Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **THURSDAY, 11 OCTOBER 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

JHarget

For Monitoring Officer

Officer contacts:
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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
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
TSL	Thames Ambulance Services Ltd
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 23 August 2018 have been circulated and the Commission will be asked to confirm them as a correct record.

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

http://www.cabinet.leicester.gov.uk:8071/ieListDocuments.aspx?CId=737&MId=8649&Ver=4

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.

7. UNIVERSITY HOSPITALS OF LEICESTER (UHL) NHS TRUST RESPONSE REGARDING RADIOLOGISTS SHORTAGES **Appendix A (Pages 1 - 4)**

University Hospitals of Leicester (UHL) NHS Trust submit a report regarding shortages of Radiologists which explains that the Royal College of Radiologists has been highlighting a national shortage of radiologists against a backdrop of consistently increasing demand. Members are asked to consider the UHL's response to the shortage.

8. LEICESTERSHIRE PARTNERSHIP NHS TRUST (LPT) UPDATE ON KEY RISK AREAS - WORKFORCE AND ESTATES **Appendix B (Pages 5 - 14)**

The Chief Executive of the Leicestershire Partnership NHS Trust (LPT) submits a report that provides an update on workforce and estates, previously identified as key risk areas. The commission is asked to note the actions by the LPT in responding to the estate and workforce risks, and comment as it sees fit.

9. PUBLIC HEALTH PERFORMANCE REPORT **Appendix C (Pages 15 - 28)**

The Director of Public Health submits a report that updates the Health and Wellbeing Scrutiny Commission on the performance of Leicester City Council's Public Health Services (funded through the ring-fenced public health grant) in 2017/18.

The Commission is asked to note current performance achievements and issues with Public Health Services in 2017/18.

10. COMMUNITY INTEGRATED SEXUAL HEALTH PROMOTION SERVICES **Appendix D (Pages 29 - 34)**

The Director of Public Health submits a report that outlines planned changes to local sexual health promotion services in response to changing local needs. The changes are subject to public consultation. The Commission is asked to note the proposed changes and agree to receive the results of public consultation on the proposed model and its changes at a future meeting.

11. INTEGRATED SEXUAL HEALTH SERVICES

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

12. WORK PROGRAMME **Appendix E (Pages 35 - 42)**

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.

13. ITEMS FOR INFORMATION / NOTING ONLY **Appendix F (Pages 43 - 84)**

Health and Wellbeing Board

Members are asked to note the following reports and presentations that went to the Health and Wellbeing Board:

12 July 2018

Learning from Winter 2017/18 – Cover Report, Mike Ryan, Director of Urgent and Emergency Care, Leicestershire, Leicester City and Rutland (LLR) System

System Resilience and Winter Planning Learning from 2017/18 and Planning 2018/19

20 September 2018

Resilience Planning Arrangements for Winter 2018/ 19 – Cover Report. Submitted by Mike Ryan, Director of Urgent and Emergency Care, Leicestershire, Leicester City and Rutland (LLR) System, Phil Coyne, Leicester City Council, Rachna Vyas, UHL and Mark Pierce, Leicester City Clinical Commissioning Group.

LLR Urgent and Emergency Care Resilience Planning Arrangements for Winter 2018/19 – presentation.

14. ANY OTHER URGENT BUSINESS

UHL Imaging Response to health and wellbeing scrutiny committee regarding Radiologist shortages

Author: Cathy Lea Sponsor: Matthew Archer Date: October 2018

Executive Summary

Questions

1. As a Trust do we have effective oversight of Radiologist recruitment and reporting?
2. Have risks to patients been fully assessed and managed?
3. Are staffing and other resources used effectively to ensure examinations are reported in an appropriate timeframe?

Conclusion

1. The Imaging team have been reporting monthly on the volume of reports to be reported, broken down by modality and length of time waiting since November 2015.
2. A strong workforce plan has allowed the Leicester radiologist team to expand, although the growth in services and the overall rise in imaging demand means a capacity gap remains.
3. Risk is assessed through separate targets held for ED, Inpatients, GP, Routine Outpatients and suspected cancer Outpatients
4. Imaging report directly to commissioners monthly as part of the quality schedule on plain film reporting turnaround times.
5. Reporting capacity gaps for Head and Neck and neuroradiology reporting have been logged on the Trust risk register
6. Creative recruitment and robust job planning have supported the management of reporting the increasing demand for cross sectional imaging. Outsourcing and waiting list initiatives are used to manage peaks and troughs of demand.

Overview

The Royal College of radiologists (RCR) has been highlighting a national shortage of radiologists against a backdrop of consistently increasing demand**.**

'Friday 9 September 2016
The Royal College of Radiologists' (RCR) latest census of the UK clinical radiology workforce published today provides further stark evidence that vital NHS services are under immense strain. For the third year in a row, the census shows that radiologist numbers are failing to keep pace with the increases in demand for scans and X-rays.
Key findings of the 2015 census:
•99% of UK radiology departments could not meet scan and X-ray reporting demands and are relying on costly and inefficient short term fixes
•Last year the NHS spent £88.2 million on outsourcing radiology reporting, an increase of 51% from the year before. The amount spent in 2015 could have paid for over 1000 full-time consultant radiologists
•Between 2012 and 2015, the consultant radiology workforce grew by 5% but the number of CT and MRI scans rose by 29% and 26%'

With the appointment of an Imaging information analyst in 2015 improved data has led to a greater transparency of reporting volumes and reporting turnaround times.

There has been a variation in the numbers of unreported plain film radiographs. Snapshot surveys for the Royal College of Radiologists have identified similar and widespread issues between Trusts. UHL's response to this survey deteriorated over 18 months leading up to 2016 and issues in out-patient backlogs widened to include in-patient and emergency plain films.
The following actions have addressed some of the capacity gaps for plain film reporting, however, outsourcing of predominantly chest plain film reporting to manage peaks and troughs of demand and capacity is still in place.

- Addressed auto-reporting and historical data quality issues.
- Plain film reporting radiographic training continues (MSK , chest& abdo) 4 reporting radiographers in training.
- Robust timetable and targets for reporting radiographers.
- Agreed service level standards for additional hours.
- Robust auto-reporting (clinically agreed) communicated to radiographers.
- New methods of auto-reporting.
- Data showing report turnaround time is being monitored.
- Meaningful data has been developed (2016) and has been shared with the Imaging and CSI leadership teams, with relevant data for inpatient, cancer and outpatient imaging being shared at a Trust level.

The volume of cross sectional reporting continues to rise at approx. 10% per year. CT referrals from ED rose by 30% in 17/18. The reporting volumes have led to pressure on the radiologists. UHL have however had success in delivering a workforce plan to increase Radiologist workforce and to look at alternative recruitment methods.

Health Education East Midlands (HEEM) have recognised a need to train more radiologists adding an additional 2 trainees per year for a 5 year cycle starting two years ago. The required support from imaging in UHL to deliver this is in place. We have 4 additional trainees in post, increasing the support for emergency flow imaging.

The UHL Imaging department has bucked the trend in terms of medical recruitment; in the last three years the team has secured 20 consultant radiologists to fill vacancies created by retirement and growth of demand.

There are currently seven vacancies (from a staff group of 69 consultants), including a retirement, a specialist post vacant for three years (head and neck) and two new expansion posts. These will be advertised by the end of January 2017.

There have been a number of factors in the success of this recruitment:

- Re-written and updated job descriptions and adverts to promote the service's specialties and excellent equipment base.
- A strong social media campaign.
- Positive messages from the current team, radiologists were asked to promote UHL in external discussions, presence and papers at conferences from our specialist radiologists.
- Trainees within the service are choosing to stay with an excellent TPD team in place. The team now has a strong group of young consultants which will encourage others to join them.
- UHL have a clinically led Imaging service, intertwined with management
- Clear strategic direction for Imaging.
- The medical leadership team have proactively engaged with candidates.
- Positive perception of the department as a place to work.
- Fellow chose to apply for a consultant post within UHL.

The Imaging department have three MTIs (overseas trainees) currently with two more to start next month. This was a new venture for Imaging in 17/18, and is working very well so far with excellent candidates who are enjoying their time at the Trust and may choose to apply for a permanent post.

UHL Imaging are using outsourced reporting to manage the growth in demand for inpatient and outpatient Imaging, reporting demand and capacity will be examined this year and further actions will be planned to address any remaining gap.

Governance and monitoring of KPIs

A daily report is available showing all outstanding reporting in all modalities (CT,MRI,Xray). Outstanding reporting is monitored at a departmental level through the monthly Imaging Quality and Safety board, and at a CMG level monthly through the Imaging assurance and performance meeting.

The Imaging department are also required to report to the CCG monthly through an agreed quality schedule on turnaround of plain film reporting, and quarterly on all reporting turnaround times.

Managing Reporting Workloads

Outsourcing

Outsourcing to a tele-radiology company forms part of the management of timely reporting for most Trusts. UHL have a contract with Medica, outsourcing predominantly MSK and Neuro cross sectional reporting. There is a demand and capacity gap for MSK reporting due to rising demand.The reporting takes place remotely and there are governance arrangements in place.

This is an effective but expensive option for managing reporting turnaround times. However outsourcing has some potential challenges including delays whilst deciding to send images out, cost, de-engagement of local staff and perhaps no relationship with UHL clinical colleagues. An issue with the current system is that responsibility for the prompt reporting of images is not fully clear.

Additionally there are hidden costs with some outsourced images being reported again in house due to quality or reliability of the reporter. Additionally complex and time consuming scans are often left for the UHL staff and can wait excessive amounts of time to be reported.

WLIs

The workload of clinical radiology continues to increase year on year and challenges radiology services to increase their efficiency while maintaining and improving the quality. Demand and capacity work shows areas where there is a mis-match that results in the need for extra capacity above normal job plans, this is underpinned by vacancies in the aligned specialties of neuro and head and neck radiology.

Current strategy supports the use of flexible sessions which have traditionally been met largely by outsourcing. However, many drivers including cost, quality and speed of turn around dictate a broader tactical spread of in and out sourcing. This also aligns our outputs more closely to delivering trust and national targets such as 6 week wait, cancer and RTT.

Imaging insourcing guidelines apply to all clinical radiologists or reporting radiographers where a report, scan or interventional procedure is required as part of an additional session of work outside of current job plans. The guidelines provide an administration process for the authorisation and allocation of this work. Currently UHL uses a mix of methods to ensure images are reported in a timely manner and patient care is maximised.

Insourcing allows the cost effective, timely reporting of images where activity exceeds set targets above the actual capacity in place at the time. Work is allocated by following an agreed rota where patients are allocated to the person by the clerical administrator. The work is identified by the use of the appropriate escalation policy, in conjunction with operational management to identify service priority and work is paid at the correct trust rate or any variation is agreed in advance by the Imaging board.

Summary

The imaging department within UHL have developed a transparent, open approach to monitoring imaging activity (referrals, scans and reporting) and are sighted to changing demand within the various subspecialties.

In addition, although a service noted as having workforce shortages nationally, the team have bucked the national trend with recruitment to both Radiologist and Radiographer vacancies over recent years, retaining local talent and attracting both regional and national talent within key specialties.

This is barely enough to keep pace with the seemingly unstoppable growth in requests for imaging from both primary and secondary care clinicians. Work has commenced to ensure that only the right patient is scanned, first time, along pathways that help the referrer to avoid requesting every patient, every time.

Appendix B

Leicestershire Partnership NHS Trust

Report to the City Health & Wellbeing Scrutiny Commission
Thursday, 11 October 2018

Update on Key Risk Areas – Workforce and Estates

Introduction

Following the previous Health & Wellbeing Scrutiny Commission, two specific risks were identified that the Scrutiny Commission wished for additional assurance from Leicestershire Partnership NHS Trust. These are:-

1. Workforce issues - specifically registered nurse vacancies, recruitment and associated use of agency and bank staff;
2. Estate infrastructure - specifically plans for the new CAMHS unit and future plans for the improvements in the Bradgate unit;

Both of these risks have been identified in previous CQC inspections. The CQC will revisit the trust between 19-23 Nov, and will visit five core services:-

- Acute adult MH inpatient services
- CAMHS community services
- Mental health services for older people – community teams
- Learning Disability Inpatient services
- Inpatient mental health rehabilitation services for Adults – Stewart House/Willows

Workforce Risks

Workforce risks are the highest scoring risks that the Trust is currently managing. This is in line with national risks where there are an estimated 40,000 registered nurse vacancies. The risk is principally confined to the nursing workforce although there are some challenges in specific areas of the medical workforce. This report will focus on the nursing workforce.
The overall trust wide summary of planned versus actual hours by ward for registered nurses (RN) and health care support workers (HCSW) in August 2018 is detailed below:

	DAY		NIGHT		
	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	Temp Workers %
June 18	98.4%	190.3%	103.4%	176.2%	29.8%
July 18	97.8%	188.7%	106.5%	172.4%	30.8%
Aug 18	**97.1%**	**193.8%**	**105.8%**	**180.1%**	**31.5%**

This table demonstrates that our wards are fully staffed, albeit about 30% is from temporary staff. Of these temporary staff, 27.2% were bank staff and 4.3% were agency staff.

The reason for the use of temporary staff is related to the number of vacancies.

The current Trust wide position for inpatient wards is detailed below.

Area	Vacant Posts		Potential Leavers		Starters/Pipeline	
	RN	HCSW	RN	HCSW	RN	HCSW
FYPC	5	5	0	0	0	0
CHS (Community Hospitals)	36.93	14.04	3	1.8	6.13	5
MHSOP	12	7	2	0	3.8	9
AMH/LD	81.6	37.75	3.4	3.4	13	0
Trust Total August 2018	**135.5**	**63.79**	**8.4**	**5.2**	**22.93**	**14**

Trust Total July 2018	**139**	**59.09**	**12**	**6**	**30**	**18.6**

The trust overall percentage for vacancies is at 11.1%. The trend over the last three years has been upward from 8%.

Longer term plans to eradicate the risks and address recruitment issues remain in place. These include:-

- rolling recruitment and retention plans, including implementation of Trust incentivised schemes for hard to recruit areas
- increased work experience placements, recruitment of clinical apprentices
- accessing recruitment fairs at local universities, schools and colleges
- robust sickness and absence management
- continuous review of workforce including new roles to enhance skill mix and increase patient facing time
- recruitment of clinical apprentices
- preparation and recruitment to cohort 3 of trainee Nursing Associates

Retention of staff is important to maintain workforce. Current nursing annual turnover is 12.1%. all staff turnover is 9.7%. Current actions underway to improve retention are:-

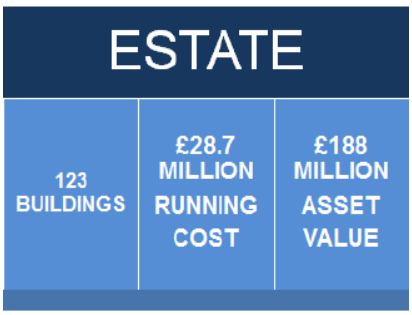
- Develop line manager and new starter 90 days road map
- Workforce groups to review potential retirees and have conversations
- Develop leadership competencies and behaviours linked to appraisal
- Developing talent management in line with national strategy
- Developing working longer and flexible working initiatives
- Developing internal transfer list, ‘itchy feet’ conversations

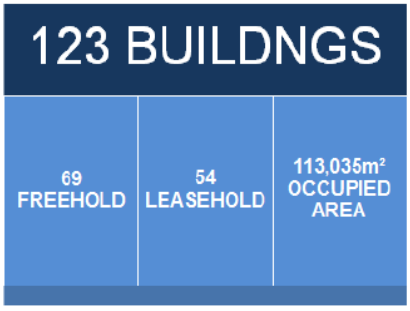
The Trust continues to demonstrate compliance with the National Quality Board (NQB) expectations. The safer staffing data is being regularly monitored and scrutinised for completeness and performance by the Chief Nurse and reported to NHS England (NHSE) via mandatory national returns on a site-by-site basis. Learning from participation in a number of NHS Improvement (NHSI) development programmes is ongoing.

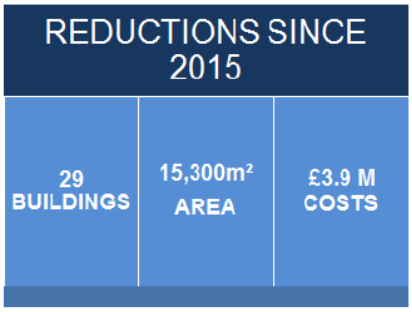
Each directorate has a standard operating procedure for the escalation of safer staffing risks and any significant issues are notified to the Chief Nurse on a weekly basis. Directorate lead nurses have oversight of the plans in place to mitigate risks for each ward to ensure safe care standards are maintained.

Estate Infrastructure

Background







	Scheme	Timescale	Value
Phase 1	**CAMHS**	**2018-2020**	**£8m**
Phase 2	**Bradgate re-provision**	**2021-2024**	**£50m**
Phase 3	**Demolish re-provided wards**	**2024**	**£5m**
Phase 4	**MSOP - 2 new wards**	**2025-2028**	**£20m**
Phase 5	**Consolidation rehabilitation wards**	**2029-2031**	**£25m**
Total capital investment pipeline			**£108m**

CAMHS - Background

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 some 15 miles away (and further away from Leicester). Patients, carers, stakeholders and staff felt that this temporary arrangement was inadequate and inappropriate from the outset and finding a permanent central relocation has been one of the actions within the Leicester, Leicestershire & Rutland STP.

Last year (2017/18), some 41% of young people were being placed outside of the area to inappropriate locations far from the family home, mainly eating disorder needs, because their

local unit does not have sufficient scope or capacity to contain demand locally. These placements included children from Leicester.

The Trust provides a CAMHS crisis service and a CAMHS community service across Leicester, Leicestershire & Rutland. These services ensure that children are only admitted as an inpatient if it is absolutely necessary to do so, and that children are discharged as soon as possible if admitted.

This service is commissioned by NHS England Specialised Commissioning and not by local CCGs.

Objectives

The expansion and permanent central relocation of the local CAMHS inpatient unit will mean that sufficient care is provided locally to:-

- Meet the relevant deliverables of the Five Year Forward View for Mental Health.
- Combine care as per the new NHS England service specification for CAMHS and eating disorders.
- Adhere to NICE standards for eating disorders.
- Adhere to the inpatient service standards of the Royal College of Psychiatry Quality Network for Inpatient CAMHS (QNIC).
- Deliver financial balance (the isolated unit in Coalville has much higher costs)
- Reduce whole system costs for out of area placements.

Sites

The original location of the unit was in the city at the Towers Hospital. The temporary location is in the market town of Coalville in the north west of Leicestershire. The proposed location is back in the city on the Glenfield Hospital site:-

Location	Site	Distance From Original
Original	Towers Hospital, Leicester	
Temporary	Coalville Community Hospital, Leicestershire	15 miles
Proposed	Glenfield Hospital, Leicester	4 miles

Whilst Glenfield Hospital is in the city, a local government boundary runs through the site and the new CAMHS unit will actually be just over the city boundary in Blaby District. This authority has granted planning permission.

Timescales

The project objective is to relocate and expand the CAMHS inpatient service to purpose built and centrally located 15-bed accommodation by March 2020 and eliminate out of area placements thereafter by March 2021.

Investment

The investment objective is to invest £8.000 million of capital funding to secure significant improvements in access and service.

Funding/Spend	2017/18	2018/19	2019/20	Total
LPT Capital Expenditure	-£0.129m	-£1.500m	-£6.371m	-£8.000m
DoH Capital Grant		£1.629m	£6.371m	£8.000m
Balance	-£0.129m	+£0.129m	£0.000m	£0.000m

Patient Numbers

The health service needs supported by the scheme are general CAMHS and eating disorder inpatient services for young people 13-17 years from Leicester, Leicestershire & Rutland (and further afield if required).

Full Business Case	2015/16 Actual	2016/17 Actual	2017/18 Actual
LLR Children Admitted Locally	64	59	51
LLR Children Admitted Out-Of-Area	45	52	35
Total LLR Children Admitted	109	111	86
Total Bed Days	7,390	8,075	5,106
ALOS	68 days	73 days	55 days
% Out of Area Placements	41%	47%	41%

Patient/Parent Engagement

There has been extensive engagement with patients and parents in determining the future nature and location of the CAMHS inpatient services.

This engagement was originally launched in 2014/15 ahead of the temporary relocation to Coalville Community Hospital in March 2015. A wide variety of opinion was sought from service users, staff, other professionals and other stakeholders who felt that the unit should be:-

- A clean and modern environment.
- Centrally located to reduce travel distances and times.
- Centrally located for easier public transport
- Have sufficient space for therapy and education
- Close to acute inpatient paediatric facilities (in Leicester City)
- Located close to on-call cover.
- Central for community staff (eg CPNs, social workers) to visit the unit to prepare for discharge.
- In a fit for purpose environment.
- In the city to attract a diverse workforce.
- A homely environment.
- A permanent solution.
- A development that allows for more CAMHS beds locally.

Since then, patients and parents have recently been involved in the design and operation of a new unit.

Strategy & Policy Context

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 NHS England service specification for CAMHS inpatient services has recently been updated to include eating disorders, such that the majority of young people with this condition are in the future to be treated in general CAMHS units and not in specialist eating disorder units.

Patient Choice

The NHS England commissioning arrangements are such that patients/parents can choose where they are admitted provided the hospital has capacity at that acute moment in time. However from the patient engagement undertaken, the majority of patients want care locally and with acceptable travel distances/times.

Presently some 41% of LLR children 13-17 years are placed out-of-area at their acute moment of need, mainly because there is insufficient capacity locally. Hence there is a real lack of patient/parent choice at present.

Some of these out-of-area placements are because the temporary CAMHS inpatient unit at Coalville has gender based dormitories. If these are full, the patient cannot be accommodated in the other gender dormitory if it has empty beds. The new unit will have single en-suite rooms meaning that gender will no longer be an issue for admissions and preventing inappropriate out-of-area placements.

The scheme provides for an expanded unit which will be able to accommodate more children locally and prevent inappropriate out of area placements. The majority of LLR children requiring an acute CAMHS admission will have been in contact with the LLR community CAMHS services. As such, it is expected that the majority of patient/parent choice will be toward the LLR inpatient unit in order to maintain the continuity of care on both admission and subsequent discharge. However, a LLR patient/parent may choose an out of area placement because Nottingham or Northampton say may be closer to their home than Leicester. A parent who works for Leicestershire Partnership NHS Trust may ask that their child is treated at another unit.

The scheme will therefore significantly increase patient choice for care closer to home and still maintain a choice to be treated elsewhere.

Benefits Criteria

The expected benefits for the scheme are:-

- Improved clinical outcomes
- Improved patient experience
- Delivery of the QNIC standards
- Financial sustainability of the service and the Trust
- Improved accessibility for families across LLR
- Strengthened CAMHS pathways
- Co-location with acute mental health services
- Relocation in the short to medium term

- Increase in public confidence in the service

Equality & Diversity

In relation to equality and diversity impact, this has been assessed using the Trust's Due Regard Screening Tool and this confirms that the scheme will not have a material impact on patients based on their protect characteristics as laid out in The Equality Act.

NHS Reconfiguration Tests

The scheme satisfies the four key tests for service configuration as set out in the NHS England guidance Planning, Assuring and Delivering Service Change for Patients (Revised March 2018):-

- Public & Patient Engagement – Patients want care closer to home and an inpatient service centrally located within the area will provide this.
- Patient Choice – The scheme increases patient/parent choice to be treated locally.
- Evidence Base – Expansion of the unit to include eating disorder services aligns with the evidence base in the national service specification, which shows that almost a quarter of acute admissions for adolescents are for eating disorders and that general CAMHS units and specialist eating disorder units achieve similar outcomes.
- Commissioner Support – The principles of the scheme fit with commissioning policies and priorities to eliminate inappropriate out of area placements and to amalgamate inpatient general CAMHS and eating disorder services.

There is no reduction of beds in the scheme and as such the *Stevens Test* does not need to be applied.

Both the Leicester and Leicestershire health overview and scrutiny committees have written to confirm that a 4 mile relocation of the unit does not constitute a substantial variation in service and as such, public consultation is not required.

Site Options Appraisal

In recent years, the Trust has looked at a wide ranging variety of public/private options to secure a permanent relocation of the CAMHS inpatient unit, including:-

- Coalville Community Hospital (Do Nothing)
- Coalville Community Hospital (Refurbishment)
- Glenfield Hospital Site (Refurbishment of Adult Wards)
- Stewart House Site (Enderby)
- Glenfield Hospital Site (New Build)
- Leicester Royal Infirmary (Children's Hospital)
- Leicester General Hospital (Neville Centre)
- New Site (NHS Purchase)
- New Site (with Private Provider)

Four of the options were shortlisted and ranked using the benefits criteria:-

- Glenfield Hospital Site (New Build) – Score 27
- Glenfield Site (Refurbishment of an Adult Ward) – Score 21
- Stewart House Site (Enderby) – Score 19

- Coalville Community Hospital (Refurbishment) – Score 12

A critical factor is section 2.22.1 of the national service specification, which requires that inpatient general adolescent service should not be an isolated or stand-alone facility and must be located with other mental health services so that there is a critical mass of staff to ensure adequate response team resource.

The only option that meets this requirement with an acute response team resource is co-location with the Trust's acute adult mental health services on the Glenfield Hospital site.

Summary

The FBC pertains to the relocation of an existing 10-bed general CAMHS inpatient unit and expansion to a 15-bed unit to accommodate inpatient eating disorder services for young people 13-17 years of age. The case for change and investment has been made across six dimensions:-

- **Strategic Case** – The scheme fits with the national strategy for all-age mental health services and the revised service specification for CAMHS and eating disorder inpatient services. It has the support of the patients, parents, staff, the commissioner, the STP, health and well-being boards and health overview and scrutiny committees. It demonstrates that there is sufficient demand for the unit to ensure that local children can be treated locally.
- **Economic Case** – The scheme has been developed from a long list of options and has the highest benefits realisation score. The scheme delivers both qualitative and financial benefits, making significant improvements in patient choice and will result in revenue savings.
- **Commercial Case** –The scheme can be realised quickly through the Trust's existing estates partner Interserve Construction Limited and has a guaranteed maximum price valid to the end of November 2018. The scheme meets most national standards with a small list of variations (derogations).
- **Financial Case** – The scheme cost is affordable with the £8.0 million public dividend capital provisionally allocated to it by the Department of Health. Costs elements have been market tested and the value for money (VFM) has been proven. No property or land sales or purchases are needed for the scheme, so there will be no delays in implementation.
- **Management Case** – The scheme can be delivered by the Trust and its partner Interserve Construction Limited by March 2020. A project team has been established, which has the capacity and capability to manage the project. Cost and other advisors are in place and ready to start. The governance arrangements for the project are also in place.
- **Clinical Case** – The Trust has the clinical capability and capacity to deliver an integrated CAMHS and eating disorder inpatient service. It has extensive experience of providing the regional adult eating disorder inpatient service and can utilise this to develop an integrated service for children.

Adult Mental Health – Bradgate Unit Reprovision

The Bradgate unit, based on the Glenfield site, is a 135 bed acute adult mental health inpatient unit. It also contains outpatient facilities.

It has been identified both internally and by the CQC that the layout of the unit does not meet the new standard of care that we would want for the people of LLR because of:-

- Sightline and layout issues – these have been mitigated for by reduction of beds on some wards
- Use of dormitory accommodation – the unit is principally formed around 4 bed dormitories which do not meet requirements for privacy and dignity of patients.

A detailed Strategic outline case is currently being prepared, although initial scoping works have begun, to rebuild the unit on the Glenfield site.

Conclusion

The Health & Wellbeing Scrutiny Commission is asked to note the actions by LPT in responding to the estate and workforce risks.

Dr Peter Miller
Chief Executive

Oct 2018

Appendix C

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Public Health Services Performance Summary 2017/18

Date: October 2018

Lead Director: Ruth Tennant

Leicester City Council

Useful information

- Ward(s) affected: All
- Report author: Ruth Tennant and Helen Reeve
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- Report version: v 1

1. Summary

This report updates Health and Well-being Scrutiny Commission on the performance of the city council's public health services (funded through the ring-fenced public health grant) in 2017/18.

2. Recommendations

2.1 Scrutiny members are asked to:

- Note current performance achievements and issues with public health services in 2017/18.

3. Report

3.1 Introduction

The aim of this performance report is to provide an update on the performance of the major public health services which are funded through the ring-fenced public health grant in 2017/18.

Under legislation, local councils have a duty to commission and provide certain services to prevent ill-health and improve health outcomes.

Some of these services are mandated (we are required by law to provide them). This includes the NHS Healthchecks programme, the 0-5 Healthy Together Programme (health visiting), the National Child Measurement Programme (provided by school nursing teams) and sexual health services. Others are at the discretion of the local authority. However, the local authority must take into consideration major health outcomes in the city (see appendix 1) in how it uses its resources, specifically the public health ring-fenced grant.

The Division of Public Health carries out a wider range of work than is captured in this report. This report focuses on the major services and programmes that the division either provides directly or are commissioned by the division and which are funded by the City Council through the public health ring-fenced grant.

The Division and wider council also meets its public health duties through joint working with the NHS as well as other organisations as well as the wider health impacts of work in the wider council such as investment in cycling infrastructure,

measures to tackle air pollution, licensing and planning responsibilities. These are not covered in this report but are an important part of how we improve health in the city in the long term.

Appendix 1 provides “at a glance” overview of a performance of Public Health contracts and services which are funded through the ring-fenced public health grant. This cover a small number of key indicators, selected from a larger performance dataset of over 100 indicators which are monitored quarterly by the division. It also outlines the key health outcomes for the city with benchmarking data from other comparable councils.

The main report provides context to these services and how they are performing in relation to the national picture and similar areas, using information from the national Public Health Outcomes Framework. This is available on-line at https://fingertips.phe.org.uk/profile/public-health-outcomes-framework.

3.2 Public Health Services for children

There are a number of public health services and programmes aimed at supporting children’s health and well-being. Early intervention – getting the basics right- in the early years of life and at school is key to improving long-term health and also in making sure children are ready to school.

Healthy Together Programme

The Healthy Together Programme, provided locally by Leicestershire Partnership Trust, provides health visiting support to every child in the city antenatally and through early childhood. Parts of this service are nationally mandated and the performance data presented in appendix 1 is nationally reported by every council.

The programme is based on national and international research evidence that shows that antenatal support and early intervention such as early identification and support for post-natal depression, breastfeeding support, infant failure to thrive in the early weeks or, at a later stage, early identification and supporting children with speech and language delay or behavioural issues is associated with better development and health outcomes for children.

Health visiting teams must see every child in the city antenatally, within 14 days of birth, at 6-8 weeks and at 2 years. At each stage, they assess babies and children’s health and development. If children are identified as having specific developmental or behavioural issues, they will be provided additional clinical support and referral to specialist clinical services (for example audiology). The service also provides specialist support to parents having a baby after the death of a baby, as a result of a still-birth or Sudden Infant Death Syndrome, and also screens new mothers for post-natal depression, providing follow-up support where needed.

The programme also covers the city's school nursing service. This provides school nursing support to all schools in the city (nurses are shared across schools). The service provides some one-to-one health assessment for children and young people who have been referred by teachers, including children with emotional health issues who do not meet thresholds for CAMHS. The service also provides on-line advice and support through its ChatHealth website and chat facility and is piloting on-line health assessments which are being rolled out across secondary schools. It also provides sexual health assessments and advice where needed.

The performance report (appendix 1) summarises performance in 2017/18 across nationally reported indicators. This shows that in 2017/18, 95% of babies in the city were being seen and reviewed by a health visitor within the first two weeks of life, providing opportunities to review feeding or development issues and maternal issues such as post-natal depression. Similar numbers were seen at 6-8 weeks with 58% of babies still breastfeeding at this point, above the national average of 44%.

At two years, 81% of all children in the city had had a detailed assessment of their language skills and physical and emotional development (the ASQ-3 review) allowing for early identification and advice around language and early literacy development, behaviour and sleep management and diet and nutrition.

The school nursing service went through significant change in 2017/18 with a new programme for schools put in place, including improved coverage across city schools, a new health and well-being screening tool put in place and the roll out of the ChatHealth service. New performance measures for the service took effect this financial year and are being reported from this financial year.

NCMP & childhood obesity

The National Child Measurement Programme is a nationally mandated programme that weighs and measures all children at the start and end of primary school. This information is then sent to parents/ carers with advice about how they can support their children to be a healthy weight and information about services that are available locally.

The programme is carried out as part of the Healthy Together Programme. Participation rates in the programme are good at both the start and end of primary school, although there has been a slight fall in 2016/17 – the most recent year that we have verified national data for.

Childhood obesity levels in the city are showing signs of stabilising (appendix 1), with 10% of children obese in reception, similar to the national position. Rates in older children at the end of reception are higher, rising to 23% and this has been increasing since 2013/14. This continues to a priority area of work for the division, including working with the city's sports clubs to expand primary school outreach programmes, working with primary schools to roll out the 'Daily Mile' programme

which supports pupils to run a mile a day at school and which is now operational in 36 schools and the recent 1,000 tweaks campaign which is encouraging children, families and parents to make small changes to improve their health and well-being. Through our investment in healthy eating initiatives in schools (see appendix 1) 72 schools are now enrolled in the 'Food for Life' programme which skills up pupils to grow and cook food as well as helping schools to promote healthy eating across the curriculum and in the wider school environment.

Oral Health

Detailed updates on the city's oral health programme have been provided to recent Scrutiny meetings but 25% of primary schools are signed up to the programme with 75% of nurseries and pre-school playgroups also involved. Since the start of the programme the percentage of children without tooth decay has improved from 53% in 2014 to 61%.

3.3 Public Health Services for adults

The council is responsible for a number of public health services for adults:

Sexual health services

Provided by the NHS, the council is responsible for open access sexual health services and some contraception services. The city's main sexual health service – currently provided at St Peter's Health Centre but shortly to move to the Haymarket centre – provides testing, treatment and advice for sexually transmitted infections, chlamydia screening, HIV testing and contraception. It also runs outreach clinics in parts of the city. We also pay for specialist contraception in some general practices in the city and emergency hormonal contraception in community pharmacies. We do not pay for cervical screening but have worked with NHS England who are responsible for this service to include cervical screening as a service that is offered by our sexual health services.

The main service at St Peter's has over 36,600 attendances each year (appendix 1), below the forecast figure of 40,300. This figure has been increasing over the last 3 years as the service has been more widely promoted. This includes 'primary attendances' (these are appointments were people are assessed and given screening for STIs or a routine contraception appointment) and 'secondary attendances' (these are appointments where people may need follow up treatment which cannot be done at a single appointment). Waiting times for appointments are monitored and patients have a choice of booked appointments and walk-in sessions are also available. When a patient cannot be seen at a walk-in session, they will be offered an appointment within 48 hours (appendix 1).

A new contract was awarded to provide this service from January 2019 when the service will also move into the Haymarket. As part of this, the service will be offering more on-line testing and testing from self-service kiosks. We will therefore be

monitoring the volume of people who chose to use this option as well as continuing to monitor waiting times and the number of people using face-to-face and on-line or self-service options.

We commission local general practices to provide Long-Acting Reversible Contraception (forms of contraception such coils or implants which are very effective at reducing unwanted pregnancies). Wider capacity issues in general practice, a reduction in the number of GPs who are trained to provide this type of contraception and low numbers of women requesting LARC forms of contraception means that LARC rates are below the national average and falling (appendix 1). We are working with the Clinical Commissioning Group and local GPs to increase the number of GPs who are accessing training and to review options to offer this service to women through a model where a GP could offer this service to patients who are registered in a different practice.

We also commission sexual health & HIV prevention services which are the subject of a separate Scrutiny paper.

Sexual health outcomes are monitored nationally (appendix 1) and within the division. The rate of new STIs has been falling since 2013 but has shown a slight increase in the last year, although at a slower rate than is the case nationally. Overall rates are similar to the national level.

Services to improve physical and mental health & well-being

Integrated lifestyle services

The Executive have agreed proposals to develop a new integrated lifestyle service for adults which would bring together the existing lifestyle services we have in place to promote healthier lifestyles. This includes the healthy lifestyles hub, adult weight management, active lifestyle scheme and smoking cessation.

These services are therefore undergoing changes with a go-live date for the new service of April 2019. However, we continue to monitor performance across our current services and these measures will also be monitored when the new service goes live.

Health and Well-being Scrutiny received a detailed report on these services, including how these services are performing at its meeting on the 23rd August 2018 so this information is not reproduced in detail in this report. In summary, the performance report for 2017/18 (appendix 1) shows that:

-The healthy lifestyles hub saw 5268 people referred by their GPs in 2017/18. 3/4s of people came from the most deprived parts of the city where health needs are greatest.

-The Active Lifestyle scheme run out of leisure centres saw just under 5,000 people last year, including 208 patients for cardiac rehabilitation and just over 2,500 people with long-term conditions that could be improve through exercise

-The smoking service worked with 2753 smokers of whom half had successfully stopped smoking after 4 weeks and also with 175 pregnant smokers of whom 45% successfully quit. The number of smokers coming to the service has declined in recent years, partly as a result of increases in e-cigarette use.

City outcomes (appendix 1) that relate to these service show that smoking prevalence (18%) remains higher than the England position (15%). However, the rate of smoking in Leicester is falling faster than is the case nationally. The number of women smoking in pregnancy has been falling with 10% smoking at the point of delivery compared with 14% in 2012/13.

Obesity rates in adults are below England levels (56% compared with 61% nationally) but the rates of physical activity in adults is lower than the national average (60% compared to 66%). Lifestyle services are part of the picture in reversing this but wider changes to the built environment such as the expansion of walking and cycling routes as well as increasing footfall at outdoor gyms and leisure centres is also key.

The performance report also describes performance in food growing initiatives that are run as part of the City's Food Plan. This supports 2 food growing schemes to skill up local people and schools to grow fruit and vegetables including Saffron Acres community food growing programme and the Conservation volunteers.

The report also outlines performance in the probation health trainers service. This service, which is provided by Inclusion healthcare who also run No 5 and provide health services to asylum seekers and homeless people in the city, supports people on probation to develop health plans and access services such as substance misuse. This service saw 269 people on probation last year of whom 153 put in place a health plan with 87% of these achieving the goals on this plan.

NHS Healthchecks

NHS Health-checks is a nationally mandated programme offered at GPs across the city. Designed to screen otherwise healthy adults once every five years for early indicators of heart disease, kidney disease & diabetes which can be prevented, the programme has just reached the end of its first five year cycle. Since 2013/14, the programme has reached 75% of eligible adults in the city, or 61,447 adults (appendix 1).

The number (rate) of people in the city who die under the age of 75 from preventable heart disease is higher than in similar cities and above the England average (appendix 1) so early identification of risk factors for heart disease and tackling

factors such as high blood pressure, exercise and diet that contribute to these continue to be an important priority within the city.

Drug and alcohol services (substance misuse)

Health and well-being Scrutiny Commission have previously received reports on our substance misuse services, including Turning Point and No. 5 with further updates planned. Following the recommissioning of these services and a period of managing a dip in the number of people accessing some services, there has been an increase in people using these services in 2017/18 and all clients are seen within 3 weeks of making contact with the service. A more detailed update focusing on this service will be presented to Scrutiny early next year.

Mental health

The division runs a number of programmes to improve mental health. This has included the local Time to Change programme which has promoted conversations around mental health to reduce the stigma associated with mental health as well as a programme to train staff from across a range of agencies to spot risk factors for suicide and learn how to manage these. In 2017/18, this reached 300 staff and evaluation of staff skills, knowledge and confidence in working with people to manage suicidal behaviour showed significant improvements after completion of the training.

Appendices

Appendix 1 Division of Public Health Summary Dashboard 2017/18, trends in outcome data in Leicester and in similar authorities.

Division of Public Health Performance Report Summary: 2017/18 Quarter 4

Key: On/Below target: On/above; 95%-100%; < 95% — Direction of travel: Worse / Similar / Better; Lower / Similar / Higher; Overall RAG

	TARGET	ACTUAL	Previous Leicester values			Current Leicester value	Direction of Travel
Children's Services							
Healthy Together Programme (0-19 year olds)							
10-14 days New baby review			Prog starts Q2	Q2 2017-18	Q3 2017-18	Q4 2017-18	
Number of babies receiving a new baby review at 10-14 days		3557		1235	1195	1127	
% of babies turning 30 days within quarter receiving a new baby review at 10-14 days	90%	95%		96%	96%	96%	→
6-8 week review		YTD	Prog starts Q2	Q2 2017-18	Q3 2017-18	Q4 2017-18	
Total number of infants who received a 6-8wk review by the end of the quarter		3470		1130	1206	1134	
% of babies receiving a 6-8 week review	90%	94%		91%	95%	96%	↑
Number of babies recorded as totally/partially breastfed at 6-8 weeks		2160		745	728	687	
% of babies recorded as totally/partially breastfed at 6-8 weeks	60%	58%		60%	57%	58%	↑
2-2.5 year development review		YTD	Prog starts Q2	Q2 2017-18	Q3 2017-18	Q4 2017-18	
Number of babies receiving a 2-2.5 year development review between 2 and 2.5 years		3123		1047	993	1083	
% of babies receiving a 2-2.5 year development review	75%	81%		84%	82%	82%	→
Total number of children due a 2½ review by the end of the quarter for whom the ASQ-3 is completed		2995		1003	949	1043	
% of babies with a completed ASQ-3 as part of their 2-2.5 year development review	75%	97%		98%	98%	97%	↓
National Child Measurement Programme	2016/17		2013/14	2014/15	2015/16	2016/17	
% participation rate in NCMP: reception year	93%	90%	93%	94%	93%	90%	↓
% participation rate in NCMP: year 6	95%	95%	95%	95%	95%	95%	→
Number of obese children: reception year		461	456	445	436	461	
% of obese children: reception year		10%	11%	10%	10%	10%	
Number of obese children: year 6		987	777	850	947	987	
% of obese children: year 6		23%	21%	22%	23%	23%	→
Healthy Eating Initiatives in Schools		YTD	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	
Number of schools enrolled in whole school food for life programme	70	72	70	71	71	72	↑
Number of enrolled schools with a whole school food policy (active and being implemented)	65	34	25	25	33	34	↑
Oral health promotion		YTD	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	
Primary schools offering supervised tooth brushing	No target	25%	21%	25%	25%	25%	→
Full day care and pre-school playgroups offering supervised tooth brushing	No target	75%	70%	75%	76%	75%	

Key: On/Below target:	On/above	Direction of travel:	Worse	Lower	Overall	TARGET	ACTUAL	Previous Leicester values				Current Leicester value	Direction of Travel
	95%-100%		Similar	Similar	RAG								
	< 95%		Better	Higher									
Adult's Services													
Sexual Health								Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec		
Integrated sexual health service							2017	Q1 2017	Q2 2017	Q3 2017	Q4 2017		
% patients offered an appointment within 48 hours of contacting a service						98%	100%	100%	100%	100%	100%		→
Sexual Health Services: Total primary and secondary activity						40,326	35679	8,941	8,521	8,733	9,484		↑
Chlamydia: Number of screens (under 25s)						3,300	2205	636	503	368	698		↑
Chlamydia: Number of positives (under 25s)						376	267	73	77	36	81		↑
Young peoples services activity						1,100	1130	361	237	153	379		↑
Health training, Healthy lifestyles, Weight management													
Healthy Lifestyles Hub / Health Trainer Programme							YTD	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18		
Healthy Lifestyles Hub: number of initial assessments						5975	5268	1,266	1262	1229	1511		↑
Healthy Lifestyles Hub: % of clients from accessing Tier 1 service from deprivation quintiles 1 and 2						75%	76%	76%	76%	77%	75%		↓
Healty Lifestyles Hub: % of new client registrations from men						40%	40%	37%	41%	39%	41%		↑
Health Trainers Probation							YTD	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18		
Health Trainers - Probation: Number of initial assessments						240	269	46	78	63	82		↑
Health Trainers - Probation: Number of clients who initiate a personal health plan						90	153	27	45	36	45		↑
Health Trainers - Probation: % of clients partially or completing succeeding in their personal health plan						81%	87%	84%	91%	90%	81%		↓
Active Lifestyle Scheme							YTD	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18		
ALS: Number of Priority 1 referrals (Cardiac/ COPD rehabilitation)						No target	208	62	51	42	53		↑
ALS: Number of priority 2 referrals (includes conditions such as diabetes, renal/liver disease, other long term conditions, high blood pressure, physiotherapy)						No target	2569	1029	759	356	425		↑
ALS: Number of priority 3 referrals (for inactive but otherwise healthy)						No target	2238	112	483	833	810		↓
ALS: Retention of priority 2 referrals at 3 months						No target	74%	no data	no data	no data	175		
Adult weight management							YTD	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18		
Total number of participants on targeted adult weight management						No target	220	39	64	66	51		↓
% of participants completing at least 60% of sessions of the adult weight management course						60.0%	69%	69%	66%	62%	82%		↑
Numbers of adults on targeted weight management course maintaining 3% weight loss after 12 months						49	75	22	15	15	23		↑
Total number of participants on enhanced adult weight management course						No target	334	81	56	74	123		↑
% of participants completing at least 60% of sessions of the adult weight management course						60%	74%	70%	75%	66%	81%		↑
Numbers of adults on enhanced weight management course maintaining 3% weight loss after 12 months						89	100	29	12	24	35		

Key: On/Below target: On/above; 95%-100%; < 95% — Direction of travel: Worse; Similar; Better — Lower; Similar; Higher — Overall RAG

	TARGET	ACTUAL	Previous Leicester values			Current Leicester value	Direction of Travel
Food growing initiatives							
Saffron Acres Project community food growing programme		YTD	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	
Number of bespoke packages of information / advice offered	70	93	28	34	27	4	↓
Number of people attending food growing skills programmes	30	20	0	8	12	0	↓
Number of schools engaged in a food growing programme	14	17	7	2	8	0	↓
The Conservation Volunteers community food growing programme		YTD	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	
Number of bespoke packages of information / advice offered	70	27	16	9	2	0	↓
Number of people attending food growing skills programmes	40	119	0	119	0	0	→
Number of schools engaged in a food growing programme	14	12	2	5	2	3	↑
Smoking cessation		YTD	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	
Number of smokers setting a quit date	No target	2753	707	684	675	687	↑
% of smokers successfully quitting at 4 weeks	35%	54%	52%	53%	57%	54%	↓
Number of pregnant women setting a quit date	No target	175	50	37	43	45	↑
% of pregnant smokers successfully quitting at 4 weeks	35%	45%	52%	51%	37%	40%	↑
Number of smokers from target SEC groups setting a quit date	No target	2194	576	540	546	532	↓
% of smokers from target SEC groups successfully quitting at 4 weeks	35%	52%	50%	51%	56%	51%	↓
GP NHS Health Checks		YTD	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	
NHS Health Checks carried out (40-74 year olds): current year		7308	1,569	1,708	1,684	2,347	↑
NHS Health Checks carried out (40-74 year olds): cumulative from 2013/14	80449	61447	55,708	57,416	59,100	61,447	↑
% of eligible population who have received a health check: cumulative from 2013/14	75%	76%	69%	71%	73%	76%	↑
Suicide Awareness		YTD	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	
Number of delegates who attended training (reported 6 monthly): Target	300	297	0	142	0	155	↑
Number of training sessions held in the last 6 months	12	12	0	6	0	6	→
Substance Misuse		YTD					
Anchor Centre (Number 5)	Q4 2017-18		Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	
Total Number of Attendees within the period (total footfall)	No target	pending	983	1,321	1,352	pending	↑
% of active street drinking clients showing a major reduction in street drinking (monthly average within quarter)	No target	pending	25%	24%	14%	pending	↑
Turning Point *Pre-release data from NDTMS and may be subject to amendment by PHE		YTD	June 2017	Sep 2017	Dec 2017	Mar 2018	
Total Numbers in Treatment (all substances, presented as a rolling 12 month period)		1695	1775	1687	1648	1695	↑
New presentations to treatment (All substances, presented as a quarterly YTD figure)		741		329	515	741	↑
Total exits (All substances, presented as a quarterly YTD figure)		751		295	544	751	↑

Outcome indicators: Trends	Compared with England:		Better	Similar	Worse	Direction of travel
			Higher	Similar	Lower	
Overarching						
	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	
Healthy life expectancy at birth, Men	57.7	56.8	58.8	59.1	60.4	↑
Healthy life expectancy at birth, Women	57.1	57.8	57.0	60.0	59.4	↓
Children						
	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	
Infant mortality (deaths under 1 year per 1,000 live births)	7.0	6.8	5.4	4.6	5.1	↓
	2012/13	2013/14	2014/15	2015/16	2016/17	
Smoking status at time of delivery	14.2	13.1	11.9	11.4	10.2	↑
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	94.9	93.3	78.7	78.4	67.9	↑
Proportion of five year old children free from dental decay			55.0		61.3	↑
Adults						
Sexual Health						
	2013	2014	2015	2016	2017	
Chlamydia detection rate in 15-24 year olds per 100,000	1867.8	1763	2165	1688	1640	↓
All new STI diagnosis rate per 100,000	926.4	801.2	869.4	736.5	756.2	↑
Long Acting Reversible Contraception: prescribing rate per 1,000		37.1	32.5	26.4		↓
	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	
HIV late diagnosis	64.7	63.2	59.0	57.8	59.8	↓
Lifestyle						
	2013	2014	2015	2016	2017	
Smoking Prevalence in adults - current smokers (APS)	21.7	19.2	20.1	17.0	17.7	↓
			2015/16	2016/17		
Percentage of adults (aged 18+) classified as overweight or obese			60.2	56.3		↑
Percentage of physically active adults			57.9	60.3		↑
Mortality	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	
Under 75 mortality rate from cardiovascular diseases considered preventable (age-standardised rate per 100,000)	73.2	75.1	78.9	77.8	73.7	↑
Under 75 mortality rate from cancer considered preventable (age-standardised rate per 100,000)	92.7	91.9	92.2	90.0	84.1	↑
Under 75 mortality rate from respiratory disease considered preventable (age-standardised rate per 100,000)	22.0	20.9	21.7	22.0	24.6	↓
Mental Health	2012/13	2013/14	2014/15	2015/16	2016/17	
Emergency Hospital Admissions for Intentional Self-Harm (age-standardised rate per 100,000)	137.4	120.9	133.3	150.7	196.2	↓

Outcome indicators: Comparison with peer areas		Compared with England:				Better	Similar	Worse
						Higher	Similar	Lower
Overarching	Time period	England	Birmingham	Bradford	Coventry	Leicester	Luton	Nottingham
Healthy life expectancy at birth, Men	2014-16	63.3	59.7	61.8	62.2	60.4	61.6	57.4
Healthy life expectancy at birth, Women	2014-16	63.9	59.3	61.1	62.9	59.4	61.5	55.1
Adults								
Sexual Health								
Chlamydia detection rate in 15-24 year olds per 100,000	2017	1882	1729.6	1635	1656	1640	1247	2128
All new STI diagnosis rate per 100,000	2017	743	923.8	536	892	756	610	1217
Long Acting Reversible Contraception: prescribing rate per 1,000	2016	46.4	33.3	46.3	44.3	26.4	29.7	49.8
HIV late diagnosis	2014-16	40.1	39.2	50.9	52.8	59.8	49.4	35.9
Lifestyle								
Smoking Prevalence in adults - current smokers (APS)	2017	14.9	13.7	18.9	15.9	17.7	14.3	19.4
Percentage of adults (aged 18+) classified as overweight or obese	2016/17	61.3	61.2	63.7	64.3	56.3	64.0	61.6
Percentage of physically active adults	2016/17	66.0	62.4	63.7	59.3	60.3	59.9	65.3
Mortality								
Under 75 mortality rate from cardiovascular diseases considered preventable (age-standardised rate per 100,000)	2014-16	46.7	63.0	63.1	57.8	73.7	61.9	74.2
Under 75 mortality rate from cancer considered preventable (age-standardised rate per 100,000)	2014-16	79.4	91.6	90.1	86.6	84.1	91.4	106.4
Under 75 mortality rate from respiratory disease considered preventable (age-standardised rate per 100,000)	2014-16	18.6	23.7	27.9	24.6	24.6	18.7	33.8
Mental Health								
Emergency Hospital Admissions for Intentional Self-Harm (age-standardised rate per 100,000)	2016/17	185.3	178.8	223.9	202.2	196.2	172.6	N/A

Children	Time period	England	Birmingham	Blackburn with Darwen	Coventry	Hillingdon	Hounslow	Leicester
Infant mortality (deaths under 1 year per 1,000 live births)	2014-16	3.9	7.9	4.9	4.6	2.0	3.9	5.1
Smoking status at time of delivery	2016/17	10.7	8.1	14.5	10.9	6.3	3.1	10.2
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2016/17	126.3	111.3	207.5	265.1	92.8	120.5	67.9
Proportion of five year old children free from dental decay	2016/17	76.7	73.9	57.4	69.3	67.5	74.3	61.3

Appendix D

Health and Wellbeing Scrutiny

Community Integrated Sexual Health Promotion Services

Lead director: Ruth Tennant

Useful information

- Ward(s) affected: All
- Report author: Matthew Curtis and Liz Rodrigo
- Author contact details: Liz.rodrigo@leicester.gov.uk

■ Report version number plus Code No from Report Tracking Database: 3.0

1. Purpose of report

This paper outlines planned changes to local sexual health promotion services in response to changing local needs. These changes are subject to public consultation. The Health and Wellbeing Scrutiny Commission is asked to:

- Note the proposed changes
- Agree to receive the results of public consultation on the proposed model and its changes at a future meeting.

2. Summary

- Leicester City Council's (LCC) Division of Public Health commissions local services to provide community sexual health promotion and HIV prevention. Contracts will expire on 31st March 2019.
- A review of sexual health needs in the city has been used to identify changes that need to be made to these services so that they meet changing sexual health in the city. The new model will focus on the provision of sexual health promotion to the most at-risk groups in Leicester.

3. Background Information

Context of review

This paper presents the proposed model for Sexual Health and HIV prevention.

The council has a mandated responsibility to provide sexual health to anyone that presents regardless of their area of residence. (This is referred to as open-access). These services detect and treat Sexually Transmitted Infections (STIs) and provide contraception. Alongside the city's Integrated Sexual Health Service (ISHS), Leicester City Council funds specific services aimed at preventing STIs and HIV in high-risk groups.

The changing face of HIV, which can now be very effectively controlled allowing people to live normal lives once on treatment, and the changing profile of STIs means that we need to review whether the services we currently provide are fit for purpose. This review has considered the current and emerging needs in the City to ensure we commission services that meet the needs of the highest risk groups in the city.

Current community based sexual health promotion and HIV prevention is targeted at three groups where rates of STIs and/ or HIV are highest: Men who have sex with men, people with HIV and people of African heritage. These contracts are due to expire on 31st March 2019.

Target Group	Provider
People with HIV and their families	Leicestershire Aids Support Service (LASS)
Men who have Sex with Men (MSM)	Trade Sexual Health
People of African Heritage	LASS

What are the current Sexual Health Promotion and HIV Prevention services intended to provide?

LASS and TRADE are currently commissioned to provide the following:

- Outreach Health Promotion, this is in LGBT social venues, churches, sports groups specific events e.g. Caribbean carnival and PRIDE
- Relationships and Sex Education Support to secondary schools
- Safer sex kit distribution
- Point-of-care (POCT) HIV testing- these finger prick tests provide results within half an hour and can be provided by trained volunteers
- Training about how to prevent HIV and STIs e.g. for nurses and youth workers
- Counselling- with individuals with sexual health behaviour issues
- Referral and signposting to sexual health and contraceptive services

The services are intended to work closely with the main Integrated Sexual Health Services (ISHS) so that anyone who needs testing or treatment for an STI or requires follow-up after an HIV test is seen rapidly by the main service.

Sexual Health Needs in Leicester

Leicester has a number of specific sexual health needs, these include:

- A high HIV prevalence rate (3.9 per 1,000 compared to 2.3 per 1000 across England 2017) this is a total of 882 Leicester residents.
- High rates of STI diagnosis among specific ethnic groups.
- A rise in syphilis and gonorrhoea rates although currently less than the England average

Analysis of the diagnosis and trend data suggests that locally our sexual health promotion services should now prioritise the following groups:

- Men who have sex with men
- People of African heritage (this includes people who identify as Caribbean) and mixed heritage people
- 16-24 year olds
- European migrants and new entrants

Men who have sex with men appear disproportionally in STI data both locally and nationally. Work required with this group includes information on safer sexual practices, easy access to condoms, HIV testing and information about Pre exposure Prophylaxis (PreP) (prescribed medication given prior to sex to prevent HIV transmission), and risk reduction work about Chem sex (this is when individuals take drugs to enhance sex, this can increase the risk of STIs and viruses such as hepatitis)

Black African, black Caribbean and mixed ethnicity individuals are disproportionately affected by HIV in different ways. Activities that promote condom use and address stigma and discrimination should be supported in all these groups, but the primary

focus of health promotion activities should differ. In the black African community, the priority should be to increase HIV testing. HIV prevalence is highest among black African women, and rates of late diagnosis are highest among black African men. Good engagement and connections to Leicester's diverse communities will be an important part of the new service to understand these needs better and to target support appropriately.

Young people under 25 are over represented in STI data as they are most likely to contract the common STIs e.g. genital warts and chlamydia. Relationships and sex education (RSE) work with FE colleges is not currently provided and is important to ensure that this age group are aware of consent, healthy sexual relationships, and where and how to access services. RSE can also contribute to discussions about stigma related to sexuality and HIV.

There is some local evidence that new entrants do not know how to access services and are not aware of what is available. In addition, some people classified with a late diagnosis of HIV have in fact been previously diagnosed abroad. Specific strategies to address this will include work with these individuals and communities and with practitioners to identify people with clinical signs associated with HIV.

What is no longer required

The treatment for HIV is now so effective that most people are well and do not need a high level of support specifically for their HIV. In addition, 'Treatment as Prevention' (TasP) means that HIV+ people on treatment with a low number of virus particles (viral load) are unlikely to transmit HIV. This means that those on effective treatment are unlikely to transmit HIV during unprotected sexual intercourse This reduces the need for such a volume of sexual health promotion support for HIV positive people.

What should we be providing?

A key local objective will be to ensure that Leicester rates of STIs remain lower than the national average, and to halt and reverse the rise in syphilis and gonorrhoea that we are seeing at a national and local level. To achieve this, we need to continue to target those groups who are disproportionately represented in the data.

The role of community sexual health promotion services is to reach these priority groups with effective sexual health messages and, where appropriate, make services easier to access for people who are not using them at the moment. This will include supporting schools and FE colleges with expertise to provide RSE.

It will also enable more HIV testing amongst groups that have not previously engaged with this service, ensure that information and advice is correctly developed and bespoke to various ages and communities.

The development of more online testing and self-managed care will support these communities in accessing services in a different way. The Community Integrated Sexual Health Promotion Services will promote these messages to the priority communities.

4. Recommendations for a new model

It is recommended that the following is commissioned:

Community based sexual health promotion work with the following priority groups :

- Men who have sex with men
- People of Black African and mixed heritage
- 16-24 year olds including Relationship and Sex Education in FE colleges
- European migrants and new entrants

These services should provide :

- Increased uptake of HIV and STI testing in communities including use of self-managed care
- Promotion of sexual health services and sexual health promotion messages to these communities via outreach and social media
- Provision of Community based 'point of care' testing (i.e. HIV testing) under the clinical governance of the ISHS. This will include brief intervention where by individual are given quick lifestyle and behaviour change advice and guidance.
- Training for professionals (such as practice nurses and youth workers) and others about sexual health in collaboration with the ISHS
- Work with these communities to reduce stigma associated with sexual health , HIV and sexuality

It is envisioned that this would be done by providing outreach into communities for example work in Male saunas, LGBT pubs and clubs and faith venues, presence at community events and focus groups, surveys and questionnaires with communities,

HIV positive people and especially those lost to follow up

All people with HIV visit the Clinical HIV service for treatment. There will be increased work with this service to ensure that there is good sexual health promotion with all HIV positive people and they are aware of how to access local services easily.

Consultation

Consultation on proposed changes is currently underway running from the 17th September and closing on the 31st October. The consultation is being promoted via local voluntary sector organisations, Citizens space and the Sexual health services.

These services will then be procured in accordance with procurement contract rules.

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	1. The commission made some recommendations to be considered as proposals for Lifestyle Services progress. 2. The Winter Plan to be shared with the commission before the winter period starts. The papers going to the HWB be shared with the commission. A paper on the impact of emergency surgeries on planned surgery be brought to a future meeting. A report on DTOC be brought to a future meeting of the commission. A report on lessons learnt be brought back after the winter period 3. Report be sent to the Executive 4. The findings following the consultation be brought back to the commission and OSC.	
11th Oct 18	1. National Shortage of Radiologists – UHL Position 2. LPT Update on Key Risk Areas – Workforce and Estates 3. Public Health Performance Report 4. Community Integrated Sexual Health Performance Services 5. Integrated Sexual Health Services Update 6. For Information Items: - Winter Care Plan (papers that went to Health and Wellbeing Board)		

Meeting Date	Topic	Actions arising	Progress
29th Nov 18	1. GP Practices in the City 2. CCG's Workforce Strategy and International Recruitment 3. Primary Care Update 4. Multi-morbidity Update 5. Update on LPT Transformation Programme 6. UHL Cancer Treatment Performance 7. Emergency surgeries and the impact on Planned Surgeries 8. Community Services Review 9. Integrated Sexual Health Services Update		
15th Jan 19	1. CCG's Enhanced Work on Diabetes 2. Turning Point – Performance Report 3. Continuing Healthcare 4. Settings of Care Policy 5. Integrated Sexual Health Services Update		
12th Mar 19	1. CCG's Update on Operational Plan 2. Delayed Transfers of Care 3. Winter Care Plan – Lessons Learnt 4. Integrated Sexual Health Services Update		

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) Consolidation of Level 3 Intensive Care 2) Update on Non-Emergency Transport (TASL – Thames Ambulance Services Ltd) 3) Update on EMAS's direction of travel 4) CCGs Engagement on Planned Care Pathways 5) Update on the STP	
28 Sept 18	1) Consolidation of Level 3 Intensive Care	

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?	

Appendix F

Leicester Health and Wellbeing Board

12 July 2018

Title: Learning From Winter 2017/18

Presenter: Mr Mike Ryan

Director of Urgent and Emergency Care

Leicestershire, Leicester City, and Rutland (LLR) System

Leicester City Council

Author contact details:

Name: **Mike Ryan**
Email: **Michael.Ryan@nhs.net**
Mobile: **07932 815529**

1.0 Purpose of the paper or presentation

The purpose of this paper is to summarise the recommendations and learning from the winter period 2017/18, and outline the approach to better resilience and patient experience for 2018/19.

The Leicestershire, Leicester City, and Rutland (LLR) health and social care system are focusing efforts toward building greater and sustainable resilience across urgent and emergency care for our patients.

2.0 Recommendations for the board to consider

The Board is asked to:

- Note summary learning points from 2017/18;
- Note the priority focus being undertaken over the coming months;
- Agree to receive finer detail at the next meeting; and
- Engage and contribute to meaningful improvements and simulation exercises currently in planning phase for later this year (September and October).

3.0 Content

Summary Position

- Overall, evidence demonstrates the urgent care system has seen more patients outside of hospital this year than in previous years, however the activity levels for individual patients with multiple attendances has increased due to the nature of care needs – particularly for the older population.

- Pressures across the entire LLR urgent care system over winter resulted in deterioration of performance with the system struggling to cope with demand; 4hr standard delivery deteriorated significantly, particularly over February and March.

- Whilst the demand has increased, this demand largely reflects more activity, higher acuity, and increased cases amongst multi-morbidity patients (e.g. frail and elderly, respiratory, cardiac) as occurs every cold weather season.

- There were higher numbers of elective cancellations than in 2016/2017 as per national instruction, as well as exceptional levels of cancellations of urgent and cancer operations not seen in previous years.

- Ambulance services remained stretched and regularly at a high escalation level for the majority of winter; patient handover times declined over winter, from November through to March, although with fewer 1 hour+ waits than in 2016/2017, and fewer total lost hours.

4.0 Next Steps

Throughout winter 2017/18, colleagues within system partners have worked tirelessly to maintain safe levels of service for patients. With the winter period no longer representing a fixed set of months and extending through into April 2018, there is a clear need to instil a more resilient system amongst partners to cope for longer periods of relentless surge.

Principally, in order to better prepare and provide a more cohesive health and social care and service this next winter period for our patients and service users, a series of tactical and operational actions are underway to establish and maintain a strong and consistent focus to:

- Ensure clinicians, front-line staff, and patients and their families help shape improvements;
- Support better alignment of provider priority work plans toward greater and sustainable system resilience leading to winter 2018/19;
- Surface any gaps and mitigate risks;
- Understand benchmarked positions, increase business intelligence, and inform evidence-based decision making; and
- Utilise desktop and simulation exercises during September and October to
    - test demand and capacity modelling predictions,
    - enable mitigation activity,
    - highlight any system funding gaps/needs, and
    - systematically review winter surge plan strengths/weaknesses for continuous improvement.

Key Areas of Focus (Tactical)

Based on the experience of past years and more recently 2017/2018, the key areas of focus 2018/2019 include:

1. Demand and Capacity Modelling and Alignment – (gaps and consideration of mitigating actions / ‘tip ins’ across the system to alleviate pressure from one provider to another);
2. Better understanding and alignment of system provider capacity, bed occupancy rates and triggers to enable best use of appropriate resource (acute, community, primary care);
3. UHL Rapid flow processes and reduce avoidable process delays;
4. Workforce capacity and capability;
5. Visibility of alternatives to admission within the community and to support rapid discharge;
6. Review and amendment to the system Operational Performance Escalation Level (OPEL) framework and thresholds;
7. Increased visibility of primary care and nursing/care home capacity, performance, and quality; and
8. Generally, knowing our numbers and using our resources wisely through regular assessment and review.

System Resilience & Winter Planning

Learning From 2017/18 & Planning 2018/19

Mike Ryan, Director of Urgent and Emergency Care

LLR Health and Social Care System

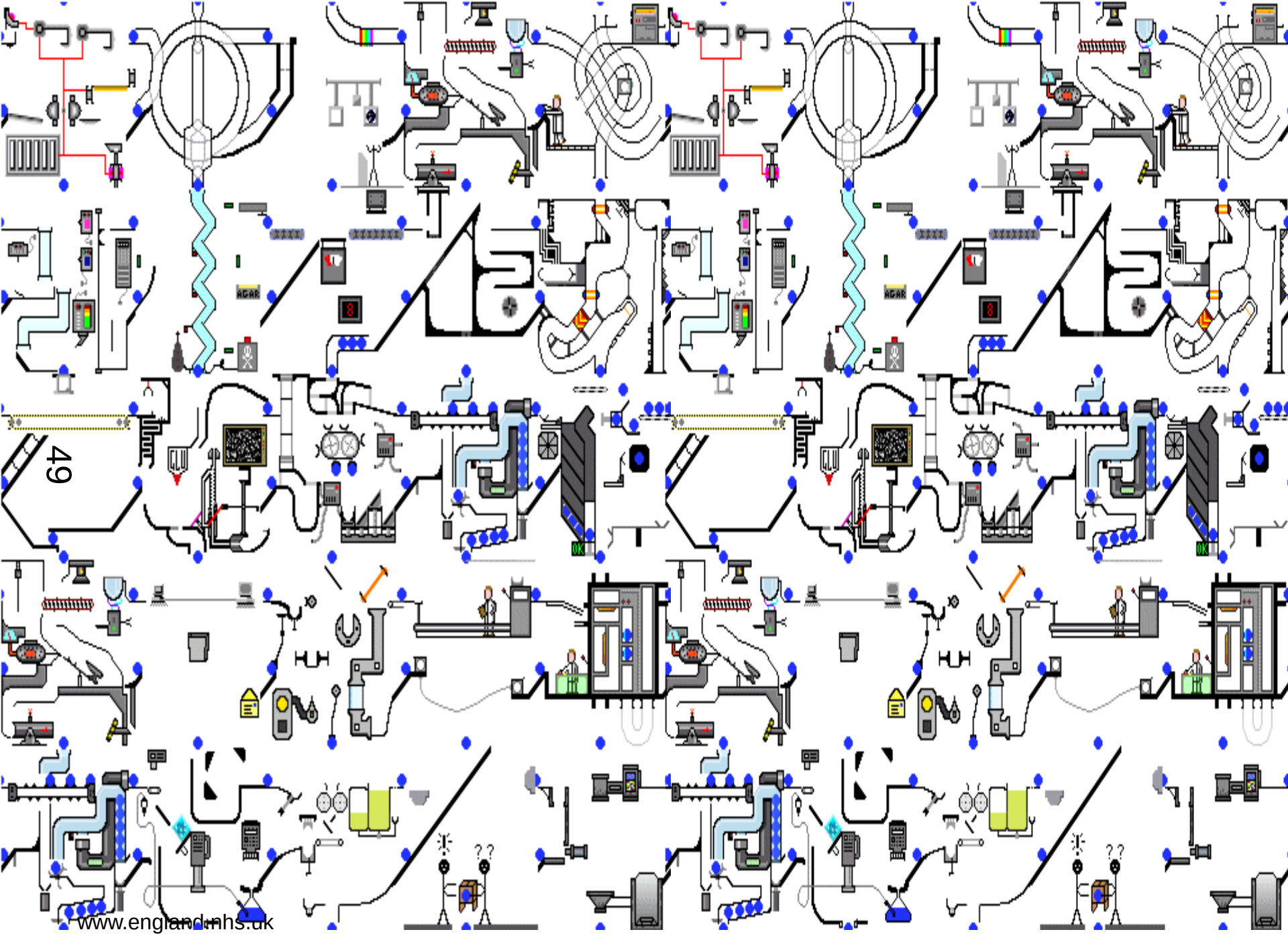
Health and Wellbeing Board

12th July 2018

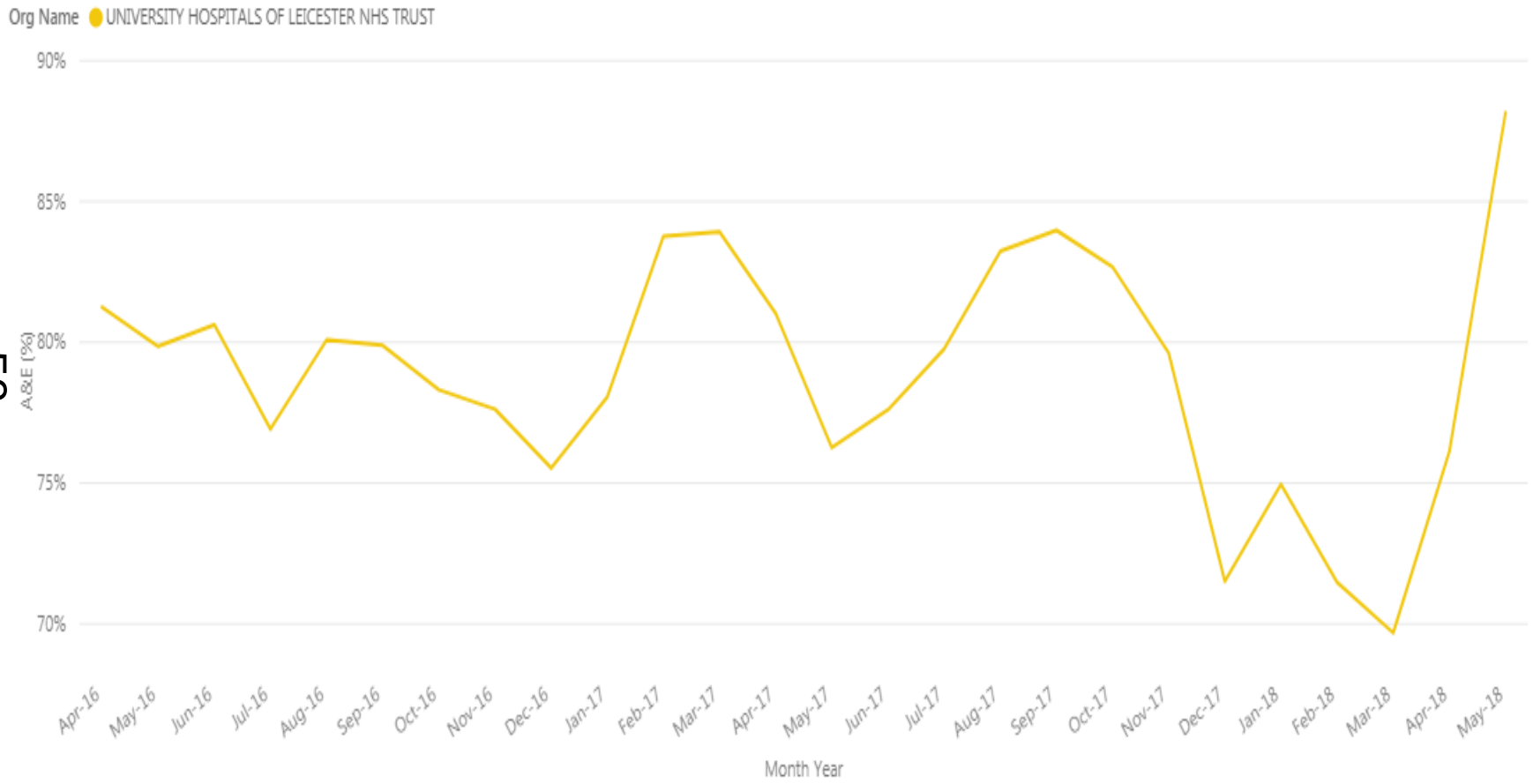
Appendix F1

Winter Headlines

- A&E performance drops in Dec, Jan & Feb every year
- In 2017/18 winter pressures extended into May.
- Less patients attending A&E in winter compared to other times of the year
- There are increases in the number of older, arriving by ambulance and admitted patients in winter (higher case mix).
- Decreases in the number of younger, non-admitted patients in winter
- Performance decrease in winter is more pronounced for older patients
- Delayed Transfers of Care (DTOC) doesn’t increase.
- Evidence of flow issues entering A&E (ambulance handovers) and being admitted from A&E (trolley waits)
- Bed occupancy and length of stay also increase



Performance Trend



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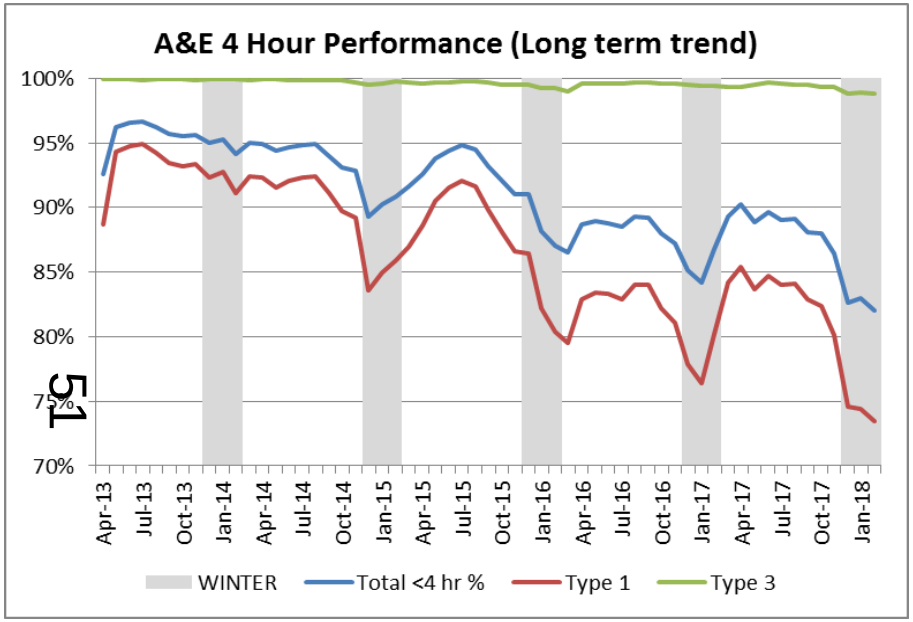
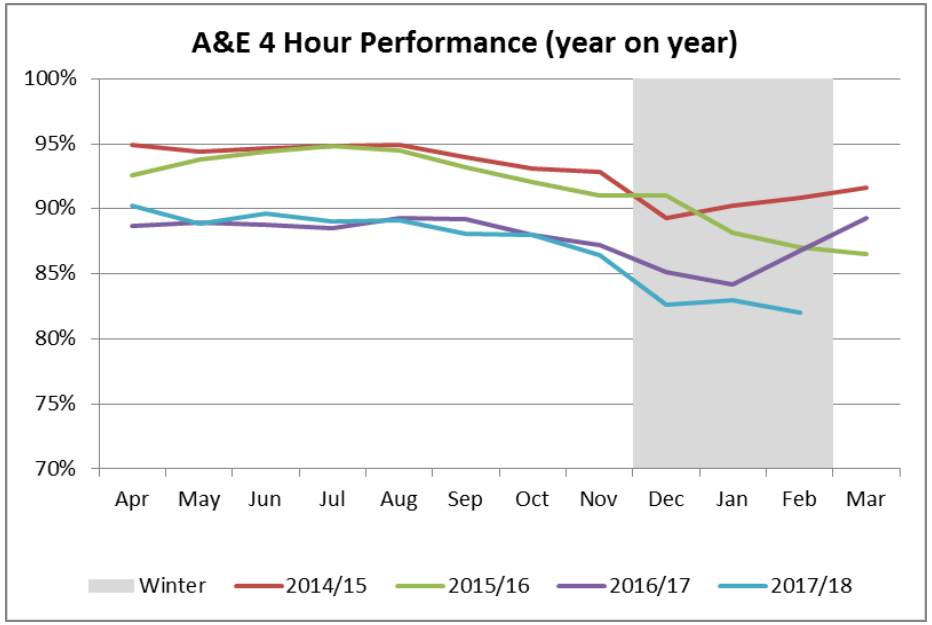
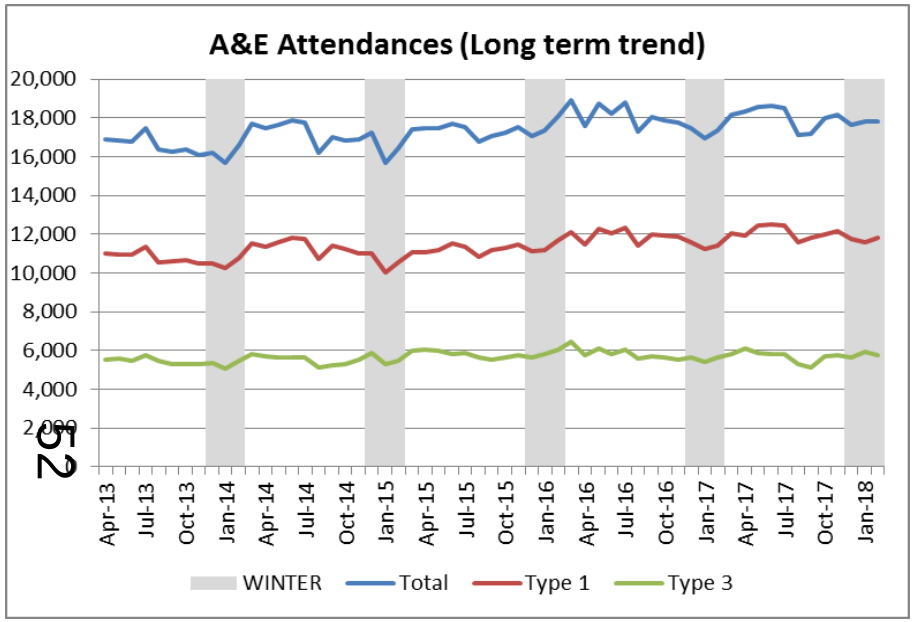
Performance

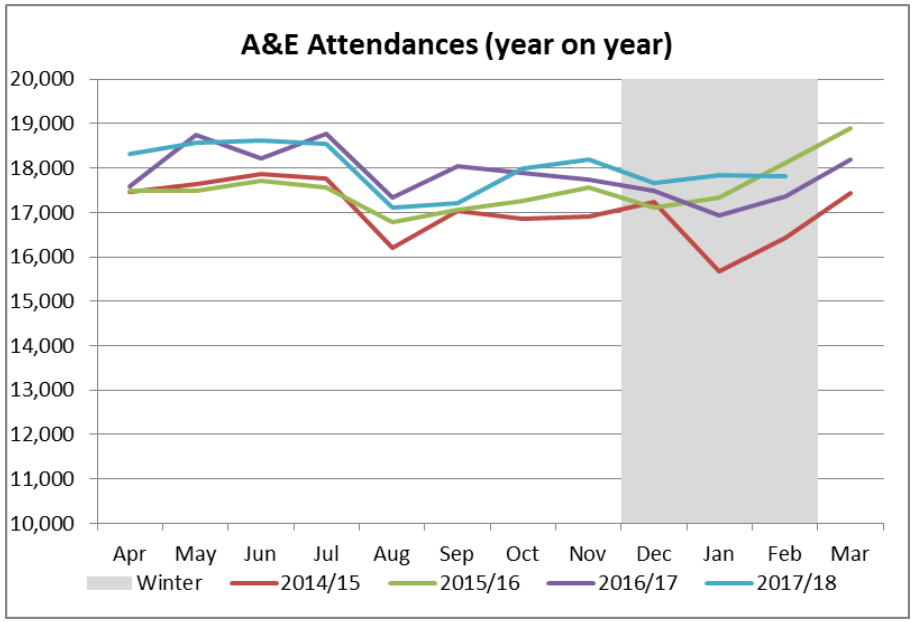




- Clear decrease in performance in Dec, Jan & Feb
- March varies, sometimes performance improves, sometimes it stays low
- On average performance in winter is 4.2% lower than the rest of the year
- This year has seen the largest decrease in winter of 6.2%
- 2013/14 saw a smaller decrease when overall performance was higher

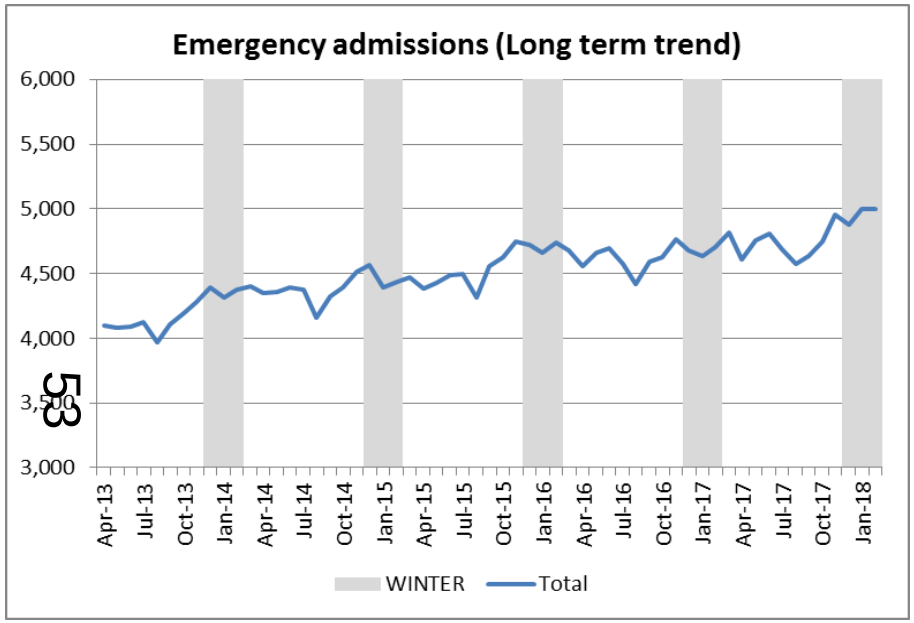
Attendances

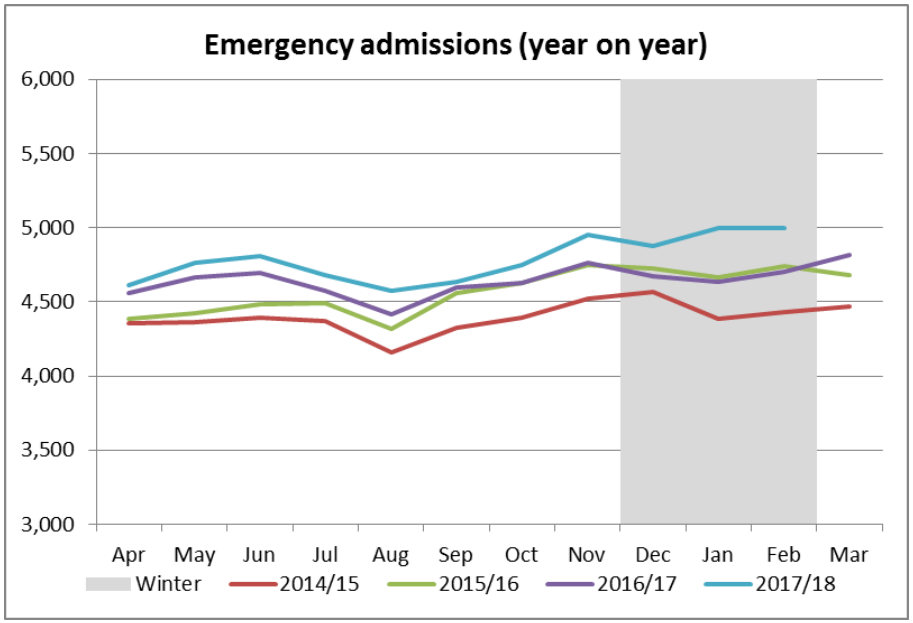




- Attendances decrease in winter
- Usually highest between March and July
- 3% lower attendances in winter

Emergency Admissions





- There has been a long term rising trend
- Emergency admissions rise in winter
- 3% higher on average in winter

Key Variables

- **Adverse Weather**
  - Variable planning, assurance, and delivery.

- **Workforce & Skill Mix**
  - Pace of response to surges in demand during periods of high staff Sickness/ Absence.
  - Ensuring the right capacity and capability.
  - Contingency and succession planning, including Trust to Trust.

Winter Planning 18/19 Desired Results

- **Enable improved and sustained quality of care and treatment for patients throughout heavy periods of surge or operational pressures**.
- Establish visible system resilience.
- Support better alignment of priority work plans toward greater and sustainable system resilience leading to winter 2018/19.
- Surface and mitigate risks.
- Understand benchmarked positions, increase business intelligence, and inform evidence-based decision making.
- Utilise desktop and simulation exercises during September and October to:
  - test demand and capacity modelling predictions,
  - enable mitigation activity,
  - highlight any system funding gaps/needs, and
  - systematically review winter surge plan strengths/weaknesses for continuous improvement.

Major Focus On…System Resilience *Characteristics*

- A patient or service user's crisis is not a system or provider's crisis.
- Maintains stability.
- Recognises the complexities and influential factors (within and external).
- Can absorb, recover, and learn from variation in demand.
- Mitigates risk and resolves issues

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LLR Timeline (c 120 working days)

May / June	• Engagement and Learning from 2017/18; strengths, areas for improvement, gaps • Priority planning and short, medium gains • Data Analysis and Evidence
July	• EPRR Exercise 'Boudica' – Simulation Exercise • IUEC Rapid Improvement Workshop 1 • Demand and Capacity Insight Position • Patient Group and Primary Care Focus
August	• OPEL Threshold and process revision/refresh • IUEC Rapid Improvement Workshop 2 • Metrics for Outcomes • Risk Share / Gap Visibility
September	• **Simulation Exercise – Wake Up 1** • **Patient Journey Scenarios** • **AEDB and Partner Agreement** • **Plan Submission**
October / November	• **Simulation Exercise – Wake Up 2** • **Readiness Assessment** • **IUEC Rapid Improvement Workshop 3** • **Assessment and Review / Escalation SRG**

Appendix F2

Leicester Health and Wellbeing Board Formal Meeting

Title:

Resilience Planning Arrangements for Winter 2018/19

Presenters:

Mr Mike Ryan, Director of Urgent and Emergency Care Leicestershire, Leicester City, and Rutland (LLR) System;
Mr Phil Coyne, Leicester City Council;
Ms Rachna Vyas, University Hospitals of Leicester;
Mr Mark Pierce, Leicester City Clinical Commissioning Group


Leicester
City Council

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1.0 Purpose of the paper or presentation

The purpose of this presentation is to provide an overview of practical winter planning arrangements and health care winter planning arrangements including our plans for frail & multi-morbidity patients.

The Leicestershire, Leicester City, and Rutland (LLR) health and social care system are focusing efforts toward building greater and sustainable resilience across urgent and emergency care for our patients and draws reference to:

- What system performance looked like last winter;
- Our assessment of the major causes for pressure that we experienced;
- The lessons that were learnt as a result;
- The actions to avoid similar issues; and
- Our assessment of our readiness for this coming winter

2.0 Recommendations for the Board to consider

The Board is asked to:

- Note the lessons learnt and actions being taken in preparation for the upcoming winter season; and
- Note the priority areas of focus being undertaken over the coming months

3.0 Content

- Please see enclosed presentation

4.0 Next Steps

- A&E Delivery Board initial plan review 5th September
- NHS England plan submission 28th September
- Simulation / Practice exercises September, October, and November.
- Routine, monthly assessment and review of plan for continuous improvement.

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

NHS
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

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

Health & Wellbeing Board

Leicester City Council

20th September 2018

Mr Mike Ryan, Director of Urgent and Emergency Care, LLR System
Mr Mark Pierce, Leicester City CCG
Ms Rachna Vyas, University Hospitals of Leicester

Appendix F3

Purpose of the Report

- Overview of:
  - Practical winter planning arrangements; and
  - Health care winter planning arrangements including our plans for frail & multi-morbidity patients
- Reference to:
  - What system performance looked like last winter;
  - Our assessment of the major causes for pressure that we experienced;
  - The lessons that were learnt as a result;
  - The actions to avoid similar issues; and
  - Our assessment of our readiness for this coming winter

Introduction - Winter System Performance 2017/18

- **Patients are living longer**
  - advances in medical treatment and health
  - aging population
  - resident growth into the area
  - lifestyle factors
  - All influence and increase 'demand' for public services

- **Intense pressure**
  - A&E performance deteriorated (known to drop in Dec to Feb)
  - …But started earlier and ended later (November to April)

- **Hospital A&E 4-hour performance**
  - below standard with an annual position of 77.7% (79% the previous year).

Our Assessment of Last Winter

Pressure felt across all parts of the system everywhere – in GP practices, GP Primary Care Hubs, Urgent Care Centres, 111 calls, Clinical Navigation Services, Out of Hours Services, Ambulances Services, A&E and within the hospitals – all higher than 2016/17 and above forecasts.

- 80% of hospital beds were occupied by older people over 75 years of age (20% of the population) - who required more care and stayed in hospital longer.

- Emergency surgical cases exceeded normal levels.

- The length of stay for medical patients at the Leicester Royal Infirmary *increased* by nearly two days from January to March 2018.

- Norovirus and/or flu resulted in closed beds at both UHL and LPT.

Our Assessment of Last Winter continued

- High elective cancellations last winter in comparison with 2016/2017 following a national instruction to all acute Trusts.

- NHS111 - 30% more calls than planned.

- Ambulance services regularly at a high escalation level; patient handover times higher than expectation (over 15 minutes).

- Staffing levels - medical and nurse staffing levels in hospital were variable with a higher than average sickness/absence rate during peak periods of demand.

The Lessons from 2017/18

- Communication began to break down as pressure was building
- Skills in forecasting were not shared across the system.
- More could have been done to protect beds for emergency activity.
- 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 A&E with conditions that could have been treated elsewhere.

The Actions to Avoid Similar Issues

- Focussed review and revision of the system **Escalation Plan.**
- The second part of the **A&E development** at UHL opened in June, with the creation of the full emergency floor, which provides improved patient assessment areas.
- UHL has re-aligned their bed capacity overall and created **additional ward capacity** to meet the expected increase in medical patient demand. Equivalent to 3 wards.
- We have **forecast** in detail how much emergency capacity is required.
- **Improved access to IT systems** so clinicians are able to see the patient's clinical record.
- New, improved **protocols** are agreed between UHL and EMAS.
- Improved **communication systems** developed between consultants and GPs.

The Actions continued

- We are introducing a **"Red Bag scheme"** for care homes, which has been shown to work elsewhere.

- We are **supporting more patients** to understand and manage their conditions, with respiratory a major focus.

- **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.

- Collaborating system-wide to design a **new pathway for frail** patients based upon local needs and national standards, alongside other interventions to help battle 'isolation' and engage carers and voluntary organisations.

Flu & Immunisation

- Nationally-led, Locally implemented.
- Working with Public Health and NHS England to deliver a proactive response to seasonal flu.
- Flu Vaccination Programme Guidance provided 1st August.
- Health, Primary Care, Public health and community pharmacy campaigns.
- Advice and Guidance
- Flu clinics
- GP practices are required to contact eligible patients for vaccination.
- Access at Multiple sites
- Offered to frontline healthcare workers every year to reduce risk of contracting and spreading virus.
- Encouragement but not mandatory

Emphasis on (Clear) Communication

Co-ordinated campaign across agencies for improved messaging:

- Local LLR Resilience Forum
- www.Staywell-LLR.org.uk
- Weather alerts and actions
- Message Board and Live Waiting Times across Providers
- Multiple Proactive action and messages
  - Get the Flu jab
  - Keep warm
  - Look out for vulnerable
  - Better Understanding of Services and Access (members of the public AND healthcare provider staff); 111 and primary care; health hubs on your doorstep,
  - Self Care – Ask your GP

Lead Agencies involved and providing message content:

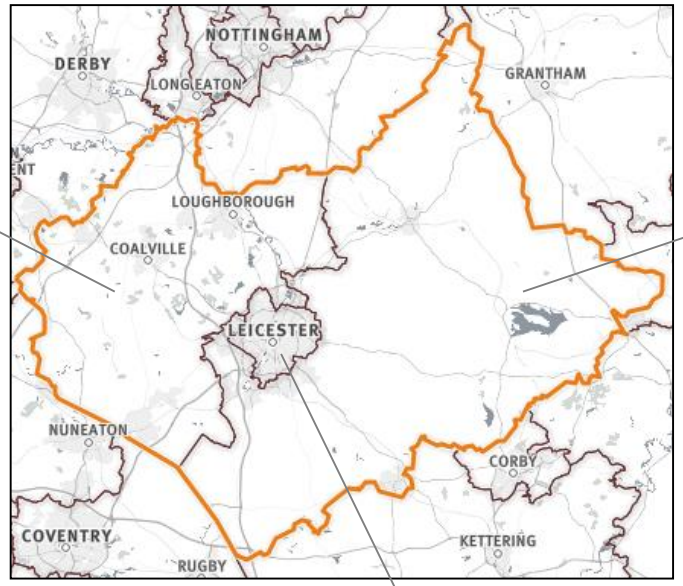
- Leicestershire Fire & Rescue Service
- Leicestershire Police
- Leicestershire County Council
- Leicester City Council
- Districts and Borough Councils
- Rutland County Council
- Environment Agency
- Health: NHS England; Public Health England; East Midlands Ambulance Service; CCGs; LPT ; UHL
- British Red Cross
- Severn Trent
- Western Power Distribution
- Multiple Charitable and Voluntary organisations.

FOCUS:
FRAIL & MULTI-MORBID PATIENTS

- Ms Rachna Vyas, UHL
- Mr Mark Pierce, Leicester City CCG

Context – Admission Patterns

West: 473 more admissions during Jan-March 2018 compared to the same time previous year

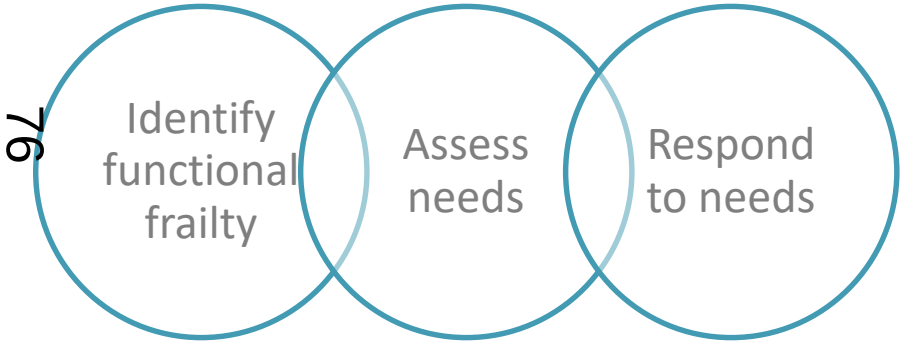


ELR: 328 more admissions during Jan-March 2018 compared to the same time previous year

City: 31 more admissions during Jan-March 2018 compared to the same time previous year

What is Frailty?

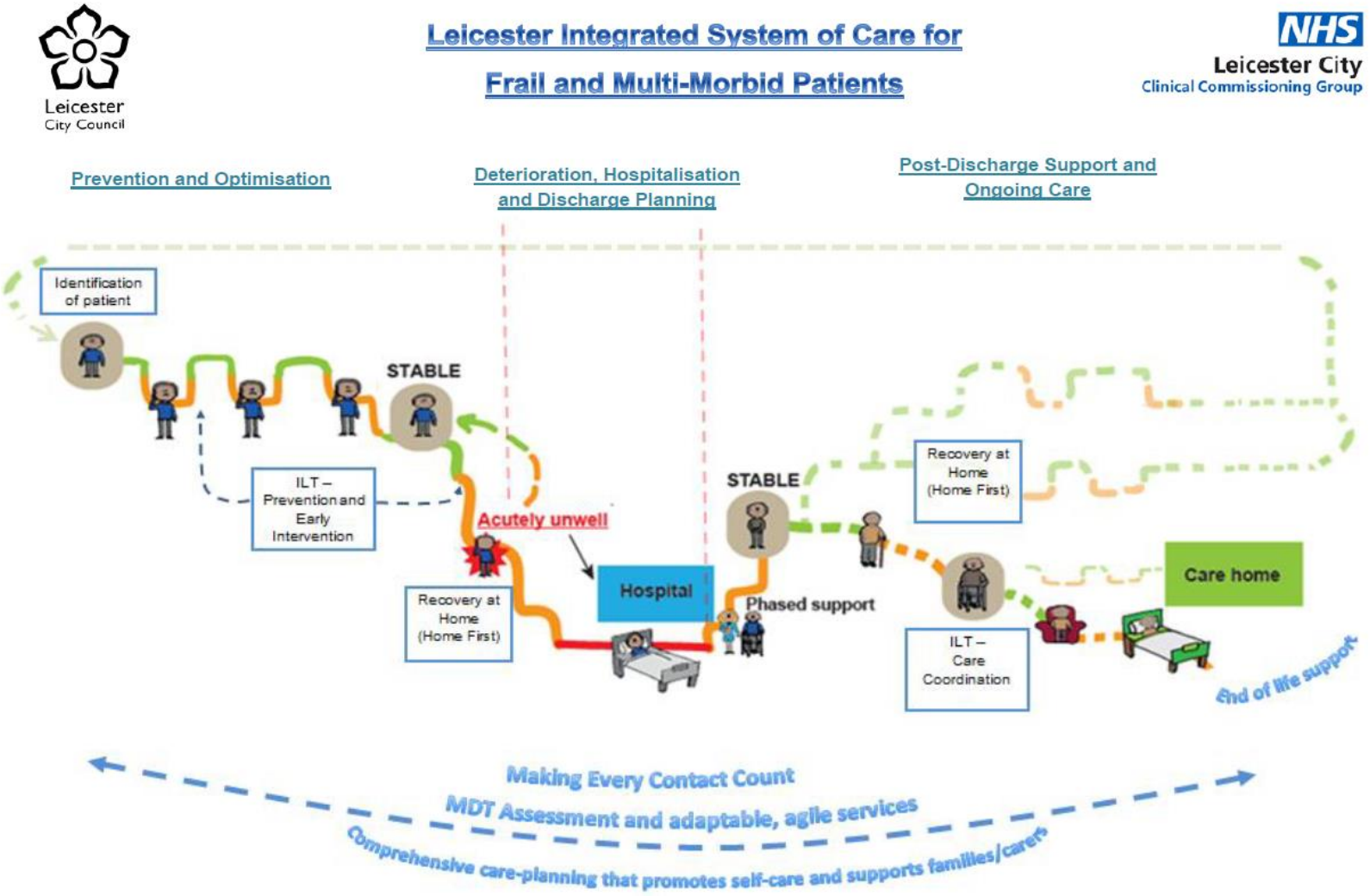
LLR Frailty Programme - Objective



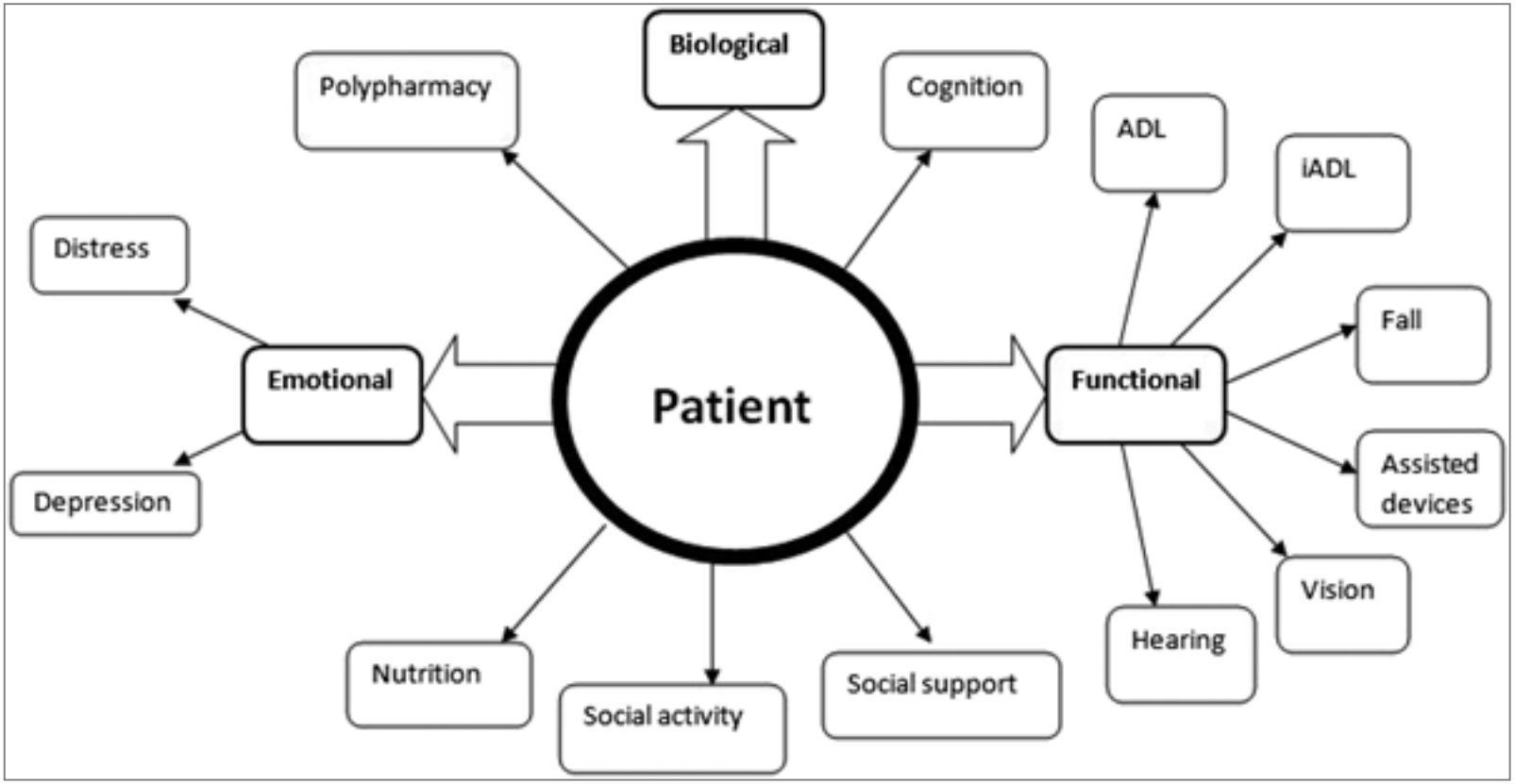
- Identify frail & multi-morbid patients & assess patients needs and wishes; and
- Respond based on a comprehensive assessment of need (medical, cognitive, functional, social, environmental)

Identification & Assessment

Our Integrated System of Care for those who are Frail



Response to Identification (1)



Response to Identification (2)

- Integrated Crisis Response Service
- Health Transfers Team
- Reablement
- Care Navigators
- Intensive Community Support
- Falls Therapy in Care Homes
- Mental Health Integrated Team
- General Practice- additional time with complex cases/care planning/ Team problem solving

Response to Identification (3)

- Care plans for those with complex needs
- Enhanced Summary Care Record – so the hospital can see the plan!
- Vaccination programme
- Medication reviews
- Support for carers
- Series of local social inclusion events – target to reduce isolation; loneliness is a big risk
- DMU student volunteers
- Health Through Warmth
- Assistive Technology and home adaptations

SUMMARY AND ASSESSMENT OF READINESS

- Mr Mike Ryan, Director of Urgent & Emergency Care, LLR System

Overall - Our Assessment of our Readiness

- Work continues with steady progress and on track.
- One Plan by end of September.
- Planning winter preparedness across dozens of organisations is technical and complex.
- Individual health and social care organisations are to review and submit their plans.
- They will also incorporate demand and capacity plans, business continuity plans, flu and infection control preparedness and adverse weather protocols.
- Multiple simulation and real scenario exercises for practice to ensure the system is clear on arrangements, contingencies, and to test for any gaps that exist ahead of winter.

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.