight loss long term.

Performance

Over 150 participants have taken part in the targeted weight management programme in 2017/18, with 69% completing at least 60% of the sessions and 75 adults maintaining 3% weight loss after 12 months.

Nearly 250 participants took part in the enhanced weight management programme in 2017/18, with 74% completing at least 60% of the sessions and 100 adults maintaining 3% weight loss after 12 months.

The appropriate groups i.e. BME groups and men are being successfully targeted. Rates of weight loss are good compared to national rates and satisfaction levels with the service are high.

Active Lifestyle Scheme (provider – Sports Services, LCC)
The service

The exercise referral scheme is for Leicester City residents, with specific health problems, who need a GP referral qualified exercise instructor to undertake an assessment and recommend a personalised exercise plan. Clients are followed up at 6 weeks, 3, 6 and 12 months and offered further assessment and support. The service has been redesigned during 2016 and in collaboration with the CCG the referral criteria have been refined, so those with multiple risk factors for heart disease, stroke and type 2 diabetes are prioritised. Patients with a lower level of risk or who are sedentary and inactive but otherwise in good health are directed to universal provision.

The separate Heart Smart group is the end stage of the cardiac rehabilitation pathway, and is operated as a closed group just for people who have had a cardiac event. The main referral route is from the UHL cardiac rehabilitation pathway.

Performance

The service receives approximately 4500 referrals per year, plus 200 referrals per year for Heart Smart. Retention rates on the programme increased dramatically in 2017 with 56% of those referred attending their first appointment. 74% of these attended the subsequent appointment. Increasing numbers of clients attended group-based sessions such as walking football, group circuit sessions and other classes for Active Lifestyle Scheme clients.

Appendix C Consultation feedback

171 people completed the consultation (online and paper) over the 8 week period. It should be noted that whilst 171 people responded to the consultation many questions were answered by low numbers of people. The breakdown of response rate by question is available in the summary report attached as appendix A. Over 50% of responses came from staff or people in a professional capacity. Below is a brief summary of the responses received;

We are looking to have one team providing the whole range of lifestyle services rather than having separate services. What are your views on this? (72 people answered this question)

- Overall there was support for this proposal with responders noting that this was a good idea and would make services more user friendly
- Comments showed that people appreciated that unhealthy behaviours often clustered and having an integrated service would help in these cases although it was also mentioned that tackling multiple behaviours can be problematic
- There were concerns about creating a generic staff member to tackle all unhealthy behaviours and the risks of losing subject expertise with people stressing the need for specialist staff to be retained
- A single booking system was seen as a positive step
- There were concerns about a new service losing a degree of personalisation that currently exists in separate services
- It was also noted that a new service should offer greater flexibility in terms of appointment times/days/venues

Greater use of online booking/support, apps, phone/text support in relation to stop smoking services and diet/physical activity and weight management services

- There was some support for all of the above in the 3 services listed although there were very limited responses to these questions (84% did not answer)

Healthy Lifestyle Apps used previously

- Only a small number of responders indicated that they had used a website/app to improve their health with couch to 5k being the most commonly cited (53% did not answer)

Group based support for stop smoking services and diet/physical activity and weight management services

- 70% of responders did not answer this question. 86 individuals did with 11 saying they would attend stop smoking support in a group, 35 would attend group based weight management and 40 would attend diet/physical activity sessions offered in a group.
- The key things people mentioned about group sessions was that access should be good and a range of times should be offered
- Comments were generally positive about the benefits of group sessions although some people were clear that they would not attend these sessions
- Cost, time and location were mentioned but friendly staff was the most common response in terms of what would be important about these services

Features that would make services more appealing

- Good accessibility
- Face to face sessions
- Evening and weekend sessions
- Friendly staff
- No/low cost

Greater use of online services

- There was some support for this with some concerns expressed about the risks of some people being excluded (>70% did not answer this question)

Which of these might you attend to increase your physical activity / lose weight?

- There was support for a wide range of activities including home based, running and outdoor gyms, yoga/pilates with the most popular being walking (35), swimming (40) and exercise classes (40)

Where would you most like to access physical activity sessions?

- A wide range of settings was given with leisure centres (61), community centres (41), parks and outdoor spaces (38) being most popular

Where would you most like to access stop smoking sessions?

- Very limited responses (23%) but some support for health centres and community centres

Walking is a free and simple way for many people to improve their health and wellbeing. Do you have any thoughts on how we could encourage people to walk more?

- There was strong support for this with a range of positive comments
- Group walks and guided walks were especially popular
- Walks to work, lunchtime walks and walks with pets were also mentioned
- Having a range of times and venues for walks was important
- Having details on walks and routes available via apps/website was also mentioned

Would you be interested in attending healthy lifestyles sessions where you could bring a friend or family member?

- There was some support (49) for this option with people suggesting that extra support can be helpful

Greater use of local volunteers to help others improve their health

- Respondents were generally supportive of this and it was seen as a good idea
- It was a clear message however that volunteers should be well trained and supported
- There was also a view that this should support and not replace the role of the health professional

Other comments

- Limited additional comments but some consistency existed such as the need to ensure sessions are run in the evenings and the role of cycling be embraced as part of encouraging healthy lifestyles
- Greater use of community assets was also mentioned
- There was a number of comments relating to the role of wider determinants such as takeaways, advertising and sustainable travel

Do you think we should provide advice and guidance on where people can get help with things such as housing, debt management, etc? - wider advice support

- 57% of people did not answer this question. Of those that did there was generally support with some concerns raised. Comments suggested this should mainly be about signposting. 2 people said no.

Focus group feedback

5 focus groups were held over a 3 week period. In total approximately 70 people were involved in these groups which comprised current and former service users along with general members of the public. Specific sessions were held for members of the South Asian population and for adults with learning difficulties. The sessions were led by 2 members of the public health team who used a broad question template to act as a guide and both independently recorded responses which were triangulated shortly after the sessions. Focus groups were not recorded in an effort to encourage participants to speak candidly and as such the notes taken were reflected back to the group during and afterwards to ensure what had been captured was a fair and accurate record of the discussion.

Whilst the discussions in the various groups were understandably different there was a considerable degree of consistency in responses. As such the key themes which emerged are shown below and where this was not consistent across the groups this is also shown.

- Overall proposal to shift to an integrated team
    - Generally a positive response to a shift towards greater integration
    - Consistent concerns about the risk of diluting professional expertise if a generic health advisor was the end goal
    - Supportive of a single team being responsible for appointment booking and having a named contact who had oversight of their journey
    - It was suggested in all of the focus groups that whilst a Leicester wide service was relevant there should be a more local offer to reflect the different needs/assets of various communities/wards

- What matters most to you about lifestyle services
    - The things that came out of all groups was the importance of the staff involved; they must be knowledgeable, empathetic and above all friendly
    - Access was also cited as a major factor with all groups suggesting that having services available in a range of settings at various times was important

- Weight Management
    - A strong feeling that group sessions were the preferred method of delivery. A recognition that some people may prefer 1:1 sessions but overwhelmingly it was felt that the benefits of a group were significant when addressing this issue.
    - The expertise of qualified staff was felt to be very important. Service users cited commercial services they had used where the advice and resources provided was at a lower level

    - The application of information in practical advice was felt to be vital e.g. advice on reading food labels
    - It was acknowledged that a service which had a specific focus on the South Asian diet and was tailored towards this audience had several benefits comparted to a generic offer
    - Service users felt that the most beneficial change the council could make to the service would be to offer it for longer
    - The groups explained that they agreed there was a place for greater support to be offered at distance either via phone or a digital channel but that this could not replace the face to face element for them

- Digital Services
    - There was a recognition in all groups that the internet was somewhere most people initially looked for advice/info on healthy lifestyles but that there were challenges in knowing which information was safe and trustworthy
    - In light of the above the was support for a single website for lifestyle service which would provide reliable information
    - Significant concern in all groups but especially when talking to adults with learning difficulties about a shift from face to face services to online. All groups were worried that as a means of saving money the council would be gradually putting all existing services online
    - Concerns also around access and the IT literacy in all groups but again especially when talking top adults with learning difficulties
    - All groups said that any website needed to be as appealing, functional and accessible as more commercial sites
    - There was a clear message that any digital platform should be available in a range of languages and feature lots of images with information kept clear and concise
    - Text reminders were felt to be a useful service
    - Online services have a role in long term maintenance of behaviour change through the use of online groups/forums
    - The ‘maps’ function was seen as useful with the ability to search by postcode and get easy access directions mentioned as a positive
    - Some attendees mentioned that they would be most likely to access a website on a smartphone rather than PC and so anything offered on line needed to operate well via this medium
    - The ‘chat’ function received both positive and negative feedback
    - Online groups were felt to have a place especially when exiting face to face services as part of a tapered reduction in support

- The role of volunteering in lifestyle services
    - A positive response to increased use of community centres, groups and greater role for local health champions
    - There was however much concern over the role volunteers would play with all groups. It was a very clear message that people felt there was a role for volunteers but this should be in support not replacement of a qualified health professional
    - Ensuring sufficient training and support was in place for volunteers was highlighted as crucial
    - Volunteers and peer mentors were seen as having particular use at entry and exit point of services
    - Issues around reliability and accountability were also flagged when using volunteers to ‘deliver’ sessions
    - It was recognised that volunteers may be more appropriate in some aspects of an integrated service than others e.g. walking groups

Appendix D Final consultation summary

Question : Are you responding to this survey as...
status
a member of the public
a current (or past) user of services
a member of staff / in a
professional capacity
Not Answered
0 89
Option Total Percent
a member of the public 46 26.90%
a current (or past) user of services 36 21.05%
a member of staff / in a professional capacity 89 52.05%
Not Answered 0 0%
Question : What is your postcode? (home or work, as appropriate)
Postcode
There were **164** responses to this part of the question.
Page 3
Question : Is English your first language?
English
Yes
No
Not Answered
0 159
Option Total Percent
Yes 159 92.98%
No 8 4.68%
Not Answered 4 2.34%
translate
Yes
No
Not Answered
0 163
Option Total Percent
Yes 2 1.17%
No 6 3.51%
Not Answered 163 95.32%
Question : Do you smoke cigarettes?
smoke
Yes
No
Not Answered
0 148
Page 4
Option Total Percent
Yes 19 11.11%
No 148 86.55%
Not Answered 4 2.34%

Question : Have you used any of these services in Leicester in the last three years? (please tick all that apply)
services accessed
Smoking cessation (Stop smoking)
Exercise referral (Active lifestyle scheme in a city leisure centre)
Healthy lifestyles hub
Health trainers (Get Healthy)
Weight management - free of charge, i.e: weightwatchers on referral, DHAL (Diet, Health and Activity in Leicester) or LEAP (Lifestyle, Eating and Activity Programme)
Not Answered
0 128
Option Total Percent
Smoking cessation (Stop smoking) 19 11.11%
Exercise referral (Active lifestyle scheme in a city leisure centre) 14 8.19%
Healthy lifestyles hub 7 4.09%
Health trainers (Get Healthy) 6 3.51%
Weight management - free of charge, i.e: weightwatchers on referral, DHAL (Diet, Health and Activity in Leicester) or LEAP (Lifestyle, Eating and Activity Programme) 17 9.94%
Not Answered 128 74.85%
Question : We are looking to have one team providing the whole range of lifestyle services, rather than having separate services.
lifestyl hub comments
There were **72** responses to this part of the question.
Question : Which of these might you use if they were available?
service options - Stop smoking support
online booking
online support
apps (phone or computer)
phone / txt support
Not Answered
0 143
Page 5
Option Total Percent
online booking 12 7.02%
online support 8 4.68%
apps (phone or computer) 10 5.85%
phone / txt support 16 9.36%
Not Answered 143 83.63%
service options - Diet / physical activity sessions
online booking
online support
apps (phone or computer)
phone / txt support
Not Answered
0 120
Option Total Percent
online booking 33 19.30%
online support 20 11.70%

apps (phone or computer) 24 14.04%
phone / txt support 20 11.70%
Not Answered 120 70.18%
service options - Weight management advice / support
online booking
online support
apps (phone or computer)
phone / txt support
Not Answered
0 123
Page 6
Option Total Percent
online booking 26 15.20%
online support 19 11.11%
apps (phone or computer) 23 13.45%
phone / txt support 21 12.28%
Not Answered 123 71.93%
Question : Have you used websites or apps in the past to improve your health?
previous web / app use
Yes
No
Not Answered
0 90
Option Total Percent
Yes 16 9.36%
No 65 38.01%
Not Answered 90 52.63%
previoisu web / app details
There were **14** responses to this part of the question.
Question : Would you use group based support for the following, if it were available? (please tick all that apply)
group support choices
Stop smoking support
Diet / Physical activity sessions
Weight management advice /
support
Not Answered
0 120
Option Total Percent
Stop smoking support 11 6.43%
Diet / Physical activity sessions 40 23.39%
Weight management advice / support 35 20.47%
Not Answered 120 70.18%
group session comments
There were **61** responses to this part of the question.
Question : Which features would make the services more welcoming for you?
service preferences
There were **69** responses to this part of the question.
Question : Would it be difficult for you to access lifestyle services support online?
no online access
There were **66** responses to this part of the question.
Page 7
Question : Which of these might you attend to increase your physical activity / lose weight? (please tick all that
apply)

sessions might attend
Beginners running group
Exercise classes (e.g. aerobics /
Zumba / spinning / circuits)
Lower intensity exercise classes
(e.g. body conditioning / aqua
aerobics / chair-based exercise)
Family exercise sessions
Gym based exercise
Outdoor gyms
Sports based activities
Swimming
Walking groups
Yoga / Pilates
Not Answered
0 96
Page 8
Option Total Percent
Beginners running group 19 11.11%
Exercise classes (e.g. aerobics / Zumba / spinning / circuits) 40 23.39%
Lower intensity exercise classes (e.g. body conditioning / aqua aerobics / chair-based exercise) 31 18.13%
Family exercise sessions 18 10.53%
Gym based exercise 29 16.96%
Outdoor gyms 14 8.19%
Sports based activities 16 9.36%
Swimming 40 23.39%
Walking groups 34 19.88%
Yoga / Pilates 39 22.81%
Not Answered 96 56.14%
Question : Where would you most like to access physical activity sessions? (please tick all that apply)
physical activity access points
At home (for example, DVD,
YouTube)
Community centres
Leisure centres
Parks and open spaces
Outdoor gyms
None
Other
Not Answered
0 94
Option Total Percent
At home (for example, DVD, YouTube) 23 13.45%
Community centres 41 23.98%
Leisure centres 60 35.09%
Parks and open spaces 37 21.64%
Outdoor gyms 16 9.36%
None 2 1.17%
Other 2 1.17%
Not Answered 94 54.97%
Other location
There were **5** responses to this part of the question.
Page 9

Question : Where would you prefer to receive advice and support on stopping smoking (if applicable)
smoking advice preference
Community centre
Health centre / GP practice
Online support
Pharmacies
Phone-based support
Other
Not Answered
0 131
Option Total Percent
Community centre 17 9.94%
Health centre / GP practice 29 16.96%
Online support 7 4.09%
Pharmacies 14 8.19%
Phone-based support 7 4.09%
Other 3 1.75%
Not Answered 131 76.61%
Other smoking support
There were **8** responses to this part of the question.
Question : Walking is a free and simple way for many people to improve their health and wellbeing. Do you have any thoughts on how we could encourage people to walk more?
encourage walking suggestions
There were **52** responses to this part of the question.
Question : Would you be interested in attending healthy lifestyle sessions where you could bring a friend or family member?
family / friends attend also
Yes
No
Not Answered
0 94
Option Total Percent
Yes 50 29.24%
No 27 15.79%
Not Answered 94 54.97%
family / friends attend comments
There were **18** responses to this part of the question.
Page 10
Question : We would like to train local volunteers to help others in the community improve their health. What are your views on...
community walks comment
There were **48** responses to this part of the question.
physical activity session comment
There were **46** responses to this part of the question.
community volunteers - further comments
There were **23** responses to this part of the question.
Question : Do you have any other thoughts on how healthy lifestyle services could be improved in Leicester that we haven't asked about already?
Further comments
There were **33** responses to this part of the question.

Question : Do you think we should provide advice and guidance on where people can get help with things such as
housing, debt management, etc?
wider advice support
Yes
No
Only in certain circumstances
Not Answered
0 98
Option Total Percent
Yes 40 23.39%
No 14 8.19%
Only in certain circumstances 19 11.11%
Not Answered 98 57.31%
wider advice comments
There were **29** responses to this part of the question.
Question : Please provide your details if you would like to join the focus group.
Name
There were **15** responses to this part of the question.
Contact number
There were **15** responses to this part of the question.
Page 11
Question : Ethnic background:
Ethnicity
Asian or Asian British:
Bangladeshi
Asian or Asian British: Indian
Asian or Asian British: Pakistani
Asian or Asian British: Any other
Asian background
Black or Black British: African
Black or Black British: Caribbean
Black or Black British: Somali
Black or Black British: Any other
Black background
Chinese
Chinese: Any other Chinese
background
Dual/Multiple Heritage: White &
Asian
Dual/Multiple Heritage: White &
Black African
Dual/Multiple Heritage: White &
Black Caribbean
Dual/Multiple Heritage: Any other
heritage background
White: British
White: European
White: Irish
White: Any other White
background
Other ethnic group:
Gypsy/Romany/Irish Traveller
Other ethnic group: Any other
ethnic group

Prefer not to say
Not Answered
0 90
Page 12
Option Total Percent
Asian or Asian British: Bangladeshi 1 0.58%
Asian or Asian British: Indian 21 12.28%
Asian or Asian British: Pakistani 2 1.17%
Asian or Asian British: Any other Asian background 1 0.58%
Black or Black British: African 0 0%
Black or Black British: Caribbean 1 0.58%
Black or Black British: Somali 0 0%
Black or Black British: Any other Black background 0 0%
Chinese 0 0%
Chinese: Any other Chinese background 0 0%
Dual/Multiple Heritage: White & Asian 0 0%
Dual/Multiple Heritage: White & Black African 0 0%
Dual/Multiple Heritage: White & Black Caribbean 0 0%
Dual/Multiple Heritage: Any other heritage background 1 0.58%
White: British 44 25.73%
White: European 3 1.75%
White: Irish 1 0.58%
White: Any other White background 2 1.17%
Other ethnic group: Gypsy/Romany/Irish Traveller 0 0%
Other ethnic group: Any other ethnic group 0 0%
Prefer not to say 4 2.34%
Not Answered 90 52.63%
If you said your ethnic group was one of the 'Other' categories, please tell us what this is:
There were **0** responses to this part of the question.
Question : Age:
Age
under 18
18 - 25
26 - 35
36 - 45
46 - 55
56 - 65
66+
Prefer not to say
Not Answered
0 91
Page 13
Option Total Percent
under 18 0 0%
18 - 25 1 0.58%
26 - 35 11 6.43%
36 - 45 16 9.36%
46 - 55 23 13.45%
56 - 65 18 10.53%
66+ 6 3.51%
Prefer not to say 5 2.92%
Not Answered 91 53.22%
Question : Disability
Q7

Yes
No
Prefer not to say
Not Answered
0 90
Page 14
Option Total Percent
Yes 19 11.11%
No 55 32.16%
Prefer not to say 7 4.09%
Not Answered 90 52.63%
Disability detail
A long standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease, or epilepsy
A mental health difficulty, such as depression, schizophrenia or anxiety disorder
A physical impairment or mobility issues, such as difficulty using your arms or using a wheelchair or crutches
A social / communication impairment such as a speech and language impairment or Asperger's syndrome / other autistic spectrum disorder
A specific learning difficulty or disability such as Down's syndrome, dyslexia, dyspraxia or AD(H)D
Blind or have a visual impairment uncorrected by glasses
Deaf or have a hearing impairment
An impairment, health condition or learning difference that is not listed above (specify if you wish)
Prefer not to say
Not Answered
0 142
Option Total Percent
A long standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease, or epilepsy 10 5.85%
A mental health difficulty, such as depression, schizophrenia or anxiety disorder 8 4.68%
A physical impairment or mobility issues, such as difficulty using your arms or using a wheelchair or crutches 6 3.51%
A social / communication impairment such as a speech and language impairment or Asperger's syndrome / other autistic spectrum disorder 1 0.58%
A specific learning difficulty or disability such as Down's syndrome, dyslexia, dyspraxia or AD(H)D 5 2.92%
Blind or have a visual impairment uncorrected by glasses 2 1.17%
Deaf or have a hearing impairment 0 0%

An impairment, health condition or learning difference that is not listed above (specify if you wish) 0 0%
Prefer not to say 7 4.09%
Not Answered 142 83.04%
Other disability
There was **1** response to this part of the question.
Page 15
Question : Sexual orientation. Do you consider yourself to be ...
sexuality
Bisexual
Gay / lesbian
Heterosexual / straight
Prefer not to say
Other (please specify)
Not Answered
0 93
Option Total Percent
Bisexual 2 1.17%
Gay / lesbian 3 1.75%
Heterosexual / straight 57 33.33%
Prefer not to say 15 8.77%
Other (please specify) 1 0.58%
Not Answered 93 54.39%
Other sex
There were **0** responses to this part of the question.
Question : What is your gender identity?
Gender
Male
Female
Other (e.g. pangender, non-binary
etc)
Prefer not to say
Not Answered
0 95
Option Total Percent
Male 23 13.45%
Female 47 27.49%
Other (e.g. pangender, non-binary etc) 1 0.58%
Prefer not to say 5 2.92%
Not Answered 95 55.56%
Other gender
There was **1** response to this part of the question.
Page 16
gender ID same as birth
Yes
No
Not Answered
0 118
Option Total Percent
Yes 51 29.82%
No 2 1.17%
Not Answered 118 69.01%
Question : How would you define your religion or belief?
religion
Atheist

Bahai
Buddhist
Christian
Hindu
Jain
Jewish
Muslim
Sikh
No religion
Prefer not to say
Any other religion or belief (please
specify)
Not Answered
0 95
Page 17
Option Total Percent
Atheist 6 3.51%
Bahai 0 0%
Buddhist 1 0.58%
Christian 24 14.04%
Hindu 9 5.26%
Jain 0 0%
Jewish 0 0%
Muslim 9 5.26%
Sikh 4 2.34%
No religion 12 7.02%
Prefer not to say 10 5.85%
Any other religion or belief (please specify) 1 0.58%
Not Answered 95 55.56%
other religion
There was **1** response to this part of the question.
Question : We are looking to have one team providing the whole range of lifestyle services, rather than having
separate services.
lifestyl hub comments
There were **87** responses to this part of the question.
Question : What are your views on group based support, and do you envisage any problems delivering this type
of support?
group session staff comments
There were **84** responses to this part of the question.
Question : We plan to improve our digital offer and to utilise technology to a greater degree (e.g websites, apps,
etc)
staff digital comments
There were **87** responses to this part of the question.
Question : We plan to train / support local volunteers who would like to help others in their community improve
their health.
staff volunteer comments
There were **86** responses to this part of the question.
Question : Do you have any further comments on lifestyle support services?
staff further comments
There were **65** responses to this part of the question.

Appendix E: EIA

Equality Impact Assessment (EIA) Template: Service Reviews/Service Changes

Title of spending review/service change/proposal	Integrated Lifestyle Service
Name of division/service	Public Health
Name of lead officer completing this assessment	Ryan Swiers
Date EIA assessment completed	12/06/18
Decision maker	
Date decision taken	

EIA sign off on completion:	**Signature**	**Date**
Lead officer		
Equalities officer		
Divisional director		

Please ensure the following:

(a) That the document is understandable to a reader who has not read any other documents, and explains (on its own) how the Public Sector Equality Duty is met. This does not need to be lengthy, but must be complete.

(b) That available support information and data is identified and where it can be found. Also be clear about highlighting gaps in existing data or evidence that you hold, and how you have sought to address these knowledge gaps.

(c) That the equality impacts are capable of aggregation with those of other EIAs to identify the cumulative impact of all service changes made by the council on different groups of people.

1. Setting the context

Describe the proposal, the reasons it is being made, and the intended change or outcome. Will current service users' needs continue to be met?

Proposal

It is proposed that several existing services including stop smoking and active lifestyles which currently operate as separate services are combined and form a single integrated lifestyle service. This is in line with emerging evidence and will provide a single point of entry for lifestyle services across the city and enable a person centred approach to be adopted. Currently services are provided by a combination of external providers and in-house delivery. It is proposed that the integrated lifestyle service will become an in-house service. This may involve TUPE of some staff and the reductions planned to meet spending review targets will necessitate a reduction in staff numbers in some areas of the service.

Changes proposed are driven to some extent by corporate savings targets and reductions in the national ring-fenced public health grant. However the changes proposed are also in recognition that residents want to 'tell their story' once and that integrated support is more effective for people who are often addressing multiple lifestyle issues.

A new service will include the integration and redesign of existing key prevention programmes and have scope to provide a broader range of services through a single point of access. The focus of the service here represents the minimum provision to make a significant impact on health, specifically cardio-vascular disease and preventable diabetes which are the biggest health challenges in the city.

The proposed new model will integrate services to promote and support healthy behaviours but will also see considerable changes in both the individual service level activity and the overall focus of lifestyle support

The aim of the integrated lifestyle service is to support local people to make positive changes to their lifestyles and ultimately improve their health and well-being. The service will play a part in ensuring health outcomes in the city improve and inequalities in health reduce. The support offered will be in line with the best available evidence and will ensure resources are distributed equitably and are reflective of the varying level of need across Leicester City and within vulnerable communities.

The proposed new service can be summarised by the following shifts in emphasis;

A) More targeted approach- currently some lifestyle services have broad inclusion criteria meaning that support may be provided free of charge to residents who have capacity to pay and the new service will cap all support to a maximum of 12 weeks free of charge and have high targets around

engagement of those in greatest need with least capacity to self-help.

B) More digital capacity- it is recognised that digital platforms represent new opportunities for behaviour change services and whilst concerns remain around applicability of this offer to some groups this is seen as an appropriate intervention level for some residents which should be maximised.
C) More group based activity- traditionally lifestyle services have been delivered through intensive 1:1 sessions; the new model will explore greater use of group based interventions increasing efficiency and building a culture of peer support.
D) More community focussed interventions- some aspects of the existing services such as physical activity have tended to focus on a gym based service and whilst this will continue to be offered for those whom it is deemed appropriate (based on a range of factors including preference, location, capability and suitability of instructors) there will be a shift towards community asset based activity (community classes, outdoor gyms, walks etc)
E) More emphasis on developing community 'activators' - a volunteer component to the programme will be developed enabling the provision of walking groups in target areas of the city and enabling the whole lifestyle programme to be supported by a growing number of trained and well supported volunteers.

Reasons for change

The rationale for change comprises 4 key considerations; current performance, local services operating in silos, a national move towards integration and self-help in line with emerging evidence of positive effect and budget constraints.

The new service also needs to be seen in the context of wider work to improve health through the physical environment across the whole city, for example, promoting active travel, cycling, increased use of outdoor spaces, embedding health in the Local Plan. Local Plans set out a vision and a framework for the future development of the area, addressing needs and opportunities in relation to housing, the economy, community facilities and infrastructure – as well as a basis for safeguarding the environment, adapting to climate change and securing good design. These measures will help drive incremental change across the whole population, with the new service providing more intensive support to people who most need this

Intended change

Existing adult lifestyle services will be redesigned and integrated into a new programme. Smoking cessation services will be downsized significantly and therefore achieve fewer quits. The adult weight management service primarily targeted at BME groups and those with long-term conditions will be recommissioned on a short term basis to trial alternative approaches to deliver this service in a cost effective way. The grant to Leicestershire and Rutland Sport will be reduced. The proposed service is detailed in section 3.5 below. A considerable focus will be on both the community and voluntary sector to support physical activity and other positive lifestyle changes along with a greater emphasis on a digital lifestyle offer. It is proposed that all services will be delivered in-house which will involve decommissioning of external services, possible TUPE arrangements for some roles and an organisational review for internal staff. The digital platform may be provided by an external provider although this will be directed by the digital

transformation board.

2. Equality implications/obligations Which aims of the Public Sector Equality Duty (PSED) are likely be relevant to the proposal? In this question, consider both the current service and the proposed changes.	
	Is this a relevant consideration? What issues could arise?
Eliminate unlawful discrimination, harassment and victimisation How does the proposal/service ensure that there is no barrier or disproportionate impact for anyone with a particular protected characteristic	The proposed service changes aim to be inclusive and meet the needs of all those likely to need healthy lifestyle support from the council. The service will provide a universal offer across the city with more targeted services and greatest levels of support directed at those areas and groups with greatest need.
Advance equality of opportunity between different groups How does the proposal/service ensure that its intended outcomes promote equality of opportunity for users? Identify inequalities faced by those with specific protected characteristic(s).	A shift to an enhanced digital offer is expected to increase equity, although any adverse effects will be mitigated by the continued availability of phone and face to face services as required. Factors in lifestyle services which can exacerbate inequalities include access and cost. The service will be offered in locations across the city in a variety of settings in addition to self-help resources. The service provided is free and so there will be no barriers to access arising from cost. However, once a service user moves on from the service they may choose to engage with other services to maintain their helathy lifestyle which do charge. cost is a consideration with some leisure services although a price point has been selected which is felt sufficient to increase 'value' placed on services without becoming an additional barrier. Subsidisation is offered where this remains the case. There are also options which are free of charge for people who wish to maintain a healthy lifestyle but are unable to meet the cost of some leisure services.
Foster good relations between different groups Does the service contribute to good relations or to broader community cohesion objectives? How does it achieve this aim?	The service is designed to enhance relations both within the local authority and with external partners in addition to making the experience of residents and partners more co-ordinated and straightforward. The focus on supporting community groups and volunteering is expected to support community cohesion.

	Engagement with other council services who have volunteers is currently underway to understand how to best attract a diverse range of volunteers from a diverse range of backgrounds and characteristics in order to ensure that the proposal fully supports the aim of fostering good relations between those who share a protected characteristic and those who do not.

3. Who is affected? Outline who could be affected, and how they could be affected by the proposal/service change. Include current service users and those who could benefit from but do not currently access the service.
Those currently enrolled on existing lifestyle programmes affected by these changes will continue to receive the existing service. It is planned that the proposed changes will be implemented from April 2019. The scope of those affected by the changes will expand as more people will be able to access support services, albeit the delivery of these services will largely shift away from 1:1 interventions in the longer term where evidence supports this locally.
4. Information used to inform the equality impact assessment What **data, research, or trend analysis** have you used? Describe how you have got your information and what it tells you. Are there any gaps or limitations in the information you currently hold, and how you have sought to address this, e.g. proxy data, national trends, etc.
Performance data has shown that the lifestyle services have mixed performance. Currently all services are tasked with reducing health inequalities which results in a disproportionate level of provision based on area deprivation and/or health condition. This approach of 'proportionate universalism' will continue within any new service. This means that there will continue to be higher levels of provision where there is greater need identified. Performance indicators which currently exist such as targeting those from areas of highest deprivation, the unemployed or people with specific conditions/circumstances including diabetes/pregnancy will remain. Information has been considered from a range of sources including the following; • Local service data for lifestyle services • Engagement with other local authorities on the development of integrated services Both of these exercises have demonstrated that integrated services can help reduce barriers to services and ensure service users do not suffer a disjointed offer but have their health considered holistically. It has also shown that such a shift can be financially beneficial without having a negative impact on outcomes. Consultation has taken place over an 8 week period which included a number of focus groups targeted at vulnerable groups and those likely to be negatively affected and/or those who may not otherwise engage with consultation. The findings of this consultation exercise have been considered in final proposals. It is also recognised that existing services could do more to monitor protected characteristics and this will

be factored into the news service to allow greater consideration of equity in the future.
5. Consultation What **consultation** have you undertaken about the proposal with current service users, potential users and other stakeholders? What did they say about: ▪ What is important to them regarding the current service? ▪ How does (or could) the service meet their needs? ▪ How will they be affected by the proposal? What potential impacts did they identify because of their protected characteristic(s)? ▪ Did they identify any potential barriers they may face in accessing services/other opportunities that meet their needs?
• 171 people completed the survey (30 paper copies, 141 online) and there were no requests for any other accessible formats. The consultation was promoted via the council website and social media, Clinical Commissioning Group, Healthwatch, Voluntary Action Leicester and through direct targeting to current and former service users. In addition local community groups were informed as were elected ,members and other partner organisations such as be active Braunstone and the local sports partnership. The themes which emerged below were consistent across respondents with no clear relationship between concerns and protected characteristics.Overall support for a shift towards integrated services with responses suggesting this would make services more user friendly • A single booking system was well received • There was support for group based sessions with people seeing this as a means of extra support. Whilst most people did not respond to this question (<30%) there was less support for stop smoking services than weight management, diet/physical activity • A recognition that there was not a 'one size fits all' and that 1:1, group based and online had a role to play • The key features affecting sessions included time location and cost. Friendly staff was cited as the biggest factor determining how successful sessions would be • People expressed a desire for sessions to be offered at evenings and weekends • A wide range of settings were seen as suitable with leisure centres (61), community centres (41), parks and outdoor (38) spaces being most popular • Strong support for developing a more extensive walking programme with people suggesting guided and group walks as a good idea • The increased use of volunteering was generally supported although there were concerns that this should not be used a mean to replace qualified staff • There were concerns about an integrated service having a generic member of staff and responses were in favour of retaining specialist staff • Regarding online services there was some concern via the consultation and focus groups about a complete shift to digital services and potential risks of exclusion • Whilst there were limited responses to questions relating to wider services such as housing and debt management there was generally support for this especially as a signposting function • Greater use of community assets was also mentioned

• There was a number of comments relating to the role of wider determinants such as takeaways, advertising and sustainable travel

6. Potential equality Impact
Based on your understanding of the service area, any specific evidence you may have on service users and potential service users, and the findings of any consultation you have undertaken, use the table below to explain which individuals or community groups are likely to be affected by the proposal because of their protected characteristic(s). Describe what the impact is likely to be, how significant that impact is for individual or group well-being, and what mitigating actions can be taken to reduce or remove negative impacts. Looking at potential impacts from a different perspective, this section also asks you to consider whether any other particular groups, especially vulnerable groups, are likely to be affected by the proposal. List the relevant that may be affected, along with their likely impact, potential risks and mitigating actions that would reduce or remove any negative impacts. These groups do not have to be defined by their protected characteristic(s).

Protected characteristics	**Impact of proposal:** Describe the likely impact of the proposal on people because of their protected characteristic and how they may be affected. Why is this protected characteristic relevant to the proposal? How does the protected characteristic determine/shape the potential impact of the proposal?	**Risk of negative impact:** How likely is it that people with this protected characteristic will be negatively affected? How great will that impact be on their well-being? What will determine who will be negatively affected?	**Mitigating actions:** For negative impacts, what mitigating actions can be taken to reduce or remove this impact? These should be included in the action plan at the end of this EIA.
Age[3]	This service is aimed at adults aged 18+. Concern exists around the capacity	Negative impact is difficult to quantify. The digital platform is only one element of the new service and evidence[4] [5]suggests that older	The digital platform will be designed to ensure it is easy to use as possible and uses plain English in order to minimise the likelihood of excluding

[3] Age: Indicate which age group is most affected, either specify general age group - children, young people working age people or older people or specific age bands

[4] Technology and Older People Evidence Review, Age UK (https://www.ageuk.org.uk/documents/en-gb/for-professionals/computers-and-technology/evidence_review_technology.pdf?dtrk=true)

	of some groups including older residents to fully engage with the proposed digital platform. Many older people have long term conditions which could be positively impacted by lifestyle services including those which promote self-help. Group based activities will be more prominent in the new service and concern exists around the appropriateness of some mixed age groups for example with relation to physical activity.	people are increasingly IT literate. Group based sessions which are inappropriate due to age mix could prevent older people attending. In addition the nature of some exercise classes can be seen as prohibitive to some older people. Having said this, group sessions may also have a positive impact in terms of social interaction. This may help to reduce loneliness and isolation which some older people may experience and could have some benefits in terms of participants' mental health and wellbeing.	people based on age. The digital transformation board will have oversight of this and testing is planned with various service user groups. Phone based support will also be available for residents of any age. The city council provide digital offers in their libraries, customer service centre and other key locations. City Council staff can signpost to appropriate services with VCS organisations where people require support to become IT proficient. Customers will be able to access pc and the internet at these various locations. Group based sessions will be delivered with groups which are appropriate to participate together and at a level which is safe and appropriate. Some degree of mixed age and ability is to be expected and staff involved in delivery will have the relevant skills and experience to manage this.
Disability[6]			Where an individual is referred to the

[5] Office for National Statistics, Internet Users, UK 2018, statistical bulletin (https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2018)

	Group based sessions may not always be appropriate for those with disabilities. Access to some community settings may also be an issue for those with disabilities.		service who has additional access requirements, reasonable adjustments will be made to enable them to participate in the session. Where there are barriers to access which cannot be mitigated for, we will offer alternative 1-1 provision. When agreeing community venues and settings consideration will be given to accessibility.
	Individuals with disabilities may find it more difficult to engage with the digital elements of the service.	The digital platform may not support those with disabilities and group activities may also be difficult for individuals to participate in.	The digital platform will be designed to be inclusive. Where referrals are made by other professionals into the service it is expected that additional support will be provided and consideration given to the appropriateness of the activities on offer. There are various organisations such as Citizens Advice Leicestershire (CITAL), Mind, Vista and other specialists who provide services for individuals with disabilities, and customers are generally able to seek help through specialist support in addition to lifestyle services. We will ensure that our services are able to support those with a range of

[6] Disability: if specific impairments are affected by the proposal, specify which these are. Our standard categories are on our equality monitoring form – physical impairment, sensory impairment, mental health condition, learning disability, long standing illness or health condition.

			disabilities and where this is highlighted as lacking we will take action to address this.
Gender Reassignment[7]	Group based activities may be problematic for trans men and trans women due to stigma	Currently there is no evidence to support that this protected characteristic is likely to be negatively impacted, although stigma is still recognised as a significant concern.	Where available we will ensure staff are appropriately trained to be sensitive to issues related to gender reassignment. More broadly staff will be compliant with training around bullying and harassment.
Marriage and Civil Partnership	At this stage none known	Currently there is no evidence to support that this protected characteristic is likely to be negatively impacted.	If any need arises, we can control standard of staff training to factor equality requirements
Pregnancy and Maternity	Some universal and group based sessions may be inappropriate for pregnant women.	This high risk group may not engage with inappropriate services.	Where this is recognised as a specific concern in relation to appropriateness of intervention specialist sessions will be provided eg 1:1 stop smoking services
Race[8]	People who do not speak English as a first language. May find access to the services difficult.	Limited access to digital resources may mean that level of intervention is ineffective.	A range of language options will be provided on the digital platform and any information materials will also be offered in different languages. This will be available via the online site but also where a need has been identified by staff or by the healthcare professional who has referred into the service. Where appropriate service users may

[7] Gender reassignment: indicate whether the proposal has potential impact on trans men or trans women, and if so, which group is affected.

[8] Race: given the city's racial diversity it is useful that we collect information on which racial groups are affected by the proposal. Our equalities monitoring form follows ONS general census categories and uses broad categories in the first instance with the opportunity to identify more specific racial groups such as Gypsies/Travellers. Use the most relevant classification for the proposal.

	Currently some services target certain ethnic groups.	Reduction in services specific to some groups may affect uptake and subsequent outcomes	be signposted to ESOL provision. Service users are triaged and where language needs are identified which would make it more difficult for someone to benefit from group sessions, 1-1 provision would be offered and the city council's translation and interpretation policy followed. Work underway with partners to ensure that some culturally specific services are provided. An example of this is ensuring that future weight management services are mindfulof the challenges of providing these services to the south Asian community.
Religion or Belief[9]	There may be some circumstances where a mixed sex group session would not be appropriate provision for an individual based on the religious beliefs or cultural requirements. Dietary advice provided may be inappropriate due to religious, ethical or cultural differences in diet.	 Advice given may be ineffective or insensitive to religious, ethical or cultural beliefs.	Where this is identified by an individual, they will be offered 1-1 provision. If there is a need identified in the future, there may be the possibility to introduce single sex provision. If any need arises, we can control standard of staff training to factor equality requirements

[9] Religion or Belief: If specific religious or faith groups are affected by the proposal, our equalities monitoring form sets out categories reflective of the city's population. Given the diversity of the city there is always scope to include any group that is not listed.

Sex[10]	At this stage none known	Currently there is no evidence to support that this protected characteristic is likely to be negatively impacted.	Staff will be trained in equality and diversity along with bullying and harassment. Sessions may be provided in single gender settings where this is required.
Sexual Orientation [11]	At this stage none known	Currently there is no evidence to support that this protected characteristic is likely to be negatively impacted.	Staff will be trained in equality and diversity along with bullying and harassment.

Summarise why the protected characteristics you have commented on, are relevant to the proposal?
The primary concerns relate to accessibility of the digital platform and appropriateness/inclusivity of group activities.

Summarise why the protected characteristics you have not commented on, are not relevant to the proposal?
Currently there is no evidence to suggest that the protected characteristics of……..are negatively affected by the changes. However, we will continue to monitor as the proposed changes are implemented, and should any disproportionate negative impact become apparent we will identify mitigating actions to reduce or remove the impact.

7. Other sources of potential negative impacts

Are there any other potential negative impacts external to the service that could further disadvantage service users over the next three years that should be considered? For example, these could include: other proposed changes to council services that would affect the same group of service users; Government policies or proposed changes to current provision by public agencies (such as new benefit arrangements) that would negatively affect residents; external economic impacts such as an economic downturn.

Yes- factors which may lead to further negative impacts include changes to government policy, additional savings targets and other changes to internal/external services which may affect some groups disproportionately. The service manager is responsible for keeping a risk register.

8. Human Rights Implications

Are there any human rights implications which need to be considered (please see the list at the end of the template), if so please complete the Human Rights Template and list the main implications below:

[10] Sex: Indicate whether this has potential impact on either males or females

[11] Sexual Orientation: It is important to remember when considering the potential impact of the proposal on LGBT communities, that they are each separate communities with differing needs. Lesbian, gay, bisexual and transgender people should be considered separately and not as one group. The gender reassignment category above considers the needs of trans men and trans women.

N/A

9. Monitoring Impact

You will need to ensure that monitoring systems are established to check for impact on the protected characteristics and human rights after the decision has been implemented. Describe the systems which are set up to:

- monitor impact (positive and negative, intended and unintended) for different groups
- monitor barriers for different groups
- enable open feedback and suggestions from different communities
- ensure that the EIA action plan (below) is delivered.

The planned reporting system will allow consideration of access, patient journey and outcome based on a number of characteristics including those covered by this report (where information is reported by the individual).

Performance management arrangements will specifically make reference to equalities requirements and responsibilities and in the event that there is evidence to suggest that should those with protected characteristics are adversely affected by the new service, action will be taken swiftly.

10. EIA action plan

Please list all the equality objectives, actions and targets that result from this Assessment (continue on separate sheets as necessary). These now need to be included in the relevant service plan for mainstreaming and performance management purposes.

Equality Outcome	Action	Officer Responsible	Completion date
Ensure EIA is kept up to date and relevant	Repeat this exercise at 6 monthly intervals and share with equalities team.	Service Manager	April 2019 onwards
Assess equality of access by the various routes into services	A single IT system will allow sophisticated analysis of which groups access which elements of the service by different means and their 'journeys' when engaged. For example the service would be able to assess if older people access group or 1:1 support predominantly. Equalities team to be involved in the design of IT system to ensure equalities can be considered in a meaningful way.	Service Manager	August- October 2018
Performance measures to	Performance indicators maintained which	Service Manager	April 2019 onwards

capture equality/equity	ensure a focus on providing services which promote equality but also greater equity in line with evidence around those with poorer health outcomes. Examples include specific targeting of pregnant women by the smoking service. These measures will be developed by the service manager and can be shared with the equalities team.		

Human Rights Articles:

Part 1: The Convention Rights and Freedoms

Article 2: Right to Life
Article 3: Right not to be tortured or treated in an inhuman or degrading way
Article 4: Right not to be subjected to slavery/forced labour
Article 5: Right to liberty and security
Article 6: Right to a fair trial
Article 7: No punishment without law
Article 8: Right to respect for private and family life
Article 9: Right to freedom of thought, conscience and religion
Article 10: Right to freedom of expression
Article 11: Right to freedom of assembly and association
Article 12: Right to marry
Article 14: Right not to be discriminated against

Part 2: First Protocol

Article 1: Protection of property/peaceful enjoyment
Article 2: Right to education
Article 3: Right to free elections

[i] Public Health England. APHO Health Profiles Leicester 2016

[ii] *Leicester Health and Wellbeing Survey 2015.* Available at: http://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/data-reports-and-information/leicester-health-and-wellbeing-survey-2015/

[iii] Sport England, Active People Survey 2015

[iv] PHE. Tobacco Control: JSNA Support Pack - Key data sources for planning effective tobacco control in 2016-17, Leicester

[v] PHE. Comprehensive local tobacco control: why invest?

[vi] Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. *BMJ.* 2004 Jun 24;328(7455):1519

[vii] Lee, 2012

[viii] NICE (2013) Public Health Guidance 46 - Assessing body mass index and waist circumference thresholds for intervening to prevent ill health and premature death among adults from black, Asian and other minority ethnic groups in the UK

[ix] Rimmer J, Wang E, Yamaki K, Davis B (2010) Documenting Disparities in Obesity and Disability. *Technical Brief No. 24*

[x] National Obesity Observatory (2010) – *Health Inequalities*. Available at https://www.noo.org.uk/NOO_about_obesity/inequalities

[xi] Everybody active, every day – an evidence-based approach to physical activity – Public Health England 2014: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf

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[xiii] NICE (2013) Public Health Guidance 10 – Stop Smoking Services

[xiv] National Centre for Smoking Cessation and Training (2014) Local Stop smoking Services and Delivery Guidance

[xv] NICE (2015) Public Health Guidance 43 – Obesity Prevention

[xvi] Everybody active, every day – an evidence-based approach to physical activity – Public Health England 2014: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf

[xvii] Health and Social Care Information Centre. Statistics on Smoking England 2015; Available from: http://www.hscic.gov.uk/catalogue/PUB17526/stat-smok-eng-2015-rep.pdf 4. Public Health England. Local Tobacco Control Profiles for England. Available from: http://www.tobaccoprofiles.info/ November 2015

[xviii] Perpetuity Research and Consultancy International Ltd. May 2013. Evaluation of Community Recognition and Understanding of the Step Right Out Campaign (smokefree homes and cars programme)

[xix] Gunther S. 2013 Evaluation of the community health trainer service

[xx] Teeman D, Featherstone D, Sims D, Sharp C (2011) *Qualitative Impact Evaluation of the Food for Life Partnership Programme*. Slough:NFER.

[xxi] Perpetuity Research and Consultancy International Ltd. May 2013. Evaluation of Community Recognition and Understanding of the Step Right Out Campaign (smokefree homes and cars programme)

[xxii] Gunther S. 2013 Evaluation of the community health trainer service

Leicester City Clinical Commissioning Group

LLR Urgent and Emergency Care Resilience Planning for Winter 2018/19

Title of the report:	**LLR Urgent and Emergency Care Resilience Planning For Winter 2018/19**
Report to:	Leicester City Health Overview and Scrutiny Commission
Section:	Public
Date of the meeting:	23rd of August 2018
Report by:	Mike Ryan, Director of Urgent and Emergency Care (LLR CCGs)
Sponsoring Director:	Sue Lock, Accountable Officer (Leicester City CCG)
Presented by:	Mike Ryan, Director of Urgent and Emergency Care (LLR CCGs) and Sue Lock, Accountable Officer(Leicester City CCG)

Purpose

1. This paper provides an overview of the ongoing work to prepare for the 2018/19 winter period across the Leicester City, Leicestershire and Rutland (LLR) Urgent and Emergency Care system. The paper includes a reflection of performance last winter, what was learnt, plus the actions being taken and the expected impact to ensure we have more resilient health and social care services this coming winter.

System Performance Winter 2017/18

2. The winter of 2017/18 saw the local urgent and emergency care (UEC) system under intense pressure, resulting in poor patient experience and weak performance against national targets. A&E performance is known to drop in December, January and February each year. However, last winter this deterioration started in November and continued through to March; it was particularly intense from February to April.

3. Hospital A&E 4-hour performance overall was sub-standard with an annual position of 77.7% (79% the previous year), and A&E waiting times performance deteriorated sharply from October onwards, dipping to a low of 66.9% in March with primary clinical focus on major conditions.

Major Causes of Pressure

4. Not surprisingly, in such a complex system, there were several factors that contributed to the pressures.

    - Pressure was felt across all parts of the system – in GP practices, GP Primary Care Hubs, Urgent Care Centres, 111 calls, Clinical Navigation Services, Ambulances Services, ED and within the hospitals. Although hospital activity levels overall and emergency admissions were not as high as in past years, there were changes to the *type* of patient, and how poorly they were, with very high numbers of cardio-respiratory cases in particular. In summary, the pressures were not caused only by the number of admitted patients, but by how poorly they were and how long they needed to stay in hospital. Many of these were older or frail patients. In Leicester City, older people make up approximately 20% of the population, yet at the height of the pressures, 80% of hospital beds were occupied by this group of patients.

    - There was a mismatch between the number of patients coming into the hospital and the ability to discharge them quickly and efficiently, causing delayed flow of patients through the hospital.

    - Due to the number of emergency surgical cases exceeding normal levels, critical care / intensive care units were often full, which resulted in high numbers of cancelled surgical cases, some of which were regrettably cancer cases. Occasional staff sickness/absence impacted upon the ability to maintain full use of critical care beds.

    - Bed occupancy was high throughout much of the winter period. This means a lack of free beds, which has a knock-on effect on internal patient flow from admissions areas, often resulting in long trolley waits. Many working days started with patients waiting for beds to become free (often termed “negative bed capacity”).

    - High numbers of medical “outliers,” (medical patients in a bed not designated for medical patients e.g. on a surgical ward) which only started to improve towards the end of March. Delivering care to patients spread across a number of wards is less efficient for clinical teams. The length of stay for medical patients at LRI increased by nearly two days from January to March 2018.

    - Higher than average “non-admitted breaches” (patients who were in ED for more than 4-hours (i.e. breached the standard) but were not admitted into hospital. Delays for such patients are often due to the demand on diagnostic services, although preventing an unnecessary admission can often reflect a better outcome for the patient.

    - Patients with Norovirus and/or flu resulted in many closed beds on a regular basis, at both UHL and LPT.

    - There was a higher number of elective (i.e. planned care) cancellations last winter in comparison with 2016/2017 following a national instruction to all

acute Trusts, as well as exceptional levels of cancellations of urgent and cancer operations.

- Activity in out-of-hospital services, including Urgent Care Centres, Primary Care Hubs, Home Visiting and Clinical Navigation services, was higher than forecast and higher than in winter 2016/17. This at times created significant pressure in these services but they were successful in preventing a significant increase in ED attendances.

- NHS111 demand rose significantly, dealing with 30% more calls than we had planned for in the period of January to March 2018.

- Ambulance services remained stretched and were regularly at a high escalation level during winter; patient handover times were higher than expectation (within 15 minutes), particularly from November through to March, although there were fewer 1 hour+ waits than in 2016/2017, and fewer total lost hours.

- Staffing levels were particularly challenged over winter across all providers. In particular, medical and nurse staffing levels in hospital were variable with a higher than average sickness/absence rate during peak periods of demand.

- Although a flu jab campaign was marketed and communicated, the uptake of flu jabs was not as high as it could be.

- Processes vary across providers and there are benefits to more standardisation.

Lessons Learnt – National

5. As well as reflecting on the lessons that the local system learnt, our actions for the future are also informed by national learning on improved ED performance. One such example is the “Patient Flow Standards” which were issued nationally and against which the system compliance is tested by the regulators. These are shown at Appendix A.

Lessons Learnt – Local

6. A number of lessons were learned locally from our experiences last year. These include:

    - Effective communication across the system often began to break down as pressure was building, resulting in increased “silo” working as partners tried to sort out the problems in their own areas.

    - Joint forward planning / forecasting of the likely activity levels and responses to them was not undertaken.

    - Skills in forecasting were not shared across the system.

- More could have been done to protect beds for emergency activity by having a stronger plan on how to deliver elective and emergency activity across the year.

- Workforce and staffing challenges were seen across several of the organisations, due to scheduling issues and staff sickness such as flu.

- There was an inability to maintain flow across the system once pressure built.

- Patients were still presenting at ED with conditions that could have been treated in primary care or via self-care, despite there being slots available in Hubs and urgent care centres.

Actions and Steps to avoid similar issues in Future

7. The Leicester City, Leicestershire, and Rutland (LLR) Urgent and Emergency Care Resilience Plan 2018/19 is currently under development in collaboration with key stakeholders across the city and county, and is due to be published during September/October 2018 following simulation exercises. This plan sets out the features / signs of increasing levels of pressure for each organisation and what the response from themselves and other partners will be as a consequence. An effective plan is key to ensuring we all take the right steps to manage the pressure but also ensures that the system can recover quickly ("bounce back") once pressure begins to decrease. The plan will be tested through simulation exercises that involve all partners, so that we are clear how the actions interact and to test whether everything has been considered. This improved communication and collaboration will be a main contributing factor to improved performance.

8. The second part of the ED development at UHL is now open, which provides improved patient assessment areas. This allows more investigations to be carried out to reach an early diagnosis, give rapid treatment and ideally prevent the need for admission to a ward.

9. When agreeing the contracts for 2018/19, the CCGs and UHL have worked together as a first step to forecast in detail how much emergency capacity is required. We have then agreed how and when the elective (planned) activity will be delivered through the year, including how many operations may need to be delivered by other providers, so that we can protect and maximise the number of emergency beds.

10. We are working to increase the access to IT systems so that clinicians are able to see the patient's clinical record (where permission has been given) to improve decision-making. This is through an increase in the number of patients who have agreed for their Summary Care Record to be seen, which in turn supports more informed clinical assessments and treatments.

11. New and improved protocols have been agreed between UHL and EMAS to manage better the handover of emergency patients when they arrive at hospital via ambulance. This helps to decrease the ambulance delays and the number of "lost hours".

12. Improved communication systems developed between consultants and GPs to give advice and guidance about patients' care and whether or not they need to be admitted.

13. We are working with Public Health and NHS England to deliver a proactive response to seasonal flu. There will be a publicity campaign raise awareness and encourage uptake of flu vaccines with the public, and a campaign to encourage uptake of the vaccine within eligible groups and frontline staff.

14. We are introducing a "Red Bag scheme" for care homes, which has been shown to work elsewhere. The bag will be used to keep all the patient's essential items together including medication, personal items etc. and which can be transported with the patient if they are admitted. The scheme also helps to smooth the discharge process.

15. We are supporting more patients to understand and manage their conditions. For instance with respiratory patients, we will be ensuing that they are accurately identified on the clinical systems, that they have a care plan setting out their condition, treatment and what to do if it worsens and to ensure they have "rescue packs" i.e. antibiotic prescriptions etc. to allow them to start treatment and prevent admission. We will ensure that they receive cold weather warnings, pollution alerts, are flagged with EMAS in the event of 999 calls and are supported by a dedicated community specialist team and ongoing education programme for professionals, patients and carers.

16. There are improved discharge pathways which aim to get patients out of hospital and either back home or into a suitable care setting for assessment of their future needs. Evidence shows that this is really important for maximising recovery.

Focusing on Frail Patients

17. Over the past few years, BCF funding has supported the development of services that focus upon particular groups of patients for whom an increased level of support can prevent hospital admission. As time has gone on, we have learnt more about where this focus has the greatest impact. Moving on from this work, we are now collaborating system-wide to design a new pathway for frail patients, based upon local needs and national standards. There are 16 high impact actions that we are focusing on, prior to winter 18/19. The points below summarise the frailty work that is in progress:-

    - Patient (and Risk) Identification -
        - Better understanding of patients through data analysis has highlighted patients who would be deemed a medium to high risk of a fall or health need, and likely need hospitalisation if not managed in primary care.
        - Improving community support for complex/frail/multi-morbid patients - CCG's are adopting a population health management approach to identify the cohort of patients who will be most amenable to the range of interventions as part of the frailty programme

    - Care Plans -

- Design and implement a system to enable each part of the system to access and enact a “care plan” through IT systems. The care plan sets out the key information about the patient, their condition, their care, their wishes and what to do if the condition worsens.
- Establish a feedback loop whereby the quality of care plans can improve through better communication between doctors and patients
- Working to establish a single, GP-led care plan

- Patient Discharge –
  - Revise discharge letters to identify specific actions which can prevent readmissions through better communication of patient needs in the community and primary care (and ambulance services).

- Frailty Checklist in Practice
  - Design and implement a standardised checklist of interventions (the “frailty checklist”) which each provider can access and use consistently.

- New Ambulatory Care Pathway –
  - Implement ‘diagnose to admit’ model (as opposed to “admit to diagnose”) and pilot and assess a care home module – New ambulatory care pathways could reduce the number of bed-based admissions into the Trust if a ‘diagnose to admit’ model was implemented.

- Frailty Evaluation/Scoring
  - Embed the use of the Rockwood Clinical Frailty Score in A&E and the emergency floor to identify patients who are likely to require support

- Coordinated discharge from hospital (with monitoring)
  - Ensure patients have the full range of health and social care response on discharge and also to reduce the risk of readmission. The current Integrated Discharge Team function started this process;

- Implement standardised daily interventions in all clinical areas for frail patients
  - Improving flow and decreasing the numbers of patients who stay too long within acute and non-acute beds will be vital for winter, and is a major national initiative. Although UHL is one of the better Trusts in the country in this area, standardising processes and the actions expected across LLR to enable flow is a key action pre-winter.

- Hospital Readmissions -
  - Implementation of a new system of reviewing readmissions that happen within 30 and 90 days of discharge, to understand what could be improved.

Assessment of Readiness for 2018/19

18. Planning winter preparedness across dozens of stakeholder organisations is challenging, technical and complex. The plan is being developed with input from the Clinical Commissioning Group, Leicester City Council, University Hospitals of Leicester (UHL), Primary Care, Community and Mental Health Care Providers,

Independent Sector Providers, patients and carers, Healthwatch, NHS England and NHS Improvement, as well as members of the local Leicester Resilience Forum, including the police, fire service, Public Health England, Health Protection, Health Education, utility companies, and several voluntary and charitable organisations. The plan will be approved by the LLR A&E Delivery Board which comprises of senior leaders across Leicestershire and Rutland.

19. Steady progress is being made to produce the plan by the end of September 2018, for submission to the regulators. Individual health and social care organisations have each been asked to review and submit their plans which will be shared and consolidated into one. They will also incorporate demand and capacity plans, business continuity plans, flu and infection control preparedness and adverse weather protocols. This will be checked and practiced via simulation exercises to ensure the system is clear on arrangements, contingencies, and to test for any gaps that exist ahead of winter.

20. The A&E Delivery Board will monitor progress of the plan production and more importantly, will ensure that any learning as we go through winter is incorporated into updated versions for continuous improvement.

APPENDIX A

Patient Flow Standards

These core principles will have specific measures to demonstrate progress and where rapid improvement can be targeted during periods of increased demand, and include:

- Patients arriving by ambulance enjoy a seamless handover to the Emergency Department (ED) without delay, supported by the transfer of patient information from the ambulance service to the hospital;

- Patients attending Emergency Departments with conditions more suited to assessment and treatment in Primary Care are streamed to co-located Primary Care services;

- All patients to receive timely assessment and clinically appropriate, high quality care in the Emergency Department;

- Patients presenting to EDs or on inpatient wards with mental health and related physical conditions receive compassionate care from all staff;

- Patients who can be discharged following a short period of observation, investigation or treatment are managed in appropriate short stay areas outside ED;

- Patients being considered for emergency admissions are rapidly assessed and where appropriate are streamed to Ambulatory Emergency Care;

- Patients with acute medical conditions are assessed and their treatment begun by a multi professional acute medical team. Patients are referred from the ED or Primary Care;

- Acute medical, surgical and speciality assessment;

- Frail patients are identified as they present to the ED or directly to assessment services and are discharged without delay when acute care is complete;

- Patients are discharged as soon as they no longer benefit from acute hospital care.

Source: National priorities for acute hospitals 2017 Good practice guide: Focus on improving Patient flow; NHS Improvement, 13 July 2017.

Leicester City Clinical Commissioning Group

Proposed changes to prescribing of medicines for minor ailments

Title of the report:	**Proposed changes to prescribing of medicines for minor ailments**
Report to:	Leicester City Health Overview and Scrutiny Commission
Section:	Public
Date of the meeting:	23rd of August 2018
Report by:	Lesley Gant, Head of Medicines Optimisation (Leicester City CCG)
Sponsoring Director:	Sarah Prema, Director of Strategy and Planning (Leicester City CCG)
Presented by:	Lesley Gant, Head of Medicines Optimisation (Leicester City CCG)

Introduction

1. Following the release of new guidance from NHS England, the three CCGs in Leicester, Leicestershire and Rutland have launched a period of engagement with patients about prescriptions for medicines to treat certain minor ailments.

2. From 1st October 2018, GPs will be encouraged by the three Clinical Commissioning Groups (CCGs) to not routinely prescribe medicines and treatments for 31 minor, short-term health conditions.

3. This would apply where:

   - The condition will clear up on its own (known as a self-limiting condition).
   - The condition can be treated by the patient themselves by buying medication from a pharmacy or supermarket.

4. Before implementing this change, we want to find out how patients locally would be affected. We particularly want to hear from families and those on a restricted income about any concerns or issues they may have.

5. At the same time, we are also asking patients for their views about how they would be impacted if the Pharmacy First Minor Ailments Scheme, which is particular to Leicester City, was no longer available in pharmacies.

Prescribing medicines for minor ailments

6. NHS England and NHS Clinical Commissioners last year established a working group in partnership with the Royal College of General Practitioners, the Royal Pharmaceutical Society, the British Medical Association, the National Institute for Health and Care Excellence, the Medicines and Healthcare Products Regulatory Agency, the Department of Health and Social Care, PrescQIPP (a prescribing support tool) and CCG representatives.

7. Together they formulated a list of 37 conditions for which they believed over the counter items should not routinely be prescribed in primary care on the basis that they are either self-limiting, or lends itself to self-care. These are further defined as:
   - A condition that is self-limiting and does not require medical advice or treatment as it will clear up on its own; and/or
   - A condition that is a minor illness and is suitable for self-care and treatment with items that can easily be purchased over the counter from a pharmacy.

8. Of the 37 conditions considered 30 were relevant for Leicester, Leicestershire and Rutland. This is because some were already covered by existing local guidance issued in September 2016.
9. Those conditions relevant to Leicester, Leicestershire and Rutland are as follows:

1. Conjunctivitis
2. Cradle Cap – infants
3. Dandruff
4. Diarrhoea (Adults)
5. Dry Eyes/Sore tired Eyes
6. Earwax
7. Nappy Rash
8. Excessive sweating
9. Haemorrhoids
10. Head lice
11. Indigestion and heartburn
12. Infrequent Constipation
13. Infrequent Migraine
14. Insect bites and stings
15. Irritable bowel syndrome
16. Mild contact dermatitis
17. Mild Cystitis
18. Mild Dry Skin/Sunburn
19. Mild/Moderate Hay fever/Rhinitis
20. Minor burns and scalds
21. Mouth ulcers
22. Oral Thrush
23. Prevention of tooth decay
24. Ringworm/Athletes foot
25. Sleep problems
26. Sun Protection
27. Teething/Mild toothache
28. Threadworms
29. Travel Sickness
30. Warts and Verruca's

10. Following development of the conditions list, NHS England undertook a national public consultation on the group's recommendations for a period of 12 weeks, from 20th December 2017 – 14th March 2018. Feedback was received from

members of the public, patients and their representative groups, NHS staff, CCGs, NHS Trusts, various Royal Colleges and the pharmaceutical industry.

11. As a result of feedback, NHS England and NHS Clinical Commissioners released national guidance entitled: "*Conditions for which over the counter items should not routinely be prescribed in primary care*" on 29th March 2018. The guidance can be accessed here: https://www.england.nhs.uk/wp-content/uploads/2018/03/otc-guidance-for-ccgs.pdf

12. There is an expectation by NHS England that CCGs will implement this guidance and that, when they do, CCGs will need to supply patients with better information on signposting so that they are able to access the most appropriate service for their needs.

Exceptions

13. The guidance sets out that there are a number of circumstances in which exceptions would apply to the recommendation to self-care, and where patients should continue to have their treatments prescribed. These are outlined below:

- Patients prescribed an OTC treatment for a long term condition (e.g. regular pain relief for chronic arthritis or treatments for inflammatory bowel disease).
- For the treatment of more complex forms of minor illnesses (e.g. severe migraines that are unresponsive to over the counter medicines).
- For those patients that have symptoms that suggest the condition is not minor (i.e. those with red flag symptoms for example indigestion with very bad pain.)
- Treatment for complex patients (e.g. immunosuppressed patients).
- Patients on prescription only treatments.
- Patients prescribed OTC products to treat an adverse effect or symptom of a more complex illness and/or prescription only medications should continue to have these products prescribed on the NHS.
- Circumstances where the product licence doesn't allow the product to be sold over the counter to certain groups of patients. This may vary by medicine, but could include babies, children and/or women who are pregnant or breastfeeding. Community Pharmacists will be aware of what these are and can advise accordingly.
- Patients with a minor condition suitable for self-care that has not responded sufficiently to treatment with an OTC product.
- Patients where the clinician considers that the presenting symptom is due to a condition that would not be considered a minor condition.
- Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.

- Individual patients where the clinician considers that their ability to self-manage is compromised as a consequence of medical, mental health or significant social vulnerability to the extent that their health and/or wellbeing could be adversely affected, if reliant on self-care. To note that being exempt from paying a prescription charge does not automatically warrant an exception to the guidance. Consideration should also be given to safeguarding issues.

14. Both locally and nationally there are a number of reasons why implementing the guidance is considered to be important. Particularly this is in maximising the availability of clinical time and making the most of limited NHS resources.

15. Every year, there are a lot of GP appointments and consultations for illnesses people could potentially treat by themselves, without having to see a doctor. People can treat these illnesses with medicines they can buy over the counter, from a pharmacy or supermarket. Many of these conditions are self-limiting and they will clear up on their own. When people go to the GP for these illnesses and when they get prescriptions for medicines to treat them, it costs the NHS a lot of money.

16. Nationally, during 2016/17, the NHS spent approximately £569 million on prescriptions for medicines which could otherwise be purchased over the counter (OTC) from a pharmacy and/or other outlets such as petrol stations or supermarkets.

17. The cost to the NHS for many of these items is far greater than the cost of the item over the counter. For example, a pack of 12 anti-sickness tablets can be purchased for £2.18 from a pharmacy. If this was to be prescribed by a GP on a prescription the cost to the NHS is over £3.00 after including dispensing fees. Once we add the cost of GP consultation and administration costs the total cost is over £35.

18. An increasing amount of information is available to the public regarding management of minor self-treatable conditions, including through the NHS Choices website. Furthermore, many community pharmacies are also open extended hours (including weekends and bank holidays) and are ideally placed to offer advice on the management of minor conditions and/or lifestyle interventions.

19. Research has shown that, in many cases, people can take care of their minor conditions if they are provided with the right information. This is turn helps the NHS by releasing health care professionals to focus on the needs of those patients with more complex and/or serious health concerns.

20. Similarly, by reducing the number of prescriptions issued for treating such conditions, resources can be redirected towards other higher priority areas that have a greater impact for patients, support improvements in services and ensure the long-term sustainability of the NHS.

21. Locally the three CCGs in Leicester, Leicestershire and Rutland are working collaboratively with a joint approach to inform and engage patients, carers and member of the public on these arrangements. We are particularly keen locally to identify any areas of concern and respond to any feedback received.

22. Patients and stakeholders can let us know their views by completing the survey online: https://www.surveymonkey.co.uk/r/LCPrescribing18.The findings from the engagement will help shape the local implementation of the changes.

Pharmacy First Minor Ailments Scheme

23. The current minor ailments scheme was established in Leicester City in 2008 with the purpose of improving access and choice for people with minor ailments.

24. At certain pharmacies, patients can receive a consultation for minor conditions and receive a product to treat that condition, free of charge. This means that the patient does not need to go to their GP for advice about such conditions. This is separate to the advice and guidance that all pharmacies are required to provide as part of their contract.

25. A list of the conditions that patients can currently receive advice and treatment for as part of the Minor Ailments Scheme is shown below:

1. Athletes foot
2. Chicken pox
3. Cold sores
4. Conjunctivitis (bacterial)
5. Constipation
6. Contact dermatitis/skin allergy
7. Cough 12 years and over
8. Cough over 1 and under 12 years old
9. Diarrhoea
10. Dysmenorrhea
11. Earwax
12. Haemorrhoids
13. Hay fever
14. Head lice
15. Headache
16. Infantile colic
17. Insect bites
18. Mouth ulcers
19. Nappy rash
20. Non-traumatic pain
21. Oral thrush
22. Ring worm
23. Simple dermatitis (Dry Skin)
24. Sore throat
25. Sprain or strain
26. Teething
27. Temperature and fever
28. Threadworm
29. Vaginal thrush
30. Verruca's/warts
31. Viral upper respiratory tract infection for children 3 months to 12 years, and those over the age of 12.

17. Under this scheme, pharmacies are paid to carry out each consultation. Currently that is £4.50 per consultation plus the price of the medicine supplied. The number of consultations is capped at 170 per month per pharmacy.

Why we are proposing to remove the service in its current form

18. We are considering removing this scheme for a number of reasons:

- The current scheme is not in line with the current local and national drive to encourage patients to look after minor ailments themselves, without the need to see a GP or obtain treatment at NHS expense.
- From 1st October 2018, it is intended that patients will no longer be able to receive prescriptions from their GP practice for medicines to treat the majority of conditions included in the Pharmacy First Minor Ailments Scheme. By allowing the scheme to continue, we would be giving patients conflicting advice: We would be telling patients that they can no longer receive a consultation and a prescription at their GP practice for certain minor conditions, but they could still receive a consultation and free treatment for many of the same conditions at some pharmacies.
- All pharmacies are required to give minor illness advice to patients as part of their normal service. It is therefore inequitable that some pharmacies (those who are in this scheme) are being reimbursed for giving this advice, whereas others are not.

19. The geographical coverage of the scheme does not provide an equitable service across the whole city population, with the majority of consultations taking place in one city ward (Spinney Hills).

20. Furthermore, where patients are exempt from paying for their prescriptions the medication is supplied without charge. None exempt patients however are required to pay the price of a prescription item (£8.80). In areas of low service provision patients are unable to access the scheme, and are therefore are paying for their over the counter medicines - which is not equitable to all of the city population.

21. Changes are also happening nationally with respect to Minor Ailment support for patients, and the impact of this needs to be considered by the CCG

22. The Digital Minor Illness Referral Service (DMIRS) has been running successfully in North East England since December 2017. In it various low acuity calls to NHS 111 are referred to community pharmacies. The Service is being extended to include the geography covered by local NHS 111 provider Derbyshire Healthcare United (Nottinghamshire, Derbyshire, Leicestershire, Lincolnshire, Northamptonshire). The service is funded through the NHS England Pharmacy Integration Fund.

23. The purpose of the Digital Minor Illness Referral Service (DMIRS) is to reduce the burden on urgent and emergency care services by referring patients requiring low

acuity advice and treatment from NHS 111 to community pharmacy. Its aim is to ensure that patients have access to the same if not better levels of care, closer to home and with a self-care emphasis where this is appropriate.

24. The agreement is for the pharmacy to provide self-care advice and support, including printed information, to all individuals referred to the pharmacy by NHS 111 on the management of specified low acuity conditions. The aim is to have the service going live locally in September.

How well is the scheme used

25. Currently across the city there are 86 pharmacies, of which 72 are eligible to take part. The scheme is consistently delivered (providing more than100 consultations per month) by only 10 pharmacies. Of these 10, only two deliver the maximum 170 consultations per month. **40 pharmacies who agreed to join the scheme have not carried out any consultations.**

26. The 10 pharmacies are mainly located in the Spinney Hills area of Leicester, with one on the outer New Parks boundary.

27. Patients and stakeholders can let us know their views by completing the survey online: https://www.surveymonkey.co.uk/r/LCPrescribing18.

Appendix D1

Revised Joint Health and Wellbeing Strategy

Report for: Health & Wellbeing Scrutiny Commission

Report Date: August 2018

Lead Director: Ruth Tennant, Director of Public Health

Useful information

- Ward(s) affected: All
- Report author: Kate Huszar and Ivan Browne
- Author contact details: Kate.Huszar@leicester.gov.uk
- Report version number plus Code No from Report Tracking Database: v1

Suggested content

1. Purpose of report

This paper presents the draft Joint Health and Wellbeing Strategy (JHWBS) 2018-2023 to the Health and Wellbeing Scrutiny Commission. The commission are asked to note the content of the proposed JHWBS and provide the opportunity to for scrutiny to support wider promotion of the draft strategy and feed in any additional comments on it as part of the consultation process.

2. Background

The production of a Joint Health and Wellbeing Strategy (JHWBS) is a statutory duty of the Health and Wellbeing Board and the ownership and governance sits with this board.

The JHWBS represents an overarching strategy for improvements to health and wellbeing for the city and seeks to inform all other plans and strategies relating to health and wellbeing across the city. It is to be used by the local authority and healthcare partners to highlight the strategic direction of health care services in the city.

The previous strategy 'Closing the Gap', launched in 2013, requires renewal to ensure that the JHWBS continues to meet the changing needs of the Leicester population. The content of the proposed 2018-2023 JHWBS, being presented, has been developed using current local intelligence such as; the Joint Strategic Needs Assessment, findings from the locally commissioned Health and Wellbeing Survey, projected population and health status profiles as well as specific intelligence from key partners.

The content of the revised 2018-2023 JHWBS has been developed collaboratively through a series of engagement workshops, undertaken between June and September 2017, which included a wide range of local stakeholders, partners, organisations and other interested parties to ensure they were provided with the opportunity to influence and shape the direction and development of the content areas from the onset. The four workshops covered the following themes;

- Healthy Places
- Healthy Minds
- Healthy Start
- Healthy Lives

Each of the workshops was well attended and some key themes emerged throughout the workshops. These included a recognition of a need for greater support for actions and initiative that seek to promote good health at the early stages of life and the need to broaden the remit of the JHWBS to ensure it places greater emphasis on seeking to address 'the causes of the causes' of ill health i.e. socio economic and environmental factors.

Subsequent to the engagement workshops, a number of additional opportunities were made available to develop and revise the content further through; development sessions with the Health and Wellbeing board members, a JHWBS workshop with local councillors (13/09/2017), presentations and Q&A with the Joint Integrated[1] commissioning Board, Adult Social care, Children's Trust Board, Leicester Safeguarding Adults Board and Leicester Safeguarding Children's Board.

LCC directorates have contributed to the development of the Health and Wellbeing Strategy and offered objectives and targets for the action plan. They have engaged in one or more of the following ways:

- Through the strategy workshops which took place in 2017 to help shape the strategy content
- Through Public Health presence at divisional meetings to explain the strategy and ask for contributions
- Through individual meetings with senior representatives of the directorate

The following directorates have been directly involved in the development process:

- City Developments and Neighbourhoods
- Culture and Neighbourhood services
- Housing
- Estates and Building services (Environment team)
- Adult Social care
- Public Health
- Education and Children's services

[1] The Joint Integrated Commissioning Board (JICB) is an operational group reporting to the Health and Wellbeing Board. Membership of the JICB includes senior managers from Adult Social Care, Children and Young People's Services and Public Health within the local authority and senior managers and governing body members from Leicester City CCG. The JICB provides an opportunity for relationship building and development of a shared understanding of the pressures and responsibilities on each of the partners which offers a context to many of the operational tensions between agencies and supports resolution when issues arise. The JICB oversees the joint procurement of domiciliary support across adult social care and Leicester City CCG. The JICB also has a governance role as part of the BCF. It agrees funding allocations, monitors progress and approves statutory returns to central government.

3. 2018-2023 JHWBS Content

The proposed 2018-2023 JHWBS places greater focus on the wider determinants of health i.e. looking at the impact of poverty, deprivation, housing and education, alongside key local health issues such as the impacts of multi-morbidity and the need to support and care for people with long term clinical conditions such as diabetes, heart disease and cancer.

The proposed 2018-2023 JHWBS comprises of five theme areas:

- **Healthy Places** – this theme recognises that the environments in which we live and work play a crucial role in health and wellbeing. Factors such as the way that environments are designed and how they can potentially influence a person's lifestyle choices (eg the degree of physical activity taken) are considered within this area. The theme aims to make places and spaces that people occupy as healthy and safe as possible, whether they are homes, schools, workplaces, parks and open space etc. All environments physical, social and online are considered in this theme.

- **Healthy Minds** – this theme highlights the importance of mental wellbeing and its relevance to everyone in society. Issues such as the increasing prevalence of mental health problems, the link between poor mental and poor physical health are included within this theme. It also seeks to tackle emerging issues such social isolation and loneliness and seeks to strive for 'parity of esteem' between physical and mental health within services and wider society.

- **Healthy Start** – this theme seeks to emphasise how important the early formative years are to good mental and physical health as an adult. The strategy recognises the significant influence of this stage on long term life attainments such as education, employment, habits and behaviours and overall life expectancy. Maternal mental health, key issues such as post-natal depression and infant mortality are also covered in this section.

- **Healthy Lives** – this theme seeks to support people in the maintenance of healthy lives through healthy choices, but it also seeks to support people who may already have a chronic condition such as CVD or diabetes or are multi-morbid to remain in the best possible health. It identifies actions to support people to live healthier lives by learning, engaging with the world around them and providing access to skills training and education.

- **Healthy Aging** – this theme specifically seeks to support people to age positively, confidently and comfortably. The focus is to support people to live longer, fulfilled lives and to have more years in good health. It recognises the challenges posed by multi-morbidity and dementia as well as social isolation and loneliness which is very pronounced amongst this group. Overall the aim is to focus on building age-friendly environments as well as the appropriate provision of personalised support to those in need.

4. The Action Plan

The actions necessary for delivering the aims and objectives of the strategy are set out within an action plan that will accompany the 2018-23 JHWBS. To support monitoring and delivery of the individual contributors to the JHWBS, under each objective sits the related themes, specific action, the responsible partner, the strategic plans/ objectives the document aligns to and the type of target it is.

Included within these targets are 'stretch' targets. These reflect important strategic goals that may be ambitious or challenging to achieve for a variety reasons including; resource availability, complexity of delivery, the need for supporting policy and/or high level cross sector strategic thinking and action. However, with an increased focus or perhaps a resource change, stretch targets should have the potentially to be achieved. An example could be an ambition to considerably increase the proportion of smoke-free homes in Leicester. This would require considerable input from legal teams, housing organisations, housing directorate, public health, adult social care and other agencies such as Housing Association to achieve.

LCC directorates have begun to contribute to stretch targets for the action plan with the understanding that these are goals to work towards over time. The inclusion of these targets in the strategy are to ensure that there is a good degree ambition in the JHWBS as well as presenting an opportunity to tackle health and wellbeing challenges utilising a multi-agency perspective supported through the Health and Wellbeing Board.

Key partner's such as the NHS, police etc. have already had the opportunity to contribute to the revised strategy but will have further opportunities to contribute to both the strategy and action plan through the engagement phase which is outlined below.

5. Consultation and engagement.

The proposed consultation period for the strategy will run from 27th August 2018 – 19th October 2018. There are three potential strands for engaging more widely with the

strategy being perused. Firstly an online consultation via the LCC consultation pages. Secondly members of the public health division will be visiting a wide range of selected partner organisations to engage with them and deliver a short presentation on the proposed JHWBS. Public Health are in the process of inviting organisations to engage with this process. It is the intention to visit their premises with a presentation. The presentation will provide an overview of the strategy, outline the consultation process and specify how they are able contribute not only to the JHWBS consultation but it subsequent delivery. Thirdly, public health will provide two dates where interested parties will be able to 'drop in' to learn more about the strategy. For this we will make a meeting room available and have staff on hand to talk people through the strategy and outline how they can contribute.

6. Recommendations

Health & Wellbeing Scrutiny Commission are asked to note the contents of this update and engage with and support the consultation and engagement process.

7. Financial, legal and other implications

7.1 Financial implications

TBC
There are no financial implications in the production of the 2018-23 JHWBS. However, delivery of the actions to support the delivery of the JHWBS will need to consider the financial implications associated with them.

7.2 Legal implications

TBC
None.

7.3 Climate Change and Carbon Reduction implications

TBC
The 2018-23 JHWBS seeks to champion increased levels of walking and cycling to improve health and wellbeing and this will potentially have a positive impact on air quality through carbon reduction from less motor vehicle usage.

7.4 Equalities Implications

TBC
The JHWBS seeks to reduce the levels of health inequalities through seeking to tackle the drivers of ill health that disproportionately impact on the more deprived within our communities.

7.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

N/A

8. Background information and other papers:

JHWBS

9. Summary of appendices:

JHWBS

10. Is this a private report (If so, please indicated the reasons and state why it is not in the public interest to be dealt with publicly)?

No

11. Is this a "key decision"?

No

Appendix D2

Health and Wellbeing Strategy and Action Plan 2018-2023

Summary report

Leicester City Council

Contents

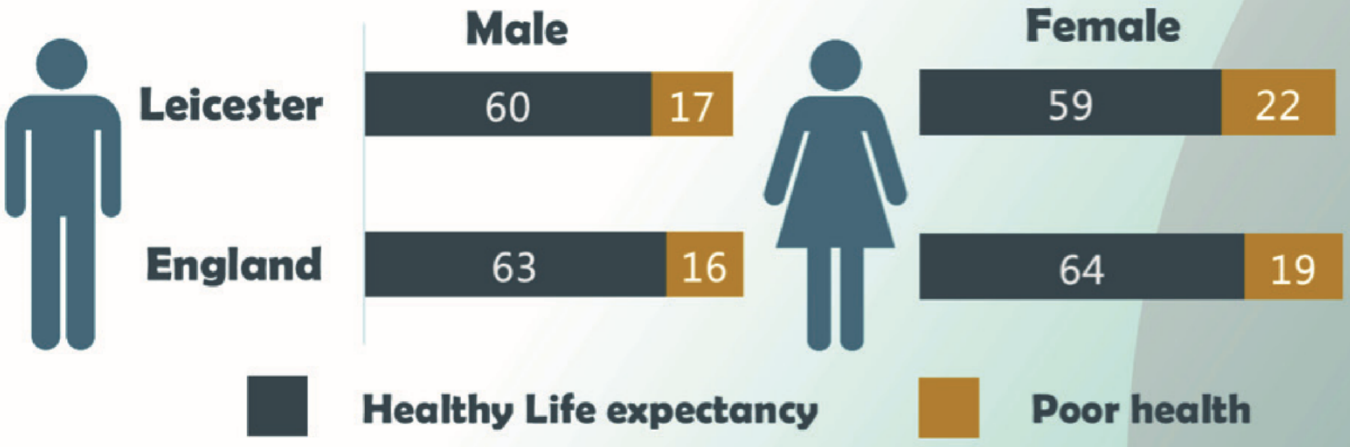
Preface

To be added once initial consultation period is complete

Leicester City Council

Joint Health & Wellbeing Strategy

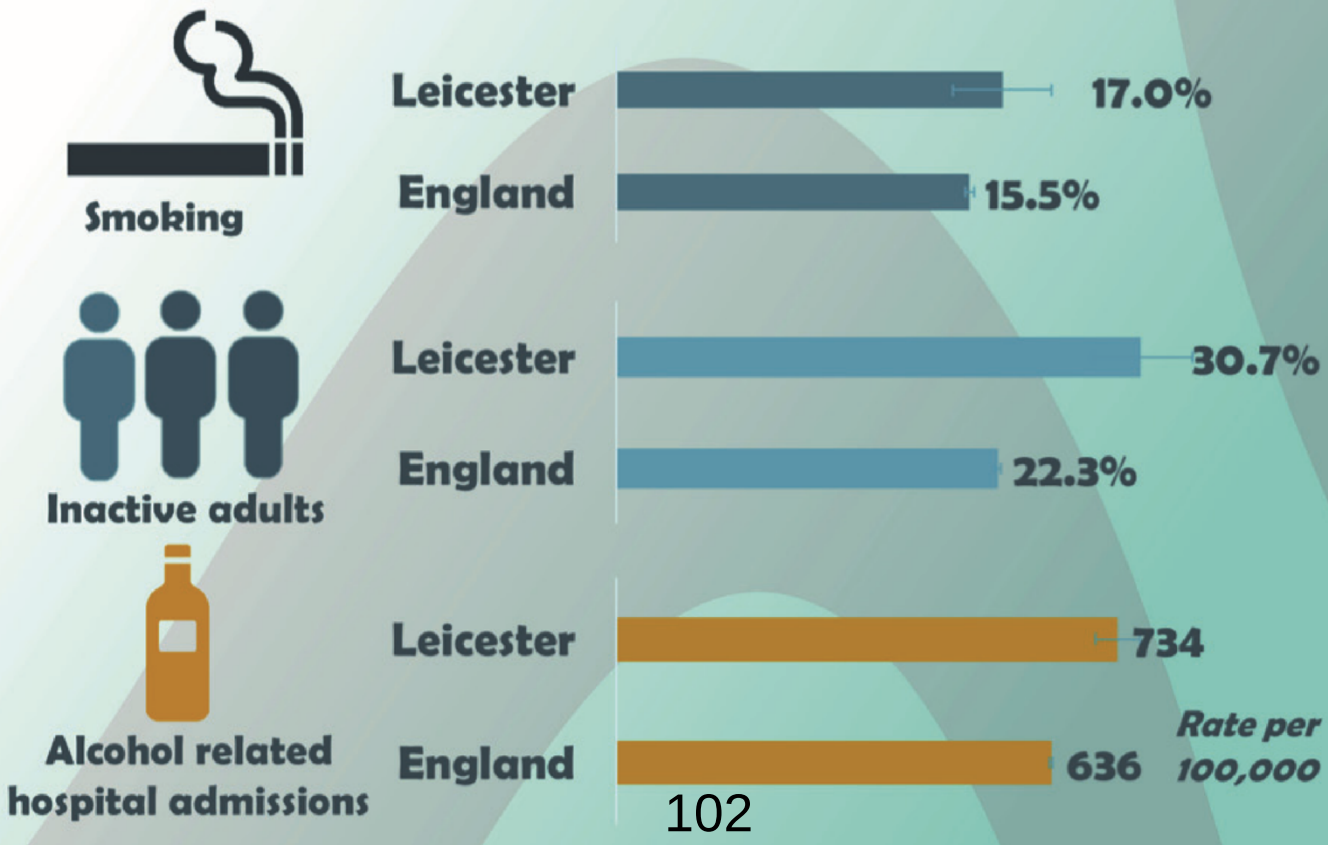
The health & wellbeing strategy will focus on reducing the years people live in poor health.



An estimated 30,529 people (16+) in Leicester have diabetes some are unaware they have the condition.

Those living in poor health are likely to experience 2 or more chronic conditions. Multiple morbidities increases with age.

Shorter life expectancy and diabetes are linked to lifestyle choices such as smoking, physical inactivity and obesity, and alcohol.



1. Introduction

This Joint Health and Wellbeing Strategy and Action Plan (JHWBSAP) sets out the city's intention to improve the health and wellbeing of its residents. The city's Health & Well-being Board has a statutory duty to produce this strategy, setting the direction for the NHS, city council, private sector, voluntary and community organisations and individuals themselves to improve health & well-being outcomes in the city.

It takes a *holistic approach to health*, which means looking at how the built environment of the city itself can influence health and wellbeing, instead of looking only at the people who live in it. It puts the 'person' at the centre, looking at all the factors in people's lives and in their living environments that can affect their health.

While health and wellbeing strategies in the past may have asked 'what is the matter with Sarah,' this strategy will ask 'what matters *to* Sarah.' We believe that looking at the issues that are important to individuals at different stages throughout their lives will help people understand their own health better and live healthier lives.

In Leicester, the demand for health and social care services is driven by *multi-morbidity*, a term which means people who are living with several different health conditions. These could be both physical and mental health conditions, and trying to help people living with several conditions is one of the city's biggest challenges. To rise to this challenge we need to change our approach. This will include working with partners in health and social care to support individuals with multiple conditions, and to develop a new approach to preventing these conditions in the first place.

The strategy is the leading Health and Wellbeing policy document for the city. It will influence other strategies from a range of partners, and will help us work together to achieve shared aims and visions. [1]

2. Overview

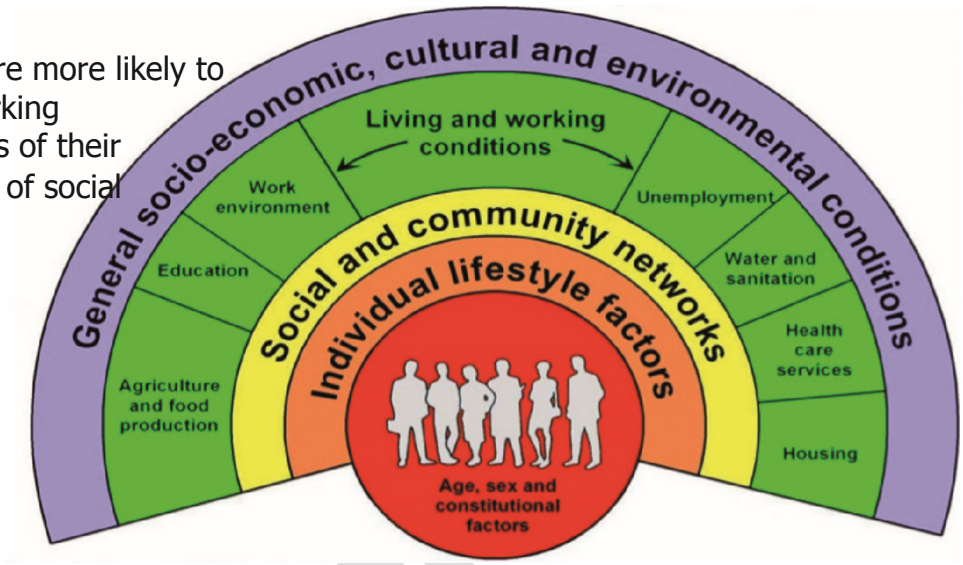
Context

Deprivation has a large impact on health and wellbeing. Statistics show that people living in poorer areas are more likely to die at a younger age, and will spend more years of their life living in ill health than people living in wealthy areas. They are also more likely to be living with multiple health challenges, including a mental health problem. This link between deprivation and poor health was described as 'a social gradient of health' in 2010 by Michael Marmot, and is a theme we will return to throughout the Strategy.

Leicester, in particular, is a deprived area compared to the country as a whole, [2] and 44% of Leicester's population live in the most deprived 20% of areas in England. [3]

People living in poorer areas are more likely to experience poor living and working conditions, particularly in terms of their income, their education, levels of social isolation, and disability.

These living and working conditions are referred to as the *'wider determinants of health'.* They have a big impact on the health of individuals, which is shown in the graphic on the right.



1 The JHWBS underpins any commissioning work undertaken by Leicester City Council and the Leicester City Clinical Commissioning Group (LC CCG) and strongly influences other important strategies and operational plans relating to health and wellbeing including; The Leicester City Clinical Commissioning Group Clinical Commissioning Action plan; The Adult Social Care Transformation Plan; The Children and Young People Plan.

2 Leicester is ranked 21st out of 326 local authority areas in England, on the 2015 national Index of Deprivation (where 1 is worst).

3 Indices of Deprivation 2015, DCLG.

Wider determinants and prevention

The Strategy and Action Plan focuses on improving health by including these wider determinants of health in its approach to healthcare. This will include taking action to address many preventable causes of ill-health, such as smoking, obesity, physical inactivity and alcohol.

These preventable causes of ill-health are all linked to the main causes of death in the city. They are also linked to a shorter 'healthy life expectancy' in Leicester compared to England and other similar parts of the country, a term that means the amount of years living in good health instead of the years lived in total. We also know that new health challenges, particularly loneliness and social isolation, are having a negative effect on both the physical and mental health of people in Leicester.

The main causes of death in Leicester are cardiovascular disease (accounting for 28% of overall deaths), cancer (24%) and respiratory disease (14%). Together, these are the reason for two out of every three deaths in Leicester. There are also 28,000 people in Leicester who have been diagnosed with diabetes, and there are many more living with the condition who do not have a diagnosis.

These conditions can all be linked to lifestyle factors, such as obesity or smoking, but the growth of these conditions is not inevitable. Slowing the growth of these conditions by recognising that we can reduce these through environmental improvement, lifestyle changes and collective action will be a major challenge for the city.

Improving the wider determinants of health will address what Marmot terms 'the causes of the causes' of ill health. His work believes that the wider determinants of health, such as socio-economic background, race, or gender, can often shape the causes of behaviours contributing to preventable ill health, such as physical inactivity. The view of the Strategy aligns with this, and we

believe there is both a strong social justice case and a strong public health case for approaching health and wellbeing in this way, closing the health gap between different parts of the city.

There is also a clear economic benefit to intervening earlier, by changing lifestyle factors that lead to ill-health. Everyday habits and behaviours, such as eating too much unhealthy food, drinking more than is recommended, continuing to smoke and not being active enough, are responsible for around 40% of all deaths in England, and cost the NHS more than £11 billion a year [1]. Pushing to change these behaviours will have cost benefits for the health sector, social care, employers and others. It will also help to stem the rising tide of pressure on public sector funding.

These behaviours, however, cannot be seen as simply a matter of poor individual choices. They are heavily shaped by public policy, and in many cases need intervention on a national scale. Despite this, there is still more to be done locally to influence and support people to build healthier behaviour into their everyday lives.

Multi-morbidity and supporting individuals

Leicester has an increasing rate of multi-morbidity, a term which means there are a growing number of people in Leicester living with more than one chronic or long term health condition. As an example of this, 25% of people with diabetes in Leicester have five or more chronic conditions, and 35% of people living with depression have three or more conditions.

Our data shows that there are 94,104 people in Leicester who are identified as frail, and/or have five or more chronic conditions. It is predicted that this group will require at least three times as much spending on healthcare over the next 12 months to meet their needs compared to a person in good health.

Multi-morbidity increases the likelihood of emergency admission to hospital, regardless of a person's age. Although multi-morbidity is more common in older people, the costs of treating patients aged 19-44 years with seven or more chronic conditions are the same as the costs of treating those over 80 years with the same number of conditions.

Alongside its prevention work, the Strategy will also continue to support those with long term health conditions and help them to maintain their health. According to the latest census, 29,522 people in Leicester are living with a health condition that impacts their daily lives. For this work in particular, the Strategy will take a holistic perspective, by looking at the person as a whole rather than at their specific conditions.

The Strategy also looks at how local environments can support health and wellbeing. This includes the open and green space in Leicester, the cultural offer of the city, and its accessibility.

Strategic approach

The aims of the strategy are present in the objectives of the Action Plan. Governance of this work will come from the city's Health and Wellbeing Board. Working to improve health through its wider determinants is a challenge, and will require working with a range of partners who are committed to making a change in order for us to be successful.

There are also other challenges to recognise when trying to put the Strategy's aims into practice. The most pressing of these is our current financial climate, with pressure being felt across the

[1] PHE Launches One You, 2016

public sector and voluntary sector. The reality is that this situation is unlikely to improve significantly during the lifetime of the strategy.

This means that the Strategy cannot rely on financial resources to deliver its aims. In order to be successful, we need to think differently about how to tackle health challenges. Working in partnership with a wide range of partners is the most effective way to do this. Full usage of community assets and resources need to be made, building on existing projects in the city such as the Braunstone Blues. Sharing non-monetary resources, such as existing materials and specialist knowledge across organisations and within communities will be key to these aims being achieved.

3. Strategy and action plan documents

The content of the Strategy has been informed by many different sources. These include:

- Local health needs identified in Leicester's Joint Specific Needs Assessments
- Local Health and Wellbeing Surveys
- Population health profiles developed by Leicester City Clinical Commissioning Group, that show how physical and mental health problems cluster in certain groups in the city
- Feedback from a series of Strategy and Action Plan workshops, where stakeholders and partners attended to provide their views on what our health priorities should be
- The priorities and objectives of existing strategies.

Improving the health and wellbeing of people in Leicester will be a complex task. An individual's living and working conditions can have either a positive or negative impact on their health, which can then influence their lifestyle choices (such as smoking, or drinking alcohol.) The strategy aims to use the potential of the wider determinants to protect and improve health.

It will also focus on reducing the negative impacts these determinants can have on health and health inequalities. These wider determinants have been considered within five different themes, which together make up the Strategy and Action Plan:

- **Healthy Places**
- **Healthy Minds**
- **Healthy Start**
- **Healthy Lives**
- **Healthy Aging**

In addition to the Strategy and Action Plan, further supporting materials will be made available to aid the delivery of the Strategy's objectives.

4. Vision

The strategy vision is to '**ensure that everyone has the opportunity to improve and maintain good physical and mental health'**. This vision will be reflected in all other strategies relating to health and wellbeing.

5. Aim

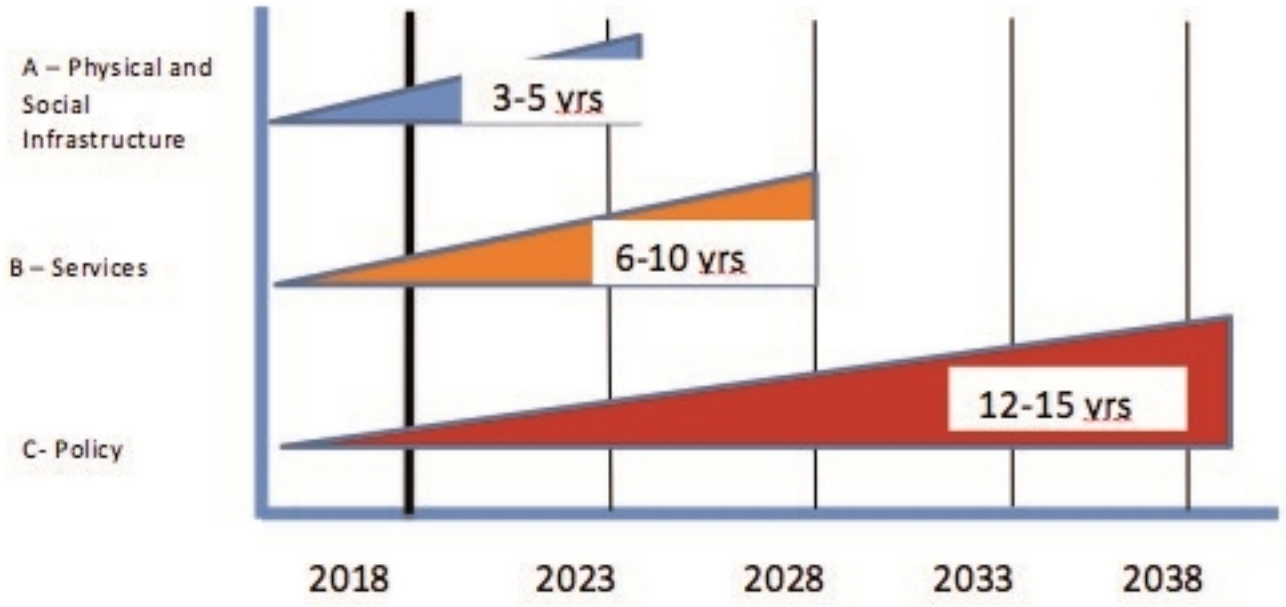
This Strategy and Action Plan has the broad aim of improving the health of people in Leicester. It will achieve this by using the wider determinants of health to change people's behaviours, continuing to support to those with ongoing health needs and by encouraging people to improve their own health.

This aim will be realised by monitoring the progress of the objectives stated in the Action Plan, as well as looking at the aims and objectives of existing strategies. However, the Strategy also includes a series of **stretch targets**. These are important objectives that need high level political input, which means they may take longer to achieve. As shown in figure 1 below, the Strategy and Action Plan has targets that will have a short, medium, and long term impact. These targets are as follows:

A - Physical and Social Infrastructure: This target includes maximising the health impacts of the local environment (such as housing, transport, local parks) . It also looks at social infrastructure, a term for the people living in local communities. Work in this area will take a 'grass roots' approach, working directly with individuals and community groups. Work in this area may have an impact within the time-frame of this action plan.

B – Services: This target emphasises the need to work across organisations in different sectors, recognising the roles of public services and private sector businesses in delivering the objectives set out in the action plan. Work in this area is medium term, with its impact being recognised within six to ten years.

C – Policy: This target includes issues that are complex to address, and require political or strategic input at very senior levels. This is a target with a longer-term outlook, as the impact of this work may not be felt for twelve years or more.



6. Key areas of focus

Focusing on the wider determinants of health means that we need to look at the impact that the wider environment of where people live and work has on health and wellbeing. Healthy Places is, then, the first key area for this strategy and action plan.

A. Healthy Places: This area develops the framework for the action plan, as it recognises that the type of environment people live and work in is always linked to their health and wellbeing. Some illnesses, such as cardiovascular disease or cancer, are caused or made worse by lifestyle factors.

Some environments encourage physical inactivity simply by the way they are designed. These are known as 'obesogenic environments'. They are often places where less healthy food is convenient to access, and it is often easier to drive than walk. Driving and traffic has an impact on the air quality of the city, also. In Leicester, national modelling has estimated that in 2010 there were 162 deaths where air pollution was a contributing factor. [2]

Figure 1, on the right, shows the many possible impacts the built environment can have on an individual's health and wellbeing. All the decisions people make about their lifestyle choices, such as whether to smoke or drink, are made within this complex structure. Understanding the local environment and the influence it has on the population is very important to improving health and wellbeing.

It makes sense for the places and spaces that people occupy to be as healthy as possible.

These include places like homes, schools, workplaces, parks and open space, libraries, museums and leisure facilities.

We are also looking at how technology in the form of apps and online platforms can be used to improve people's health.

[2] PHE / DEFRA

All of these environments, be they physical, social, or online, impact on the health of people living in and around them.

In terms of this Strategy, a 'healthy place' is one that promotes good health and wellbeing through as many means as possible. This may include adapting the physical environment for greater accessibility, improving air quality of a place, or ensuring homes are of a decent standard. It can also mean ensuring that public places are safe, accessible and dementia friendly and other practical elements. It will also include encouraging and enabling people to make healthier choices whenever and wherever they can.

HEALTHY PLACES AMBITION: Make Leicester a healthv environment to live and work in

Key Objectives:

- Influence the environment to accommodate healthy living (A)
- Ensure decent homes are within the reach of every citizen (B)
- Increase opportunities for sustainable transport (C)
- Improve air quality in the City (D)
- Maximise and regenerate open and green space (E)
- Develop and encourage healthy neighbourhoods (F)
- Increase physical activity levels in Leicester residents (G)

B. Healthy Minds: In Leicester, mental health is clearly linked with wider health inequalities. Those living in poorer, more deprived communities are most likely to have a mental illness. Across Leicester there are high rates of depression and anxiety and psychosis, along with a high number of claims for Employment and Support Allowance due to living with a mental illness[3].

Mental health and wellbeing affects everyone – it is everybody's business. Sustaining mental wellbeing is crucial for people to live long and healthy lives. Prevalence rates suggest that one in four working age adults may experience a common mental health problem at any point in their lives. In Leicester, this is estimated to be between 34,000 and 38,000 people, and it affects more women than men.

Around 3,400 people in the city have an enduring mental illness such as schizophrenia, bipolar affective disorder and other psychosis. Mental illness is linked to physical health problems. Many people with long term health conditions experience depression, and people with mental illness are also more likely to smoke, drink alcohol, and use drugs and are less likely to take up preventative measures such as Healthchecks. People with diagnosed mental illness are less likely to exercise although exercise has clear benefits for mental health. As a result, people with diagnosed mental health problems, live less long than the rest of the population: 19 years less for men and 18 less for women.

Mental illness can be the result of trauma such as sexual or domestic violence and it often occurs with other health conditions. 35% of people suffering with depression will have three or more

[3] 38 in 1000 working age people in Leicester claim ESA for mental and behavioural disorders compared to 27.5 for England(SOURCE: NOMIS 2016)

other chronic conditions. Obesity disproportionally affects people living with a mental illness or a learning and physical disability. Antipsychotic medication can cause significant weight gain,[4] and diabetes.

This emphasises the need for 'parity of esteem' between mental and physical health, which is to view both mental and physical health equally and with the same level of importance. It is also important to promote positive health and wellbeing by encouraging and supporting people to maintain their mental health by directing them to self-care resource and reducing stigma associated with mental illness.

Social isolation and loneliness are both noted to be an increasing challenge in communities. Research suggests that there are clear correlations between loneliness and poor mental and physical health. The poor health outcomes include higher blood pressure, greater body weight and higher cholesterol, [5] higher risk of cardiovascular diseases[6] and increased risk of dementia and Alzheimer's. [7]

Social isolation and loneliness can affect anyone at any age (Age UK 2010) [8] and in any circumstances. Although instances are increasing amongst young and middle aged people, older people are considered to be disproportionately affected by social isolation.

HEALTHY MINDS AMBITION: Ensure mental health is considered in all aspects of place and the life course

Key Objectives:

- Improve mental health and wellbeing in Leicester city residents (G)
- Increase physical activity levels in Leicester residents (I)
- Maximise and regenerate open and green space (E)
- Ensure decent homes are within the reach of every citizen (B)
- Develop and encourage healthy neighbourhoods (F)
- Reduce the prevalence of chronic conditions in Leicester (L)
- To support and facilitate stakeholders and other organisations in the education and promotion of positive health and wellbeing (N)

C. Healthy Start: Leicester is a young city, where 38% of its population are aged 0 to 24 compared to 30% across the whole of England.[9] Having the healthiest start to life as possible is critical, as many factors that make up an individual's health are determined in these formative years. What happens in this period of an individual's life can have a considerable impact on their future mental and physical health.

[4] elevated cholesterol levels, risk factor for CVD

[5] Shankar et al (2011) Loneliness, social isolation, and behavioural and biological health indicators in older adults, Health Pychology, 30(4), 377-385

[6] Steptoe, et al. (2004) 'Loneliness and neuroendocrine, cardiovascular, and inflammatory stress responses in middle-aged men and women', Psychoneuroendocrinology, 29(5) pp. 593-611

[7] Valtorta et al (2014). Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies. Heart, 2016

[8] Age UK (2010) Loneliness and isolation evidence review, London: Age UK

[9] MYE, ONS 2016

It also influences future life achievements such as education and employment, habits and behaviours and overall life expectancy. The Strategy recognises that health and wellbeing for children begins before birth, and so the Action Plan includes objectives to support healthy pregnancies within the Healthy Start theme. The mental health of mothers during pregnancy and up to a year after childbirth, is also included in this section. If left untreated, the negative impact of conditions such as post-natal depression have long lasting consequences for the mother, the child and other family members.

Infant mortality is a major challenge both in the city and nationally; the UK has the fourth highest infant mortality rate of comparable countries. The proportion of children growing up in relative income poverty has also been increasing since 2009/10. This is a reversal of steady improvements that had been taking place from the late 1990s. [10]

HEALTHY START AMBITION: Give Leicester's children the best start in life

- Increase opportunities for sustainable transport (C)
- Maximise and regenerate open and green space (E)
- Improve mental health and wellbeing in Leicester city residents (G)
- Improve levels of healthy eating in Leicester (H)
- Increase physical activity levels in Leicester residents (I)
- Reduce levels of overweight/obesity in Children and Adults (J)
- Increase the number of people engaging in protective behaviours (K)
- To reduce levels of infant mortality
- Support women and their families to experience a healthy pregnancy (M)
- To support and facilitate stakeholders and other organisations in the education and promotion of positive health and wellbeing (N)

D. Healthy Lives: Encouraging people to live healthy lives can be a way of managing existing health challenges and to combat some emerging risks to health. This is important in terms of reducing the number of people who are suffering from multiple chronic illnesses. Tackling physical inactivity, poor diet and unhealthy habits can improve an individual's quality of life and life expectancy.

As an example, cardiovascular disease (CVD) is the cause of around 28% of all deaths in Leicester. The highest rates are found in south Asian communities and in areas with the highest level of deprivation. It is more likely to occur with increasing age and amongst men.

Having an unhealthy diet, living an inactive lifestyle, being overweight or obese, smoking, consuming excessive amounts of alcohol and stress are all factors that contribute to CVD and other conditions such as diabetes. There are 28,000 people in Leicester diagnosed with diabetes, and an estimated additional 30,529 people who have diabetes but are undiagnosed. Reducing this will need sustained effort to identify people with early signs which left unchecked could lead to diabetes as well as making sure that people with diabetes receive optimal support and treatment. The city's new status as one of an international network of Cities Combatting Diabetes will help to drive this action locally.

[10] International comparisons of health and well-being in early childhood' (Nuffield Trust / RCPH)

Leicester has a high number of people aged 50+ who have multi-morbid conditions. These can be any combination of physical conditions, mental health conditions or learning difficulties. People with multi-morbid conditions often also experience social isolation and loneliness.

Working with adults to improve their learning is key to improving overall health and wellbeing. Having a better education will lead to better job prospects, which in turn leads to a better standard of living and better reported overall health.

The city's cultural assets also have an important part to play in improving both physical and mental health. Leicester Museums and other cultural organisations in the city have already put in place schemes such as museums volunteering, dementia friendly workshops which have a wide range of therapeutic benefits and there is significant potential to develop this further and strengthen the links between the local GPs and the NHS and some of these activities.

E. Healthy Aging: Leicester has an increasing older population as a general increase in life expectancy means people are living for longer. However, this has resulted in a higher number of people living in ill health for longer. In Leicester, men spend 17 years and women spend 22 years

HEALTHY LIVES AMBITION: Encourage Leicester residents to adopt healthy behaviours sustainable throughout life for increased healthy life years

Key Objectives:

- Influence the environment to accommodate healthy living (A)
- Ensure decent homes are within the reach of every citizen (B)
- Increase opportunities for sustainable transport (C)
- Improve air quality in the city (D)
- Maximise and regenerate open and green space (E)
- Develop and encourage healthy neighbourhoods (F)
- Improve mental health and wellbeing in Leicester city residents (G)
- Improve levels of healthy eating in Leicester (H)
- Increase physical activity levels in Leicester residents (I)
- Reduce levels of overweight/obesity in Children and Adults (J)
- Increase the number of people engaging in protective behaviours (K)
- Reduce the prevalence of chronic conditions in Leicester (L)
- Support women and their families to experience a healthy pregnancy (M)
- To support and facilitate stakeholders and other organisations in the education and promotion of positive health and wellbeing (N)
- Increase the priority of health and wellbeing in existing work places (O)
- Support increase in better quality employment and better income (P)
- Take steps to reduce social isolation, particularly amongst the elderly (Q)

with a reported poorer quality of life.

As well as being detrimental to the individual, this causes financial difficulties when trying to provide enough health and social care services for the general population. People over 65 account for nearly 60% of the total cost of emergency admissions. The top three causes of hospital admissions are for CVD (16%), respiratory conditions (15%) and general injuries (13%).

The number of emergency hospital admissions from patients with five or more chronic conditions increases steadily in line with the patients age once they reach 50 years. This means that the older they are, the more likely they are to be suffering with multiple conditions. Encouraging

better health and wellbeing amongst older people could mean that they live more years in better health. Healthy ageing is about more than just reducing illness. It is about making older people feel valued and helping them to become actively engaged with their communities and helping to make positive connections with other community members.

Healthy ageing is about more than just reducing illness. It is about making older people feel valued, and helping them to become positively engaged with their communities and other community members. It is also about ensuring that vulnerable older people remain safe from exploitation and abuse.

The risk of developing chronic illnesses and conditions such as sensory impairments or dementia increases with age. Leicester has around 3,000 people diagnosed with dementia of which 97% are aged over 65 years[11]. Making communities safe and accessible for people with dementia is important, and the city will aim to continue and expand on its work to have 'dementia friendly' public spaces and promoting the Dementia Friends social movement. Living with a visual or hearing impairment or with dementia can exacerbate a person's feelings of loneliness and isolation which in turn often leads to depression and other physical or mental health conditions. The city will also work to support carers of people with dementia by providing information and using museum collections as a resource for things like practical memory activities.

The strategy aims to improve quality of life and reduce isolation and loneliness. It is about looking at and taking into account issues that affect an older persons quality of life such as feeling safe, having access to transport and ensuring that spaces and places are age friendly with suitable seating, access to toilets etc. It is also about supporting informal carers, usually family or friends. Very often these carers are older people themselves – spouses or partners or adult children who may be juggling work and a family and who have their own lives to lead alongside their caring role.

The Strategy is committed to providing older adults with a voice, and working with the NHS and

HEALTHY AGEING AMBITION: Enable Leicester residents to age comfortably and confidently

Key Objectives:

- Ensure decent homes are within the reach of every citizen (B)
- Increase opportunities for sustainable transport (C)
- Maximise and regenerate open and green space (E)
- Improve levels of healthy eating in Leicester (H)
- Increase physical activity levels in Leicester residents (I)
- Reduce the prevalence of chronic conditions in Leicester (L)
- Take steps to reduce social isolation, particularly amongst the elderly (Q)

[11] Leicester, Leicestershire Rutland Joint Dementia Strategy 2019-2022

7. Consultation

Consultation surrounding the Health and Wellbeing Strategy and Action Plan has occurred in three ways:

- Each of the five main themes was the topic of a strategy workshop where stakeholders, partners, and professionals from a range of organisations made suggestions for improving health and wellbeing in each area. A summary of the workshops can be found.
- The aims and objectives were developed by engaging with authors of existing health-related strategies and plans
- The Strategy and Action Plan will also go through an eight week public consultation period, which will give organisations and members of the public an opportunity to engage with the document and make comment.

8. Delivering the action plan objectives

The aims and objectives of the Strategy can be found in the Action Plan at the back of this document. It must be noted that the Strategy has been developed in a time of extreme financial pressure across the public and private sector. This situation has a considerable impact on how the aims and objectives can be delivered.

Stakeholders and partners will have to find different ways of working towards these shared goals with funding as reduced as it is. One way to do this is to continue with existing collaborative working arrangements and extend this to include wider partners, organisations and community groups.

Working with multiple partners can lead to other challenges, as each organisation or department has their own governance structure and priorities to work to, which can sometimes lead to conflict.

The Action Plan recognises this, and aims to be clear in terms of what it is trying to do and what is expected from partner organisations.

The city's Health and Wellbeing Board is responsible for developing the Action Plan and for ensuring that its aims and objectives are met. The Council is a democratic body which means that it is accountable to the general public and the Health and Wellbeing Board is a board that members of the public are able to attend.

This is different to our partner organisations who are held to account by different governing bodies or structures which may not be public facing. The Action Plan aims to make roles and responsibilities for different organisations clear from the beginning, to ensure the Strategy and Action Plan are delivered smoothly.

9. Oversight and Governance

As this is the leading Health and Wellbeing Strategy for the city, it needs to have good visibility, strong leadership and a clear governance structure. This will aid in delivering its objectives to schedule.

The Health and Wellbeing Board has overall responsibility for creating and delivering the Joint Health and Wellbeing Strategy and Action Plan. Members of the Board include representatives from the local authority, health services, other public sector services and Healthwatch. Oversight of the Strategy will come from partners of this board. The Health Scrutiny Committee will also provide a further level of accountability as the Action Plan progresses.

On a day to day basis, the strategy will be managed by the Joint Integrated Commissioning Board, and a working group which will report directly to the Health and Wellbeing Board. It is this group's role to progress the aims of the Strategy by delivering the Action Plan's objectives.

Membership of this working group will reflect the Strategy's priority of addressing the wider determinants of health. This group will be responsible for ensuring that the objectives remain relevant and achievable as time goes on, and that the action plan delivers on these objectives.

10. Strategy action plan -aims and objectives

The aims of the Strategy apply to each of the five major themes; Healthy Places, Healthy Minds, Healthy Start, Healthy Lives and Healthy Ageing. The Action Plan highlights a number of specific objectives that are key to delivering the Strategy overall.

The objectives have been developed through consideration of current health priorities and in consultation with leaders of other strategies. Although the intention is for targets to remain the same throughout the lifetime of the action plan, the working group can review and refine them if a significant change out of our control, such as a change to national measurement programmes, threatens to undermine their usefulness.

Appendix F1

Leicestershire Partnership
NHS Trust

From the Office of Dr Peter Miller
Direct dial: 0116 295 0911

A University Teaching Trust
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16 July 2018

Councillor Elly Cutkelvin,
Leicester Health Overview &
Scrutiny Committee
City Hall, 115 Charles Street,
Leicester, LE1 1FZ

Dear Councillor Elly Cutkelvin,

New CAMHS Inpatient Unit – Letter of Support

In 2015, the Trust had to relocate its 10 bed child and adolescent mental health (CAMHS) inpatient facility on a temporary basis, from the old Towers Hospital site in Leicester to Coalville Community Hospital. Patients, carers, stakeholders and staff felt that this temporary arrangement was inadequate and inappropriate from the outset and finding a permanent relocation has been one of the actions within the Leicester, Leicestershire & Rutland sustainability and transformation plan.

In 2017, the Department of Health announced that Leicestershire Partnership NHS Trust (LPT) had been successful in securing an £8.0 million capital grant for a new 15-bed combined CAMHS and Eating Disorder inpatient unit on the Glenfield Hospital site in Leicester.

The national Five Year Forward View for Mental Health states that inappropriate placements to inpatient beds for children and young people will be eliminated, including both placements to inappropriate settings and to inappropriate locations far from the family home (out of area treatments) by March 2021. The expansion and permanent location of the local CAMHS inpatient unit will mean most of the young patients locally will no longer be placed out of area for inpatient care.

Since the award of funding, LPT has been working with its construction partner to design the new unit on the Glenfield Hospital site and to secure planning permission from Blaby District Council. We are now preparing the full business case, which has to be sent to the Department of Health for final approval before construction begins. This will run through to February 2020 and the service will relocate in March 2020.

As part of that business case, we are required under national guidance to include a letter of support from the local Health Overview & Scrutiny Committees and write to ask that you provide this to our project director David Bell (at david.bell@leicspart.nhs.uk). There has been extensive service user and carer engagement in the past, with full support for having the unit centrally located. Given that the permanent relocation from the Towers Hospital site to the Glenfield Hospital site is just 4 miles, it would be very helpful if your letter could confirm that this is not a substantial development or variation in the service.

If you need any assistance with the letter, please do not hesitate to contact David in the first instance.

Yours sincerely

Dr Peter Miller
Chief Executive
Leicestershire Partnership NHS Trust

Author: Richard Baines, Helen Riddleston, Suzi Glover, Geraldine Ward

Context

1. The purpose of this paper is to brief the Leicestershire, Leicester and Rutland Health Overview Scrutiny Committee on the process and service development to re-provide and expand renal dialysis services for the population of Lincolnshire and Leicestershire and Rutland (LLR).

   The private provider contracts that are in place for Lincolnshire (Grantham, Boston and Skegness) and Leicestershire and Rutland (Hamilton) are up for renewal and therefore we are in the process for planning the future of the service in those areas. The objective will be to:-

   a) To provide and facilitate the delivery of high quality and most cost-effective care for the patients.

   b) Improve capacity and access to local outpatient haemodialysis facilities for patients in LLR and this includes an improved pathway for inpatients for the population of Lincolnshire and the surrounding area. There is a 4% growth in the number of people requiring dialysis treatment is forecast - refer to renal registry report) and we know that patients treated with dialysis have increasingly complex health and social care needs.

   c) To meet national standards - Patients should travel less than 30 mins of their home to access haemodialysis

   Over the last few years we have successfully delivered new dialysis units in Northampton, Kettering and most recently Peterborough. From the point of view of LLR it should also be noted that the wider renal service is also being considered with the plans for reconfiguration being factored into the planning.

Current Service – Leicestershire and Rutland	Future
Leicester General Hospital – (UHL)	Reconfiguration Plans –future Kidney centre model in discussion.
Loughborough Satellite Unit	Remain as is with potential to develop a minimal care area within the existing footprint.
Hamilton Satellite Private provider fully managed Service	Tender
Heath Lane Surgery (UHL)	Self -care facility to remain as is.
Current Service Lincolnshire	
Lincoln County Hospital (UHL)	In patient and day-case service development – clinical pathway to repatriate Lincolnshire patients
Grantham Satellite Unit – Private Provider – fully managed service	Tender
Boston Satellite Unit – Private Provider – Fully Managed Service	Tender
Skegness Satellite Unit – Private Provider – Fully Managed Service	Tender

Background

It is proposed that the expansion programme would have 2 phases to it. The first phase would address the immediate need for increased capacity and the private provider contract which is coming to an end.

The second would work alongside the reconfiguration programme to address the longer term capacity issues and some other aspects of the renal service.

Quality and Patient Experience

Although dialysis is a lifesaving treatment for people with End Stage Renal Disease (ESRD), dialysis is also a significant life changing experience for every individual that needs it.

For many patients with ESRD, dialysis greatly improves their well-being and their life. However, for some renal patients, it may not be as beneficial due to other health problems.

Patients receiving in centre haemodialysis attend the dialysis unit for 3.5-4.5 hours of treatment three times each week. In addition there is travel time which many patients find difficult to endure. It is therefore critical to get the planning right when considering service development.

The types of things that influence a good quality haemodialysis patient experience are as below:

a) A suitable clean and welcoming environment that allows HD to be delivered efficiently in a calm setting
b) Suitable appointment times with HD treatments commenced in a timely manner
c) Flexibility with appointment times to enable patients to attend special events
d) A unit 'close to home' with minimal travel time without delays (standard is within 30 minutes from home)
e) Good communication supported by information about their condition and treatment
f) Continuity of care delivered by competent staff
g) On-going support to assist them in accepting their life change and adapting their lifestyle as required
h) Effective 'problem free' vascular access

We are in the process of surveying all patients treated with dialysis on a one to one basis. However, we have recently hosted a consultation event (13th May) and whilst the number of attendees was a minority they made valid and interesting points highlighting how they felt the service should develop. These include:-

a) A preference for some dialysis provision to be on the GH site
b) Direct admission to a renal services therefore avoiding an admission to ED
c) Communication between the ward and the dialysis unit is important

Taking the above into account the clinical and managerial team have developed a robust service specification.

The Renal and Transplant service develops from a strong position and in particular it:

a) Is a tertiary referral renal centre serving a population of 2.2 million people.
b) Is the hub for one of the largest renal networks in the country providing care for over a 1000 people across the network with end-stage kidney disease. The clinical outcomes are good or on a par with comparable services as evidenced by successive renal registry reports.
c) Has a strong ethos of multi-professional working with nationally prominent figures working in our pharmacy, dietetic, nursing, H&I as well as clinical teams. Clinicians are recognised for holding prominent roles in national bodies such as the Royal College of Physicians.
d) Is the driving force behind the highly successful East Midlands NIHR CRN research network. The clinical service is vastly enhanced by internationally regarded clinician scientists.
e) Offers a very good training environment – evidenced by undergraduate and postgraduate feedback as well as consistently attracting high quality trainees from overseas.

The Programme of Work

The Hamilton, Boston, Grantham and Skegness units are fully managed, private provider units. Through procurement process services will be expanded, to deliver a different service model to fit with the change in acuity and case-mix of patients. The location may remain the same or may be in the close proximity. The plan would be a stepwise increase in patient numbers and capacity usage over a number of years.

This would allow us to cater for the predicted growth in numbers as well as cater for the more complex, frail patients requiring the premium middle of the day slots. To meet the required procurement regulations the plan is for the procurement to commence on 25th July 2018.

Outpatient Haemodialysis Provision - Procurement - The following procurement lots have been agreed:

Lot 1: Lincolnshire

a) Boston (Current) or similar location based on postcode data.
b) Grantham (Current) or similar location based on postcode data.
c) Skegness (Current) or similar location based on postcode data.

Lot 2: Leicestershire and Rutland

a) Hamilton (Current) or similar location based on postcode data.

Input Sought

The committee is asked to support the service development and tender process and note the anticipated benefits for the patients.

Appendix F3

Annual report 2017/18

Healthwatch Leicester

Contents

Message from our previous Chair and Acting Chair

This past twelve months has seen further changes for Healthwatch Leicester largely external and some internal. With regard to board members, in December 2017 Karen Chouhan stood down from the position of Chair of the board and Sylvia Reid became the acting Chair, pending the outcome of the bid tender (as explained below in 'the future' section) at which point it was intended to advertise for the position. Sadly as mentioned below we did not win the contract and so Sylvia remains as acting chair until the new provider takes over on 01st April 2018.

Staff

The staff team numbers have ebbed and flowed this year due to a combination of factors. Other than the planned internal re-organisation, these factors were all beyond our control. Such unforeseen changes consequently brought additional challenges for the staff and Board. Two new post-holders were appointed to replace the roles of CEO and Engagement Officer. We were very fortunate to appoint Omita Gaikwad in July as CEO. Omita has a wealth of experience in health care delivery in Leicester and Leicestershire. Omita immediately grasped the challenge of identifying the problems, restructuring the office and providing first class strategic and operational leadership. In October Claire Knowles was appointed as Project Engagement Officer. Although we were delighted that Barbara Czyznikowska had gained her well deserved position at the University of Leicester, we knew that Barbara's insight and enthusiasm would be difficult to replace. Fortunately a strong field of candidates were attracted to her position and Claire was the successful candidate. Claire has a similar background to Barbara's in social law and has worked for Macmillan Cancer Charity and more recently the Alzheimer's Society. Claire has very quickly established herself as a highly regarded engagement practitioner.

Key Themes and highlights

The public event due to be held in May 2017 was cancelled due to the unexpected General Election held in June. The outcome of that election has contributed to the earlier plans for STP being revisited. It is envisaged that meaningful and genuine consultation on STP, now a Sustainable Transformation Partnership rather than a plan, will recommence in the Summer of 2018. One unfolding outcome of the STPs has been the promotion of an emerging concept of Accountable Care Systems or Organisations, which are intended to group the accountability for health and social care under one accountable body. We are aware of the concerns people and Third Sector groups have expressed regarding ACOs. We are given to understand such new models of provision are no longer being progressed and we are hopeful that much of the best practice as generated through the work of the Better Care Together team can take a higher profile.

This year we were very proud of the work done with young people and for young people. Young Advisors Leicester attended our board meeting in October to give a presentation about the work they had done for Healthwatch Leicester on: 'Evaluating Young People's Experiences of Transitioning in Local Health Services in Leicester'. Jaimini from the group talked about the difficulties that young people experience when moving from fully supported Children's Social Care to Adult Social Care. The majority of health services required transition at 18; with plans coming into place between 16 and 17 years of age. However, in some of the most important services such as Accident and Emergency, young people can transition at 16 years of age. The recommendations coming out of the report were then taken forward to the appropriate agency.
Communications have been a key priority this year. In November we launched our new style of fortnightly newsletter and website, bringing local health and social care news and information to our members and stakeholders, raising the profile of Healthwatch locally and using social media to connect with a wider audience.

The Future-2018 - 2021

In case you missed the consultation and publicity, the Healthwatch Leicester contract is to merge with that of Healthwatch Leicestershire from 1st April 2018 and will become HWLL. We submitted an ambitious and strong bid for the contract tender. Karen Chouhan and Omita Gaikwad led on this important work. Our thanks goes to Karen and Omita, staff and Board members who shared their insights, worked cooperatively together to produce a challenging and exciting activity model. We congratulate Engaging Staffordshire Communities (ECS) who have been awarded the HWLL contract and we have worked collaboratively to ensure this important transition builds on the sound foundations that have been laid down through our community engagement and networking. ECS already manage five Local Healthwatch most of which are in the West Midlands. ECS are a Company partner of the Market Research Society (MRS) and we are confident their well developed networks and expertise will bring a new depth and breadth to the work of Healthwatch Leicester & Leicestershire.

The dedication and commitment shown by Board members, staff and authorised reps over these past three years has been exceptional. No challenge has been too big or small for these people even when resourcing constraints of varying descriptions have been challenging. All of HW Leicester's personnel have been determined to overcome the problems, seek resolution and do their best often in difficult circumstances to achieve a successful outcome. It is envisaged that such tenacity will continue to flourish in the new organisation. As you'll appreciate there is an air of poignancy in writing this closing Annual Report. Whilst we are disappointed not to have been successful in the contract competition, we are rightly satisfied with our achievements over these past months. We know over these past three years we've begun to develop and reach the City's compassionate community of people who produce outstanding achievements across all walks of life in this City. We've sewn some seeds which we look forward to seeing grow.

Finally we would like to thank past and present board members, staff and volunteers for helping us build Healthwatch Leicester and leaving a lasting legacy of public and patient involvement in health and social care for the new company.

Message from our Chief Executive, Omita Gaikwad

I joined Healthwatch Leicester in July 2017 as an interim CEO with a primary focus on developing and strengthening an initially incomplete operational team, sustaining and delivering core service provision and providing strategic drive, alignment and input to the Healthwatch Leicester Board as they geared themselves up towards not only submitting a thorough and local needs based bid for the new Healthwatch Leicester and Leicestershire contract, but also in preparation towards delivering against this.

As highlighted in Chairs message, the team have at times been operationally challenged in a number of ways, but despite this were able to rise to the occasion, identifying both key areas of growth and best practice ready to transition across to a more improved, effective and integrated Healthwatch presence across the new Leicester and Leicestershire contract.

Due to gaps in staffing provision throughout the year, although public engagement activity was not at its' peak, time and energy was steered towards reviewing and developing our existing communications presence and exploring ways to increase potential digital engagement impact in new and innovative ways. Efforts were also made towards strategically identifying potential partner organisations from within the voluntary sector adding to more effective and long term secondary engagement channels being established.

Further routes into local higher education institutes have also been explored and developed as a key source for both on going volunteering resource and research based initiatives.

No doubt all individuals of Healthwatch Leicester who transition across to the new providers of the HWLL contract will be an asset to the organisation going forward and will continue to contribute efforts with passion and dedication.

Message from our new Executive Director

It's the time of year that the Annual Report is prepared and published documenting the work achieved over the last financial year.

Engaging Communities Staffordshire have been delivering the contract to provide Healthwatch in Leicester and Leicestershire since 01 April 2018.

We are looking forward to build on the sound work of the former provider and build on their legacy of ensuring the voice of the public in Leicester is heard by providers and commissioners of health and social care services within the city.

We are committed to continuing our work and ensuring that people in Leicester have a strong voice and get to have a say in the changes to the way health and social care services are delivered.

We will continue to increase the number of Enter and View Visits to a range of health and social care provision such as Residential Homes, GP Surgeries, Dentists and Opticians as well as hospital wards and learning disability and mental health services.

To deliver this we will proactively recruit more volunteers and support them to train as Authorised Representatives so that our Enter and View visits are lay member led.

Our Community Outreach Leads will continue to build the network of organisations we work with to enable us to hear from as many people as possible.

We are very much looking forward to the next 12 months working with commissioners and service providers, but most importantly with the people of Leicester in order to amplify the public and patient voice. Whilst we have working relationships with commissioners and providers of services we still ensure that we remain a critical friend so that we can represent, support and inform the public.

- Simon Fogell, Executive Director

Highlights from our year

1,900

This year we've reached 1,900 followers on social media

Our **8** volunteers help us with everything from Research to Enter & View

We've visited **5** local services

Our reports have tackled issues ranging from **Imaging** to **Maternity Services**

We've spoken to **277** people on Dental services

We've given **339** people information and advice

Who we are

You need services that work for you, your friends and family. That's why we want you to share your experiences of using health and care with us – both good and bad. We use your voice to encourage those who run services to act on what matters to you.

As well as championing your views locally, we also share your views with Healthwatch England who make sure that the government put people at the heart of care nationally.

Health and care that works for you

People want health and social care support that works – helping them to stay well, get the best out of services and manage any conditions they face.

sure your views shape the support you need.

People's views come first – especially those who find it hardest to be heard. We champion what matters to you and work with others to find ideas that work. We are independent and committed to making the biggest difference to you.

Your Voice Counts

Our purpose

To find out what matters to you and to help make

Your views on health and care

Listening to people's views

Some facts and figures -

339 requests for help/ or experience shared from members of the public.

277 – Relating to dentists or dental information

We have been working in partnership with Healthwatch Rutland and NHS England on highlighting areas of greater dental needs. We have also seen an increase of need in dental support in care home due to more residents having their own teeth, this was most evident by the number of care home workers calling our helpline for local dentist information. This has led to an NHS England work group looking at this newly identified issue.

Common themes or trends -

Access to services is a common thread through many of the issues raised with us and where further information has been sought. Problems with accessing services ranging from dropping out of a GP catchment area or the cancellation of surgery in hospital.

Of the 62 contacts we referred to POhWER 13 times.

Making sure services work for you

Our Enter and View team

Sue Mason - Chair, Kim Marshall-Nichols, Moraig Yates, John Bryant, Janina Smith, Lynn Pearson, Michael Gilhooley and Micheal Smith (staff support)

Where have we been?

Westcotes Health Centre

As a large GP service with multiple GP surgeries and the newly established "Healthcare Hubs", this site was visited to gather patient experience of established GP services and emerging GP service support.

Patients using all the services were very pleased with the level of service received. The main issue identified was the lack of signage about where the Healthcare Hub was located and the impact that had on other GP services located in the building.

This was acknowledged by the service provider and substantial improvements have since been made making it clear where new patients to the hub should go within the building.

GP Assessment Unit and Acute Medical Unit.

As a new service established during significant re-design of the Emergency Department, the GP Assessment Unit was visited. This was part of a larger visit also looking at the Acute Medical Unit based within the Leicester Royal Infirmary.

Through this visit we were able to observe how Emergency medicine at the hospital trust is changing to better cope with A&E admissions.

The patient experience was seen to be very positive as patients were well cared for and the one-stop-shop capacity of the GP Assessment Unit was able to access diagnostic services much quicker, which meant patients could be tested and diagnosed much quicker.

Issues were highlighted around signage within the waiting area as well as concerns around how well the change had been communicated to other primary care services.

As the service has now changed location, Healthwatch was invited to review the service before it opened to the public.

Beaumont Hall

The last visit of 2017-18 was done to a Leicester City care home Beaumont Hall, this was due to historic ratings from the Care Quality Commission and from discussions with partners in Leicester City Council.

Residents were very happy with their care within the home and we observed many steps to better engage with the elderly residents through meaningful activities and the layout of the home. We even saw a Leicester Tigers player playing rugby with the residents.

Enter & View Revisit

To review what steps have been taken after issues have been highlighted in Enter and View visits, our process is to revisit the service. This is not a full visit but allows any improvements to be recorded.

Grey Ferrers

Following on from our visit to the home in July 2016, we revisited the home this year. As the provider of the home has changed it would make some comparisons difficult however speaking to residents and their families they are still receiving a high level of care. Whilst some recommendations had not been taken forward, this was due to financial reason and did not compromise residential care.

It was noted that changes had taken place to improve how the home is managed and some issues around physical access and display of sensitive information had been take forward.

The Evington Centre

In June 2016 we visited both services based within the Evington centre – Rehabilitation services and Mental Health Services for Older People.

This year we have been able to revisit the Mental Health Services for Older People and are planning to revisit the Rehabilitation services.

Following the refurbishment of the Gwendoline ward we are able to see how patients and staff views were evident through the process, which after feedback on our previous visit it a big step forward. Staff and patients both saw benefits to the refurbished ward and the planned refurbishments of the Wakerley ward will, hopefully, continue this.

Issues still remain about how the service is able to place more challenging dementia patients into community homes, as less care homes have the capacity to take them on. We would also like to see onsite social worker support from Leicester City council.

Partnership working

Being supported or being able to support the work of other organisations is a key tool for Healthwatch. This allows us undertake bigger and more impactful projects whilst at the same time developing strategic and operational partnerships.

Working with other Healthwatches -

A fundamental relationship in our work is working with neighbouring Healthwatches. Below are some examples of joint Healthwatch working -

- Early in 2017 Healthwatch Leicestershire went into the new A&E department of Leicester Royal Infirmary to survey patients. Staff and volunteers of Healthwatch Leicester City supported surveying patients. This resulted in the report "Check in @ the new ED" highlighting a number of improvements to the service.
- "Settings of Care" policy change – Working with Healthwatch Rutland and other voluntary organisations we have challenged changes to local policy for continuing healthcare funding criteria. We were pleased when the proposed changes were rejected.
- We have been supported by Authorised representatives from neighbouring Healthwatches when undertaking Enter and View visits, with Healthwatch Leicestershire joining our Enter and View visit to the GP Assessment Unit of Leicester Royal Infirmary.

Working with Health or Social Care organisations

Being able to work productively with the NHS and Social Care services is also fundamental to being able to represent the patient voice and to improve local services.
Through 2017 we have worked with the patient experience team in Leicester City Clinical Commissioning Group to survey patients using outpatient clinics across the acute hospitals in Leicester. This has resulted in a much clearer picture of the patient experience which will be used going forward in discussions with the health commissioners and providers.
We continue to the be proud of our involvement of the RUOK project, which is a multi organisation project between Leicestershire Partnership Trust, National Rail, Council Public Health teams, Samaritans, Healthwatch and Police. Working to challenge mental health stigma and encourage better mental health and wellbeing.
Through funding from NHS England we have worked with Barnardo's to bring together a forum for young carers and capture their experience using health and social care services. The forum has allowed young carers to highlight problems they have faced and to suggest how services can be improved.

HW Leicestershire in A&E

In 2017 a number of our Authorised representatives supported the visit of the newly opened A&E department in the Leicester Royal Infirmary. This led to better refreshments available in the waiting area.

UHL outpatient clinics

Through 2017-18 the Authorised Representatives have been supporting a joint Healthwatch and Leicester City CCG project to survey patients using different outpatient clinics through our local hospitals. Collecting over 500 surveys and bringing together a more detailed picture of what different patient groups feel about using some UHL services.

Issues have been identified around access to services as well as setting patient expectations before attending clinics.

As this work has recently finished we will be looking to work with the local NHS to take these findings forward.

Next steps

Going forward we are keen to develop closer working relationships with the Care Quality Commission and have our Authorised Representatives supporting CQC inspections, gather more patient feedback on services.

It is our hope to also work closer with the quality teams in our Councils.

Working with Leicester City CCG - Patient Experience on the front line

Throughout the year we have also been working closely with the Leicester City Clinical Commissioning Group and their Patient Experience Manager to build a better picture of the patient experience in out/inpatients in our local hospitals.

Working with other organisations

- We have now supported the peer review of both main NHS provider trusts within Leicester City, looking at complaint handling. This has involved reviewing complaint cases and highlighting areas for improvement around keeping the patient and their family informed. A number of recommendations have been implemented for the complaints process of the trust and this has led to improved communication.
- RUOK (Are you OK) – for the third year, we have continued to work as a key partner as part of a multi organisational group looking to highlight mental wellbeing and targeting mental health stigma. We worked with the Police, Leicestershire Partnership Trust, the Transport Police and other voluntary organisations in organising and running events across the city.

Making Safeguarding Personal – we have been working with the Engagement Officer of the Leicester Adult Safeguarding Board in engaging with the local community. Healthwatch has also been chairing the Service User Reference Group of the safeguarding board.

Helping you find the answers

Emergency and additional Dental Access in Leicester, Leicestershire, Rutland and Lincolnshire

Healthwatch Leicester have been actively involved in the area of Dentistry and have built a really good relationship and worked closely with the Dental Community – Leicestershire Dental Committee, NHS England's Local Dental Network Committee and the Oral Health Promotion Board.

In the last 12-18 months, HW Leicester having been pushing for further dental access for patients in Leicester City and in December 2017, new Emergency Dental Access was put in place which covers Leicester City and Leicestershire County, also Lincolnshire and Rutland.

We are very proud to have been part of this work and have worked tirelessly over the last 3 years to achieve more dental access for the people of Leicester City and also Leicestershire, with support from Healthwatch Rutland and Healthwatch Lincolnshire.

We also have to thank the Leicestershire Dental Committee and NHS England's Central Midlands Team for all their hard work in making this happen.

Domiciliary Dental Services in Care Homes

One of the issues that we have tackled is Domiciliary Care for residents in Care Homes. After some discussion and debate, Jason Wong (NHS England) and Chair of the Local Dental Network (LDN) set up a Gerodontology Group which is a sub-group of the Local Dental Network which sits with NHS England's Central Midlands team.

The original idea came out of Healthwatch Leicester and Rutland looking at how patients could be transported from home to dental practices using Patient Transport. When that was not as possible, Jason Wong suggested we look at how dentists could treat patients in Care Homes, rather than patients finding their way to a dentist which for some residents would not be possible. So the Gerodontology Group was set up.

The group which also includes Healthwatch Rutland and Healthwatch Lincolnshire and chaired by Kenny Hulme who is a local Lincolnshire dentist carried out research with the use of surveys and intelligence from other areas to establish what was needed and to look at what was possible.

The Group looked at the model used in Sheffield called ROCS (Residential Oral Care Sheffield) which has been in operation in Sheffield for 10 years. It covers 72 of the 74 Care Homes in Sheffield and works by going into care homes, triaging patients so appropriate care is given. It is funded through a 2% top slicing of the income of dental practices that participate in the scheme and consists of 10-15 dentists who carry out the work. This is the preferred model of the Gerodontology Group and also NHS England Central Midlands Region.

Jason Wong, who is Chair of the LDN had now produced a Business Plan which is going through the process of agreement and hopefully services will eventually be available to Care Home residents in the Central Midlands area as soon as January 2019.

This has been a particularly good outcome for patients who cannot access dental practices in the normal way but will be able to be treated in their Care Home.

We are very proud to have been part of the group and would like to thank particularly Jason Wong, Chair of the LDN who helped to create the Group and all those who participate including members of the Leicestershire Dental Committee and the support of Healthwatch Rutland and Healthwatch Lincolnshire.

Establishing the first ever Leicester City Young Carers' Forum in partnership with Barnardo's CareFree

We are delighted that we were able to establish the new Young Carers' Forum for the City, and enabled young carers to have a voice and a platform to share their insight about local health and social care services. It is crucial that the young carers and their families are given all the support needed and all involved work together to assist the whole family needs.

The Forum has representation from seven young carers groups across the City, aged 12-18 and two representatives from the City's Young People's Council aged 16-20. This year the Forum has focused the work on Primary Care access and information, and 'Whole Family Working'. The young people have highlighted several issues to improve support for young carers, including:

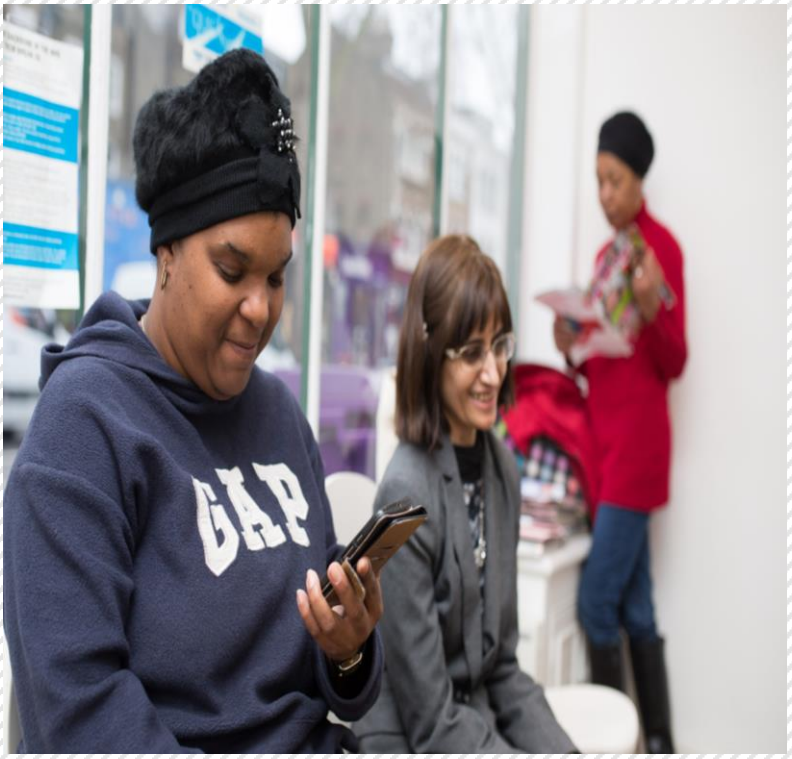
- Involvement in decision making by professionals when their care is being planned;
- The issues of respite care, opportunities for them to have a break from caring and the importance of better consideration of sibling carers.

As part of the project, the group of young people in Leicester who are supported by a Barnardo's service are currently also producing a short film in a bid to raise awareness of issues faced by young carers.

Ten young people aged from 15 – 19 years old who attend Barnardo's Leicester Young Carers' service, have planned, produced and star in a thought-provoking film sharing their own experiences as young carers.

The films clips will be used as a training and awareness raising tool for professionals who work with children and young people across the county including GPs, nurses and teachers.

Healthwatch Leicester has been very fortunate to work in collaboration with Barnardo's CareFree on this project, and we hope to continue our partnership over the forthcoming months.



Our plans for next year

What next?

Following the transfer of the Healthwatch contracts to the new provider – Engaging Communities Staffordshire, it is key that a strong team and Board are put into place to carry on the work of Healthwatch.

As the budgets available for Health and Social Care continue to reduce and the demand on services grow, the role of Healthwatch becomes even more important to represent the views of the people of Leicester and Leicestershire.

Key priorities will include –

- Working with the providers and commissioners of Health and Social Care services to ensure patients lived experience is built into the earliest stages of service review and scrutiny as the roll out of the Sustainable Transformation Plan continues.
- Working with the Voluntary Sector to strengthen the diminishing resource and support available to public and service users.
- Educate and inform the public on how to influence the changes within Health and Social Care services.

Our people


talk
to us
...we are listen
GP Services
Hospital Services
Mental Health
Ambulance Services

Board members

Sylvia Reid (Acting Chair), Sylvia is a retired Senior Manager from the public education sector, has in partnership with her husband, set up and run small businesses. Sylvia has initiated and supported a range of community developments in a variety of contexts through volunteering.

Karen Chouhan (Chair from 2014 until December 2017), Karen is a senior manager in the East Midlands for the Workers' Educational Association. Karen remains on the Board after stepping down as Chair in December 2017.

Reg Mawdsley (Treasurer), Reg has been Treasurer since 2014. Reg is Director of Finance and Corporate Services for Action Homeless Leicester and Company Secretary of Action Trust Leicester

Naina Patel is a PhD student researching Dementia in BME communities and supports the South Asian health action group to raise awareness of diabetes and other health conditions in communities.

Surinder Sharma was the National Director for Equality & Human Rights at the Department of Health & the NHS and is now a Professor & Co-Director, Unit for Diversity, Inclusion & Community Engagement at the University of Leicester.

Sue Mason is a retired NHS professional who chairs the Enter and View sub Committee. Susan has an interest in all Primary Care for all ages.

Staff

Chief Executive Officer (July 2017 to March 2018) – Omita Gaikwad

Research and Scrutiny Officer - Micheal Smith

Project Engagement Officer (from October 2017) Claire Knowles

Barbara Czyznikowska (until July 2017)

Executive Assistant - Gillian Jillett

Temporary Administrative Assistant – Fatima Sattar

Student Healthwatcher (Volunteer) – Hafsah Dassu

Our Authorised Representatives are –

- Sue Mason – Chair of the Enter and View group – Board member
- Moraig Yates
- Kim Marshall-Nichols
- John Bryant
- Janina Smith
- Lynn Pearson
- Michael Gilhooley

Our finances

Income	£
Funding received from local authority to deliver local Healthwatch statutory activities	192,696
Additional income	3,426
Total income	196,122
Expenditure	**£**
Provision of Service	140,473
Governance	5,924
Other resource expenditure	38,440
Total expenditure	£184,836
Balance remaining	11,286

The views and stories you share with us are helping to make care better for our local community

Mike Smith
Healthwatch Officer

Contact us

This report was first drafted by Healthwatch Leicester.

Since 1st April 2018, Engaging Communities Staffordshire have provided the contract for Healthwatch Leicester and Leicestershire.

To contact the local Healthwatch Leicester and Leicestershire team:

Address: Clarence House, Humberstone Gate, Leicester, LE1 3PJ

Phone number: 0116 2518313

Email: Enquiries@healthwatchll.com

Website: www.healthwatchll.com

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Appendix F4

Update on Oral Health in Leicester

Report for: Health & Wellbeing Scrutiny Commission

Report Date: August 2018

Lead Director: Ruth Tennant, Director of Public Health

Useful information

- Ward(s) affected: All
- Report author: Laura Carvell
- Author contact details: Laura.Carvell@leicester.gov.uk 0116 454 2017
- Report version number plus Code No from Report Tracking Database: v1

Suggested content

1. Purpose of report

This is the fourth report to the Health & Wellbeing Scrutiny Commission and provides an update on Oral Health in Leicester.

2. Summary

In 2012/13 Leicester had the highest proportion (53.2%) of dental decay in five year olds in England. Poor oral health can impact a child's diet, nutrition, sleep, social interactions, work, school readiness and confidence. Dental decay is more common in people from areas of relative deprivation, and the wider determinants[1] of health impact on oral health as they do general health. Poor oral health and dental decay have been shown to be multi-generational; caregivers with higher decay are more likely to have children with high decay.

Therefore improving oral health to improve children's health was made a priority for Leicester City Council's Public Health team in 2013.

In September 2013 Leicester City Council established the Oral Health Promotion Partnership Board (OHPPB) to facilitate and coordinate responsibilities and activities for improving oral health across partner organisations. The OHPPB includes representatives from NHS England, Health Education England, Public Health England, HealthWatch, Leicestershire County Council and LCC Children's Services.

Three months after being established, the Board agreed and endorsed the first Oral Health Promotion Strategy (OHPS) for preschool children (2014-2017). The OHPPB developed Leicester's early intervention programme Healthy Teeth, Happy Smiles! (HTHS!). A range of resources and activities aimed at adults & children have been developed and implemented since 2014.

The ambition of the board is to see a 10% increase in the number of 5 year olds who are decay free by 2019. Public Health England's latest data for dental decay in five year olds was released in May 2018 and Leicester has had a significant 15% improvement, therefore exceeding the original target. The BDA (British Dental Association) praised Leicester for the work on improving children's oral health.[2]

1 Poverty, poor housing, access to food, access to services, education and unemployment

[2] https://www.bda.org/news-centre/press-releases/child-tooth-decay-gap-persisting?utm_source=twitter&utm_medium=social&utm_campaign=tooth_decay_gap

However, Public Health England also released a Local Authority Variation Report in May 2018[3] with Leicester listed in the 30 worst areas for child oral health in the country. Therefore oral health remains a priority.

The Council has received an award from the Royal Society of Public Health for its programme of oral health improvement for children. The Chief Dental Officer and her deputies have visited Leicester on multiple occasions to assess our programme and its impact.

3. Recommendations

Health & Wellbeing Scrutiny Commission are asked to note the contents of this update.

4. Report

Health Teeth, Happy Smiles!

Healthy Teeth, Happy Smiles! is an early intervention programme that works both 'on the ground' and strategically to improve the oral health of Leicester's children. The programme is jointly funded by LCC and NHS England.

HTHS! includes an Oral Health Promotion Service at Leicester City Council that has 2 Health Promoters, a Programme Officer and a Prevention Programme Assistant. This team deliver the Supervised Toothbrushing scheme and oral health campaigns, and they work with partners, community groups, etc. to embed oral health messages in the wider health and care work happening in Leicester.

Activity Update

NHS England's Starting Well: Leicester is one of 13 areas to be included in the initial 12 month pilot of NHSE's Starting Well programme. This programme seeks to improve the involvement of dentists in oral health prevention work. This ties in with our existing HTHS! Dental Practice Accreditation Scheme so the team are working closely with the practices involved and NHS England to support this.

National Smile Month: National Smile Month (NSM) is a country-wide campaign held annually. This year NSM ran from 14th May – 14th June. LCC took part in NSM with a variety of activities throughout the month. NSM was launched in over 20 early years settings at 11am who took part in synchronised toothbrushing. The launch event was picked up by The Leicester Mercury. 13 Lift the Lip clinics were held across the city in toddler sessions. Foundation Dentists spoke to families about their oral health and how to check for decay. During the sessions we spoke to 175 parents and assessed 215 children. All children were given a goodie bag with leaflets, a brushing chart, toothbrush and toothpaste in. An evaluation of the campaign is currently being conducted.

Educational Resource Packs: In January 2018 oral health resource packs were launched city wide for Early Years Foundation Stage and Key Stage 1. The packs include lesson plans, activities and a storybook. They are aimed at incorporating oral health messages into lessons that fit with the national curriculum. The packs are available to download for free via our webpage. Various communication channels have been used to promote the packs. So far they have been downloaded by over 20 settings and work is ongoing to increase this. An evaluation

[3]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/707179/Local_authority_area_variation_in_the_oral_health_of_five-year-olds.pdf

will be carried out in January 2019.

Supervised Toothbrushing Programme (STB): All early years settings in the City have been given the opportunity to take part in a supervised toothbrushing programme with free training and free resources provided by the Council.

The numbers of settings currently offering STB:

Measure	Previous Briefing	Current Position
STB Programme (Primary Schools) : - Proportion of offering STB - Number of children involved	 25% (n=19) 1865	 26% (n=20) 2006
STB Programme (Early Years Settings; nurseries and preschools) : - Proportion offering STB - Number of children involved	 75% (n=90) 5583	 73% (n=87) 5706
STB Programme (Special Schools) : - Proportion offering STB - Number of children involved	 25% (n=2) 106	 25% (n=2) 106

Primary Schools: Since the last briefing an additional school has started doing supervised toothbrushing. From September 2018 the team will be getting in touch with all primary schools who do not participate to request a meeting with the EYFS lead to get more schools involved.

Early Years Settings: Slightly less settings are involved due to a setting closure and the team being unable to get hold of some settings. Although the number of settings participating has decreased the number of children involved has increased due to some settings increasing the number of children they have on roll.

Special Schools: The supervised toothbrushing in specials schools has been offered to an additional school after a successful pilot at Ellesmere College.

<u>Accreditation Schemes</u>

Dental: there are now three city practices accredited with full ‘Healthy Teeth, Happy Smiles!’ status. Nine practices are working toward accreditation. This quality mark of excellence demonstrates their commitment to improving oral health by supporting and promoting dental prevention.

Early Years: Seven nurseries have achieved accreditation during a 12 month pilot. The scheme aims to lay solid foundations for good oral health throughout life via regular toothbrushing, health eating & regular visits to the dentist. Evaluation of the scheme is being carried out to determine the added value of the scheme over and above STB.

5. Financial, legal and other implications

5.1 Financial implications

The OHPPB has a ring fenced partnership budget funded by Leicester City Council & NHS England to cover the years 2014 to 2019.

5.2 Legal implications

None.

5.3 Climate Change and Carbon Reduction implications

Healthy Teeth, Happy Smiles! works to ensure deliveries and travel around Leicester are managed in an efficient way. The team is registered to use the Council's electric car scheme to further reduce our impact on the environment.

5.4 Equalities Implications

Healthy Teeth, Happy Smiles! provides both targeted and universal events and services. The programme does not disadvantage any particular group of people.

5.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

N/A

6. Background information and other papers:

None

7. Summary of appendices:

None

8. Is this a private report (If so, please indicated the reasons and state why it is not in the public interest to be dealt with publicly)?

No

9. Is this a "key decision"?

No

Health and Wellbeing Scrutiny Commission

Work Programme 2018 – 2019

Meeting Date	Topic	Actions arising	Progress
5th Jul 18	1. Lifestyle Services Review – Consultation Findings and Proposals 2. Leicester Royal Infirmary ED – Phase 2 3. NHS Operational Planning and Contracting Guidance 2017 – 2019 4. Integrated Sexual Health Services Update	1. A further report to come to the next meeting of the Commission with background information, performance data and reasoning for the chosen model. 2. Members asked that signage, including internal signage, and external car parking and highway signage is reviewed. It was agreed to write to the Secretary of State for Health to support the need to provide bursaries for nurses. It was also agreed to arrange a site visit for commission members to the Emergency Department. 3. Cllr Cutkelvin to write to the CCG with further questions. 4. The Director was asked to ensure that the Executive were informed of the Commission's concerns relating to the design and layout of the entrance to the service, having regard to the shared space implications and the potential impact of the future hotel development	

Meeting Date	Topic	Actions arising	Progress
23rd Aug 18	1. Lifestyle Services Review 2. Winter Care Plan 3. Prescribing Medicines for Minor Ailments 4. Joint Health and Wellbeing Strategy 5. Integrated Sexual Health Services Update 6. For Information Items: - Oral Health Update - Dialysis Services in the city - CAMHS relocation - Healthwatch Annual Report		
11th Oct 18	1. GP Practices in the City 2. CCG's Workforce Strategy and International Recruitment 3. LPT Update on Bank Staff and Infrastructure improvements 4. Public Health Performance Report 5. Integrated Sexual Health Services Update		
29th Nov 18	1. Primary Care Update 2. Multi-morbidity Update 3. UHL Cancer Treatment Performance 4. Community Services Review 5. Continuing Healthcare 6. Settings of Care Policy 7. Integrated Sexual Health Services Update		
15th Jan 19	1. CCG's Enhanced Work on Diabetes 2. Update on LPT Transformation Programme 3. Turning Point – Performance Report 4. Integrated Sexual Health Services Update		
12th Mar 19	1. Integrated Sexual Health Services Update		

Items from 2017/18

Meeting Date	Topic	Actions arising	Progress
11 Jan 18	1. CQC Inspections on GP practices 2. Drugs & Alcohol Services (Turning Point) – CQC Inspection 3. Anchor recovery hub – Update on how it is progressing following a move to the new site 4. Public Health Performance Report 5. Draft Revenue Budget 2018/19 Report	1. An update the CCG's workforce strategy and international recruitment to come to a future meeting. 2. It was recommended that signposting be improved at the centre on Granby Street to ensure service users are directed to the correct centre if Granby Street was not appropriate; and a further report with performance data be brought to a future meeting of the Commission.	1. Added to 23/8 2. Info has been circulated to Members.
7 Mar 18	1. CQC Inspection of LPT 2. Winter Care Update 3. STP – Verbal Update 4. Lifestyle Services Review – Update	1. The updated action plan to come back to a future meeting of HWB SC or taken to LLR SC. Infrastructure Plans for the Bradgate Unit and issues around LPT bank staff is added to the Work Programme. An update of the LPT's transformation plan, including the progress made is brought back to a future meeting. The CCG to inform the commission of their thoughts as to the LPT's CQC ratings and what their expectations are. 2. Chair to raise concerns about the term 'stranded patients' for patients in hospital for 7 days with Jon Ashworth as Shadow Health Secretary. A further update on lessons learnt from this winter period to be brought back to a future meeting. A report on performance for Cancer Patients at UHL to be brought back to a future meeting. The minutes of this meeting to be shared with the Health and Wellbeing Board.	

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee

Meeting Date	Topic	Actions arising
14 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.
14 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.
27 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.
27 Apr 18	1) Update on LPT NHS Trust Improvement Plan following their CQC Inspection 2) Update on CHD Services in East Midlands and the NHS England review into PICU and ECMO services nationally 3) Update from UHL NHS Trust following their CQC Inspection 4) Update on EMAS Quality Improvement Plan	1) A further update from the LPT is brought back to the committee in a years' time. 2) Continue to monitor performance against the targets set by NHS England and an update be brought to the committee in a year's time, and to include targets, issues around winter pressures and the numbers of referrals. Also a letter to be sent to Nottingham City Council to request that they encourage the University Hospitals of Nottingham to refer their congenital heart patients to UHL and to share with them the minutes of the meeting. 3) Further CQC inspection reports of UHL, along with the resulting action plans, are brought to future meetings of the committee. 4) A further update from EMAS is brought back to the committee in a years' time.
4 Sept 18	1) Update on Non-Emergency Transport (TASL – Thames Ambulance Services Ltd) 2) Update on EMAS's direction of travel 3) CCGs Engagement on Planned Care Pathways 4) Update on the STP	

Joint Health and Wellbeing Meetings with other LCC Scrutiny Commissions

Meeting Date	Topic	Actions arising
7 Nov 17	**Joint meeting with Children, Young People and Schools Scrutiny Commissions:** 1) Children's Mental Health - Future in Mind - CAMHS 2) CQC Review of Health Services for LAC and Safeguarding	1) The following is requested at a future joint meeting: • Further meeting to look at the specific services available and at what stage these interventions/services are provided; effectively mapping all services for children's mental health and what is offered and by whom. • What governance structures in place, who is accountable to whom for different elements, including LA, LPT, schools etc, as well as what services are available. • Examples of anonymised case studies which help understand a child's journey through services as part of this report. • Clarity about the role of schools and how they fit into the process and their role in identifying young people and how they are supported to help young people into the right pathway. • Commission Members to have sight of the Local Transformation Plan • Invite headteachers to the next meeting to get their viewpoint. • Further information on the CAMHS 'improvement journey' with particular information on how the improvements have impacted on outcomes. • More detail about what happens to those who are not 'accepted' by CAMHS
13 Nov 18	**Joint meeting with the Adult Social Care and Children, Young People and Schools Scrutiny Commissions:** 1) Children's Mental Health 2) 0-19 Healthy Child Programme 3) SEND Area Review inc. Transitions of LAC into Adulthood 4) Learning Disabilities Mortality Review (LeDeR) Programme 5) Update on Healthwatch contract	

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	
GP Workforce Plan	To be shared with the Commission.	
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?	