Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 27 November 2013 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Mrs. R. Palmer (0116 305 6098)**

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Membership

Dr. S. Hill CC (Chairman)

Dr. T. Eynon CC	Mr. J. Miah CC
Dr. R. K. A. Feltham CC	Mr. M. T. Mullaney CC
Mr. S. J. Hampson CC	Mr. J. P. O'Shea CC
Mr. W. Liquorish JP CC	Mr. A. E. Pearson CC

Please note: this meeting will be filmed for live or subsequent broadcast via the Council's web site at http://www.leics.gov.uk/webcast – Notices will be on display at the meeting explaining the arrangements.

AGENDA

Item		Report by
1.	Minutes of the meeting held on 11 September 2013.	(Pages 5 - 14)
2.	Minutes of the meeting held on 12 September 2013.	(Pages 15 - 20)
3.	Question Time.	
4.	Questions asked by members under Standing Order 7(3) and 7(5).	
5.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	

6.	Declarations of interest in respect of items on the agenda.		
7.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.		
8.	Presentation of Petitions under Standing Order 36.		
9.	Quality Improvement Programme.	Leicestershire Partnership NHS Trust	(Pages 21 - 86)
10.	Emergency Care Update.	West Leicestershire and East Leicestershire and Rutland CCG	(Pages 87 - 90)
11.	Update on Current Issues	University Hospitals of Leicester NHS Trust	(Pages 91 - 100)
12.	Update on Implementation of the Estates Strategy.	East Midlands Ambulance Service NHS Trust	(Pages 101 - 106)
13.	Annual Report of the Director of Public Health	Director of Public Health	(Pages 107 - 174)

A copy of the Annual Report of the Director of Public Health is attached as a separate document for Members and is available from the Committee Officer on request. It can be viewed on the County Council's website at http://politics.leics.gov.uk/ieListDocuments.aspx?CId=1045&MId=3885&Ver=4

14. Date of next meeting.

The next meeting of the Committee is scheduled to take place on Wednesday 22nd January at 2.00pm.

15. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

Members serving on Overview and Scrutiny have a key role in providing constructive yet robust challenge to proposals put forward by the Cabinet and Officers. One of the most important skills is the ability to extract information by means of questions so that it can help inform comments and recommendations from Overview and Scrutiny bodies.

Members clearly cannot be expected to be experts in every topic under scrutiny and nor is there an expectation that they so be. Asking questions of 'experts' can be difficult and intimidating but often posing questions from a lay perspective would allow members to obtain a better perspective and understanding of the issue at hand.

Set out below are some key questions members may consider asking when considering reports on particular issues. The list of questions is not intended as a comprehensive list but as a general guide. Depending on the issue under consideration there may be specific questions members may wish to ask.

Key Questions:

- Why are we doing this?
- Why do we have to offer this service?
- How does this fit in with the Council's priorities?
- Which of our key partners are involved? Do they share the objectives and is the service to be joined up?
- Who is providing this service and why have we chosen this approach? What other options were considered and why were these discarded?
- Who has been consulted and what has the response been? How, if at all, have their views been taken into account in this proposal?

If it is a new service:

- Who are the main beneficiaries of the service? (could be a particular group or an area)
- What difference will providing this service make to them – What will be different and how will we know if we have succeeded?
- How much will it cost and how is it to be funded?
- What are the risks to the successful delivery of the service?

If it is a reduction in an existing service:

- Which groups are affected? Is the impact greater on any particular group and, if so, which group and what plans do you have to help mitigate the impact?
- When are the proposals to be implemented and do you have any transitional arrangements for those who will no longer receive the service?
- What savings do you expect to generate and what was expected in the budget? Are there any redundancies?
- What are the risks of not delivering as intended? If this happens, what contingency measures have you in place?

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Agenda Item 1

Leicestershire County Council

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 11 September 2013.

PRESENT

Dr. S. Hill CC (in the Chair)

Dr. T. Eynon CC	Mr. J. Kaufman CC
Dr. R. K. A. Feltham CC	Mr. W. Liquorish JP CC
Mr. S. J. Hampson CC	Mr. J. Miah CC
Mr. D. Jennings CC	Mr. A. E. Pearson CC

In attendance.

Geoffrey Smith OBE, Healthwatch Representative

For minute 9:-

Mr E F White CC, Cabinet Lead Member for Health
Jane Chapman, Chief Strategy and Planning Officer, East Leicestershire and Rutland Clinical Commissioning Group (CCG)
Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland CCG
Angela Bright, Chief Operating Officer, West Leicestershire CCG
Tony Menzies, Project Manager, West Leicestershire CCG
Dr Saurabh Johri, NHS 111 Clinical Lead
Jane Taylor, Leicester, Leicestershire and Rutland Emergency Care Director
John Adler, Chief Executive, University Hospitals of Leicester (UHL)
Dr Catherine Free, Emergency Care Medical Lead, UHL
Rachel Griffiths, Project Director, Site Reconfiguration, UHL
Mark Wightman, Director of Communications and Marketing, UHL.

1. Appointment of Chairman.

RESOLVED:

That it be noted that Dr S Hill CC has been appointed Chairman of the Health Overview and Scrutiny Committee for the period ending with the Annual Meeting of the County Council in 2014.

2. Appointment of Deputy Chairman.

RESOLVED:

That Mr S J Hampson CC be elected Deputy Chairman of the Health Overview and Scrutiny Committee for the period ending with the date of the Annual Meeting of the County Council in 2014.

3. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 35.

4. Questions asked by members under Standing Order 7(3) and 7(5).

The Chief Executive reported that no questions had been received under Standing Order 7(3) and 7(5).

5. Urgent Items.

There were no urgent items for consideration.

6. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Dr T Eynon CC declared a personal interest in all items on the agenda as a salaried GP.

7. Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.

There were no declarations of the party whip.

8. Presentation of Petitions under Standing Order 36.

The Chief Executive reported that no petitions had been received under Standing Order 36.

9. Improving Emergency Care.

The Committee considered a report and presentation of the local NHS which set out NHS plans for improving emergency care in Leicestershire, with particular regard to arrangements for Winter 2013. A copy of the report and presentation marked 'Agenda Item 9' is filed with these minutes.

The Chairman welcomed the following NHS officers to the meeting:-

Jane Chapman, Chief Strategy and Planning Officer, East Leicestershire and Rutland Clinical Commissioning Group (CCG)
Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland CCG
Angela Bright, Chief Operating Officer, West Leicestershire CCG
Tony Menzies, Project Manager, West Leicestershire CCG
Dr Saurabh Johri, NHS 111 Clinical Lead
Jane Taylor, Leicester, Leicestershire and Rutland Emergency Care Director
John Adler, Chief Executive, University Hospitals of Leicester (UHL)
Dr Catherine Free, Emergency Care Medical Lead, UHL
Rachel Griffiths, Project Director, Site Reconfiguration, UHL
Mark Wightman, Director of Communications and Marketing, UHL.

Arising from discussion the following points were raised:-

Improving Emergency Care

(i) Concern was expressed that performance in meeting the target of treating 95% of patients accessing emergency care within four hours was not consistent. It was acknowledged that performance varied on a daily basis and that the aim was to address this inconsistency. Over the last few weeks a number of actions had been put in place to improve performance. These actions were starting to have a positive impact on performance, which had been recorded last week as 92.9%. It would take time for some of the actions to have an effect. The Committee felt that this was an area which could usefully be revisited at its next meeting in order to consider progress.

(ii) Actions being taken to improve performance included the following:-
- Establishment of a command and control centre;
- Engagement of staff at senior level;
- Senior consultants' shifts extended to midnight seven days a week;
- Increasing assessment beds by 15 to 72;
- Reassessing the mix of planned care and emergency care beds;
- Getting the right skill mix amongst staff.

(iii) The new single point of access for the Emergency Department had resulted in 30% of patients being redirected to the Urgent Care Centre. However, the impact of this change on performance had been reduced because the patients still using the Emergency Department were the most complex and ill patients.

(iv) Senior Emergency Department consultants met four times a day to monitor performance and consider deployment of staffing resources. The commissioners reviewed performance on a daily basis. Performance could also be reviewed by Emergency Department operational staff using the command and control centre. This was an information hub which enabled staff to look at trends, variations and escalations in activity. It was acknowledged that there were problems with the timeliness of information received from wards and discharge but, without moving to electronic patient records, there was no immediate solution to this. Overall, it was felt that the new system was an improvement.

(v) With regard to discharging patients, it was noted that the information required by the County Council's Customer Service Centre was similar to that required by the CCGs. It was suggested that a common template for data collection should be developed and used across health and social care. The Committee was advised that work was ongoing to develop a single assessment process across health and social care. To ensure that this happened, it would need to be treated as a project rather than being added to workloads.

(vi) It was noted that the Secretary of State had allocated £10 million to UHL for Winter 2013 and that additional match funding would be provided by the CCGs. Members welcomed this but were concerned about sustainability after winter. However, they were assured that sustainability was a key element of the programmes being developed and was being assessed through the evaluation process.

(vii) A wealth of data pertaining to emergency care was collected by the CCGs and could be used to ascertain where patients came from, what their condition was, the percentage treated in the Emergency Department and the percentage of patients that should have been treated by their GP. This information would be broken down to locality level with a view to identifying whether there were particular locality issues resulting in those patients accessing the Emergency Department.

Emergency Planning and Resilience

(viii) Concern was expressed that, in the past, Leicestershire had seen a high number of hospital admissions from residents in care homes. The Committee was advised that plans to support care home staff to manage their patients were being put in place. One such scheme being developed was to have residents in a care home treated by the same GP practice. This enabled the GP practice to carry out ward rounds, advance care planning and end of life care. East Leicestershire and Rutland CCG had also invested in working with care homes. Both CCGs supported staff to understand and record what was normal for each patient.

Emergency Floor Development

(ix) The development of a single emergency floor would require the movement of a number of outpatient specialties to the General or Glenfield Hospital. These included vascular services, dermatology and rheumatology. UHL intended to group these services logically as it was hoped that this would provide an enhanced service.

(x) Members welcomed the proposals for the development of a single emergency floor. It was felt that this was a logical development which would improve patient flow. The strategic business outline case had been submitted to the Trust Development Authority for approval and UHL would be meeting with the national Director of Finance the following day. Although formal approval and funding had not yet been received, UHL intended to proceed with the enabling scheme of moving outpatient services. It was hoped that Phase 1, the new Emergency Department, would be completed by Winter 2014/15.

(xi) It was noted that the proposed changes to the Emergency Department and the consequent changes to the location of a number of outpatient clinics fell within the definition of “a substantial variation in the provision of such services” and would therefore normally be the subject of formal consultation. However, the Committee was of the view that the proposed changes would enhance the provision of emergency and outpatient services in terms of accessibility and clinical outcomes and believed that the proposed changes were in the best interests of patients and the public. It was therefore suggested that the Committee waive its right to be formally consulted on condition that the UHL Trust undertook to provide it with a detailed project plan outlining at the minimum the following:-

- the outpatient services to be moved, their new location, the rationale for moving and the timing of such moves;
- the development of proposal to improve car parking and public transport access to the General and Glenfield Hospitals;
- the plan for the expansion of the Emergency Department and associated services at the LRI, the timing of changes and actions to be taken to minimise disruption to patient services and care whilst building works were being carried out.

UHL would also be expected to provide regular updates on the progress of works and any variations to the plans and to meet with the Committee or its representatives if there were any concerns raised by members of the Committee about the implementation of the proposals.

(xii) Concern was expressed that the proposal being put forward by UHL would not have the anticipated impact on parking availability at the Leicester Royal Infirmary due to reductions in public transport. Members recommended that UHL gave consideration to a park and ride system for its sites. This suggestion was welcomed and it was noted that UHL had discussed with Leicester City Council linking the hospital hopper service to the existing park and ride sites.

(xiii) The benefits of having acute services located on a small number of centralised sites was queried. However, national evidence had resulted in a direction of travel towards fewer sites providing specialised services. For patients that did not need specialist care the aim remained for as much as possible to be done in the community.

NHS 111 Service

(xiv) Concern was expressed that quality monitoring did not include consideration of patient experience. This was acknowledged; the focus was on clinical quality. Although feedback was collected from patients when they accessed other parts of the system and a listening booth was being used at venues across Leicestershire to gain patient views of the NHS, this was not felt to be sufficient.

(xv) The CCGs would continue to manage the NHS 111 service once it had been rolled out in Leicestershire. It was likely that it would be a number of months before the CCGs were confident that the processes were robust and the service could handed over. Members welcomed this cautious approach, given issues elsewhere in the country with the roll out of the service.

Minor Injury and Illness Services

(xvi) Members welcomed the consultation as it would improve access, understanding and patient flows in Minor Injury Units across East Leicestershire and Rutland. It was also expected that it would have a positive impact on demand for the Emergency Department. It was anticipated that the public consultation would commence in a couple of weeks and would last for eight weeks. The views of Patient Representative Groups (PRGs) would be sought at a meeting with PRG chairs which would take place shortly. The consultation would be advertised in GP surgeries and any changes would be communicated to patients. Members welcomed the intention for a proactive marketing campaign which would make patients aware of what services were available and where.

(xvii) Work was also in hand to develop enhanced service provision in the community hospitals, particularly at Loughborough Community Hospital. The urgent care centre had been moved to the community hospital and work was now being undertaken with local GPs to look at improving patient pathways. Part of the commissioning process for 2014/15 would include identifying which services should be available at Loughborough Community Hospital and how provision could be improved.

(xviii) Oadby Walk in Centre would not form part of the public consultation because it was commissioned by NHS England rather than East Leicestershire and Rutland CCG. However, East Leicestershire and Rutland CCG had a role influencing the provision of services at the walk in centre to ensure they were appropriate and met patients' needs. It would be helpful for this to be made clear as part of the consultation process.

(xix) Concern was expressed that Section 106 monies to improve primary care services were not being collected and that the sums sought from developers were insufficient. The Section 106 monies were managed by NHS England, although it was the aim of CCGs to utilise the primary care estate to its full potential, including out of hours. Members recommended greater co-operation between NHS organisations in order to achieve this.

The Chairman then drew the Committee's attention to the written comments which had been submitted by Healthwatch, a copy of which is filed with these minutes. Geoffrey Smith OBE was invited to make further comments on behalf of Healthwatch. He expressed concern that problems with emergency care frequently reoccurred in Leicestershire. He was hopeful that this time would be different as the whole system seemed to be working together and integration of health and social care was now a national priority. With regard to the plans for the new emergency floor, Healthwatch welcomed them and felt that they gave the public confidence that the system would improve. The proposed links between the park and ride and hospital hopper were welcomed as they would improve access for the public.

The Cabinet Lead Member for Health, Mr E F White CC spoke in support of the Leicestershire approach to the roll out of the NHS 111 Service.

RESOLVED:

(a) That this Committee is of the view that the proposals to relocate a number of the existing clinics currently based at the LRI to either the Leicester General Hospital site or to the Glenfield Hospital site so as to release space for the proposed expansion of the Emergency Department and associated facilities are significant and as such constitute a 'substantial variation' which would normally need to be the subject of formal consultation;

(b) That this Committee, having considered the outline of the proposals set out in (a) above is of the view that such changes would, if fully implemented as described, improve the accessibility of services and improve patient experiences and outcomes and, in view of this, agrees that it would not be in the interest of people of Leicestershire for it to insist upon formal consultation as this would divert resources away from the project team charged with the delivery of these necessary changes, therefore waives its right to be formally consulted on condition that the UHL Trust undertakes to:-

(i) provide the Committee with a detailed project plan outlining at the minimum the following:-

- the outpatient services to be moved, their new location, the rationale for moving and the timing of such moves;
- the development of proposal to improve car parking and public transport access to the General and Glenfield Hospitals;
- the plan for the expansion of the Emergency Department and associated services at the LRI, the timing of changes and actions to be taken to

minimise disruption to patient services and care whilst building works are being carried out

(ii) provide regular updates on the progress of works and any variations to the plans;

(iii) to meet with the Committee or its representatives if there are any concerns raised by members of the Committee about the implementation of the proposals.

(c) That the comments now made be submitted to UHL and the CCGs for consideration;

(d) That an update on the work of the Urgent Care Board at its next meeting be submitted to the Committee;

(e) That a report on the impact of winter on the Emergency Department be submitted to the Committee in Spring 2104;

(f) That the public consultation on changes to minor injury and minor illness services in East Leicestershire and Rutland be considered by the Committee at its next meeting.

10. Change to the Order of Business.

The Chairman sought and obtained the consent of the Committee to vary the order of business from that set out on the agenda.

11. Strategic Review of Adult Preventative Mental Health Services in Leicestershire.

The Committee considered a report of the Director of Adults and Communities which provided an update on the strategic review of adult preventative mental health services in Leicestershire and the implementation of the proposed service re-design to the Voluntary Service Officers Service and invited comments on the proposed commissioning option for the Adult Mental Health Social Drop In and Befriending Services. A copy of the report marked 'Agenda Item 11' is filed with these minutes.

Healthwatch had submitted written comments on this item, a copy of which is filed with these minutes.

Arising from discussion the following points were raised:-

(i) Officers from the Adults and Communities Department had attended social drop in clinics as part of the consultation process and had engaged with members of the black and minority ethnic (BME) community who had indicated that they would prefer a more inclusive service, not least because it could help with developing English language skills. The proposal to make social drop in services more inclusive was therefore welcomed by the Committee.

(ii) Members commented that often people attending self-help groups did not move on and suggested that encouraging service users to become more involved with the local community should be a requirement of the new service. However, it was acknowledged that for some people, moving on was not possible. Members welcomed the proposed flexibility of the new process which would both support people to access universal services and move on and would encourage the

establishment of peer support groups and the setting of informal goals for service users who were not able to do so.

(iii) It was noted that referral pathways into the social drop in and befriending service had not been robust and the intention to improve access was welcomed as were the intentions to improve performance monitoring.

RESOLVED:

That the comments now made be submitted to the Cabinet for consideration.

12. New Review of Congenital Heart Disease Services.

The Committee considered a report of the Chief Executive which provided an update on the current position with regard to the national review of children's congenital heart services and advised of the role that the Committee could have in the new process. A copy of the report marked 'Agenda Item 10' is filed with these minutes.

Healthwatch had submitted written comments on this item, a copy of which is filed with these minutes.

Since the report had been written, NHS England had met with the Centre for Public Scrutiny (CfPS) to discuss the role of Local Government in the new review. CfPS had advised that engagement with Local Government should not be limited to Overview and Scrutiny Committees.

NHS England had written to Councillor Cooke, who had chaired the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee meeting which had referred the previous review to the Secretary of State, asking how he wished to be involved in the new review. The Committee would be advised of his response.

RESOLVED:

(a) That the report and information now provided be noted;

(b) That officers be requested to update the Committee of any relevant developments during the review process.

13. Protocol between the Health and Wellbeing Board, the Health Overview and Scrutiny Committee and Healthwatch Leicestershire.

The Committee considered a report of the Chief Executive which sought approval of the protocol between the Health and Wellbeing Board, Health Overview and Scrutiny Committee and Healthwatch Leicestershire. A copy of the report marked 'Agenda Item 12' is filed with these minutes.

Healthwatch had submitted written comments on this item, a copy of which is filed with these minutes.

It was reported that the Health and Wellbeing Board had approved an amendment to the protocol at its meeting on 5 September to recognise that Healthwatch were participating observers of the Clinical Commissioning Group Board meetings.

RESOLVED:

That the protocol, as amended by the Health and Wellbeing Board on 5 September, be approved.

14. Date of next meeting.

It was noted that the next meeting of the Committee would be held on Wednesday 12 September at 4.00pm.

2.30 - 4.50 pm CHAIRMAN
11 September 2013

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Agenda Item 2

Leicestershire County Council

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Thursday, 12 September 2013.

PRESENT

Dr. S. Hill CC (in the Chair)

Dr. T. Eynon CC
Dr. R. K. A. Feltham CC
Mr. S. J. Hampson CC
Mr. D. Jennings CC
Mr. W. Liquorish JP CC

In attendance.

Geoffrey Smith OBE, Healthwatch Representative
Sue Noyes, Acting Chief Executive, LPT
Satheesh Kumar, Medical Director, LPT
Cathy Ellis, Deputy Chair, LPT
Toby Sanders, Managing Director, West Leicestershire Clinical Commissioning Group (CCG)
Dr Graham Johnson, East Leicestershire and Rutland CCG
Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland CCG

15. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 35.

16. Questions asked by members under Standing Order 7(3) and 7(5).

The Chief Executive reported that no questions had been received under Standing Order 7(3) and 7(5).

17. Urgent Items.

There were no urgent items for consideration.

18. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Dr T Eynon CC declared a personal interest in the report on the Bradgate Mental Health Unit (minute 21 refers) as a salaried GP with a special interest in mental health.

19. Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.

There were no declarations of the party whip.

20. Presentation of Petitions under Standing Order 36.

The Chief Executive reported that no petitions had been received under Standing Order 36.

21. Bradgate Mental Health Unit

The Committee considered a report from the Leicestershire Partnership NHS Trust (LPT) and a report from the Care Quality Commission (CQC), both of which set out the current issues and challenges affecting LPT with specific reference to the CQC visit to the Bradgate Mental Health Unit in July 2013. A copy of the reports, marked 'Agenda Item 7a' and 'Agenda Item 7b' is filed with these minutes.

The Committee also considered a supplementary report from LPT which described the psychology input for the Bradgate Unit, a copy of which is filed with these minutes.

Healthwatch had submitted written comments on this item, a copy of which is filed with these minutes.

The Chairman welcomed the following NHS representatives to the meeting:-

Sue Noyes, Acting Chief Executive, LPT
Satheesh Kumar, Medical Director, LPT
Cathy Ellis, Deputy Chair, LPT
Toby Sanders, Managing Director, West Leicestershire Clinical Commissioning Group (CCG)
Dr Graham Johnson, East Leicestershire and Rutland CCG
Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland CCG

The Acting Chief Executive of LPT reported that CQC had made a follow up visit to the Bradgate Unit on Monday 9 September. At that visit, CQC had seen some improvements but had requested more information and indicated that a further visit was needed before they could reach a robust judgement on whether LPT had met the requirements of the warning notices issued in July.

The Acting Chief Executive also reported that an inpatient at the Bradgate Unit had committed suicide during August. An independent review into the suicide had been commissioned by LPT.

The Managing Director of West Leicestershire CCG reported that the CCGs had been aware of the challenges facing LPT. However, the CQC inspection had highlighted issues where changes which the CCGs thought had been implemented had not been done with consistency. This had led to a different approach to performance management of LPT.

The role of the CCGs during August had been to move the regulation of LPT by the Trust Development Authority, CQC, CCGs and NHS England Area Team into a single process so that there was clarity and consistency on outstanding issues and LPT were not overburdened with inspection. This work had achieved a measure of success. The proposal for a single quality improvement programme for LPT had been submitted to the regional Quality Surveillance Group on 19th August, this had been followed up by a risk summit on 29th August and a further meeting, including Healthwatch and Adult Social Care, to agree terms of reference or a Quality Improvement Assessment Group which

would meet fortnightly and support LPT, assess and oversee implementation of the changes and hold LPT to account for delivery.

Arising from discussion the following points were raised:-

(i) The open and transparent approach taken by LPT and its commissioners was welcomed. However, the Committee shared the concerns of Healthwatch that the new plan would not deliver the required improvements in care and security and sought assurance from LPT on this matter. The Committee was advised that the approach taken to respond to CQCs concerns was different from previous action plans because LPT was focussed on what success should look like and whether patients were seeing a difference. The improvement plan was linked to the new CQC inspection regime as it was felt that this would help to deliver high quality care.

(ii) The Committee was advised that changes at the Bradgate Unit were focussed on how staff worked and related to each other. Nursing leadership had been improved by the appointment of two senior matrons, whose role included inspecting patient notes and inputting into the daily ward reviews and weekly in-depth reviews. The importance of the weekly review had been lost over the last two years. It had now returned to being a review of each patient's care plan and discharge plan with multi-disciplinary input. A structured template for information from nurses and junior doctors to be fed into the daily ward review had also been developed.

(iii) LPT acknowledged that safe staffing numbers had not been adhered to. This was now being addressed through the recruitment of 24 nurses and the daily monitoring of staffing levels and quality of care. The Committee welcomed this change but remained concerned that it had not been addressed previously.

(iv) The Committee was pleased to note that clinical supervision on the wards was being improved as this was an effective way to support staff development. The involvement of senior clinicians in observing ward rounds and providing feedback was also felt to be a positive change. In addition, LPT was now trying to learn from examples of good practice through four weekly meetings where staff from several wards would discuss issues and share practice examples. It was recognised by LPT that the organisation had previously been too inward looking so it was also now working more with partners.

(v) Members queried how LPT would know if the actions being implemented were having an effect at ward level. LPT advised that performance would be evaluated through ward rounds, clinical supervision and audits carried out by the senior matrons. Members expressed concern that these measures might not necessarily result in an improved understanding and management of risk. With regard to this particular issue, LPT was now linking findings from risk assessments to meaningful actions and ensuring that they were captured in the care plan. Training on risk management would also be provided to staff and it would be one of the areas of focus during clinical supervision.

(vi) The Committee was assured that the use of agency and bank staff did not mean that LPT was in financial difficulty. Bank staff had generally been working for LPT for a long time and were suitably qualified. It was recognised that the use of agency staff involved more risk, hence the daily monitoring of staff levels. LPT had also invested in staff and improved the ratio of qualified to unqualified staff from 40:60 to 60:40.

(vii) Members emphasised the importance of having well written, good quality, procedural documents. LPT confirmed that these documents were being reviewed to ensure they were sufficiently robust. The personal accountability of staff in terms of understanding processes and following them correctly was also being emphasised. Staff had been allowed one month in which to clarify their understanding of the operation of procedures.

(viii) Serious concern was expressed that patients did not have sufficient one to one support from staff during the day. Although therapeutic liaison workers were on the wards during daytime and nurses undertook one to one sessions with patients, this was not felt to provide the required quality of care. Members were extremely concerned to hear that, although LPT felt it meet the staffing level for safe care, it did not have enough staff to provide quality care for inpatients.

(ix) The range of psychological therapies available for patients was of particular concern to members. The current service was not felt to be satisfactory; the psychology sessions on the ward and input from the personality disorder team were to support staff rather than patients and, despite NICE guidance to the contrary, Cognitive Behavioural Therapy for psychosis for each patient had never been commissioned for LPT.

(x) The CCGs were considering a wide range of issues across LPT services, not just those relating to services at the Bradgate Unit and therefore had to ensure that each part of inpatient, crisis resolution and community mental health services were commissioned equitably. The CQC inspection was being treated as an opportunity to ensure that the response came from the whole system. For example, a forum for clinicians and GPs had been created by the new Medical Director prior to the CQC inspection to talk through problems across mental health services.

(xi) It was acknowledged that LPT had not been satisfied with security at the Bradgate Unit. Accordingly, a receptionist had been appointed to be on duty at weekends.

(xii) 'Near misses' including incidents of self harm, absconding and medication errors and omissions were electronically recorded and investigated locally. Serious incidents were investigated at Trust level. Implementation of action plans relating to serious incidents had been a weakness at LPT; systems were now in place to identify and investigate trends and learn from them.

(xiii) Leadership of the improvement plan would come from the Trust Board. The Board had confidence in the Executive Team and would be looking for systematic delivery of actions across the organisation. Wards would report to the Trust Board and Board members were carrying out regular ward visits.

The Chairman then invited Geoffrey Smith OBE to make comments on behalf of Healthwatch. Healthwatch was encouraged that LPT was now committed to listening to the concerns of patients and would continue to support LPT through its role as consumer champion.

RESOLVED:

(a) That the comments and concerns now raised be submitted to CQC and LPT for consideration;

(b) That an update on progress with improving the quality and safety of patient care at the Bradgate Unit be submitted to the Committee in three months' time.

22. Date of next meeting.

It was noted that the next meeting of the Committee would be held on Wednesday 27 November at 2.00pm.

4.00 - 5.15 pm CHAIRMAN
12 September 2013

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Agenda Item 9

Leicestershire Partnership NHS
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 27 NOVEMBER 2013

REPORT OF LEICESTERSHIRE PARTNERSHIP NHS TRUST

QUALITY IMPROVEMENT PROGRAMME

Purpose of report

1. The purpose of this report is to update the Committee on Leicestershire Partnership NHS Trust's (LPT) Quality Improvement Programme.

Background

2. The Health Overview and Scrutiny Committee, at its meeting on 12 September, considered a report from LPT which set out the current issues and challenges affecting the Trust, with particular reference to the findings from the Care Quality Commission (CQC) visit to the Bradgate Mental Health Unit in July. The Committee resolved to receive an update on progress with improving the quality and safety of patient care at the Bradgate Unit in three months' time.

3. Appendix A to this report is a paper which was considered by the Trust Board at its meeting on 31 October. This paper sets out progress on the actions agreed at the Risk Summit held on 29 August, including the development of the Quality Improvement Programme. The Quality Improvement Programme itself is attached as Appendix B and Appendix C is the engagement plan.

4. Members will receive an oral update on developments since the meeting of the Trust Board on 31 October at this meeting.

Conclusions

5. The Committee is recommended to note the contents of this report and consider whether members wish to receive further updates on this issue.

Background papers

Report to the Health Overview and Scrutiny Committee on 12 September 2013: Bradgate Mental Health Unit.

Circulation under the Local Issues Alert Procedure

None

Officer to Contact

Peter Miller
Chief Executive, LPT

List of Appendices

Appendix A:LPT Trust Board, 31 October 2013: Paper F – Leicestershire Partnership Trust's Quality Improvement Programme
Appendix B: Quality Improvement Programme
Appendix C: Engagement Plan

Relevant Impact Assessments

Equality and Human Rights Implications

6. One of the aims of the Quality Improvement Programme is to ensure that care provided by LPT is able to accommodate the needs of individuals with diverse needs and backgrounds.

APPENDIX A

Leicestershire Partnership NHS
NHS Trust

F

TRUST BOARD PAPER - 31 OCTOBER 2013	
Title	**Leicestershire Partnership Trust's Quality Improvement Programme**

Executive Summary

Introduction

The Trust was issued with two warning notices by the Care Quality Commission in July 2013 and a 30 day plan to address immediate actions related to care planning and discharge planning was enacted, as reported previously to this Board.

Outcome of the Risk Summit

Due to the escalation of concerns about the Trust's adult mental health services a Risk Summit was convened on August 29 where local stakeholders and agencies came together to share their concerns with the Trust. Actions arising from the summit included:

1) The Trust was required to produce a Quality Improvement Programme to provide assurance that the necessary improvements to the safety and care of patients in the Trust's adult mental health services were being undertaken and could be sustained into the future.

2) The Trust was required to design and produce a regular SITREP (operational) report so that the Trust and commissioners could jointly examine staffing, bed occupancy and other operational matters on a daily/weekly basis for additional assurance, particularly with respect to patient safety.

3) That an Oversight and Assurance Group be formed to hold the Trust Board to account collectively

Progress on Risk Summit Actions

The SITREP was immediately designed with commissioners and has now been operating for 2 months.

The Oversight and Assurance Group was also immediately put into place and meets every two weeks convened by the NHS Trust Development Authority (TDA).

It was agreed that the Trust would develop the Quality Improvement Programme (QIP) collaboratively during September and October with a view to approval of the programme plan by the Oversight and Assurance Group and the Trust Board by the end of October.

The aim of this document is to provide a single, consolidated and coordinated plan of action to address the risks and issues raised, showing the timeframes for improvements to be made, how improvements will be measured, who is responsible for the respective elements of the programme and how the Trust will be held accountable for delivery internally and externally of the overall programme.

The Development of the Quality Improvement Programme

Over the last 8 weeks the QIP has been developed in partnership with a wide range of stakeholders including our leadership team, our clinical and operational staff, the NHS Trust Development Authority, local clinical commissioning groups, local authorities and their scrutiny committees, local Healthwatch, local service user groups, their advocates and voluntary sector organisations. A copy of the engagement plan is attached at Appendix A

The Trust is extremely grateful to all parties who have engaged in this intensive piece of work and for the opportunity to discuss the issues we have faced in an honest and transparent way throughout. The overall format of the QIP has been recommended by the Trust Development Authority.

Measuring Achievement

A feature of the QIP is the inclusion of specific metrics so that improvement can be evidenced over time, and where applicable a trajectory for improvement will be developed to show the scale and pace of change we are aiming for.

Some of the metrics already have established baselines and mechanisms for data collection. Others are new areas of focus or represent new ways of working, and therefore require the development of baseline information and additional mechanisms for collecting and analysing data. The programme indicates timescales for this work where appropriate.

In terms of governance arrangements, the delivery of the QIP will be governed internally via a new Quality Improvement Programme Board reporting directly into the Trust Board. Delivery will be assured by the Oversight and Assurance Group which was formed following the Risk Summit and which will hold the Trust Board to account externally for delivery.

The Oversight and Assurance Group is external to the Trust and chaired by the NHS Trust Development Authority (TDA).

The Oversight and Assurance Group is established for the period of time that the Trust's position is escalated to the TDA and will determine at which stage the Trust will be de-escalated with respect to the assurance achieved on the Quality Improvement Programme.

The role of the Oversight and Assurance Group is therefore as follows:

- Approve the Quality Improvement Programme

- Hold the Trust Board to account and assure the delivery of the programme externally
- Determine which specific actions from our programme are the ones that they wish to see achieved in order that we can be de-escalated; following which, the programme will continue to be assured by the Trust Board and its local commissioners, e.g. as business as usual.

Cultural Change

It is important to stress that much of this programme is about cultural change, including some important changes in professional practice and clinical leadership that have a direct impact on the safety, effectiveness and experience of care in the adult mental health unit (and elsewhere in the Trust).

We have also listened carefully to feedback from service users, voluntary sector groups, advocacy groups, councillors, and service users about where further cultural changes are needed from their perspective.

While these changes can and will be the subject of audit against key metrics in terms of quantitative measurement, the Trust is keen to ensure that equal emphasis is given to qualitative and softer measures of improvement.

The overall experience of staff and patients in the planning, delivery and experience of care is where we wish to see the greatest impact of these cultural changes. We expect to see this translated into improved public confidence in the quality of the Trust's services, and that there are tangible improvements in our leadership, accountability and transparency.

Extending the programme across other aspects of the Trust's Business and Services

While the QIP focuses primarily on adult mental health services, we have identified a number of thematic areas of the plan where action will be immediately extended across other clinical divisions.

We have also reflected in depth, as an organisation and as a Board, on the lessons learned from the July CQC report, and the events leading up to this at the Trust, along with various other aspects of the escalation period we have experienced. We are very aware of the impact this has had on our patients, staff, stakeholders and the public in general. Our discussions with local scrutiny committees have focused heavily on these matters.

Our overall approach to quality assurance and risk management is being fundamentally reviewed as a result of reflecting on lessons learned, including for example the introduction of improved early warning systems for our clinical services and a review of our approach to regulatory assurance, being led by our Chief Nurse.

It is the Trust's ambition to use the QIP as an important stepping stone on our quality improvement journey. Through the QIP and work in hand to refresh our

quality strategy we must go well beyond "recovery" and aim again for excellence in line with our organisational vision.

We recognise there are expectations internally and externally about demonstrating a stepped change in the pace of our actions and the impact they are having, but we also need to sustain improvement for the medium and longer term. The timescales we have set out in the QIP therefore intend to strike a balance between these two requirements.

Although the QIP will be the subject of the external Oversight and Assurance Group for the remedial period (e.g. until we are de-escalated by the TDA), the Trust will continue to develop and deliver its quality improvement plan on a rolling programme of work. The Quality Improvement Programme will therefore:

- Become business as usual
- Cut across all clinical services
- Remain top priority
- Be highly visible form ward to board.

We will continue to be open, honest and transparent about our progress and welcome all challenge and feedback on any aspect of our care and services at any time.

Sharing our Learning

Our experience may be valuable to other Trusts who face similar challenges in delivering sustainable high quality mental health care, especially given the escalating pressure this month on the overall capacity and quality of mental health care nationally and the introduction of the new CQC inspection regime.

We will actively share what we have learned for the benefit of other Trusts locally, regionally and nationally.

We are also responding to the new Chief Inspector of Hospital's national engagement about the methodology for assessing community and mental health trusts under the new CQC Inspection regime

Recommendations

The Trust Board is asked to:

- Approve in principle the Quality Improvement Programme and associated metrics subject to the approval of (and any amendments required) by the Oversight and Assurance group
- Approve the LPT governance arrangements, including establishing the Quality Improvement Programme Board with effect from November 2013

Related Trust Objectives	• We will continuously improve quality and safety with services shaped from user and care experience, audit and research. • We will build our reputation as a successful, inclusive organisation, working in partnership to improve health and

	wellbeing.
Risk and Assurance	The delivery of the QIP will provide measurable improvements in quality assurance for the care and treatment of patients in the adult mental health service and other clinical services within the Trust.
Legal implications/ regulatory requirements	The delivery of the QIP will provide improved assurance that CQC standards can be maintained in the medium term. Failure to maintain CQC regulatory standards can lead to fines and/or deregulation of the affected services.
Presenter	Peter Miller, Chief Executive
Author(s)	LPT Executive Team Judy McCarthy, Head of Strategic Programme Office Will Legge, Chief Information Officer

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APPENDIX B

Leicestershire Partnership NHS
NHS Trust

"Quality Improvement Programme"

A programme to achieve sustainable high quality adult mental health services so the Trust and its stakeholders can be confident about the quality of care for local service users

October 2013

Contents

Quality Improvement Programme

1. Introduction

In response to concerns raised at the Risk Summit on 29 August 2013, the Trust has worked with a wide range of people to develop this Quality Improvement Programme.

The programme contains a comprehensive set of activities to address specific risks identified following an inspection by the Care Quality Commission in July 2013, and a number of other related risks and issues of concern that have been raised by local commissioners, local Healthwatch, NHS England and the Trust Development Authority. All these matters were discussed in depth at the Risk Summit and at the inaugural meeting of the Oversight and Assurance Group held on 11th September 2013.

The aim of this document is to provide a single, consolidated and coordinated plan of action to address the risks and issues raised, showing the timeframes for improvements to be made, how improvements will be measured, who is responsible for the respective elements of the programme and how the Trust will be held accountable for delivery internally and externally of the overall programme.

The programme has been developed from a number of concerns identified by stakeholders:-

- Governance
- Workforce and Leadership
- Quality Strategy
- Quality Assurance
- Clinical and Operational Effectiveness;
- Cultural Change
- Transparency
- External Regulation + Reviews

A programme management approach will be undertaken to deliver this programme and report on progress. A programme management approach is already established within the Trust and is currently being used to manage delivery of the other service improvements in our clinical divisions.

Scope

A number of serious concerns were raised about the quality of the Adult Mental Health inpatient service at the Bradgate Unit by the Care Quality Commission in their report following an inspection in July 2013. The Trust immediately initiated urgent work to address the report findings including the implications of two warning notices issued to the Trust which related to discharge planning and care planning.

While the Trust focused initially on these matters in July and August 2013, the Trust has since performed an intensive piece of work in September and October to develop a medium term Quality Improvement Programme. While the focus for this has primarily been for our Adult Mental Health service, the programme also recognises that high quality, safe services must be sustained across all our clinical divisions.

The culture of quality improvement and quality assurance within the organisation clearly needs further development so that lessons learnt from our Adult Mental Health service are fully embedded and readily transferred across other areas of the Trust. The programme therefore includes how we will create a stronger platform for quality through our refreshed quality strategy and put in place a much better system to alert the Trust from “ward to Board” to any future risks to deterioration in quality care across all our services.

The Quality Improvement Programme therefore has a number of aims that apply across all our clinical services as illustrated in the box on page 5 below.

AIMS

- Ensuring the most effective care is provided in a person centred manner
- Service users (and wherever possible those that matter most to service users such as their carers, family members, friends) are actively involved in the decisions regarding their care
- Improving the safety, communication and service user involvement in the discharge process
- Ensuring safe staffing levels and a skill mix that takes into account all the factors that affect the intensity of care and support needed to address individual care plans
- Improving the quality of physical health care on mental health wards
- Improving the ease of developing and using care plans as well as embedding care plans within the care process
- Enhancing the skills of staff in the assessment and effective management of risk
- Providing support and creating opportunities for staff to learn continuously from practice (near misses, serious incident investigation recommendations, service users feedback) and reduce clinical variability
- Improving the patient experience, healing nature and safety of the environment
- Ensuring treatment and recovery focuses on the wider determinants of health and wellbeing (employment, housing, finances, social isolation etc.)
- Care provided is able to accommodate the needs of the individuals with diverse needs and backgrounds

Principles for Improving

This Quality Improvement Programme has been designed to embed the following principles:

1) **Rights** - the programme is underpinned by the statutory requirements placed on all Trusts by the NHS Constitution and Duty of Candour

2) **Planning** – the Trust has a clear, consolidated programme of work that collectively meets the needs of our service users, the Trust and all stakeholders/agencies.

3) **Service User and public participation** – service users, their advocates and public representatives have played an important role in developing this Quality Improvement Programme. Clinicians, directors and staff are working together on the "Quality Improvement Programme Board" with these stakeholders and will continue to do so throughout the delivery of the programme, and as "business as usual" within the Trust. In developing the improvement activities we have listened carefully to the views of service users, their advocates, local voluntary sector organisations, county and city councillors, and our own democratically elected shadow council of governors

4) **Listening to the views of staff** – the Trust is committed to improving staff experience and the levels of staff engagement and staff satisfaction. There are a number of established ways in which the Trust seeks the views of staff including formal consultative forums, the annual NHS staff survey and the Trust's local quarterly pulse surveys, staff support groups and the Trust's various feedback mechanisms which have been further strengthened this year by adopting to the "speak out safely campaign" which actively encourages staff to raise concerns about care quality. Staff views are also obtained through some of the mechanisms established to improve patient experience including the 'Changing your Experience for the Better' programme and Trust Board member visits to clinical areas. The Listening into Action (LiA) programme also brings staff together to share their thoughts and ideas and make improvements together. The Trust has already captured a large range of staff views through large engagement events, and is currently rolling out the programme to the first set of teams within the Trust and putting place the quick wins that have been prioritised.

5) **Openness and transparency** – all possible information and intelligence relating to the quality of the care provided to our patients has been and will continue to be made available to our partners and stakeholders including our Shadow Council of Governors, local Clinical Commissioning Groups, local Healthwatch, Patients' Panel, Staffside representatives, the Care Quality Commission (CQC), the General Medical Council (GMC), Health Education East of England (HEEoE), the NHS Trust Development Authority (NTDA) and NHS England. The Trust continues to be open to expertise from outside of the Trust and welcomes this advice and expertise. The Trust Board recognises its role in promoting this work and being held accountable. The Trust Board continues to challenge itself and take on board feedback from all parties on the type, quantity and quality of information shared in the public domain whether via our public meetings, website, newsletters, media, social media and other routes.

6) **Cooperation between organisations** – this programme has been built around strong cooperation between all of the different organisations that make up the local health and care system, placing the interests of service users first at all times.

7) **Leadership** - this programme recognises the development needs of clinical and managerial leaders within the Trust and has been designed so that improvements can be made in the management culture of the organisation from ward to Board, with the Board promoting a leadership style built on service user centred values.

2. Background

Context

On 30 July 2013 the Trust was served with two Warning Notices, in line with the CQC Enforcement Policy, against the Bradgate Mental Health Unit registered location. In addition the unit was also judged as non-compliant with three Outcomes resulting in three Compliance actions against Outcomes 7, 14 and 16.

Outcome 4	**Care and welfare of people who use services**	**Warning Notice**
Outcome 6	**Cooperating with other providers**	**Warning Notice**
Outcome 7	Safeguarding people who use services from abuse	Compliance Action
Outcome 14	Supporting workers	Compliance Action
Outcome 16	Assessing and monitoring the quality of service provision.	Compliance Action

The inspection report was published on 20 August and is available on the CQC web site. The report and Enforcement notices were shared at the Trust public Board meeting on Thursday 29 August 2013.

An action plan was sent to the CQC on Wednesday 4 September 2013 and on Thursday 5 September 2013 and Friday 6 September 2013 requests were received for the provision of further information.

On Monday 9 September 2013 the CQC returned to the unit to review progress against the two Warning Notices.

The population and communities we serve

The following characteristics summarise the population we serve.

- A catchment population of approximately one million people living within the city of Leicester and the surrounding counties of Leicestershire and Rutland.
- In common with the national pattern, more boys are born than girls; however as women tend to live longer, the ratio of males to females is approximately 50:50.
- Our local catchment area falls within the boundaries of NHS Midlands and East, in which we play an active role in the provision of specialist services on a wider regional basis.
- We relate to three local authorities, seven district and borough councils, and three Clinical Commissioning Groups.
- The City of Leicester and counties of Leicestershire and Rutland bring together a rich mix of urban, suburban and rural districts, diverse in cultural heritage and ethnicity.
- The total Leicester City population as at 2012 is 331,606 which represents an 18% increase since 2001.
- Deprivation is a significant issue for many of our citizens. Almost half of our population is highly disadvantaged. Of the 152 local authority areas in the UK, Leicester has the 20th most deprived population, with almost half of these people living in the fifth most deprived areas in England.
- Rutland residents and the majority of the population in South Leicestershire have above average levels of affluence compared to the rest of England. However, there are pockets of relative deprivation concentrated mainly in urban areas.
- The majority of the population who live in Leicestershire County and Rutland are white British (91% and 97% respectively)[1], whilst Leicester City has a more diverse population than England overall, with approximately 50% from Black and minority ethnic groups (BME). The majority of Leicester's BME population are South Asian, with 37% from Indian background.[1]
- There are also a significant populations from other countries such as Eastern Europe, who also represent diversity, but are not represented in BME statistics.
- In addition, the population figures are not well established for other vulnerable groups such as asylum seekers and those with protected characteristics under the equalities act, such as lesbian, gay, bi sexual and transgender people.
- A large number of students live in Leicester, and therefore there is a youthful population with almost half aged under 29, and that number is increasing. There is a higher proportion of people in the older adult categories in Leicestershire County and Rutland.

[1] 2011 figures from Office for National Statistics

- The populations of both the City and Counties are forecast to increase by 2015. There will be significant growth in the 0 – 14 age group and those of working age in Leicester City with lower, albeit significant growth, in the over 65s. This pattern is counter to that seen in the Counties where the major growth is in the over 65 age groups.

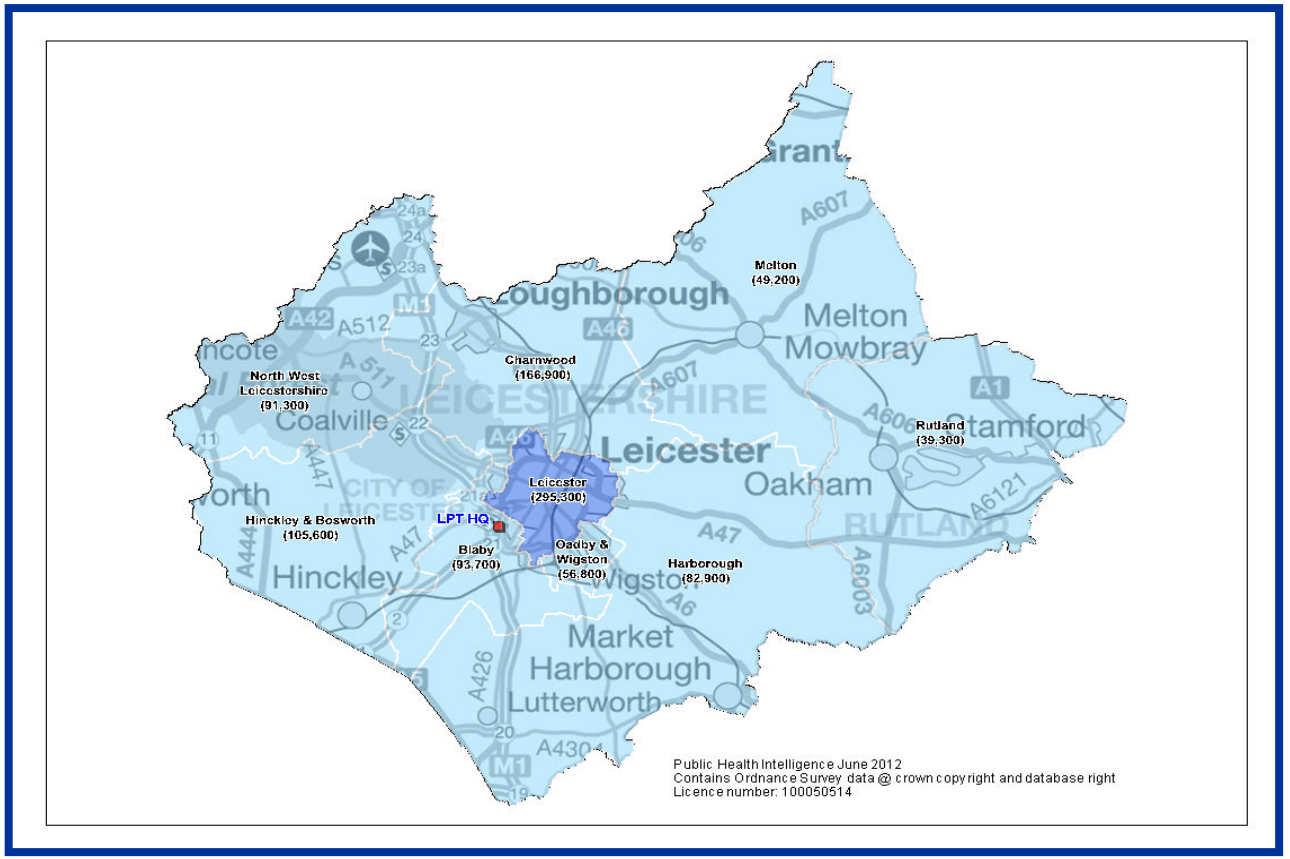
Our commissioners

Our services are commissioned primarily by the three Clinical Commissioning Groups of Leicester, Leicestershire and Rutland, authorised in 2012, these are:

- West Leicestershire
- East Leicestershire and Rutland
- Leicester City
- Some of the Trust's services are also commissioned on a regional/national basis through specialist commissioning

The counties of Leicestershire and Rutland are generally more affluent and less ethnically diverse, with demography older than the national average. There are approximately 680,000 people living mainly in suburban areas and market towns, with pockets of deprivation and approximately 12% of people living in isolated rural villages.

Area Map


Melton
(49,200)
Melton
Mowbray
Loughborough
Charnwood
(166,900)
North West
Leicestershire
(91,300)
Coalville
LEICESTERSHIRE
Leicester
(295,300)
Leicester
Oakham
Rutland
(39,300)
Stamford
LPT HQ
Hinckley & Bosworth
(105,600)
Hinckley
Blaby
(93,700)
Oadby &
Wigston
(56,800)
Harborough
(82,900)
Market
Harborough
Lutterworth
A607
A46
A42
A512
A511
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A447
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A444
A426
A6
A1
A6121
A6003
A4304
Public Health Intelligence June 2012
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Health and Care Economy

We operate primarily within the health and social care economies of LLR and work with three corresponding local authorities and seven district councils.

Local Authorities:

- Leicester City Council
- Leicestershire County Council
- Rutland County Council

District Councils:

- Blaby District Council
- Charnwood Borough Council
- Harborough District Council
- Hinckley and Bosworth District Council
- Melton Borough Council
- North West Leicestershire District Council
- Oadby and Wigston Borough Council

The Service User's Perspective

The ability to listen to what matters to people who use and experience our services, and the views of those who matter most to them (e.g. carers, friends, family) and to act on this feedback is the Trust's method of demonstrating its values being turned into action. Demonstrating that we have listened and made changes also underpins our dedication to being an open and transparent organisation.

The Friends and Family Test (FFT) is a national tool based on the commercial Net Promoter Score Test and is a tool used for providing a simple, headline metric, which when combined with a follow up question and triangulated with other forms of feedback, can be used across services to drive a culture of change, recognising and sharing good practice. The overall aim of the process is to identify ways of improving the quality of care and experience of the service users (and those who matter most to them) using NHS services in England

The Trust is participating in a national pilot to roll out the FFT to other services outside of the acute sector, which is the main area of NHS care where the test is currently formally applied and reported. We are feeding back our experience of using this test with our service users in community and mental health services, and have been giving our views of how the test may need adapting in these settings. As part of this we are also working with local commissioners and we have agreed that a further roll-out of the FFT across priority services would provide useful information to the Trust in line with its plans to introduce the 'Changing Your Experience for the Better' programme across all clinical areas. The FFT is used in that context as a baseline and improvement measurement, alongside feedback data from the customer services team (from complaints, concerns and compliments) and through the Trust's Staff Listening into Action Engagement Programme, staff pulse surveys and the annual staff survey.

3. Governance

The Trust has a number of systems and processes in place to provide assurance to the Trust Board and other key stakeholders about the governance of the organisation. These include a committee structure, a risk management system and strategy, a comprehensive risk register and an escalation framework to ensure Trust Board members are aware of all risks to the successful delivery of the organisations key strategic objectives.

In order to place focus on this programme of work a Quality Improvement Programme Board will be established within the Trust. This will be chaired by the Chief Operating Officer, (or Medical Director and Chief Nurse in their absence), and will consist of representatives from each of the divisions. Terms of reference and membership for the Quality Improvement Board are being finalised by early November, and will be published on our website as soon as possible. The first meeting of the Quality Improvement Programme Board will take place in November.

As part of the assurance process, the Quality Improvement Programme Board will develop a risk register to ensure where progress is not being made as quickly as expected, mitigating actions are put in place.

The Quality Improvement Programme Board will be held to account by the Trust Board who will receive the minutes of the Programme Board and the risk register on a monthly basis.

The Quality Improvement Programme Board will provide assurance to the Trust Board, on a monthly basis, regarding the delivery of the programme, including highlighting any risks to delivery and the mitigating actions being taken to ameliorate those risks.

The Quality Improvement Programme Board activities will also be considered by the Trust's existing Quality Assurance Committee (http://www.leicspart.nhs.uk/Library/QAC_TOR.pdf

The Oversight and Assurance Group is external to the Trust and chaired by the NHS Trust Development Authority. The Oversight and Assurance Group is set up for the period of time that the Trust's position is escalated to the NHS Trust Development Authority and will determine at which stage the Trust will be de-escalated with respect to the assurance achieved on the quality improvement programme. The role of the Oversight and Assurance Group is therefore as follows:

- Approve the programme of work assure the delivery externally
- Determine (during November 2013) which specific actions from our programme are the ones that they wish to see achieved in order that we can be de-escalated - following which the programme will continue to be assured by the Trust Board and its local commissioners, e.g. as business as usual.

The programme will be signed off and closed when all actions have been delivered and the Trust Board, in conjunction with key stakeholders, have received adequate assurance that the programme has been completely delivered and the improvements are sustainable.

However the Trust Board will adopt the Quality Improvement Programme approach and roll it out to other areas of the Trust. When this happens, our progress will be very clear and transparent both in terms of the completion of the programme of work shown in this document and the addition/roll out to other areas of our business, with regular reports via our public Trust Board meetings.

Also our engagement and communication about our Quality Improvement Programme will continue throughout the delivery of this programme of work and into any extension into other areas of the Trust's work. Therefore local scrutiny committees, local VCS organisations, health and wellbeing boards, service user groups, our council of governors, and many others will continue to be closely engaged in our progress and will continue to shape our future aspirations.

Governance Structure

4. Programme Baselines

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
1	Crisis Support (CRHT)	Delivery of CRHT against operational framework (by audit)	100%	Action plan in place to establish baselines	01/02/2014	Chief Operating Officer
2	Crisis Support (CRHT)	Adherence to the new CRHT shift handover protocol being implemented by January 2014	100%	New initiative; baseline to be established	01/02/2014	Chief Operating Officer
3	Crisis Support (CRHT)	SitRep for CRHT implemented and achieving tolerance levels across staffing metrics	80%	New initiative; SitRep to be designed and implemented with Commissioners	01/05/2014	Chief Operating Officer
4	Pre-Admission	Transmission of complete care information with out of area placement providers upon placement within 24 hours	100%	New initiative; based on checklist implementation	01/02/2014	Chief Operating Officer
5	Pre-Admission	Bed Occupancy level	85%	91.8% @ Sept 2013	31/03/2014	Chief Operating Officer
6	Pre-Admission	Delayed Transfer of Care	≤ 7.5%	5.7% @ Sept 2013	01/11/2014	Chief Operating Officer
7	Pre-Admission	Average Length of Stay	30 days	34.6 days @ Sept 2013	03/06/2014	Chief Operating Officer
8	Pre-Admission	Number of out of area placements	≤ 20	26 @ 17.10.13	30/03/2014	Chief Operating Officer
9	Admission	Number of MDT assessment templates completed on admission (by audit)	100%	New initiative; baseline to be established	01/05/2014	Medical Director
10	Admission	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit)	100%	71% @ Sept 2013	01/02/2014	Chief Nurse
11	Admission	Number of admissions seen by a senior doctor within 48 hours (by audit)	100%	New initiative; baseline to be established	01/03/2104	Medical Director

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
12	On-going care on the In-patient Unit	Adherence to service user leave protocols (by audit)	100%	Action plan in place to establish baselines	01/05/2014	Chief Nurse
13	On-going care on the In-patient Unit	Number of service users offered advocacy where clinically appropriate (by audit)	80%	New initiative; baseline to be established	31/12/2013	Chief Nurse
14	On-going care on the In-patient Unit	Number of staff with current valid therapeutic observation of patients training	85%	90.1% @ Aug 2013	01/12/2013	Director of HR & OD
15	On-going care on the In-patient Unit	Number of scheduled weekly ward rounds attended by nurse and doctor versus plan	100%	100% @ 21/10/13	01/02/2014	Medical Director
16	On-going care on the In-patient Unit	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit)	100%	71% @ Sept 2013	01/02/2014	Chief Nurse
17	Discharge	Number of care plans reflecting discharge planning (by audit)	90%	59% @ Sept 2013	01/02/2014	Chief Nurse
18	Discharge	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their discharge planning (by survey)	80% (*Set at 80% in recognition of those people who decline to be involved)*	67% @ Dec 2012	01/11/2014	Chief Nurse
19	Discharge	Continuity of care from the same consultant/community worker	80%	New initiative; baseline to be established	01/04/2014	Chief Operating Officer
20	Staffing	60:40 skill mix qualified / unqualified ratio achieved on the Bradgate Unit	100%	New initiative; recruitment trajectory in place	01/05/2014	Chief Operating Officer
21	Staffing	5 / 5 / 3 staffing levels achieved on the Bradgate Unit	100%	100% @ 17/10/13	01/11/2013	Chief Operating Officer
22	Physical Healthcare	Number of care plans reflecting physical healthcare needs where identified (by audit)	100%	90% @ Sept 2013	01/05/2014	Chief Nurse
23	Physical Healthcare	Number of physical healthcare assessments undertaken versus admissions (by audit)	100%	92% @ Sept 2013	01/05/2014	Chief Nurse

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
24	People with Personality Disorder	Number of Bradgate Unit staff with current valid personality disorder training, against plan	80%	Training commences Nov 2013; baseline data captured from 1st cohort Nov 2013	01/11/2014	Medical Director
25	Risk Assessment	Complete risk assessment documentation present in care record for current episode of care	100%	92% @ Sept 2013	01/03/2014	Chief Nurse
26	Risk Assessment	Number of staff with current valid risk assessment training	80%	92.1% @ Sept 2013	01/05/2014	Chief Nurse
27	Handover	Adherence to In-patient handover protocol (by audit)	100%	New initiative; baseline to be established	01/01/2014	Chief Nurse
28	Continuous learning & staff support	Number of debriefing sessions versus number of violent incidents and Serious Incidents reported	100%	New initiative; baseline to be established	01/01/2014	Chief Nurse
29	Continuous learning & staff support	Attendance rate of MDT learning forums against Terms of Reference	80%	New initiative; baseline to be established	01/01/2014	Medical Director
30	Continuous learning & staff support	Number of MDT learning forums held versus plan	100%	New initiative; baseline to be established	01/01/2014	Medical Director
31	Improvement of the environment	Adherence of staff to seclusion process and policy (by audit)	100%	Action plan in place to establish baselines	01/05/2014	Medical Director
32	Improvement of the environment	Adherence of all seclusion environments to national standard	100%	Baseline will be set by environmental audit	Dependent upon scale of work	Chief Operating Officer
33	Improvement of the environment	Number of ligature assessments undertaken in the Bradgate Unit	100%	All In-patient wards completed	01/12/2013 Non In-patient areas	Chief Operating Officer
34	Improvement of the environment	Improvement in PLACE survey results	90%	PLACE baselines (Sept 2013): • Cleanliness: 87.37% • Condition, appearance and maintenance: 75.12% • Privacy, dignity and wellbeing: 81.96% • Food and hydration: 84.79%	Dependent upon scale of work and 2014 PLACE assessments	Chief Operating Officer

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
35	Equality	Documented consideration of Equality & Diversity patient needs in care plan	100%	87%@ Sept 2013	01/05/2014	Chief Nurse
36	Equality	Number of staff trained in Equality & Diversity Training	80%	96.1%@ Sept 2013	01/11/2014	Director of HR & OD

Governance

Improving the acute care pathway

Crisis Support (CRHT)

Aim – enhanced level of crisis support

Theme	Mapped to	Action	Supporting Action	Lead	Timescale
Improving the response, efficiency and quality of assessment and support provided to patients with acute mental health problems	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Thematic analysis of Serious Incidents within CRHT.** a. Implement the recommendations from the thematic review of serious incidents		Chief Nurse	31/03/2014
	SI 133782 actions 2 and 3 commission internal review of handover between shifts in AMH SPA and review delegation of tasks between SPA and Acute Assessment and Home Treatment **Keogh area of improvement:** - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Office based co-ordinator on each shift to ensure safe allocation of work and hand over between shifts** a. Documented protocol for CRHT handover b. Initial role description for the co-ordinator	Assess the quality of the allocation of cases by co-ordinators	Chief Operating Officer	01/02/2014
			Develop a trajectory to improve the allocation of cases by co-ordinators to the appropriate level of staff/skill mix (qualified or unqualified)	Chief Operating Officer	01/02/2014
			Develop a trajectory for measuring improvements in handover effectiveness	Chief Operating Officer	01/02/2014

	Keogh area of improvement: - *Safety* - *Clinical and operational effectiveness* - *Workforce*	**3. Provide routine assurance information against current service model/staffing.**	Implement a SitRep report for CRHT	Chief Operating Officer	01/05/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**4. Co-produce a longer term service model, based on a more detailed diagnostic with the CCG's**	An agreed new service model with commissioners Implement new service model	Chief Operating Officer	31/03/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**5. Refresh/agree between AMH and commissioners the definitions of risk levels and thresholds for CHRT assessment within the agreed timeframes within the triage process. (2hrs, 4 hrs, 72hrs – may need to revisit these time spans especially the 4-72hrs)**		Medical Director	01/05/2014

CRHT Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
1	Crisis Support (CRHT)	Delivery of CRHT against operational framework (by audit)	100%	Action plan in place to establish baselines	01/02/2014	Chief Operating Officer
2	Crisis Support (CRHT)	Adherence to the new CRHT shift handover protocol being implemented by January 2014	100%	New initiative; baseline to be established	01/02/2014	Chief Operating Officer
3	Crisis Support (CRHT)	SitRep for CRHT implemented and achieving tolerance levels across staffing metrics	80%	New initiative; SitRep to be designed and implemented with Commissioners	01/05/2014	Chief Operating Officer

Pre-admission To ensure a speedy and well-co-ordinated process for admission					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the quality of care and patient safety throughout the process of the admission	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**1. Address the bed capacity position for AMH patients** a. Review bed capacity/configuration and ward configuration to achieve sustainable occupancy levels b. Implement solutions by agreement with commissioners	Set a baseline and trajectory for sustainable occupancy levels underpinned by benchmarking data	Chief Operating Officer	31/12/2013
			Set baseline and trajectory for ALOS	Chief Operating Officer	31/12/2013
			Set baseline and trajectory for DTOC	Chief Operating Officer	31/12/2013
			Set baseline and trajectory for reducing out of area placements	Chief Operating Officer	31/12/2013
			DN: Additional metrics will be developed in line with the actions that come out of the review such as the availability and uptake of alternatives to admissions such as step up and step down beds/access to suitable housing solutions/crisis house etc.		
	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Streamline admission and gate keeping to avoid duplication** a. Adhere to the assessment protocol b. Set a standard for the time between agreement to admit and admission taking place c. Checklist of core information to be provided between admitting team and inpatient team including 'out of area' placements	Measure adherence to the admit time standard	Chief Operating Officer	01/02/2014
			Measure the reduction in the duplication of assessments between different parts of the AMH team	Chief Operating Officer	01/02/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Ensure robust process in place for sharing of information/contact with out of county providers**	Set trajectory for the percentage completeness of transmission of the information within 24 hours (with agreed valid exceptions) for admitting service users within LLR and 'out of area'	Chief Operating Officer	01/02/2014

Pre-admission Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
4	Pre-Admission	Transmission of complete care information with out of area placement providers upon placement within 24 hours	100%	New initiative; based on checklist implementation	01/02/2014	Chief Operating Officer
5	Pre-Admission	Bed Occupancy level	85%	91.8% @ Sept 2013	31/03/2014	Chief Operating Officer
6	Pre-Admission	Delayed Transfer of Care	≤ 7.5%	5.7% @ Sept 2013	01/11/2014	Chief Operating Officer
7	Pre-Admission	Average Length of Stay	30 days	34.6 days @ Sept 2013	03/06/2014	Chief Operating Officer
8	Pre-Admission	Number of out of area placements	≤ 20	26 @ 17.10.13	30/03/2014	Chief Operating Officer

Admission To ensure a thorough assessment and development of a good quality care plan					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the quality and effective-ness of clinical care in the first 72 hours of Inpatient stay	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Develop a multi-disciplinary assessment template and process**		Medical Director	01/02/2014
	The results of the AMH Inpatient Survey is being presented on 28 October –action plan will follow **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**2. Those most important to the individual (e.g. carer, family or friends) involvement** a. Pilot introduction of entry and exit questionnaires for service users (and wherever possible those that matter most to service users such as their carers, family members, friends) to test experience of care levels of engagement (e.g. exit questionnaires to assess – *were your needs met?)* b. Admission checklist to capture specific actions and data wherever possible for those that matter most to service users such as their carers, family members, friends) engagement c. Contact GP to advise patient admitted and LPT to extract relevant patient information from the GP within 24 hours (service user summary/discussion where possible)	Measure adherence to admissions checklist in relation to wherever possible those that matter most to service users such as their carers, family members, friends), engagement and GP contact The wards will complete a *Triangle of Care* self-assessment in order to establish a baseline and understand the potential gaps for the involvement and communication with those most important to the individual (e.g. carers, family or friends). Following the self- assessment, actions will be identified and support will be provided in order to address any areas of weakness by the Trust's Patient Experience team.	Medical Director	01/05/2014

	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**3. Seen by senior doctor within the first 48 hours**	Set baseline and trajectory to achieve 100% of admissions being seen by a senior doctor within 48 hours	Medical Director	01/03/2014
	Appleby action plan action 9.1 – Access and Community Services Interface Meeting to review information sharing **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**4. Sharing information between community and Inpatient team** a. Develop an operating protocol for sharing information with community services (inpatient and named nurse and CPN regular contact)		Medical Director	01/05/2014

Admission baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
9	Admission	Number of MDT assessment templates completed on admission (by audit)	100%	New initiative; baseline to be established	01/05/2014	Medical Director
10	Admission	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit)	100%	71% @ Sept 2013	01/02/2014	Chief Nurse
11	Admission	Number of admissions seen by a senior doctor within 48 hours (by audit)	100%	New initiative; baseline to be established	01/03/2104	Medical Director

On-going care on the Inpatient Unit To improve the quality of inpatient care					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Ensuring the most effective care is provided in a person centred manner. *Patient, and wherever possible, carers / family are actively involved in the decisions regarding their care*	**CQC Action Plan – Outcome 4, no. 2** **Review of patient involvement in care plans** **Keogh area of improvement:** - *Patient experience* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Service user led care** a. Demonstrate improvements in service user(and wherever possible those that matter most to service users such as their carers, family members, friends) involvement in care planning	Measure service user, (and wherever possible those that matter most to service users such as their carers, family members, friends) satisfaction and experience through;	Chief Nurse	01/02/2014
			• the entry and exit questionnaires	Chief Nurse	01/02/2014
			• impact of VCS ward forums	Chief Nurse	01/02/2014
			• regular audit of care plans/discharge plans	Chief Nurse	01/02/2014
	Quality Schedule LR 2 **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Redefine and monitor the daily ward reviews** a. Review the process and template used		Medical Director	01/02/2014

	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**3. One to one sessions for service users** a. Ensure service users are • Seen weekly by a senior doctor • Receive a 1:1 session with a junior doctor b. Ensure service users • Receive two 1:1 sessions per week with their named nurse		Medical Director	01/02/2014
	Appleby action plan action 7.2 – Review of clinical psychology provision to wards **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**4. Review the provision of psychological therapy on the wards** a. Define and agree the model of psychological therapy we are aiming for across the inpatient areas and benchmark b. Consider models from elsewhere c. Agree how much improvement can be generated by improved nurse skill mix on the wards and what represents additional investment	Measure achievement of agreed levels of support against a trajectory	Chief Operating Officer	31/03/2014
	Appleby action plan action 6.1 – development of prompt cards for observation **Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness*	**5. Training and education for nursing staff and health care workers in undertaking therapeutic observation of service users** a. Review the therapeutic observation policy b. Ensure comprehensive training plans in place	Measure effectiveness through clinical supervision	Medical Director	01/11/2014

	CQC (MHA) Ashby Ward action plan, action 4 Review of recording section 132 including access to IMHA **Keogh area of improvement:** - *Patient experience* - *Clinical and operational effectiveness*	**6. Improving access to Advocacy** a. Implement standard service user information boards in every ward, and supplement with scrolling digital display	Measure how often we reiterate the information via MHA processes for those detained and for informal patients via Therapeutic Liaison Workers	Chief Nurse	01/11/2014
	CQC (MHA) Ashby Ward action plan, action 5 pilot revised section 17 form **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness*	**7. Service user leave** a. Establish a clearer protocol for escorting and home leave	Measure leave cancellation rates and the reason for cancellation	Chief Nurse	01/11/2014

On-going care on the in-patient unit Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
12	On-going care on the In-patient Unit	Adherence to service user leave protocols (by audit)	100%	Action plan in place to establish baselines	01/05/2014	Chief Nurse
13	On-going care on the In-patient Unit	Number of service users offered advocacy where clinically appropriate (by audit)	80%	New initiative; baseline to be established	31/12/2013	Chief Nurse
14	On-going care on the In-patient Unit	Number of staff with current valid therapeutic observation of patients training	85%	90.1% @ Aug 2013	01/12/2013	Director of HR & OD
15	On-going care on the In-patient Unit	Number of scheduled weekly ward rounds attended by nurse and doctor versus plan	100%	100% @ 21/10/13	01/02/2014	Medical Director
16	On-going care on the In-patient Unit	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit)	100%	71% @ Sept 2013	01/02/2014	Chief Nurse

Discharge To improve the safety, communication and patient involvement in the discharge process					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the safety, communication and patient involvement in the discharge process	**CQC Action Plan – Outcome 6, no. 2 (b) and (d) Discharge care plan and discharge planning meetings** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Improved discharge care plan** a. Further improve the discharge care plan documentation b. Implement discharge care plan documentation c. Set date for a pre-discharge meeting at the 1st MDT and inform/invite service user (and wherever possible those that matter most to service users such as their carers, family members, friends) community team and relevant stakeholders. Discharge care plan to be finalised in this meeting d. Establish a discharge communication protocol e. Establish a revised discharge summary by agreement with GPs and implement the new process	Monitor the implementation and the professional effectiveness via an updated discharge tool and service user satisfaction exit questionnaires and GP satisfaction via GP feedback/survey	Chief Nurse	01/02/2014
	CQC Action Plan – Outcome 6, no. 2 (d), (e), (g) Planning meetings, liaison with social care managers and social workers **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Achieve much more detailed earlier engagement with social workers on care planning, risk assessment and discharge planning with social care needs identified as early as possible.** a. Design new protocol for county and city hospital social workers covering the Bradgate Unit	Evidence of social work involvement in MDT meetings	Chief Nurse	01/02/2014
			Evidence in care plans and discharge plans of social work involvement and impact of actions taken	Chief Nurse	01/02/2014

Discharge Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
17	Discharge	Number of care plans reflecting discharge planning (by audit)	90%	59% @ Sept 2013	01/02/2014	Chief Nurse
18	Discharge	Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their discharge planning (by survey)	80% (*Set at 80% in recognition of those people who decline to be involved)*	67% @ Dec 2012	01/11/2014	Chief Nurse
19	Discharge	Continuity of care from the same consultant/community worker	80%	New initiative; baseline to be established	01/04/2014	Chief Operating Officer

Additional Specific Actions

Staffing

Theme	Mapped to	Action	Supporting Action	Lead	Timescale
Ensuring safe staffing level that takes account of all acuity factors	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Develop a phased approach and implement a SitRep for AMH in conjunction with commissioners with agreed thresholds and triggers which incorporate acuity, staffing/skill mix and bed occupancy metrics** a. SitRep commenced in the Bradgate Unit August 2013; i. Agreement to regularity of reporting ii. Agreement to metrics iii. Agree the escalation actions that will be taken by the Trust to address any operational issues arising from the SIT REP b. Roll out SitRep to other parts of AMH (e.g. CRHT) c. Move to a new skill mix of staff (60/40 ratio)	Recruitment plan	Chief Operating Officer	01/05/2014

	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Roll-out SitRep to other inpatient areas in other divisions**	Early warning dashboard development for other divisions	Chief Operating Officer	01/05/2014

Staffing Baselines

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
20	Staffing	60:40 skill mix qualified / unqualified ratio achieved on the Bradgate Unit	100%	New initiative; recruitment trajectory in place	01/05/2014	Chief Operating Officer
21	Staffing	5 / 5 / 3 staffing levels achieved on the Bradgate Unit	100%	100% @ 17/10/13	01/11/2013	Chief Operating Officer

Physical Health Care					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the quality of physical health care on mental health wards	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Review the admission assessment protocol/proforma including the input of senior medical staff in assessing and meeting physical health needs** a. Review the proforma b. Prepare a mandatory checklist for essential investigations	Check compliance and quality of information through auditing the admission documents	Medical Director	01/05/2014
	Wellbeing Strategy audit action 2 Medical and Nursing directors to consider requirement for LPT wellbeing co-ordinator role **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Use existing MDT proforma to discuss physical health need and management during weekly ward rounds**	Check compliance through auditing undertaken by Senior Matrons	Medical Director	01/05/2014

	Appleby action plan action 5.1 – recruitment of RGN **Action 5.2 – introduction of Track and Trigger** **CQC Action Plan – Outcome 4, no. 3** **As above** **SI 132244 action plan action 1 and 6 as above.** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Implement a training programme for mental health nursing staff to include specific physical health assessment needs, skills and care delivery** a. Recruit to the post of Physical Health Nurse b. Develop training package on physical health assessment and management; facilitated by Physical Health Nurse	Monitoring of training attendance	Chief Nurse	01/05/2014

Physical health care Baselines

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
22	Physical Healthcare	Number of care plans reflecting physical healthcare needs where identified (by audit)	100%	90% @ Sept 2013	01/05/2014	Chief Nurse
23	Physical Healthcare	Number of physical healthcare assessments undertaken versus admissions (by audit)	100%	92% @ Sept 2013	01/05/2014	Chief Nurse

People with Personality Disorder					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the skills of staff in managing people with personality disorder	**Appleby action plan action 7.1 – progress with personality disorder care pathway** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Implement rolling programme of training**	Personality Disorder audits of care plans for evidence of improvements to quality of the care plan for people with Personality Disorder; measure also via exit survey with service users	Medical Director	01/11/2014
	Keogh area of improvement: - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Strengthen the existing reflective practice groups to have a greater focus on case studies and lessons learned**	Staff satisfaction with the sessions every 6 months and monitor levels of attendance	Medical Director	01/11/2014

	Keogh area of improvement: - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Strengthen the complex case reviews to focus on lessons learned and changes to practice**	Staff satisfaction with the sessions every 6 months and monitor levels of attendance	Medical Director	01/11/2014

People with Personality Disorder Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
24	People with Personality Disorder	Number of Bradgate Unit staff with current valid personality disorder training, against plan	80%	Training commences Nov 2013; baseline data captured from 1st cohort Nov 2013	01/11/2014	Medical Director

Care Plans					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the ease of developing and using care plans as well as embedding care plans within the care process	**Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Review the care plan format to improve documentation and streamline for ease of use**	Test the effectiveness of the new format via staff feedback and patient feedback	Chief Nurse	01/02/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Provide bespoke training and development via supervision to individuals to improve the quality of care planning**		Chief Nurse	01/02/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. On-going monitoring of care plans using the existing audit and cycle identified for all Bradgate unit care plans**		Chief Nurse	01/02/2014

Risk Assessment					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Enhancing the skills of staff in the assessment and effective management of risk	**Appleby action plan action 10.1 – Integritas training** **CQC Action Plan – Outcome 14, no. 3 (e) and Outcome 16, no. 1 (c)** **As above** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Deliver an enhanced MDT interactive risk management training programme (this complements the existing mandatory rolling programme ref the Morgan risk tool)**	Regularity of sessions and attendance levels	Chief Nurse	01/05/2014
			The implementation of the agreed risk management approaches into supervision	Chief Nurse	01/05/2014
			Measure effectiveness also via sampling supervision notes	Chief Nurse	01/05/2014
			Measure also via evidence from MDT reviews and use of risk assessment	Chief Nurse	01/05/2014
			Measure via the routine risk assessment audits via care plans	Chief Nurse	01/05/2014

	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Enhance clinical leadership to risk management training through named individuals**	Measure the effectiveness of the agreed risk management approach via supervision	Medical Director	01/05/2014
			Names individuals identified and evidence through their job plans to be able to conduct the role	Medical Director	01/05/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Review and strengthen the peer review approach for consultant's practice; ensure there is a systematic approach across AMH with clear standards including risk management** a. Identify, agree and implement appropriate audit tool		Medical Director	01/05/2014

Risk assessment Baselines

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
25	Risk Assessment	Complete risk assessment documentation present in care record for current episode of care	100%	92% @ Sept 2013	01/03/2014	Chief Nurse
26	Risk Assessment	Number of staff with current valid risk assessment training	80%	92.1% @ Sept 2013	01/05/2014	Chief Nurse

Hand Over

Theme	Mapped to	Action	Supporting Action	Lead	Timescale
Checking and searching procedure to be clear and consistent. Guided with intelligence on risk posed by the patient	**Appleby action plan action 2.2 – review of handover policy** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Harmonise, review and improve the protocol which includes all aspects of handover (e.g. ward to ward handovers; shift to shift, internal/external; daily review) with clear diagrams/flow charts to assist staff to follow systematic processes** a. Implement training programme		Chief Nurse	01/01/2014

Hand Over Baselines

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
27	Handover	Adherence to In-patient handover protocol (by audit)	100%	New initiative; baseline to be established	01/01/2014	Chief Nurse

Embedding a system for continuous learning & Staff support					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Providing support and create opportunities for staff to learn continuously from practice (near misses, SI investigation recommendations, patient feedback) and reduce clinical variability	**Keogh area of improvement:** - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Review and strengthen the policy for staff support, including for violence, aggression and Serious Incidents**		Chief Nurse	01/01/2014
	Keogh area of improvement: - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Identify and provide additional training for specific staff who can lead debriefing sessions**	Include database of key people and their training, the number of sessions they have led, along with feedback from staff who have attended those sessions	Chief Nurse	01/01/2014
	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Develop a MDT forum for reviewing lessons learned ref. professional practice**	Measure resulting changes in practice and other actions taken	Medical Director	01/01/2014

	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**4. Utilise all available data such as staff feedback, service user experience, professional practice and Serious Incident thematic review to implement new mechanisms for disseminating lessons learned** a. Develop and implement ward level scorecards b. Develop and implement early warning data sets		Medical Director	01/05/2014

Continuous learning & staff support Baselines

Ref	Theme	Metric	Target	Baseline	Timescale	Lead
28	Continuous learning & staff support	Number of debriefing sessions versus number of violent incidents and Serious Incidents reported	100%	New initiative; baseline to be established	01/01/2014	Chief Nurse
29	Continuous learning & staff support	Attendance rate of MDT learning forums against Terms of Reference	80%	New initiative; baseline to be established	01/01/2014	Medical Director
30	Continuous learning & staff support	Number of MDT learning forums held versus plan	100%	New initiative; baseline to be established	01/01/2014	Medical Director

Improvement of the Environment					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Improving the patient experience, healing nature and safety of environment		**1. Ward environment** a. PLACE results are available for each inpatient area – recommendations to be actioned b. Cleaning schedule to be reviewed with manager of Domestic Services to ensure that cleaning requirements are met	FM metrics in the Interserve contract PLACE action plan implementation	Chief Operating Officer	01/05/2014
	Appleby action plan action 8.1 – review of ligature risk assessments **CQC Action Plan – Outcome 16, no. 3 (f) (g)** **CQC (MHA) Ashby Ward action plan, action 7**	**2. Ward environment – patient safety** a. Review Ligature assessment policy b. Ligature risk assessment – review to be completed for each ward using new tool from Ligature Risk Policy (approved March 2013) *NB: the ligature risk assessment review referred to here will be completed across Bradgate by end of October with report to QAC.* c. Refurbishment of bathrooms to the 4 old wards to remove already identified ligature risks (already in 13/14 Capital programme and awaiting commencement date of work) d. Structural solutions to minimise patients with high risk absconding – SALTO system, additional CCTV, intercoms and additional security doors to be installed throughout the Bradgate site including Glenvale area	Staff satisfaction with environment	Chief Operating Officer	01/05/2014
				Chief Operating Officer	30/11/2013
				Chief Operating Officer	30/11/2013

		– Capital works approved and work has commenced e. Review of current fencing – business case to be developed following recommendations		Chief Operating Officer	31/12/2013
	CQC Action Plan – Outcome 7, no. 1 (d) (e) **Review of seclusion rooms and resulting building work** **1 (g)** **Review of Seclusion Good Practice Group** **Keogh area of improvement:** - *Patient experience* - *Safety* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Seclusion** a. Review of all seclusion rooms to ensure fit for purpose b. Costs to be obtained for air conditioning to seclusion rooms c. Seclusion Group – this group is to be chaired by a clinician and purpose of the group will be to ensure that seclusion practice is monitored and that best practice is being adhered to as per the seclusion policy – this group is already in place and a lead clinician has been identified as Chair – the Chair of the Seclusion Group will write the annual seclusion report which is submitted to the SCQG	Feedback on the seclusion room changes from staff and service users	Chief Operating Officer	01/05/2014
			Evidence of improvements to privacy and dignity including those relating to single sex accommodation arrangements	Chief Operating Officer	01/05/2014

Improvement of the environment Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
31	Improvement of the environment	Adherence of staff to seclusion process and policy (by audit)	100%	Action plan in place to establish baselines	01/05/2014	Medical Director
32	Improvement of the environment	Adherence of all seclusion environments to national standard	100%	Baseline will be set by environmental audit	Dependent upon scale of work	Chief Operating Officer
33	Improvement of the environment	Number of ligature assessments undertaken in the Bradgate Unit	100%	All In-patient wards completed	01/12/2013 Non In-patient areas	Chief Operating Officer
34	Improvement of the environment	Improvement in PLACE survey results	90%	PLACE baselines (Sept 2013): • Cleanliness: 87.37% • Condition, appearance and maintenance: 75.12% • Privacy, dignity and wellbeing: 81.96% • Food and hydration: 84.79%	Dependent upon scale of work and 2014 PLACE assessments	Chief Operating Officer

Equality Meeting the needs of individuals with Diverse needs					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Care provided is able to accommodate the needs of the individuals with diverse needs and backgrounds	**CQC Action Plan – Outcome 14, no. 1 (b) (d)** **Keogh area of improvement:** - *Patient experience* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**1. To improve overall staff awareness of the needs of service users by revising the equality and diversity training so that this has a focus on the assessment of the protected characteristics and how care is planned and delivered with these in mind**		Director of HR & OD	01/11/2014
	CQC Action Plan – Outcome 14, no. 1 (a) **CQC (MHA) Thornton Ward action 6 staff to ensure use of interpreters** **Keogh area of improvement:** - *Patient experience* - *Workforce* - *Clinical and operational effectiveness*	**2. Ensure appropriate provision and access to language and communication support to enable service user communication, including translation services**		Chief Nurse	01/05/2014

Equality Baselines						
Ref	**Theme**	**Metric**	**Target**	**Baseline**	**Timescale**	**Lead**
35	Equality	Documented consideration of Equality & Diversity patient needs in care plan	100%	87%@ Sept 2013	01/05/2014	Chief Nurse
36	Equality	Number of staff trained in Equality & Diversity Training	80%	96.1%@ Sept 2013	01/11/2014	Director of HR & OD

Effective governance Supporting effective governance of the Trust					
Theme	**Mapped to**	**Action**	**Supporting Action**	**Lead**	**Timescale**
Ensuring the adequacy of Ward to Board mechanisms to support effective governance of the Trust	**Keogh area of improvement:** - *Clinical and operational effectiveness* - *Leadership & governance*	**1. Establish a Board Assurance and Escalation Framework that describes the effective ward to board reporting mechanisms to ensure effective governance of the Trust**		Chief Nurse	31/12/2013
	Keogh area of improvement: - *Clinical and operational effectiveness* - *Leadership & governance*	**2. Review the organisational risk management strategy to ensure there is effective ward to board reporting and management of risks across the Trust**		Chief Nurse	31/12/2013
	Keogh area of improvement: - *Patient experience* - *Safety* - *Workforce* - *Clinical and operational effectiveness* - *Leadership & governance*	**3. Implement the priority areas from the Trust's analysis of the Francis Report**	Board Analysis of Francis Report Thematic actions agreed in Q2 Progress report in Q3 (October Board Report) Annual Review Q4	Chief Executive Officer	February 2013 June 2013 October 2013 February 2014

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APPENDIX C

Leicestershire Partnership NHS
NHS Trust

QUALITY IMPROVEMENT PROGRAMME (QIP)
CORPORATE ENGAGEMENT PLAN

Appendix 1

Key for RAG Rating	
	Action not commenced
	Action On-going and to time
	Action Completed
	Action has missed deadline

Communications & Reputation Management **Director with lead responsibility:** **Director of Business Development**			
Patient, Carers & Service Users	**Who**	**By When**	**Progress/Assurance**
Contact patient and carer groups with information and reassurance	Chief Nurse	Complete	An initial meeting was organised with service users at Network for Change on 13/09/13 in response to group concern.
"*Changing your experience for the better*" – review recent comprehensive results from service user focus groups within AMH	Chief Nurse	Complete	A meeting was organised for 17/09/13 inviting voluntary and community sector organisations to provide them with information regarding the CQC findings, Trust actions and to hear from them about any concerns they may have. Patient experience team and AMH Divisional Director have undertaken a thematic review of these findings to support development of Quality Improvement programme.

External Stakeholders	Who	By When	Progress/Assurance
Forwarding draft CQC report (July inspection) to lead commissioner	Chief Operating Officer	Complete	Completed 08/08/13
Share response with the CCGs electronically before 15/8/13	Chief Nurse	Complete	Completed 15/08/13
Meeting with Local Health Watch	Chief Nurse		LPT Chairman met with Local Health Watch representatives on 17/09/13 Letter from Local Health Watch to Acting CEO in August reference CQC update. Letter from Local Health Watch to CEO in October and meeting on 30/10/13
Commissioner awareness, involvement and support for the immediate and medium term actions: set up an extraordinary exec team meeting with commissioners	Director of Finance	Complete	Commissioner meeting held 15/8/13.
MP Briefings	Acting CEO	Complete	Regular appointments in place. All MPs offered a telephone call updating them on the position ref July inspection. All MPs receive monthly LPT stakeholder briefings
Immediate initial meeting with TDA to brief on CQC and FT.	Acting CEO and Exec team	Complete	Constructive meeting held with TDA on 13/8/13 Actions incorporated into Immediate Action Plan and Quality Improvement Programme where applicable. Further meeting with TDA on 2/9/13.
Meetings with CCGs to further develop QIP Plan and metrics	Chief Nurse	Complete	Meetings held 24/9/13 and 03/10/13 to confirm and challenge content of the latest version of the QIP and discuss proposed metrics. On-going TDA input via Oversight & Assurance Group and monthly IDM meetings

Local Authorities, Scrutiny Committees and Health and Wellbeing Boards	Who	By When	Progress/Assurance
Briefing sessions offered to overview and scrutiny committees x3	Director of Business Development	2/8/13	All scrutiny officers contacted, this led to:- • Leicestershire County Council; Medical Director and Chief Operating Officer attended to present report on 12/9/13 • Follow up meeting at Leicestershire County Council on 27/11/13 (CEO, Chief Nurse and Medical Director) to present update report. • Leicester City; Acting CEO and Director of Business Development attended to present report on 3/9/13 and Chairman, Medical Director and Director of Business Development attended to present update report on 15/10/13 • Rutland County Council; Director of Business Development and Chief Nurse attended and presented report on 26/9/13 The Chair of the Leicestershire County and Rutland Adult Safeguarding Board was invited to the Leicestershire County Council scrutiny meeting on September 12; we suggested the same approach for Leicester City.
Generic Report produced for Scrutiny Committees that can be adapted over time/to address specific council queries.	Director of Business Development	21/8/13	Report completed and submitted initially for Leicester City deadline for papers (21/8)
Briefing sessions to be offered to safeguarding adults boards locally x 2	Director of Business Development	Complete	Incorporated into scrutiny plans above
Briefing sessions offered to the chairs of the three local health and wellbeing boards	Director of Business Development	10/08/13	Acting CEO office contacted all three Chairs to offer individual briefings as needed. Acting CEO briefing meeting held with Councillor Ernie White on 21/8/13. Chairman meeting Councillor Rory Palmer on 30/10/13

Internal Communications	Who	By When	Progress/Assurance
Statement on the receipt of the full CQC report Statement on increasing independence of SI investigations	Director of Business Development	Complete	Complete – combined and issued via staff briefing and stakeholder briefing on 7/8/13
Statement to clarify suicide numbers – for Chair and CEO	Chief Nurse	Complete	Issued to CEO and Chair on 6/8/13. Further detail and refinements made to data analysis by Chief Nurse by 20/8
Communications forward planner showing reputational issues and mitigation plans	Director of Business Development and Head of Communications	Complete	Complete - shared at Senior Management Team on 5/8/13 Updated for Executive Team meeting on 12/8/13 and then updated bi-weekly and presented at Executive Team meetings and Senior Management Team meetings.
Communications forward events planner and channel of good news stories	Director of Business Development and Head of Communications	Complete	Forward planner in place and managed proactively via divisional communications leads.
Cascade of CQC report (July inspection) through AMH	Chief Operating Officer and Divisional Director	Complete	Cascaded. Medical Director confirmed all appropriate clinical staff have received it personally.
On-going staff communication to reinforce Trust Board's support and report our progress	Acting CEO & Chair through communications	Complete	Special editions of team brief on CQC Report (July inspection) through July and August
Acting Chief Executive initial meeting with AMH Consultants at Bradgate Unit	Acting Chief Executive	Complete	Acting Chief Executive held constructive meeting with AMH Consultants on 9/8/13. Medical Director to lead on taking forward the key issues raised which focused on what is preventing good quality care from their perspective.

Issue CQC report to other Divisional Directors and discussion/action on: • thematic review of CQC report by other divisions • additional divisional communications/leadership on patient safety and record keeping • identification of other areas of CQC risk (Oakham House/Agnes Unit) where record keeping/case note improvements and other interventions are needed	Director of Business Development/Chief Operating Officer	Complete	Discussed with Divisional Directors who are progressing actions accordingly. COO follow up via fortnightly Ops team and monthly Executive Performance Reviews with Divisions Initial Thematic review complete and reported to Senior Management Team on 19/8/13
Briefing arrangements for lead governor/governor communications	Board Secretary	Complete	Acting CEO met with staff governors 29/8/13. Chairman/Lead Governor considered extra-ordinary Council of Governors meeting. Lead Governor receiving all stakeholder briefings and regular updates from the Chairman. Council of Governors briefed at their July and October meetings
Trust Board and CQC Report/Response	Acting Chief Executive	Complete	Complete: Response shared with Trust Board at 29/8/13 meeting/development session. Paper presented to Trust Board in public session 29/8/13 including immediate action plan, warning notices and full CQC report.
Weekly briefing for Board to be shared with Matrons across all divisions	Chief Nurse	On-going	
Other Communications actions	**Who**	**By When**	**Progress/Assurance**
Small suite of initial public facing products on the Trust, patient safety and other activities/profile. Review of ward information packet at the Bradgate Unit	Medical Director, Chief Operating Officer and Head of Communications	On-going	Initial topics agreed w/c 12/8/13. Initial products by 30/8/13, then rolling programme. Refreshed service user ward information packet draft being reviewed by communications and VCS during October
Annual General Meeting on 7/09/13	Acting Chief Executive	Complete	Meeting to finalise arrangements 15/8/13. Communications plan for CQC July inspection report publication finalised 22/8/13 including AGM aspects

Co-ordination ref publication of CQC Report and associated communications including handling for Trust Board and Risk Summit on 29/8/13.	Chief Nurse and Director of Business Development	Complete	LPT Communications plan developed and enacted 27-30 August in relation to the publication of the CQC report Communications handling plan developed and enacted for the Trust Board meeting. Coverage by BBC East Midlands Today, Leicester Mercury and BBC Radio Leicester. Co-ordination of communications following the Risk Summit being led by Area Team. LPT fully engaged in this process and issued a further staff and stakeholder briefing w/c 2/9/13.
Weekly stakeholder update to core communications stakeholder list	Director of Business Development and Head of Communications	Complete	To review regularly at 3 and 6 weeks. First bulletin 31/7/13; second bulletin 08/8/13; third bulletin 12/8/13 & 13/8/13 (Now monthly as before)
Continuing engagement – October 2013 onwards	**Who**	**By When**	**Progress/Assurance**
Engagement with Senior Leadership Group (approx. 150 people) on the Quality Improvement Programme	CEO		Meeting arranged for 27/11/13
New Ward Forums at Bradgate Unit, inclusive of patients, VCS and Ward Staff	Chief Operating Officer, Chief Nurse and Medical Director		Ward Forums are in the process of being arranged/re-established
Communications plan for the publication of the September CQC inspection Report	Director of Business Development		Communications plan in place
On-going VCS engagement	Director of Business Development and Head of Patients Experience	On-going	Post the September briefing, a further VCS engagement follow up session was held on 22/10/13 to gather feedback on the draft Quality Improvement Programme with the next session planned for 12/11/13
Trust Board engagement	CEO	On-going	Board development sessions 25/7/13 in relation to the July inspection CQC report. Board development sessions held 29/8/13, 26/09/13 and 31/10/13 with continual focus on quality assurance and transparency

Agenda Item 10

NHS
West Leicestershire
Clinical Commissioning Group
NHS

East Leicestershire and Rutland
Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 27th NOVEMBER 2013

REPORT OF WEST LEICESTERSHIRE AND EAST LEICESTERSHIRE AND RUTLAND CCG

EMERGENCY CARE UPDATE

Purpose of report

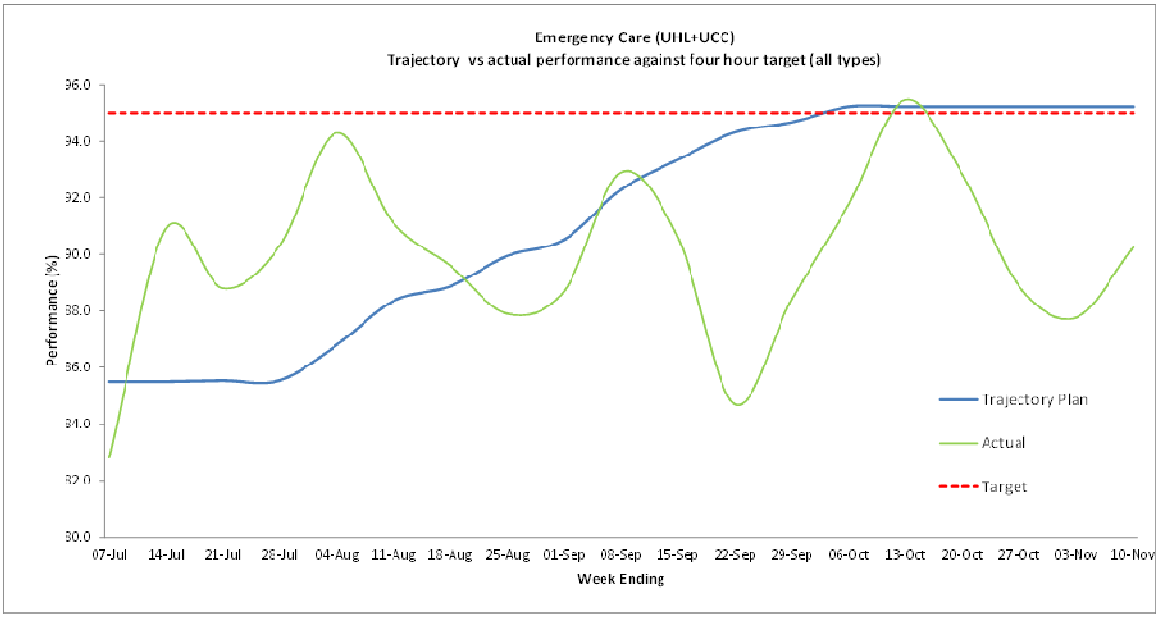
1. This paper seeks to update the committee in relation to performance of the local urgent and emergency care system, in particular UHL's performance against the national four-hour standard for A&E, and the actions taken by the three LLR CCGs collectively and the wider health economy to address the underlying issues affecting the emergency pathway and its impact on A&E performance.

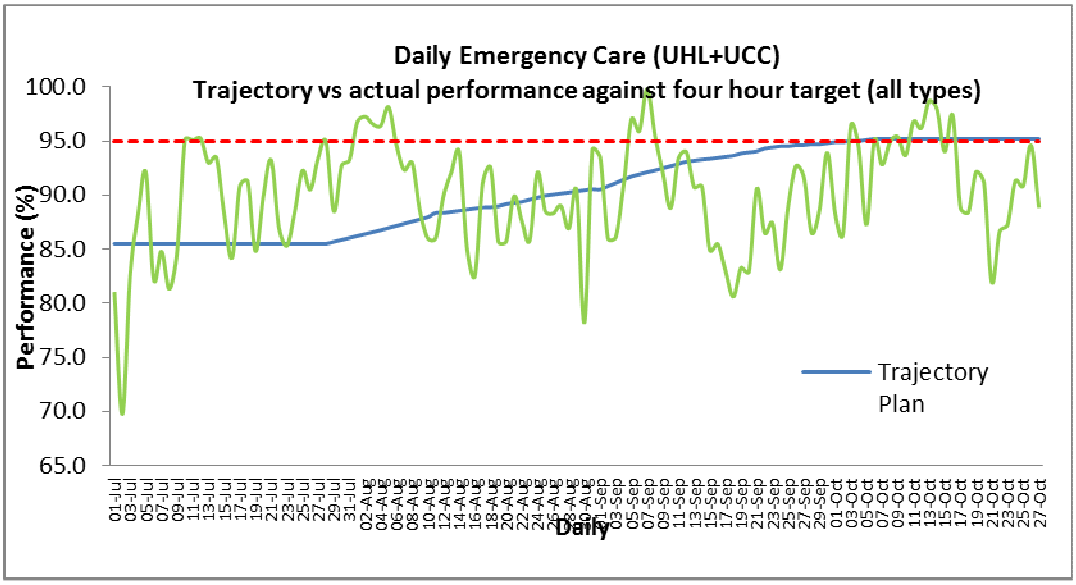
Background

2. Some improvement was seen in the A&E 4 hour target at the beginning of October but daily variability is still a current barrier to an improved overall performance position. The work streams are focusing on various elements of flow to support a streamlined process, better communication and flow through the organisation in addition to discharge earlier in the day.

Current Performance

3. At the beginning of October A&E performance was beginning to show positive signs of recovery and for one week 95% (patients seen within 4 hours) was achieved. However performance was not sustained and deteriorated over three consecutive weeks with some improvement seen for the week ending 10th November was 90.2%.





The graph above shows daily variation, the significant daily variances then impact adversely on the overall weekly position.

Emergency Care Hub

4. The emergency care hub was set up at the end of September as part of the CCG response to under performance of the A&E target and to support improvement alongside the UHL executive team. The Hub is based at the LRI and involves directors and senior staff from the CCG's and UHL.

5. Following a series of engagement workshops with staff from across the Trust and wider health economy, 5 streams of work were identified and are being led by each of the directors.

6. The 5 work streams each have a number of aligned projects; all of which are expected to have a positive impact on performance in the short and medium term, the medium term being up to the end of March 2014:

Inflow – there are currently 14 projects being pursued to support admission avoidance and optimising community based care through alternative pathways.
ED practice and specialty engagement - this includes reviewing the discharge medication process, Emergency Department processes and engagement with specialty teams.
Ward Practice - focuses on enhancing clinical leadership, recruitment, discharge processes and maximising the time to care.
Operational – this includes the operational arrangements for the management of surge and flow, review of capacity and review of non-clinical support roles
Multi organisational integration – Streamlining how organisation work together - Integrated discharge team, reducing Delayed Transfers of Care, supporting transfer of care options when patients are medically fit. Review of the mental health pathway and services accessed through the Emergency Department and Urgent Care Centre.

7. There is significant engagement across partners to progress the identified work streams. The Hub delivery group is meeting weekly to share and drive progress; this is being underpinned by KPI's (key performance indicators) for each of the work streams to support the monitoring of performance and delivery against intend outcomes.

Quality

8. Quality reports are being presented through the Urgent Care Working Group (formerly the Urgent Care Board) to enable quality and safety to be considered alongside performance and delivery progress, in addition to providing the qualitative impact of the projects being undertaken.

Winter Planning

9. There are 3 pieces of work currently being undertaken to support delivery through the winter period :
   a. The formation of a capacity and demand management plan for LLR which identifies escalation triggers and associated actions and how they are managed across LLR.
   b. LLR Winter plan which sets out key actions being taken by each of the partner organisations during the winter period particularly recognising the 10 day period over the Christmas and New Year bank Holiday period.
   c. Resource planning during the Christmas period.

10. All partner organisations have contributed to the plans which are now being finalised and rolled out across organisations.

11. The plans were tested at an exercise last week which supported the integrated work being undertaken and enabled organisations to further refine and develop the plans.

Conclusions

12. Achieving sustainable patient flow across the emergency care pathway remains a focus of actions and attention. When flow is achieved A&E performance improves. To achieve sustainability each of the work streams need to deliver the identified actions and build on the positive contribution of all multi agency partners.

13. This will allow us to ensure Leicestershire's emergency care system provides high quality care that meets the needs of our patients and offer the assurance required by NHS England.

Officer to Contact

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Agenda Item 11

University Hospitals of Leicester NHS
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 27 NOVEMBER 2013

REPORT OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

UPDATE ON CURRENT ISSUES

PURPOSE OF REPORT

1 The purpose of this report is to update the Health Overview and Scrutiny Committee on the following issues:-

- The proposed development of UHL's emergency floor;
- UHL's hospital mortality rates;
- The forthcoming CQC hospital inspection programme;
- UHL's financial position 2013/14.

2 The following Trust postholders will be in attendance at the Committee meeting to present this report:-

- Dr K Harris – Medical Director
- Mr A Seddon – Director of Finance and Business Services
- Ms N Topham – Project Director, Site Reconfiguration

EMERGENCY FLOOR

3 At its meeting held on 11 September 2013, the committee received a report and presentation from the local NHS setting out plans to improve emergency care in Leicestershire, with particular reference to arrangements for Winter 2013.

4 The report and presentation included information on UHL's proposal to develop a single emergency floor.

5 At that time, the Trust's preferred option required the movement of a number of outpatient specialties to either the Leicester General Hospital or Glenfield Hospital.

6 Members welcomed the proposals for the development of a single emergency floor, while noting that the proposed changes to the location of a number of outpatient clinics fell within the definition of 'a substantial variation in the provision of such services' and would therefore normally be the subject of formal consultation.

7 However, the Committee was of the view that the proposed changes would enhance the provision of emergency and outpatient services in terms of accessibility and clinical outcomes and believed that the proposed changes were in the best interests of the patients and the public.

8 It was therefore suggested that the Committee waive its rights to be formally consulted on condition that the Trust undertook to provide it with a detailed project plan outlining a range of information stipulated by the Committee.

9 Since September, the Trust has continued to review options for development of the emergency floor.

10 A report on the preferred solution is to be submitted to the public Trust Board meeting on 28 November 2013. At the time of writing, this report has yet to be finalised. The report will be published on 22 November 2013.

11 Those representatives of the Trust attending the Committee meeting on 27 November 2013 will report orally on the preferred solution for the development of the emergency floor.

12 At this stage, it remains the Trust's intention to finalise and submit the Full Business Case to the NHS Trust Development Authority (TDA) in June 2014. The Trust anticipates that work will start in the Autumn of 2014, but this is subject to TDA approval.

UHL'S HOSPITAL MORTALITY RATES

13 Hospital mortality is a complex subject and is defined in a number of ways.

14 Crude mortality is the number of deaths divided by the number of admissions – not adjusted for case mix.

15 Hospital standardised mortality ratio (HSMR) is the number of in-hospital deaths divided by the number of 'expected' deaths (expected is calculated from case mix and socio-demographic information, BUT not severity of the diagnosis). It is expressed as a number greater or lesser than 100, with 100 being the England average.[1]

16 Then there is the standardised hospital mortality index (SHMI)[2], which is like HSMR but with deaths 30 days post-discharge included.

17 No one measure is perfect, but all give useful signals and are used to alert for problems.

18 At the public Trust Board meeting held on 31 October 2013, the Trust Board received a comprehensive report prepared by Dr K Harris, Medical Director, on the outcome of a review of hospital mortality rates at the Trust.

19 UHL's mortality in 2012/13 as assessed by HSMR was 101, slightly above the average of 100 but 'within expected'. Further work is being undertaken to understand this.

20 The latest SHMI for UHL covering the same time period is 106 which, again, is 'within expected'.

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[1] Source : Dr Foster: www.drfosterhealth.co.uk
[2] Source: Heath and Social Care Information Centre www.hscic.gov.uk

21 UHL's ambition is to be significantly better than average and this is one of the key drivers behind the 'Saving Lives' workstream of the Trust's Quality Commitment, which aims to save 1000 extra lives over the next 3 years.

22 In this regard, significant progress has been made with the implementation of the Respiratory Pathway, to manage patients with severe respiratory illness like pneumonia.

23 Within the overall Trust results, there are differences between hospitals: in 2012/13, the Leicester Royal Infirmary's HSMR was 114, the Leicester General Hospital's 81 and the Glenfield Hospital's 82.

24 It is of note that in 2012/13, 64% of the emergency and sickest patients were treated at the Leicester Royal Infirmary, compared to 20.5% at the Leicester General Hospital and 15.5% at the Glenfield Hospital.

25 The Dr Foster hospital guide for 2013 will publish both Trust and site – specific mortality rates for 2012/13 and this will show the Leicester Royal Infirmary, home to the Leicester, Leicestershire and Rutland Emergency Department, as having a 'higher than expected HSMR'.

26 Dr K Harris, Medical Director, will expand on this subject when presenting the report at the Committee meeting.

CQC WAVE 2 ACUTE HOSPITAL INSPECTION PROGRAMME

27 The Care Quality Commission has developed a new model for monitoring a range of key indicators about NHS Acute and Specialist Hospitals. These indicators relate to the 5 key questions they will ask of all services – are they safe, effective, caring, responsive and well-led?

28 The results of the CQC intelligent monitoring report (October 2013) identifies that UHL has 5 indicators in the category of 'risk', and 5 at an 'elevated risk' out of a total of 150 indicators. This places UHL in the risk category of 1 overall, the highest risk.

29 Consequently, the CQC have given notice that UHL will be within the next wave of inspections commencing in January 2014. The Trust has recently received notification that inspection of the Trust will start on 13 January 2014.

30 The core site visit is likely to last between 2 and 5 days, and the inspection take around 2 weeks in total, but this includes the CQC team's preparation day and any follow-up work needed.

31 As well as inspecting all 3 hospital sites, the CQC inspection team will inspect 8 key service areas: A&E; acute medical pathways including the frail and elderly; acute surgical pathways; critical care; maternity; paediatrics; end of life care and outpatients.

32 The inspections will be a mixture of announced and unannounced and may include inspections in the evenings and weekends, when the CQC states that they know people can experience poor care.

33 The CQC will decide whether hospitals are rated as outstanding; good; requires improvement; or inadequate. If a hospital requires improvement or is inadequate, the CQC will expect it to improve. Where there are failures in care, the CQC will work with Monitor and the NHS Trust Development Authority to make sure that a clear programme is put into place to deal with the failure and hold people to account.

34 A response to each of the indicators identified as elevated risk/risk is detailed below.

- **Dr. Foster: Deaths in low risk diagnosis groups (Elevated Risk)**

35 There were 81 patients who died in 2012/13 that were coded as having a 'low risk diagnosis'. The types of diagnosis included in this group are: abdominal pain, transient cerebral ischemia, chest pain, abdominal hernia, normal pregnancy, crushing injury/internal injury. Preliminary review of the data suggests that some patients were subsequently confirmed as having a 'higher risk diagnosis' (stroke, myocardial infarction). Others appeared to have other co-morbidities that significantly affected their outcome (e.g. patient admitted with 'internal injury' also had alcoholic cirrhosis of the liver and oesophageal varices).

36 The details of each of the patients in this group are now being cross referenced with the relevant Morbidity and Mortality reviews to ensure that any areas for learning have been acted upon. At the same time, the clinical coding will be checked as one patient was coded with a 'primary diagnosis of abdominal pain' but was admitted to the coronary care unit.

- **Maternity outlier alert: Puerperal sepsis and other puerperal infections (Elevated risk)**

37 In August 2013 the CQC wrote to notify UHL of the fact that analysis of maternity indicators undertaken by the Care Quality Commission had indicated that rates of puerperal sepsis and other puerperal infections within 42 days of delivery at our Trust have remained significantly high since the previous alert for this indicator was closed in April 2012.

38 A case-note review, the review of audit data regarding serious septic illness and the review of audit data regarding post-caesarean section wound infection all confirmed good clinical outcomes and failed to identify any concerns regarding quality of care. However, there were a number of issues identified that need to be addressed.

39 These include:

- A need to improve coding of septic illness diagnoses to more accurately reflect the clinical diagnoses
- A need to validate and benchmark the data being collected with regard to severe septic illness on our E3 database

- A need to identify and implement at least one Quality Outcome Indicator to be included as a regular item on our maternity dashboard
- A review of pathways of care for women after discharge from hospital in conjunction with primary care colleagues

40 An action plan is being implemented to address these points.

- **A&E waiting times more than 4 hours (Elevated risk)**

41 Performance against the 4 hour wait is subject to regular detailed reporting at the Trust Board. It is well recognised that the current Emergency Department is too small, having been designed for around 115,000 patients a year rather than 160,000 that come through the Department. A scheme for investment in the Emergency Department has been developed.

42 Working with partners a "single front door" process was introduced in July 2013 guiding patients to the most appropriate care.

43 Executives across the healthcare community have been meeting on a weekly basis to work on sustainable solutions that will improve performance, patient experience and staff satisfaction. This work is now focused in particular upon improving the flow of patients by expediting discharge. This is a multi-agency task and is key to improving performance. This is because the Trust's calculations have shown that it is some 75 acute beds short of the required capacity with little scope to increase that capacity due to staffing and space constraints.

- **Whistleblowing alerts (Elevated risk)**

44 From the reporting period UHL have received three whistleblowing concerns; one in relation to overcrowding in the Emergency Department and two in relation to cleanliness at the LRI and LGH.

45 UHL provided the CQC with a response for each concern raised. The Director of Clinical Quality liaised with the Medical Director, Chief Nurse, Interim Director of Operations and Senior Management team of the Acute Division and Emergency Department to be able to provide a comprehensive response to address the issues raised with regards to standards of care.

46 The Lead Nurse Infection Prevention and the Deputy Director of Facilities compiled a response with regards to the standards of cleanliness across the hospital sites.

- **Serious Education Concerns (Elevated risk)**

47 The Trust is aware of and is addressing ongoing issues with medical education. The Medical Director presented a report to the Executive Team on a recent Local Education Training Board's Education Review for Trainee Doctors which focused on areas such as Paediatrics, Obstetrics and Gynaecology, Anaesthetics, Trauma and Orthopaedics, and all Foundation Trainees. This year there are 48 areas of improvement, of which 13 areas are

RAG rated 'red' to indicate urgent action being required. Some of the areas of improvement can be categorised into the following areas:

- Education Resources
- Identification of Different Levels of Medical Staff
- Trainee Rotas:
    - Foundation Year 1 doctors working core level doctor rotas is a concern.
    - Doctors advised that they were often required to work longer than the duty rota
    - Excessive hours being worked over consecutive days
- IT Systems
- Phlebotomy
- Service Level Induction

48 A number of these issues have already been resolved by the Trust, for example there are plans for a new library at the LRI site, and there will be an Educational Lead for each Clinical Management Group and implementation of the colour coded ID badge holders and lanyards for Medical Staff.

- **Composite indicator: In-hospital mortality- Paediatric and congenital disorders and perinatal mortality (Risk)**

49 Better understanding of the methodology is required in order to investigate properly as this is a composite indicator of two groups of patients (paediatric/congenital disorders and perinatal mortality) and different methods are used for creating the outcomes for each of the groups

50 The 'risk' is associated with the first part of the indicator and not the perinatal mortality. The indicator assessed as at 'risk' is a combined indicator and includes paediatric and congenital disorders plus perinatal mortality.

51 The Risk only relates to the Paediatric and Congenital Disorders.

52 Within the indicator are 5 main diagnostic groups:

- Cardiac and circulatory congenital anomalies
- Other congenital anomalies
- Genitourinary congenital anomalies
- Digestive congenital anomalies
- Nervous system congenital anomalies

53 The Trust believes that the group that is 'alerting' is 'other congenital anomalies' and within that group there is a subgroup which is alerting – congenital diaphragmatic hernia (there were 5 deaths in 34 patients).

54 The Children's Mortality and Morbidity Lead for both the LRI and GH has reviewed all paediatric cardiac deaths in 2012 with the PICANET lead. Within this review were 3 of the congenital diaphragmatic hernia patients (2 of the patients died subsequent to being transferred back to their original hospitals). All 3 babies had been accepted for ECMO and known complications of ECMO and subsequently died.

55 The majority of Trusts where babies are managed with these conditions will only have those babies that require relatively minor operations and specifically in respect of the Congenial Diaphragmatic Hernia babies (closing of the diaphragm area where the hernia is) - so their mortality numbers will be next to nil whilst, because the Trust houses an ECMO service (and consequently receives the complex babies), numbers will be substantially higher.

56 The Trust's congenital anomalies mortality is unlikely to compare favourably with the majority of hospitals in England because the Trust receives babies with the worst type of congenital abnormality, both because the Trust is a cardiac centre but more so because of ECMO (there are only 4 such centres in the UK). Deaths have been reviewed and any learning acted upon and outcomes are monitored both by PICANET and NICOR (previously CCAD).

- **PROMs EQ-5D score: Groin Hernia Surgery (Risk)**

57 UHL's patients reported a similar health gain to the England average for 2011/12 (UHL 0.85 England 0.88). For 2012/13, the provisional data published on the HSCIC website, shows UHL's performance dropping to 0.39 (England average remains at 0.88). This drop appears to be disproportionate and UHL has requested validation of the data by Quality Health 9the data provider).

- **TDA - Escalation Score (Risk)**

58 The TDA Accountability Framework sets out five different categories by which Trusts are defined depending on key quality, delivery and finance standards.

59 The five categories are (figures in brackets are number of non FT Trusts in each category as at July 2013):

Category 1: No identified concerns (18 Trusts)
Category 2: Emerging concerns (27 Trusts)
Category 3: Concerns requiring investigation (21 Trusts)
Category 4: Material issue (29 Trusts)
Category 5: Formal action required (5 Trusts)

60 Confirmation was received from the NHS Trust Development Authority during October that the University Hospitals of Leicester NHS Trust was escalated to Category 4 – Material issue. This decision was reached on the basis of the significant variance to financial plan for quarter one and continued failure to achieve the A&E 4hr operational standard.

- **Composite risk rating of Electronic Staff Record items relating to staff turnover (Risk)**

61 Using the Electronic Staff Record as its data source, the CQC calculate turnover as the number of leavers in the last 12 months divided by the average headcount in the last 12 months. During 2012/13 specifically, this figure has been distorted by the transfer of 406 facilities and switchboard staff to the employment of Interserve. This quantity equates to approximately three months' turnover.

62 Turnover rates are regularly monitored and reported to the Trust Board on a monthly basis via the Quality and Performance Report. No specific issues have recently been highlighted. In addition, the National Workforce Assurance Tool does not indicate that turnover is a specific issue at the Trust when compared to peers.

- **Composite risk rating of ESR items relating to staff stability (Risk)**

63 The same data set is used by the CQC for staff turnover; however, the stability index measures the number of employees with greater than 12 months service divided by the number of employees 12 months ago. This is equally distorted by the turnover attributed to the TUPE transfer of facilities staff (98.77% of those transferring had more than 12 months service).

64 Dr K Harris, Medical Director, will expand upon the information set out in this section of the report at the Committee meeting on 27 November 2013.

FINANCIAL POSITION 2013/14

65 At the end of September 2013, the Trust was reporting a deficit of £16.6m, approximately £16m adverse to the planned deficit of £0.6m.

66 The Trust's 2013/14 Annual Operation Plan (AOP), approved by the Trust Board in March 2013, included reference to an underlying deficit, estimated at £12m.

67 Reflecting this position and the level of delivery risk in 2013/14, the Trust Board's approval of the AOP in March 2013 was accompanied with a request to Commissioners and the NHS TDA for 'strategic transitional financial support' of £15m. This was intended to cover:

- restoration of the annual plan contingency to the intended level of £10m;
- provision against further slippage in recovery of the financial 'run rate';
- funding towards the commencement of strategic site reconfiguration projects – designed to address the long term financial sustainability of the Trust's clinical services.

68 2013/14 year to date results are disappointing. Continued overheating of emergency demand has led to adverse operational and financial consequences. Delivery of key emergency access targets has been compromised, despite investment of substantial non-recurrent financial resources.

69 There has been considerable expert external support, changes in clinical management and operational processes and solid Commissioner support, but A&E performance remains amongst the bottom quartile of NHS acute Trusts. A successful nursing recruitment campaign – with c500 posts vacant - remains a fundamental challenge for the Trust.

70 To cope with the additional emergency demand, and to ensure safe staffing levels, the Trust has resorted to substantial use of bank and agency staffing.

Nursing ratios were reviewed and enhanced in the light of the Francis report recommendations and existing local acuity reviews. Partly as a result, the Trust has averaged over £3.5 million per month in non-contractual payments, primarily for locum doctors, nurses and other healthcare workers, despite an increase in permanent headcount.

71 Cost controls have been stretched and, in part, found wanting. Revised procedures have been implemented over the last two months, in particular over the use of agency nursing staff, and the Trust is seeing improvements in the underlying run rate. Enhanced controls of non-pay have been announced more recently – with a theme being stronger compliance with existing processes. However, these controls have to be balanced against the need to maintain safe staffing levels.

72 In the light of the deteriorating in-year performance, all business areas (formerly Clinical Divisions, now Clinical Management Groups) have produced detailed recovery plans, which are subject to review by the Executive Team.

73 There is a range of possible financial outcomes for the 2013/14 year, depending on both the Trust's cost control performance and the availability of funding from both local Commissioners and, potentially, national sources.

74 At the time of writing this report, the Trust's Executive Team is in the process of conducting a 2013/14 year-end reforecast. The results are soon to be published in the form of a report to be submitted to the public Trust Board meeting on 28 November 2013.

75 Mr A Seddon, Director of Finance and Business Services, is attending the meeting on 27 November 2013 and will then update the Committee on the latest position.

CONCLUSION

76 The Committee is invited to receive and comment upon this report. Representatives of the Trust will be in attendance at the Committee meeting (as identified in paragraph 1.2 above) to respond to the comments and questions of Members.

OFFICER TO CONTACT

Stephen Ward
Director of Corporate and Legal Affairs, UHL

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Agenda Item 12

East Midlands Ambulance Service NHS
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 27 NOVEMBER 2013

REPORT OF EAST MIDLANDS AMBULANCE SERVICE

UPDATE ON IMPLEMENTATION OF THE ESTATES STRATEGY

Purpose of report

1. The purpose of this report is to provide an update to the Health Overview and Scrutiny Committee (HOSC) on the East Midlands Ambulance Service (EMAS) plans for ambulance stations within Leicestershire County.

2. Senior officials from EMAS will attend the November HOSC meeting to provide an update on the latest progress against the EMAS Estates Project plan and to answer questions.

Background

3. EMAS provides emergency 999 and urgent care services for the counties of Derbyshire, Leicestershire, Rutland, Lincolnshire (including North and North East Lincolnshire), Northamptonshire and Nottinghamshire. EMAS also provides Patient Transport Services in north and north east Lincolnshire and parts of Nottinghamshire.

4. The EMAS service area covers a territory of 6,425 square miles and incorporates a population of over 4.8 million. Each year 770,000 emergency 999 calls are responded to by 2,700 plus staff.

5. The EMAS service area is a diverse region and is characterised by year on year call growth reflecting population expansion in the East Midlands.

6. The EMAS operating model has three business units comprising the East, North and South divisions with the latter incorporating the counties of Leicestershire and Northamptonshire. These divisions operate out of 64 ambulance stations, both freehold and leasehold.

7. Most of the EMAS estate is aging with over £13m of backlog maintenance required. Many sites will worsen over time and it will be costly to bring them up to standard. They are not sustainable in terms of both efficiency and their impact on the environment.

Being the Best

8. Following a full scale review of how the service is managed EMAS established a change programme, Being the Best, with the aim of improving performance and raising levels of patient care. This programme incorporates changes to the ambulance service estate, a new service model and re-organising the management

structure. The programme includes improvements in how EMAS organises its fleet, logistics and vehicle “make ready” services.

9. Following the initial Being the Best proposals, the EMAS Board gave approval for an extensive formal public consultation which ran from September to December 2012. The consultation activities were wide ranging, with over 37,000 consultation documents circulated. This consultation ran in parallel with an internal staff consultation.

10. In relation to the EMAS estate, the Being the Best proposals featured the introduction of a hub and spoke model. A hub is a reporting base for staff including a variety of staff welfare facilities. Some of the hubs will also include fleet and make ready services to ensure vehicles are prepared and available to the support operations. This model will also incorporate Community Ambulance Stations (CASs) which are facilitated deployment points located strategically around the Trust’s locality in optimum locations to meet demand. Being greater in number compared to current Ambulance Stations, the CAS give frontline crews more access to facilities and more places to respond to calls from. They will have domestic services provided as required but are basically rest stops for crews. Being the Best aims to have the majority of all Community Ambulance Stations in shared premises. Discussions to this end have been planned with both Police and Fire Services in Leicestershire (and across the whole East Midlands).

11. The location of Hubs and CASs were chosen after considerable performance analysis of data, both historic and current. Using a specialist software tool the optimum locations have been selected to maximise ambulance response times.

12. Following the consultation and the estate optimisation exercises EMAS have chosen a mix of 28 hubs and 108 CASs as the preferred model. The Trust Board in March 2013 approved this model. The September Trust Board also authorised the twinning of certain existing stations once an appropriate CAS is in place. Twinning is the closure of redundant stations and will release capital to help fund the building or refurbishment of future hubs.

13. The hub and spoke model will enable the required changes in how support services are delivered and will help EMAS improve service performance, patient care, staff welfare and value for money.

14. Crews who move to another station base will notice a difference in terms of where they pick up their vehicle at the start of their shift and where they return it to at the end of their shift. The rest of their shift will remain as it is now. EMAS will continue to use strategic stand-by points, including at the new 108 Community Ambulance Stations (CAS), so we are in the right location to respond to the next 999 call.

15. CAS will bring improvement to colleague welfare in that crews can wait for the next call in more comfort in shared premises (with other NHS or emergency service organisations) or modular facilities, allowing crews to use toilet or drink making facilities and when scheduled, have their meal break.

Impact on the South Division

16. In the EMAS South Division (Leicestershire and Northamptonshire) there are planned hubs at:
    - Leicester;
    - Kettering;
    - Northampton;
    - Hinckley;
    - Loughborough;
    - Ashby;
    - Melton Mowbray;
    - Market Harborough;
    - Brackley.

17. The additional CAS sites in Leicestershire are:
    - Leicester West;
    - Loughborough;
    - Radcliffe;
    - Wigston;
    - Shepshed;
    - Coalville;
    - Leicester Centre;
    - Blaby;
    - Goodwood;
    - Melton;
    - Lutterworth;
    - Leicester North East;
    - Kirby;
    - Mountsorrel.

18. The table below provides information relating to the 'twinning' of ambulance stations in Leicestershire.

Twinned Station vacated	Identified CAS location	Current Status	Estimated date of operational CAS
Coalville to Loughborough	Loughborough	The plan is to "twin" Coalville with Loughborough station. EMAS are at an advanced stage of negotiation with a partner organisation to share a site at Coalville. However, this twinning is unlikely to occur until March 2014.	March 2014
Melton To Oakham	Oakham	This is an unusual site in that the local council hold the lease on our Melton site and have served notice that EMAS must vacate the premises by 31/12/13 as the site is to be redeveloped. A CAS site has been identified in commercial	December 2013

		premises in Melton and the staff will move to Oakham station at the end of the year. Eventually a new hub will be built in Melton but there is no date for this as yet.	
Lutterworth	N/A	Lutterworth is an existing station. There is no plan to vacate this site as yet so it will effectively become the CAS. Eventually Hinckley station will be refurbished as the hub	No change.
Narborough to Goodwood	TBC	The plan is to twin Narborough station with Goodwood. However this will depend on the exact location of the local hub so there is no date as yet for the Narborough twinning.	TBC
Ashby	N/A	Ashby will be the location for a new build hub so there is no need for a local CAS.	N/A
Divisional HQ	N/A	It is likely that this site will eventually be closed but there is no firm date as yet. The current proposal is that Gorse Hill will be the hub in this location.	N/A

Resource Implications

19. EMAS' improvement programme is not about reducing costs. It has always been about improving the response to emergency 999 calls, providing better care and improving the working lives of staff. The improvement programme has been designed using best practice examples of change already made in other ambulance services. For example, the West Midlands Ambulance Service has seen a positive impact on response times, particularly in rural areas, following the introduction of a hub and spoke model included Make Ready Teams.

Conclusions

20. In summary, the current EMAS estate is too big for purpose; stations remain empty for the majority of the day because paramedics are so busy out on the road; many premises are in the wrong location due to changes in road networks and communities growing

21. Moving to a hub-and spoke-model means that ambulances will be deployed more efficiently and will be nearer to patients. This is not all about the bricks-and-mortar of ambulance stations – many of which were built on assumptions more than 50-years ago.

22. Clinicians will be supported by Make Ready teams based at each hub and ambulance station to clean and stock emergency vehicles, thereby allowing the

skilled crews to get out on the road faster to respond to calls and ensuring that they have the right equipment with them.

23. The introduction of community ambulance stations will mean crews no longer have to return to large urban-centre ambulance stations during their shift and will be less likely to be drawn away from more rural areas.

Background papers

Report to the Adults, Communities and Health Overview and Scrutiny Committee on 27th November 2013: Being the Best Public Consultation Emerging Themes and Update.
Report to the Adults, Communities and Health Overview and Scrutiny Committee on 11th March 2013: Revised Proposals for the Estates Strategy in Leicestershire.

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Agenda Item 13

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 27 NOVEMBER 2013

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2013

Purpose of report

1. The purpose of this report is to inform the Health Overview and Scrutiny of the publication of the Director of Public Health's Annual Report 2013. The Annual Report is a statement on the health of the population of Leicestershire and is a key resource for shaping commissioning decisions to improve the health status of the population. A copy of the Annual Report is appended to this report.

Policy Framework and Previous Decisions

2. The Health and Wellbeing Board considered and gave its support to the Annual Report at its meeting on 5 September 2013.

3. The Cabinet considered the Annual Report at its meeting on 20 November 2013. Any comments made by the Cabinet will be reported to this meeting.

4. The responsibility for producing an independent report is a statutory requirement of the local authority.

Background

5. The Director of Public Health's (DPH) Annual Report is an independent report on the health of the population of Leicestershire. It is a statutory responsibility of the council to publish it.

6. This year's report focuses on the health of adults, as the third and final report in a series that has worked through the life course, focusing on key health issues at different stages of our lives. It has been developed in collaboration with Leicestershire County Council and Public Health England.

7. Last year's report focussed on the health and wellbeing of older people and this report includes an update on progress against the recommendations made in that report.

8. The report outlines some of the major influences on the health of adults, gives a picture of the current situation in Leicestershire, and makes a number of recommendations for action. The report considers the following areas:

    - Health inequalities;
    - Tobacco control;
    - Healthy weight;
    - Substance misuse;

- Sexual health;
- NHS Health Checks;
- Health at work;
- Mental health; and
- Health protection.

9. Implementation of the recommendations of this report will have a significant positive impact on the health of Leicestershire's population.

Resource Implications

10. None arising from this report. Full implementation of the recommendations of the report will require changes in resource use by a number of organisations that will need to be quantified before implementation.

Timetable for Decisions

11. The Annual Report will be considered by the County Council on 4 December 2013.

Recommendations

12. The Health Overview and Scrutiny Committee is asked to note the Director of Public Health's Annual Report 2013 and support its recommendations

Reason for Recommendation

13. The purpose of a Director of Public Health is to improve the health and wellbeing of the people of Leicestershire and Rutland. This is done by reporting publicly and independently on trends and gaps in the health and wellbeing of the population in and by making recommendations for improvement to a wide range of organisations.

14. One of the roles of the Director of Public Health is to be an independent advocate for the health of their population. The Annual Reports are the main way by which Directors of Public Health make their conclusions known to the public.

Background papers

Director of Public Health Annual Report 2011
Director of Public Health Annual Report 2012
Both accessible from http://www.lsr-online.org/reports/director_of_public_health_annual_reports

Circulation under the Local Issues Alert Procedure

15. None.

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List of Appendices

Director of Public Health Annual Report 2013

Relevant Impact Assessments

Equality and Human Rights Implications

16. Implementation of the report's recommendations would have a positive impact on health inequalities.

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Leicestershire County Council

Director of Public Health Annual Report 2013

Health through the life cycle: Report 3 - Working Age Adults

Foreword

Public health aims to stop people from becoming unhealthy. This year, responsibility for public health transferred from the NHS to local government and I believe that, by being part of Leicestershire County Council, my team can make an even bigger difference to the health of the population. Our priorities are to tackle obesity, promote mental health and reduce the harm caused by alcohol and tobacco. We also want to reduce health inequalities, whether they are within particular areas or within particular social groups.

Leicestershire is one of the healthiest places in England, but that overall picture masks certain issues and we're determined to tackle them. Being part of the council enables us to work more closely with key services such as education, social care and transport. Another advantage of being part of a council is that we will enjoy clearer, more direct links to the public.

Councillors sit on the health and wellbeing board, which helps to bring together councils and NHS bodies to set priorities and work together effectively. We work closely with the county council's cabinet member for health, to ensure our work fits in with the public's priorities and the decision-makers are aware of the opportunities to link up.

We are also keen to work closely with community forums and other council initiatives that encourage neighbourhoods to identify issues and consider how to solve them.

This is the first Director of Public Health's Annual Report to be published from our new base within the County Council. This report is the third report in a series of three looking at health and wellbeing issues through the life cycle, with a focus on working age adults. It reviews the key health issues that we need to address with our working age population to help people to enjoy longer healthier lives.

I would like to thank all of the people that have contributed to this report, particularly the staff in Public Health and Chief Executives at Leicestershire County Council, and the Health Protection Team and the Screening and Immunisation Team at Public Health England. I would particularly like to thank Janine Dellar whose hard work editing and coordinating this series of reports has been crucial.

Dr Peter Marks
Joint Director of Public Health Leicestershire and Rutland

Contents

List of Tables

List of Figures

Introduction

1. Background

This is the last in a series of three reports from Leicestershire's Director of Public Health reviewing health across the life cycle. This report focuses on the health and wellbeing of working age adults. Earlier reports focussed on the health of children[1] and the health of older people.[2]

This report is supported by the Joint Strategic Needs Assessment (JSNA) for Leicestershire County Council.[3]

Adults form a large segment of the population. Choices and behaviours during adulthood can have profound impacts on people's health for the rest of their lives. Being in positive employment is a critical influence on health and wellbeing, and the public health challenges in adulthood include preventing chronic illness later in life.[4]

Taking into account the nature and quality of employment, there is strong evidence to suggest that work is generally good for physical and mental health and wellbeing.[5] For healthy people of working age, many disabled people, most people with common health problems and social security beneficiaries, work can be therapeutic and can reverse the adverse health effects of unemployment.[6]

Conversely, improving health is also important for increasing employment.[5] Particular groups of people have traditionally had lower chances of being in work, including disabled people, people with mental health conditions and people with long term conditions.[7]

The costs of working-age ill-health in the UK run to £100 billion per year – this is more than the annual budget for the NHS.[5] Around 172 million working days were lost to sickness absence in 2007, at a cost of over £13 billion to the economy.[5] Of these, the leading causes were mental health problems and musculoskeletal conditions.

In England, one in ten people provide unpaid care to relatives or friends, and 1.2 million people care for over 50 hours a week. In the 2001 census, carers providing high levels of care were twice as likely to report poor health compared with those who did not have any caring responsibilities.[8]

Towards the end of a person's working life diseases such as cancer start to form a significant proportion of all deaths. Early detection and diagnosis of cancer has a significant impact on health outcomes, and can be achieved through earlier symptomatic diagnosis or screening.

Note:

This report is a report on the health of Leicestershire's population. However, because public health transferred into the local authority in April 2013 the data is not always available for Leicestershire. Where the data is not available just for Leicestershire the report references data for Leicestershire County and Rutland (LCR).

2. Key health policy drivers

The transfer of responsibility for public health to local authorities, and the establishment of Leicestershire's Health and Wellbeing Board, is a real opportunity to work together across the wider partnerships for maximum health benefit. The key to this will be collaboration between the county council, district councils, Clinical Commissioning Groups (CCGs), the Leicester Shire Economic Partnership and other partners to facilitate development of local strategies for improving adult health and wellbeing.

Appendix A provides a summary of the new public health system.

Key documents:

"Our Health and Wellbeing Today",[4] emphasises the fact that health and wellbeing needs evolve throughout our lives and the need to consider the influences on health at all stages of the life cycle. This report emphasises the links between work and good health and the need to promote healthy lives throughout the life course to reduce premature mortality and support better health in later years.

"Healthy Lives, Healthy People",[9] the public health White Paper published in November 2010, proposes ways in which populations need to be supported to "live well", by increasing access to healthy choices. It also discusses the positive benefits to health of working and the government's plans to increase people's access to work. In addition to supporting people to find work, the paper discusses the need for employers to support their staff to be healthier.

"The Marmot Review, *Fair Society, Healthy Lives* – A Strategic Review of Health Inequalities in England post 2010"[10] drew attention to the evidence that social inequalities result in many lives being cut short and many people not living life to the full and enjoying opportunities open to them. The review reinforced the message that disadvantage starts before birth and accumulates throughout life. It suggests that the greatest return comes from addressing inequalities in childhood, however it is possible to work to address inequalities at any stage of the life course for a significant return in terms of population health outcomes.

"Working for a healthier tomorrow"[5], a review by Dame Carol Black (2008), looks at the health of working age adults, the role of health on people's ability to work, and the role of working in influencing health. The review set out three main objectives:

- Prevention of illness and promotion of health and wellbeing;
- Early intervention for those who develop a health condition; and
- An improvement in the health of those out of work – so that everybody with the potential to work has the support they need to do so.

3. Public health priorities in Leicestershire

Leicestershire County Council published its first Joint Health and Wellbeing Strategy (JHWS) for 2013-16 in December 2012.[11] This strategy was based on the evidence and analysis of the JSNA refresh completed in 2012.

The main aim of the strategy is to "add quality and years to life" by improving health throughout people's lives, reducing health inequalities and focusing on the needs of the local population.

The core of the strategy is to focus collective efforts on improving outcomes related to four priorities:

- Getting it right from childhood;
- Managing the shift to early intervention and prevention;
- Supporting the ageing population; and
- Improving mental health and wellbeing.

Central to the strategy is the need to work together across the wider partnership to deliver the best outcomes for the people of Leicestershire. In order to ensure that this happens, these four priorities are supported by a cross cutting theme:

- Tackling the wider determinants of health by influencing other boards.

This report focusses on working age adults and how the partnership can work together to manage that shift to early intervention and prevention. The key public health priorities that are considered in this report are:

- Health inequalities;
- Tobacco control;
- Healthy weight;
- Substance misuse[a];
- Sexual health;
- NHS Health Checks;
- Health at work; and
- Mental health.

[a] In this report, the term substance misuse includes the misuse of alcohol, illicit drugs and Novel Psychoactive Substances (NPS), sometimes known as 'legal highs'.

Summary of Recommendations

Inequalities

- The Health and Wellbeing Board must work with the wider Leicestershire Together Partnership to influence:
  - » Welfare support: working with the voluntary sector and other relevant partner agencies to ensure those most vulnerable to welfare reforms are supported and not disproportionately affected by welfare reforms. Also ensuring a smooth transition between benefits and returning to work;
  - » Access to training and education: agencies should work together to make it easier for people from disadvantaged backgrounds and the long term unemployed to become trained, educated and gain relevant experiences in order to obtain and keep jobs;
  - » Healthy workplaces: working in partnership with local businesses and enterprise to embed health protection and health promotion incentives into their workforce, creating a healthier and more productive workplace;
  - » Getting people back to work: working in partnership with local enterprise and voluntary sector organisations to improve access to paid and unpaid work for the long term unemployed. This should include long term support programmes for people once they have returned to work;
  - » Addressing equality and diversity: improve the quality and security of employment across Leicestershire and Rutland including ensuring public and private sector employers adhere to equality guidance and legislation.

Assets

- To adopt an assets based approach across Leicestershire and use this to influence commissioning of public health interventions;
- To increase the measurement and evaluation of assets within the JSNA for Leicestershire to underpin future commissioning decisions and influence the future development of the JHWS.

Tobacco control

- To help young people to resist taking up smoking and to motivate and support all smokers to quit, including through stop smoking services;
- To lobby the government to maintain support in implementing the *"Under the Counter"* legislation (Tobacco Advertising and Promotion (Display) (England) Regulations 2010) for tobacco products in small shops to begin in April 2015;
- To lobby the government to revisit their decision on standardised packaging of tobacco products.
- To encourage all smokers to Step Right Out and not smoke inside their home or car for the benefit of their loved ones;
- To address the problems of underage and illegal tobacco, through gathering high quality intelligence for trading standards, and increasing awareness and enforcement of the issue.

Healthy weight

- To ensure that future policies and planning decisions reduce the obesogenic environment[b] through county and district council partnership working, and to make physical activity and healthy eating an easier choice.
- To continue to develop population scale weight management services, delivered in creative and innovative ways for example, through partnership with commercial sector providers.
- To continue to build opportunities for routine daily physical activity into people's lives, through programmes for the whole population, as well as through targeted interventions to support the most inactive individuals to increase their levels of activity.

Substance misuse including alcohol

- To integrate into children and family services work to prevent substance misuse and intervene early when issues arise;
- To build the capacity of frontline staff in key organisations to deliver information and brief advice, particularly relating to alcohol;
- To share more of the treatment of substance misuse between specialist community services and GP practices;
- To focus on supporting recovery and reintegration, with an emphasis on understanding the resources that exist within communities to help to deliver this;
- To ensure the safe transfer of substance misuse treatment in criminal justice settings to the new provider of services.

Sexual health

- To ensure prevention of sexual ill-health is prioritised and developed in line with the latest evidence;
- To ensure information about sexual health and services is widely available;
- To continue to improve access to sexual health services for Leicestershire residents, and develop robust care pathways across sexual health and other relevant services such as alcohol and drug misuse services.

[b] The term 'obesogenic environment' refers to 'an environment that promotes gaining weight and one that is not conducive to weight loss' within the home or workplace.

NHS Health Checks

- To commission a NHS Health Check programme that includes the new dementia awareness and alcohol auditing components;
- To ensure that all GP practices support the NHS Health Check programme;
- To develop a media campaign to increase uptake for NHS Health Checks;
- To consider other models and services for delivery of NHS Health Checks for hard to reach groups (such as pharmacies or health centres).

Health and work

- To deliver on the recommendations of Dame Carol Black's review, Working for a Healthier Tomorrow, through collaborative working with partners;
- To improve promotion of health and wellbeing and prevention of illness in the workplace;
- To improve provision of early interventions for those at work who develop a health condition;
- To address the additional health needs of those who are out of work;
- To help people who have not yet found work, or have become workless, to enter or return to work, with a special emphasis on 16 to 18 year olds who are classed as Not in Education, Employment or Training (NEET).

Mental health

- To work with partners to prioritise mental health and to deliver on the emerging mental health strategy;
- To strengthen mental health and wellbeing for all, thereby recognising that good mental health is more than the absence of mental illness;
- To address wider determinants of health and to enable individuals to fulfil their potential through partnership working across departments and agencies;
- To protect investment in prevention and tackle the wider determinants of health as the return on investment per pound spent in this area is good.

Health Protection

- To establish and operate a Health Protection Board that seeks to provide assurance to the local authorities in Leicestershire, Leicester and Rutland (LLR) about the adequacy of prevention, surveillance, planning and response with regard to health protection issues.
- To continue to assure that NHS England maintain high coverage and uptake of national immunisation and screening programmes

The health of working age adults

1. Demography

The 2011 Census reported:

- The population of Leicestershire in 2011 was 650,489; [12]
- In 2011, 400,968 people were aged 18-64 (62%) and 417,671 were aged 16-64 (64%);[12]
- The population of Leicestershire aged 18-64 is projected to increase 413,300 by 2021, an increase of 12,200 people or 3.1%.[13]

The **ethnicity** of the population of Leicestershire is included in the 2011 Census. This demonstrates that:[12]

- 595,000 people are from White ethnic backgrounds (91%);
- 41,000 people are from Asian ethnic backgrounds (6%);
- 4,000 people are from Black ethnic backgrounds (<1%);
- 9,000 people are from Mixed ethnic backgrounds (1%).

The **general health** status and the limiting **long term condition or disability** for people aged 16-64 reported in the 2011 Census indicates:[12]

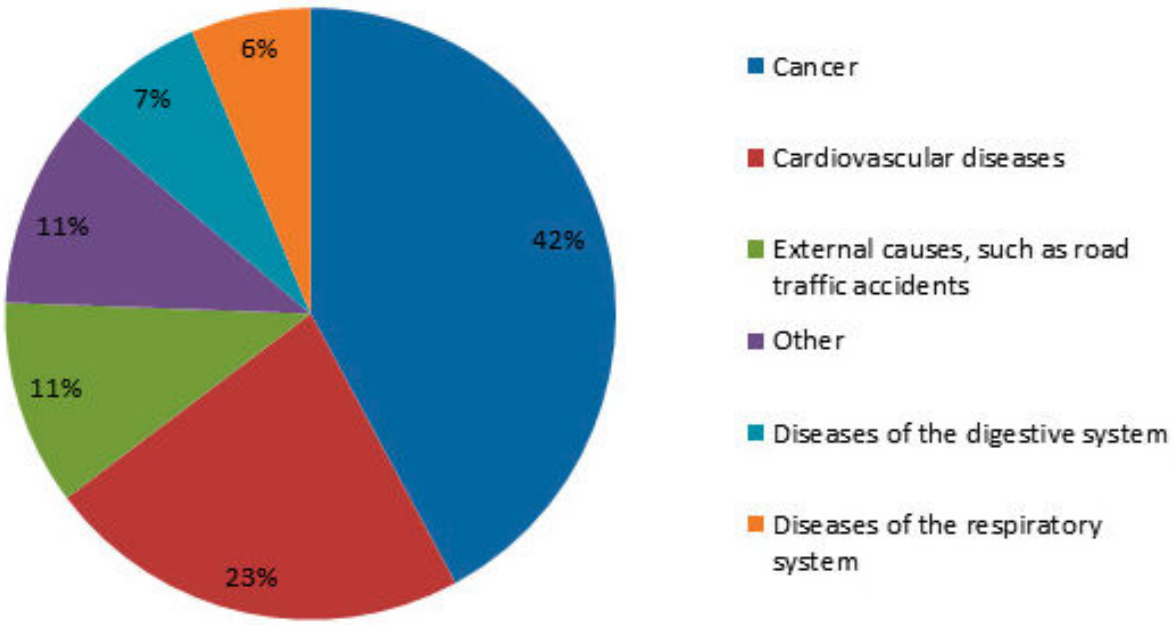
- 354,000 people reported that they were in good or very good health (87%);
- 40,000 people reported that they were in fair health (10%);
- 12,500 people reported that they were in bad or very bad health (3%);
- 26,500 people have their activities limited a little by their condition or disability (7%);
- 16,300 people have their activities limited a lot by their condition or disability (4%).

2. Mortality in working age adults

In 2011 in Leicestershire, there were:

- 5,456 deaths for all residents;[14]
- 817 of these deaths were in people aged 16-64 years (15% of all deaths);[14]
- The main causes of death for this age group are (Figure 1):
  - Cancer (42%);
  - Cardiovascular diseases (23%);
  - External causes, such as road traffic accidents (11%);
  - Diseases of the digestive system (7%);
  - Respiratory diseases (6%).

Figure 1: Mortality by Cause in Leicestershire, 2011, Age 16-64



Source: ONS Public Health Mortality File

2.1. Longer Lives

Longer Lives is a major initiative of Public Health England that was launched on 11 June 2013 and can be accessed from: http://longerlives.phe.org.uk/.

The first phase of Longer Lives is a new website to illustrate how premature mortality (deaths under 75 years) varies between English local authorities, and to provide links to examples of how some of the most important causes can be reduced at population or individual levels.

Longer Lives displays premature mortality from all causes, cancer, heart disease and stroke, lung disease and liver disease.

The key findings for Leicestershire for premature mortality between 2009 and 2011, when compared with the national average are:

- Between 2009 and 2011 there were 5,355 premature deaths in Leicestershire;
- The premature mortality rate for Leicestershire is 236 per 100,000 population, this is significantly lower (or better than) the England rate;
- Leicestershire ranks 30 out of 150 local authorities in England (1=best and 150=worst).

The results for Leicestershire compared with the national average demonstrate that at a national level Leicestershire is performing very well. However, Leicestershire is an affluent area and it is important that we compare Leicestershire population with areas that have a similar socio-economic profile to assess how the area is comparing with similar areas ("peer groups").

Local authorities have also been allocated to ten groups according to their index of multiple deprivation, allowing their premature mortality rates to be compared with 14 other areas that have similar socio-economic status. The results for Leicestershire show:

- For all cause premature mortality, Leicestershire ranks 13th out of 15;
- The all cause premature mortality rate for Leicestershire is significantly higher (or worse) than the average for the peer group of local authorities.
- Leicestershire is the 13th most deprived of the 15 local authorities in this group, a key driver for premature mortality rates.

The headline results for the four most common causes of premature mortality in Leicestershire are summarised in Table 1.

Table 1: Longer Lives Summary

Cause	Number of premature deaths	Premature Death Rate per 100,000 population	Rank and Significance compared with England	Rank and Significance compared with peer group
All causes	5,355	235.6	30 ●✓	13●✗
Cancer	2,301	99.4	32 ●✓	12●↓
Heart disease and stroke	1,210	52.3	32 ●✓	13●✗
Lung disease	452	18.7	39 ●✓	13●↓(out of 14)
Liver disease	261	12.0	38 ●✓	10●✗(out of 14)

Source: Longer Lives http://longerlives.phe.org.uk/

Key:
- ●✓ Significantly better than average
- ●↑ Better than average
- ●↓ Worse than average
- ●✗ Significantly worse than average

The JHWS includes priority actions that will contribute to improvements in premature mortality across Leicestershire.

Cancer: Following a report to the Health and Wellbeing Board on cancer mortality it was agreed that the biggest issue in Leicestershire was early diagnosis of symptomatic cancer and a specific priority was added to the JHWS to reflect this. Screening performance in Leicestershire is good and it appears that treatment outcomes are also good once cancers are diagnosed. The key lifestyle factors that contribute to cancers: smoking, obesity and alcohol are also all included as priority actions in the JHWS.

Heart disease and stroke: The major preventative aspects of heart disease and stroke (smoking, obesity and alcohol) are identified as priorities in the JHWS, as are improvements in stroke care and management of long term conditions (including heart disease itself and diseases that increase the risk of heart disease and stroke such as diabetes and high blood pressure). The NHS Health Checks programme, now a mandatory service for local authorities, is aimed at early identification of disease and risk factors and the county council is working closely with the two CCGs in Leicestershire to increase the uptake of these checks.

Lung disease: Smoking is the biggest risk factor for lung disease and is a priority in the JHWS. The CCGs have both been very active in working with GP practices to improve the detection and management of chronic lung diseases.

Liver disease: Of the four disease areas in this report, liver disease has the lowest number of deaths and Leicestershire is below the England average. However, the number of deaths in Leicestershire appear to be increasing at a greater rate than in England as a whole, despite hospital admissions for alcohol related illnesses starting to decrease locally. The biggest risk factor for liver disease is alcohol, which is already identified as a priority area in the JHWS and has been the subject of intensive work through the community budgets programme.

Longer Lives identifies the key lifestyle interventions that contribute to these premature mortality rates. These are demonstrated in Table 2.

Table 2: Longer Lives common causes of premature mortality

	Cancer	Heart	Lung disease	Liver disease
Smoking	✓	✓	✓	
Alcohol	✓			✓
Obesity, poor diet and physical activity	✓	✓		✓
High blood pressure		✓		
Air pollution			✓	
Hepatitis				✓

Source: Longer Lives http://longerlives.phe.org.uk/

3. Hospital care for working age adults

Table 3 details the spend on hospital services commissioned by LCR Primary Care Trust (PCT) on behalf of Leicestershire residents in 2012/13. The total spend for Leicestershire residents in 2012/13 was £311 million, £141 million was spent on adults aged 16-64 years, 45% of total spend.[15]

Table 3: Hospital activity for Leicestershire residents in 2012/13 - all ages and 16-64 year olds

	All Ages		16-64 Year Olds	
	Activity	Cost	Activity	Cost
Hospital inpatient stays	164,00	£232 million	84,000	£99 million
Hospital outpatient attendances	660,00	£67 million	359,000	£36 million
Accident and emergency department attendances	127,000	£13 million	71,000	£7 million
Total hospital activity spend		£311 million		£142 Million

Numbers may not sum due to rounding
Source: HERA Health, Evidence, Reporting, Analysis, NHS Leicester, Leicestershire and Rutland

4. Long term conditions in adulthood

The prevalence of many common long term conditions increases with age. However, towards the end of their working lives adults are starting to be affected by the illnesses that will reduce their independence as they become older. The disease burden for a number of long term conditions for people aged 16-64 years is indicated in Table 4

Diseases have only been included where we can separate the working age adults from the overall data.

Table 4: Estimated number of people aged 16-64 years in Leicestershire with common long term conditions in 2010

	Number of people
Coronary Heart Disease	9,355
Coronary Obstructive Pulmonary Disease	7,536
Hypertension	86,355
Stroke	3,699

Source: APHO Estimates of disease prevalence

5. Estimates of care needs in adulthood

Projecting Adult Needs and Service Information (PANSI) can be found at www.pansi.org.uk. It gives access to projections of the numbers, characteristics and care needs of people aged 18-64 in England at national, regional and council level. This data demonstrates that by 2021, the working age population of Leicestershire is predicted to increase by 3.1%. Most of the predicted increases in adult social care needs from PANSI are in line with, or less than, this population increase. However, some characteristics and care needs are predicted to increase at a greater rate:[16]

- Profound hearing impairment predicted to increase by 7.4% by 2020;
- Moderate or serious physical disabilities by 4.1% by 2020;
- Moderate or serious physical care disability 4.3% by 2020;
- Young onset dementia 6.1% increase by 2020.

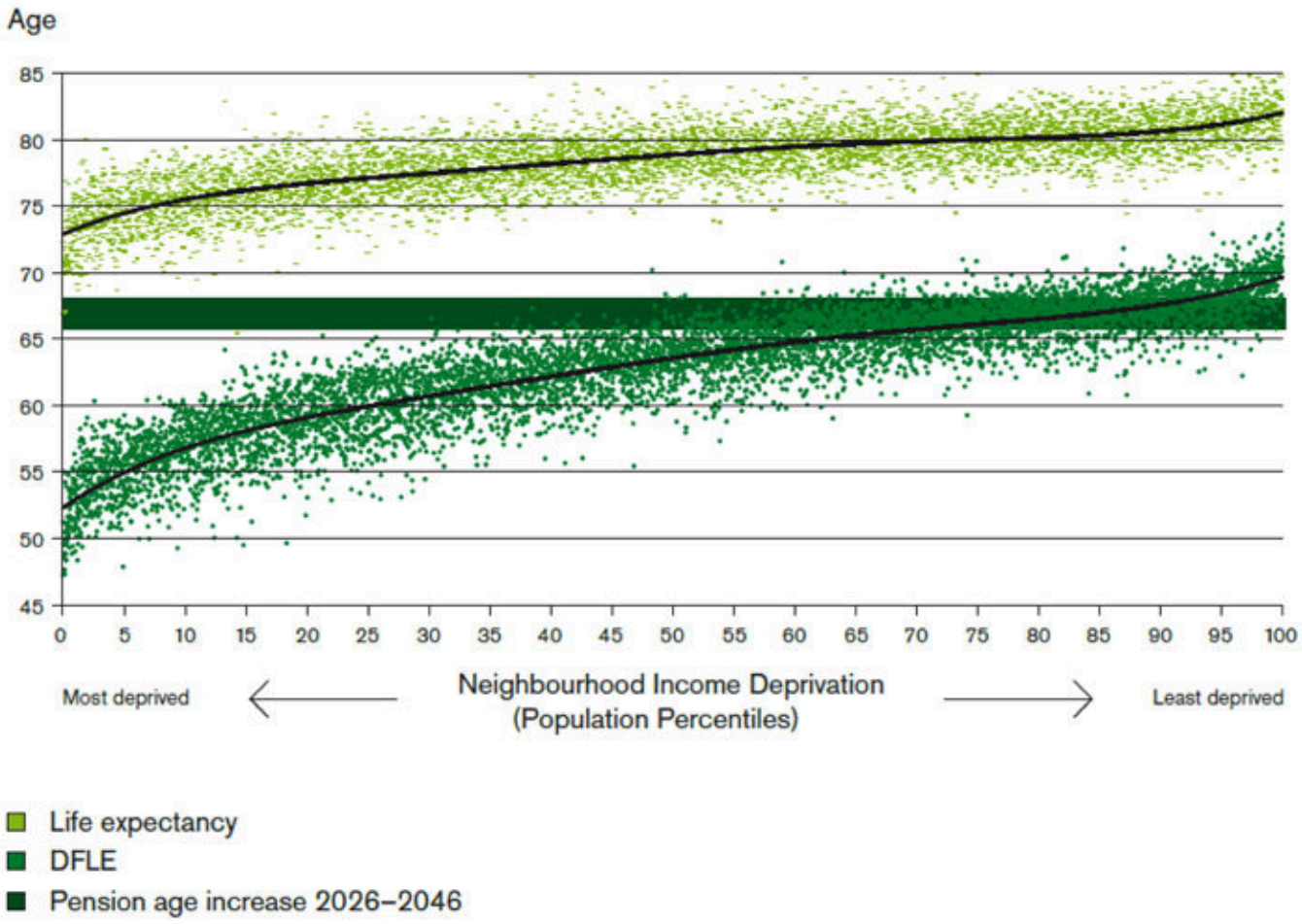
More detailed information is presented in the data appendix.

6. Health inequalities

Everyone in Leicestershire has a right to a long and healthy life. On the whole, the working age population of Leicestershire is affluent and healthy. Yet some working age people still unjustly experience worse health or die younger than others, because of who they are and where in Leicestershire they live.

Health inequalities are unjust differences in the health of our population. They stem from social inequalities, caused by disparities in the distribution of money, power and resources across our population. Many inequalities affecting the working age population will have been determined before birth. Inequalities become more established in each stage of life; growing in breadth and the extent of disadvantage caused. The accumulating effects of inequalities include worsening states of health and wellbeing for those disadvantaged at each life stage. This ultimately results in differences between those disadvantaged and the rest of society widening over a lifetime. Health inequalities allowed to perpetuate in our working aged population will result in poorer health outcomes in the future old age population.

Figure 2: Life expectancy and disability-free life expectancy at birth, persons by neighbourhood income level, England, 1999-2003

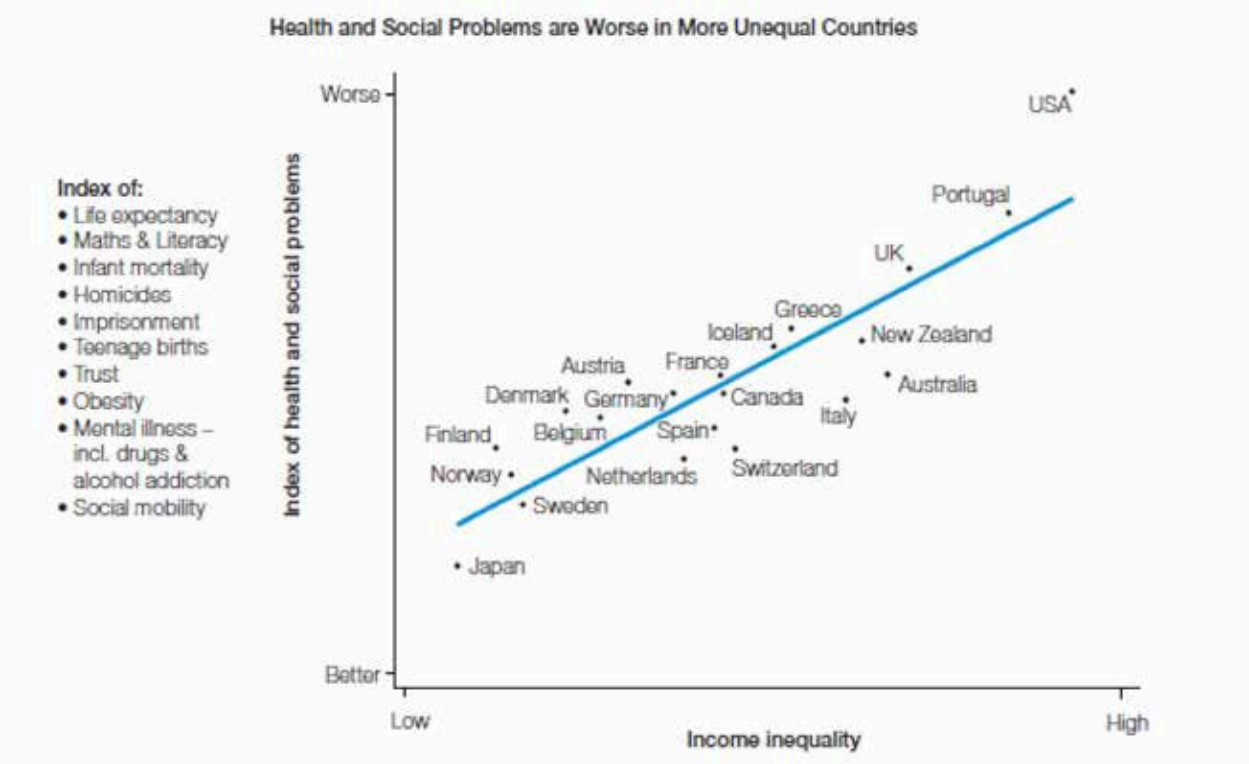


Source: Fair Society, Healthy Lives: Strategic review of health inequalities in England post 2010.

Health inequalities between deprived and non-deprived areas have grown in the last decade. Measures of inequalities consistently show that the higher a person's socio-economic status the better their health and the longer their life expectancy (Figure 2).

The Spirit Level by Wilkinson and Picket (2009) provides evidence that there is a relationship between income inequality and social problems in relatively wealthy societies where there are greater levels of income inequality.[17] The graph in Figure 3 illustrates that the UK has a high level of income inequality that is driving a range of health and social problems.

Figure 3: Correlation between income inequality and an index of health and social problems



Source: Wilson and Pickett

As well as geographical and economic inequality, inequalities exist within specific population groups as a result of other forms of social exclusion. These groups can suffer worse health and experience difficulty in gaining access to health care. Examples include black and minority ethnic people (BME); disabled people; people with mental health problems; lesbian, gay, bisexual people and transgender people (LGBT); prisoners and offenders; gypsies and travellers; the homeless; asylum seekers and refugees. Additional risk factors for these groups can include poor support systems, isolation, substance misuse and unemployment. Examples of these health inequalities are included in Table 5.

Rural deprivation and rural health inequalities are important issues for Leicestershire. On average people in rural communities enjoy better health and wellbeing than their urban counterparts. However, many rural areas are characterised by high levels of inequality within them with real difficulties faced in many rural communities. Poverty, lack of services, poor public transport and traumatic social or economic changes at a local level are examples.

To reduce health inequalities our actions should focus on reducing the social gradient in health. Universal proportionalism advocates allocating resources in proportion to need, i.e. across the social gradient the intensity of investment should increase with need. Key drivers for health inequalities in working aged people are:

- Employment;
- Worklessness; and
- Income and the impact of welfare reforms.

Table 5: Examples of inequalities affecting different population groups

Group	Example of Health Outcome	Comment
BME Groups	Men born in South Asia are 50% more likely to have a heart attack or angina than men in the general population. Bangladeshis have the highest rates, followed by Pakistanis, then Indians and other South Asians.[18]	Classical risk factors like smoking, blood pressure, obesity and cholesterol fail to account for all these ethnic variations. Other factors include the long term impact of migration, racism and discrimination, poor delivery and take-up of health care, differences in culture and lifestyles, and biological susceptibility.
Learning disabilities	People with learning disabilities have poorer health than their non-disabled peers, differences in health status that are, to an extent, avoidable.[19]	All cause mortality rates among people with moderate to severe learning disabilities are three times higher than in the general population, with mortality being particularly high for young adults, women and people with Down's syndrome
Offenders	Adults and young people in contact with the criminal justice system are more likely to be socially excluded and experience high levels of health inequalities.	They are more likely to suffer from mental health problems and learning disabilities, and to have problems with drugs or alcohol. The link between offending, reoffending and wider factors, including health, is widely recognised.[3]
LGBT	Studies show that lesbian, gay and bisexual people show higher levels of anxiety, depression and suicidal feelings than heterosexuals.	Poor levels of mental health among gay and bisexual people have often been linked to experiences of homophobic discrimination and bullying.[20]
Gypsies and travellers	Gypsies and Travellers die earlier than the rest of the population and experience worse health, yet are less likely to receive effective, continuous healthcare.[21]	Gypsy and Traveller communities experience wide ranging in-equalities and the lack of suitable accommodation underpins many of the in-equalities that these people experience and a lifespan of experiencing racism and discrimination in education, access to health care, employment and other social and public contexts
Homeless	The average age of death of a homeless person is 47 (43 for homeless women), compared to 77 for the general population.[22]	Drug and alcohol abuse are particularly common causes of death among the homeless population, accounting for just over a third of all deaths. Homeless people are more than nine times more likely to commit suicide than the general population.
Asylum Seekers and Refugees.	Asylum seekers are one of the most vulnerable groups within our society, with often complex health and social care needs.[23]	Within this group are individuals more vulnerable still, including pregnant women, unaccompanied children and people with significant mental ill-health.[24]

Source: Leicestershire County Council Public Health Department

6.1. Employment

Working, whether paid or not, provides a wealth of health and social benefits to individuals, families and community. Employment can provide material gains (if paid), but also delivers social value, personal growth and fulfilment of aspirations leading to better mental and physical health.

Amongst our working population there are inequalities reflected and reinforced by differences in types of employment and in the level of control and reward in particular job roles. The type of employment has a gradient with socio-economic class and inequalities. Poorer people are more likely to be routine manual workers: characteristically these are more physically demanding jobs, with little legal, financial or emotional security or rewards.

Children who grow up in low-income or workless households are more likely to suffer worse health themselves, be workless and live in poverty when they become adults. The prevalence of psychiatric disorders among children in families whose parents have never worked is almost double that among children with parents in low-skilled jobs.[5]

6.2. Worklessness

People who are unemployed generally experience worse health compared to those in employment. The negative health effects of worklessness result from:

- Living in relative or absolute poverty;
- Being more likely to develop risky behaviours; and
- Increased risk of physical and mental health problems.

Education and retraining are key opportunities to get people back into the workplace and to sustain their position there. A clear gap exists between educational and training attainments at all ages across the social gradient. This increases the likelihood of school leavers from lower socio-economic groups not having the skills or education to secure or retain a job.

Case study - Leicestershire and Rutland Probation Health Trainer Service

A team of health trainers and health champions recruited from the 'offender' community to support offenders to improve their social and health status by:

1. Helping offenders register with GPs and dentists;
2. Working on a one-to-one basis with offenders developing a personal health plan and facilitating health improvement particularly around diet, fitness, smoking cessation and alcohol use and also addressing wider determinants of health including employment, income, benefits and housing;
3. Delivering group work sessions on general health and wellbeing issues to offenders attending the criminal justice drug treatment programmes (CJDT) or participating in offending behaviour group work programmes;
4. Participating in multiagency health promotion campaigns.

6.3. Welfare

The current economic climate and increasing cost of living present challenges for our population with more people affected by poverty both in and out of work. Half of working-age adults (and children) in poverty live in a working household.[25] The number of people in low-income, working households has grown almost every year, from 5 million in 2000/01 to 6.1 million in 2009/10, an increase of more than one-fifth in ten years.[25] Adults who do not work and those with low incomes are most likely to need support from our welfare state.

The current welfare reforms seek to more appropriately allocate welfare budgets to eligible claimants. This includes the introduction of a Universal Credits System, to replace the means tested benefit with affect from 2013.[26] Welfare cuts are likely to hit low-income households more than once, through changes to both income-related and housing benefits.[25] Welfare support is no longer concentrated in the social rented sector – the numbers of private renters in poverty are now as high, having doubled in the last decade.[25] Changes to disability benefit could also mean low-income disabled people being hit even harder.

During this period of economic down-turn and welfare reform it is important to ensure that the most vulnerable in our society are not disproportionately affected.

Recommendations

- The Health and Wellbeing Board must work with the wider Leicestershire Together Partnership to influence:
  - Welfare support: working with the voluntary sector and other relevant partner agencies to ensure those most vulnerable to welfare reforms are supported and not disproportionately affected by welfare reforms. Also ensuring a smooth transition between benefits and returning to work;
  - Access to training and education: agencies should work together to make it easier for people from disadvantaged backgrounds and the long term unemployed to become trained, educated and gain relevant experiences in order to obtain and keep jobs;
  - Healthy workplaces: working in partnership with local businesses and enterprise to embed health protection and health promotion incentives into their workforce, creating a healthier and more productive workplace;
  - Getting people back to work: working in partnership with local enterprise and voluntary sector organisations to improve access to paid and unpaid work for the long term unemployed. This should include long term support programmes for people once they have returned to work;
  - Addressing equality and diversity: improve the quality and security of employment across Leicestershire and Rutland including ensuring public and private sector employers adhere to equality guidance and legislation.

7. Leicestershire's working age assets

'A glass half-full', published by the Improvement and Development Agency on behalf of the Local Government Association in 2010[27] introduced the assets principles:

- Assets are any resource, skill or knowledge which enhances the ability of individuals, families and neighbourhoods to sustain their health and wellbeing. Assets can include such things as supportive family and friendship networks, community cohesion, environmental resources and employment security;[28]
- Assets approaches make visible, value and utilise the skills, knowledge, connections and potential in a community. They promote capacity, connectedness, reciprocity and social capital. The aim is to redress the balance between meeting needs and nurturing the strengths and resources of people and communities;
- Asset working seeks ways to value the assets, nurture and connect them for the benefit of individuals, families and neighbourhoods. Instead of starting with the problems, it starts with what is working, what makes us feel well and what people care about. The more familiar deficit approach starts with needs and deficiencies and designs services to fix the problem and fill the gaps.

Current evidence proposes that the important factors for life satisfaction are being happy at work and participating in social relationships. High income and occupational status are less important than have been previously believed.[29]

The importance of the quality of relationships both at work and at home needs to be recognised in the work environment. Work teams where there are good relationships between workmates are more productive and have lower levels of sickness absence. The same is true of working arrangements where allowance is made for giving support and care to family members.[29]

Mental wellbeing is a core asset, protecting and enhancing the lives of individuals and communities.[29]

There is a tendency to think about illness rather than wellness and to consider the things that make people ill, rather than the things that promote wellbeing. For example, when we are asked whether we are 'well', we tend to answer in terms of 'not being ill'. These immediate responses are reflected in two general tendencies in public health policy:[29]

- A tendency for the promotion of health and wellbeing to be framed largely in terms of the prevention of illness and injury rather than the promotion of wellness;
- A tendency for health policy interventions to be focused initially on encouraging people to withdraw from risk rather than on removing risk from the environment.

An assets approach to health and development encourages the full participation of local communities in the health development process. Assets can be viewed at individual, community and institutional levels, for example:

- Individual level might focus on building self-esteem and resilience for young people;
- Community level could look at social networks and community cohesion;
- The institutional level might examine how local authority transport planners could promote active transport and prioritise walking and cycling above other forms of transport.

Where to start?

Jane Foot outlines the ten key 'asks' to creating a whole system approach.[29]

1. Understand health as a positive state and its determinants as those factors that protect and promote good health and wellbeing, rather than describing health as disease and the risk factors for ill-health.
2. Describe the population's health through the assessment of assets, that is, looking at the presence of good health and wellbeing and indicators on what creates and influences good health, rather than needs assessment that only includes information on disease, death and risk factors for illness.
3. Map community assets. This would include the valuable resources and places, the strengths, knowledge and skills of people, understanding what the community define as assets using asset mapping approaches.
4. Sustain and build assets within communities through continuous community development and approaches that empower citizens and communities. Enable communities to connect and utilise their assets.
5. Assess individual strengths when working to improve personal outcomes (through services and personalisation) and provide interventions that release personal assets and build on people's strengths and the assets in their local community.
6. Community budgets and commissioning that builds on existing community assets and provides professional input to enhance assets and provide additional support where needed.
7. Adopt organisational development and service improvement approaches that appreciate and build on what's already working well.
8. Map health assets within and across organisations to understand the internal and external resources, skills and strengths.
9. Share and exchange assets between public, private and community bodies to improve efficient use of resources and give power to communities.
10. Research and monitoring that incorporates the evaluation and development of asset based outcomes, indicators and measures.

In 2012, the Leicestershire JSNA refresh included a chapter on assets in Leicestershire.[3] This report found that overall there are strong feelings of neighbourliness in Leicestershire. However, generally people in the 'rural' areas feel more positive about their neighbourhood, while those people from 'deprived areas' feel less positive about it.

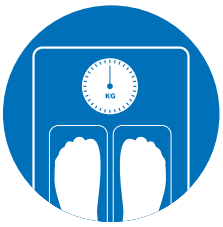
Recommendations

- To adopt an assets based approach across Leicestershire and use this to influence commissioning of public health interventions;
- To increase the measurement and evaluation of assets within the JSNA for Leicestershire to underpin future commissioning decisions and influence the future development of the JHWS.

Improving the health of working age adults

Stopping smoking

The single most important thing you can do to improve your health.
You are up to 4 times more likely to quit if you get help from the NHS Stop Smoking Service. To find your local service call 0800 085 2917 or text LIFE to 80800.



Maintain a healthy weight

Maintain, or aim for, a healthy weight (BMI 20-25). Eating a healthy diet - Eating at least 5 portions of fruit & vegetables each day and cutting down on fat, salt and added sugar is the most effective way to loose weight if you are overweight or obese.

Being physically active

Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more, one way to approach this is to do 30 minutes on at least 5 days a week. Exercise is important for everyone in staying healthy and maintaining a healthy weight.

If you drink, keep within sensible limits

If you drink alcohol, have no more than 2-3 units a day (women) or 3-4 units a day (men), with at least 2 alcohol free days per week. You can use this website to calculate your units and keep track of your drinking: http://www.nhs.uk/Livewell/alcohol/Pages/Alcoholtracker.aspx

Look after your sexual health

This means enjoying the sexual activity you want, without causing yourself or anyone else any suffering, or physical or mental harm. Sexual health is not just about avoiding unwanted pregnancy or sexually transmitted infections - but using a condom will help with both.

Mental Health

Manage your stress levels. Talking things through, relaxation and physical activity can help. Have a good work/life balance. Developing interests outside of work can help reduce stress and improve productivity.

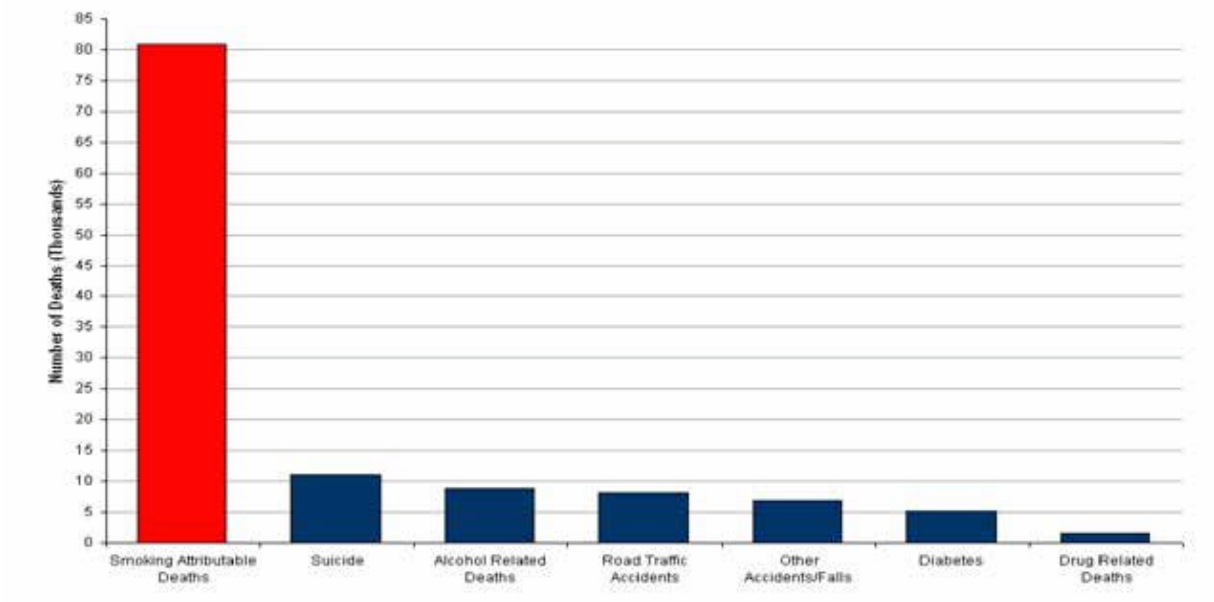
Source: The Picture of Ill-health in Warwickshire, Joint Director of Public Health Annual Report 2012

1. Tobacco control

Tobacco use is the single biggest cause of preventable deaths in England, killing over 80,000 people per year. This is greater than the combined total of preventable deaths caused by obesity, alcohol, traffic accidents, illegal drugs and HIV infections (Figure 4).

Smoking accounts for about half of the difference in life expectancy between those in the lowest and highest income groups.[10] One in every two regular smokers is killed by tobacco, and half of them will die before the age of 70, losing an average 10 years of life.[30]

Figure 4: Comparison of preventable deaths in England



Source: A Smokefree Future, Department of Health, 2010

Key facts

- Approximately 17% of adults in Leicestershire smoke. This equates to approximately 88,300 people;[31]
- Between 2008 and 2010 there were an average of 884 smoking related deaths per year in Leicestershire;[32]
- In 2010/11 there were 5,227 hospital admissions attributable to smoking in Leicestershire.[33]

1.1. What we are doing locally

Tobacco-free Leicestershire and Rutland (TLR) is the local tobacco control alliance and has the agreed mission to reduce the prevalence, power and influence of tobacco through advocacy, education and community organisation. 2013/14 will see continued expansion of the tobacco free young person programme and an increased focus on illegal tobacco enforcement,[c] advocacy and programme evaluation. TLR has been in existence since 2011 and has been **CLeaR** (**C**hallenge, **L**eadership and **R**esults) accredited (a mark of excellence) since May 2012.

[c] Illegal tobacco includes smuggled, bootlegged and counterfeit tobacco. Smuggled is generally legitimate tobacco that has evaded tax. Bootlegged is tobacco brought into UK illegally and without paying tax. Counterfeit is fake tobacco that is often made abroad and sold cheaply and tax free in the UK

TLR programmes include:

- Step Right Out (designed to encourage people not to smoke in their home or car);
- STOP! (the Stop Smoking service);
- The Tobacco Free Young Person programme (which uses a whole school approach to reduce tobacco use by young people);
- Underage sales test purchasing programme and illegal tobacco sales, both with trading standards.

Leicestershire continues to increase access to stop smoking services, both for the general population and with targeted activities in populations at greatest risk of smoking. This has been enabled by increasing the number of public sector employees trained in brief advice and interventions.

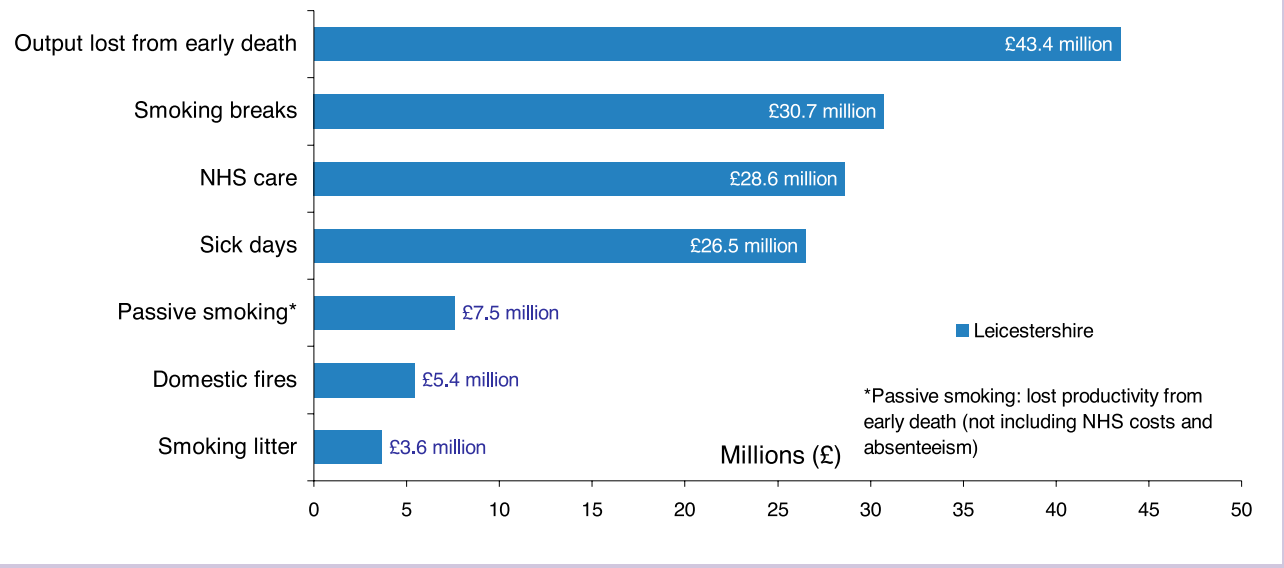
Adults smoking can have a significant impact on the health of their children. Children have the right to be protected from exposure to second hand smoke, which has a significant impact on the health of a child before birth, in childhood, and into adulthood.

Parents must recognise that passive smoking causes ill-health in children and that they have a responsibility not to harm their children. There is a high level of awareness about the impact of second hand smoke (SHS): 92% of adults are aware that exposure to SHS increases a child's risk of chest infections and 86% are aware of an increased risk of asthma.[34] People are less likely to be aware of the risks associated with cot deaths (58%) and ear infections (35%).[34]

The case for investment

- The annual costs of tobacco are estimated at: £146 million in Leicestershire:

Figure 5: The costs of tobacco in Leicestershire



Source: ASH Ready Reckoner

Case study - Stopping smoking during pregnancy

Sarah is 24 years old, lives in Loughborough and is a smoker. She has an 18 month old child and is pregnant with her second child. Her partner also smokes. Her father has mental health problems.

Sarah did not stop smoking in her previous pregnancy as her first attempt led to an increase in symptoms of anxiety and depression. As a result she was really worried about attempting to stop in this pregnancy in case it triggered similar symptoms. However, with encouragement from her midwife she has been using the stop smoking service for four months. The service created a personalised programme for her, which included discussing how nicotine withdrawal can lead to anxiety and what can be done to manage this, such as regular use of nicotine replacement medication (NRT).

Sarah is now managing well as a non-smoker and is no longer using NRT. She says "One of the things that really made a difference was that the stop smoking service would continue to support me when life got really tough. I lapsed when my dad attempted suicide, but my advisor was always there to listen to me and get me back on track. She would text me when I needed advice between appointments. I also got regular tests to show how my carbon monoxide levels were decreasing."

Recommendations

- To help young people to resist taking up smoking and to motivate and support all smokers to quit, including through stop smoking services;
- To lobby the government to maintain support in implementing the *"Under the Counter"* legislation (Tobacco Advertising and Promotion (Display) (England) Regulations 2010) for tobacco products in small shops to begin in April 2015;
- To lobby the government to revisit their decision on standardised packaging of tobacco products.
- To encourage all smokers to Step Right Out and not smoke inside their home or car for the benefit of their loved ones;
- To address the problems of underage and illegal tobacco, through gathering high quality intelligence for trading standards, and increasing awareness and enforcement of the issue.

2. Healthy weight

Healthy weight, particularly tackling obesity, remains a high priority both locally and nationally, with recognition that this is a highly complex issue requiring a comprehensive, co-ordinated and sustained response. Two out of three adults are overweight or obese.[35] Around seven in ten people consume more salt than is recommended[36] (leading to an estimated one in three people with high blood pressure[37]); only three in ten adults eat the recommended five portions of fruit and vegetables a day;[36] only three or four in ten adults say they do the recommended levels of physical activity every week.[35]

Leicestershire County Council is committed to reducing the levels of obesity in the adult working population and is developing a long term strategy to address what is likely to be a major challenge for public health for the next 50 years.

Key facts

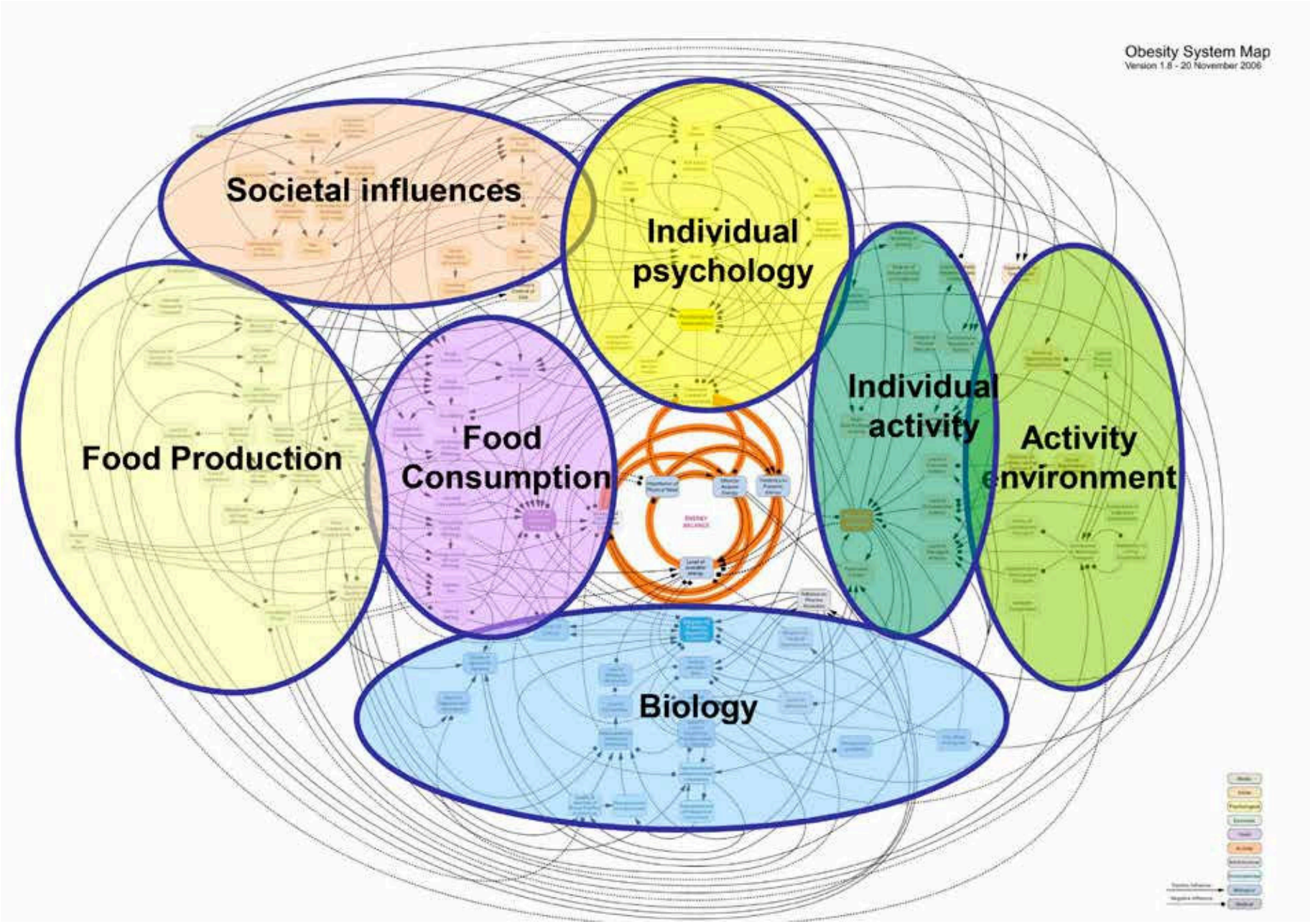
- Approximately 24.3% of adults in Leicestershire are obese. This equates to approximately 125,500 people (18+);[32]
- Approximately 30.3% of adults in Leicestershire report following a healthy diet. This equates to approximately 156,500 people (18+); [32]
- Approximately 11% of adults in Leicestershire report following the recommended levels of physical activity. This equates to approximately 58,600 people (16+).[32]

Addressing obesity requires a multi-faceted approach to change behaviours around physical activity, weight management, and food and nutrition. Underlying all of these is the requirement to fundamentally change the obesogenic environment in which we now live. The term 'obesogenic environment' refers to 'an environment that promotes gaining weight and one that is not conducive to weight loss' within the home or workplace. An example would be a sedentary desk-based job at a location that is only accessible by car. The physical environment we inhabit and how Government applies laws and regulations can strongly influence an individual's opportunities, as well as barriers, to eat healthily and be physically active.

The Foresight Report (2007) has mapped out the factors and systems that influence obesity.[38] This is illustrated in Figure 6. The diagram illustrates the complexity of the issues that are facing the population with respect to obesity and the challenges that commissioners face in working with the population and individuals to address obesity.

Figure 6: Foresight Obesity Systems map (FOSM)

Source: Tackling Obesity; Future Choices, Foresight Report. http://www.bis.gov.uk/foresight/our-work/projects/published-projects/tackling-obesities



The case for investment

In 2007, the cost to the economy (including the NHS) of people being overweight or obese was an estimated £16 billion. This was predicted to rise to £50 billion a year by 2050, if the conditions were left unchecked.[38] The costs can be further broken down to:

- The direct cost of obesity to the NHS was £2.3 billion and the direct cost of being overweight, but not obese, was estimated as £1.9 billion;[38]
- The cost to society as a whole, including those resulting from unemployment, early retirement and associated welfare benefits were estimated at an additional £11.6 billion;[38]
- The direct costs to the NHS were forecast to increase to £7.1 billion (obesity) and £2.6 billion (overweight) respectively by 2050 and the overall cost to society was predicted to rise to £50 billion (including NHS costs, but not social care by local authorities).[38]

Generally, the upfront costs of most preventive interventions will not be repaid for a number of years. However, these costs will usually be small in comparison with the future health benefits and the long term cost savings from reductions in type 2 diabetes, cardiovascular disease and some cancers.

2.1. What we are doing locally

Tackling obesity is a complex challenge requiring long term and sustained interventions aimed at an individual, family, community and cultural level, over a number of decades. Locally and nationally we are still at the very early stages of developing effective interventions and are still learning which interventions will have the greatest impact. Leicestershire is developing a comprehensive and diverse obesity strategy across three key areas:

- Maintaining a healthy weight;
- Physical activity; and
- Food and nutrition (including food sustainability).

Maintaining a healthy weight

The past two years in Leicestershire have seen the development of a new healthy weight pathway for adults (and a maternal healthy weight pathway for pregnant women), in order to map existing services and identify gaps in provision and inform future commissioning requirements. Following this process, 2013/14 will see significant new investment in number of new and existing programmes:

- Further investment in Lifestyle, Eating and Activity Programme (LEAP), a targeted, community based weight management programme for individuals with a body mass index (BMI) greater than 28 with co morbidities or greater than 30, delivered by the Leicestershire Nutrition and Dietetic Service (LNDS);
- New investment in universal weight management services, delivered in partnership with commercial weight management organisations;
- New investment in maternal weight management services including a new telephone based support service for pregnant women and a pilot physical activity and lifestyle programme for pregnant women.

Physical activity

Increasing levels of physical activity remains a central component of Leicestershire's obesity strategy, both as a mechanism to maintain a healthy weight, and importantly as an effective preventative measure to reduce the incidence and worsening of many chronic health conditions.

In Leicestershire, there is an extensive range of physical activity opportunities for adults delivered by Leicestershire and Rutland Sport and district councils. 'Active Together' is a county wide programme across Leicestershire that aims to encourage everyone to become "more active more often". There are physical activity development officers based at the district councils who are there to help the population become more active. Each district offers a programme of regular and easily accessible activities from walking, yoga, hooping and dance, to Pilates, jogging, Buggyfit and bowls, with the aim of offering suitable activities for people of all abilities and ages.

In addition to generally raising activity levels across the whole population, Leicestershire also has a number of specific strategic aims. The intention is to increasingly target the most inactive and deprived populations, and to shift the focus away from elite sport to the building of routine physical activity into daily life. A number of initiatives currently support this aim including a new and innovative Sport England funded pilot project in Greenhill ward, Coalville. 'Sport 4 health buddies' will use innovative one-to-one mentoring and support to encourage inactive individuals and their families to try walking, cycling and other sports, possibly for the very first time.

The more established and long running community based programmes, 'Exercise on referral' and 'Heartsmart' support patients with existing medical conditions to rehabilitate or recover using one-to-one tailored programmes delivered by trained physical activity instructors. Both programmes will continue to expand in every district in 2013/14, offering an increasing range of activities suitable for those individual requiring a gentle and monitored introduction to routine physical activity.

Food and nutrition

A number of new programmes will address the underlying knowledge and skills required in order for individuals to eat healthily in a sustainable and affordable manner. The Adult Learning Skills 'basic cookery skills' programme develops ability and knowledge around healthy food, nutrition and preparation, whilst new programmes will support and encourage communities to grow their own fruit and vegetables.

Public health has a central role in reducing the long term impact of the increasingly obesogenic environment facing the population, as it is a key determinant for poor health and unhealthy lifestyles. The department will be building upon programmes started in 2012/13 with a substantial new programme of work in 2013/14 focussing upon food sustainability and food culture, particularly aimed at introducing a positive food culture for children, but also the wider community. Over the next decade, flagship programmes such as "Food For Life", "Master Gardeners", and "Back to Basics" Cookery programmes will positively alter Leicestershire people's relationship with how they purchase, grow, prepare and cook food.

Case study - Smarter Travel for Business

Leicestershire County Council's local sustainable travel plan "Smarter Travel for Business" is an excellent example of a strategic approach to reducing the obesogenic environment, through adaptation and improvement of the local transport infrastructure in order to make walking and cycling more attractive and appealing travel choices. The programme is focussed on the economically deprived areas of Loughborough and Coalville. More generally, since 2000, there has been significant investment in the walking and cycling network across Leicestershire, whilst the county's "Choose How You Move" campaign encourages people to get fit, save money, have fun and help the environment by leaving their cars at home.

Recommendations

- To ensure that future policies and planning decisions reduce the obesogenic environment through county and district council partnership working, and to make physical activity and healthy eating an easier choice.
- To continue to develop population scale weight management services, delivered in creative and innovative ways for example, through partnership with commercial sector providers.
- To continue to build opportunities for routine daily physical activity into people's lives, through programmes for the whole population, as well as through targeted interventions to support the most inactive individuals to increase their levels of activity.

3. Substance misuse

Key facts

- In 2011/12 there were 11,485 alcohol related hospital admission for Leicestershire residents;[39]
- In 2012/13 1,153 adults in Leicestershire were reported in effective drug treatment (structured tier 3 services[d]);[40]
- In 2012/13 1,378 adults in Leicestershire were reported in effective alcohol treatment (structured tier 3 services);[40]
- The Health Profile for Leicestershire 2012 estimates 23% of adults are drinking at an increasing or high risk level. This equates to approximately 123,000 adults (16+) in Leicestershire, based on the 2011 census[32]

Alcohol plays an important role in society and in the economy. However, where it is misused alcohol is a major contributor to a range of harms at considerable cost. These harms include:

- Harms to the health of individuals;
- Crime, anti-social behaviour, domestic violence, and drink-driving and its impact on victims;
- Loss of productivity and profitability; and
- Social harms, including problems within families.

Nearly seven million adults are drinking at levels that increase the risk of harming their health. The same number report 'binge' drinking which, in addition, increases their risk of accidents and anti-social behaviour.[41]

3.1. What we are doing locally

Substance misuse has a far reaching impact on individuals, families, communities and the agencies who provide services to them. To reflect this Leicestershire and Rutland Substance Misuse Partnership Board has agreed a shared partnership vision:

'Working together to make Leicestershire and Rutland a healthier and safer place by reducing the harm and inequalities caused by substance misuse, in a sustainable and cost effective way.'

The board will work with the Police and Crime Commissioner and community safety partners to tackle the direct and indirect impact of substance misuse on anti-social behaviour and crime.

Key actions for tackling substance misuse are set out in the action plan for the JHWS. These include:

- Integrating into children and family services, work to prevent substance misuse and intervene early when issues arise;
- Training programmes to support frontline staff in key organisations to deliver information and brief advice, particularly relating to alcohol;
- Sharing more of the treatment of substance misuse between specialist community services and GP practices;
- Understanding trends in substance misuse and the resources that exist within communities to support recovery and reintegration;

[d] Structured tier 3 services are community services provided by community drug teams, drug dependency units and day treatment

- Ensuring the safe transfer of substance misuse treatment in criminal justice settings to the new provider of services.

Over recent years there has been an increase in the number of people with drug related problems entering into treatment and support. In response to local need there has been an increase in access and treatment for people with alcohol related problems. By making this a priority, there has been a shift from 80% drug users and 20% alcohol users in treatment in 2009/10, to 57% drug users and 43% alcohol users in treatment in 2012/13. The number of both drug using clients and alcohol using clients has continued to rise every quarter.

One of the key priorities relating to alcohol use/misuse is to reduce the proportion of the population that are admitted to hospital for alcohol related causes. Locally, there are a number of initiatives that are aimed at reducing the health harms of alcohol. These include the delivery of brief alcohol interventions in primary care settings, increasing the capacity of the alcohol specialist nurses within hospital emergency departments (ED) and reducing the number of alcohol frequent attenders at ED.

Whilst continuing the success in increasing the number of people entering treatment, the national and local focus is to ensure people recover from their dependency and successfully move out of treatment. There has been an increase in local access to mutual aid support groups (for example, Alcoholics Anonymous, Narcotics Anonymous, Self-Management and Recovery Training (SMART Recovery)). However, to ensure people are able to reintegrate into their communities and gain employment they will require the support of other partners.

Each year the public health team reviews local needs and services and identifies any changes or gaps in service provision. Whilst the number of opiate users entering treatment is levelling out, there are different trends emerging both locally and nationally. Over the past few years Novel Psychoactive Substances (NPS), sometimes known as 'legal highs' have made local, national and international news, and been linked to hospital admissions and 42 deaths across the UK.[42] Local services have identified a rise in individuals seeking help for recreational substance misuse and in particular the use of mephedrone. For this reason a specific campaign has been launched across Leicestershire and Rutland.

The case for investment

Data submitted by the Department of Health to the Health Select Committee[43] estimate the costs of alcohol misuse as follows:

- NHS in England – £3.5 billion per year (at 2009/10 costs);
- Crime in England – £11 billion per year (at 2010/11 costs);
- Lost productivity in the UK – £7.3 billion per year (at 2009/10 costs);
- The submission estimates that the total cost to society is about £21 billion per year (this does not include the impact of alcohol misuse on families and communities).

The National Institute for Health and Clinical Excellence (NICE) (2009) estimated that screening for, and giving people brief advice on, alcohol problems could save social services and the NHS more than £124.3 million in care and treatment services over a 30 year period.[44]

Case study - Novel Psychosocial Substances (NPS) are also known as 'Legal Highs'

The "Legal Highs Lethal Lows" campaign aims to highlight the risks and harm these substances can cause through initiatives aimed at young people and young adults. Through the campaign individuals or concerned friends and family members can access advice, help and support.

Phase 1 of the campaign was launched in December 2012, and included a new website www.legalhighslethallows.co.uk, a digital phone application, a poster campaign in taxis across Leicestershire, a poster campaign displayed in licenced premises over Christmas and New Year, and advertisements on local radio. The campaign attracted local and national press interest with a number of articles being published and partnership support for the campaign. Over 3,000 individuals visited the campaign website and there were a number of direct requests for help on legal high use directed to our services.

Phase 2 of the campaign has now been launched to run over the summer months and is aimed at those attending local festivals, alongside a specific campaign during university freshers' week in September.

Case study – Alcohol related frequent attendees initiative

There are individuals that regularly attend hospital with specific alcohol related issues known as alcohol high impact users (AHIU). This cohort is responsible for a disproportionally high number of bed days within hospitals at a high cost.

The initiative involves alcohol liaison staff at the University Hospitals of Leicester identifying these high impact users and working closely with both the individual and the specialist treatment service (Swanswell) to ensure referral into specialist support. Once engaged within the specialist service users receive intensive support. Initial results show a significant reduction in representation and readmission to hospital of the high impact users, and, due to the higher visibility of the alcohol liaison nurses a general increase in referrals to specialist treatment services of those alcohol users who do not meet the high impact user threshold.

Overall this is supporting our aim of reducing alcohol related hospital admissions

Recommendations

- To integrate into children and family services work to prevent substance misuse and intervene early when issues arise;
- To build the capacity of frontline staff in key organisations to deliver information and brief advice, particularly relating to alcohol;
- To share more of the treatment of substance misuse between specialist community services and GP practices;
- To focus on supporting recovery and reintegration, with an emphasis on understanding the resources that exist within communities to help to deliver this;
- To ensure the safe transfer of substance misuse treatment in criminal justice settings to the new provider of services.

4. Sexual Health

Key facts

- In 2012, there were 1,166 abortions in women aged 20 years and over in Leicestershire.[45]
- The rate of abortions (all ages) in Leicestershire is lower than the England average (12.7 per 1,000 compared with 16.6).[46]
- Significantly fewer NHS abortions (67% West Leicestershire, 69% East Leicestershire and Rutland) than the England average (78%) are performed at 10 weeks or less gestation.[47]
- LCR has a significantly higher rate of GP prescribed Long-Acting Reversible Contraception (LARC) 62% than the England average of 52% (2011/12).[48]
- In 2011, there were 18,883 attendances to Genitourinary Medicine (GUM) for sexually transmitted infections (STI) by Leicestershire residents (all ages).[49]
- For diagnoses of acute STIs, each district of Leicestershire has a rate significantly lower than the England average.[48]
- Human immunodeficiency virus (HIV) prevalence across LCR is low with 243 people accessing HIV related care in 2011.[50]

Good sexual health is important to individuals and society. Needs vary according to age, sexuality and ethnicity, and groups such as gay and bi-sexual men and some black and ethnic minorities are more at risk of poor sexual health. The National Framework for Sexual Health Improvement[51] identifies the ambition that all adults have access to high quality services and information. It is important that people understand contraceptive options and where they are available, can provide guidance to their children about relationships and sex and have information and support to access testing and early diagnosis to prevent transmission of HIV and STIs.

As people get older their need for sexual health services may reduce but they should not be overlooked. STI rates in the over 50s are low but increasing. Physical health problems that affect sexual health become an increasing issue.

Achieving good sexual health is complex and there are variations in need for services and interventions for different individuals and groups. Prevention work is important to help people to make healthy decisions and to reduce prejudice, stigma and discrimination that can be linked to sexual ill-health.

The case for investment

- For every £1 spent on contraception, £11 is saved in other healthcare costs;[52]
- LARC is more cost effective than condoms and the pill for reducing the risk of pregnancy;[53]
- Early testing and diagnosis of HIV reduces treatment costs by over £10,000 per person per year;[54]
- Early access to HIV treatment significantly reduces the risk of onward transmission;[55]
- Some STIs, if left undiagnosed, cause long term and life threatening complications, including cancers.

4.1. What we are doing locally

In April 2013 the responsibility for commissioning sexual health services moved to a number of different agencies. Local authorities became responsible for a range of sexual health interventions and services as part of their public health responsibilities.

Leicestershire County Council, Rutland County Council and Leicester City Council are jointly commissioning a new integrated sexual health service to improve access and allow more people to visit one clinic for all of their sexual health needs. This service will commence on 1 January 2014. The service will operate across Leicestershire, Leicester and Rutland offering a more consistent, high quality and cost effective service. There will be increased opening times and additional sites in Leicestershire for young people's clinics so offering more choice for patients. This new service will bring together current local sexual health provision into one service. Across Leicester, Leicestershire and Rutland this includes the Chlamydia Screening Service, GUM and contraceptive services (family planning).

The integrated service model will enable:

- Clear and unified management arrangements;
- Innovative service models and approaches;
- Clear clinical leadership and accountability across the entire provision;
- A seamless experience for the user; and
- A value for money service.

Work continues to provide women with accessible contraceptive choices by improving provision of LARC from general practice and specialist sexual health services.

A variety of prevention programmes and services are delivered to hard to reach populations at higher risk of poor sexual health including men who have sex with men, people in African communities, commercial sex workers and people affected by HIV.

Case study - Leicester, Leicestershire and Rutland sexual health services website

The introduction of the website www.leicestersexualhealth.nhs.uk which assists people of all ages to get information about sexual health issues and local services, including an online booking facility for GUM services. The website will continue to be developed and updated. It will include information for practitioners as well as for the public in the future.

Recommendations

- To ensure prevention of sexual ill-health is prioritised and developed in line with the latest evidence;
- To ensure information about sexual health and services is widely available;
- To continue to improve access to sexual health services for Leicestershire residents, and develop robust care pathways across sexual health and other relevant services such as alcohol and drug misuse services.

5. NHS Health Checks

Key facts

- In 2013/14 there are an estimated 205,000 residents of Leicestershire eligible for a health check;[56]
- In 2012/13, approximately 56,500 people were invited and approximately half of these people actually had an NHS Health Check (LCR);[57]

The NHS Health Check programme is a national prevention programme to identify people at risk of developing vascular diseases: heart disease, stroke, diabetes, kidney disease or vascular dementia. Vascular diseases are the leading cause of early deaths in England and everyone is at risk of developing them. However, these diseases can often be prevented, even if you have a family history.

Everyone in England aged between 40 to 74 years will be invited for a NHS Health Check once every five years if they do not have a previous diagnosis of vascular disease. The checks are designed to assess a patient's risk of developing vascular disease and give them personalised advice on how to reduce it. It is estimated that one in five people who go for a NHS Health Check will be highlighted as at risk of developing a vascular disease in the near future.

The case for investment

National figures suggest that each year NHS Health Checks:[58]

- Prevents 1,600 heart attacks and saves at least 650 lives;
- Prevents over 4,000 people from developing diabetes;
- Detects at least 20,000 cases of diabetes or kidney disease allowing people to manage their condition and prevent complications.

5.1. What we are doing locally

NHS Health Checks became the mandatory commissioning responsibility of local authorities in April 2013. Locally they are delivered through GP practices. In addition, the national programme has also been developed to include vascular dementia awareness and alcohol consumption risk.

GP practices are required to invite 100% of people who meet the eligibility criteria and are encouraged to achieve an uptake of 65%. There are over 205,000 residents of Leicestershire who are eligible for a NHS Health check once in the next five years. At least a fifth of those eligible (41,000) should be invited for a NHS Health check each year, over the next five years.

In 2012/13, GP practices in LCR exceeded this target figure for numbers of invites sent for NHS Health Checks. 51% of people across Leicestershire County and Rutland invited, attended and received a check. These figures suggest that practices are inviting all eligible patients but are struggling to deliver the NHS Health Check because of attendance issues.

Public Health are working with CCGs to develop and implement a standardised template for NHS Health checks to make data collection simpler, improve data collection quality and consistency. This will be implemented in October 2013.

Case study - Health checks make a big difference

Beck Tomlin and her team of Health Care Assistants at Long Lane Surgery in Coalville, deliver NHS Health Checks to their eligible registered patients. As Beck explains, NHS Health Checks' really can help people live healthier and for longer.

"…a chap came for his NHS Health check in June and we realised he had a very high risk of developing cardiovascular disease if he didn't change his lifestyle (QRISK of 21.6% and total cholesterol 6.1). People who have such a high risk are often put onto statins to reduce their risk of developing CVD.

At his NHS Health check we also identified areas in his diet and lifestyle to improve and agreed to meet up to check his progress.

Three months later, he had lost a stone in weight and significantly reduced his cholesterol. His risk of developing CVD had reduced so much that there was no longer any need to consider statins.

This just shows how much of a difference we can make to peoples physical and mental wellbeing through NHS Health checks."

Recommendations

- To commission a NHS Health Check programme that includes the new dementia awareness and alcohol auditing components;
- To ensure that all GP practices support the NHS Health Check programme;
- To develop a media campaign to increase uptake for NHS Health Checks;
- To consider other models and services for delivery of NHS Health Checks for hard to reach groups (such as pharmacies or health centres).

6. Health and work

Key facts

In the 2011 Census, for people aged 16-74 years in Leicestershire:[12]

- 342,139 people were economically active[e] (71%), including
  - 70,396 employed part time (15%)
  - 195,058 employed full time (41%)
  - 47,062 self-employed (10%)
  - 14,534 unemployed (3%)
  - 15,089 were full time students (3%)
- 137,323 people were economically inactive[f] (29%), including
  - 73,264 retired (15%)
  - 29,200 students (6%)
  - 15,363 looking after home of family (3%)
  - 12,666 long term sick or disabled (3%)
  - 6,830 other (1%)

There is growing evidence on how closely health, work and wellbeing are connected. The 2006 report, *"Is work good for your health and wellbeing?"*[59] found that work is usually good for health and work is also known to be the best route out of poverty. Work generally:

- Makes people healthier;
- Helps people with a health condition get better; and
- Improves the health of people returning to work from unemployment.

'Workplace health' refers to the combined efforts of the employer and the workers to encourage and support healthy lifestyle habits, making healthy choices the easy choices. Creating a health and wellbeing programme in workplaces can boost productivity and help staff to be happier and healthier at work and at home. Evidence suggests that early interventions to improve health in the workplace are effective.

Workplace sickness absence levels are substantial. From 2010 to 2011, approximately 26.4 million working days were lost due to workplace injury and ill-health. Stress and back pain are the two biggest causes of absence from work; while about 10.8 million working days were lost because of work related stress, depression and anxiety.[60]

[e] A person aged 16 to 74 is described as economically active if, in the week before the census, they were in employment, as an employee or self-employed; not in employment, but were seeking work and ready to start work within two weeks; or not in employment, but waiting to start a job already obtained and available. Full time students who fulfil any of these criteria are classified as economically active.

[f] A person aged 16 to 74 is described as economically inactive if, in the week before the census, they were not in employment but did not meet the criteria to be classified as 'Unemployed'. Students who fulfil any of these criteria are also classified as economically inactive.

Unemployment is also a major determinant of health and wellbeing. About a quarter of the working age population are not in work. Of these, approximately 20% are unemployed but actively seeking work. The remainder have a variety of reasons for being out of the labour market, only one of which is ill-health. According to Labour Force Survey data, 28% of those who are economically inactive are so because of sickness, injury or disability.[5] Those who have been unemployed long term or those who have never worked are two to three times more likely to have poor health than those in work.[59]

Families without a working member are more likely to suffer persistent low income, poverty and poorer health outcomes. Parental ill-health and worklessness increases the risk of childhood stress, behavioural problems and poor educational achievement.[61]

Moving into adulthood is a key milestone for all young people. In England, 10% of 16 to 18 year olds are classed as NEET. Since 2000, the number of young adults (those under the age of 25) who have been on incapacity benefits for five years or more has more than doubled from 21,000 to 54,000.[5] Those who have few or no qualifications or experience of working need particular support to help them back on the path to success.

Dame Carol Black's 2008 review of the health of Britain's working age population, *"Working for a Healthier Tomorrow"*, recognised the beneficial impact that work can have on an individual's state of health and set out a vision based on three principles:[5]

- Prevention of illness and promotion of health and wellbeing;
- Early intervention for those who develop a health condition; and
- An improvement in the health of those out of work.

The report also highlighted the £100 billion cost of ill-health in our workplaces due to 175 million working days lost to sickness absence each year and the 2.6 million people not working and receiving benefits because of a health issue and other factors. The numbers receiving incapacity benefits reveal that the proportion with mental health conditions has increased dramatically over the last decade, from 26% in 1996 to 41% in 2006. Dame Carol Black also noted the impact of specific health issues in people of working age including obesity, smoking, reduced mental wellbeing and physical inactivity. In addition there is a growing body of evidence that workers with health issues such as obesity and depression are less productive.[62]

In response to the report, the National 'Health and Work Advice and Assessment Service' is being launched in Spring 2014. This will ensure that employers receive bespoke, independent advice for cases of sickness absence lasting more than four weeks.

The case for investment

- Sickness absence in Britain costs the economy an estimated £15 billion per year. This includes lost productivity and output, time spent on sickness absence management and healthcare costs;[63]
- Approximately 5 million people of working age receive out of work benefits – about half of this group receive incapacity benefits.[64] Health related benefits cost the state £13 billion a year;[63]
- On average, employers lose 9.1 working days per employee per year in the public sector, 8.8 days in the non-profit sector and 5.7 days in the private sector to sickness absence;[65]
- The NICE business case tool for promoting mental wellbeing at work estimated that mental ill-health costs UK employers almost £1 million per year. For an organisation with 1000 employees, the annual cost of mental ill-health was estimated to be more than £835,000. Identifying problems early, or preventing them in the first place, could result in cost savings of 30%. This is equivalent to cost savings of more than £250,000 per year.

NICE has produced a series of guidelines for early interventions to improve health in the workplace (http://guidance.nice.org.uk/PHG/Published). The guidance demonstrates that improved productivity is associated with effective management of long term sickness absence, and with smoking cessation.

Presenteeism refers to loss in productivity caused by employees working when ill and therefore performing at a lower level because of their illness and is a significant problem facing businesses. Presenteeism accounts for 1.5 times as much working time lost as absenteeism and is more common among higher paid staff. [66] The Sainsbury Centre for Mental Health calculated that presenteeism from mental ill-health alone costs the UK economy £15.1 billion per annum, while absenteeism costs £8.4 billion.[67]

6.1. What we are doing locally

The Leicestershire and Rutland workplace health and wellbeing group was established in 2011 to review the existing workplace programmes across both counties. A mapping exercise identified a wide range of workplace health programmes run by a broad range of organisations including Fit4Work, local authorities, Leicestershire and Rutland Sport, Leicestershire Stop Smoking Service and Loughborough College. At the same time work is underway to develop tools to support the roll-out nationally of the workplace charter in the East Midlands region.[68]

The Leicestershire and Rutland Workplace Health Group has undertaken a programme of work to develop a new "integrated pathway" in order to join up the various local programmes to encourage universal adoption of workplace charter standards and the systematic cross referral of clients between programmes and better coordination of activity across the variety of specialist provider services. As part of this, commissioners in Leicester, Leicestershire and Rutland have extended the remit of the Healthy Workplaces Programme (see case study) to develop as an expert hub for Leicestershire workplace programmes, with the first task of developing a website to promote and collate data on the specialist programmes available locally.

Case study - Healthy workplaces

This is a project delivered by the Leicestershire Fit for Work team aimed at supporting small and medium enterprises (SMEs) in relation to workplace health. 98.5% of businesses based within Leicestershire employ fewer than 100 people and the Chartered Institute of Personnel and Development (CIPD) estimates that SMEs of this size could be losing up to £119,900 per year in staff health issues, increasing the likelihood of serious financial instability for these companies.

The team engages and works with SMEs to improve the health of their employees by identifying the health needs of their workforce and by developing actions to address these needs to ensure maximum health and cost benefit through workplace interventions. These interventions aim to deliver a workforce that is healthier, happier and more productive. This provides protection against financial hardship and promotes a better quality of life by allowing people to make the most of their potential.

Leicestershire Fit For Work service is part funded by Leicestershire County Council and Leicestershire CCGs. It provides expertise and services to improve the health of the working age population and to address health inequalities by supporting people at risk of becoming unemployed due to ill-health. Clients receive one-to-one support from a dedicated case manager in the early stages of sickness absence, with the aim of making access to work and access to the support services readily available. The service works with local GPs and their patients to achieve a quicker return to work, reduce sickness absence, flow onto benefits and by supporting individuals who develop illness to remain in or return to work.

Recommendations

- To deliver on the recommendations of Dame Carol Black's review, Working for a Healthier Tomorrow, through collaborative working with partners;
- To improve promotion of health and wellbeing and prevention of illness in the workplace;
- To improve provision of early interventions for those at work who develop a health condition;
- To address the additional health needs of those who are out of work;
- To help people who have not yet found work, or have become workless, to enter or return to work, with a special emphasis on 16 to 18 year olds who are classed as NEET.

7. Mental Health

Key facts

- In Leicestershire 64,923 people aged 18-64 in 2012 were predicted to have a common mental health disorder.[16,g] Approximately 1% of adults have a serious mental illness such as schizophrenia or bipolar disorder;[69]
- An estimated 30 per cent of all people with a long term condition also have a mental health problem;[70]
- In 2010 there were 39 deaths from suicide and injury undetermined in Leicestershire;[71]
- It is estimated in 2012 there were 9777 adults in Leicestershire between 18-64 years of age with a learning disability.[16] The number of working age adults with learning disabilities is expected to increase due to individuals with learning disabilities living longer.

Mental health is more than the absence of mental illness. The World Health Organisation defines mental health as:

> *"A state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community".*

In this positive sense, mental health is the foundation for individual wellbeing and the effective functioning of a community.

Everyone has mental health needs. Mental health is a significant public health issue with mental illness being the largest single source of burden of disease in the UK.[72] No other health condition matches mental illness for the combined extent of its prevalence, persistence and breadth of impact. One person in four will experience some kind of mental health problem in the course of their lifetime and one person in six per year.[73]

Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour.

Mental health promotion is about building on the existing strengths, assets, skills, resources, networks, social and community supports, and relationships that enhance our sense of competence and belonging. It is about giving people the opportunity to experience control over their lives through activities that lead to increased self-esteem, quality of life, and social connectedness.

Mental health promotion and prevention should be central to the agendas of local authorities and partners. A public health approach to mental health and wellbeing recognises the importance of addressing the wider determinants across the life course to both prevent mental illness and promote wellbeing. People with higher wellbeing have lower rates of illness, recover more quickly, remaining well for longer and generally have better physical and mental health. Protection of mental health and wellbeing includes tackling a range of social determinants. Some preventative actions include:

- Strengthening the social inclusion and participation of working age adults, particularly the unemployed;
- Increasing physical activity levels to the recommended 30 minutes a day of moderate physical activity on five or more days of the week;

[g] Common mental disorders (CMDs) are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety, and include obsessive compulsive disorder.

- Addressing violence in the community with a particular focus on domestic violence and child abuse;
- Ensuring healthy standard of living for all by tackling homelessness and improving the quality of housing available;
- Increase employment opportunities;
- Improve access to resources and services which protect mental wellbeing, for example increasing benefit uptake and increasing opportunities for physical, creative and learning activities.

Both a population and targeted approach are required to effectively promote mental health and wellbeing in children and young people, adults and older people. It also requires the participation of a wide range of stakeholders. The early detection of those with mental illness is important for maximising the positive outcomes of treatment.

People with learning disabilities

The life experiences of working age adults with learning disabilities are unique and variable due to the disability severity. It is estimated that over four in five (83%) of individuals with learning disabilities who are of working age are unemployed. People with learning disabilities who live in private households are more likely to live in areas of high social deprivation compared to individuals living in supported accommodation. Working age adults with multiple learning disabilities are less likely to participate in leisure and community activities compared to individuals with mild or moderate learning disabilities.[74] These issues should be addressed by the relevant services to ensure individuals with learning disabilities are able to play a full role in society and fulfil their potential.

The case for investment

Mental illness often begins in childhood and continues through life resulting in substantial human, social and economic costs. Mental illness has significant economic costs including estimated wider costs in England of £105 billion a year. Research shows that should mental health care and treatment arrangements remain at their current levels, there will be a substantial increase in the impact of mental health problems on the economy in the future.[80]

The Department of Health commissioned a study to identify and analyse the costs and economic pay-offs of a range of interventions in the area of mental health promotion, prevention and early intervention:[81]

- Early diagnosis and treatment of depression at work programme to have an economic pay-off of £5.03 per £1.00 expenditure, split between the NHS, public sector and non-public sector;
- Workplace health promotion programmes were found to have a pay-off of £9.69 per £1.00 of expenditure;
- Attempting to address social determinants of mental health through debt advice services, the economic pay-off was £3.55 per £1.00 of expenditure.

Overall many of the mental health related programmes were found to have economic pay-offs for the NHS, other public sector services, and for non-public sector services.

7.1. What we are doing locally

Leicestershire's JHWS has identified improving mental health and wellbeing as a key priority, with a key action to

> *'promote positive mental health promotion and the early detection of mental health problems across the age ranges'.*

The council is working on a multiagency mental health strategy linked to the priorities in the JHWS.

This will identify actions to:

- Promote positive mental health and wellbeing;
- Continue to improve the early detection and management of people with common and severe and enduring mental health needs.

The 2013-16 Leicester, Leicestershire and Rutland (LLR) Suicide Prevention Strategy is being progressed by the LLR Suicide Audit and Prevention Group which is made up of partners across the NHS, local authority, police and voluntary sectors.

Other priorities include working with key stakeholders to address wider health inequalities and social determinants of health, for example, housing, social exclusion and income inequality and the potentially negative impact of benefit changes and other economic changes linked to the economic downturn.

The council will continue to work with NHS and other partners to improve the management of people with common and severe and enduring mental health problems (SMI) by identifying their needs and addressing risk factors for premature mortality in people with SMI.

Case study - Books on prescription

A campaign aimed at optimal management of mental illness and promotion of mental health through availability of 'self-help' books and other resources in libraries.

Case study - Time to change

The 'time to change' campaign is a local multi-agency campaign aimed at reducing the reduce stigma and discrimination relating to mental illness.

Recommendations

- To work with partners to prioritise mental health and to deliver on the emerging mental health strategy;
- To strengthen mental health and wellbeing for all, thereby recognising that good mental health is more than the absence of mental illness;
- To address wider determinants of health and to enable individuals to fulfil their potential through partnership working across departments and agencies;
- To protect investment in prevention and tackle the wider determinants of health as the return on investment per pound spent in this area is good.

Health protection

1. Infectious diseases

Health protection covers a wide range of "threats" to health. These include many diverse areas such as infectious diseases, "superbugs", flooding, radiation, poisons and food safety. It is important that the health, safety and protection of the population from all external threats to health is rigorously maintained.

1.1 Food borne disease

The largest number of notifiable infections both nationally and locally continues to be food-borne disease (food poisoning). Nationally the Food Standards Agency (FSA) estimates that there are around a million cases of foodborne illness in the UK each year, resulting in 20,000 hospital admissions and 500 deaths. Locally during 2012 there were 692 reported cases.[75] However the majority of cases go unreported and this can be seen to be the tip of the iceberg.

Table 6: Leicestershire County and Rutland reported cases of foodborne disease to Health Protection Unit East Midlands South 2008 to 2012

	Leicestershire and Rutland				
Disease	**2008**	**2009**	**2010**	**2011**	**2012**
Food Poisoning (Campylobacter/ Salmonella /Non-specific Gastroenteritis)	696	726	849	772	692

Source: East Midlands Health Protection Unit 2013.

The responsibility for enforcement of food safety legislation lies with environmental health officers within district councilsl. They work closely with Public Health England to investigate cases of food poisoning and to ensure that food business operators work according to the legal standards determined by European and national regulations. As a significant number of foodborne diseases occur in the home we also ensure through work in schools and communities that we have education and awareness raising activities that promote food safety and reduce the huge burden of food borne disease.

1.2 Pertussis (whooping cough) in pregnancy

There has been a considerable increase in pertussis since the middle of 2011. This increase has occurred across England and Wales. The highest rates are in infants less than three months of age who are at the greatest risk of complications and death. Babies under eight weeks are too young to gain protection from the childhood immunisation schedule.

A temporary programme of immunisations for pregnant women after 28 weeks of pregnancy began in September 2012. The purpose is to boost antibodies in the vaccinated women so that pertussis antibodies are passed from mother to baby. This aims to protect the infant before routine immunisation can be started at eight weeks of age.

1.3 Tuberculosis (TB)

Tuberculosis is caused by the bacteria Mycobacterium tuberculosis. It can cause disease in the lungs as well as other sites such as the lymph nodes and bones.

TB, although curable with antibiotics, has re-emerged as a major public health problem and is the leading cause of death worldwide from a curable infectious disease. In England cases fell progressively until the mid-1980s but started to rise again in the early 1990s.[76]

Case numbers in the UK are at their highest for nearly thirty years and now exceed 9,000 per year. Much of this rise affects disadvantaged communities including certain ethnic minority groups and those with social risk factors such as homelessness and drug and alcohol misuse. This concentration in particular sections of the community provides unequivocal evidence for a need to strengthen efforts to control the disease through a range of measures targeted at key risk groups and in particular those living in urban areas. NICE have recently issued guidance on the management of TB in hard to reach groups. TB is a disease associated with poverty and specific groups of the population are at heightened risk:

- Close contacts of infectious cases;
- Those that have lived in, travel to, or receive visitors from places where tuberculosis is still very common;
- Those with immune systems weakened by HIV infection or other medical problems;
- The very young and the elderly as their immune systems are less robust;
- Those with chronic poor health and malnutrition because of lifestyle problems such as homelessness, drug abuse or alcoholism.

Between 2009 and 2011 there were an average of 41 new cases of TB reported per year. The incidence rate per 100,000 population of 6.3 in Leicestershire (95% CI 4.5-8.5) is significantly lower than the England average of 15.4 (95% CI 15.1-15.6).[77] Public Health England are currently undertaking a full health needs assessment of TB across Leicester, Leicestershire and Rutland.

1.4 2013/14

From 2013 as a result of the Health and Social Care Act 2012 Leicestershire County Council has acquired some new responsibilities with regard to protecting the health of their populations. Specifically the local authority is required, via its Director of Public Health (DPH), to assure itself that relevant organisations have appropriate plans in place to protect the health of the population and that all necessary action is being taken. In order to discharge these responsibilities, a Health Protection Board has been established as a sub-group of the three health and wellbeing boards for Leicester, Leicestershire and Rutland. The Health Protection Board is the way the health and wellbeing boards will be assured that the health protection agenda is being adequately addressed and considered in sufficient detail. It will also provide a reporting route should a health and wellbeing board have specific health protection concerns.

Emerging issues of relevance to working age adults include:

- Multi-drug resistant organisms such as multi-drug resistant TB;
- Pandemic 'flu and other emerging diseases such as Middle East Respiratory Syndrome Coronavirus.

2. Screening

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.

The NHS in England operates a number of screening programmes that are offered to people of working age. The relevant programmes are:

- Breast cancer screening;
- Cervical cancer screening;
- Bowel cancer screening; and
- Diabetic eye screening.

The purpose of screening is to identify a disease, or in some cases a risk factor, in such a way that the chance of a better health outcome is increased. This latter part of the statement is important; there is no point in going through screening and getting an earlier diagnosis of a problem if treatment at that stage is not going to confer an advantage for the individual.

Screening programmes do not usually provide a clear diagnosis. The purpose of a screening programme is to separate those who are unlikely to have a particular condition from those who have a higher chance of having the condition based on the screening test undertaken. The latter group will then be asked to attend for further diagnostic tests to see if they really have the condition in question or not. If the answer is yes, then treatment will be offered.

As screening programmes are offered to the whole population at risk they can be very costly. In order for the population to gain significant benefit from a screening programme it is important that a high percentage of the population makes use of them. The costs of a screening programme are to a large extent fixed. If only half of the eligible people take up a service the cost will be less, but probably not very much less, than if 80 or 90% of people take it up. With only 50% uptake we will only see around 50% of the potential benefit for the population, so the cost per life saved will increase dramatically if uptake is low.

2.1. Breast cancer screening

Screening for breast cancer is offered to all women aged 50-70 years on a three yearly cycle. The basic test is an x-ray of the breast called a mammogram. The advent of digital mammography has led to an extension of the age range on a trial basis so in Leicestershire women are now invited from age 47 to 73 years. Women who are over this age can continue to have breast screening if they request it but they will not be routinely called.

The national minimum standard for coverage (the number of people eligible who attend for the service) is 70% with the achievable standard being 80%. In Leicestershire and Rutland the performance for April 2011-March 2012 was 84.4%, the best in the East Midlands and one of the best in the country.[78]

Table 7: NHS Breast Screening coverage of women aged 53-70 as at 31 March 2011 and 2012

	As at 31 March 2011	As at 31 March 2012
England	77.2%	77.0%
East Midlands	81.8%	81.3%
Leicestershire County and Rutland	84.9%	84.4%

Source: Compendium of Clinical Indicators, Health and Social Care Information Centre

2.2. Cervical cancer screening

Cervical screening is not a test for cancer. It is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix (the neck of the womb). The first stage in cervical screening is taking a sample using liquid based cytology.

Cervical cancer screening is offered to all women aged from 25 to 64 years. The screening interval for those aged 25-49 years is three yearly and for 50-64 it is five yearly. There is currently a national trial of using a test for the human papilloma virus (HPV) which is done on the smear specimen as part of the screening process. This process is currently in use in the service that covers Leicestershire.

Coverage for the year 2011/12, calculated as the percentage eligible having had a smear within the last five years, is shown below. As can be seen, uptake in LCR is higher than the national average. Coverage specifically for those aged 25-49 years is calculated on the percentage eligible having had a smear within the last three years. This figure of 78.3%, which is higher than the national and regional average, would benefit from being over 80%.[79]

Table 8: Cervical cancer coverage 2010/11 and 2011/12

	2010/11 (%)			2011/12 (%)		
	25-49	50-64	25-64	25-49	50-64	25-64
England	73.7	78.0	78.6	73.5	77.8	78.6
East Midlands	76.9	80.4	81.4	76.5	79.8	81.0
Leicestershire County and Rutland	79.2	81.6	83.2	78.3	81.2	82.7

Source: NHS Cervical Screening Programme Statistical Bulletin 2011-12

2.3. Bowel cancer screening

Bowel cancer screening started in LCR in 2007. It is offered to men and women aged 60-69 and from June 2012 the service has been rolled out for men and women up to the age of 74 years.

A screening kit is sent in the post to eligible people every two years. The kit requires people to submit a very small specimen of faeces on a specially designed card. The specimen is then tested in a laboratory for the presence of very small quantities of blood. The test is referred to as faecal occult (meaning hidden) blood, or FOB.

A positive test may suggest the presence of a polyp or of bowel cancer. People with a positive screening test will be offered further diagnostic tests and treatment as necessary.

Probably because of the nature of the test the acceptability of this programme has been harder to achieve with the population. The uptake rates for LCR for the last two calendar years, 2011 and 2012, have been 58.5% and 64.8% respectively compared to a national standard of 60%.[82]

2.4. Diabetic eye screening programme

People with diabetes run the risk of a number of complications of which sight threatening retinopathy is one. Everyone with diabetes from the age of 12 is invited to have an annual photograph of their retinas to assess the presence and extent of any changes that may threaten their sight. If changes are found it may be necessary offer laser therapy to the back of the eye and there is also now the option of injections into the eye following recent guidance from NICE.

Table 9: NHS diabetic eye screening coverage 2010/11 and 2011/12

	2010/11	2011/12
England	91.6%	91.9%
East Midlands	92.3%	92.2%
Leicestershire County and Rutland	93.3%	92.4%

Source: Public Health England Immunisation and Screening Team

Recommendations

- To establish and operate a Health Protection Board that seeks to provide assurance to the local authorities in LLR about the adequacy of prevention, surveillance, planning and response with regard to health protection issues.
- To continue to assure that NHS England maintain high coverage and uptake of national immunisation and screening programmes.

Feedback from actions for 2012

In March 2012 the Leicestershire Together (LT) Board agreed 4 priority outcomes for Leicestershire, including (in response to the increasing ageing population) that "Services are designed to mitigate the impacts of an ageing population and enable older people to live independently for longer".

This recommendation was further reinforced by recommendations included in the DPH Report 2: Older People, published in September 2012.

Work in response to this LT priority outcome included carrying out a peer review based on the following hypotheses and exploring issues of strategy, governance, and accountability across Leicestershire.

Hypotheses

- As the population of over 50s in Leicestershire increases, the demand on services will be unaffordable based on current service delivery;
- Some services are delivered in silos, meaning the customer is potentially receiving disjointed and uncoordinated services, impacting on the quality of care they ultimately receive;
- Some organisations operating models are focussed more on reactive service delivery and less on the delivery of early intervention or preventative services;
- By re-designing how we support older people in Leicestershire, acknowledging the changing needs at different ages and life events, we can improve the lives of older people and reduce the costs to the public and voluntary sector.

Sandra Whiles, Chief Executive at Blaby District Council, led the peer review team which included Matthew Lugg, Director of Environment and Transport at Leicestershire County Council, Senior Officers from public health in Leicester City, Warwickshire County Council, a senior elected member from Nottinghamshire and the Chair of the Older Peoples Engagement Network (OPEN). The team interviewed 52 commissioners/providers as well as elected members representing the county council and district councils.

The following link is to a succinct and thought provoking animation (5 minutes in length) that sets the context of the review and reminds those involved of the emotional impact of ageing. Charlie and Marie: A tale of ageing (http://vimeo.com/21592651)

The interim findings of the peer review are shown below.

Peer review findings

We need to:

- Change how we think. Create a whole system approach focussing on striking the right balance between providing the right services and enabling individuals and communities to support themselves;
- Enable People. Supporting people to ensure they recognise the impact of their lifestyle choices from an early age, and ensure that we provide services and support that are person centred, not condition based;
- Empower Communities. Work with communities to create a culture of sustained self support and address the assumed dependency on universal public sector services;
- Better Insight, better decisions. More regular and robust evidence to inform the design and delivery of effective solutions.

The next stage of the programme is to capture the views of patients, carers and service users. A stakeholder event held in May identified a range of groups to contact in order to fully understand the needs, wishes and aspirations of older and ageing individuals in the county. As a result a detailed engagement plan is being prepared across the partnership to engage with these groups.

On completion of this exercise, the views expressed by patients, carers and service users will be put together with the views expressed in the peer review in order to define future services in Leicestershire.

It had been anticipated that the definition of new commissioning and delivery plans for Leicestershire would be completed by this autumn. However, activity has focussed on the wider health and local government integration initiatives, following recent announcements by Government. Government is incentivising local areas who demonstrate innovation in integration of health and local government and Leicestershire partners are keen to play a key role in this.

Whilst this shift in focus has resulted in a three to six month delay in progressing the ageing well programme, the focus and desired outcomes of both programmes are very much aligned. The findings of the ageing well peer review and subsequent stakeholder engagement activity will feed into the integration activity and, as a result, help drive through the transformation of services required.

Appendix A: The new public health system

Public health in Local Authorities

On the 1st April 2013, Local Authorities took over responsibility for public health services for their local communities. Leicestershire County Council has a new duty to promote the health of the population. The council is also responsible for ensuring that robust plans are in place to protect the local population and in providing public health advice to NHS commissioners (West Leicestershire CCG and East Leicestershire and Rutland CCG).

Leicestershire County Council is now responsible for commissioning the following services:

- Children's public health
- Sexual health
- Public mental health
- Obesity programmes
- Drug misuse
- Alcohol misuse
- Tobacco control
- Nutrition
- NHS Health Check Programme
- Reducing and preventing birth defects
- Health at work
- Accidental injury prevention
- Seasonal mortality

Public Health England

Public Health England (PHE) was established on 1st April 2013. It will carry out nationwide and specialist functions for public health. Locally public health will be led by local authorities.

Public Health England's three main functions will be:

- Delivering services to national and local government, the NHS and the public. This includes health protection services, public health intelligence services, development of evidence and nationwide communications strategies;
- Leading for public health; and
- Supporting the development of the specialist and wider public health workforce.

Public health services commissioned by NHS England

In addition to Local Authority Public Health and Public Health England, NHS England will commission the following public health services:

- Public health services for children from conception to age 5;
- Immunisation programmes;
- National screening programmes;
- Public health care for people in prison and other places of detention; and
- Sexual assault referral services.

Leicestershire's Health and Wellbeing Board

Leicestershire's Health and Wellbeing Board was formally established on the 1st April 2013. This statutory board builds on the work of the Shadow Health and Wellbeing Board that was in place from April 2011.

The Health and Wellbeing Board has a fully operational sub structure with supporting boards leading work on:

- Integrated Commissioning;
- Staying Healthy;
- Substance Misuse; and
- Health Protection.

The main focus of the work of Leicestershire's Health and Wellbeing Board in 2012 has been to:

- Refresh and publish the Joint Strategic Needs Assessment (JSNA) for Leicestershire and engage with a wide range of stakeholders in this process;
- Identify and agree local priorities from this assessment;
- Develop and publish our first Health and Wellbeing Strategy and engage with a wide range of partners in this process;
- Oversee the delivery of work plans from the substructure groups; and
- Prepare for statutory status of the Board with effect from April 2013.

The Health and Wellbeing Board has also covered a number of other important topics this year, for example:

- Local CCG commissioning strategies and authorisation;
- The vision for local Healthwatch;
- Local emergency planning arrangements;
- The implications of the Adult Social Care White Paper;
- Cancer mortality rates in Leicestershire;
- The Annual Report of the Director of Public Health, which focused on older people;
- Future Special Educational Needs provision for Children;;
- The Better Care Together programme - planned changes in healthcare services across the sub-region;
- The introduction of the NHS 111 telephone number (a national development).

Further information about the Health and Wellbeing Board is available from www.leics.gov.uk/healthwellbeingboard.htm

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