Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 9 September 2015 at 2.00 pm**

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

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

Email: **rosemary.palmer@leics.gov.uk**

Membership

Dr. S. Hill CC (Chairman)

Mrs. R. Camamile CC	Mr. J. Kaufman CC
Mrs. J. A. Dickinson CC	Mr. W. Liquorish JP CC
Dr. T. Eynon CC	Mr. J. Miah CC
Dr. R. K. A. Feltham 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 10 June 2015.	(Pages 5 - 12)
2.	Question Time.	
3.	Questions asked by members under Standing Order 7(3) and 7(5).	
4.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	
5.	Declarations of interest.	
6.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.	

7.	Presentation of Petitions under Standing Order 36.		
8.	Better Care Together Update.	Better Care Together	(Pages 13 - 44)
9.	Implementing "Fit for Future": A Review of Community Health Services in Ashby.	West Leicestershire Clinical Commissioning Group and Leicestershire Partnership NHS Trust	(Pages 45 - 52)
10.	Community Health Services in Ashby: Representations made by the Ashby Civic Society.	Chief Executive	(Pages 53 - 62)
11.	Results of Care Quality Commission Inspection at Leicestershire Partnership NHS Trust.	Leicestershire Partnership NHS Trust	(Pages 63 - 72)
12.	Re-procurement of Community Substance Misuse Treatment Services.	Director of Public Health	(Pages 73 - 90)
13.	Oral Health of Five Year Olds.	Director of Public Health	(Pages 91 - 98)
14.	Quarterly Performance Report.	Chief Executive and Greater East Midlands Commissioning Support Unit	(Pages 99 - 116)
15.	Review of Dental Health Service.	NHS England	(Pages 117 - 142)

16. Dates of future meetings.

Future meetings of the Committee will take place at County Hall at 2pm on the following dates:-

11 November 2015;
20 January 2016;
30 March 2016;
15 June 2016;
14 September 2016;
2 November 2016.

17. 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, 10 June 2015.

PRESENT

Mrs. R. Camamile CC
Mrs. J. A. Dickinson CC
Dr. T. Eynon CC
Dr. R. K. A. Feltham CC
Dr. S. Hill CC
Mr. D. Jennings CC
Mr. J. Kaufman CC
Mr. J. Miah CC
Mr. A. E. Pearson CC

In attendance

Rick Moore, Chairman of Healthwatch Leicestershire;
Tim Slater, General Manager Leicester, Leicestershire and Rutland Division, East Midlands Ambulance Service (minute 10 refers);
Bal Johal, Deputy Chief Nurse Leicestershire Partnership NHS Trust (minute 12 refers);
Wendy Ferguson, Community Manager, Leicestershire Partnership NHS Trust (minute 11 refers);
Caroline Trevithick, Chief Nurse and Quality Lead, West Leicestershire Clinical Commissioning Group (minutes 13 and 14 refer);
Richard Carroll Chief Executive, Central Nottinghamshire Clinical Service (minute 14 refers);
Dr Sarah Hull, Organisational Medical Director, Central Nottinghamshire Clinical Service (minute 14 refers).

1. Appointment of Chairman.

That Dr. S. Hill CC be appointed Chairman of the Health Overview and Scrutiny Committee for the period ending with the date of the Annual Meeting of the County Council in 2015.

(Dr. S. Hill CC in the Chair)

2. Election of Vice-Chairman.

That Mrs. J. A. Dickinson 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 2015.

3. Minutes of the meeting held on 25 February 2015.

The minutes of the meeting held on 25 February 2015 were taken as read, confirmed and signed.

4. Question Time.

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

5. 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).

6. Urgent items.

There were no urgent items for consideration.

7. 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.

Mrs. J. A. Dickinson CC declared a personal interest in all items on the agenda as she was a member of the Leicestershire Partnership NHS Trust Shadow Council of Governors and she had a relative employed by the University Hospitals of Leicester NHS Trust.

Mr. J. Miah CC declared a personal interest in all items on the agenda as he had a relative employed by the University Hospitals of Leicester NHS Trust and a personal interest in the report on the proposed relocation of Charnwood Community Mental Health Teams (minute 11 refers) as he was a member of Charnwood Borough Council.

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

There were no declarations of the party whip.

9. Presentation of Petitions under Standing Order 36.

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

10. Leicestershire (LLR) Divisional Update.

The Committee considered a report of the East Midlands Ambulance Service (EMAS) NHS Trust, which provided the key performance information for the EMAS Divisional area of Leicestershire, split to Clinical Commissioning Group (CCG) level, an update on frontline staff recruitment and summarised the divisional priorities described in Local Delivery Plan 2015-16. A copy of the report marked ‘Agenda Item 10’ is filed with these minutes.

The Committee welcomed Tim Slater, General Manager of the Leicester, Leicestershire and Rutland (LLR) Division, EMAS to the meeting to present the report and answer questions.

The Committee was pleased to note that all targets had shown improvements during the current financial year and were continuing to improve. The Committee also welcomed the thorough analysis of performance being undertaken across all targets. The Committee was pleased to have learnt that EMAS worked closely with the CCGs and the University

Hospitals of Leicester NHS Trust (UHL) on issues such as understanding the causes behind the long waits and ambulance turnaround.

Arising from discussion the following points were made:-

(i) The Committee raised concerns over the delays in the handover of patients from ambulances to UHL sites. With respect to this issue the Committee was advised that the delays in transferring patients from ambulances amounted to 11,676 operational hours of an ambulance lost, which equated to the loss of working capacity of three ambulances per day. In the last fortnight a new handover system had been introduced which advised UHL in real time of patients en route to the hospital. This had demonstrated some improvements in turnaround times over the weekend, but they had not been sustainable. EMAS would continue to monitor the situation. The Health and Wellbeing Board was also considering a report on ambulance turnaround times at its next meeting.

(ii) The Leicester Royal Infirmary (LRI) continued to be one of the country's busiest hospital sites, with a limited capacity and a large proportion of patients self-presenting to the Accident and Emergency Department (A&E). To that end, the capacity at LRI was to be increased by the creation of a new emergency floor. Caution was advised on behalf of EMAS to ensure 'future-proofing' of the new facility in terms of patient capacity.

(iii) There was limited space for patients to wait to be seen once the ambulance had arrived at A&E so it was not possible to have a single paramedic taking responsibility for a number of patients grouped together. It was felt that during busy periods UHL needed a more responsive escalation process as the provision of extra space for grouping patients under the care of a single paramedic would only be triggered if six or more patients were waiting in the back of the ambulances. It was hoped that new handover system would enable UHL to be more responsive to demand.

(iv) The Committee welcomed the high rate of patients treated by EMAS who were not then conveyed to hospital as this demonstrated the promotion of alternative pathways. However, concern was also expressed that 999 calls were being made inappropriately. The Committee was pleased to note that EMAS was working to educate clinicians with regards to the different service offerings in each CCG area. To that end a pilot mobile directory of services had been launched.

(v) The 111 service was able to dispatch ambulances if, following an assessment, the call handler felt it was necessary to do so. The service had a mixture of call handling capability, including both clinical and non-clinical staff. It was not possible to identify if the introduction of the 111 service had led to an increase in demand for ambulances, although EMAS had undertaken an analysis of ambulances despatched by 111, and found that in many cases it was not appropriate.

(vi) EMAS was not required to report the mortality rate of patients, so it was difficult to determine whether ambulance delays had an impact on life expectancy.

(vii) EMAS had previously reported challenges in retaining qualified paramedics to the Committee. It was now reported that a number of qualified paramedics were returning to EMAS. The new staffing model included ambulance technicians as

well as paramedics and Emergency Care Assistants; ambulance technicians were qualified staff who could progress to being paramedics. This was felt to be a safer model as it increased the number of qualified staff available and was also more sustainable.

RESOLVED:

(a) That the Leicestershire (LLR) Divisional Update and improvements made at EMAS be noted;

(b) That the joint report from the East Midlands Ambulance Service, University Hospitals of Leicester and the Clinical Commissioning Groups regarding ambulance turnaround times at the Leicester Royal Infirmary being submitted to the Health and Wellbeing Board on 16 July be shared with all members of the Committee.

11. Proposed Relocation of Charnwood Community Mental Health Teams.

The Committee considered a report from Leicestershire Partnership NHS Trust (LPT) on the Proposed Relocation of Charnwood Community Mental Health Teams, which set out the proposals to relocate adult community mental health service and older persons' community mental health service in Charnwood from its current bases at Town Hall Chambers, and Cameron Stastny House, Loughborough to Loughborough Hospital. A copy of the report marked 'Agenda Item 11' is filed with these minutes.

The Committee welcomed Wendy Ferguson, Community Manager for Mental Health Services for Older People, LPT to the meeting to present the report and answer questions.

The Committee supported the proposals to relocate both services to Loughborough Hospital. Some concern was expressed that without the availability of suitable public transport it would be difficult for the patients' relatives, as well as staff, to access the new location. The Committee was advised that LPT had liaised with bus companies to address this concern and had shared the outcomes of this liaison as part of the consultation.

RESOLVED:

That the proposal by Leicestershire Partnership NHS Trust to relocate its adult community mental health service and its older persons' community mental health service in Charnwood from their current bases to Loughborough Hospital be supported.

12. Safer Staffing Update - Inpatient Wards.

The Committee considered a report from LPT which outlined the current position with regards to the National Quality Board (NQB) Safer Staffing requirements across the three operational divisions in LPT. The report was aimed at providing assurance that safer staffing levels were maintained and highlighting the ongoing work undertaken to support recruitment and retention of qualified staff. A copy of the report marked 'Agenda Item 12' is filed with these minutes.

The Committee welcomed Bal Johal, Deputy Chief Nurse from LPT to the meeting to present the report and answer questions.

Arising from discussion members were advised as follows:-

(i) The use of agency staff was a nationwide rather than local phenomenon. Patient safety was the priority, and to that end deployment of bank and agency staff was essential. The approach undertaken by LTP, however involved attempts to manage temporary staff locally with the use of own bank staff rather than agency staff whenever possible, and a coordinated approach to the recruitment of agency staff, including set rates and recruitment route.

(ii) Nurses chose agency or bank work because it enabled them to work flexibly around family, caring or other commitments. The Committee was assured that permanent staff received greater financial benefits and opportunities for career progression, unlike agency work. Bank nurses were regularly offered the opportunity of becoming full time members of staff.

(iii) The recruitment of nurses from overseas was not currently part of LPT's plans. Concern was expressed that there was a risk that nurses recruited from overseas would not be retained, and would choose to be employed by agencies instead. The Committee was assured that there was no evidence that this was the case.

(iv) The staff retention issues were caused by staff moving internally rather than losing staff to the external organisations, and were no more significant that other mental health trusts. The development of the new pathways, such as care in the community, resulted in staff moving from inpatient wards to the community services.

(v) The temporary move of the Inpatient Child and Adolescent Mental Health Service to Ward 3 of Coalville Hospital posed a risk of losing experienced staff due to increased travel times. LPT was proactively working with affected staff to plan for the future, maintain staff and provide adequate support.

RESOLVED:

(a) That the current position with regards to the National Quality Board Safer Staffing requirements across the three operational divisions in Leicestershire Partnership NHS Trust be noted;

(b) That officers from Leicestershire Partnership NHS Trust be requested to write the committee with further details regarding the staffing issues at the Inpatient Child and Adolescent Mental Health Service at Ward 3 of Coalville Hospital.

13. <u>Learning Lessons to Improve Care Clinical Taskforce. - Update.</u>

The Committee considered a report and presentation from West Leicestershire Clinical Commissioning Group (WLCCG) on behalf of the Learning Lessons to Improve Care Clinical Task Force (UHL, LPT & 3 LLR CCGs), which provided an update of progress made in addressing the findings and recommendations in the Learning Lessons to Improve Care (LLtIC) report 2014. A copy of the report marked 'Agenda Item 13' and the slides forming the presentation is filed with these minutes.

The Committee welcomed Caroline Trevithick, Chief Nurse and Quality Lead at WLCCG and SRO for LLtIC Clinical Task Force to the meeting for this item.

The Committee was pleased to hear that improvements were being made and welcomed the comments made in the second progress update since the publication of LLtIC report.

Arising from discussion the following points were raised:-

(i) The Standardised Hospital Mortality Index (SHMI) rate was not site specific, although UHL was now disaggregating it in reports to the Trust Board. It was noted that the SHMI for LRI was higher than the Glenfield and General Hospitals. It was further advised that UHL looked at morbidity and mortality ratios by speciality rather than the hospital as whole. An example of this was the work undertaken at LRI to reduce the mortality rates linked to pneumonia, which had decreased since the last year. The CCGs welcomed the focus on SHMI by UHL and were pleased with the focus on monitoring and reducing mortality rates.

(ii) UHL was also undertaking an analysis of mortality rates for patients within 30 days of discharge from hospital. Anecdotal evidence suggested that the out of hospital SHMI was going up whilst the hospital SHMI was decreasing. A case note review of a cohort of patients who had died within 30 days of discharge was currently being undertaken; feedback from this was expected in July. This would enable the LLtIC Task Force to test whether the current set of actions were appropriate.

(iii) The engagement event used to test whether patient outcomes had improved consisted of approximately 30 clinicians from UHL, LPT and Primary Care. This was not felt to be representative enough to draw conclusions. The Committee was advised however, that going forward the Learning Lessons to Improve Care (LLtIC) task force would perform 'pulse checks' to allow more systematic feedback across the whole of clinical work force across LLR. In addition, an outcomes framework to demonstrate progress with implementing the findings of the review was being developed.

RESOLVED:

(a) That the progress in addressing the findings and recommendations in the Learning Lessons to Improve Care report be noted;

(b) That a progress report on implementation of the findings of the LLtIC review, including the outcomes framework be submitted to a future meeting of the Committee.

14. <u>Out of Hours Service Provided by Central Nottinghamshire Clinical Services.</u>

The Committee considered a report from West Leicestershire Clinical Commissioning Group on behalf of the 3 LLR CCGs, and presentation from Central Nottinghamshire Clinical Services (CNCS), which provided details of the outcome of the Care Quality Commission (CQC) review of the LLR Out of Hours Service and the progress being made to improve the quality of care. A copy of the report, marked 'Agenda Item 14, and the slides forming the presentation are filed with these minutes.

The Committee welcomed Caroline Trevithick, Chief Nurse and Quality Lead at WLCCG, Richard Carroll, Chief Executive of CNCS and Dr Sarah Hull, Medical Director of CNCS to the meeting for this item.

Arising from discussion the following points were raised:-

(i) Serious concern was expressed that the CQC inspection had identified significant failings with the Out of Hours Service provided by CNCS. In particular, the Committee was concerned that standards for patient safety were not being met. CNCS apologised unreservedly for the poor service that had been provided for patients and confirmed that an action plan was now in place to address the issues highlighted by CQC.

(ii) The Committee was concerned that the trigger for improvement appeared to be the CQC and questioned the robustness of CCG contract monitoring. It was acknowledged that, prior to the CQC inspection, a number of contract queries had been raised and that the CCGs had been working with CNCS to make improvements. The CCGs had subsequently identified the need to make changes to their contract monitoring process to enable the required outcomes to be achieved.

(iii) CNCS had started out as an out of hours GP service which had expanded rapidly without the appropriate infrastructure being in place. This resulted in a poorly managed service with a lack of robust checks and balances in place. Actions to address these issues had been stepped up since the CQC inspection, and it was expected that all the actions would be delivered by the timescales in the plan. It was confirmed that the CCGs would continue to support CNCS as they had demonstrated the commitment and drive to make improvements. If the actions did not translate into real and sustainable improvements, then consideration would be given to the future provision of the service.

(iv) The CCGs had undertaken a risk assessment which demonstrated that clinical risk was being managed. GPs had been involved in the assessment to provide clinical input. Mid Nottinghamshire CCGs, who also had a contract with CNCS, was supporting it to strengthen clinical governance. The Committee welcomed this but cautioned that frequency of low level risk could become a significant issue in itself and recommended that the CCGs continue the robust monitoring of risk.

(v) Actions being put in place including the upskilling of reception staff to support them to recognise the deterioration of patients. Patients were also now seen on a priority basis; with the priority being assigned by the 111 service when the call was taken. Staffing levels were also being increased so that medicines could be checked appropriately.

Rick Moore, Chairman of Healthwatch Leicestershire stated that should next CQC inspection fail to demonstrate that sustainable improvement had been made, the contract should be terminated.

RESOLVED:

(a) That the outcome of the Care Quality Commission review of the Out of Hours Service provided by Central Nottinghamshire Clinical Services (CNCS) be noted;

(b) That a report outlining the progress made to improve the quality of care be presented to Health Overview and Scrutiny Committee on 11 November 2015.

15. Commentary Against Quality Accounts.

The Committee considered a report of the Chief Executive which asked the Committee to consider delegating the task of commenting on the Quality Accounts for the provider health trusts, specifically UHL, LPT and EMAS, to the Chief Executive, after the consultation with the Chairman and Spokesmen of this Committee. The report also presented the commentaries on the Quality Accounts 2014-15 for UHL, LPT and EMAS. A copy of the report marked 'Agenda Item 15' is filed with these minutes.

RESOLVED:

(a) That the Commentary against the Quality Accounts 2014/15 for UHL, LPT and EMAS be noted;

(b) That the role of commentating on the Quality Accounts of health provider organisations be delegated to the Chief Executive after consultation with the Chairman and Spokesmen of the Health Overview and Scrutiny Committee.

16. Date of next meeting.

It was noted that the next meeting of the Committee would be held on 9 September at 2pm.

2.00 - 4.41 pm CHAIRMAN
10 June 2015

Agenda Item 8

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

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 9 SEPTEMBER 2015

REPORT OF BETTER CARE TOGETHER

BETTER CARE TOGETHER UPDATE

Purpose of report

1. The purpose of this report is to update the Committee on:
   (a) BCT plans and progress in relation to community health services;
   (b) Engagement process related to the future of Hinckley hospital;
   (c) Provide a summary of ELR strategy;
   (d) To describe the link between UHL recent strategy and BCT community proposals.

Policy Framework and Previous Decisions

2. Progress in developing the Better Care Together (BCT) Programme was reported to the Health and Wellbeing Board on 16 July 2015. There was also an all Member Briefing on 22 July 2015 which provided a general update on the Programme.

Background

3. The Better Care Together Programme was launched in January 2014 with the aim to:-

   (a) Deliver high quality, person-centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital;

   (b) To reduce inequalities in care (both physical and mental) across and within communities in Leicester, Leicestershire and Rutland (LLR) Local Health and Social Care Economy (LHSCE);

   (c) To increase the number of people with mental, physical health and social care needs reporting a positive experience of care across all health and social care settings;

   (d) To optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the health care system;

   (e) All health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate;

(f) To improve the utilisation of workforce and the development of new capacity and capabilities where appropriate, in the people and the technology used.

4. In order to achieve these goals the commissioners and providers who form the BCT partnership have identified that improvements are required to the way community health services are delivered. These services will also need to be expanded in some areas to allow a shift of unnecessary care out of the acute hospitals. The aim is that services can be delivered to patients in the most appropriate and ideally more accessible place, potentially their own home.

5. Providing care for patients in their own home using multidisciplinary teams can ensure the independence of those individuals is maintained for longer. Given the predicted increasing age of the Leicestershire population and the impact that long term conditions have on the ability of individuals to cope without support on a daily basis, it is essential that the health and care system in Leicestershire transforms. This transformation aims to provide a community service offering, which is broader than today, targeted at patients' needs, and delivered by multi-disciplinary teams, who communicate and operate in an integrated way.

6. The transformation also aims to provide a relatively new and rapidly growing multi-disciplinary service, sub-acute care, which merges the sophisticated technology of a hospital with the efficient operation of a skilled facility in a non-acute setting. The plan is to create two sub-acute wards in Leicestershire's community hospitals to support patients who have completed acute treatment and need a short period of complex care before they enter rehabilitation. This will also relieve pressure on the acute provision at Leicestershire Partnership Trust (LPT), University Hospitals of Leicester NHS Trust (UHL), and support the move from three acute sites to two. The relationship between the BCT programme and the UHL strategy is described in Appendix 1.

7. An overview of the potential changes to the community service offering can be found in Appendix 1.

8. In the present community offering there are services which do not run as efficiently as necessary, or meet the National Institute for Health and Care Excellence (NICE) guidance for nursing staff. To provide not only the best clinical care but also sustainable care, the transformation aims to ensure that where services need to be consolidated, this change takes the views of the public into account. The present thinking on the future configuration of in-patient services in Leicestershire is described in Appendix 1. The final proposals are being developed and will be subject to the public consultation.

9. The Clinical Commissioning Groups (CCGs) have made significant progress in determining their community services offering and have already carried out significant public and patient engagement in some cases. The summary of the discussions relating to the Community Hospitals in Hinckley is described in Appendix 2 and an extract from East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) strategy for community services is included in Appendix 3. The situation regarding St Luke's in Market Harborough is not outlined in this paper and will be dealt with by appropriate parties during the presentation.

Consultation

10. A public consultation on elements of the BCT programme is planned to be initiated in late November 2015 assuming all assurances have been provided and agreement given. This consultation is likely to contain consultation on the utilisation of community hospitals in the context of the overarching community health care offer. It is also likely to contain a consultation on maternity services which will include a discussion about services delivered out of Melton Community Hospital.

Resource Implications

11. The potential changes to community health care services will have resource implications on both, the utilisation of buildings and the size and shape of the community care services workforce. The details of these are presently being assessed and will only be known once the changes to the services are decided post-consultation and decision making.

Timetable for Decisions

12. The detail of BCT changes to the community services offering will be concluded in September 2015 and shared with NHS England assurance groups October 2015 with the goal to initiate consultation in November 2015. Presentations will be made to local authority scrutiny committees as required throughout the process.

Conclusions

13. As part of the overall change programme known as BCT the delivery of services in the community care service will change over the next four to five years. The majority of change will be an increase in the availability of services and the moving of some services from an acute setting to the community setting. However there will also be some changes in the utilisation of the overall community estate and the locations where residents of Leicestershire receive their care. As a result these proposals are in places subject to a public consultation.

Background papers

Kings Fund: Reconfiguration of clinical services, November 2014

Leicestershire Council Draft Joint Strategic Needs Assessment, July 2015

Leicestershire Council Better Care Fund Planning Template, September 2014

Circulation under the Local Issues Alert Procedure

None.

Officer to Contact

Name and Job Title:
Mary Barber BCT Programme Director
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List of Appendices

Appendix 1: Community Services Offering
Appendix 2: Hinckley Update
Appendix 3: ELR Plans Summary

Relevant Impact Assessments

Equality and Human Rights Implications

14. In process as part of the planned consultation.

Crime and Disorder Implications

15. None.

Environmental Implications

16. None.

Partnership Working and associated issues

17. None.

Risk Assessment

18. None.

Better care together

Leicester, Leicestershire & Rutland health and social care

Community Services Offer

Summary of proposed improvements

Owner: Mary Barber

21.8.15

Appendix 1: Submitted to Leicestershire HOSC to support community services offering discussion

Rutland County Council healthwatch Leicester City Council Leicestershire County Council NHS

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

1. Background:

Community care services consist of a wide range of services that are available to patients either via referral by their GP or on discharge from hospital. In Leicestershire they include

- Planned care including minor operations and rehabilitation support
- Crisis support to prevent hospital admissions
- Step down services including Intensive community support delivered in a patients home
- Unscheduled care such as dealing with a blocked Catheter
- Inpatient beds for stroke rehabilitation
- Inpatient beds for rehabilitation and care of the elderly
- Inpatient beds for palliative care

The design work that has taken place as part of the Better care together (BCT) programme and the Leicestershire Better Care Fund (BCF) has identified that across the county a number of these services need to be improved and re-organised if the local health care system is to improve quality of care, increase sustainability and cope with an ageing population with a prevalence of long term conditions.

Overall the change will be positive for the residence of Leicestershire with more services being offered in accessible community settings as opposed to City hospitals. This paper describes how each of the relevant BCT work-streams plan to increase and improve care provided in this care setting.

2. The Evidence Base for change

The Reconfiguration of Clinical Services is an evidence-based review by the Kings Fund, which looked at the drivers of reconfiguration and the underpinning evidence. It builds on a major analysis commissioned by the National Institute for Health Research (NIHR) and reviews of service reconfigurations conducted by the National Clinical Advisory Team (NCAT).

For community health services, the evidence base is as follows:

- There is strong patient satisfaction associated with virtual ward programmes and case management programmes. Available evidence points to a positive impact of integrated care programmes on the quality of patient care and improved health or patient satisfaction outcomes. Patients are more satisfied with hospital at home than with inpatient care because it was possible to provide a more personal style of care and staying at home was considered to be more therapeutic.

- A significant proportion of hospital beds are occupied by frail older people and people with Long-term conditions who would be more appropriately cared for in the community. For some conditions, admissions can be avoided with more proactive care, and in many cases, length of stay could be reduced if there were more services to support rehabilitation and

discharge. This would deliver a much better patient experience.

- Evidence to support the impact of large-scale reconfigurations of hospital services on finance is almost entirely lacking.

- However, there is a lot of evidence to suggest that it can be hard for community-based initiatives, including changes to primary care, to significantly reduce hospital admissions. Delivering improvement seems to require new ways of working across a system, including within hospitals, supported by good continuity of primary care. Even with successful implementation, there is little evidence to suggest that more community-based models of care will generate significant savings. Future workforce projections also present challenges to community-based models of care.

- There is mixed evidence on the capacity of community and primary care-based initiatives to reduce unplanned hospital admissions and help keep people at home. A recent literature review found that continuity of care (being able to see the same professional) reduced unscheduled secondary care. The table below outlines the areas BCT needs to focus on to have an impact on hospital admissions.

Table 2 **Summary of evidence on the impact of community-based initiatives on unplanned admissions**

Intervention	Impact on unplanned admissions	Disease area/client group	Evidence source
Case management	Reduces	Heart failure and some older frail people	(Purdy *et al* 2012) (Purdy 2010)
Care co-ordination as part of integrated health and social care teams	Reduces	Older frail people	(Philp *et al* 2013)
Specialist clinics	Reduces	Heart failure	(Purdy *et al* 2012)
Education and self-management	Reduces	Adults with asthma and COPD	(Purdy *et al* 2012) (Purdy 2010)
Exercise and rehabilitation	Reduces	COPD and cardiac	(Philp *et al* 2013) (Purdy *et al* 2012)
'Virtual integration'	No significant reduction	Diabetes +/or over 75	(Curry *et al* 2013)
Virtual wards	No impact	High risk	(Bardsley *et al* 2013)
Vaccine programmes	No impact	Asthma, COPD, older people	(Purdy *et al* 2012)
Medication reviews	No impact	Older people, people with heart failure or asthma	(Philp *et al* 2013) (Purdy *et al* 2012)
Falls prevention	No impact	Older frail people	(Philp *et al* 2013)
Integrated care pilots	Increases emergency admissions Decreases elective admissions	Varied	(Roland *et al* 2012)
Hospital at Home	Increases	Older patients with a range of conditions	(Purdy *et al* 2012)

Table 3 Impact of primary care factors on unplanned admissions

The table summarises findings from Purdy (2010) in a review of the evidence on avoiding hospital admissions.

Factor	Impact	Disease area/client group
Small and single-handed practices	Depends on condition – can increase admissions	
Continuity of care	Reduces admissions (but some studies less conclusive)	Ambulatory care sensitive conditions
Out-of-hours care – clinician factors	Wide variation in admission rates between GPs	
Out-of-hours care – change in GP contract	None	
Quality of primary care as measured by the Quality and Outcomes Framework (QOF)	Evidence inconclusive	

Ref: The Kings Fund, The reconfiguration of clinical services 2014

The Kings Fund also describe that there is evidence that community

- Poor implementation is a key obstacle to community-based initiatives achieving significant impact on rates of admission (Bardsley *et al* 2013). There are also risks of supply-induced demand (Roland and Abel 2012).

- The key to reducing the use of acute beds lies in changing ways of working across a system, including changes within hospitals, rather than piecemeal initiatives (Edwards 2014; Imison *et al* 2012; Simmonds *et al* 2012).

This national experience of service reconfiguration has been taken into account in the design of future services. The lack of evidence that such changes to community services improves system financial sustainability highlights the need for the BCT partnership to be conscious of where financial savings will be delivered and to drive them out throughout the change process. These financial benefits may be found in various parts of the whole system which is in line with the evidence that reducing acute beds requires system change.

Locally, work has been done to establish an evidence base for change. A number of utilisation reviews have previously been conducted in University Hospitals Leicester (UHL) and Leicestershire Partnership Trust (LPT) which illustrate the potential for change within the system. These studies identified the potential for shift in activity from acute to community settings if admission protocols and settings of care are improved out of hospital, and inappropriate admissions and inappropriate continued stays in both organisations were addressed.

A series of ward audits have been completed. These audits covered 160 patients across 6 UHL wards and identified a quantum of patients that do not need to be cared for in an acute setting. The audit work has focussed on establishing these patient's needs to inform the model of care that needs to be in place for care to transfer safely and effectively to the community.

The ward audits identified that 43 out of 160 patients could be cared for by the LPT Intensive Community Support Service (ICS), if the service could meet a specific set of patient needs. This is shown in the diagram below.

The MDT ward audits identified that 43 out of 160 patients could be cared for at home if the following needs could be met by ICS

- No triggers in the last 24hrs
- EWS of 0 or 1
- Less than QDS observational monitoring
- Oxygen requirements can be met
- Nebs can be managed
- Chest physio (daily only)
- No drains/mini trachy/suctioning
- Low flow CPAP can be managed
- Non-community available meds required (except IV chemo)
- No cardiac intervention (monitoring)
- No renal replacement
- No continuous IV fluids
- No fluid balance monitoring
- No additional biochemistry monitoring
- Dietician input can be managed
- No NGT/parenteral/drains
- No additional monitoring other than standard
- No radiological requirements
- Specialist team involvement can be managed
- Extensive TVN input can be managed
- IV therapy requirements can be managed

Row Labels	Count of Number
15 - respiratory	12
28 - cardiology	2
31 - medicine	9
38 - diabetology	5
43 - medicine	15
Grand Total	**43**

Row Labels	Count of Number
Cardiology	2
Diabetes	5
Medicine	24
Respiratory	12
Grand Total	**43**

Agreement from group that this is a reasonable list of needs to be met by ICS

These finding support the increase in the availability of ICS services that will be described later in this document.

3. Relationship with UHL Strategic Plan

The achievement of the UHL strategic plan is dependent on the reconfiguration of community services and thus on the BCT consultation. An additional dependency is the planned re-configuration of women's services including maternity, which will be consulted as part of the BCT public consultation.

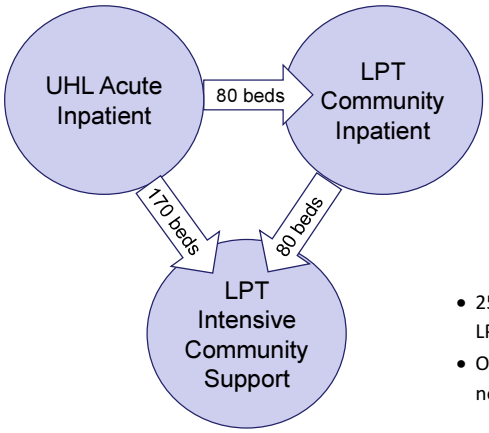
A number of the changes described below will need to be successful for UHL to achieve its strategy and these include

- Planned care activities being increased in community settings
- Improved support of patients with long term conditions to self-care
- Improved diagnostics so that long term conditions can be identified and treated earlier
- Improved admission prevention and support in a crisis

- Increase in the level of Intensive Care Support services in the community
- Implementation of Sub-acute services in the community
- Reconfiguration of the community estate to support overall change in ways of working

The diagram shows the interdependencies between the UHL strategy to become a smaller more specialised service provider with the changes to LPT in patient and ICS community services. For convenience the "currency" of beds is used, however the ICS services are not delivered via physical hospital beds but are services provided at home. Work to explain the relationship between staff levels required to deliver ICS services and number of beds no longer required in an acute setting is ongoing and the present assumptions generate the numbers shown in the model.

- UHL to become smaller and more focused as a Trust, ensuring that local services are integrated with primary and social



- 80 sub-acute beds to be established in community hospitals
- Ability to care for a new cohort of more acute patients in a community inpatient setting

- 250 additional "home beds" to be created in the LPT ICS service
- Operating model in place which meets patient's needs and ensures they can be cared for at home

4. Planned Care:

The overarching strategy for planned care is to move more services into community settings out of the acute setting of UHL carry out more day surgery and repatriate patients who presently go out of county for planned care services. The information below is taken from the Planned Care teams' overview of their plans and is being used to develop the narrative for BCT public consultation.

Community strategy for future service model

The impact of these changes on each locality is presently being completed however it is expected that many community hospitals will see an increase in services. The present profile of where planned care is delivered via the Alliance contract and view of proposed changes is described below.

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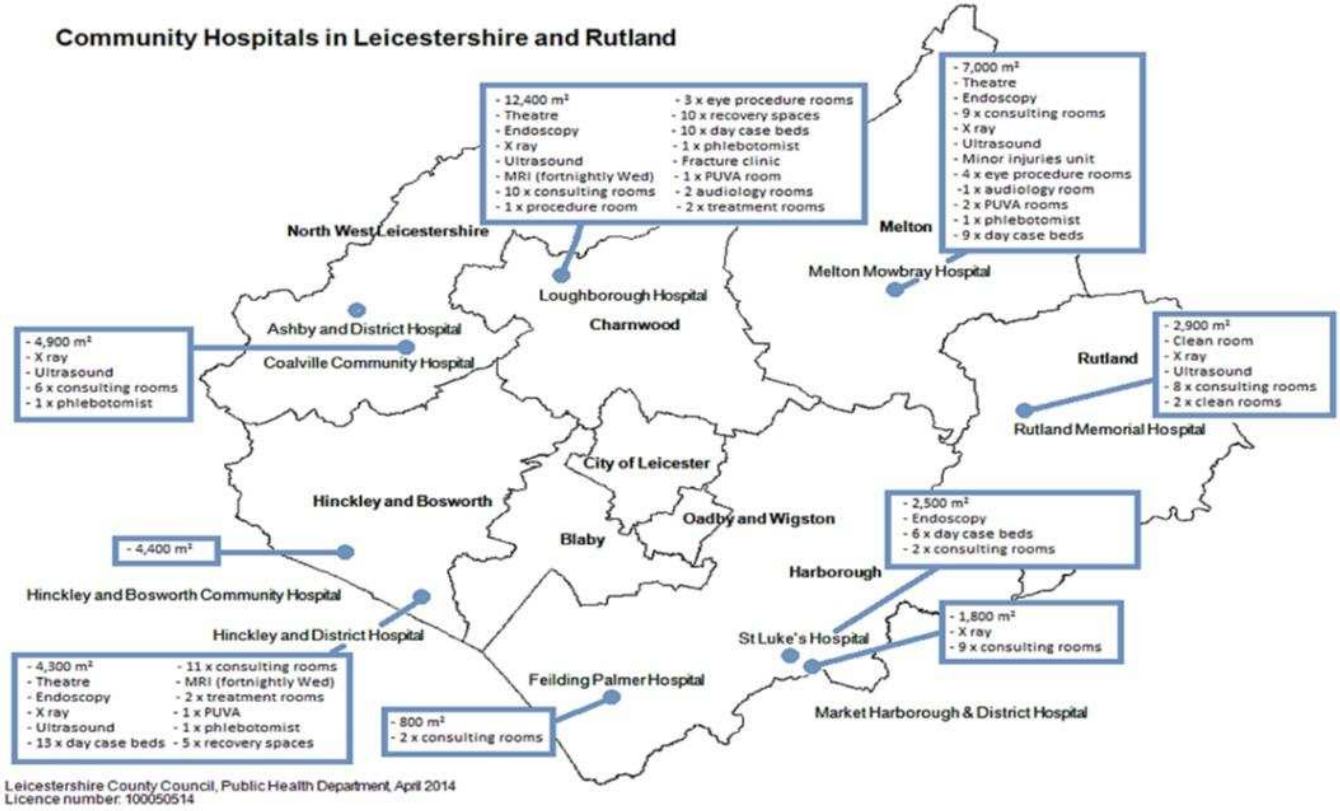
Alliance Community Sites



Potential changes are:

Melton

- Theatre site for ELR Day Case activity done under General Anaesthetic
- Expand endoscopy lists
- Create clean room for additional Day Case activity
- Retain X-Ray, U/S
- Potential for medical day case facility

Rutland Memorial

- Expand as an outpatient site
- Increase diagnostics/one stop shop services
- Develop clean room for Day Case /Out Patient Procedure
- Retain X-Ray and U/S
- Potential for medical day case facility

Market Harborough

- Move Out Patients services to St Luke's new build
- Increase endoscopy activity on St Luke's site
- X-Ray and U/S at St Luke's
- Create clean room in new build for day case and Out Patient procedures

Lutterworth

- Review future of outpatient activity at Fielding Palmer
- Move activity to primary care sites or to Market Harborough
- If site retained as a Hub, potential for medical day case facility?

Implications for sites in West Leicestershire

- The Alliance anticipate continuing to operate from three sites in West CCG (Loughborough, Hinckley and Coalville)
- Case mix of activity may change, potential to concentrate activity in particular specialisms on one or site to maximise use of clinical capacity
- Hinckley needs redevelopment to provide high quality patient environment
- Endoscopy at Hinckley not JAG accreditable, will impact on ability to carry out future work there. Need to consider whether a new endoscopy unit is part of the potential redevelopment of the Hinckley site
- Potential to concentrate General Anaesthetic work in one theatre and use procedure rooms for majority of day case procedures –more modelling and clinical validation required to confirm this
- Alliance could use vacated ward(s) to carry out day case activity such as chemotherapy, infusions etc
- Undertaking review of provision of MRI – economics of mobile MRI
- Engagement with local people via Alliance engagement events and BCT consultation

5. Additional services for those with Long Term Conditions

There are also plans to increase the services for those with Long Term Conditions delivered in community settings. Options presently being considered are

- Additional Bowel scope screening services at Loughborough and St Luke's hospital
- Establishment of community respiratory clinicians and Loughborough hospital as part of an integrated respiratory service
- Specialists nurse/therapists available in the community as part of an enhanced cardio-vascular disease pathway

6. Crisis support to prevent hospital admissions

The approved Leicestershire BCF plan encompasses a number of initiatives that are already increasing services in the community with the goal of preventing unnecessary hospital admissions. These include the following;

- Integrated Urgent Response: These are integrated rapid response community services aimed at avoiding unnecessary hospital admissions for those requiring urgent assistance. Services include a new rapid assessment service for the frail and elderly and people who fall. There is also a plan to develop primary care seven day services that integrate effectively with community based health and care services.

- Hospital Discharge and Reablement: Making significant improvements in the timelines and effectiveness of discharge pathways from hospital especially for frail elderly people, reducing the length of hospital stays. This includes consolidating, integrating and extending community based services into a 24/7 service with a single point of access.

7. Step Down services including intensive community support delivered in a patients home

Sub-Acute Inpatient Care

As part of the overall transformation the community hospitals will increase their provision of sub-acute services which are described below along with LPT's proposed plans which are presently being discussed with the CCG's

Sub-acute care is a relatively new and rapidly growing multi-disciplinary service, which merges the sophisticated technology of a hospital with the efficient operation of a skilled facility in a non-acute setting. Patients with sub-acute needs are those who have had their acute illness, injury or exacerbations treated, but require a short period of complex care and further treatment before they enter the rehabilitation phase of their care pathway. Sub-acute care is less intensive than acute hospital care and more intensive than inpatient rehabilitation – It sits between the two.

Ward audits have identified a number of patients in acute hospital beds, who have sub-acute needs and could be treated closer to home, for a short period of time, in a sub-acute facility if such a facility was available in Leicester, Leicestershire & Rutland. It is proposed to develop two such facilities in Leicestershire as a replacement for acute hospital beds on a like-for-like basis, with the two facilities spread across Leicestershire to give as many patients and their carers the best possible geographical access to this new service. In time, it may be possible to offer sub-acute care at more than two facilities.

Sub-acute patients will receive coordinated services from a multi-disciplinary team including physicians, nurses, therapists and other relevant professional disciplines, with a goal orientated care plan based on their individual needs. Patients will step down to sub-acute care from the acute hospitals in Leicester and will step down again from sub-acute care to local rehabilitation

services provided by an increased level of ICS service in their area (predominantly in their own home, but in their local community hospital if that is not possible).

The location of the two sub-acute wards proposed for Leicestershire is presently in discussion. Both CCG's agree that the existing in-patient bed configuration will need to be re-focused to provide sub-acute care that is presently provided via an acute bed at UHL.

Intensive Community Support:

The intensive community support (ICS) service provides an intensive rehabilitation service to promote independence and recovery for frail older people in an environment that they are most familiar with (i.e. their own home). The multidisciplinary service is advance nurse practitioner led, with medical inputs from the patient's GP as required. The service aims to prevent or reduce the need for permanent or long term care packages, by promoting, supporting and encouraging self-management.

The service is available to all suitable patients registered with a Leicestershire GP. It operates from 8.00am to 10.00pm every day of the year, with overnight support available (through better care funded support). Response time is within 2 hours of referral.

ICS is a scheduled care service, with capacity and phasing as follows:

Year	2014/15	2015/16	2016/17
Beds	126	256	376
Occupancy Rate	90%	90%	90%
Length of Stay	Up to 26 days	Up to 10 days	Up to 10 days

The information below provides examples of the types of interventions delivered by the ICS service. This list is not exhaustive but gives an indication in the types of patients suitable for the service:

- Low Impact – Eye drops, TED stocking reapplications, simple dressings, bladder irrigation, bladder scan, pressure area care, meds prompt, BM check, equipment, leg washing and hosiery application, pessary, meds admin, INR, injection (S/C and I/M), insulin, nephrostomy care, catheter care/bag change, stoma bag, ear drops, safe and well assessment, observations, bloods, care of the elderly, removal of sutures/staples, equipment checks, splinting review.

- Medium Impact – End of life care, chemo pump, Doppler, MS and MND, AUR, catheter, continence, ear syringing, safeguarding, exacerbation of long term conditions, chronic and acute wound care, Hick and PICC lines, IVs, bereavement visits, cannulation, PEG, bowel care, end of life assessments, support, non-complex gait re-education, transfer practice, exercise programmes, outdoor mobility practise, equipment assessment and provision, modification of existing splints.

- High Impact – ICS assessment, falls assessment, HART assessment, CHC fast track, other assessments, complex patients, neurological treatment, falls assessment, complex exercise programmes, therapy initial assessment, complex gait re-education, complex initial assessments, splinting assessment and provision, respiratory assessment and treatment, ADL rehabilitation.

- Hyper Impact – CHC assessment, complex interventions in excess of 2 hours, seating assessments, positioning assessment and provision of individualised equipment.

The findings outlined in the evidence base described earlier have been scaled up to establish which specialties the additional 130 beds will come from. This approach has been sense checked by reviewing the total bed base for the targeted specialties, and cross-checking against the percentage of patients in each specialty that were identified as suitable for ICS in the original audit work. This quantitative work has been considered alongside qualitative feedback from the MDT teams completing the audits, and work with the business intelligence teams, and the out of hospital community services project is confident that 130 beds worth of activity can be transferred to ICS in 2015/16.

Specialty	Beds worth of activity to be moved to ICS
Medicine	72
Respiratory	36
Diabetes	15
Cardiology	7
Total	**130**

The BCT plan to increase the level of this service over the next two years and will require changes to staffing levels. The following additional staff numbers are required to implement the additional 130 beds in 15/16:

Year	**2015/16**
Qualified Nurses	25.79
Physiotherapists	15.47

Occupational Therapists	15.47
Unqualified staff (nursing and therapy)	34.38
Admin	3.00

UHL and LPT have been working together to try to encourage staff to transfer from UHL to LPT in order to allow the first 65 beds to transfer. Open Days have been held with positive levels of interest. Staff have attended Taster Days and a number submitted formal expressions of interest and attended an interview. The process is ongoing and highlights one of the major area of risks to the progress of the programme of changes at pace which is the ability to attract the right staff both in terms of numbers and quality.

The impact on Social Care has also been assessed. Up to one hour of generic social care support per patient per day may be delivered through the ICS model, depending on patient need. This is to ensure the model delivers effective integrated care and efficiently uses our collective resources by reducing duplicated health and social care visits for patients supported by both services. The specific services that will be in scope to be delivered during this hour are currently being developed with all three local authorities.

In-patient beds:

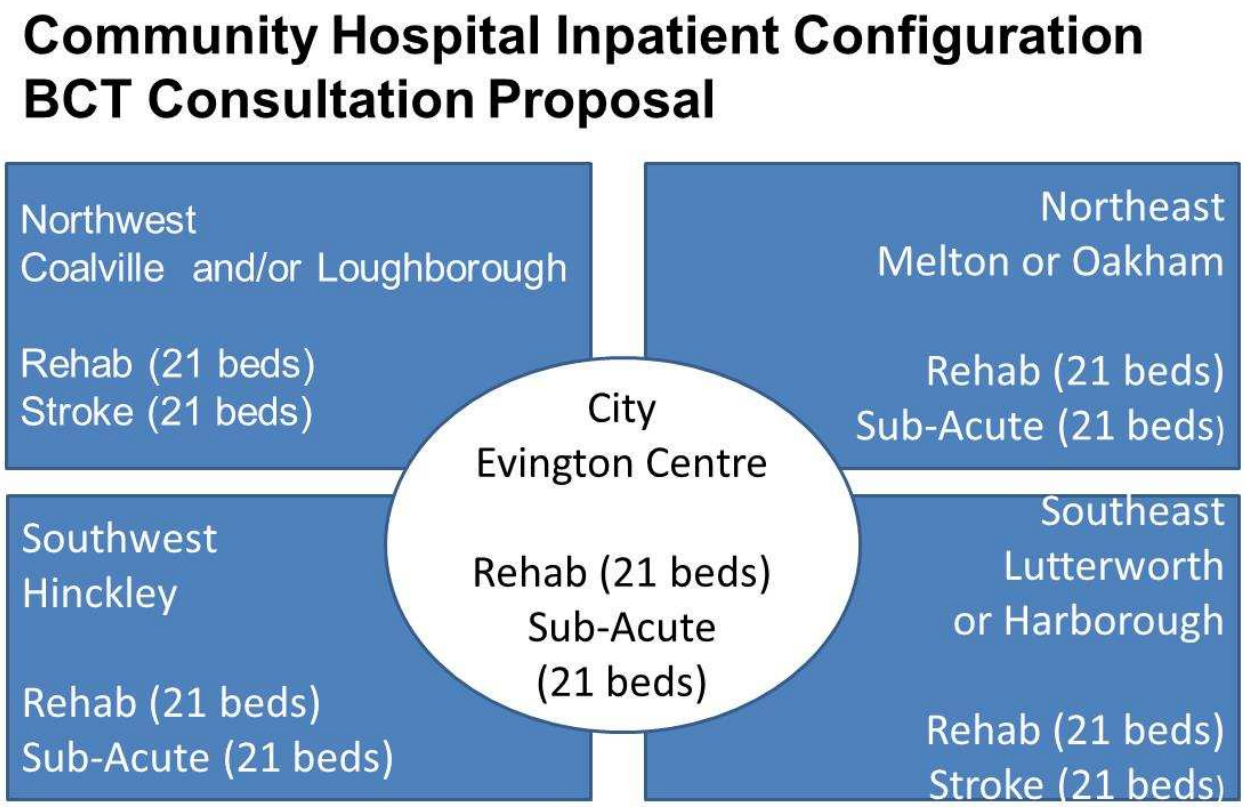
As described above the overall number of in-patient beds in Leicestershire will need to be re-focused to support the improvements to sub-acute care. Additionally there are clinical and workforce drivers that lead to a proposal to reduce the number of community hospitals having in-patient beds.

There are nine community hospitals in Leicestershire & Rutland, each accommodating a range of outpatient, diagnostic and inpatient services. These community hospitals are in Coalville, Hinckley (two), Loughborough, Lutterworth, Market Harborough (two), Melton and Oakham. Over the past decade, more services have been provided in the community setting and there has been less demand for inpatient services in both the acute and community hospital setting.

As such, many of the community hospitals now only have one inpatient ward, operating in isolated conditions which is not felt to be consistently safe for patients nor sustainable in the future from a staffing perspective. Guidance from the Royal College of Nursing on safer staffing for older people wards identifies that community hospital inpatient wards to operate with 1 registered nurse per 7 patients to provide basic safe care and ideally at 1 registered nurse per 5 patients for ideal good quality care. NICE guidance identifies ward size (and layout) as a factor in the provision of safe care and Leicestershire Partnership NHS Trust seeks to have wards that are 21 beds in size to adhere to the RCN and NICE guidance. The sustainability of community hospital inpatient services requires there to be two or more wards on community hospital sites, so that there is sufficient staff to deal with complex clinical and non-clinical situations as they arise and ensure continuous patient safety throughout.

The LPT proposal is that there will be sufficient community hospital inpatient demand for 10 wards (i.e. 5 rehabilitation, 2 stroke rehabilitation and 3 sub-acute care), which will need to be sited in pairs on 5 of the community hospital sites across the whole of Leicester, Leicestershire and Rutland.

The final configuration is still in discussion with the CCGs however the initial principles proposed by LPT are summarised below.



8. Conclusion

As part of the overall change programme known as BCT the delivery of services in the community care service will change over the next 4 to 5 years. The majority of change will be an increase in the availability of services and the moving of some services from an acute setting to a community setting. However there will also be some changes in the utilisation of the overall community estate and the locations where citizens of Leicestershire receive their care. As a result these proposals are in places subject to a public consultation.

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Hinckley Community Hospitals

Update from West Leicestershire CCG
Appendix 2

Owner: Mary Barber

Rutland County Council healthwatch Leicester City Council Leicestershire County Council NHS

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Background

Community health services are currently delivered from a number of locations in Hinckley including GP surgeries and patients own homes. Supporting the delivery of these services are four principle sites:-

- Hinckley and District hospital site, which includes Hinckley Health Centre and offers outpatients and day case services and has an operating theatre, X-ray, ultrasound and endoscopy available on site. There are no overnight beds.
- Hinckley and Bosworth Community hospital provides non-elective care currently with 42 beds. There are no diagnostic facilities at the hospital
- Hynca Lodge, which offers adult mental health care for adults, specifically older patients.
- The Orchard Resource Centre which provides a base for community adult mental health professionals.

The two hospitals in Hinckley are 1.5 miles apart, with the District hospital being in the centre of Hinckley and the Bosworth site on the outskirts of the town.

The Hinckley and District Hospital and Health Centre has outpatient facilities and also houses a GP surgery. Services are provided through the Alliance contract which offers a broad range of services including day case and outpatient procedures and consultations, and are supported by on-site diagnostics. GPs also have direct access to the plain X-ray and ultrasound diagnostic services within the hospital and use them extensively.

Hinckley and Bosworth Community hospital has 42 beds open in two wings: One wing has a four bed ward plus 19 rooms which are single en-suite. The second wing has 19 beds open: a four bed ward with a further 15 rooms being single en-suite. There are a further four single en-suite rooms which are currently closed. During the 2013 community hospitals utilisation review 54% of inpatients at Hinckley and Bosworth hospital were identified as being fit for discharge but awaiting either a place in a residential or nursing home or waiting for other health and/or social services packages of home care in order to be discharged.

NHS West Leicestershire CCG are committed to improving outcomes for patients, supporting more people to live independently in their own homes and wrap support around patients to avoid unnecessary hospital admissions and to ensure that when people are admitted they are returned to their community in a timely way. In order to do this the shape of services need to change.

Over the last 12 – 18 months the CCG has engaged widely using an Experience Led Commissioning model to understand the views of patients carers and staff about what is important to them for services across Hinckley and Bosworth.

The key themes emerging from this engagement have been:

- Expand community-based care
- Building hubs of care
- A review to scope all possible community care
- Invest in fit for purpose hospital buildings
- Invest in relationships
- Join up support for exercise and mobility preservation; make it integral to improving outcomes
- Improve care before and after hospital

- Support family carers to do a good job
- Adopt a more person-centred approach; especially to prescribing medication
- Power to the people: improve self-care
- Focus on prevention
- Focus on staff wellbeing
- Power for the people: the CCG and the community work together to hold providers to account.
- Make unpopular decisions based on evidence. Take money away from people who are not doing the work.

Further engagement is planned in September and October ahead of the wider BCT consultation.

Proposals/Options

In order to deliver improved community services in response to the public views; NHS West Leicestershire CCG are looking at rationalising the services delivered on the Hinckley hospital site in order to free up resource to enable more people to be supported at home. What this will mean for people of Hinckley is that; there will an increased level of support for people with long term conditions and those who are vulnerable available in the community close to where people live. When people do need the care of a specialist centre there will be capacity and capability in the community for them to be returned home as soon as their condition allows for their long-term care and rehabilitation.

There are a number of possibilities for delivering these improvements through the consideration of how Hinckley hospital is used:

- Continuous improvement using contractual levers to deliver improved outcomes
- Targeted investment to maintain specific services can be delivered on site
- Commission more activity on the site to prevent people going to other hospital sites which may be out of area
- Deliver activity in alternative settings e.g. primary care settings

To inform the proposals for change a mapping process is being undertaken to understand what services are currently provided on the site along with the activity and what services could be developed here or delivered in an alternative setting.

Engagement and consultation

The next step for engagement is to hold two Pledge and Design events to tell people what we have learnt and share the range of possible ways we could design and improve services based on evidenced based research we have gathered. At the events we will work through the challenges we will need to overcome and opportunities that each of the possibilities present. With the community, we will then work out what is feasible and appropriate for the community. These events are scheduled to be held on the 5th October 2015. Consultation will form part of the BCT public consultation.

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Resource Implications

The CCG recognises that there are challenges around workforce with a scarcity in certain specialties and difficulties in recruitment. To deliver the new model of care with a focus on care in the community and more investment in the prevention agenda requires a different type of workforce. The CCG plans include the development of smart generic workers (similar to the old SEN role) that can work across the boundaries of health and social care. The type of work this role would undertake would be supporting daily living activities alongside a mindfulness approach that would enable them to understand an individual's needs, supporting them to maintain independence.

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Summary of East Leicestershire and Rutland CCG Community Services Strategy

Appendix 3: BCT HOSC 9th Sept 15

Owner: Mary Barber

APPENDIX

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Leicester, Leicestershire & Rutland health and social care

1. Background

East Leicestershire and Rutland (ELR) CCG have a detailed strategy for the future of community services that they commission. The document describes the situation today and outlines a future model of care and the workforce challenges that need to be addressed to achieve that goal. This is not yet a public document so the Case for Change and a summary of the future services and workforce challenges are described here.

2. The case for change

The CCG's review of current models that are being delivered by providers including engaging with local partners and stakeholders has clarified the problems encountered by patients, carers and GPs when accessing health services locally.

There is widespread acceptance and agreement that change is both necessary and desirable.
There is equal recognition and acceptance by all concerned – including the CCG – of the importance of engaging with local stakeholders as part and parcel of agreeing and implementing the final decisions on how to proceed in detail.

The principles and factors which will influence the design of a proposed service model are:

- Home First as a prominent principle of service delivery;
- Demographic pressures – more people in the CCG area will be over 70 years of age by 2030 and many of those people will be living with a range of complex health issues requiring rehabilitation and reablement;
- Patients find accessing care confusing and setting up a care package for a patient is complicated and time consuming for primary care;
- Recruitment of GPs is becoming more difficult and it is likely that recruitment locally will not be able to keep pace with demand;
- GPs will be managing a higher acuity patient in the home;
- Significant and unacceptable variation in response times across the area covered by the CCG;
- Communication between GPs and community service staff is reported to be sporadic at times and as a result is felt to be inefficient;
- Significant recruitment and retention issues in community nursing workforce with a high vacancy rate;

- Community services set up to deliver care aimed at providing an alternative to and avoiding hospital admissions is impacted by inability to recruit staff and the pace of Better Care Together changes;

- Current condition of estate across ELR is variable and is – in parts - poorly utilised;
- Small numbers of physical beds are spread across four sites which risks compromising clinical quality (limited peer review, isolation of staff) and is not cost effective; (HBN Adult 0401 – 24 beds); and

- Under-utilisation of current Intensive Community Support (ICS) beds.

3. Future model of care

Model Overview

It is acknowledged that the 32 GP practices within ELR CCG are starting to work more closely together to support the delivery of a different and improved model of primary and community services. Locally, there are networks of practices working together to develop innovative methods of general practice, but although these networks will strongly influence local patient needs, there is a move towards a single ELR-wide federation which would be a key partner to deliver the needs of patients for both primary and community services, This service would be delivered for group/hubs of patients up to 40,000 in size to ensure local universal cover. The CCG aims to deliver 'wraparound community services'. 'Wraparound' can be defined as a team of individuals / services who are relevant to the care of an individual collaboratively developing and implementing an individualised plan of care, known as a wraparound plan. Specifically for ELR CCG this means staff from different agencies communicating and operating as one team, including physicians working beyond the hospital walls with colleagues in primary and social care enabling services to be designed around general practice as the centre of patient care.

We are proposing for discussion a hybrid model where community teams will work with and be answerable to general practice groups. Under this proposed model, it is envisaged that teams can be reconfigured in terms of bases to be near to the populations that they serve.
There will be an expectation that teams will be required to be locality specific and be co-located (and integrated) with social care staff. Jointly appointed Community Matrons (GP provider contract) will help to bridge the gap in accountability.

This type of proposed model lends itself to the development of a single service specification for community health services with a possibility to include social care provision in agreement with local authority partners. This will support the development of outcome based contracts. The requirement to undertake risk assessments and preventative work will be strengthened.

It is suggested that a future community service model could have 3 main Levels:

Level 1 - Local Wraparound Services (Hub);
Level 2 - Medium Scale Services including rehabilitation and reablement; and
Level 3 - Large Scale Services including sub-acute care.

Level 1 and 2 may be interchangeable depending on patient needs and numbers of practices covered.
Joint training and education across practices will support professional development and changing service requirements.

Level 1 – Local Wraparound Services

In Level 1 some local services will be delivered in individual GP practices or hubs. Services may include:

- Scheduled care community nursing services;
- Centralised complex patient lists with designated GP leads for care coordination;
- Therapy services;
- Pharmacy support;
- Community Matrons; and
- Community geriatrician support.

Level 2 – Medium Scale Services - including rehabilitation and reablement

In total we are suggesting that ELR CCG requires up to 8 substantive administration bases for community and social care services each serving a population of around 25-45k. This would mean aligning administrative bases for community teams to the geographical areas that they cover as part of implementation planning. At this level services could be shared across larger groups of practices. This could include:

- Centralised complex patient lists with designated GP leads for care coordination;
- Specialised asthma, diabetes, cardiac, musculoskeletal, respiratory and cancer services;
- Rehabilitation and reablement; and
- Community geriatrician support.

All 8 areas could provide co-located health and social care teams comprised of social care, therapy services, planned and unscheduled care teams, mental health teams and voluntary sector. The CCG will obviously want to engage and work with the GP practices, the LLR Alliance and the Local Authority to determine a final settled agreement on sites for the delivery of selected outpatients' services.

Links between community and acute care could be strengthened to give planned and unscheduled care teams a stronger remit to work with local providers to either prevent admission or bring patients out into the community earlier supporting the direction of the Better Care Together Programme and the Urgent Care Workstream.

Level 3 – Large Scale Services - Sub Acute

Some services may need larger critical mass to be viable. This group of services includes:

- Access to acute consultant advice - systems for 24/7 support across ELR CCG;
- Ambulatory services; and
- Physical beds.

A wider range of ambulatory services are suggested for Melton, Rutland, Lutterworth and Market Harborough Hospital sites subject to the critical mass being available to make the service sustainable and the results of clinically-led engagement. Services may include:

- Lower volume out patients;
- Diagnostics – (plain film x-ray, ultrasound, ECG);
- Podiatry;

- Therapies;
- Specialist nurse teams;
- Intravenous administration; and
- Urgent Care and 7-day service offer.

Work undertaken through the LLR Better Care Together Programme has confirmed that the current bed base in the community does need to be maintained to enable the left shift of activity from Leicester General Hospital enabling patients from the 'sub acute ' category to be cared for in a community hospital instead. The current configuration of community hospital beds means that ward teams are geographically isolated and resources including staffing are used inefficiently.

In addition the CCG Community Services Strategy emphasises the research showing the benefits of avoiding hospital admissions for the elderly and those with chronic disease. Particularly important are the links between the disruption and stress caused by a hospital admission including the increased risk of health care acquired infections which delays recovery associated with longer stays in hospital beds. The category of patient who previously may have been admitted to a community hospital bed will be able to receive their care in their own home. The current 88 physical beds are, at the present time supplemented by 48 virtual beds. This virtual bed number is likely to at least double over the next 3 years.

Patients in virtual beds could benefit from full multidisciplinary care for up to 24 hours if necessary, targeted to individual needs to enable recovery and rehabilitation within their own environment. The consolidation of physical beds described above is supported in the LLR Better Care Together Strategic Plan and also reflects the future model of care proposed by LPT.

It is envisaged that physical beds will, in future, be on no more than 2 sites, yet to be confirmed. The precise location of these will be subject to further engagement and consultation as part of Better Care Together

4. Workforce

Workforce features heavily in the proposed community services model and is one of the greatest areas of risk of implementation.
A Better Care Together Workforce Enabling Group has been established to support, leadership and delivery of a workforce planning and education commissioning strategy across the LLR system.

This is clearly a positive approach to addressing health economy wide workforce issues, however ELR CCG will need to have specific workforce plans in place to address current and future issues and meet the requirements of a new model including:

- Addressing the high vacancy rate for community nursing;
- Current under resourcing of ELR CCG's primary care and community nursing workforce;
- Integration of primary, community, social care, medical and non-medical workforce;
- Lack of transparency of actual nursing numbers available to the CCG;
- Perceived poor use of current workforce with excessive administration and duplication of tasks; and
- Integration with telehealth and telecare.

A full review of workforce will be undertaken to identify capacity and workforce requirements across Leicester, Leicestershire and Rutland.
The outputs from this review will indicate the levels of recruitment, training and movement of staff between different sectors and at different skill levels and will include future community and primary care workforce requirements

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Leicestershire Partnership NHS Trust

West Leicestershire Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 9 SEPTEMBER 2015

REPORT OF WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP AND LEICESTERSHIRE PARTNERSHIP NHS TRUST

IMPLEMENTING "FIT FOR FUTURE": A REVIEW OF COMMUNITY HEALTH SERVICES IN ASHBY

Purpose of report

1. The purpose of this report is to summarise the process which led to the decision to close Ashby and District Community Hospital (ADH), and update the Health Overview and Scrutiny Committee with regard to the plans for its implementation.

2. It should be noted that the term 'Boards' used in this report refers to the governing Boards of West Leicestershire Clinical Commissioning Group (WLCCG) and Leicestershire Partnership NHS Trust (LPT).

Policy Framework and Previous Decisions

3. At an extra-ordinary board meeting on 27 May 2014, the Boards approved proposals to change the model of care for Ashby community health services, which will result in the closure of ADH.

4. The Boards received assurance in relation to the clinical case for change, the comprehensive process of patient and public engagement which was used to shape the clinical case for change, evidence that the Secretary of State for Health's "four tests" had been met, and that obligations in relation to Due Regard had been considered. The paper is available on either organisation's website (hyperlink below). The Board meeting where the decision was made was held in public.

5. It was noted that the National Clinical Advisory Team (NCAT) supported the proposal to close ADH and reinvest resources in other community services.

Engagement and Consultation

6. An extensive engagement phase was used to develop the clinical case for change, receive public feedback and engage with staff at ADH. A wide range of activities took place including:-
   (a) Public meetings;
   (b) Clinical engagement events;
   (c) The development of the Ashby Patient and Public Panel;
   (d) Staff Briefings at Ashby District Hospital;
   (e) Seldom Heard Engagement;
   (f) Partnering with key stakeholders.

7. The evidence of the range of stakeholder engagement and the feedback received is available in the May 2014 Board papers, or on the public website of both Boards.

8. Formal public consultation commenced on 6 February 2014 and closed on 6 April 2014. A copy of the consultation document is available in the May 2014 Board papers on the public website of both Boards.

9. Patient, public, staff and other stakeholder views were sought on two future options:-
   (a) Option 1: Make better use of the services in Ashby District Hospital;
   (b) Option 2: Move services out of Ashby District Hospital to other local places, increase the range of community health services and provide more care in people's homes.

10. WLCCG and LPT commissioned Community Research, an independent company experienced in consultation design and delivery, to help analyse and report on the responses. Their independent report is attached as Appendix 1 to this report.

11. In response to the public consultation 52 per cent of the respondents(202 people), supported the option to move services out of Ashby District Hospital to other local places, increase the range of community health services and provide more care in people's homes. It should be noted that public consultation was one of a number of methods to secure public and stakeholder feedback, and the actual number of people and organisations who were consulted and engaged with during this period was much higher. The Boards acknowledge and appreciate that not all members of the public will support the decision; however the Boards were assured by the clinical case for change and supporting evidence.

Implementation

12. Since the decision has been made, the Boards have received a range of assurances in relation to performance against pre-determined metrics which demonstrate that performance of services, which provide alternatives to in-patient bed based services at ADH, meet patient and commissioner expectations.

13. A business case for the relocation of services currently provided from ADH has also been approved, with a summary version at LPT's public board and a full commercially confidential version at LPT's confidential board. The confidential version of the business case has subsequently been disclosed as part of an Freedom of Information (FOI) request in which commercially sensitive financial information was redacted.

14. The Boards appreciate that some members of the public have challenged the cost of repairs to the building and the viability of the business case. It should be noted that sufficient assurance was received by the Board members to proceed, as the survey which identified the costs of repairs which would bring the hospital up to a safe standard was provided by NHS Estates experts. It is important to note that all building work undertaken in a hospital setting must meet clinically safety standard and fulfil statutory compliance requirements.

15. Plans for relocating services provided from ADH are outlined below:

(a) In-patient beds (closed in October 2014)

(i) During 2012-13, an analysis of bed usage at ADH indicated that 25 per cent (4 out of 16) beds were occupied by residents with an Ashby postcode. Further analysis showed that almost 50 per cent of patients occupying the beds could be safely cared for at home if an alternative service was available.

(ii) In response to this, during 2012-13 the Intensive Community Support (ICS) service was established, providing a home based rehabilitation service for people who are able to receive rehabilitation in their home. West Leicestershire has 48 home based ICS "beds" which are used flexibly across the district.

(iii) Both prior to, and since the closure of the 16 in-patient beds at ADH, Ashby residents requiring in-patient rehabilitation in a community hospital are able to access in-patient care in any community hospital. LPT's policy is to place people in a community hospital bed as close to their home as possible. It is recognised that occasionally this may be further away from home than desirable, both pre- and post- closure of the beds at ADH. It is worth noting that prior to the closure of the beds at ADH, the majority of people with postcodesLE65 or LE67 received their in-patient rehabilitation at Coalville Community Hospital. This pattern has not changed since the closure of the beds. In the 6 months prior to the closure of the beds, two patients with LE65 or LE67 postcode were noted to have been placed at Market Harborough Community Hospital. In the six months post closure, there were no placements of people with LE65 or LE67 postcode placed outside of the three West Leicestershire Community Hospitals (Coalville Community Hospital, Loughborough Community Hospital, Hinckley and Bosworth Community Hospital).

(iv) The numbers of people with LE65 or LE67 postcode accessing in-patient palliative, or end of life care services in a community hospital are very small. In the six months prior to closing the beds, one patient accessed these services at ADH, and ten at Coalville. Post closure of the beds, four people with these postcodes have received palliative, or end of life care services at Coalville Community Hospital. Post closure of the beds, no-one with LE65 or LE67 postcode has been placed in a community hospital outside of West Leicestershire for palliative or end of life care services. It should be noted that the palliative care suite at ADH was rarely used, as due to the layout of the building the room was located a considerable distance away from the main body of the ward, compromising patient observation and potentially posing a patient safety risk.

(v) Significant work has been undertaken to improve flow through community hospital beds, aligned to the LLR Urgent Care Board's Discharge work stream. It should be noted that in four of the seven County Community Hospitals with in-patient beds (excluding ADH), a statistically significant reduction in length of stay has been achieved. The reduction in length of stay in 2014 -15 equates to the additional capacity to admit 679 patients when

compared to the 2013-14 baseline, or the equivalent of an additional 37 beds. In terms of County Community Hospital in-patient capacity, the 2014-15 reduction in length of stay adequately mitigates for the closure of 16 in-patient beds at ADH.

It is important to note that, despite reducing the LLR bed base by 16 beds in October 2014, no additional winter pressure beds were opened across the local health system, unlike previous winters.

(b) Out-patient consultant led (elective) services (relocated in April 2015)

(i) There were four consultant led outpatient clinicians operating from ADH. Out of the 300 consultant clinic appointments per year at ADH, 75 per cent attendees travel from Coalville for their appointment. For those who require a diagnostic intervention (eg X-ray), they are required to make a second attendance at Coalville Community Hospital as ADH does not have imaging facilities.

(ii) These services have all been relocated to Coalville Community Hospital, where patients will receive their imaging and other tests on one site, therefore reducing the repeat visits for a diagnostic intervention and improving the patient experience. This was considered to be beneficial from a clinician and patient perspective.

(iii) The Leicester, Leicestershire and Rutland Alliance is developing plans to provide more local elective services for the people of Ashby from April 2016. These include plans for local ophthalmology, dermatology, cardiology and ear, nose and throat (ENT) clinics in collaboration with local opticians and GP practices in Ashby.

(c) Nurse and therapy led clinics (pending relocation to Hood Park Leisure Centre)

(i) Hood Park Leisure Centre has been approved as the alternative site for community nursing and musculo-skeletal (MSK) clinics. The clinical and professional support for a change in emphasis from a clinical model centred on “illness” to a model underpinned by “wellness” scored highly in the option appraisal and both the Leisure Centre and Boards are confident in an approach which creates a “Health and Well-Being Zone” for the people of Ashby.

(ii) The Boards appreciate that there are public concerns about planning permission at Hood Park Leisure Centre and consider this a matter for North West Leicestershire District Council. If planning permission is not secured, or timeframes become extended, the option appraisal will be re-visited and other local alternatives will be explored.

(d) Team and administrative bases (pending relocation to Legion House, Ashby)

(i) It should be noted that the business case does not support the use of clinical space for administrative team bases because there are more cost effective ways of providing this space. A range of team bases have been secured and

the location of these has largely been driven by clinical staff, who have expressed a preferable location. Preferences have then been reviewed from a "value for money" perspective.

(ii) Team bases for district nurses, health visitors and administrative staff currently located in ADH will relocate to Legion House in Ashby. The team base for school nurses has already relocated to Whitwick Health Centre. This was the preferred option for the school nursing team and afforded a small saving to LPT.

16. All services which were available at ADH have either been, or will be relocated. In addition, the ICS service provides a local alternative to in-patient care in people's home, when it is a safe and appropriate option.

17. LPT has given public assurance that ADH site will not be disposed of until all services have been relocated. Disposal will be overseen by the Department of Health and in accordance with NHS Estates Code.

18. Since the decision was made in May 2014, the Boards have regularly re-confirmed their support for the decision to change the model of care and the plans to relocate services to alternative settings.

Better Care Fund (BCF)

19. The Better Care Fund has been a key enabler in enhanced community based services, and the range of community services available to the people of Ashby have expanded since the in-patient beds closed. Over the last year the Better Care Fund has invested locally in:-

(a) A rapid response falls service;
(b) A night assessment service to enhance the Integrated Crisis Response Service;
(c) An Older Person's Assessment Unit (OPU) based at Loughborough community hospital.

Better Care Together (BCT)

20. The BCT programme involves very significant changes in the way that health and social care is delivered to local people, with a shift away from reliance on acute hospital care towards preventative and community-based strategies. As a result, it will be necessary to adjust the balance of capacity across the system, be that in terms of actual beds or home based 'virtual' beds such as those provided ICS.

21. The above changes in capacity will be taking place against a backdrop of very high current pressure on capacity across the system. It is anticipated that this will lead to some questioning of the rationale underpinning the BCT planning assumptions. As a consequence, the BCT Partnership Board has commissioned the development of a system capacity model, using agreed principles across LLR. This work includes best practice modelling of bed occupancy to ensure that targets are appropriate across LLR. Although bed occupancy in LPT is below the contractual occupancy target commissioned by the CCG, which has been identified by the recent CQC report as

an area of concern, the CCG and LPT will continue to work together to support flow through the system and collectively manage the consequent impact on occupancy.

22. The net result of this modelling will determine the bed and other capacity required by different parts of the system in order to deliver services in a sustainable way whilst implementing the changes envisaged by the BCT Programme. The Boards appreciate the level of public concern in this regard. It should be noted that even if the capacity modelling exercise indicates the requirement for additional in-patient capacity in community hospitals, there are void spaces in more modern community hospitals which will be utilised to meet this need. The Boards are committed to commissioning and providing modern day healthcare from facilities which are fit for the future.

Conclusion

23. It is appreciated that some members of the public remain concerned about the decision to relocate services and close the ADH; however the Boards are confident in the processes which led to the decision being made. In March 2014 the Health Overview and Scrutiny Committee supported Option 2, with the caveat that any decision regarding community health services in Ashby should not be taken in isolation and that it would be important for West Leicestershire Clinical Commissioning Group to ensure that provision of community beds was maintained across West Leicestershire. The Boards recognise and appreciate public concern about the decision to close ADH, but remain confident that appropriate assurances have been received and the business case is viable.

24. A comprehensive process of local public engagement was instrumental in shaping the clinical case for change; one element of this process was the formal public consultation process.

25. All services provided from ADH have, or will be relocated, as the plans for implementation are progressed.

26. Quarterly Board assurance processes remain in place to allow on-going scrutiny whilst the implementation plan is executed.

Background Papers

http://www.leicspart.nhs.uk/_Aboutus-Trustboardmeetings2014-May2014Extraordinarymeeting.aspx

http://www.westleicestershireccg.nhs.uk/page/extra-ordinary-board-meeting-27-may-2014

Circulation under the Local Issues Alert Procedure

Mr. J. G. Coxon CC

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List of Appendices

Appendix 1 - Community Research Report.

Relevant Impact Assessments

Equality and Human Rights Implications

In taking the decision on 27 May 2014, the Boards were assured that obligations in relation to Due Regard had been considered. This is the legal duty that public sector organisations have to promote equality.

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Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 9 SEPTEMBER 2015

REPORT OF THE CHIEF EXECUTIVE

COMMUNITY HEALTH SERVICES IN ASHBY: REPRESENTATIONS MADE BY THE ASHBY CIVIC SOCIETY

Purpose of report

1. The purpose of this report is to present representations made to the Committee by the Ashby Civic Society with regard to the closure of Ashby District Hospital. This is also the subject of a report elsewhere on the agenda from West Leicestershire Clinical Commissioning Group and Leicestershire Partnership NHS Trust. It is proposed that the two items are considered together.

Background

2. The representations consist of a letter to the Health Overview and Scrutiny Committee, which is attached as Appendix 1 to this report, and a report summarising the recent history of events leading to the proposed disposal of Ashby and District Hospital, which forms Appendix 2 to this report.

3. For clarification, the County Council's Constitution states that any decision to refer a matter to the Secretary of State for Health can only be made by the full Council. The Committee would therefore need to have cogent and compelling reasons for making any such recommendation to the Council.

Conclusions

4. The Committee is asked to consider the representations made by the Ashby Civic Society alongside the report submitted by West Leicestershire Clinical Commissioning Group and Leicestershire Partnership NHS Trust which appears elsewhere on the agenda for this meeting.

Circulation under the Local Issues Alert Procedure

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List of Appendices

Appendix 1 – Letter from the Ashby Civic Society to the Health Overview and Scrutiny Committee
Appendix 2 – Report from the Ashby Civic Society summarising the recent history of events leading to the proposed disposal of Ashby and District Hospital

APPENDIX 1

Ashby de la Zouch Civic Society

Shaping the future and preserving the heritage of our town

30-7-15

To the members of the Leicestershire County Council Health Overview Scrutiny Committee,

The enclosed document summarises the recent history of events leading to the proposed disposal of Ashby and District Hospital. We are respectfully referring this matter to you, asking you to reconsider the evidence for closure because we believe that:

a) you could not have had all the relevant information you required in your previous considerations and
b) the Overview and Scrutiny Committee of Leicestershire County Council has the power to request the Secretary of State to re-consider the closure and disposal of the hospital as we have been advised recently.

As you are aware one of the preliminaries to disposal of an NHS property is a demonstration of **public and patient engagement**. In this case this seems to have consisted of less than one eighth of a percent of the population of Ashby's 13,000 residents, is this a demonstration of fair engagement?

Your OSC is charged with reviewing the adequacy of performance indicators to monitor change the delivery of healthcare . In this case the NHS has offered many performance indicators but in our view the real tests or indicators for the loss of the hospital are: "where are the patients being treated ? Is is local? And if not, where?"

We understand that according to your guidelines , you would expect to see **a clear strategy and action plan that takes into account changes in the service environment.** Therefore, are you convinced , that the following has been adequately taken into account in this closure plan:

1. The population increase in and around Ashby due to increased home building ,
2. The expected increase in an ageing population with the associated increased health needs
3. The access issues due to poor transport transport links in Ashby de la Zouch ,
4. Bed planning which demonstrates the synergy between acute and community hospital beds in Leicestershire and across the borders of Derbyshire and Staffordshire which reflects the traditional referral patterns for Ashby patients .It follows that this should assure the public of an increased capacity to cope with the apparent increasing failure of the NHS to cope with winter bed crises?
5. There exists a convincing evidence base for the alternative treatment options to the in- patient admissions at ADH.

Your committee needs to be confident that the proposed strategies **are adequately resourced in terms of money and staff.** We wonder whether you have seen a straightforward explanation of capital and revenue expenditure forecasts of all the available options set out before the closure decision; and whether you can be confident of workforce planning which are paramount to the newly proposed alternatives to in patient care to be delivered in the Community. We are particularly worried about current skilled staff shortages and the rising

costs of unskilled labour which will be required to support people in their own homes with the introduction of the Living Wage? (BBC report of 27 July 2015 , by Nick Tigge)

When you review the full panoply of services designed to replace the hospital can you say that the public as service users of the future have been consulted? Does the Business case prior to the decision to close look like the Implementation Business Case drawn up in November last year?

Has the public been consulted on the use of building changes such as the Leisure Centre at Hood Park being used for health purposes rather than the leisure function for which it was gifted?

Unless you can see full and satisfactory reassurances to these doubts we ask that you should, in your role as guardians for the people of Ashby and District, refer the matter to the Secretary of State.

Yours Sincerely

Mr Ken Ward

Chairman

Ashby Civic Society

Enclosed: The Imminent Closure of Ashby Cottage Hospital, is it flawed?

APPENDIX 2

The Imminent Closure of Ashby Cottage Hospital, is it flawed?

Introduction

In May 2014 the new chief executive of NHS England , Simon Stevens, launched into his new role by stating that "the NHS must stop closing cottage-style hospitals and return to treating more patients in their local community"[1]. Following this statement the Community Hospital Association received a number of positive unexpected calls from commissioners and hoped that the lot of the community hospital was changing[2] ; sadly not in the case of Ashby District Hospital. In the same month on the 27-5-14, Leicestershire Partnership Trust (LPT) and West Leicestershire Clinical Commissioning Group (WLCCG) announced the closure of the Ashby District Hospital (ADH).

Ashby District Hospital was built by charitable local funding and opened in 1897 following which the ownership was transferred to the NHS in 1948. At this time it was hoped it would remain a healthcare facility ad infinitum. Originally it was extensively and effectively used by the local GPs until a few years ago when NHS management unilaterally took control from the local GPs thus making it near impossible for them to use it.

The hospital provided 16 inpatients beds mainly for rehabilitation after acute hospital stays, post day case procedures, respite care and end of life care. In addition to this there were outpatient services for visiting consultants (general surgery ,ophthalmology , ENT and dermatology), physiotherapy, dietician, sexual health services for young people , administrative base for the district , school and community nurses and specialist nurse led services (stoma, respiratory and heart failure ,continence) .

Closure and Public Consultation

This closure announcement followed just two months of what the LPT and WLCCG described as local consultation or in reality, a paper survey which involved 388 respondents. The LPT outcome was that 52% of respondents (which means a difference of opinion in a mere 15 people) were in favour of the closure of the ADH. However many of the respondents were from outside of the area and given that Ashby de la Zouch has a population of nearly 13,000 inhabitants, it remains our opinion that this result was not representative of the local population.

As a result of this the Ashby Civic Society (ACS) supported by the Town Council (which has expressed opposition to this closure on many occasions) has campaigned to bring the plight of the ADH to the general public. In September 2014, members of the ACS conducted a 2 week survey on the main street of Ashby de la Zouch. In our survey, the result demonstrated that 99% of the 3,080 respondents opted for the retention of the ADH and only 27 respondents opted for closure which was quite contrary to the results published by the Trust.

[1] Is Simon Stevens right to back community hospitals? Health Care Professionals Network, The Guardian.
[2] ibíd.

Subsequently the ACS approached the LPT and the WLCCG in order to present the considerable concerns of the Ashby residents. The survey was presented in September 2014 but it would appear that this vital evidence base was not taken into consideration with respect to their deliberations. In our view, despite numerous presentations and communications to both of these organisations, there has been no public consultation consisting of a proper process of dialogue which is necessary for an informed decision.

In the absence of further public engagement, the ACS organised a public meeting on the 26th February 2015 in order to discuss the future of ADH and the survey results further. The meeting was well attended with over 200 local people and the majority wishing to retain the hospital. This allowed the views of local politicians, GPs and other relevant stakeholders to engage with Ashby residents. However both the LPT and the WLCCG refused to attend the public meeting thus denying the inhabitants of Ashby de la Zouch the opportunity of expressing their views and participating in a two way dialogue.

Unfortunately despite the local opposition to the closure of our NHS hospital, the LPT closed the inpatients beds in the September 2014. This left a gap in the palliative care, end of care and rehabilitation beds in the Ashby region and throughout the following winter none of the acute hospitals in Leicester, Burton or Derby hit the government's winter bed targets which depend on having community available into which patients can be discharged.

As a consequence, some post acute patients (many of them elderly) are having to travel to hospitals in Derby, Hinckley, Lichfield, Market Harborough etc. which are neither easily accessible by public transport routes or within an easy driving distance. We have been told that the outpatient services which were all sited on the one site are now to be dissipated throughout the region. We have been denied access to the full business plans for the closure and can therefore not make sense of the decisions to close nor of the economics of the plan.

Of urgent concern is the needs gap which exists for end of life and palliative care in the Ashby region since the closure of the inpatient beds. In July 2015 the Care Quality Commission (CQC) quoted this as a particular concern and stated that *"the trust had no end of life strategy ... and staff were unable to show us evidence of clinical audits"*[3].

With respect to the outpatient services, we have been told that the hospital will remain open until alternative suitable accommodation is found. It has been proposed that our outpatient services are to be dissipated across the region into a variety of privately leased properties. Indeed, office facilities for the community nurses are about to be leased from Legion House at an estimated cost of £12,000 per annum while the ADH remains open.

[3] www.cqc.org.uk/sites/default/files/new_reports/AAAD5236.pdf

Unfit for Purpose?

On the 27th May 2014, Dr Nick Wilmott (Urgent Care Lead) from the WLCCG stated;

"The outpatients facilities at the moment are not fit for purpose ...Part of our plans now are to provide state of the art outpatient facilities , a greater range of specialities and more services closer to people's homes."[4]

In our opinion, outpatient services scattered around the NWL district is not what one would call "state of the art facilities". There appears to a considerable contrast in what is happening and what has been promised!

It would seem that the ADH had been deemed as unfit for purpose following a report commissioned by the LPT from Ernst and Young in August 2012[5]. However only a month later, in September 2012, the CQC[6] (the national inspectorate for the NHS) visited the site finding the hospital to be in good order and fit for purpose. Yet again it would appear that there is a significant contrast between the results of these two reports.

In March 2015, the CQC audited the Leicester Partnership Trust the outcome of which is most informative about the status of community health inpatient services. Despite the assurance from the Trust that there has not been any adverse effects following the closure of the Ashby beds , the community inpatient service was rated as requiring improvement;

"*Bed occupancy for the last two quarters of 2013/2014 was around 89% .Overall community hospital occupancy rates for March 2015 were 94%, which reflected bed pressures in the local region .It is generally accepted that when occupancy rates rise to above 83% , it can start to affect the quality of care provided to patients and the orderly running of the hospital. The trust confirmed the service line was contracted to 93%, the trust recognised this was not an appropriate target and was working with commissioners to negotiate a more appropriate target.*[7]

There were three out of the five questions that were rated as "requires improvement".

1. Are services safe?
2. Are services caring?
3. Are services well-led?

And so yet again there is a contrast between the re-assurances that we have received about adequate inpatient bed provision for the region from the LPT/WLCCG. Indeed there was a 96% occupancy rate at our nearest community hospital, Coalville, in December 2014. This correlates with the anecdotal stories we have received from the general public of a waiting list to be admitted to Coalville. It appears that not only are there insufficient beds in

[4] Ashby times May 27th2014
[5] Community Hospitals :The Way Forward Ernst and Young August 2012
[6] Care Quality Commission ;Review of Compliance ,Ashby District Hospital November 2012
[7] CQC ;LPT NHS Trust Community Health Inpatient Services Quality Report 10-7-15

the region but in addition the trust is using a target that is inappropriate and in our view risks patient safety. The commissioning group has been unable to provide the bed modelling data which would show the relationship between acute and community hospital bed requirements for the future. In our view this is objective evidence that reinforces our concerns that there has been a premature closure of services before fully introducing and adequately assessing alternative services.

It seems that the amount of alleged repairs and maintenance have formed a major part of the case for closure of the hospital and in part led to it being been deemed as unfit for purpose. Under the Freedom of Information Act, the Ashby Civic Society has repeatedly requested copies of this vital information. Eventually, the LPT provided various pieces of data which do not correspond to our specific requests and are uninformative. In our opinion clear and unambiguous information should have been visible in the full business plan. If this is a true reflection of the state of the hospital (which we contest strongly having photographic proof of the condition of the hospital) we would like to make two points .Firstly, why has the hospital been allowed to fall in such a state of disrepair over the last few years? A cynic might surmise that this has been a deliberate act in order to prejudice the decision of the closure of Ashby Hospital. If so is this not a blatant disregard for patient safety? Or secondly, this quote has been grossly overestimated to prejudice the decision on the closure of the Ashby Hospital.

We are sceptical about the quality of the data presented to the WLCCG and of the quality of their decision making .We are not alone in this. According to the Board Assurance Framework document presented at the May 2015 WLCCG meeting , *"the information and data recorded and reported by the LPT is inaccurate and leads to patient's care being delayed or disrupted and/or commissioners making incorrect service improvements and investments"*[8] . This concern is repeated in the recent CQC audit report. In our view this is of direct relevance to the decision to close the ADH as surely this calls into question the validity of any decisions made by these two organisations .How can the population of Ashby have confidence in their actions?

Business Case

On numerous occasions, the ACS has made requests about the business case which justified the decision to close the hospital. To date we still have not been supplied with a comprehensive and adequate economic, clinical or psycho-social business case for closure. Yes, we have been sent vague and, at times, incomprehensible documents in response to our specific questions. The latest of which we only recently received on the 21-7-15, the Business Implementation Plan which is dated the 7-11-14 (which post -dates the decision to close by a considerable period of time). Why the delay in receiving this document? In our view the document is written with the presumption that ADH is closing and a proper evaluation of the ADH case is not included. Interestingly, it has been written by construction consultants (Holbrow–Brookes)! This plan does not include actual costing of private rental agreements

[8] Board Assurance Framework Paper L ,WLCCG Board Meeting 12-5-15

and the estimated saving appears to be based on the capital receipt of the sale of Ashby Hospital. This would mean the loss of a NHS building asset which is a long term investment in exchange for a short term budget balance. In our view, this shows a total disregard for the terms of establishment of the hospital through charitable subscription; the transfer of the building to the NHS in goodwill that it would continue in perpetuity as a healthcare facility; and disregards any future healthcare potential of the site. It would appear that the pursuit of financial gain over health benefits to the public have taken priority by seeking the best price for the building rather than an improvement in the quality of care given to patients. In any case where is the "state of the art facility "in this plan which was promised by the WLCCG? It would seem that the current plan bears no resemblance to the original plan and appears to change at each corner, could this be a symptom of the lack of a coherent plan in the first place?

Four Key Tests

It appears that there are four tests that need to be satisfied before the sale of an NHS hospital can go ahead[9] ;

1. Support from GP Commissioners. In our view this purports to have been satisfied but on what data and evidence has that support been based on given our previous comments?
2. Clarity of the clinical evidence base. In our view this test has not been satisfied as evidenced by the CQC report which shows that patient safety has been put at risk by the inadequate provision of community beds.
3. Strengthened Public and Patient engagement .In our view this has not been satisfied given the refusal over the past year to acknowledge the views of 3,000 Ashby residents and failure to attend a public meeting with them. Indeed the attitude of the WLCCG and LPT has been that the decision has been made and cannot be reversed.
4. Consistency with current and prospective choice. In our view this has not been adequately explained and indeed it is clear that future patient choice has been impaired by the removal of some services and by the intended sale of an important healthcare asset of land and buildings.

Therefore it is our view that enough doubt exists into whether this decision has been appropriately handled and presented by the LPT and WLCCG .In our view this case (and the decision) needs to be reviewed again through the Leicestershire County Council Health Overview Scrutiny Committee as advised by the Department of Health. Once this has been achieved it is our view that it should be re- referred back to Mr Hunt , who only recently in July 2015 stated that he wanted to reduce the bureaucracy , increase patient centred decision and achieve transparency throughout the NHS, to reconsider his approval for disposal .

[9] Ministerial Correspondence on behalf of Jeremy Hunt ,DOH 25-6-15

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Leicestershire Partnership NHS
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 9 SEPTEMBER 2015

REPORT OF LEICESTERSHIRE PARTNERSHIP NHS TRUST

RESULT OF CARE QUALITY COMMISSION INSPECTION AT LEICESTERSHIRE PARTNERSHIP NHS TRUST

Executive Summary

Leicestershire Partnership NHS Trust (LPT) had a statuary inspection of its services carried out by the Care Quality Commission (CQC) in March 2015. LPT provides integrated Mental Health, Learning Disabilities and Community Health Services for a population of approximately 1 million in Leicester, Leicestershire and Rutland. It provides a wide range of physical and mental health services covering the whole life span, such as school nursing, health visiting, community hospitals, community nursing services, end of life care, mental health services for older persons, IAPT, acute mental health wards, community pediatricians and DIANA nursing services.

The final report of the CQC inspection was received by the Trust on 2 July 2015 followed by a Quality Summit on 7 July 2015. The report was published on 10 July 2015.

Overall the Trust has been rated as 'requires improvement' with three of the five inspection domains (effective, responsive and well led domains) rated as requiring improvement, one (Patient Safety) as inadequate and one (Caring) as good. This paper describes the process of review, the themes from the report and the actions that will be taken as a result of the report. It also describes the governance processes for the Trust Board to receive assurance on the delivery of the required actions.

Introduction/Background

1. The CQC is the Regulatory Body of NHS and Social Care Services. They undertook a statutory inspection of services at Leicestershire Partnership NHS Trust in the week commencing 9 March 2015. Their inspection team consisted of 106 inspectors including lead inspectors, subject experts and experts by experience. The timeline for the visit and the publication of the report was:

   (a) Visit commenced week commencing 9 March 2015 followed by initial verbal feedback;
   (b) Initial concerns letter received on 20 March 2015;
   (c) Reports (x17) received 8 June 2015;
   (d) Factual accuracy challenges returned on time – 23 June 2015 – c220 comments over 70 pages;
   (e) Final report received by LPT on Thursday 2 July 2015;
   (f) Quality Summit – 7 July 2015;
   (g) Final report published Friday 10 July 2015;
   (h) Date for completion and submission of action plan - 4 August 2015.

Immediate Feedback and Actions

2. The immediate concerns letter raised the following issues:

   (a) Mental Health Act practice and scrutiny inconsistent
   (b) Mental Capacity Act: inconsistent application and awareness
   (c) Ligature issues on acute and low secure settings
   (d) Seclusion: seclusion facilities at the Bradgate Unit and the Herschel Prins Unit did not meet best practice guidelines
   (e) Mixed sex accommodation breeches and management of a young person on an adult ward
   (f) Medication management: arrangements did not ensure the safe management of medicines and prescribing within the drug and alcohol community services.

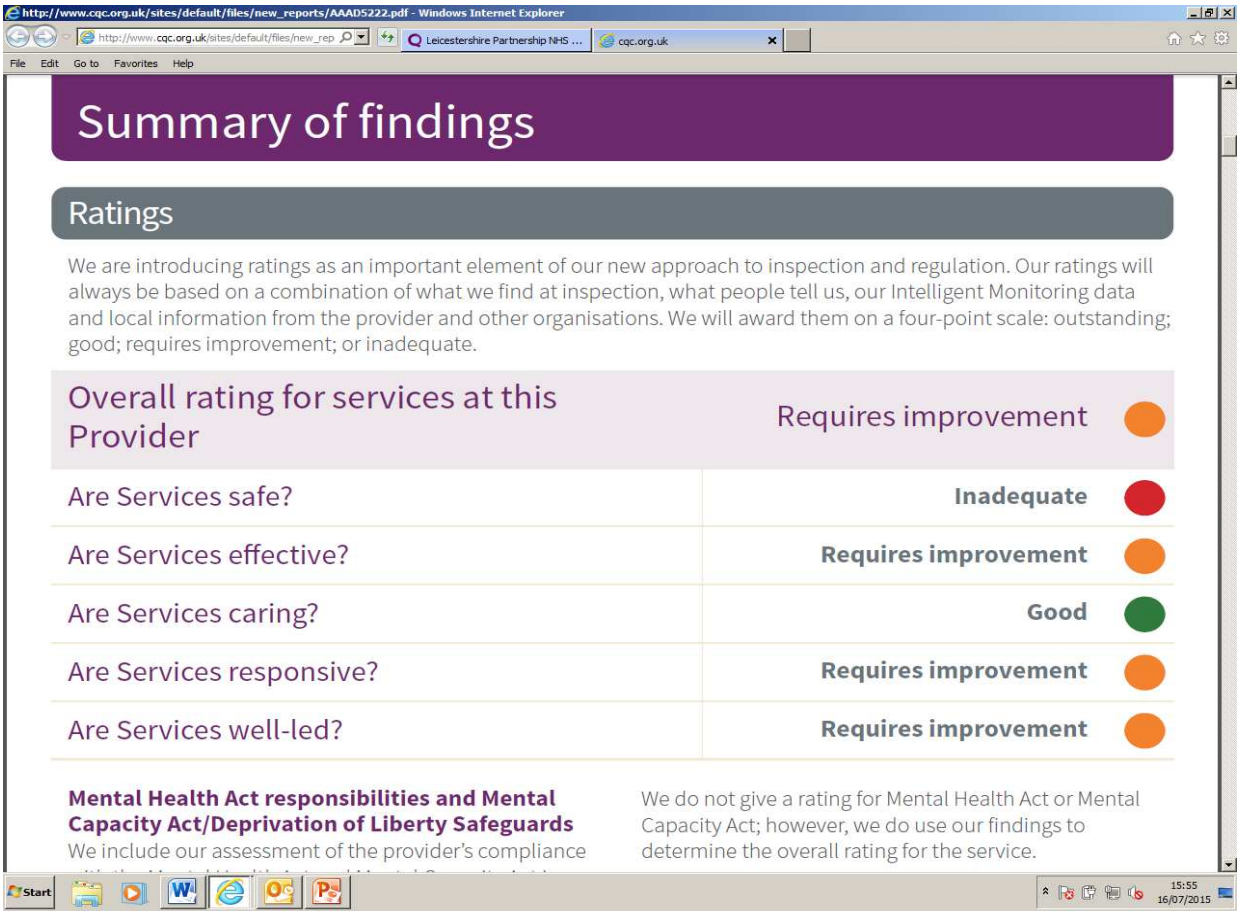
3. These concerns were responded to immediately, and an action plan was developed. The range of actions included:-

   (a) immediate strengthening of Mental Health Act scrutiny process
   (b) positive and pro-active care initiative,
   (c) improvement in seclusion monitoring,
   (d) urgent focus on improving the safety of environment (ligature points and seclusion).

4. The current status of the action plan is:-

Red	Action not completed by the date given to the CQC and a REMEDIAL PLAN has not been received by the Regulation and Assurance Team from the action LEAD	0
Amber	Action reported by LEAD as unlikely OR has not met the deadline given to the CQC. Remedial action has been provided and revised deadline provided	1
Green	Action progressed and delivered by due date given to CQC and evidence awaited	39
Blue	Action complete and evidence received by Regulation and Assurance Team - ACTION CLOSED	31

Final Report and Thematic Analysis



5. There are 17 reports in total, 16 core service reports and one overall report. The breakdown of the ratings is as follows:-

	Safe:	Effective:	Caring:	Responsive:	Well-Led:	**Overall:**
Specialist Community Health Services for Children and Young people						
Community based Mental Health Services for Adults of Working Age						
Child and Adolescent Mental Health Wards						
Community Mental Health Service for People with Learning Disabilities or Autism						
Community based Mental Health Services for Older People						
Mental Health Crisis Services and Health based places of safety						
Long stay/Rehabilitation Mental Health wards for working age adults						
Specialist Services – Community based Substance Misuse Services for Adults of Working Age						
Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units						
Wards for Older People						
Community End of Life Care						
Community Health Inpatient Services						
Community Health Services for Adults						
Forensic Inpatient/Secure Wards						
Wards for People with Learning Disabilities or Autism						
Community Health Services for Children, Young People and Families						
LPT – Overall Provider Report						

6. The themes arising from the report include:-

   (a) Safer staffing and the use of temporary staff

(b) Physical environment – seclusion, ward layout, line of sight, single sex accommodation, general maintenance
(c) MHA/MCA compliance
(d) Patient safety – ligature points, restrictive practice, seclusion, learning lessons in CAMHS
(e) Demand and Capacity – AMH, CAMHS, Community therapies
(f) Workforce – engagement, morale, appraisal, mandatory training

Quality Summit and Outcomes

7. The quality summit was held on 7 July 2015. Attendees included the LPT executive team and Chair, CCG representation from chief officers and quality leads, CQC lead inspector and team, Trust Development Authority, Health Education England, representatives from Healthwatch, Leicester, Leicestershire and Rutland and NHS England.

8. It was agreed that there would be an external process of scrutiny put in place in addition to the normal quality governance processes. Healthwatch expressed its wish to be further involved in oversight. Commissioners agreed to continue to work with us on capacity and demand issues. The Trust committed to ensuring that the board was well sighted on operational risks.

Publication and Communication Strategy

9. The final report was published on Friday, 10 July 2015. In advance of publication a communication plan was developed.

10. The Trust anticipated there may be concerns expressed from staff, patients and stakeholders about the 'requires improvement' rating, and in particular the inadequate indicator for the safety of aspects of our services. Therefore our plan aimed to:-

(a) Reassure service users/patients and their families of the immediate steps taken to improve safety on the Bradgate Unit, Herschel Prins and CAMHS services; including support for staff to offer reassurance and information.
(b) Reassure staff of the plans in place; maintaining morale and engagement of all staff but in particular, of those most affected by the inadequate or requires improvement ratings; with clear feedback mechanisms.
(c) Reassure and provide balanced information to stakeholders and commissioners, with clear feedback mechanisms.
(d) Provide a medium to longer term involvement and empowerment framework for staff, service users and stakeholders to support service improvements and development.

11. In brief, media interviews were carried out with local media, briefing material was sent to all stakeholders and visits were made to various clinical areas. Vodcasts were released to staff and the public and website information was updated.

Service Improvement

12. The CQC required the Trust to respond with an action plan addressing the 'Must Do's' identified within the 16 reports by the 4 August 2015. These actions relate to the requirement actions as described in the report. There are 38 specific actions that are required.

13. Appendix 1 to this report sets out a progress update on the items in the Action Plan which relate to the Bradgate Unit and are rated Amber.

14. These are important actions for the Trust to take forward in a reasonably urgent timeframe, to ensure that our services are safe, responsive, caring, well led and effective.

15. It is anticipated that all actions will be complete within a six month timeframe.

16. These actions will be reported through existing governance systems with enhanced capacity for scrutiny and risk escalation.

17. However there is much more to do than the 'must do's' if the Trust is to achieve sustainable improvements. It should not just aim for compliance with minimum standards but aim to achieve excellence, moving the 'requires improvement' to 'good' and the 'good' to 'outstanding'. Our approach to continuous quality improvement, has already been described in both our clinical strategy and quality strategy but the Trust needs to see this move forward at pace creating the right culture, involving:-

    (a) Listening continuously to our users which include our patients, their families and carers.
    (b) Work in an integrated manner improving the coordination of care and delivery of services.
    (c) Our staff working together in high performing multidisciplinary teams to deliver the right cares for our users at the right time and place.
    (d) Enhancing the power of front line clinicians to innovate and improve the care continually.

Governance, Assurance and Escalation of Risks

18. The Trust Board has already approved a risk management strategy, escalation and assurance framework and there is no intention to substantially change this.

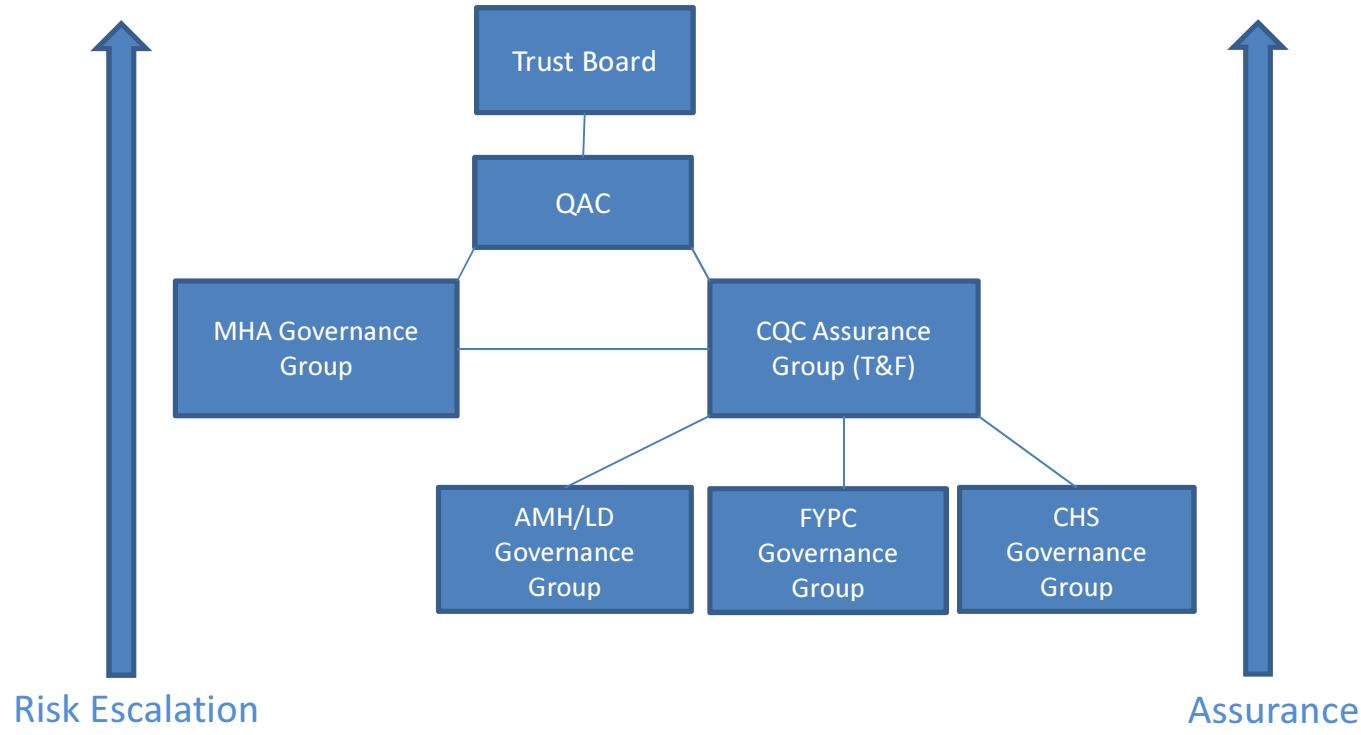
19. There will however be a time limited assurance group overseeing the implementation of the action plan.

20. Membership of this group has included invitations for the CCGs and TDA to participate to ensure a higher level of understanding of progress and assurance is received by stakeholders.

21. The Chief Nurse/Deputy Chief Executive from the Trust is also meeting with the Director of Nursing, CCG, and the Head of Quality, TDA, to ensure greater oversight of delivery.

22. This group will report to the Quality Assurance Committee (QAC), a Trust Board Committee, and then to the Trust Board.

23. QAC has the role of providing oversight to the scrutiny and assurance of the plan and its delivery.



Conclusion and Next Steps

24. The Trust is now displaying all the ratings from the inspection at individual sites where services are provided.

25. Focus will now be given to the delivery of the urgent action to ensure compliance with the safety aspects of the report and the delivery of the requirement actions.

26. In the medium term the Trust needs to continue to strengthen its approach to continuous quality improvement and staff and service user engagement to provide sustainable improvements in the future.

27. The Trust is talking with the CQC to understand their next steps and the timings of any re-inspection to provide public assurance that we have addressed their most serious concerns.

Officer to contact

Dr Satheesh Kumar
Medical Director

List of Appendices

Appendix 1 - Progress Update regarding Bradgate Unit Amber rated actions August 2015

Appendix 1

Progress Update regarding Bradgate Unit Amber rated actions August 2015

Seclusion policy – This is being amended to reflect the use of seclusion and segregation in all LPT areas using restrictive practices. It is currently out with members of the seclusion group for final comments and will be agreed at the seclusion group in September 2015. Updated staff training will commence following approval and publication of the policy.

MCA/DOLS – The first AMH/LD Champions Event took place in August and there are now only 5 wards requiring a champion. These are being identified in September. Data is fed back to Matrons but further work by the Adult Safeguarding Lead is taking place on supporting staff to action areas identified for patients or process improvements.

Environmental works to specified wards - Work continues and is expected to be completed in the next 4 weeks. Outstanding items are the double doors on Thornton ward and the changes to ceiling hatch entry as these require health and safety considerations.

All seclusion rooms in the Trust have been reviewed against the recommended standards and aspects that do not meet the guidance identified; these are currently being costed and will be reviewed by the seclusion group in September. The Trust is linking this review to the work on less restrictive practice and may not be refurbishing all seclusion rooms and using some as de-escalation areas. The work in some wards is also extensive and may require ward alterations/ refurbishments.

Meeting mixed sex guidance - This is currently resolved as the Belvoir Unit is not admitting female patients; the Trust is currently using alternative area placements or patients are staying on acute wards with additional support where assessed as appropriate. The Trust is currently completing an optional appraisal regarding future female PICU provision.

Meeting mixed sex guidance - The Trust has reviewed the three older wards identified as not meeting guidance related to the provision of toilets/ bathrooms for single sex and found that there is not sufficient scope to alter the existing layout without considerable changes. The Trust plan to move to single sex wards for these wards between October and November 2015.

Agenda Item 12

Version 2

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 9 SEPTEMBER 2015

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

RE-PROCUREMENT OF COMMUNITY SUBSTANCE MISUSE TREATMENT SERVICES

Purpose of report

1. The purpose of this report is to consult the Committee on the final model for the re-procurement of Community Substance Misuse Treatment Services across Leicestershire and Leicester City, with the potential to include Rutland in the future if deemed mutually beneficial.

2. For the purpose of this report, substance misuse refers to problematic drug use and alcohol dependency. Substance misuse treatment refers to specialised, structured intervention in criminal justice, and other community settings and early help in hospital settings.

Policy Framework and Previous Decisions

3. The Re-Procurement will support the County Council's Transformation Programme, particularly in relation to "working the Leicestershire pound", "managing demand through prevention" and, potentially, "integrating with partners". This direction of travel also supports the Joint Health and Wellbeing Strategy objectives of "managing the shift to early intervention and prevention" and "improving mental health and wellbeing".

4. A report was presented to the Cabinet on 16 March 2015 where it was agreed that the Director of Public Health, in consultation with the Director of Corporate Resources, be authorised to agree the preferred option for commissioning and delivering community substance misuse treatment services from 1 July 2016, following expiry of the current contracts. This option has now been the subject of engagement with stakeholders.

Background

5. A service review was undertaken in February/March 2015. This Review assessed local substance misuse treatment needs and service activity based on a survey of service users, families/carers and staff. It provided the background for an options appraisal, which subsequently identified the preferred option as an integrated single substance misuse treatment service across Leicestershire, Leicester City and Rutland.

6. The Office of the Police and Crime Commissioner (OPCC) contributes financially to the criminal justice elements of substance misuse services for both, adults and young people, and has been central to the decision on the preferred model. Leicester City

Council and the OPCC have also agreed to progress the integrated service model as the preferred option. Rutland County Council is not in a position to progress the model at this stage, but the procurement will include the potential to include Rutland in the future if deemed mutually beneficial.

7. The proposed service model will provide age appropriate services for adults and young people, including those involved in the criminal justice system. The model will have a "recovery" focused approach with the main components of engagement, treatment, on-going mutual aid support, and expert advice to the wider workforce.

8. The service will be accessible with a Single Point of Contact (SPOC) providing optimal geographical access across the County. There will be a hub and spoke model within the County, which will comprise of at least 2 hubs and a variety of additional "spokes" venues .The proposed model will have six days a week access, delivering proactive engagement with under-represented groups and those with diverse needs.

9. The single service model will allow for specialist expertise in mental illness/health, children's safeguarding and criminal justice interventions.

10. The key objectives of the model will be to:-
    (a) ensure safe and effective service;
    (b) support vulnerability;
    (c) reduce harm;
    (d) support sustainable recovery;
    (e) strengthen groups and communities.

11. The desired key outcomes of the model are:-
    (a) freedom from dependence on drugs/alcohol;
    (b) sustained recovery including meaningful activity (e.g employment/volunteering);
    (c) prevention of drug related deaths;
    (d) improvement in mental and physical wellbeing;
    (e) reduction in crime and reoffending;
    (f) capacity to be an effective and caring parent.

Consultation

12. A soft market test was conducted in June/July 2015 by Leicestershire County Council covering Leicestershire County Council, Leicester City Council and Rutland County Council. The purpose of this test was to measure the scope for the market for the proposed model, and whether the model was feasible and deliverable. The results obtained were very promising with 18 responses by close of the market test, all of which indicated that the proposals were feasible and deliverable.

13. Drawing on various feedback, the varying needs among different age cohorts were highlighted. Discrete provision for young people separate from the adult provision was suggested. There were also responses in relation to mental health and dual diagnosis, including a recommendation that the service should encompass specific expertise and robust pathways.

14. Following the initial engagement survey, further consultation with those most directly impacted took place throughout July and August 2015 across Leicestershire,

Leicester City and Rutland. This included an electronic questionnaire (with paper versions and easy-read options available) and 12 focus groups including staff groups, service user groups, recovery groups, and other directly affected professional groups. Over 200 electronic responses were received during the consultation process.

15. A report on the feedback from the questionnaires and groups is currently being written. Throughout the consultation process regular feedback was monitored and common emerging themes have been observed and noted, which that can be highlighted at this stage.

16. There is emerging support for the proposed model. Comments include that the approach reflects 'common sense' and it would allow service users to access services in the best location for them, rather than based on area of residence. There is a concern however about the loss of specialist expertise particularly in relation to criminal justice interventions, and work with young people.

17. The points raised within the consultation can be addressed by writing the detailed specifications for the model, ensuring that an integrated model does not lose the specialist expertise required to work with particularly vulnerable groups.

Resource Implications

18. For 2015/16, the Leicestershire County Council Public Health budget allocations for the three services under review are approximately:-

    (i) Treatment for adults in criminal justice settings (excluding prisons) across Leicester, Leicestershire and Rutland – £0.9 million;

    (ii) Treatment for adults and young people in other community settings across Leicestershire and Rutland (including GP shared care) – £3.3 million;

    (iii) Early help for people attending hospital for reasons relating to alcohol across Leicester, Leicestershire and Rutland – £50,000.

The above components of the service equate to the total of £4.3 million.

19. Combined, these investments account for around one sixth of the total value of the 2015/16 Public Health Grant for Leicestershire. The scale of this investment largely reflects the nature of these specialist clinical services.

20. The Medium Term Financial Strategy (MTFS) includes a requirement to create headroom within the Public Health Grant to maximise the effectiveness of the Grant. This headroom will be achieved by reviewing existing services and commissioning best value. The next stage would be to identify prevention initiatives elsewhere in the Authority that contribute to public health and could be funded from the Grant.

21. The Re-Procurement of an Integrated Community Substance Misuse Treatment Services has the potential to contribute to the County Council's MTFS savings as well as improve quality and outcomes for service users. For example, the integration of services that are currently commissioned separately could contribute to savings on the

costs of operational and contract management infrastructure. Wider benefits would be realised through the inclusion of the project in the County Council's Transformation Programme.

Timetable for Decisions

22. Following the consideration of this report by Health Overview and Scrutiny Committee the final model of the service will be presented to the Cabinet on 11 September 2015. This will ensure that the timetable for procurement is met and the new contract can be in place as required by 1 July 2016.

Conclusions

23. In March 2015 Cabinet approved the recommendation that the Director of Public Health in consultation with the Director of Corporate Resources agree the preferred option for commissioning and delivering community based substance misuse services from 1July 2016. Further consultation has taken place since then. The Committee is asked as part of that consultation process to agree the proposed model to enable the re-procurement to take place.

Background papers

16th March 2015 Report to the Cabinet on the Re-Procurement of Community Substance Misuse Treatment Services.

Circulation under the Local Issues Alert Procedure

None.

Officer to Contact

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Email: Julian.mallinson@leics.gov.uk

List of Appendices

Appendix 1 - Consultation Questionnaire.

Relevant Impact Assessments

Equality and Human Rights Implications

24. People who misuse alcohol and drugs often experience social discrimination and

encounter barriers in accessing care services, broader advice and support (including housing, work opportunities etc).

25. As the development of the specifications progresses, these will be formally assessed to ensure that the model does not discriminate against any of the protected characteristics. Age and proximity to the geographical location of services, will be particularly relevant to the integration of the adult and young people's services.

Crime and Disorder Implications

26. As well as improving individual health and wellbeing, an effective substance misuse treatment system is expected to benefit crime and disorder. For example, people who are treated for and supported to recover from substance misuse are less likely to re-offend or behave anti-socially.

Partnership Working and associated issues

27. The re-procurement of Community Substance Misuse Treatment Services is a partnership between Leicestershire County Council, Leicester City Council and the Office of the Police and Crime Commissioner, with the potential to include Rutland County Council in the future if deemed mutually beneficial. Other partners, including current providers, have been consulted on this re-procurement.

Risk Assessment

28. The re-procurement of Substance Misuse Treatment Services is included in the County Council Transformation Programme. As such, risks are managed through the Transformation Programme, with project management support from the Transformation Unit.

28 A Substance Misuse Redesign Project Board has been established to include each of the three authorities and the OPCC. The Board has a risk management and governance role and is accountable through member organisations. For Leicestershire County Council this is the Public Health Departmental Management Team (DMT).

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Leicestershire County Council

Rutland County Council

Leicester City Council

Have your say on proposed changes to the substance misuse support services in Leicester, Leicestershire and Rutland.

Tell us how this might affect you - Leicestershire County Council:
www.leics.gov.uk/haveyoursay/substancemisuse

Leicester City Council: **http://consultations.leicester.gov.uk**

Rutland County Council:
www.rutland.gov.uk/substancemisuse

For general enquiries or comments about this consultation phone **0116 305 0705** or email **phbookings@leics.gov.uk**

Public consultation: Submit your views by midnight 16 August 2015

Why change?

Currently, Leicester, Leicestershire and Rutland councils each commission their own substance misuse support services. Current provision comes to an end in June 2016 which has provided an opportunity to review our services and look at how we can work together and share resources. This will help us to provide more integrated services and make it easier for people to access the support they need.

During 2014-2015 as individual councils we undertook initial consultation and reviewed a number of our substance misuse services. The feedback and results from this initial work helped to shape our current proposals.

Leicester, Leicestershire, and Rutland councils and the Office of the Police and Crime Commissioner are now proposing to put in place one substance misuse service which would cover Leicester, Leicestershire and Rutland from July 2016.

We are now in a position to progress together and jointly develop more detailed plans about future substance misuse services.

Over the next few weeks you will have the opportunity to tell us what you think of the proposal for one substance misuse service. Your feedback will help to further shape the model of delivery.

We are consulting the public on this proposal from 13 July 2015 until midnight on 16 August 2015.

Your views are important to us so that we can better understand how the proposals could affect you and how we can make these changes work best for you.

What is the current service?

Across Leicester, Leicestershire and Rutland, we currently have a number of specialist substance misuse services which vary in size and geographic area; six of the services are identified below:

1. Leicester, Leicestershire and Rutland wide criminal justice services
2. Leicester city only - adults
3. Leicester city only - young people - criminal justice and non-criminal justice
4. Leicestershire and Rutland combined adults and young people
5. Leicestershire only - young people in criminal justice services
6. Leicester, Leicestershire and Rutland hospital-based alcohol liaison service

Our proposals in detail – the new model

The new service would combine the six specialist services listed above into one single service which serves Leicester, Leicestershire and Rutland. This will make it easier to access support across the three authorities and reduce areas of duplication and running costs.

The service model would include a focus on:

- supporting individuals into recovery
- providing support services including treatment and harm reduction programmes
- providing services appropriate to the age of the user
- services that would be available at locations across Leicester, Leicestershire and Rutland to ensure they are accessible to all
- referrals from the criminal justice system for both young people and adults (for example on arrest, at court and through community sentences)
- joined-up working with health, social care, criminal justice services and those that support vulnerable individuals and families.

How the consultation will work

The consultation begins on 13 July 2015 and will end at midnight on 16 August 2015.

To submit your views please fill out the consultation questionnaire and make sure it reaches us by midnight on 16 August 2015 at the latest. Leicester, Leicestershire and Rutland councils will make the questionnaire available online from 13 July 2015. The questionnaire is available at **www.leics.gov.uk/haveyoursay/substancemisuse**

We will also be holding a series of meetings for those people most affected by the changes including service users and/or their family members, staff and carers. Support will be available as required to ensure that all service users have the opportunity to participate.

Paper copies of the questionnaire are available on request by calling 0116 305 0705.

If you are able to, please complete the questionnaire online as it will save us money.

You can send your completed questionnaire to the following freepost address:

Substance misuse consultation
Leicestershire County Council
Room 300B
Have Your Say
FREEPOST NAT 18685
Leicester
LE3 8XR

If you need help to complete this questionnaire or have any questions about the consultation, please call **0116 305 0705** or email **phbookings@leics.gov.uk**

Your feedback will be used to inform the decisions about these proposals.

This information is also available in Easy Read format

Call **0116 305 0705**
or email
phbookings@leics.gov.uk

What happens next?

Your feedback will be incorporated with the other consultation feedback received. This information will then be presented for discussion with Executive Members at Rutland County Council and Leicester City Council. The Cabinet at Leicestershire County Council will also discuss these findings in September 2015. The results from the consultation will be published on the council websites in due course.

You can view the latest information in a number of ways

Visit us online **www.leics.gov.uk/haveyoursay/substancemisuse**
Our web pages will be kept up-to-date with the latest information and developments.

You'll also be able to access the questionnaire at **www.leics.gov.uk/haveyoursay/substancemisuse**

Send an email to **phbookings@leics.gov.uk** to register for the latest news and updates

Follow us @leicscountyhall for general updates from the council, including the developments on the budget.

Alternatively, you can telephone **0116 305 0705** to ask for information in printed or alternative formats.

જો આપ આ માહિતી આપની ભાષામાં સમજવામાં થોડી મદદ ઇચ્છતાં હો તો 0116 305 0705 નંબર પર ફોન કરશો અને અમે આપને મદદ કરવા વ્યવસ્થા કરીશું.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਵਿਚ ਕੁਝ ਮਦਦ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0116 305 0705 ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਅਸੀਂ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਦਵਾਂਗੇ।

এই তথ্য নিজের ভাষায় বুঝার জন্য আপনার যদি কোন সাহায্যের প্রয়োজন হয়, তবে 0116 305 0705 এই নম্বরে ফোন করলে আমরা উপযুক্ত ব্যক্তির ব্যবস্থা করবো।

اگر آپ کو یہ معلومات سمجھنے میں کچھ مدد درکار ہے تو براہ مہربانی اس نمبر پر کال کریں 0116 305 0705 اور ہم آپ کی مدد کے لئے کسی کا انتظام کر دیں گے۔

假如閣下需要幫助，用你的語言去明白這些資訊，請致電 0116 305 0705，我們會安排有關人員為你提供幫助。

Jeżeli potrzebujesz pomocy w zrozumieniu tej informacji w Twoim języku, zadzwoń pod numer 0116 305 0705, a my Ci dopomożemy.

Have your say on proposed changes to the substance misuse support service

Please note: Your responses to the main part of the survey (Q1 to Q12, including your comments) may be released to the general public in full under the Freedom of Information Act 2000. Any responses to the questions in the 'about you' section of the questionnaire will be held securely and will not be subject to release under Freedom of Information legislation, nor passed on to any third party.

Q1 In what role are you responding to this consultation? Please tick one only

- ☐ Service user
- ☐ Family member/carer of someone experiencing substance misuse
- ☐ Interested member of the public
- ☐ Member of council staff
- ☐ Work for a substance misuse provider
- ☐ Representative of a voluntary sector organisation or charity
- ☐ GP/pharmacist or other healthcare professional
- ☐ Other professional/stakeholder e.g. elected member, council representative, business etc.
- ☐ Other (please specify below)

Other (please specify)

Q2 If you are a representative of a service provider, voluntary organisation/charity, GP/pharmacist or other professional/stakeholder, please provide your details.

Name:

Organisation:

This information may be subject to disclosure under the Freedom of Information Act 2000

Q3 We propose that the new service provides convenient access points within Leicester, Leicestershire and Rutland. Users would be able to get to venues convenient to them wherever they live in Leicester city, Leicestershire or Rutland.

To what extent do you agree or disagree with this proposal? Please tick one only

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
☐	☐	☐	☐	☐	☐

Q4 Why do you say this?

Q5 We propose that the new model will provide substance misuse services for both adults and young people. The services would be tailored to meet individual need in a way that is appropriate for their age, e.g. young people, young adults or older people.

To what extent do you agree or disagree with this proposal? Please tick one only

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
☐	☐	☐	☐	☐	☐

Q6 Why do you say this?

Q7 We would like the new service to provide a service to adults and young people in the criminal justice system (e.g. court ordered treatment) as well as all other users.

To what extent do you agree or disagree with this proposal? Please tick one only

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
☐	☐	☐	☐	☐	☐

Q8 Why do you say this?

Q9 Overall, on balance, to what extent do you agree or disagree with our new model of service? Please tick one only

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
☐	☐	☐	☐	☐	☐

Q10 Why do you say this?

Q11 Do you have any alternative ideas for how we should provide substance misuse support services?

Q12 Do you have any other comments?

Please CONTINUE if you are a service user, family member/carer of someone experiencing substance misuse or an interested member of the public.

Professionals and other stakeholders, thank you, you have now completed the questionnaire.

About you

The councils are committed to ensuring that their services, policies and practices are free from discrimination and prejudice and that they meet the needs of all sections of the community.

To enable us to check that what we are providing is fair and effective, we would be grateful if you would answer the questions below. You are under no obligation to provide the information requested, but it would help us greatly if you did.

Q13 Are you male or female? Please tick one only

- ☐ Male
- ☐ Female

Q14 Do you identify as transgender? For the purposes of this question 'transgender' is defined as an individual who lives, or wants to live, full time in the gender opposite to that they were assigned at birth. Please tick one only

- ☐ Yes
- ☐ No

Q15 What was your age on your last birthday? Please tick one only

- ☐ Under 16
- ☐ 16-24
- ☐ 25-34
- ☐ 35-59
- ☐ 60-74
- ☐ 75+

Q16 Which area do you live? Please tick one only

- ☐ Leicester City
- ☐ Leicestershire County - Blaby District
- ☐ Leicestershire County - Charnwood Borough
- ☐ Leicestershire County - Harborough District
- ☐ Leicestershire County - Hinckley and Bosworth Borough
- ☐ Leicestershire County - Melton Borough
- ☐ Leicestershire County - North West Leicestershire District
- ☐ Leicestershire County - Oadby and Wigston Borough
- ☐ Rutland County
- ☐ Don't know
- ☐ Other (please specify)

Other (please specify)

Q17 What is your full postcode? This will allow us to see how far people travel to use services

Q18 Are you a carer of a person aged 18 or over? Please tick one only

- ☐ Yes
- ☐ No

Q19 Do you have a long-standing illness, disability or infirmity? Please tick one only

- ☐ Yes
- ☐ No

Q20 What is your ethnic group? Please tick one only

- ☐ White - English/Welsh/Scottish/Northern Irish/British
- ☐ White - Irish
- ☐ White - Gypsy or Irish Traveller
- ☐ White - Any other White background
- ☐ Mixed/multiple ethnic groups - White and Black Caribbean
- ☐ Mixed/multiple ethnic groups - White and Black African
- ☐ Mixed/multiple ethnic groups - White and Asian
- ☐ Mixed/multiple ethnic groups - Any other mixed/multiple ethnic background
- ☐ Asian or Asian British - Indian
- ☐ Asian or Asian British - Pakistani
- ☐ Asian or Asian British - Bangladeshi
- ☐ Asian or Asian British - Chinese
- ☐ Asian or Asian British - Any other Asian background
- ☐ Black or Black British - African
- ☐ Black or Black British - Caribbean
- ☐ Black or Black British - Any other Black/African/Caribbean background
- ☐ Other ethnic group - Arab
- ☐ Other ethnic group - Any other ethnic group

Q21 What is your religion? Please tick one only

- ☐ No religion
- ☐ Christian (all denominations)
- ☐ Buddhist
- ☐ Baha'i
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Any other religion

Q22 Many people face discrimination because of their sexual orientation and for this reason we have decided to ask this monitoring question. You do not have to answer it, but we would be grateful if you could tick the box next to the category which describes your sexual orientation. Please tick one only

- ☐ Bi-sexual
- ☐ Gay
- ☐ Heterosexual / straight
- ☐ Lesbian
- ☐ Other

Thank you for your assistance. Your views are important to us. This information will then be presented for discussion with Executive Members at Rutland County Council and Leicester City Council. The Cabinet at Leicestershire County Council will also discuss these findings in September 2015. The results from the consultation will be published on the council websites in due course.

Please return to: Substance misuse consultation, Leicestershire County Council, Room 300B, Have Your Say, FREEPOST NAT 18685, Leicester, LE3 8XR

No stamp is required

Data Protection: Personal data supplied on this form will be held on computer and will be used in accordance with the Data Protection Act 1998. The information you provide will be used for statistical analysis, management, planning and the provision of services by the county council and its partners. Leicestershire County Council will not share any information collected from the 'About you' section of this survey with its partners. The information will be held in accordance with the council's records management and retention policy. Information which is not in the 'About you' section of the questionnaire may be subject to disclosure under the Freedom of Information Act 2000.

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Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 9 SEPTEMBER 2015

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

ORAL HEALTH OF FIVE YEAR OLDS

Purpose of report

1. The purpose of this report is to provide the Committee with an overview of child oral health in Leicestershire and an update on public health activity around oral health promotion and oral health survey.

Policy Framework and Previous Decisions

2. Commissioning of oral health promotion activity and the local component of the national dental public health epidemiological survey are statutory responsibilities for Local Authorities.

3. A key priority within the Leicestershire Health and Wellbeing Strategy is "getting it right from childhood" by giving children the best start in life. Prevention of tooth decay is one of the key outcome measures in the action plan for assessing achievement of this strategy.

Background

National context

4. Oral health is an essential part of a person's overall health and wellbeing and has been improving for both adults and children across England. However, recent data shows that dental caries (one of the most common dental diseases) is the most common reason for children to be admitted to hospital, with nearly 26,000 admissions last year in England, mostly for extraction of teeth under general anaesthetic.

5. Tooth decay can lead to pain and sepsis (a common and potentially life-threatening condition triggered by an infection), limitations in food choices and days lost from school and work (Murphy, 2013). Dental caries can occur at any age but can occur more frequently in earlier years of life particularly in lower socio-economic groups. It is therefore important for good oral health as well as dietary behaviours to be established in the formative years of life (Murphy, 2013).

6. As with other diseases, the greatest burden of poor oral health tends to be upon disadvantaged and socially marginalised populations. A major factor in the development of dental caries is the frequent intake of refined sugar, which also contributes to the development of other health problems such as obesity. Dental caries is therefore a major predictor of poor diet.

Leicestershire context

7. The health of children in Leicestershire is generally similar to, or better than, the England average. A key priority within the Leicestershire Health and Wellbeing Strategy is 'getting it right from childhood' by giving children the best start in life. Ensuring that children have good oral health is an important contributor to this aim.

8. However, key populations within Leicestershire are at risk of poor oral health due to poor diet and nutrition and poor oral hygiene. There are socio-demographic differences in oral health across Leicestershire. Data from the oral health survey of five year old children in 2012, and 3 year old children in 2013 showed, that the prevalence and severity of tooth decay in some areas of Leicestershire County (Blaby, Charnwood and Northwest Leicestershire) were significantly higher than the England average.

Three year olds

9. In Leicestershire 18.6% of three year old children have experience of obvious dental decay (caries), having one or more teeth that were decayed to dentinal level, extracted or filled because of caries (%d3mft>0) compared to 11.7% in England. This is the second highest percentage throughout the East Midlands behind Leicester only.

10. However the tooth decay found in these three year olds overall is less severe than that seen nationally. Across Leicestershire, for three year olds with any decay, an average of 2.09 teeth are affected, compared to 3.08 nationally.

11. In the districts the picture is largely similar. Blaby and Charnwood both have a higher proportion of three year olds affected by tooth decay than the national average (25% and 29% compared to 11.7% for England). However in both districts the severity is much lower than found nationally. None of the other districts are significantly different to the national average in terms of the percentage and the severity of tooth decay among three year olds affected.

12. The table below shows data for three year olds and compares Leicestershire to the England average. Several other lower tier Local Authorities within Leicestershire were added for further comparison.

Table 1: Oral health survey of three year old children 2013 Data Table Leicestershire

	% d3mft > 0 (average % of children with some decayed, filled or missing teeth)	**Mean d3mft > 0** (average number of affected teeth where there is some decayed, filled or missing teeth)
Blaby	25.14	1.61
Charnwood	29.3	2.23
Harborough	13.16	1.6
Hinckley and Bosworth	17.31	2.76
Melton	14.49	2.11
North West Leicestershire	14.52	2.39
Oadby and Wigston	13.32	2.15
Leicestershire	18.6	2.09
England	11.7	3.08

Based on fewer than 30 volunteers

Five Year olds

13. In Leicestershire 37.1% of five year old children had experience of some dental decay (caries) in the 2011/12 national survey compared to 27.9% in England. Of those with some decay, the average number of teeth affected in England was 3.38, compared to 2.56 in Leicestershire. Within Leicestershire there is variation in decay amongst five year olds with North West Leicestershire having the highest level of decay and prevalence (41.6%) after Leicester, when compared to the England average (27.9%).

14. The table below shows data for five year olds and compares Leicestershire to the England average, and several other lower tier Local Authorities within Leicestershire for further comparison.

Table 2: Oral health survey of five year old children 2012 Data Table Leicestershire

	% d3mft > 0 (average % of children with some decayed, filled or missing teeth)	**Mean d3mft > 0** (average number of affected teeth where there is some decayed, filled or missing teeth)
Blaby	39.3%	2.46
Charnwood	38.4%	2.41
Harborough	33.5%	2.26
Hinckley and Bosworth	34.7%	2.94
Melton	35.1%	2.51
North West Leicestershire	41.6%	2.68
Oadby and Wigston	35.4%	2.35
Leicester	53.2%	3.88
Leicestershire	37.1%	2.56
England	27.9%	3.38

Local actions

15. On 1 April 2015 responsibility for commissioning oral health promotion and the annual oral health epidemiological survey transferred to local authorities from NHS England. A new oral health promotion contract commenced on 1 August 2015. Deliverables from this contract are detailed in paragraphs 16, and 21 – 25 below.

16. The provision of the epidemiological survey also commenced on the 1 August 2015. The survey population group is set nationally and the 2015/16 survey will focus on the oral health of older people. It is expected that in future years the focus of the survey will return to children.

The oral health promotion programme

17. Historically the level of oral health promotion resource and activity has been particularly low. NHS England commissioned a low level of oral health promotion activity for Leicestershire amounting to one day of an oral health promotor's time. From summer 2014 in the run up to taking over the contract public health staff developed a plan to ensure a greater focus on oral health. It was felt appropriate to work largely on prevention of tooth decay in under-fives given the results of the 2012 and 2013 surveys and to get this work underway. The plan includes establishing a range of routine evidence based oral health promotion activities, using current data and information to inform areas and groups to focus on. Alongside this is work to gain a greater understanding of oral health need and behaviours in Leicestershire so that future work can be more effectively targeted.

18. Given the results of the surveys showing that Leicestershire has high levels of childhood tooth decay, some additional funding has been secured to take this work forward. Funding for the plan has come from:-

    (a) Transfer of the recurrent funding for oral health promotion and epidemiological services from NHS England in 2015;

    (b) Additional non-recurrent funding in 2013/4 from NHS England used to procure oral health promotion materials, resources and targeted work;

    (c) Additional non-recurrent funding for 2015 from NHS England to support the oral health promotion pathway for children who have been referred for tooth removal under general anaesthetic, fluoride varnish project and insight research work;(d) Funding from the public health grant to support and increase in oral health promotion capacity.

The various strands of this plan are outlined below.

Understanding oral health need and behaviours in Leicestershire

19. A regional oral health needs assessment has been undertaken by Public Health England and the Local Area Team of NHS England. This includes Leicestershire and is due to be published in autumn 2015.

20. Local insight research is being commissioned to investigate the high levels of dental decay in parts of Leicestershire identified through the National Survey. This research

will help officers to understand oral health behaviours, particularly in areas of high decay, and explore which oral health promotion interventions are likely to be most effective in our communities. This will be used to tailor Leicestershire's oral health promotion strategy for children.

Universal oral health promotion for young children

21. Parents of every child born in Leicestershire receive a copy of "My personal child health record" commonly known as "the red book". New oral health promotion pages have been included with evidence-based information and advice for parents regarding their children's oral health. The materials have been developed through social marketing techniques in collaboration with Leicester City Council and are branded 'Healthy Teeth, Happy Smiles'.

22. From 2015 Health Visitors are providing "my first toothbrush and toothpaste" pack for every child at the 4 month contact (7000 packs a year). This will be done as part of an oral health promotion discussion with parents to enable proactive and positive oral health and dietary behaviours. The Standard Operating Framework for health visitors and school nurses has been revised to include oral health and the appropriate messages to impart at key stages, e.g. discouraging prolonged bottle use, visiting a dentist, encouraging the uptake of fluoride varnish when the child turns 3 years old, encouraging water drinking and discouraging the consumption of sugary drinks and foods. This is supported by the "Healthy teeth happy smiles" materials.

23. The oral health promotion service will work with pre-school providers to establish supervised tooth brushing for all children in their setting (at least 80 nurseries and 70 pre-schools). They will also deliver health promotion events and training for professionals and dental practice staff throughout the year (30 per year).

24. The oral health promotion service will continue to distribute oral health promotion materials to families through a variety of settings including children's centres, at key times in the year (e.g. during National Smile Month).

25. During National Smile Month (May/June 2015) the Public Health Department worked with libraries and children's centres to engage families around oral health in their children. This included oral health topic 'wriggly readers' sessions in libraries, bottle swaps (swapping bottles with rubber teats for free flow cups) and distribution of toothbrush and toothpaste packs. Interviews with BBC Radio Leicester were used to spread oral health messages to a wider audience.

Targeted oral health promotion support

26. A Development Officer post has been supplemented to deliver an oral health promotion activity as part of the Active Bean Club programme. This involves working with a number of pre-school settings across Leicestershire in 2015-16 to:-

    (a) raise the issue and importance of oral health;
    (b) cascade the training to suit the establishment needs;
    (c) provide oral health sample materials;
    (d) signpost to other oral health promotion resources;

(e) assist in supporting local initiatives such as bottle, cup and tooth brush swaps;
(f) promoting supervised tooth brushing and assisting in getting these programmes underway within the settings the development officer is working with.

27. The Public Health Department is working with the Leicestershire and Lincolnshire Local Area Team of NHS England on a project to ensure that families of children under five who have teeth extracted under a general anaesthetic will receive intensive oral health advice and support to prevent further dental decay and subsequent extractions for the child and their siblings.

28. Arrangements are being made to provide toothbrush and toothpaste packs to be distributed in food banks in order to ensure that families most in need still have access to these products.

Dentistry

29. Dental practices are also a key resource in promoting good oral health and encouraging parents to take their children to the dentist from the time their first milk teeth arrive is an essential message. Dentists are paid on a banding system with three treatment bands where band 1 payments cover a range of mainly prevention related treatments and advice and in the case of children application of fluoride varnish. From the age of three, children should be offered fluoride varnish application at least twice a year. This is free of charge for children on the NHS and known to be an effective preventative treatment. The Public Health Department will be working closely with NHS England who holds the contracts with dentists to ensure this is offered more widely.

Workforce development

30. Continuing Professional Development events on oral health have been held for dental practices across Leicestershire in 2015. These were used to promote the latest evidence based toolkit for prevention. Training events for dental practice staff will continue as part of the new oral health promotion service.

31. From early 2015 frontline healthcare staff (health visitors and school nurses) and other professionals working with families with young children (including children's centre staff) have been given training in oral health promotion in order to ensure consistent and high quality information and advice is given to all parents of young children. These will continue on a rolling programme.

Resource Implications

32. There are no additional resource implications to those outlined in paragraph 20.

Conclusions

33. Oral health is variable across Leicestershire with 37% children having some dental decay by the age of five.

34. Responsibility for commissioning oral health promotion activity and the national dental health survey transferred to Leicestershire County Council from NHS England

in April 2015. This has provided an opportunity to give an increased focus to oral health and to utilise additional resource provided from NHS England to sustain a more integrated and developed oral health promotion service.

35. A new and extended oral health promotion service has been commissioned and commenced on 1 August 2015. Activity will include a range of universal and targeted approaches including direct work with children and families and training of frontline staff that come into contact with children.

36. The next dental health survey is of older adults in extra care housing and this will shortly be underway.

Background papers

See: Dental Public Health Intelligence Programme Survey results:
http://www.nwph.net/dentalhealth/

Circulation under the Local Issues Alert Procedure

None.

Officers to Contact

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List of Appendices

None.

Relevant Impact Assessments

Equality and Human Rights Implications

37. No impact assessments have been undertaken.

Crime and Disorder Implications

None.

Environmental Implications

None.

Partnership Working and associated issues

38. Leicestershire County Council Public Health have worked collaboratively with a range of partners including the Leicester, Leicestershire and Rutland Oral Health Partnership Board, Health Visiting teams, childcare settings and children's centres.

Risk Assessment

Table 3

	I	L	RAG (after mitigation)	mitigation
Oral health promotion contract has limited impact on oral health in young children	Red	Amber	Green	• Service specification is based on guidance from Public Health England on Commissioning Better Oral Health. Evidence-based interventions such as supervised tooth brushing and information and advice have been included. • Contract will be performance managed against key indicators • Insight work being undertaken with local families to ensure co-produced interventions.

HEALTH OVERVIEW AND SCRUTINY COMMITTEE - 9 SEPTEMBER 2015

REPORT OF THE CHIEF EXECUTIVE AND GEM COMMISSIONING SUPPORT PERFORMANCE SERVICE

PERFORMANCE UPDATE AT END OF QUARTER 1 2015/16

Purpose of Report

1. The purpose of the report is to provide the Committee with an update on performance against current performance priorities set out in the Health and Wellbeing Strategy and Commissioner Performance Frameworks, based on data available at the end of quarter 1 2015/16.

Background

2. The Committee currently receives a joint report on performance from the County Council's Chief Executive's Department and the Greater East Midlands (GEM) Commissioning Support Performance Service. This report encompasses:

   a. Performance against key metrics and priorities set out in the Better Care Fund plan and with progressing health and social care integration.
   b. An update on key provider performance issues and performance priorities identified in Clinical Commissioning Group Plans.
   c. An update on the delivery of priorities identified in the Joint Health and Wellbeing Strategy and key areas of adult social care, public health and children's health services, using a variety of related performance measures and targets.

Better Care Fund and Integration Projects

3. The dashboard attached as Appendix A summarises current performance against the indicators and targets within the Better Care Fund (BCF) plan and the impacts of the supporting projects, particularly related to avoiding emergency admissions.

Admissions to Care and Nursing Homes

4. Avoiding permanent placements in residential care homes is a good indication of delaying dependency; research suggests where possible people prefer to stay in their own home rather than move into residential care. There were 710.5 permanent admissions to either residential or nursing care of people aged 65 and over per 100,000 population at the 2014/15 year end. The

current data shows an estimate of the full year figure for 2015/16. At 589.3 admissions per 100,000, this is forecast to meet the BCF target.

Older People at Home 91 Days After Discharge

5. A key measure in the Better Care Fund (BCF) is the Adult Social Care Outcomes Framework (ASCOF) metric that measures the proportion of people discharged from hospital via reablement services that are still living at home 91 days later. For those people discharged between February '15 and April '15 and accommodation location between May and July '15 the figure was 83% against the BCF target of 82% and is currently rated 'green'. The 2014/15 year end figure of 83.5% also exceeded the BCF target.

Delayed Transfers of Care (DTOC)

6. The BCF metric is based on delayed days through the month and cumulatively for each quarter against a set of quarterly targets. The quarterly BCF target for Q1 of 2015/16 is 275.6 delayed days per 100,000 population. The number of days delayed has fallen significantly and performance in quarter 1 has met the target at 238.74, this is also somewhat lower than the position at the end of Q4, 2014/15 (364.7). An alternative method of monitoring delayed transfers of care is a snapshot of people delayed on the last Thursday of each month. This is the method used in the national Adults Social Care Outcomes Framework (ASCOF). For ASC a target has been agreed that the average of these snapshots across the 12 months should be no higher than 8.6. Based on the last Thursday of April, May and June, the average was 7.7 and therefore meeting the target.

7. UHL also reports DToC delays based on the number of patients discharged as a percentage of occupied bed days. There was very good progress with DToCs reaching a low of 1.2% for Q1 2015/16 against a national target of 3.5%.

Emergency Admissions

8. NHS England (NHSE) have confirmed they will use a central Monthly Activity Return (MAR) to determine performance for each Health and Wellbeing Board against the pay for performance target on emergency admissions. During 2015/16, work has been undertaken using the available data to estimate overall performance against this pay for performance metric. This is provisional data and subject to change.

9. Data for the period January – July 2015 shows the health and care economy in Leicestershire County continues to have a higher than targeted level of total emergency admissions, despite a variety of actions including the introduction of four emergency admissions avoidance schemes.

10. The tables below show the total number of avoided admissions that the four BCF emergency admission avoidance schemes have achieved against the pay for performance target so far.

Monthly Performance

	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Monthly Target	166	166	166	168	168	168	172	172	172	174	174	175
Actual avoided admissions	149	139	136	156	157	157	153					
Monthly variance against target	-17	-27	-30	-12	-11	-11	-19					

Total Performance

	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Cumulative Target	166	332	498	666	834	1,002	1,174	1,346	1,518	1,692	1,866	2,041
Cumulative actual avoided admissions	149	288	424	580	737	894	1047					
Cumulative variance against target	-17	-44	-74	-86	-97	-108	-127					

11. Further work has now been completed by the Step Up/Step Down Programme Board to increase the number of appropriate referrals to the schemes. A number of actions are being implemented within the schemes to increase referrals, including:

- Direct referrals to the Older Persons Unit (OPU) from key nursing homes started at the beginning of July.
- ED professionals can make next day referrals to the Integrated Crisis Response Service and OPU services. Further work to promote this service continues. Clinical representatives from the OPU and ICRS service attended the Primary Care Coordinators team meeting to discuss the referral routes further.
- Data is being monitored to identify if referrals are being received via the new routes and the suitability of the referrals.
- The GP 7 day pilot services have been reviewed and are currently being reshaped by both CCGs. The trajectories for both schemes will be reviewed as part of this process.

12. There are a number of indicators in the NHS Outcomes Framework that relate to unplanned hospitalisation and emergency admissions. The urgent care action plan has been updated to reflect actions to be delivered over the next 3 months focusing on admission avoidance, and UHL and LPT (Leicestershire Partnership Trust) flow and discharge. This has been reviewed with the NHS Regional Team.

Patient Experience

13. The BCF metric covering patient/service user experience is derived from a GP survey asking patients whether they have sufficient support from local services/agencies to help manage their long term condition. The most recent data, published in July 2015, shows 61.6% agreement, down slightly from the baseline of 64.2%. Delivery of the improvement is therefore rated amber at this stage.

Emergency Admissions and Injuries Due To Falls

14. Work continues to obtain actual data updates fully in line with the BCF definition for metric 6 (injuries due to falls). In the meantime there are a number of other proxy indicators in the NHS Outcomes Framework that relate to emergency admissions.

Integration Project Delivery

15. Within the current Better Care Fund scheme delivery progress updates, a number of issues have been noted and these are set out below.

Scheme	**Commentary**
Glenfield Hospital Admission Avoidance	This scheme was put on hold last year due to a review of a number of projects in UHL. A meeting was held on 29 June to now start taking this project forward. A business case is being developed for the scheme.
Bed Based Reablement	A review of the original residential reablement service is required to ensure that outcomes are being delivered in line with the scheme's original expectations. The review will need to consider other options that are available. The opening of Oak Court has been delayed by a further month due to ongoing building works. It is now anticipated that Oak Court will open at the beginning of September.
Safe Minimum Transfer Data Set	The minimum data set system has experienced some delays as a result of IT resource constraints. The system is to be hosted by UHL. Further to an IT stakeholder meeting held in June, UHL have been revisiting the schedule and resource availability. A revised timeline has been proposed with a new provisional go live date in November put forward. November is still subject to confirmation and will be confirmed shortly. Once confirmation has been received, project plans will be updated and revised schedules shared.

Provider and CCG Dashboard - Appendix B

16. Attached as Appendix B is a dashboard that summarises information on provider and CCG performance. The Everyone Counts Dashboard sets out the rights and pledges that patients are entitled to through the NHS. The indicators within the dashboard are reported at CCG level. Data reported at provider level does differ, and delivery actions indicate where this is a risk. The report highlights Amber and Red issues on an exception basis.

18 Weeks Referral to Treatment (RTT)

17. RTT admitted, non-admitted and incomplete targets remain compliant at UHL in June. The persistent effort by all involved has delivered aggregate compliance in the 3 RTT standards as well as showing significant improvements across several specialties. The systematic approach taken should now provide a solid foundation for consistency of delivery; however achieving this consistency will remain a challenge.

Diagnostic Waiting Times

18. Problems in endoscopy have had a big impact on diagnostics 6 week wait performance which is not expected to regain compliance until September. In order to address long patient waits in endoscopy, UHL are working to put on weekend lists, providing 60-90 additional scopes per weekend.

52 Week Waiters (incompletes at UHL)

19. The majority of the 52 week breaches have occurred as a result of a Trust-wide review of planned waiting lists at specialty level. Therefore the following actions will be taken Trust-wide:

- Communication around planned waiting list management to all relevant staff
- System review of all waiting list codes
- All General Managers and Heads of Service to sign a letter confirming review and assurance of all waiting lists
- Weekly review at Head of Operations meeting for assurance.

Accident and Emergency (A&E) - 4 Hour Waiting Time (UHL)

20. Performance of the 4 hour wait target at UHL's Accident and Emergency department continues to slowly improve with required levels being met on some days - with the emphasis being on sustainable improvement via work streams overseen by the Urgent Care Board. More significant changes are now underway on the new A and E Department aimed at future improvements.

Cancer Waits – 2 Week Waits, 31 Day Waits, 31 Day Waits for Surgery, 62 Day Waits

21. There is concern around the backlog in the 62 day waits especially Lung and Lower Gastrointestinal. The 62 day target is now predicted to recover in October 2015.

22. An Intensive Support Team are to provide additional targeted cancer support and are due to visit UHL in August 2015. Other actions being undertaken include:

- Translation of the 2 week wait (2ww) patient communication into 8 languages.
- CCG Clinical Leads developed an action plan for Primary Care in preparing patients who will need to attend for an endoscopy.
- Regular meetings between UHL Cancer Leads, NHS England, CCG Contracting and Quality.
- Updated patient communication disseminated to practices to help minimise DNAs (Did Not Attends) and maximise patient engagement for those patients on 2ww pathway.

Cancelled Operations – Non Readmitted within 28 Days (UHL)

23. The cancelled operations metric was compliant in May 2015 at UHL as all patients who had an operation cancelled were re-admitted within 28 days. There were two 28 day breaches in June; one each from UHL and Alliance. The UHL patient was a paediatric case awaiting complex surgery. The surgeons were not available to perform the operations within 28 days of the first cancellation. The Alliance cancellation is being investigated.

Pressure Ulcers (Grade 2)

24. There were 10 pressure ulcer cases in April 15, with an improvement made in May and June to 8 per month. An action plan was developed in April for approval at the nursing and midwifery executive. An alert was raised to ensure that the matter of mattress delays was urgently reviewed.

Never Events

25. There was one Never Event in May at UHL – the incorrect dosage of insulin was administered, which resulted in no harm.

East Midlands Ambulance Service (EMAS)

Ambulance Response Times, Handovers and Ambulance Crew Clear

26. For EMAS as a whole organisation the national Red 1 target (arrival within 8 minutes for immediately life threatening incidents) was achieved at a regional level, but not at Leicestershire level.

27. The Better Patient Care Transformation Board focuses on the next stages of development for EMAS and will support the delivery of a range of initiatives designed to transform service delivery across the region.

28. As a result of the position a Contract Performance Notice was issued and a meeting has taken place between EMAS and NHS Erewash/Hardwick CCG's. A Remedial Action Plan (RAP) is in the process of being agreed and will focus on the actions being undertaken to improve performance.

29. The 2015/16 contract now requires agreement of improvement across the CCG level. Actions during periods of peak demand are being undertaken to ensure patient safety.

Outcomes Framework - Clinical Commissioning Group (CCG) Performance – Appendix C

30. The Outcomes Framework covers 5 domains and a set of indicators within each one that CCGs are nationally accountable to NHS England to ensure improvement on, attached as Appendix C. Data for a number of indicators have now been published, and the following provides an overview by exception.

Dental Patient Experience

31. Across ELR specifically there has been a deterioration in positive responses to patients responding to their overall experience and access to NHS Dental Services. Narrative below is provided by NHS England.

32. There has been no increase in direct patient calls or complaints, to explain the decline in the overall experience. Additional patient satisfaction information is also received from NHS Business Services Authority Dental Services, to the end of June for Leicestershire and Lincolnshire, and was above the overall England position. This is a separate survey to that carried out to the GP survey. At this stage it is not proposed to undertake an additional survey in the ELR area unless the experience continues to fall again in the next survey results, in 6 months' time.

33. In terms of access, additional activity has been commissioned across Leicestershire and Lincolnshire to maintain access, this included Practices in ELR but a number did struggle to deliver the additional activity due to the timeframe from approval to the end of March. Additional activity will be allocated in September, there has been significant interest to date and a number of ELR practices have expressed an interest so this should result in access increasing in the next two quarters of 2015/16. A separate report on the agenda deals with a review of the Dental Health Service.

Dementia Diagnosis

34. This indicator is to improve the number of people who have a clinical diagnosis of dementia; it measures the number of people with a diagnosis of dementia as a proportion of the number estimated to have the condition

(prevalence). At March 2015, there were 60.3% of patients diagnosed with dementia for West Leicestershire CCG and 54% diagnosed for East Leicestershire and Rutland (ELR) CCG against a national standard of 67%. Work continues with practices to increase Dementia Diagnosis Rates. There is currently no 2015/16 data available, the data is due to be published in September and will be based on the Cognitive Function and Ageing Study II (CFASII) methodology.

Increase the quality of life for people with long term conditions

35. Data was released in January in relation to 2013/14, relating to the quality of life for those people with a long term condition. West Leicestershire and East Leicestershire and Rutland have a higher score than the England average (England - 73.0, West Leicestershire – 75.1, East Leicestershire and Rutland – 75.5) though West Leicestershire and East Leicestershire and Rutland did not achieve their target score. A target has been set for 2014/15 and the indicators have been RAG rated as amber with the data expected to be published in September 2015.

Employment of people with mental illness (difference between England population and people with mental illness)

36. This quarterly reported data outlines the gap between overall employment, and employment of those people with a mental illness. This figure fluctuates between quarters significantly. In the past 12 months there has been an overall increase in the employment rate of people with mental illness from 42% to 47% across Leicestershire.

Public Health and Prevention Priorities Dashboard - Appendix D

37. Appendix D to this report is a dashboard summarising performance against key strategic health and wellbeing priorities. The priorities include Better Public Health, Better Physical Health, improving Children and Young People's Health and Better Mental Health. Data has been updated for a number of indicators, the following provides an overview by exception.

38. In June Public Health England produced its summary health profile for 2015 for Leicestershire. Whilst most areas show above average performance the profile suggests just two areas significantly worse than the England average – incidence of malignant melanoma and recorded diabetes. The wide range of public health data is being assessed in the context of an updated Joint Strategic Needs Assessment, which will be available shortly. The JSNA will inform a future refresh of the Health and Wellbeing Strategy priorities.

Drug Treatment

39. Indicators showing the successful completion of drug treatment for opiate users and non-opiate users have both improved slightly between quarters 3 and 4 of 2014/15. Successful completions fluctuate quarter on quarter and opiates performance remains within the top quartile range and significantly

above national performance. A separate report on the agenda deals with Substance Misuse Provision.

Smoking Cessation

40. LPT as the previous provider did not expect to hit target and did not hit the target. There are likely many reasons for this including greater prominence of the use e-cigarettes and by the end of the contract (certainly Q4) one of those reasons was the transition into a new service for half the LPT LSSS staff and transfer to the City Council for the other half. The transition for LCR staff into the new provider, Quit 51, went and continues to go smoothly and the service has started out well already. Access and quit dates set are up compared to the same time last year for each of the first three months of Q1 2015/16. It is also worth noting that the "lag time" for data is already much improved and we should continue to see data reported in closer to "real time" as we move forward.

Adult Obesity/Physical Activity

41. Leicestershire is continuing to develop a comprehensive strategy to reduce inactivity and overweight adults and started a whole systems transformation review of physical activity in May 2015 in order to develop a system wide response to the problem. The Physical Activity outcomes shown are well within reasonable expectations and reflect the current “state of play” with regard to what is a growing societal problem of increasing inactivity and obesity.

Child Obesity

42. 2014 data regarding excess weight for 4-5 year olds and 10-11 year olds shows that Leicestershire figures are very similar to 2013 and the county remains in the top performing quartile of all authorities. However continuing improvement in this area is still a priority.

Breastfeeding

43. The percentage of mothers initiating breastfeeding has reduced from 74.2% (2012/13) to 68.7% (2013/14). However, breastfeeding prevalence at 6-8 weeks has increased from 45.2% during 2013/14 to 46.5% during 14/15 showing an increasing trend for the last 2 years.

Child Oral Health

44. A survey of the oral health of five year olds was conducted in 2012 and published in Autumn 2013. This identifies the prevalence and severity of dental decay by measuring the number of decayed, missing and filled teeth, this report identified the oral health of 5 years olds as an issue. Data from the more recent Oral Survey of 3 year olds shows Leicestershire children to have a significantly higher percentage of decayed, missing or filled teeth compared to the national average. The figure in Leicestershire is 18.6% compared to

12% nationally. A separate report on the agenda deals with this issue in more detail.

Infant Mortality

45. The Infant mortality rate remains the same as the 2010-12 data for 2011-13 at 3.6 per 1,000 live births, we are currently in the second quartile, a rate of 3.1 or less would be required to reach the top quartile.

NHS Health Checks

46. The take up of NHS health checks by those eligible has increased during quarter 1 to 47.6% against a long term target of 61%, however the cumulative result is currently at 46.7%.

Mental Health

47. As per NHS England's Improving Access to Psychological Therapies (IAPT) team, nationally published data only is now used to assess performance against the Access target. Current actions include:

- Rolling recruitment of additional staff, including increasing the establishment to 25.4 wte (whole time equivalent) from 20.4 wte.
- County Council Adult Social Care services promoting the service and exploring opportunities to offer self-referrals.
- A waiting time data validation exercise will take place in August.
- Establishing pathways focusing on Insomnia (an indicator of anxiety and depression), the intention is to provide self-referral leaflets with repeat prescriptions of hypnotics which will result in lower dependency on hypnotic drugs in Quarter 2.

48. Child and Adolescent Mental Health Service (CAMHS) improvements were identified as a priority area by the Health and Wellbeing Board at previous meetings. The LPT data for patients receiving treatment within 13 weeks (routine) has shown a slight decline on the previous reported data to 77.4% at May 2015 against a target of 95%. A comprehensive plan has now been formed within the organisation to change the way these services are accessed and delivered and is currently in its implementation phase.

49. The excess under 75 mortality rate in adults with serious mental illness has declined from 362.6 in 2011/12 to 384.5 in 2012/13. The suicide rate has also declined from the previous reported data to 8.8 per 100,000 population, this equates to 169 people for the period 2011-13.

50. % people with a low satisfaction score is currently at the same level as the England average at 5.6%. This positions Leicestershire in the 2nd quartile and currently missing the top quartile target. The % of people with a high anxiety score has declined slightly in 2013/14 and Leicestershire is now in the 3rd quartile.

51. Mental Health related data has been updated for a number of indicators from the LPT Board reports, the following provides an overview by exception.

Occupancy Rate – Mental Health	The YTD to June 15 result is 88.8%, above the <=85% target. The Trust figure does not consider that certain services have different targets, e.g., MHSOP has a 90% target; Specialist Services represents Eating Disorders with a 80% target and INCLUDES patients on leave; CAMHS INCLUDES patients on leave; Adult represents Adult Acute only and LD represents the Agnes Unit with a target of 95% for the 4 new Intensive Support beds but 85% otherwise.

Recommendations

52. The Committee is asked to:

a) note the performance summary, issues identified this quarter and actions planned in response to improve performance; and

b) comment on any recommendations or other issues with regard to the report.

List of Appendices

Appendix A – Better Care Fund Summary Dashboard
Appendix B – Provider and CCG Performance Summary Dashboard
Appendix C – Outcome Framework CCG Performance Summary Dashboard
Appendix D – Public Health and Prevention Priorities Summary Dashboard

Background papers

Leicestershire Partnership Trust Board Papers can be found at the following link:
http://www.leicspart.nhs.uk/_Aboutus-Trustboardmeetings2015.aspx

University Hospitals Leicester Trust Board meetings can be found at the following link:
http://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/

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APPENDIX A — BETTER CARE FUND — Q1 2015/16

	Metric	Target	Current Data	Trend	RAG	Commentary
Better Care Fund Overarching Metrics	♦ METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population, per year	670.39	589.3		G	The current data shows an estimate of the full year figure for 2015/16. At 589.3 admissions per 100,000, this is forecast to meet the target. Target is for March 2016.
	♦ METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	82.01%	83.0%		G	The target relates to hospital discharges between October and December 2015 followed by accommodation location between January and March 2016. The measure is monitored on a rolling period with the current performance relating to hospital discharges between February and April 2015 and accommodation location between May and July 2015.
	♦ METRIC 3: Delayed transfers of care from hospital per 100,000 population, average monthly rate per quarter	350.48	238.74		G	BCF DToCs targets are quarterly and 275.6 covers the period Apr-Jun '15. The number of days delayed has fallen significantly and performance in Q1 has met the target. The target shown is for March 2016 i.e. Q4 of 2015/16.
	♦ METRIC 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, average monthly rate per quarter	717.44	769.92		R	Target shown is pay for performance target of 717.44 for December 2015. March 2016 target is 656.16. Current data shows the monthly average for the period April to June 2015 - quarter 1 of 2015/16. This is provisional data and subject to change when the Better Care Support Team publish revised guidance and the submission template. (Q1 15/16 target 692.55)
	♦ METRIC 5: Patient / service user experience. Patients satisfied with support to manage long term health conditions	66.80%	61.6%		A	Current data contains aggregated data collected from Jul-Sept 2014 and Jan-Mar 2015, results published in July 15. Target is for March 2016.
	♦ METRIC 6: Emergency admissions for injuries due to falls in people aged 65 and over per 100,000 population, per month	140.47			NA	Target is for March 2016. Work is still underway to identify this data at County HWBB level.

Metric Supporting	Scheme Details	P4P Target	Current Month Target	Current Month Data	Cumulative Target	Cumulative Data	Commentary
♦ METRIC 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, average monthly rate per quarter	♦ Rapid Response Falls Service ♦ 7 Day Working Primary Care ♦ Rapid Assessment for Older Persons Unit ♦ Integrated Health and Care Crisis Response	2041 (Dec 15)	172	**153**	1174	**1047**	Current month data is for July 2015, cumulative data is January to July 2015

		Indicator	Latest Data	Data Period	Trend	DOT	RAG	Indicator	Latest Data	Data Period	Trend	DOT	RAG
UHL	Patient Experience	♦ Friends & Family Test Score - in-patients	96.0%	Q1 (2015/16)		⇨	G	♦ Friends & Family Test Score - A&E	95.0%	Q1 (2015/16)		⇨	G
		♦ Friends & Family Test Score - Maternity	96.0%	Q1 (2015/16)		⇨	G						
	ED Waiting Times	♦ UHL Emergency Dept. Waiting Time < 4 Hours	92.3%	Q1 (2015/16)		⇧	A	♦ 12 Hour Trolley Waits	0	Q1 (2015/16)	LOW	⇧	G
		♦ Emergency Dept. Handovers between UHL ED & Ambulance > 30 mins	21.2%	Q1 (2015/16)	LOW	⇩	R	♦ Emergency Dept. Handovers between UHL ED & Ambulance > 1 Hour	7.8%	Q1 (2015/16)	LOW	⇩	R
	DTOC	♦ UHL Delayed Transfers of Care - no. of patients as a % of occupied bed days	1.2%	Q1 (2015/16)	LOW	⇧	G						
	Hospital Quality	♦ Cancelled Operations - non re-admitted in 28 days	98.3%	Q1 (2015/16)		⇧	R	♦ Cancelled operations- Cancelled for a second time	0	Q1 (2015/16)	LOW	⇨	G
		♦ Pressure Ulcers (Grade 2)	26	Q1 (2015/16)	LOW	⇩	A	♦ Pressure Ulcers (Avoidable Grade 3 & 4)	7	Q1 (2015/16)	LOW	⇧	G
		♦ Mixed Sex Accommodation	0	Q1 (2015/16)	LOW	⇨	G	♦ Safety Thermometer (% No Harms)	94.5%	Q1 (2015/16)		⇨	G
		♦ Never Events	1	Q1 (2015/16)	LOW	⇨	R	♦ 52 Week waiters (incomplete)	242	Orthodontics Q1 (2015/16)	LOW	⇩	R
ALL PROVIDERS	Referral to Treatment	♦ 18 Week Referral to Treatment Admitted (All Providers) (WLCCG)	89.3%	Q1 (2015/16)		⇧	A	♦ 18 Week Referral to Treatment Admitted (All Providers) (ELRCCG)	90.5%	Q1 (2015/16)		⇧	G
		♦ 18 Week Referral to Treatment Non Admitted (All Providers) (WLCCG)	96.0%	Q1 (2015/16)		⇨	G	♦ 18 Week Referral to Treatment Non Admitted (All Providers) (ELRCCG)	95.9%	Q1 (2015/16)		⇨	G
		♦ 18 Week Referral to Treatment Incomplete (All Providers) (WLCCG)	96.0%	Q1 (2015/16)		⇧	G	♦ 18 Week Referral to Treatment Incomplete (All Providers) (ELRCCG)	96.3%	Q1 (2015/16)		⇧	G
	Diagnostic Waiting Time	♦ Diagnostic Waiting Times < 6 weeks (All Providers) (WLCCG)	96.8%	Q1 (2015/16)		⇩	A	♦ Diagnostic Waiting Times < 6 weeks (All Providers) (ELRCCG)	97.1%	Q1 (2015/16)		⇩	A
	Cancer Wait Times	♦ Cancer 2 week wait (WLCCG)	90.6%	Q1 (2015/16)		⇩	A	♦ Cancer 2 week wait (EL&RCCG)	91.0%	Q1 (2015/16)		⇩	A
		♦ Cancer 2 week wait Breast symptoms (WLCCG)	95.4%	Q1 (2015/16)		⇩	G	♦ Cancer 2 week wait Breast symptoms (EL&RCCG)	95.7%	Q1 (2015/16)		⇩	G
		♦ Cancer 31 day (WLCCG)	93.7%	Q1 (2015/16)		⇩	A	♦ Cancer 31 day (EL&RCCG)	95.7%	Q1 (2015/16)		⇧	A
		♦ Cancer 31 day surgery (WLCCG)	92.4%	Q1 (2015/16)		⇧	A	♦ Cancer 31 day surgery (EL&RCCG)	89.9%	Q1 (2015/16)		⇩	R
		♦ Cancer 31 day anti cancer drug (WLCCG)	99.0%	Q1 (2015/16)		⇩	G	♦ Cancer 31 day anti cancer drug (EL&RCCG)	100.0%	Q1 (2015/16)		⇨	G
		♦ Cancer 31 day radiotherapy (WLCCG)	95.5%	Q1 (2015/16)		⇨	G	♦ Cancer 31 day radiotherapy (EL&RCCG)	94.4%	Q1 (2015/16)		⇨	G
		♦ Cancer 62 day (WLCCG)	79.3%	Q1 (2015/16)		⇩	R	♦ Cancer 62 day (EL&RCCG)	77.6%	Q1 (2015/16)		⇩	R
		♦ Cancer 62 day - from screening service (WLCCG)	90.2%	Q1 (2015/16)		⇧	G	♦ Cancer 62 day - from screening service (EL&RCCG)	95.8%	Q1 (2015/16)		⇧	G
		♦ Cancer 62 day - consultant upgrade (WLCCG)	100.0%	Q1 (2015/16)		⇧	G	♦ Cancer 62 day - consultant upgrade (EL&RCCG)	100.0%	Q1 (2015/16)		⇧	G

KEY: Directional Arrows show direction of travel from the previous data reported (⇧ = improving performance, ⇩ = declining performance, ⇨ = no change)

KEY: G - On target or on track to meet target, A - Off target by narrow margin, R - Off target by significant amount

		Indicator	Latest Data	Data Period	Trend	DOT	RAG	Indicator	Latest Data	Data Period	Trend	DOT	RAG
EMAS	East Midlands Ambulance Service	♦ Ambulance Response Times Cat A Red 1 (8 minutes) conditions life threatening & most time critical (WLCCG)	67.6%	Q1 (2015/16)		↑	R	♦ Ambulance Response Times Cat A Red 1 (8 minutes) conditions life threatening & most time critical (ELRCCG)	62.0%	Q1 (2015/16)		↑	R
		♦ Ambulance Response Times Cat A Red 2 (8 minutes) conditions life threatening & most time critical, less so than Red 1 (WLCCG)	67.7%	Q1 (2015/16)		↑	R	♦ Ambulance Response Times Cat A Red 2 (8 minutes) conditions life threatening & most time critical, less so than Red 1 (ELRCCG)	61.5%	Q1 (2015/16)		↑	R
		♦ Ambulance Response Times Cat A - ambulance arriving at the scene within 19 minutes (WLCCG)	92.8%	Q1 (2015/16)		↑	A	♦ Ambulance Response Times Cat A - ambulance arriving at the scene within 19 minutes (ELRCCG)	88.1%	Q1 (2015/16)		↑	R
		♦ Ambulance Response Times Cat A Red 1 (8 minutes) conditions life threatening & most time critical	75.1%	Q1 (2015/16)		↑	G	♦ Ambulance Response Times Cat A Red 2 (8 minutes) conditions life threatening & most time critical, less so than Red 1	74.0%	Q1 (2015/16)		↑	A
		♦ Ambulance Response Times Cat A - ambulance arriving at the scene within 19 minutes	93.9%	Q1 (2015/16)		↑	A						
		♦ Emergency Dept. Ambulance Crew Clear > 30mins	2.3%	Q1 (2015/16)	LOW	→	R	♦ Emergency Dept. Ambulance Crew Clear > 60 mins	0.4%	Q1 (2015/16)		→	R
IAPT	Mental Health	♦ Psychological Therapies - % of people who enter the service (WLCCG)	11.9%	YTD May 15		→	R	♦ Psychological Therapies - % of people who enter the service (EL&RCCG)	12.7%	YTD May 15	LOW	→	A
		♦ Psychological Therapies- Recovery rate (WLCCG)	58.0%	YTD May 15		↑	G	♦ Psychological Therapies- Recovery rate (EL&RCCG)	65.0%	YTD May 15	LOW	↑	G
		♦ Pyschological Therapies - 6 week waits (WLCCG)	41.0%	YTD May 15		→	A	♦ Pyschological Therapies - 6 week waits (EL&RCCG)	46.0%	YTD May 15		→	A
		♦ Psychological Therapies- 18 week waits (WLCCG)	95.0%	YTD May 15		→	G	♦ Psychological Therapies- 18 week waits (EL&RCCG)	96.0%	YTD May 15		→	G
LPT	Mental Health	♦ % Delayed Patients (DToC) - Mental Health	7.3%	(YTD Jun 15)	LOW	↓	G	♦ Occupancy Rate - Mental Health	88.8%	(YTD Jun 15)		↓	A
		♦ Average Length of Stay - Mental Health	92.1	(Jun 15)	LOW	↓		♦ Median Length of Stay - Mental Health	27	(YTD Jun 15)	LOW	↓	
		♦ % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric in-patient care (WLCCG)	95.0%	(YTD Jun 15)		↑	G	♦ % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric in-patient care (ELRCCG)	97%	(YTD Jun 15)		→	G
		♦ Early intervention in Psychosis - % newly diagnosed cases against commissioner contract	103.0%	(YTD Jun 15)		↓	G						
	Community & Other	♦ % Delayed Patients (DToC) - Community	1.1%	(YTD Jun 15)	LOW	↑	G	♦ Occupancy Rate - Community	90.8%	(YTD Jun 15)		↓	A
		♦ Average Length of Stay - Community Hospital rehab wards	16.2	(YTD Jun 15)	LOW	↑	G	♦ % Admissions Gate Kept	97.7%	(YTD Jun 15)		↑	G
		♦ Total number of Home Treatment episodes carried out by Crisis Resolution team year to date	524	(YTD Jun 15)		↑	G	♦ Patient experience of community mental health services					
	Quality - Safe Care	♦ Never Events	0	(YTD Jun 15)	LOW	↑	G	♦ Patients safety incidents reporting	4002	(Sep-14)		↑	G
		♦ STEIS - SI actions plans implemented within timescales	100.0%	(YTD Jun 15)		↑	G	♦ Compliance with hygiene code			LOW		A
		♦ MRSA Bacteraemia Cases - Community	0	(YTD Jun 15)	LOW	→	G	♦ Clostridium Difficile (C Diff) Cases	3	(YTD Jun 15)	LOW	↑	G

KEY: Directional Arrows show direction of travel from the previous data reported (↑ = improving performance, ↓ = declining performance, → = no change)

KEY: G - On target or on track to meet target, A - Off target by narrow margin, R - Off target by significant amount

APPENDIX C — CCG INDICATORS — QUARTER 1 2015/16

CLINICAL COMMISSIONING GROUP

	Indicator	WL CCG Latest Data	WL CCG Data Period	WL CCG Trend	WL CCG DOT	WL CCG RAG	EL&R CCG Latest Data	EL&R CCG Data Period	EL&R CCG Trend	EL&R CCG DOT	EL&R CCG RAG
DOMAIN 1	♦ 1 year survival from all cancers	67.4	2011			G	70.2	2011			G
	♦ 1 year survival from breast, lung and colorectal cancer	68.4	2011			G	69.6	2011			G
	♦ Potential years of life lost (PYLL) from causes considered amenable to healthcare	1771.8	2013	LOW		A	1701.5	2013	LOW		A
DOMAIN 2	♦ Unplanned Hospitalisation for chronic ambulatory care sensitive conditions (adults) per 100,000 population	736	Q1 (2015/16 local data)	LOW		R	783	Q1 (2015/16 local data)	LOW		R
	♦ Unplanned Hospitalisation for asthma, diabetes and epilepsy in under 19s per 100,000 population (WLCCG)	103	Q1 (2015/16 local data)	LOW		G	203	Q1 (2015/16 local)	LOW		R
	♦ Health-related quality of life for people with long term conditions	75.1	(2013/14)			A	75.5	(2013/14)			A
	♦ Estimated diagnosis rate of people with dementia	60.3%	(Mar 15)			R	54.0%	(Mar 15)			R
	♦ Proportion of people feeling supported to manage their own condition	64.6%	(2013/14)			G	67.1%	(2013/14)			G
	♦ Employment of people with long term conditions (difference between England population and people with LTC)	10.3%	(Leics Oct - Dec 14)	LOW		G	10.3%	(Leics Oct - Dec 14)	LOW		G
	♦ Health-related quality of life for carers	0.810	(2013/14)			G	0.837	(2013/14)			G
	♦ Employment of people with mental illness (difference between England population and people with mental illness)	38.0%	(Leics Oct - Dec 14)	LOW		R	38.0%	(Leics Oct - Dec 14)	LOW		R
DOMAIN 3	♦ Emergency Admissions for acute conditions that should not usually require hospital admission	1131	Q1 (2015/16 local data)	LOW		R	1207	Q1 (2015/16 local data)	LOW		R
	♦ Rate of emergency admissions within 30 days of discharge	1517	Q1 (2015/16 local data)	LOW		A	1632	Q1 (2015/16 local data)	LOW		R
	♦ Emergency Admissions for children with Lower Respiratory Tract Infections (LRTI) per 100,000 population	130	Q1 (2015/16 local data)	LOW		G	133	Q1 (2015/16 local)	LOW		G
	♦ Proportion of people 65 and over offered rehabilitation following discharge from acute or community hospital										
DOMAIN 4	♦ Overall experience of NHS Dental Service	86.0%	(Jul 14 - Mar 15)			G	83.0%	(Jul 14 - Mar 15)			A
	♦ Access to GP Services	73.0%	(Jul 14 - Mar 15)			R	72.0%	(Jul 14 - Mar 15)			R
	♦ Access to NHS Dental Services	95.0%	(Jul 14 - Mar 15)			G	95.0%	(Jul 14 - Mar 15)			A
DOMAIN 5	♦ Incidence of health associated infection MRSA	0	Q1 (2015/16)	LOW		G	0	Q1 (2015/16)	LOW		G
	♦ Incidence of health associated infection CDIFF	84	FOT Q1 (2015/16)	LOW		A	56	FOT Q1 (2015/16)	LOW		G
PRIMARY CARE	♦ Satisfaction with the quality of consultation at a GP Practice	431	(Jul 14 - Mar 15)			A	440	(Jul 14 - Mar 15)			A
	♦ Satisfaction with the overall care received at Surgery	85.1%	(Jul 14 - Mar 15)			G	85.0%	(Jul 14 - Mar 15)			R

APPENDIX D — PUBLIC HEALTH AND PREVENTION INDICATORS — QUARTER 1 2015/16

	Indicator	Latest Data	Data Period	Trend	DOT	RAG	Indicator	Latest Data	Data Period	Trend	DOT	RAG
MENTAL HEALTH	% of people with a low satisfaction score - self-reported well-being (Leics) (PHOF 2.23i)	**5.6%**	2013/14	LOW	↓	A	% of patients that received treatment in Child & Adolescent Mental Health Services (CAMHS) within 13 weeks - (routine)	**77.4%**	May-15		↓	R
	% of people with a low happiness score - self-reported well-being (Leics) (PHOF 2.23iii)	**7.1%**	2013/14	LOW	↑	G	% of patients that received treatment in Child & Adolescent Mental Health Services (CAMHS) within 4 weeks - (urgent)	**97.1%**	May-15		↓	G
	% of people with a high anxiety score - self-reported well-being (Leics) (PHOF 2.23iv)	**21.5%**	2013/14	LOW	↓	A	Average length of stay in acute hospitals - mental health	**92.10**	Jun-15	LOW	↓	NA
	Excess under 75 mortality rate in adults with serious mental illness (Leics) (PHOF 4.09)	**384.50**	2012/13	LOW	↓	A	Delayed transfers of care (mental health service users)	**7.3%**	YTD Jun 15	LOW	↓	G
	Suicide rate (Persons per 100,000) (Leics) (PHOF 4.10)	**8.80**	2011-13	LOW	↓	A	% of adults in contact with secondary mental health services living in settled accommodation (ASCOF 1H)	**42.0%**	2013/14		↓	R
	Emotional health of looked after children - mean SDQ scores (PHOF 2.08)	**17.80**	2011			A						
PUBLIC HEALTH	Slope index of inequality in life expectancy at birth (Males) (Leics) (PHOF 0.2iii)	**6.20**	2011-13	LOW	↓	G	% of adults classified as overweight or obese (Leics) (PHOF 2.12)	**65.4%**	2012	LOW		A
	Slope index of inequality in life expectancy at birth (Females) (Leics) (PHOF 0.2iii)	**5.00**	2011-13	LOW	↑	A	% successful completion of drug treatment - opiate users (PHOF 2.15i)	**9.5%**	Q4 2014/15		↑	A
	Life expectancy at birth (Males) (Leics) (PHOF 0.1ii)	**80.20**	2011-13		↑	G	% successful completion of drug treatment - non-opiate users (PHOF 2.15ii)	**36.7%**	Q4 2014/15		↑	A
	Life expectancy at birth(Females) (Leics) (PHOF 0.1ii)	**84.10**	2011-13		↑	A	Admissions to hospital for alcohol related causes (rate per 100,000) (Leics) (PHOF 2.18)	**143.53**	Q4 2014/15	LOW	↑	A
	Take up of the NHS Health Check Programme – by those eligible (2.22iv)	**47.6%**	Q1 2015/16		↑	A	Chlamydia diagnoses (rate per 100,000 15-24 year olds) (Leics) (PHOF 3.02ii)	**1494**	Q2 2014/15			A
	Under 75 mortality rate from all cardiovascular diseases (Persons per 100,000) (Leics) (PHOF 4.04i)	**68.50**	2011-13	LOW	↑	G	People presenting with HIV at a late stage of infection - % of presentations (Leics) (PHOF 3.04)	**48.7%**	2011-13	LOW	↑	G
	Under 75 mortality rate from respiratory disease (Persons per 100,000) (Leics) (PHOF 4.07i)	**23.90**	2011-13	LOW	↑	G	Under 18 conceptions (rate per 1,000) (Leics) (PHOF 2.04)	**20.90**	2013	LOW	↑	G
	Under 75 mortality rate from cancer (Persons per 100,000) (Leics) (PHOF 4.05i)	**131.10**	2011-13	LOW	↑	G	Prevalence of smoking among persons aged 18 years and over (Leics) (PHOF 2.14)	**18.0%**	2013	LOW	↑	A
	Under 75 mortality rate from all liver disease (Persons per 100,000) (Leics) (PHOF 4.06i)	**14.40**	2011-13	LOW	↑	G	Number of self-reported 4 week smoking quitters (Leics)	**670**	Q4 2014/15		↓	A
	% of eligible women screened - breast cancer (Leics) (PHOF 2.20i)	**83.3%**	2014		↓	G	% of women smoking at time of delivery (Leics) (PHOF 2.03)	**10.7%**	2013/14	LOW	↑	G
	% of eligible women screened - cervical cancer (Leics) (PHOF 2.20ii)	**78.4%**	2014		↓	G						
PHYSICAL HEALTH	% of physically active children - participation in more than 3hrs a week of community sport only	**42.5%**	2014/15		↓	G	% of physically inactive adults (Leics) (PHOF 2.13ii)	**26.3%**	2013	LOW	↓	A
	% of physically active children - participation in more than 3hrs a week of curriculum sport only	**53.4%**	2014/15		↓	G	% of adults participating in one or more sports a week for 30 minutes or more (Leics)	**38.1%**	Apr 14 - Mar 15		↑	G
	% of physically active adults (PHOF 2.13i)	**57.8%**	2013		↓	A						
CYP HEALTH	% of mothers initiating breastfeeding (PHOF 2.02i)	**68.7%**	2013/14		↓	A	% of children with excess weight - 4-5 year olds (Leics) (PHOF 2.06i)	**20.8%**	2013/14	LOW	↑	A
	% of mothers breastfeeding at 6-8 weeks (PHOF 2.02ii)	**46.5%**	2014/15		↑	A	% of children with excess weight - 10-11 year olds (Leics) (PHOF 2.06ii)	**30.1%**	2013/14	LOW	↑	G
	% children aged 5 years with one or more decayed, missing or filled teeth (PHOF 4.02)	**37.1%**	2012	LOW		R	Infant Mortality (PHOF 4.01)	**3.60**	2011-13	LOW	→	A

KEY: Directional Arrows show direction of travel from the previous data reported (↑ = improving performance, ↓ = declining performance, → = no change)

KEY: G - On target or on track to meet target, A - Off target by narrow margin, R - Off target by significant amount

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Agenda Item 15

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 9 SEPTEMBER 2015

REPORT OF NHS ENGLAND CENTRAL MIDLANDS

GENERAL DENTAL SERVICES URGENT CARE CONSULTATION AND SPECIAL CARE DENTISTRY PRE-ENGAGEMENT PROCESS

Purpose

1. The purpose of this report is to give the Health Overview and Scrutiny Committee an opportunity to respond to the dental consultation and pre-engagement processes being undertaken in Leicester, Leicestershire, Rutland (LLR) and Lincolnshire to inform dental procurement programmes in 2016.

2. The two dental procurements relate to:-

   (i) General Dental Services: Urgent Dental Care for Leicester, Leicestershire and Rutland (LLR);
   (ii) Special Care Dentistry Services for Leicestershire and Lincolnshire.

Background Information

3. NHS England Central Midlands are responsible for commissioning of NHS dental services across Leicestershire and Lincolnshire. The procurements will be open to existing and new providers. NHS England is working with Greater East Midlands and Arden Commissioning Support Unit to support the engagement and consultation processes for the procurement programmes.

4. The LLR Dental Access Centre provides NHS urgent dental care services to patients with an urgent need, who do not regularly receive dental care or, for patients when their practice is closed and they have an urgent need. The Dental Access Centre is based in Nelson Street in Leicester. This is a triage service and they provide either self-help pain relief advice or arrange for the patient to have an urgent dental appointment. Where a patient requires further routine care after an urgent course of treatment, they will be required to seek routine care at an alternative dental practice. The service opening times are 9.00am to 5.00pm Monday to Friday and 9.00am to 12noon on Saturday, Sunday and Bank Holidays.

5. The LLR Dental Out of Hours service provides urgent dental care during 6.30pm to 8.00am Monday to Friday and 24 hours at weekends and Bank Holidays. There is an on-call dentist available between 6.30pm to 10.00pm Monday to Friday and 1.00pm to 6.00pm at weekends and Bank Holidays. The Dental Out-of- ours service is accessed via 111 and all patients are triaged. The on-call dentist will arrange to see the patient at the Dental Access Centre if it is determined the patient cannot wait until the next day.

6. The community dental service in Leicestershire and Lincolnshire is concerned with the provision of dental care and enabling the improvement of oral health of individuals and groups in the society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often a combination of a number of these factors. As such, care will be provided to patients who have a need beyond the skill set and facilities of a general dental practitioner.

7. The Special Care Dentistry Services also provides dental treatment under general anaesthesia in secondary care sites with access to critical care facilities (ITU for paediatrics) for children who require multiple extractions, children with complex health needs who require restorative treatment or children when it is not possible to provide dental care using alternative treatments methods, and for adults with a moderate or severe learning disability that impacts upon their ability to co-operate.

8. The Lincolnshire special care dentistry service provides a Pain and Anxiety Management services for adults and domiciliary care for house bound patients. Domiciliary care in Leicestershire is limited.

9. A pre-engagement process for both procurement programmes was undertaken in March 2015 to seek patients' views on dental services in order to shape future services.

10. The pre-engagement questionnaire for general dental services: urgent care in LLR was concerned with how to improve access to urgent and routine dental treatment and received 254 responses. The main findings were:

    (i) In general, there was uncertainty about how to access out-of-hours services and many people were not aware of the Dental Access Centre;
    (ii) Of those who responded who used the Dental Access Centre, there was an equal split between people from Leicester and people from Leicestershire, with a smaller number from Rutland, indicating that people are willing to travel some distance for urgent dental care;
    (iii) Overall, the data could indicate that there is a patient need for dental services to be available from 8am to 8pm, especially on weekdays;
    (iv) Engagement work conducted in offices indicated a strong; preference for evening appointments between 5pm and 8pm, and for early morning appointments before 9am. Preferred days were weekdays but also the availability of weekend appointments was desirable for this cohort of workers.

11. The pre-engagement questionnaire for Special Care Dentistry for Leicestershire and Lincolnshire was seeking views from patients on the service and any areas that required improvement. The initial pre-engagement received 20 responses from the on-line questionnaire. The themes from the initial pre-engagement process were:

    (i) Patients would like extended opening times i.e. before 9.00 am or between 5-8pm;
    (ii) 45% of patients are travelling under 10 miles;
    (iii) 25% of patients are travelling between 10 to 20 miles;
    (iv) 10% of patients are travelling between 20 to 30 miles;

(v) Majority of patients are being seen within 13 weeks of their referral;
(vi) Patients want continuity of care;
(vii) 5% of patients/carers stated the service exceeded their expectations, 45% are very satisfied with the service, 10% satisfied, 10% either unsatisfied or disappointed and 35% did not respond;
(viii) Would like improvement in accessing domiciliary care for patients in care homes or housebound patients, access to adult dental phobic services and why a patient is being referred into this specialist service.

General Dental Services Urgent Care for Leicester, Leicestershire and Rutland Consultation

12. NHS England is now undertaking a formal consultation process for general dental services: urgent dental care for LLR. The consultation is seeking patient and public views on the service model to improve access to general dental services: urgent care. The consultation process commenced on 3 August 2015 and will close at midnight on the 1 November 2015. There are two options for consideration, these are:

(i) Option 1: Urgent dental care service

This option will provide urgent dental care services for patients who are not accessing regular NHS dental care with an urgent need or for patients with an urgent need when their practice is closed. The urgent dental care service will be delivered from the Dental Access Centre in Nelson Street, Leicester. This option will merge the existing Dental Access Centre urgent care service and the Dental Out of Hours service to create a revised urgent care service. The opening times for the revised urgent dental care service will be determined by the consultation process, if this is the preferred option. This option will be funded within the existing financial envelope.

(ii) Option 2: 8am to 8pm service providing NHS urgent and routine dental care in two locations

This option is to replace the existing urgent care services (Dental Access Centre and Dental Out of Hours services) with two new practices providing urgent and routine care. The practices will be open from 8am to 8pm, 7 days a week, 365 days a year. The two practices will provide urgent dental care for patients who do not regularly receive dental care, provide urgent dental care for patients when the local practices are closed and provide routine dental care for patients. Patients accessing urgent dental care, who do not regularly receive NHS dental care will be given the opportunity to access regular NHS dental care, however, this is subject to their capacity. The locations for two new practices will be determined by the consultation. Possible locations for this option are one in Leicester City and one in a market town in either Leicestershire County or Rutland. This option requires funding from existing urgent care services and additional investment, which has been identified, if this is the preferred option.

13. The consultation process will be advertised in libraries, community centres, medical practices, dental practices and pharmacies across LLR. Copies of the consultation document with the questionnaire will be available on-line, and

hard copies at the Dental Access Centre. Patients and the public can contact the Greater East Midlands and Arden Commissioning Support Unit to request a hard copy for completion.

14. A public meeting for the consultation has been arranged to be held on 7 October 2015 between 6pm to 8pm at the Adult Learning Centre in Leicester.

15. The outcome of the consultation will be considered by NHS England in late November to determine the preferred service model to be commissioned. A dental consultation email account has been established for managing any queries.

16. NHS England will also be undertaking a further consultation exercise regarding general dental services for Leicester, Leicestershire, Rutland and Lincolnshire for those general dental services contracts that are time limited and require re-procurement, and to reflect the outcomes of the oral health needs assessment (subject to financial envelope available for commissioning of additional general dental services). This will be the subject of a separate report to the Health Overview and Scrutiny Committee.

Special Care Dentistry for Leicestershire and Lincolnshire Pre-engagement

17. The pre-engagement process for Special Care Dentistry was extended for an additional 6 weeks to enable patients, carers, wider health community and stakeholders the opportunity to provide feedback to assist with improving existing services.

18. This process has adopted a targeted approach to enable patients, carers and parents accessing the existing Community Dental Services across the Leicestershire and Lincolnshire community clinics to have an opportunity to feedback their views. Stakeholders were advised of the extended pre-engagement process for special care dentistry to enable them the opportunity to provide feedback. The questionnaire is available on-line and easy read hard copies are available in the different community clinics.

19. It has been agreed to commission special care dentistry for Leicestershire and Lincolnshire and to align the existing services for consistency. The pre-engagement process is to seek views on the existing services and to identify any areas of improvement for consideration. The new special care dentistry services will continue to be provided from the existing community dental services clinics and staff will be offered the opportunity to TUPE across to maintain continuity of services.

20. The pre-engagement process for Leicestershire commenced on 17 August 2015 and will close on 25 September 2015. The pre-engagement outcome will be considered by NHS England in November 2015 to agree future commissioning arrangements for special care dentistry services.

Procurement Programmes

21. NHS England will procure new service arrangements from 1 December 2016 for general dental services: urgent care and special care dentistry services. The two procurement programmes will commence in January 2016. New contracting arrangements will be awarded in June 2016, which will allow for

an extensive mobilisation period to establish the new service arrangements by the new providers.

Conclusion

22. The Health Overview and Scrutiny Committee is asked for its views on the options for urgent dental care services and also to indicate any areas where the special care dentistry service could be extended/improved. These views will be fed back to NHS England as part of the consultation process.

Officer to Contact

Jane Green, Assistant Contract Manager, Dental and Optometry, NHS England
Email: england.leiclincsdentalconsultation@nhs.net

List of Appendices

Appendix – Consultation Questionnaire

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NHS England

HAVE YOUR SAY...

...on how urgent dental care could be accessed in the future for Leicester, Leicestershire and Rutland.

Public Consultation:

3 August 2015 - 1 November (midnight) 2015

This document will tell you why we are considering making changes to urgent dental services in Leicester, Leicestershire and Rutland (LLR).

Within this document you will be presented with two possible options of how urgent dental care could be provided in the future.

To complete the survey online go to https://consult-engage.gemcsu.nhs.uk/gemcsu/how-should-urgent-dental-care-be-accessed and submit by midnight on 1 November 2015.

Improving Access to Urgent Dental Care

NHS England is responsible for commissioning NHS dental services to meet local needs. Currently urgent dental care services are provided at the Dental Access Centre (for patients not receiving regular dental care or when patients practice is closed, i.e. Saturday, Sunday and Bank Holiday mornings) in Nelson Street, off London Road, Leicester, LE1 7BA and by the dental out-of-hours service. These services are due to end on 30 November 2016 and a new service will be established from 1 December 2016.

There are several reasons changes to NHS dental services in Leicester, Leicestershire and Rutland (LLR) are necessary.

1 To ensure that we are meeting the demand for NHS dental services for urgent and routine care.

2 To meet the needs of our LLR population.

3 To improve our population dental health.

4 To provide good quality care.

Within this document you will be presented with two possible options of how urgent dental care could be provided in the future. Details can be found on pages 9 to 12.

We hope that you will take part in this public consultation and provide feedback.

This is your opportunity to help us improve NHS urgent dental care services for patients locally. If you wish to speak to us face to face about the options then you are welcome to attend the public meeting on 7 October 2015 from 6pm to 8pm at the Adult Education Centre, 2 Wellington Street, Leicester, LE1 6HL.

How were the two options reached?

To develop the options we reviewed local needs in the 'oral needs health assessment'. An oral health needs assessment is a document providing an overview of the local NHS dental needs. For example, it contains details of the local population profile, what services are currently available, identifies any service gaps and makes recommendations to the commissioning organisation on areas that could improve the oral health of the local population, to inform the development of a commissioning strategy.

We also engaged with residents across LLR through the use of targeted outreach, and promoted an online survey which asked people's opinions about their current experiences of accessing urgent dental care. The survey was promoted in the local media, through key health stakeholders, such as the three Healthwatch teams, through the voluntary and community sectors and by attending face-to-face meetings. We also provided hard copies of the survey to all the NHS dentist practices in Leicester, Leicestershire and Rutland and all of the libraries (3,000 surveys were disseminated in total).

We believe that the following proposals reflect local people's views and needs, that is, to have good quality care, within a reasonable distance and which offers good value for money.

The public consultation is from the **3 August 2015 to midnight on 1 November 2015**.

How to get involved

The questions we would like you to answer are at the end of this document (page 14), along with details on how you can provide feedback.

We can assure you that **no decisions have been made** and **we will use the public consultation feedback when considering and agreeing future service arrangements.**

If you wish to complete the survey online then please go to https://consult-engage.gemcsu.nhs.uk/gemcsu/how-should-urgent-dental-care-be-accessed

The following information will provide you with an overview of how the current services operate, what urgent dental care services actually involve and the current picture of Leicester, Leicestershire and Rutland oral health needs. This will help you to make an informed decision on which option you think will better suit the needs of our population.

Health Needs of the Population of Leicester, Leicestershire and Rutland

Oral Health

Oral health problems include tooth decay, gum disease, tooth loss and oral cancers. Many of the risk factors such as diet, tobacco, alcohol and stress are the same as for many chronic conditions, such as cancer, diabetes and heart disease. As a result, interventions that aim to tackle these risk factors (taking a 'common risk approach') will improve general health as well as oral health.

It is of concern that significant inequalities in oral health exist on a national, regional and local level. People living in deprived communities consistently have poorer oral health than people living in more affluent communities.

Children's Oral Health

- Children in Leicester have some of the worst levels of dental decay in England.
- Children's access to NHS dental services in Leicester City and Rutland is higher than the local and national averages*.
- Children's access to NHS dental services in Leicestershire County is lower than the local and national averages*.
- Despite being largely preventable, tooth decay is the most common oral disease affecting children and young people in England. While children's oral health has improved over the past 20 years, almost a third (27.9%) of five-year-olds still had tooth decay in 2012.

Adult Oral Health

- Adult access to NHS dental services in Leicester City is higher than the local and national averages*.
- Adult access to NHS dental services in Leicestershire County and Rutland is lower than the local and national averages*.

** Based on March 2014 data for routine and urgent dental care.*

Existing Urgent Dental Care Services

What do we mean by NHS urgent dental care services?

NHS dentists are required to see patients with urgent dental care within 24 hours, e.g., same day or next day, subject to capacity and severity of the problem. Urgent dental care services may provide:

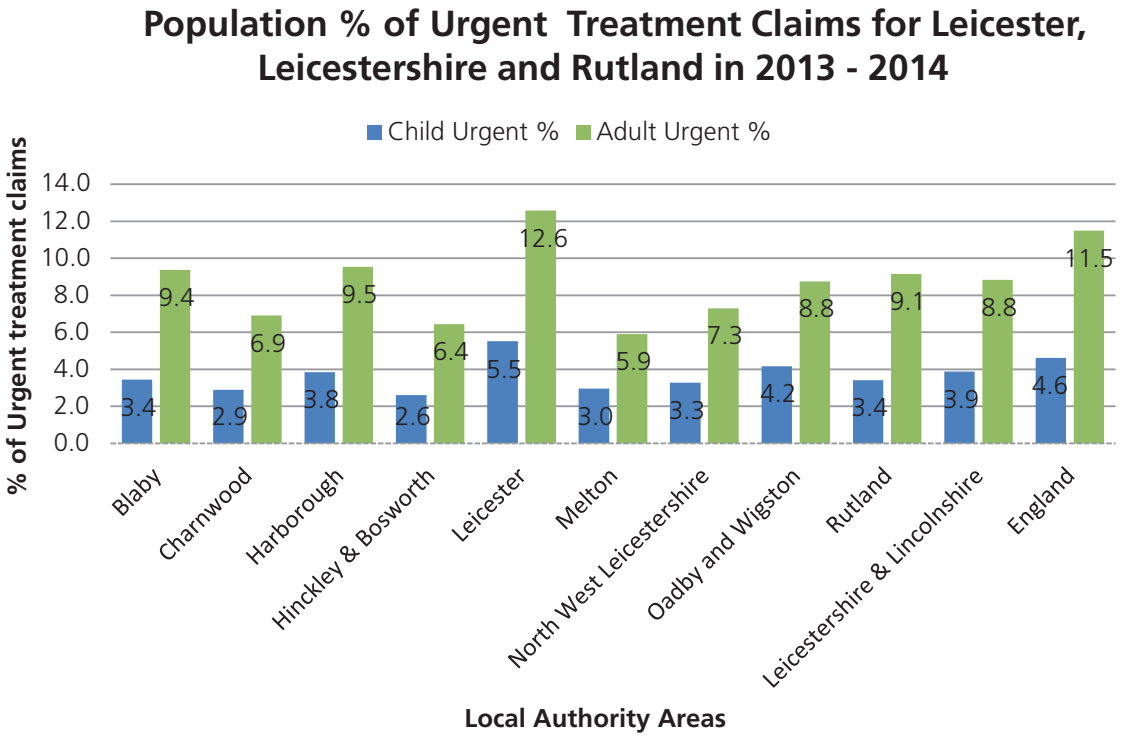
- Advice on managing pain until the patient can be seen by a dentist.
- Antibiotics for infections.
- The offer of an appointment for dental treatment to relieve dental pain, e.g. which may involve tooth extraction, temporary fillings or dressings.
- Sign-posting to access dental services for follow-up routine dental treatment, if required.

Who is accessing urgent dental treatment in Leicester City, Leicestershire and Rutland?

The graph below shows access to NHS urgent dental treatment across the different localities based on urgent treatment claim forms. This graph excludes access to private urgent dental treatment.

Key Points

- Leicester City children and adults accessing urgent dental care are above the national average.
- Leicestershire and Rutland children and adults accessing urgent dental treatment are below the national average.



It is acknowledged that not all patients seek to access regular dental care but access NHS dental services when they have an urgent dental need. Currently patients can access NHS urgent dental care via the following routes:

- NHS dental practices (for patients who receive regular dental care or the practice has capacity to see new patients for an urgent course of treatment)
- Dental Access Centre based in Nelson Street, off London Road, Leicester, LE1 7BA, for patients not receiving regular dental care or when their NHS practice is closed on a Saturday, Sunday and Bank Holiday mornings
- Dental out-of-hours service
- Accident and Emergency (A&E) for patients with dental facial trauma or dental facial swelling who have difficulty in breathing.

Accessing Urgent Dental Treatment Through The Current Service

Leicester's Dental Access Centre

The Dental Access Centre in Nelson Street, Leicester, provides urgent dental care services from 9am to 5pm Monday to Friday, and 9am to 12 noon on Saturday, Sunday and Bank Holidays. However, telephone services are available from 9am to 4.30pm Monday to Friday and 9am to 10.30am at weekends and Bank Holidays. Urgent appointments are available from 9am to 3.30pm (with the first two appointments pre-booked) Monday to Friday. Eighteen appointments are available on Saturday mornings and nine appointments available on Sunday and Bank Holiday mornings. The following points apply to the service:

- This service is for patients who do not receive regular dental care but have an urgent dental need, or for patients with an urgent need when their NHS dental practice is closed on a Saturday, Sunday and Bank Holiday mornings
- All patients who have telephoned or walked in are assessed by a dental nurse
- A dental nurse may provide self-help pain relief advice or signpost patients to their NHS dentist.
- The dental nurse will offer an urgent appointment on the day with a dentist based on their urgent clinical need (subject to appointment availability)
- The Dental Access Centre does not provide routine dental care
- Standard NHS dental charges apply.

Dental Out-of-Hours Service

The dental out-of-hours service operates from 6.30pm to 8am Monday to Friday and 24 hours on Saturday, Sunday and Bank Holidays. The dental out-of-hours service provides urgent dental care via the NHS 111 telephone service:

- For patients within Leicester, Leicestershire and Rutland and temporary residents/visitors to the area
- All patients who contacted NHS 111 will be assessed by a call handler
- The call handler or nurse may provide self-care advice to manage pain and advise patients to contact their dentist the next day for an urgent appointment
- Forward the patient details to the on-call dentist
- On-call dentist will contact patients and may offer advice or book urgent appointments to see them either at the Dental Access Centre or at their practice
- May advise patients to attend A&E in exceptional circumstances.

Standard NHS charges apply for provision of urgent dental care at the Dental Access Centre and the dental out-of-hours' service.

When to use Accident and Emergency (A&E) Services

YOU SHOULD ONLY GO TO A&E FOR DENTAL PROBLEMS IF…

1. You have suffered facial trauma to the teeth and jaw.
2. You have swelling around the eye or swelling resulting in difficulty swallowing. This may indicate an acute infection which could make breathing difficult.
3. You have uncontrollable haemorrhaging (escape of blood from a ruptured blood vessel).
4. Avulsed permanent teeth (children/adult with knocked out teeth. These need to be re-fitted within one hour and stabilised and then followed up by a dentist).

Patients **SHOULD NOT attend A&E** for **assistance with urgent dental care** that does not meet the above criteria or attend Urgent Care Centres or GPs for antibiotics prescriptions for managing dental pain or infection.

The Urgent Dental Care Services Opening Times

Monday to Friday

<table>
<tr><th></th><th>9am to 5pm</th><th>5pm to 6.30pm</th><th>6.30pm to 10pm</th><th>10pm to 8am</th></tr>
<tr><td>Dental Access Centre (DAC)
Urgent dental care for patients not receiving regular dental care</td><td>All telephone and walk-in patients are assessed. Patients are:
given self-help advice
sign-posted to their dentist
booked an urgent appointment.</td><td>NO SERVICE AVAILABLE</td><td>SERVICE IS CLOSED</td><td>SERVICE IS CLOSED</td></tr>
<tr><td>NHS 111

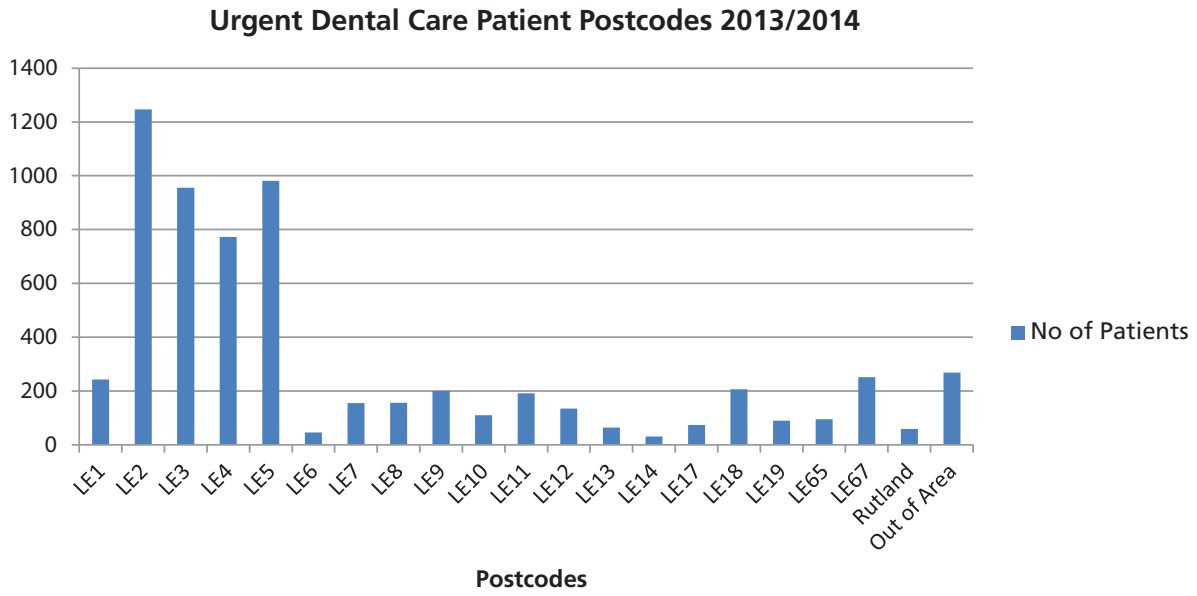
Dental Out-of-Hours Service</td><td colspan="2">Patients telephone NHS 111 for urgent dental care. Assessed patients are:
given self-help advice to manage pain and advised to contact their dentist or the DAC (if not receiving regular dental care).</td><td colspan="2">Patients telephone NHS 111 for urgent dental care. Assessed patients are:
gives self-help advice to manage pain over-night and advised to contact their dentist or the DAC (if not receiving regular dental care) the next day.
forward contact details to on-call dentist.</td></tr>
<tr><td>Out-of-Hours on-call Dentist</td><td>SERVICE IS NOT AVAILABLE</td><td>NO SERVICE AVAILABLE</td><td>On call dentist will contact patient:
provide pain relief advice
arrange to see patient at DAC or at own practice</td><td>SERVICE IS CLOSED</td></tr>
</table>

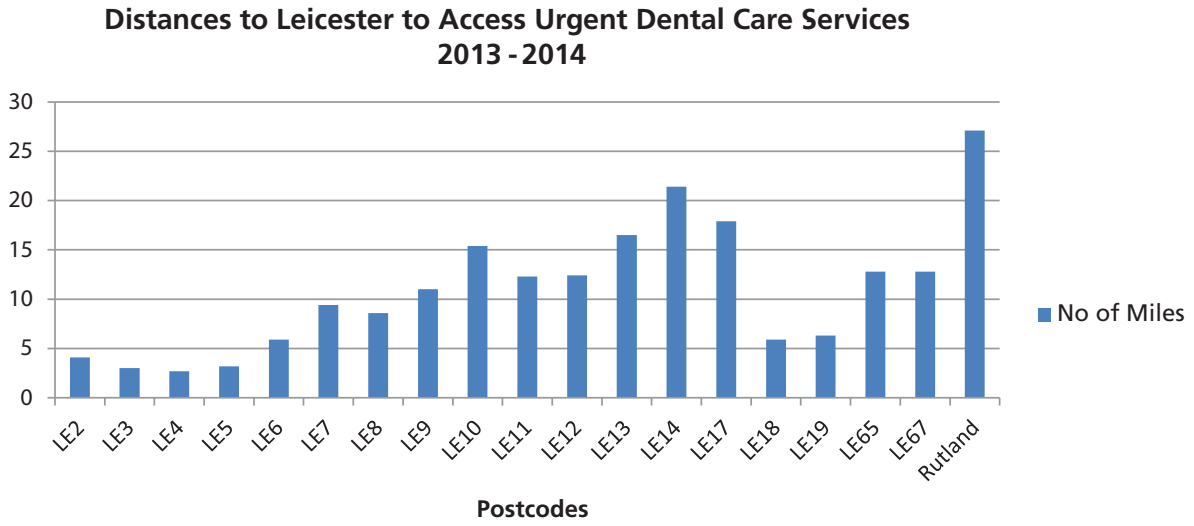
Saturdays, Sundays and Bank Holidays

	9am – 12 noon	12 noon – 1pm	1pm – 6pm	6pm – 9am
Dental Access Centre (DAC) Urgent dental care for patients not receiving regular dental care	All telephone and walk-in patients are assessed. Patients are: • given self-help advice • sign-posted to a dentist • booked an urgent appointment.	**SERVICE IS CLOSED**	**SERVICE IS CLOSED**	**SERVICE IS CLOSED**
NHS 111 **Dental Out-of-Hours Service**	Patients telephone NHS 111 for urgent dental care. Assessed patients are: • given self-help advice to manage pain over-night and advised to contact their dentist or the DAC (if not receiving regular dental care) the next day • forwarded contact details to on-call dentist.			
Out-of-Hours on-call Dentist	**SERVICE IS NOT AVAILABLE**	**SERVICE IS NOT AVAILABLE**	On call dentist will contact patient: • provide pain relief advice • arrange to see patient at DAC or at own practice	**SERVICE IS NOT AVAILABLE**

Patients Accessing Urgent Dental Care in Leicester, Leicestershire and Rutland

The graphs below detail patients' postcodes and distance travelled to access current urgent dental care services at the Dental Access Centre and the dental out-of-hours' service.
The graphs show that the patients across Leicester, Leicestershire and Rutland are using NHS urgent dental care services and are willing to travel to access care.





Why is change needed?

NHS England has undertaken a review of the urgent care dental services for Leicester, Leicestershire and Rutland to plan new dental services. To assist with planning for the future we have refreshed our oral health needs assessment for our local population to inform future service decisions.

The service review has identified the following:

1. There are gaps in service, i.e. 5pm to 6.30pm Monday to Friday, between the closure of NHS dental practices/Dental Access Centre and dental out-of-hours services and 12 noon to 1pm on Saturday, Sundays and Bank Holidays between the closure of the Dental Access Centre and dental out-of-hours' service, as shown in the urgent dental care opening hours details on pages 6 and 7.
2. Dental Access Centres were originally established to improve access to urgent dental care as a short-term solution only.
3. Evidence supports the need to improve access and capacity to urgent dental care to meet our population needs.
4. Our pre-engagement feedback indicates that patients would like access to extended opening hours, e.g. early morning, evening and weekend appointments.
5. Evidence that patients are having difficulties in accessing urgent dental care from local NHS dental practices.
6. Routine dental care is not provided by the Dental Access Centre and patients who require routine treatment after receiving urgent treatment, e.g. to replace a temporary filling have to be signposted to routine care from an alternative NHS dental service.
7. The Dental Access Centre surgeries are not fully utilised, e.g. out of four dental surgeries: up to two are used for urgent care, one is dedicated for the out-of-hours service only, and one is not utilised.
8. There is a requirement to meet procurement law and competition guidance for securing future NHS service providers when current arrangements and contract terms cease.
9. There is a requirement to demonstrate value for money.

Proposed Changes and Options

The following options look at how we can deliver NHS Dental Services to make more effective use of the resources available to us.

There are two options to improve access to urgent care dental services.

Please Note: **This public consultation is not about making cuts and/or saving money.**

It is about providing access to the right care, in the right place, when patients need it, while ensuring the money available does all of those things as effectively as possible.

OPTION ONE: Urgent Care Dental Service

Merge the existing Dental Access Centre and dental out-of-hours services with revised opening times. The service would be delivered from the Dental Access Centre in Nelson Street, (off London Road, Leicester, LE1 7BA).

The service would provide:

- Urgent dental care to patients who are not receiving regular dental care or for patients who could not be seen at an NHS dental practice
- Opening hours to be determined from the consultation feedback
- Patients requiring urgent dental care would be assessed by dental nurses
- Patients would be given advice on managing pain, signposted to contact their dentist (if they have one) or advised on how to access regular NHS dental care
- Offered an urgent dental appointment on the same day or next day (subject to capacity)
- Standard NHS patient charges would apply, e.g. £18.80 for an urgent course of treatment
- The NHS 111 service would continue to provide self-help pain relief advice out of hours when the service is closed.

Positive	Negatives
• Maintaining access to urgent care for patients who are not receiving regular dental care, patients with an urgent need when their NHS practice is closed and out of hours' services • Central location in Leicester with good public transport links • Improve cover arrangements as existing arrangements revised into one service • Short travelling distances for the majority of patients accessing the existing services.	• Not all assessed patients requiring an urgent appointment would be seen (dependent on capacity) • Service will not provide routine NHS dental treatments • Patients would need to seek alternative NHS dental treatment for follow-up routine care after urgent treatment • Long travelling distances for patients who live in Leicestershire county and Rutland • Premises not fully utilised • High premises costs • Service to be provided within existing funding arrangements.

Frequency Asked Questions: Option One

1. Will I have to pay for urgent NHS dental care services?

It will depend on whether you meet the NHS dental services patient charges exemption criteria. If you meet the exemption criteria then your NHS treatment will be free. If you do not meet the exemption criteria, then you will be required to pay £18.80. Please note each NHS urgent appointment is classed as one complete course of treatment to manage your urgent dental need. Details of NHS dental charges and exemptions are available on the NHS Choices website at http://www.nhs.uk/NHSEngland/AboutNHSservices/dentists/Pages/nhs-dental-charges.aspx

2. How can I access urgent dental care?

You can contact the Dental Access Centre during their opening hours. Please note that all patients who telephone or walk in will be assessed. When the Dental Access Centre is closed, you will need to contact the NHS 111 service. The NHS 111 service will either provide advice on managing dental pain overnight, signpost you to your dentist the next day (if you have one), or advise you to contact the Dental Access Centre the next day or in exceptional circumstances you may be advised to attend A&E.

3. Will I be assessed before being offered an urgent dental appointment?

Yes, all patients will be assessed by a dental nurse and will offer an urgent appointment on the same or next day, based on your clinical need. This will also be subject to the availability of urgent appointments.

4. Will this option provide longer opening hours to access NHS urgent dental care?

Yes, the pre-engagement survey has indicated patients would like longer opening hours to NHS urgent dental care services. The extended opening hours are to be determined based on the consultation outcome. Please refer to consultation survey questions on page 14 to see available options of when these times could potentially be, based on your choice.

5. Can I access follow-up NHS routine care?

No, this option will only provide access to NHS urgent dental care services for patients. If you require further routine dental care, then you would need to seek an alternative NHS dental practice. NHS Choices has details of which NHS dental practices are taking on new NHS patients at www.nhs.uk. Alternatively you can contact Healthwatch on 0116 251 8313 for Leicester, 0116 257 4999 for Leicestershire and 01572 720381 for Rutland.

6. Will I be able to become a NHS patient?

No, this is not available under this proposed service option. Please see number 5 above on how to find a NHS dentist.

OPTION TWO: Creating a New NHS Urgent and Routine Dental Care Service (8am to 8pm, 7 days a week, 365 days of the year)

To establish two new dental practices providing urgent and routine dental care to patients from 8am to 8pm, seven days a week, 365 days a year, including all Bank Holidays. When local practices are closed, the sites will provide urgent care services. The creation of the new practices is based on the oral health needs assessment and the review of existing contracting arrangements.

This service would provide:

- Access to urgent dental care
- Access to urgent dental care for patients outside their normal dental practice opening hours
- Routine dental care to urgent care patients (subject to practice capacity to take on new patients)
- Service available between 8am to 8pm, seven days a week, 365 days a year
- Urgent care patients to be assessed
- An urgent dental appointment on the same day or next day (subject to capacity)
- Normal NHS patient charges would apply, e.g. £18.80 for an urgent course of treatment
- The NHS 111 service would continue to provide self-help pain relief advice out of hours when the service is closed, sign-posting to NHS dental practices that have capacity and may advise patients to attend A&E in exceptional circumstances.

New Service Locations

Possible locations of these practices could be based centrally within Leicester City and one in a market town within Leicestershire County/Rutland. A question in the survey on this option (page 15) allows you to provide possible locations of where the practices could be.
The consultation feedback will be considered with the oral health need assessment to determine the locations.

Positive	Negatives
• Improves NHS dental access • Longer opening times, which are more convenient for patients • Provide more capacity/appointments to meet patient needs • Provides urgent and routine dental care • The service to be delivered across two locations • Reduce travelling distances for patients (depending on location) • Service contactor provides premises • Improved links with NHS 111 service and other urgent care providers • Engagement shows patients would appreciate the flexibility of more than one location for urgent care • Demonstrates value for money.	• The existing Dental Access Centre and Dental Out-of-Hours services would cease • Additional investment required to help establish the 8am to 8pm practices • Potential close down of the Dental Access Centre if unable to lease the premises.

Frequently Asked Questions: Option Two

1. Will I have to pay for urgent NHS dental care services?

It will depend on whether you meet the NHS dental services patient charges exemption criteria. If you meet the exemption criteria then your NHS treatment will be free. If you do not meet the exemption criteria, then you will be required to pay £18.80. Please note each NHS urgent appointment is classed as one complete course of treatment to manage your urgent dental need. Details of NHS dental charges and exemption criteria are available on the NHS Choices website at
http://www.nhs.uk/NHSEngland/AboutNHSservices/dentists/Pages/nhs-dental-charges.aspx

2. How can I access urgent dental care?

You can contact NHS dental practices directly or call 111 for pain relief advice and be signposted to an NHS dental practice or look at NHS Choices to check which NHS dental practices have capacity to see new patients, or contact Healthwatch on 0116 251 8313 for Leicester, 0116 257 4999 for Leicestershire and 01572 720381 for Rutland.

The new dental practices will be open from 8am to 8pm, seven days a week, 365 days a year. They will assess patients to understand their clinical need and will either book an urgent appointment the same day or next day or provide pain relief advice until they can be seen by a dentist.

If you require urgent dental care when the 8am to 8pm practices are closed, you will need to call NHS 111. The NHS 111 service will provide advice on managing pain overnight and signpost to your dentist the next day (if you have one), or advise you to contact an NHS dental practice the next day, or in exceptional circumstances you may be advised to attend A&E.

3. Will I be assessed before being offered an urgent NHS dental appointment?

Yes, all patients will be assessed by a dental professional and will be offered an appointment on the same or next day based on urgent clinical need.

4. Will this option provide longer opening hours to access NHS urgent dental care?

Yes, this option will provide access to NHS urgent dental care from 8am to 8pm, seven days a week, 365 days a year.

5. Can I access follow-up NHS routine care?

Yes, patients will be given the choice to have NHS routine dental care at the same practice (this is subject to the practices capacity).

6. Will I have the opportunity to become a NHS patient?

Yes, you will be given the choice to become a NHS patient at the practice, however, this is subject to their capacity. NHS dental practices' capacity to see new patients will vary. Under this proposed option, the practices will be able to see and treat NHS patients. Please note that NHS patient charges are applicable where patients do not meet the NHS dental patient charges exemption criteria. NHS dental charges vary depending on the type of dental treatment required. The NHS dental charges are £18.80 for Band 1 treatment (examination, diagnosis, advice or urgent care), £51.30 for Band 2 treatment (fillings, extractions and root canal fillings) and £222.50 for Band 3 treatment (complex treatment, i.e. dentures, crowns, bridges). You will only ever be asked to pay one charge for each complete course of treatment, even if you need to visit your dentist more than once to finish it. Details of NHS dental charges, exemption criteria and treatment under each band are available on the NHS Choices website at
http://www.nhs.uk/NHSEngland/AboutNHSservices/dentists/Pages/nhs-dental-charges.aspx

Engagement Outcomes

The pre-public consultation survey in Leicester, Leicestershire and Rutland (LLR) was concerned with how to improve access to urgent and routine dental treatment. In total 254 responses were received. The survey was available online and over 3,000 surveys where disseminated into all LLR dental practices and libraries. Outreach was also conducted in many of the main supermarkets as well as at focused meetings with seldom heard groups.

- In general, there was uncertainty about how to access out-of-hours services and many people were not aware of the Dental Access Centre
- Of those who responded who used the Dental Access Centre, there was an equal split between people from Leicester and people from Leicestershire, with a smaller number from Rutland, indicating that people are willing to travel some distance for urgent dental care
- Overall, the data could indicate that there is a patient need for dental services to be available from 8am to 8pm, especially on weekdays
- Engagement work conducted in offices indicated a strong preference for evening appointments between 5pm and 8pm, and for early morning appointments before 9am. Preferred days were weekdays but also the availability of weekend appointments was desirable for this cohort of workers.

About this Consultation

Cabinet Office Code of Practice on Consultation This consultation is being carried out in accordance with the guidelines published by the Cabinet Office on 17 July 2012, and available at: www.gov.uk/government/publications/consultation-principles-guidance
If you would like to talk to someone about how this consultation has been put together and delivered, please contact NHS England Central Midlands Primary Care Dental Commissioning Team, telephone 0113 824 9522, email england.leiclincsdentalconsultation@nhs.net

THANK YOU

Thank you for taking the time to read this document. We hope it gives you a clearer understanding of why we are proposing changes to urgent dental care services in Leicester, Leicestershire and Rutland. By working together we can help these valuable services evolve, to meet the changing needs of local people and remain a vital part of your NHS. Please can you take a few minutes to complete the attached questionnaire?

If you wish to complete the survey online then please go to:
https://consult-engage.gemcsu.nhs.uk/gemcsu/how-should-urgent-dental-care-be-accessed

Access to NHS Dental Services for Leicester, Leicestershire and Rutland Questionnaire

Your views are important to us to help develop dental services for Leicester, Leicestershire and Rutland.

Q1. Have you used urgent dental care services in the last 12 months?

Yes ☐ No ☐

Q2. Where did you access urgent dental care services?

☐ NHS Dental Practice
☐ Dental Access Centre
☐ Dental Out-of-Hours Service
☐ Private Dentist
☐ Other, please give details:

.....

.....

Q3. The two options described in this document highlight how services can be provided in the future. Which of these options do you feel would most meet the future needs of patients in Leicester, Leicestershire and Rutland? *(please tick one)*

☐ Option One: Urgent Dental Care Service with revised opening times from the existing Dental Access Centre based in Leicester

☐ Option Two: 8am to 8pm Service providing urgent and routine dental care in two locations, seven days a week, 365 days a year

If choosing Option One please tick the time you would like the Urgent Dental Care services to be available:

☐ Existing opening times (9am – 5pm Monday to Friday, 9am - 12noon Saturday, Sunday and Bank Holidays with an on-call dentist 6.30pm-10pm Monday to Friday and 1pm-6pm at weekends and Bank Holidays)

☐ 9am-6.30 pm Monday to Friday, 9am-6pm Saturday, Sunday and Bank Holidays

☐ 9am-7pm Monday to Friday and 9am-6pm on Saturday, Sunday and Bank Holidays

☐ Other, please state below:

.....

.....

If choosing Option Two Urgent and Routine Dental Care, please indicate where you would like the new potential service(s) to be located, e.g. if one is in Leicester City, in which market town in Leicestershire County/Rutland should the other be?

☐ Loughborough ☐ Melton Mowbray ☐ Hinckley ☐ Oakham

☐ If other, please state below

.....

.....

Q4. Why did you choose this option?

☐ Location ☐ Good public transport links ☐ Better access

☐ If other, please state below

Q5. Overall how satisfied are you with how you have been consulted?

☐ Very Satisfied ☐ Satisfied ☐ Neither satisfied or dissatisfied

☐ Dissatisfied ☐ Very Dissatisfied

Q6. Do you have any further comments about the consultation process?

Q7. If you would like to comment on ways to improve access to NHS dental services, please use the space below.

EQUALITIES MONITORING

NHS England recognises and actively promotes the benefits of diversity and is committed to treating everyone with dignity and respect regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. To ensure that our services are designed for the population we serve, we would like you to complete the short monitoring section below. The information provided will only be used for the purpose it has been collected for and will not be passed on to any third parties.

1. Are you responding?

On behalf of an organisation?

☐ Yes ☐ No

If yes, please state the name of the organisation

.....

If no, and you are responding as an individual, please complete the rest of the questionnaire to help our equalities monitoring

2. Which area do you live?

☐ Leicester City
☐ Leicestershire County - Blaby District
☐ Leicestershire County - Charnwood Borough
☐ Leicestershire County - Harborough District
☐ Leicestershire County - Hinckley and Bosworth Borough
☐ Leicestershire County - Melton Borough
☐ Leicestershire County - North West Leicestershire District
☐ Leicestershire County - Oadby and Wigston Borough
☐ Rutland County
☐ Don't know
☐ Other (please specify)

.....

3. What is your full postcode? This will allow us to see how far people travel to use services

.....

4. What is your gender?

☐ Male ☐ Female ☐ Transgender ☐ Prefer not to say

5. If female, are you currently pregnant or have you given birth within the last 12 months?

☐ Yes ☐ No ☐ Prefer not to say

6. What is your age?

☐ Under 16 ☐ 16-24 ☐ 25-34 ☐ 35-59 ☐ 60-74 ☐ 75+ ☐ Prefer not to say

7. What is your ethnic group?

☐ Asian or Asian British
☐ Black or Black British
☐ Chinese
☐ Mixed dual heritage
☐ White or White British
☐ Gypsy/Romany/Irish traveller
☐ Arab
☐ Prefer not to say
☐ Other (please specify) .....

8. Do you look after, or give any help or support to family members, friends, neighbours or others because of either:

☐ Long-term physical or mental-ill-health/disability
☐ Problems related to old age
☐ No
☐ I'd prefer not to say
☐ Other, please describe: .....

9. Are your day-to-day activities limited because of a health condition or illness which has lasted, or is expected to last, at least 12 months? *(Please select all that apply)*

☐ Vision (such as due to blindness or partial sight)
☐ Hearing (such as due to deafness or partial hearing)
☐ Mobility (such as difficulty walking short distances, climbing stairs)
☐ Dexterity (such as lifting and carrying objects, using a keyboard)
☐ Ability to concentrate, learn or understand (Learning Disability/Difficulty)
☐ Memory
☐ Mental ill-health
☐ Stamina or breathing difficulty or fatigue
☐ Social or behavioural issues (for example, due to neuro diverse conditions such as autism, attention deficit disorder or Aspergers' syndrome)
☐ No
☐ Prefer not to say
☐ Any other condition or illness, please describe: .....

10. What is your sexual orientation?

☐ Bisexual ☐ Heterosexual/straight ☐ Gay ☐ Lesbian ☐ Prefer not to say

☐ Other (please state).....

11. Are you:

☐ Single – never married

☐ Co-habiting – Living as a couple

☐ Married/civil partnership

☐ Separated (still married)

☐ Divorced

☐ Widowed

☐ Prefer not to say

☐ Other (please specify) .....

12. What is your religion and belief?

☐ No religion

☐ Baha'i

☐ Buddhist

☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)

☐ Hindu

☐ Jain

☐ Jewish

☐ Muslim

☐ Sikh

☐ Prefer not to say

☐ Other (please specify) .....

Thank you for taking the time to complete this questionnaire. The results of this questionnaire will help support NHS England when they are looking at dental services provided to patients.

Please send it to:
Primary Care Commissioning Team
NHS England
Freepost Business reply
RRUE-JRBR-RGGT
Fosse House
6 Smith Way
Enderby
Leicestershire
LE19 1SX

Questionnaires should be returned by midnight on 1 November 2015.

Other languages and formats

We can provide versions of this leaflet in other languages and formats such as Braille and large print on request. Please contact the Engagement and Involvement department, telephone 0116 295 4183

Somali

Waxaan ku siin karnaa bug-yarahaan oo ku qoran luqado iyo habab kale sida farta indhoolaha Braille iyo daabacad far waa-wayn markii aad soo codsato. Fadlan la soo xiriir qaybta Ka-qaybgalka iyo Dhex-gelidda, lambarka telefoonka waa **0116 295 4183**

Polish

Jeżell chcleliby Państwo otrzymać kopię niniejszej ulotki w tłumaczeniu na język obcy lub w innym formacie, np. w alfabecie Braille'a lub w powiększonym druku, prosimy skontaktować się telefonicznie z zespołem ds. zaangażowania (Engagement and Involvement) pod numerem telefonu **0116 295 4183**

Cantonese

如有要求，我們可以將本宣傳手册用其他語言或格式顯示，如盲文或大號字體。請致電我們的"參與部門" (Engagement and Involvement Department) **0116 295 4183**

Gujarati

આ પત્રિકાનાં સંસ્કરણો અમે અન્ય ભાષાઓ અને સ્વરૂપોમાં જેમ કે બ્રેઇલ અને મોટી પ્રિન્ટમાં વિનંતી કરવાથી પૂરાં પાડી શકીશું. કૃપા કરી એન્ગેજમેન્ટ એન્ડ ઇન્વોલ્વમેન્ટ ડિપાર્ટમેન્ટનો, ટેલીફોન **0116 295 4183** પર સંપર્ક કરો.

Hindi

अनुरोध किए जाने पर हम आपको इस सूचना-पत्र के संस्करण अन्य भाषाओं और स्वरूपों में प्रदान कर सकते हैं जैसे ब्रेल और बड़ा प्रिंट। कृपया टेलीफ़ोन **0116 295 4183** पर एंगेज़मेंट एंड इन्वॉल्वमेंट डिपार्टमेंट से संपर्क करें।

Arabic

يمكننا تقديم نسخ أخرى من هذه النشرة بلغات أو تنسيقات أخرى مثل برايل أو الأحرف الكبيرة حسب الطلب. برجاء الاتصال بقسم المشاركة والانخراط على هاتف رقم **0116 295 4183**

Urdu

طلب کرنے پر ہم اس کتابچے کا ترجمہ دیگر زبانوں اور صورتوں مثلاً بریل یا بڑے حروف میں بھی فراہم کرسکتے ہیں۔ براہ کرم انگیجمینٹ اینڈ انوالمینٹ ڈپارٹمنٹ سے اس نمبر پر رابطہ کریں **0116 295 4183**

Punjabi

ਅਸੀਂ ਇਸ ਕਿਤਾਬਚੇ ਦੇ ਸੰਸਕਰਨ ਬੇਨਤੀ ਕਰਨ ਤੇ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਅਤੇ ਫਾਰਮੇਟਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਪ੍ਰਦਾਨ ਕਰ ਸਕਦੇ ਹਾਂ। ਕਿਰਪਾ ਕਰਕੇ ਐਂਗੇਜ਼ਮੈਂਟ ਅਤੇ ਇਨਵੋਲਵਮੈਂਟ ਵਿਭਾਗ (Engagement and Involvement Department) ਨੂੰ ਸੰਪਰਕ ਕਰੋ, ਟੈਲੀਫੋਨ **0116 295 4183**

Bengali

আপনার অনুরোধে আমরা এই লিফলেট এর সংস্করণ অন্যান্য ভাষায় এবং ব্রেইল ও বড় হরফে প্রদান করতে পারি. অনুগ্রহ করে সংশ্লিষ্টতা এবং সম্পৃক্ততা বিভাগ এর সাথে যোগাযোগ করুন, টেলিফোন **0116 295 4183**