Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 16 January 2019 at 2.00 pm**

Location: **Sparkenhoe Committee Room - County Hall**

Contact: **Mr. E. Walters (0116 3052583)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Dr. R. K. A. Feltham CC (Chairman)

Mr. T. Barkley CC	Dr. S. Hill CC
Mr. D. C. Bill MBE CC	Mr T. Parton CC
Mrs. A. J. Hack CC	Mrs. J. Richards CC
Mr. D. Harrison CC	Mrs. M. Wright CC

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

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 7 November 2018.		(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 in respect of items on the agenda.		

6.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.		
7.	Presentation of Petitions under Standing Order 36.		
8.	Public Health Medium Term Financial Strategy 2019/20 to 2022/23.	Director of Public Health	(Pages 13 - 25)
9.	Active Lives Survey 2018 - Physical Activity Levels in Leicestershire.	Director of Public Health	(Pages 27 - 31)
10.	Royal College of Physicians report on Outpatient Appointments.		(Pages 33 - 42)
11.	Date of next meeting. The next meeting of the Committee is scheduled to take place on 13 March 2019 at 2:00pm.		
12.	Any other items which the Chairman has decided to take as urgent.		

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Public Scrutiny website www.cfps.org.uk.

The following questions have been agreed by Scrutiny members as a good starting point for developing questions:-

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

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Agenda Item 1

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 7 November 2018.

PRESENT

Dr. R. K. A. Feltham CC (in the Chair)

Mr. T. Barkley CC	Dr. S. Hill CC
Mr. D. C. Bill MBE CC	Mr T. Parton CC
Mrs. A. J. Hack CC	Mr. T. J. Pendleton CC
Mr. D. Harrison CC	Mrs. J. Richards CC

In attendance
Micheal Smith, Healthwatch Leicester and Leicestershire.
Caroline Trevithick, Interim Accountable Officer, WLCCG (minute 40 refers).
Kate Allardyce, NHS Midlands and Lancashire Commissioning Support Unit (minute 41 refers).
Mr. J.B. Rhodes CC (minute 43 refers).

33. Minutes of the previous meeting.

The minutes of the meeting held on 5 September 2018 were taken as read, confirmed and signed.

34. Question Time.

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

35. Questions asked by members.

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

36. Urgent items.

There were no urgent items for consideration.

37. 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.

It was noted that all Members who were District/Borough Councillors would wish to declare a personal interest in Item 11 – the Development of a Unitary Structure for Local Government in Leicestershire (minute 43 refers).

38. Declarations of the Party Whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

39. Presentation of Petitions.

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

40. Hinckley and Bosworth Community Health Services.

The Committee received a report of West Leicestershire Clinical Commissioning Group (WLCCG) which provided an update regarding the Hinckley and Bosworth Community Services review. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed Caroline Trevithick, Interim Accountable Officer, WLCCG, to the meeting for this item.

Arising from discussions the following points were noted:

(i) Members welcomed the bid that had been submitted by WLCCG for funding from NHS England for capital investment in Hinckley and Bosworth. It was clarified that the bid had been submitted four separate times to NHS England, rather than it being a four stage bidding process. The Hinckley project was a high priority in the Leicester, Leicestershire and Rutland Sustainability and Transformation Partnership and therefore it was hoped that NHS England would recognise that the bid had a large amount of local support and therefore look favourably upon it. There were clinical risks in continuing to provide services at the current Hinckley and District Hospital site at Mount Road due to the viability of the hospital environment and these risks were currently being managed but without capital investment the risk would ultimately become too great to manage.

(ii) Concerns were raised by Members that less people would be able to walk or use public transport to access services at the Sunnyside site due to it not being in the centre of the town and therefore car parking would become an issue. Reassurance was given that there was good car parking availability at the Sunnyside site, and also once existing staff and services had moved out of the Mount Road site then car parking space at Mount Road which had previously been used for staff parking would be able to be used by patients.

(iii) A member raised concerns that there was no Urgent Care Centre in Hinckley and patients were expected to travel to Nuneaton for urgent care despite high levels of traffic between Hinckley and Nuneaton which caused delays.

(iv) It was moved by Mr Bill, seconded by Mr Barkley and carried that the Committee, recognising the seriousness of the situation, should write to NHS England and the Secretary of State for Health and Social Care in support of the bid for funding for capital investment to maintain services within Hinckley and Bosworth.

RESOLVED:

(a) That the update regarding Hinckley and Bosworth Community Services, and in particular the proposals for Hinckley and District Hospital, be noted;

(b) That the Committee write to NHS England and the Secretary of State for Health and Social Care in support of the bid for funding for capital investment to maintain services within Hinckley and Bosworth.

41. Performance Report.

The Committee considered a joint report of the Chief Executive of the County Council and NHS Midlands and Lancashire Commissioning Support Unit, which provided an update of performance to the end of October 2018. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Committee welcomed Kate Allardyce, NHS Midlands and Lancashire Commissioning Support Unit to the meeting to present the report.

Arising from discussions the following points were noted:

(i) Members welcomed the 38% reduction in days lost due to delayed transfers of care, though noted that the actual number of days lost was still significant. The Committee was pleased to note that action plans were in place to further reduce the amount of days lost, and emphasised the importance of ensuring that the improvements in performance were sustainable. It was agreed that the action plans would be circulated to members after the meeting.

(ii) In response to a query about whether swab tests could be used to make the prescribing of antibiotics more accurate, it was confirmed that GP and laboratory capacity, as well as the resources that would be required to implement it, meant that it was unlikely that regular swab testing would be introduced. GPs provided a reasonable diagnosis based on symptoms. Swab testing was carried out in secondary care for less common conditions.

(iii) Under the CCG Improvement and Assessment Framework there was a metric for cancer patients to wait no more than 62 days from referral to first definitive treatment. There were nine other national cancer metrics one of which related to patients receiving first definitive treatment within one month of a cancer diagnosis. Members requested a separate report for a future Committee meeting which set out each metric and the performance against it. It was also agreed that the overall suite of performance reports for CCGs, UHL, LPT, BCF, Public Health etc would be reviewed to ensure that a full set of metrics were being reported to give members a full picture of performance in LLR in all key areas.

(iv) A Member raised concerns regarding the waiting times for ENT and ophthalmology outpatient appointments. Micheal Smith advised that Healthwatch Leicester and Leicestershire had carried out some work on the patient experience of Ophthalmology appointments and were also conducting a separate piece of work on the impact on patients of appointment cancellations generally. He agreed to share the results of this work with the Committee.

(v) The data in the report related to all patients that resided in the geographical area covered by the LLR Clinical Commissioning Groups therefore it included patients that accessed services outside of the County such as the George Eliot hospital in Nuneaton, or Kettering General Hospital. This could explain why the performance figures for East Leicestershire could be significantly different to the figures for West Leicestershire as the performance of the out of county hospitals would be fed into either the data for east or west Leicestershire depending on where the patient lived.

(vi) Some recent figures for children of excess weight in Leicestershire indicated that there had been a significant deterioration compared to the previous year however it was believed that there had been a problem with the accuracy of the data for the Hinckley and Bosworth area therefore performance may be better than it appeared. An investigation into the data issues was ongoing.

(vii) Newly available figures showed that breastfeeding prevalence in Leicestershire at 6-8 weeks after birth for 2017/18 was at 45% which was better than the national average.

RESOLVED:

(a) That the performance summary, issues identified and actions planned in response to improve performance be noted.

(b) That the improvement in performance for days lost due to delayed transfers of care be welcomed.

(c) That officers be requested to produce a report for a future meeting of the Committee regarding the nine national cancer performance metrics and the performance in Leicestershire against those metrics.

42. Director of Public Health Annual Report.

The Committee considered the Annual Report of the Director of Public Health for 2018. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Committee thanked the Director of Public Health for an informative and easy to read report. Arising from discussions the following points were noted:

(i) The Director of Public Health had used his 2018 report to focus on specific areas that he wished to highlight and encourage partners to work on, rather than reporting on the whole of the Public Health Department's remit. For example the creation of an integrated weight management pathway was an area where partners such as clinical commissioning groups had previously been asked to assist with but further work was still needed to be carried out by partners, and the Director of Public Health had used his Annual Report to reiterate this point.

(ii) The Committee endorsed the Director of Public Health's proposals to treat the patient as a whole rather than focusing on a specific illness or condition that the patient had. The emphasis on social prescribing was welcomed. In response to a suggestion that more social activities should be available through GP Practices the Director of Public Health explained that the philosophy was to take the patient away from GP Practices, however, more work could be carried out to develop Patient Participation Groups.

(iii) There was evidence to show that loneliness and social isolation led to depression and anxiety, but it was not possible to demonstrate the impact on the local population due to issues around data protection and data sharing. However, the County Council was currently undertaking work to improve co-ordination across agencies in the response to loneliness and social isolation.

(iv) The Director offered to produce a report on lifestyle behaviours for a future Committee meeting.

RESOLVED:

(a) That the Annual Report of the Director of Public Health be welcomed;

(b) That the comments now made be submitted to the Cabinet for consideration at its meeting on 23 November 2018.

43. The Development of a Unitary Structure for Local Government in Leicestershire.

The Committee considered a report of the Chief Executive which had been submitted to the Cabinet on 16 October in response to the Cabinet resolution of 6 July 2018 to enable the Cabinet to consider outline proposals for the development of a unitary structure for local government in Leicestershire. A copy of the report marked 'Agenda Item 11' is filed with these minutes.

The Director of Corporate Resources was also present to introduce the report and made reference to the Chancellor's budget announcement the previous week, which had been more positive than expected. He anticipated that Government departments outside of health would see a flat real-terms increase in growth and suggested that the following caveats should be borne in mind:-

- Whether all Government departments would be treated the same, or whether services such as defence and the police, education and welfare would receive a greater share of funding;
- The Government's funding did not allow for changes in population or demand for services; there was a likelihood that these would increase, particularly for social care, and therefore increase funding requirements;
- The costs could increase at a faster rate than inflation.

Although the pace at which savings were required might be slower, the County Council would still need to make savings. After making the maximum permitted increase in council tax, the County Council would still need to save between £10 million and £15 million per year to meet ongoing funding pressures.

The Cabinet Lead Member for Resources, Mr J B Rhodes CC, reminded members that the cost pressures in adult and children's social care were significant. The proposals meant that a single unitary authority in Leicestershire would have an extra £30 million per year, less if two unitary authorities were established, which would enable front line services to be protected. The County Council was reaching the point were further savings were difficult to make.

Mr Rhodes also advised the Committee that one of the drivers for seeking unitary status was strategic. Currently, when engaging with other councils across the region, the

County Council did not have the power to act on behalf of the whole county and would therefore need to seek approval from the district councils, which could significantly slow the process down. The East Midlands did not attract investment on the same scale as the West Midlands; it was thought that was partly because of the fragmented nature of local government in the East Midlands. Being able to speak with single voice on behalf of the county would strengthen Leicestershire's position.

Arising from discussion the following points were raised:-

Financial Situation

(i) Leicestershire received less funding than Northamptonshire, on a per head basis. A rough estimate of the order of magnitude of £30 million was provided to the Committee *[it was subsequently clarified to be £16 million per annum]*. There were a number of inequalities in council funding, which was why the Government was undertaking the Fair Funding Review. It was hoped that the outcome of the review would be beneficial to Leicestershire, but the uncertainty around Brexit and Government commitment to provide the NHS with additional funding had to be borne in mind.

(ii) Structural reform appeared to be the Government's preferred option for financially struggling councils. Northamptonshire County Council was the highest profile example but there were also instances of smaller district councils which had been encouraged to merge. It was noted that there were some examples of shared service arrangements within Leicestershire's councils, but these were not widespread or on a large scale.

(iii) From a financial point of view, a unitary structure was more efficient. Savings could be generated from back office services and management, protecting front line services.

Model Unitary Structure

(iv) The Cabinet Lead Member for Resources did not believe that a county unitary would be too remote for Leicestershire residents. 80% of local government services in Leicestershire were delivered by the County Council and a number of these were already managed centrally but delivered locally. Members were not criticised for being remote when handling casework.

Options Appraisal

(v) It was suggested that the report could have included a wider range of options and queried whether the debate should continue, given the letter from MPs asking the Leader to cease work and the response from District Council Leaders, that they would acquiesce to the request. The Cabinet Lead Member for Resources advised that the status quo was an implicit option in the report and confirmed that a large part of the work to develop proposals for a unitary structure of local government in Leicestershire had already been completed. The District Council Leaders' response was therefore disappointing.

(vi) Members expressed disappointment in the stance taken by District Council Leaders and local MPs, which, in their opinion, had sought to suppress debate

before it could be established whether a unitary structure of local government was in the best interests of Leicestershire residents or not.

(vii) A view was expressed that the views of District Council Leaders and MPs should not be ignored; the Secretary of State would not approve proposals for unitary local government where there was significant local opposition. It was therefore suggested that the County Council should focus on its fair funding campaign. However, a number of members of the Committee suggested that, from their experience, District Council Leaders did not appear to have consulted with other members of their council before reaching their decision. A further view was expressed that it was better for the local area to make a decision voluntarily than be forced into it due to the financial situation of the council. Local Government should be allowed to debate its future and determine the best way of protecting front line services. The view was expressed that, if structural reform did not happen now, it would happen at some point in the future.

(viii) It was suggested that as the option for a dual unitary would require the splitting of existing County Council services, which currently worked well on a countywide basis, it was likely to be less efficient and to add to the complexity of local government, particularly for partners and service users.

Services in a Unitary Structure

(ix) It was felt that for both public health and health, housing and care integration there was a compelling case for the development of a single unitary authority for Leicestershire, as opposed to two unitary authorities. Leicestershire would benefit from an overall, single strategic vision for these services, with much greater power to deliver through a single organisation.

(x) In terms of air quality, monitoring responsibility sat with district councils but both the County Council's Public Health and Environment and Transport departments had a role to play. Members felt that the two tier structure of local government created complexity and made it more difficult to have a coherent and consistent response across the county.

(xi) There was currently a lack of consistency across the county in terms of the health and wellbeing services provided by the district councils. This was not always in the best interests of Leicestershire residents. In terms of supporting people to be physically active, a unitary structure would allow a cohesive approach to sport and physical activity facilities, cycle ways, walk ways and green spaces. Public Health and the Environment and Transport Department currently had a joined up approach to cycle ways, but this did not include district council managed green spaces.

(xii) It was felt that there would be benefits to a strategic, single approach to the development of assistive technology, and to the allocation of Disabled Facilities Grants (DFG), which would be better than the current arrangements, noting that some councils had not spent their full allocation. DFG resources could be utilised more flexibly across Leicestershire to match variable demand better and support other aspects of housing services and support. It was also noted that the delivery of adaptation services, in terms of Occupational Therapist support and expertise, involved staff from both District and County authorities, and this could cause additional handoffs and delays to decisions being made.

(xiii) A view was expressed that, in their casework, members currently had to co-ordinate between district council and County Council issues and could therefore find that their impact was diluted. A single authority for Leicestershire would have more power and influence which could be better for local residents.

(xiv) Members were reminded that the Clinical Commissioning Groups across Leicester, Leicestershire and Rutland (LLR) were likely to develop a single management structure in the near future. Services such as the Police and Fire Services were also LLR-wide. A number of members were of the view that it would be beneficial if local government boundaries in the area moved closer to being co-terminous with other public sector organisations.

RESOLVED:

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

(b) That the comments of the Committee be forwarded to the Scrutiny Commission for consideration at its meeting on 14 November 2018.

44. Date of next meeting.

RESOLVED:

That the next meeting of the Committee would be held on 16 January 2019 at 2:00pm.

10.30 am - 3.20 pm
07 November 2018

CHAIRMAN

Agenda Item 8

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 16th JANUARY 2019

MEDIUM TERM FINANCIAL STRATEGY 2019/20 – 2022/23

JOINT REPORT OF THE DIRECTOR OF PUBLIC HEALTH AND THE DIRECTOR OF CORPORATE RESOURCES

Purpose of Report

1. The purpose of this report is to:

   a) provide information on the proposed 2019/20 to 2022/23 Medium Term Financial Strategy (MTFS) as it relates to Public Health; and

   b) ask the Committee to consider any issues as part of the consultation process, and make any recommendations to the Scrutiny Commission and the Cabinet accordingly.

Policy Framework and Previous Decisions

2. The County Council agreed the current MTFS in February 2018. This has been the subject of a comprehensive review and revision in light of the current economic circumstances. The draft MTFS for 2019/20 – 2022/23 was considered by the Cabinet on 18 December 2018.

Background

3. The MTFS is set out in the report to Cabinet on 18 December 2018, a copy of which has been circulated to all members of the County Council. This report highlights the implications for the Public Health Department.

4. Reports such as this one are being presented to the relevant Overview and Scrutiny Committees. The views of this Committee will be reported to the Scrutiny Commission on 28 January 2019. The Cabinet will consider the results of the scrutiny process on the 8 February 2019 before recommending an MTFS, including a budget and capital programme for 2019/20, to the County Council on the 20 February 2019.

Service Transformation

5. In the 2015 Autumn Statement the Chancellor announced a 3.9% annual reduction over a 5 year period in Public Health allocations to local authorities. This has resulted in reductions in national funding levels of 2.6% in both 2018/19 and 2019/20. In addition the Chancellor announced that the ring-fence on the grant would continue for 2018/19 and 2019/20. It is still expected that Public Health will be funded from retained business rates from April 2020 although this is yet to be confirmed. The Department and the services it commissions and delivers continue to be structured in line with statutory

duties and the Target Operating Model as set out in the Early Help and Prevention Review. The Department will consider the in-house provision of services as a preferred option, where appropriate, recognising that specialised health improvement treatment services will continue to be externally commissioned through the NHS and third sector markets.

6. The Department is continuing to make efficiencies and service improvements by promoting digital and self-serve access to services where appropriate, bringing services in-house, identifying opportunities for income generation and integrating contracts in areas such as sexual health and substance misuse.

Proposed Revenue Budget

7. Table 1 below summarises the proposed 2019/20 revenue budget and provisional budgets for the next three years thereafter. The proposed 2019/20 revenue budget is shown in detail in Appendix A.

Table 1 – Revenue Budget 2019/20 to 2022/23

	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000
Original prior year budget	-703	-486	-1,036	-1,016
Budget transfers and adjustments	87			
Add proposed growth (Appendix B)	650	20	20	
Less proposed savings (Appendix C)	-520	-570		
Proposed/Provisional budget	**-486**	**-1,036**	**-1,016**	**-1,016**

8. Detailed service budgets have been compiled on the basis of no pay or price inflation. A central contingency will be held which will be allocated to services as necessary.

9. The central contingency also includes provision for an annual 1% increase in the employers' contribution to the Local Government Pension Scheme based upon the 2016 triennial actuarial revaluation of the pension fund.

10. The total gross proposed budget for 2019/20 is £27.0m with contributions from health transfers, and various other income sources totalling £3.3m. The ring-fenced grant allocation for 2019/20 is £24.215m.

11. The proposed net budget for 2019/20 of - £486k is distributed as shown in Table 2 below:

Table 2 - Net Budget 2019/20

	£000	%
Public Health Leadership	1,342,916	5.6
Local Area Co-ordination	772,679	3.3
Quit Ready	603,699	2.5
First Contact Plus	158,584	0.7
Other Public Health Services	268,700	1.1
Programme Delivery	331,357	1.4

Other Prevention Services	1,326,891	5.6
Children's Public Health 0-19	8,825,013	37.2
Sexual Health	3,842,362	16.2
NHS Health Check Programme	543,000	2.3
Substance Misuse	3,774,330	15.9
Physical Activity	1,141,951	4.8
Obesity Programmes	613,000	2.6
Health protection	99,506	0.4
Tobacco Control	85,000	0.4
Leicester-Shire and Rutland Sport	0	
Total	**23,728,988**	**100.0**
Public Health Ring Fenced Grant	**-24,215,000**	
Total Net Budgeted Spend	**-486,012**	

Budget Changes and Adjustments

12. Growth and savings have been categorised in the appendices under the following classification;

    * item unchanged from previous MTFS
    ** item included in the previous MTFS, but amendments have been made
    No stars - new item

13. This star rating is included in the descriptions set out for growth and savings below.

14. Savings have also been classified as 'Eff' or 'SR' dependent on whether the saving is seen as efficiency or service reduction or a mixture of both. 'Inc' denotes those savings that are funding related and/or generate more income.

GROWTH

15. Growth bids made by Public Health are in response to national issues faced by all public health authorities and not internally generated initiatives; as a result they are kept to a minimum.

16. Details of proposed growth are set out in Appendix B and provide for an additional £0.7m per annum by 2022/23. These are described in the following paragraphs.

*G13 Reductions to Public Health specific grant (offsetting savings have been included in this and previous MTFS); £0.65m in 2019/20.

17. The reduction in grant is as a direct result of the Chancellor's Autumn Statement 2015 where an annual average reduction of 3.9% over a five year period was announced.

**G14 Integrated Sexual Health Service - increased testing expected as result of new Pre Exposure Prophylaxis (PrEP) treatment for HIV risk groups; £20,000 in 2020/21 rising to £40,000 in 2021/22.

18. PrEP is a retro-viral drug; tests have suggested that it is effective at reducing the spread of HIV amongst high risk groups. Local authorities (under the Health and Social Care Act 2012) are responsible for the increased testing that will be required when the treatment is introduced.

SAVINGS

19. Details of proposed savings are set out in Appendix C and total £0.5m in 2019/20 rising to £1.1m per annum by 2022/23. These are detailed in the following paragraphs.

*PH1 Eff/SR Early Help and Prevention Review - review of externally commissioned prevention services £0.5m in 2019/20 rising to £1m in 2020/21

20. Cabinet approved the Early Help and Prevention Strategy on 17 June 2016.

21. The current profile of the savings is such that in 2019/20 contracts in three areas have been identified which will be reduced or de-commissioned to achieve the £0.49m savings target. The savings required in 2020/21 have been significantly progressed. However, further work is required in some areas and savings of £66,000 are yet to be identified. Further information on the individual savings areas is included in the table below:

Contract and Provider	**Saving Value and Year**	**Progress**
Integrated Sexual Health (3 contracts)	£0.29m in 2019/20	The service has been re-commissioned with effect from January 2019 and the contract value has been reduced.
NHS Health Checks (GPs)	£0.15m in 2019/20	Work has been completed to support primary care in providing a more effective commissioned service. It is expected that this will deliver the saving in full.
Heart Smart	£50,000 in 2019/20	The service has been decommissioned.

Homelessness Prevention	£0.2m in 2020/21	A report was taken to Cabinet in November 2018 where it was agreed that the DPH will consult on a new delivery model for outreach support. It is proposed that the existing arrangements costing £320,000 are decommissioned and replaced with a community outreach model costing £120,000. This would be developed in line with the Local Area Coordination model (LAC). A number of additional Coordinators could be recruited as either part of the broader service or as specialist posts.
Substance Misuse Treatment Services	£0.15m in 2020/21	It is expected to make part of the savings target by decommissioning the assessment service provided by the City Council as there is duplication with the service provided by the current substance misuse contractor, realising a saving of £60,000. It is proposed to make the balance of the savings through an integrated substance misuse service which involves combining the community substance misuse treatment service, inpatient detox service and residential rehabilitation service.
YP Tobacco Programme	£80,000 in 2020/21	The current contract costs £115,000 and, subject to extension, will end in July 2019. The service is to promote an understanding of the risks associated with smoking to school age children. A traded offer to schools is being considered to generate the saving. However this is considered a medium risk as schools may not take up the service.
Adults & Communities, Support for Carers Contract	£19,000 in 2020/21	The current contract has been extended until 31 October 2019 in order that scoping work can be undertaken to model different levels of respite/support required. The saving will be implemented when the new contract is awarded.
TBC	£66,000 in 2020/21	The balance of the EHAP savings will now be included in the total required to be found from savings under development.
	£1.005m	

PH2 Eff Integrated Lifestyles; £20,000 in 2019/20 rising to £65,000 in 2020/21

22. The scope of the project is to improve the integration of lifestyle services and review the service delivery model for adult weight management to bring it in-line with approaches used in the stop smoking and First Contact Plus services. The service is currently commissioned from Leicestershire Nutrition and Dietetic Services. A new service design which is expected to generate ongoing savings of £65,000 was approved by Cabinet in October 2018. The new in-house service will come into effect in October 2019, this will include online resources, telephone advice and support as well as face to face support for targeted service users.

*PH3 Eff Review of Staff Absence; £10,000 in 2019/10 rising to £20,000 in 2020/21

23. To reflect the support being put in place to reduce staff absence a financial target has been allocated to all departments. The department will continue to manage absence and it is expected that this saving will be achieved in full.

Savings under Development

24. Contracts already under consideration, which are expected to generate savings of £0.6m in 2020/21 are shown in the table below.

The Departmental Management Team is meeting in January 2019 to agree those commissioned services which will be reviewed to produce the balance of the £1.1m savings target for the 2020/21 MTFS.

	Description of saving	**Approach**
0-19 Health Visiting & School Nursing £8.6m contract value	The current contract runs from April 2017 to March 2020.The savings will be made from contract negotiation. Savings proposed £0.5m.	A draft approach with the provider has been agreed which will see a phased recruitment freeze applied to the school nursing element of the service with a continued shift to a 'digital offer' in mitigation.
Schools Traded Offer £150,000 contract value	There are a number of current services that are delivered to schools including young person's physical activity as well as various specialist training elements. The department are exploring the option of moving these to a traded service model. Savings proposed £100,000	Work is underway to identify which strands of the delivery could be included in such an offer as well as identifying an aligned date for possible transition.

External Influences

25. Demand Led Activity

Sexual Health services are required to be provided on an open access basis and therefore there is a risk to the achievement of the MTFS. Health Checks are also demand driven.

26. Inflation

The department continues to be at risk of inflationary pressures due to the Public Health Grant not being increased by central government to reflect pay and other price increases. The first year of the 3 year NHS pay deal was funded by the Treasury however there has been no assurance from the Department of Health as to whether it will meet increased provider costs for years 2 and 3 of the deal.

Other Funding Sources

27. There are a number of funding sources that contribute to the overall budget for Public Health.

Funding Source	Description	Value £	RISK RAG
Public Health Grant	Public Health Grant Allocation.	24,215,000	GREEN
Sport England Grant	Leicester-Shire and Rutland Sport receive funding to deliver a number of programmes. Funding varies each year, according to the programmes supported.	500,000	GREEN
Better Care Fund	Funding allocation for First Contact Plus.	154,000	GREEN
Rutland County Council	The provision of Public Health support to the authority and a section 113 agreement for Mike Sandys as the DPH.	151,000	GREEN
University Hospitals Leicester	The provision of Public Health support for specialist projects. This is agreed annually and is not yet in place for 2019/20.	140,000	AMBER

Office of the Police and Crime Commissioner	This funding is a contribution to the (drugs) treatment contract.	110,000	GREEN
Clinical Commissioning Groups	To meet the costs of contraceptive devices which are fitted to treat an existing medical condition.	100,000	GREEN
District Councils	Contribution towards the infrastructure of Local Area Coordination.	70,000	GREEN
Leicester City Council and Rutland County Council	Contributions to the costs of the Community Infection Prevention and Control Team.	60,000	GREEN

Background Papers

Cabinet 18 December 2018 - Medium Term Financial Strategy 2019/20 to 2022/23
http://politics.leics.gov.uk/mgAi.aspx?ID=53670#mgDocuments

Circulation under Local Issues Alert Procedure

None.

Officers to Contact

Mike Sandys, Director of Public Health
Tel: 0116 305 4239

Chris Tambini, Director of Corporate Resources, Corporate Resources Department
Tel: 0116 305 6199
E-mail: **chris.tambini@leics.gov.uk**

Helen Moran, Assistant Finance Business Partner – A&C, CEX and PH
Tel: 0116 305 7609
E-mail: **helen.moran@leics.gov.uk**

List of Appendices

Appendix A – Revenue Budget 2019/20
Appendix B – Growth & Savings 2019/20 – 2022/23

Equality and Human Rights implications

28. Public authorities are required by law to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between people who share protected characteristics and those who do not; and
- Foster good relations between people who share protected characteristics and those who do not.

29. Many aspects of the County Council's MTFS may affect service users who have a protected characteristic under equalities legislation. An assessment of the impact of the proposals on the protected groups must be undertaken at a formative stage prior to any final decisions being made. Such assessments will be undertaken in light of the potential impact of proposals and the timing of any proposed changes. Those assessments will be revised as the proposals are developed to ensure decision makers have information to understand the effect of any service change, policy or practice on people who have a protected characteristic.

30. Proposals in relation to savings arising out of a reduction in posts will be subject to the County Council Organisational Change policy which requires an Equality Impact Assessment to be undertaken as part of the action plan.

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APPENDIX A

PUBLIC HEALTH DEPARTMENT

REVENUE BUDGET 2019/20

Net Budget 2018/19 £		Employees £	Running Expenses £	Internal Income £	Gross Budget	External Income £	Net Budget £
-24,872,000	**Public Health Ring-Fenced Grant**	0	0	0	0	-24,215,000	-24,215,000
	Department						
1,479,220	Public Health Leadership	1,333,420	452,850	-126,725	1,659,545	-316,629	1,342,916
671,020	Local Area Co-ordination	794,979	47,700	0	842,679	-70,000	772,679
621,390	Quit Ready	334,199	269,500	0	603,699	0	603,699
204,810	First Contact Plus	331,104	13,500	-32,000	312,604	-154,020	158,584
275,360	Other Public Health Services	0	277,300	0	277,300	-8,600	268,700
319,260	Programme Delivery	263,357	68,000	0	331,357	0	331,357
1,326,890	Other Prevention Services	0	1,326,891	0	1,326,891	0	1,326,891
	Total						
8,827,510	**0-19 Childrens Public Health**	0	8,825,013	0	8,825,013	0	8,825,013
	Sexual Health						
4,228,610	Sexual Health	0	3,942,362	0	3,942,362	-100,000	3,842,362
548,050	NHS Health Check programme	0	543,000	0	543,000	0	543,000
	Total						
3,756,830	**Substance Misuse**	0	3,886,186	0	3,886,186	-111,856	3,774,330
	Physical Activity and Obesity						
1,131,450	Physical Activity	0	1,141,951	0	1,141,951	0	1,141,951
656,000	Obesity Programmes	0	613,000	0	613,000	0	613,000
	Total						
115,000	**Health Protection**	156,156	2,150	0	158,306	-58,800	99,506
95,000	**Tobacco Control**	0	85,000	0	85,000	0	85,000
	Leicester-Shire and Rutland Sport	1,040,965	1,210,743	-1,391,251	860,457	-860,457	0
-615,600	**TOTAL PUBLIC HEALTH**	**4,254,180**	**22,705,146**	**-1,549,976**	**25,409,350**	**-25,895,362**	**-486,012**

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APPENDIX B

	References 2018 MTFS			NEW 2019 MTFS 2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000
			GROWTH				
			Reduced Income				
*	G13		Reductions to Public Health specific grant (offsetting savings are included)	650	650	650	650
			Demand & cost increases				
**	G14		Integrated Sexual Health Service - increased testing expected as result of new Pre Exposure Prophylaxis treatment for HIV risk groups	0	20	40	40
				650	**670**	**690**	**690**
			SAVINGS				
*	PH1	Eff/SR	Early Help & Prevention – Externally Commissioned Services	-490	-1,005	-1,005	-1,005
	PH2	Eff	Integrated Lifestyles	-20	-65	-65	-65
*	PH3	Eff	Review of staff absence	-10	-20	-20	-20
				-520	**-1,090**	**-1,090**	**-1,090**

* items unchanged from previous Medium Term Financial Strategy

** items included in the previous Medium Term Financial Strategy which have been amended

Eff = Efficiency saving; SR = Service reduction; Inc = Income

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Agenda Item 9

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 16th JANUARY 2019

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

ACTIVE LIVES SURVEY 2018 – PHYSICAL ACTIVITY LEVELS IN LEICESTERSHIRE

Purpose of report

1. The purpose of this report is to provide information to the Health Overview Scrutiny Committee on the results of the latest 'Active Lives' Survey by Sport England and to highlight trends in physical activity in Leicestershire.

Policy Framework and Previous Decisions

2. Increasing levels of physical activity in the population would have a positive impact on four of the outcomes of the Leicestershire Health and Well Being Strategy:
    a. Outcome 1: The people of Leicestershire are enabled to take control of their own health and wellbeing;
    b. Outcome 2: The gap between health outcomes for different people and places has reduced;
    c. Outcome 3: Children and young people in Leicestershire are safe and living in families where they can achieve their potential and have good health and wellbeing;
    d. Outcome 4: People plan ahead to stay healthy and age well and older people.

3. The Health and Social Care Act 2012 places a statutory duty on the County Council to take appropriate steps to improve the health of people living in Leicestershire.

Background

4. The Active Lives Survey 2018 is the latest in a series of surveys by Sport England to measure physical activity across the country. Nationally 185,000 responded to the survey with 3,496 of those from Leicestershire.

5. The survey produces estimates of the percentage of people meeting the Chief Medical Officer's (CMO) guideline of undertaking 150 minutes or more of physical activity a week, It also provides data on the percentage of 'fairly active' and inactive people as well as data on the types of activity undertaken.

6. These estimates include the activities of walking, cycling, dance, fitness and sporting activities, but exclude gardening which is seen as being outside of Sport England's remit.

Physical activity performance - adults

Leicestershire Performance

7. Since the Active Lives survey was first carried out in 2015/16, levels of physical activity Leicestershire have changed from a position of being above the national average, although not statistically significantly, to being statistically significantly below the national average. In 2015/16, the percentage of Leicestershire residents doing more than 150+ minutes physical activity a week was 62.3% (Confidence Interval (CI) range 60.5-65.3%), compared to a national average of 62.1% (CI range 61.8-62.4%). This declined in 2017/18 to 59.3% of adults in Leicestershire doing more than 150 minutes of physical activity a week (CI range 57.0-61.6%), compared to a national average of 62.3% (CI range 62.0-62.6%).

8. Figures from the latest survey show Leicestershire physical activity levels as being significantly below the national average. Correspondingly, the increase in the percentage of 'inactive' adults, that is those undertaking less than 30 minutes a week of physical activity, is statistically significant when compared to the national average.

Figure 1 : Active Lives Adults data (16+), May 2017/18

	May 2017 - May 2018		
	Active (150+ minutes a week)	Fairly Active (30-149 minutes a week)	Inactive (<30 minutes a week)
	Rate (%)	Rate (%)	Rate (%)
England	62.3%	12.5%	25.2%
Leicestershire	59.3%	13.2%	27.5%
Leicester	58.3%	13.1%	28.6%
Rutland	58.8%	13.5%	27.7%
Blaby	59.7%	14.1%	26.2%
Charnwood	58.4%	11.9%	29.7%
Harborough	63.4%	13.9%	22.7%
Hinckley and Bosworth	58.4%	14.8%	26.9%
Melton	61.8%	12.7%	25.5%
North West Leicestershire	57.2%	12.5%	30.3%
Oadby and Wigston	58.5%	13.6%	28.0%

Key
Red: significantly worse than national average
Green: significantly better than national average
Amber: similar to the national average

District performance

9. Table 1 below shows the performance by district for 17/18. Activity levels range from a low in North West Leicestershire of 57.2% of adults undertaking 150+mins of physical activity, to a high in Harborough of 63.4%.

10. Compared to the baseline year of 15/16, some districts have achieved modest gains in performance. The percentage of active adults in Harborough has increased by 3.2% and in Blaby and Melton by 1%. In other districts large falls in active adults have occurred. In North West Leicestershire the percentage of active adults has declined by 8.3% and in Charnwood by 9.2%.

Table 1 :Physical activity levels: May 2017 - May 2018

	Active (150+ minutes a week)	Change compared to baseline	Change in the last 12 months
Blaby	59.7%	+1.2%	-0.3%
Charnwood	58.4%	**-9.2%**	**-3.4%**
Harborough	63.4%	+3.2%	+3.2%
Hinckley and Bosworth	58.4%	**-3.4%**	**-1.1%**
Melton	61.8%	+1.8	+0.9%
North West Leicestershire	57.2%	**-8.3%**	**-5.9%**
Oadby and Wigston	58.5%	**-1.4%**	**-1.0%**
Leicestershire	59.3%	**-3.6%**	**-1.6%**
England	62.3%	+0.2	+0.3

Figures in bold indicate statistically significant changes

National trends in activity

11. Local analysis of the types of activity undertaken is not yet available from Sport England, but national figures would suggest that, for men, participation in sport has declined (although not significantly) whereas walking for leisure and for travel has increased significantly.

12. For women, the national trend is towards a significant increase in walking for leisure and a significant decline in participation in dance for fitness.

Comparison across councils nationally

13. Analysis by County Council areas shows a number have achieved a statistically significant increase in physical activity since the baseline year: Suffolk, Nottinghamshire and Hampshire. The only County to see a statistically significant decline is Leicestershire.

14. Across unitaries, metropolitan boroughs and district councils there is no immediately discernible pattern by authority, although it is of note those areas that are relatively more affluent (Test Valley, Runnymede, Poole, Eastleigh for example) have achieved significant increases in performance while more deprived areas seem to be associated with worsening performance (Corby, Sefton and Rotherham for example). However this is by no means a uniform pattern with some deprived areas (Manchester, Salford, Chorley) making significant gains and some relatively affluent areas (North West Leicestershire, Charnwood, Broadland, Wealden) seeing a decrease in physical activity levels.

Physical activity performance – children and young people

15. Alongside the adult active lives survey, this year has seen the first national Active Lives Children and Young People's (CYP) survey. This is a school-based survey measuring participation in sport and physical activity inside and outside of school as well as attitudes towards sport and physical activity among CYP in school years 1-11 (roughly children aged 5 to 16) across England. It provides estimates at a national and local level to inform government policy (e.g. Primary PE and Sports premium and the Childhood Obesity Plan) and local decision making.

16. This first national report includes information about levels and types of activity, swimming proficiency, volunteering within sport and physical activity as well as mental wellbeing and individual and social development data, broken down by key demographics.

Active Lives CYP (school years 1-11), Academic Year 2017/18

	Active every day (60 minutes or more every day)[1]	Active across the week (an average of 60 minutes or more a day but not every day)[1]	Fairly active (an average of 30-59 minutes a day)[1]	Less active (less than an average of 30 minutes a day)[1]
	Rate (%)	Rate (%)	Rate (%)	Rate (%)
England	17.5%	25.7%	23.9%	32.9%
Leicestershire	18.1%	27.0%	24.1%	30.8%
Leicester	15.0%	25.9%	16.3%	42.8%
Rutland	14.2%	26.8%	25.5%	33.5%
Blaby	18.2%	25.7%	29.1%	27.0%
Charnwood	18.8%	28.1%	21.1%	32.0%
Harborough	18.0%	29.5%	25.3%	27.3%
Hinckley and Bosworth	20.4%	27.4%	22.6%	29.7%
Melton	15.4%	22.9%	23.3%	38.5%
North West Leicestershire	15.1%	27.9%	26.0%	31.0%
Oadby and Wigston	26.2%	27.8%	16.9%	29.1%

Key
Red: significantly worse than national average
Green: significantly better than national average
Amber: similar to the national average

17. For Leicestershire, the results indicate that activity levels in children and young people are not significantly different from the national average, at either the County levels or district level. The exception to this is activity levels for Oadby and Wigston that are significantly higher than the national average.

Timetable for Decisions

18. The report will be considered by Cabinet on the 8th February 2019.

Conclusions

19. Although difficult to draw conclusions at this stage, if the local decline in certain areas is due to falls in broader physical activity, such as walking and cycling, rather than a decline in sporting participation, it may point to the desirability of a better joined up approach across Leicestershire. This should bring together sport, physical activity, transport, infrastructure planning and green spaces into one system.

Background papers

Active Lives Children and Young People Survey - 2017/18 Report (national summary): https://www.lrsport.org/researchandevidence/active-lives-children-and-young-people-survey---201718-report

Active Lives Adult Survey - May 17/18 Report (national summary): https://www.lrsport.org/researchandevidence/active-lives-adult-survey---may-1718-report

Circulation under the Local Issues Alert Procedure

None

Officer to Contact

Mike Sandys
Director of Public Health
Tel: 0116 305 4239
Email: Mike.Sandys@leics.co.uk

Relevant Impact Assessments

Equality and Human Rights Implications

20. The Equality Act 2010 imposes a duty on the local authority when making decisions to exercise due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster food relations between people who have a protected characteristic and those who do not. An overarching physical activity strategy for Leicestershire would need to consider its impact on protected characteristics groups.

Resource Implications

21. There are no resource implications arising directly from this report.

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Agenda Item 10

University Hospitals of Leicester NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 16th JANUARY 2019

REPORT OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

ROYAL COLLEGE OF PHYSICIANS REPORT ON OUTPATIENT APPOINTMENTS

Purpose of report

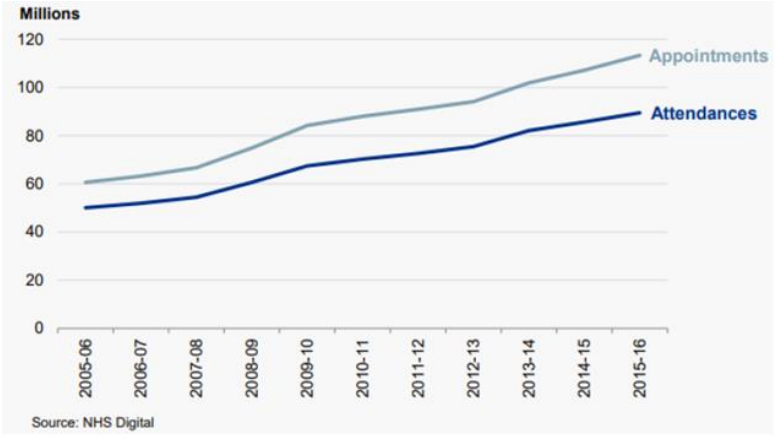
1. The purpose of this report is to brief the Committee on the action that the University Hospitals of Leicester (UHL) NHS Trust is taking in response to the recently published report by the Royal College of Physicians (RCP): Outpatients: The Future *Adding value through sustainability* and to also provide members with an overview of work that has been undertaken over the past 12 months to improve Outpatient services across the Trust.

Policy Framework and Previous Decisions

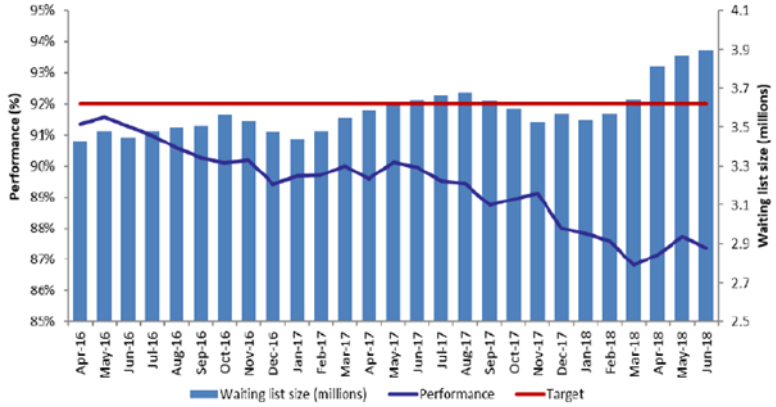
2. This report outlines the way forward in response to the recommendations made within the Royal College of Physicians report: Outpatients: The Future *Adding value through sustainability* and builds on the 5 Year Forward Review. It demonstrates how UHL will build on work undertaken to date to transform its Outpatient services in order to mitigate unsustainable demand for services.

Background

3. University Hospitals of Leicester see nearly 1 million outpatient attendances each year (938,000 last year). Nationally referral rates for outpatient services continue to increase year on year:



4. Waiting lists are growing and performance is deteriorating as Acute Hospitals can no longer keep pace with demand. Nationally 75% of hospital waiting lists are for outpatient appointments:



5. University Hospitals of Leicester NHS Trust is no different. For the period April 2018 – October 2018 UHL received a 3% increase in referrals across all specialities with higher rates of referrals for the same period the previous year in 54% of sub-specialties (61 in total). The percentage increase for specialities with high referral rates varies between 6% and 28%.Whilst much of what acute hospitals do has changed over the last decade the OP model is still the same as it was when the health service was first established.

6. An important shift is taking place in the burden of disease, from mortality to morbidity, with people living for many years with chronic conditions, in pain and with mental ill health. Much of this is preventable, yet the NHS remains, at heart, a treatment service for people when they become ill, and we lack a comprehensive approach to keeping us well. Time has now come to change this historic model.

7. The Outpatient Transformation Programme remains one of the Trust's Annual Priorities for 2018/19. It continues to form part of our Quality Commitment. It has also become an integral part of the Leicester, Leicestershire and Rutland (LLR) system-wide transformation programme for planned care as demand on the acute sector outpatient services continues to rise in a way that is unsustainable in the longer term. More recently the programme has also become an integral part of UHL's financial recovery plan.

8. The Royal College of Physicians report is very timely and is welcomed by the Trust. Most importantly it has confirmed that what we have been doing to date has been focussed on doing the right things: to shift the emphasis on patients to manage their own care, to tackle the demand that we do not have the capacity to deal with and to review whether all outpatient appointments are necessary. The report will however help us to take stock of what we are currently doing and to refresh our thinking on the national outpatient productivity challenge. The Royal College of Physicians report will support the Trust, and wider healthcare system, in placing greater emphasis on how we can best manage demand and in particular support patients in helping us on this journey.

9. There is recognition internally within UHL, and across the health system, that demand for outpatient services continues to grow in an over pressurised system in which the acute sector is struggling to meet demand in terms of capacity and staffing. It is acknowledged that we need to significantly change what we currently do as patient's needs and expectations are changing, technological solutions are available to support patients in their care and hospital centric outpatient care is no longer the most appropriate model of care.

10. UHL has had in place an outpatient transformation programme for some time, however the scale and scope of the programme over the last year has expanded considerably. The programme incorporates 3 major work streams:

    - Making best use of time and resources through our Outpatient Optimisation programme;
    - Improving quality and the experience patients have of our Outpatient services, including getting some of the fundamentals right;
    - Using technology to help us deliver services in a very different way and help us reshape how patients will interact with Outpatient services in the future.

Internal Transformation Programme

11. In 2017/18 the Programme was largely focussed on getting some of the basics right. We called this "fixing the fundamentals" which is in keeping with research from the Picker Institute, referenced within the RCP report, which shows that a patient's satisfaction with their outpatient visit is most likely to be influenced by the organisation of the department, being treated with respect and dignity and having the reason for their attendance addressed, in that order. Also important are their interactions with the doctor, cleanliness, and the information they receive about discharge, treatments, tests or medications. To date we have developed a number of initiatives to address these areas. Examples are seen in the development of:

    - Customer care training (Apprenticeship scheme and statutory and mandatory on-line e-learning package);
    - LEAN methodology to improve efficiency and eliminate waste during the clinic sessions;
    - Developing a draft standard operating procedure on outpatient expectations and standards;
    - Wayfinding apps (in development);
    - Improving quality of information provided in clinic appointment letters.

12. We continue to build on this as part of our journey to improving the experience patients have of our Outpatient services.

13. Over the past 6 months we have now shifted our attention to redesigning processes, eliminating waste and focussing on sustainable demand and capacity management. This includes our programme for Optimising Outpatients as well as working with colleagues across the LLR health economy, as partners of the Planned Care Board, undertaking fundamental redesign of patient pathways. This has involved an LLR system wide review at speciality level for a defined number of specialities.

14. Internally there is a high level of support for improving IT capability across our outpatient services. During the financial year 2017/18 there were some specific IT projects that were agreed for delivery. The priority projects, identified as "must do's" were:

    - Delivering referrals electronically between GPs and UHL Clinicians (Electronic Referral Service, ERS). Nationally it was mandated that by October 2018 all GP referrals need to be made electronically. Local implementation was supported through the development and use of the **P**athway and **R**eferral **I**mplementation **S**yste**M** (PRISM) which is used as a decision support tool by GPs to ensure patients are referred to the right

specialist, first time) and implementation of advice and guidance. Implementation of E-Referrals was achieved on time.

- Implementing Advice and Guidance: To support the PRISM and ERS process the Trust and partners in primary care are now actively promoting the use of Advice and Guidance to help manage demand. Advice & Guidance (A&G) services are intended to help ensure patients are seen and treated in the right place, at the right time, as quickly as possible. They are intended to help GPs make a better and more informed decision on the most appropriate course of action for their patients. The GP Forward View sets out the need to break down barriers between primary and secondary care and improve GP access to consultant advice on potential referrals. Better integration between primary and secondary care is also an integral part of the developing multi-specialty community provider new care systems. A&G is one way the NHS can practically deliver these new ways of working.

- Outpatient correspondence – This involves the procurement of a new supplier /transcription service for outpatient clinic letters which will facilitate improved turnaround times for letters and the ability to improve the quality of letters received by patients. We are hoping to use this opportunity to implement the RCP recommendation that clinic letters should be written to the patient in a way that supports them in managing their own health. The IT capability to deliver this project is currently being developed. The Trust aims to start early delivery of the new system in pilot areas in the spring of 2019.

- 2 way text reminder service: The Trust has just launched a 2 way text reminder service, moving from the historic one way reminder service. The Trust will seek to build on the early successes of implementing a 2 way text reminder service for patients in order to address administrative factors described within the RCP report alongside considering in greater detail convenience for patients. This service has allowed us to start a 2 way dialogue with patients about their appointment. As a Trust we experience high cancellation rates and although our rates of patients who fail to attend for their appointment (DNA rates) are relatively good there is room for improvement. Again our 2 way text reminder is the start of improving communication with our patients, planning with them and making sure we make the best use of resources in order to alleviate some of the pressures on outpatient services. There are plans to extend the 2 way text reminder service to other areas offering outpatient services such as Imaging and Therapy services in the near future. This will be an interim solution as a pre-cursor to the development of patient portal and our digital journey for outpatients.

15. UHL delivers 938,000 outpatient appointments per annum in 108 different sub-specialities across 3 hospital sites. In determining where our priorities for improvement are, given the scale size and complexity of our outpatient services, we have used the Getting It Right First Time (GIRFT) programme and the Model Hospital tool as a way of assessing efficiency and quality. Through application of these and other tools we have begun to apply some of the key principles for delivering sustainable outpatient services to a number of services where there is the greatest potential gain: Cardiology, Gastroenterology, Elective Orthopaedics, Ophthalmology, Dermatology and ENT. Internally we have looked to improve efficiency within these services but more importantly we have worked with partners across the health system to change traditional

models of care and develop new care pathways that start to reduce the activity burden on our acute hospitals.

External System-wide Transformation Programme

16. UHL has played an active role as a member of the STP Better Care Together Planned Care Board to develop different ways of working. The aim of this work is manage demand for Outpatient services, create longer term sustainability and ensure patients are seen in the most appropriate setting by the most clinically appropriate person in settings such as primary and community services as appropriate to their needs. This not only serves to address the inexorable rise in demand but is in keeping with the RCP report recommendations that suggest services should be designed to minimise disruption to patients, valuing patient and carers time and beginning to shape patient behaviour in terms of supporting them to manage their own health through healthier lifestyles.

17. Consistent with UHL's analysis of priority areas for redesign, the Planned Care Board have also focussed on transforming pathways within the same specialities: Ophthalmology, Cardiology, Gastroenterology, Ear Nose and Throat (ENT) Dermatology and Elective Orthopaedics. Plans have taken into account two key national transformation priorities (First Contact Practitioner and Ophthalmology). Programmes of work have not solely focussed on demand management but have also aimed at tackling a reduction in the need for follow up appointments, a review of diagnostic imaging and non-imaging referral pathways and provision and other service reviews. Wherever possible alternatives to face to face consultations are increasingly being sought.

18. Initiatives delivered to date in 2018/19 are summarised in the table below:

Theme	**Initiative**
Demand management	75% of all relevant specialties providing Advice & Guidance
	210 PRISM pathways introduced across 31 specialities with clinical agreement from both secondary and primary care
	Primary Care peer review identifying alternatives to referral to acute/secondary care
	101 Low value treatment policies
	30% Deflection through musculoskeletal triage
Reducing follow up attendances	Remote post op hip and knee follow up
Managing capacity for diagnostic tests and investigations	8 diagnostic pathways developed to reduce the number of inappropriate tests
Improved use of capacity across the system	Services in primary care accessing capacity in the Alliance

19. Going forward UHL will continue to work in partnership with members of the Planned Care Board and partners across the health and social care system to respond to the increasing national focus on transforming outpatient services, incorporating the RCP recommendations and other guidance into programmes of work, as outlined below.

Proposals: **Actions UHL and our partners are taking in response to the RCP report**

20. Since receiving the report we are considering the further opportunities presented by the report, building on the achievements to date. We continue to experience an over pressurised system where our hospitals are struggling to meet demand. For some specialities we still continue to see growth in demand despite many in-year initiatives delivering alternative solutions to acute hospital care. There is an acceptance across the system that there is opportunity for improvement that delivers quality services for patients whilst making best use of the "LLR £". Increasingly our focus is shifting to value both clinician and patient/carer time, focussing on longer term value for the patient measured through clinical outcomes.

21. For some time UHL has had to rely upon the constant use of additional flexible capacity in order to meet waiting time targets and deliver timely services to patients. The Trust recognises that this is not sustainable in the medium or long term and therefore it will seek to optimise the benefits of alternatives to the traditional hospital model of care and increase the availability of non-face-to-face appointments going forward.

22. In many instances long term follow up is not required and in some instances repeated appointments do not add value to the patients care or management. In considering this and in keeping with the theme of value we will be seeking clinicians' views on pathways that are commissioned in other health systems that deliver follow-up aftercare in community settings. One such pathway is for the on-gong management of children with cerebral palsy. UHL will seek to learn from case studies, not only presented in the RCP report, but from other Trusts and health economies across the country. Through this we will seek to identify pathways that have been commissioned that promote care in community settings or alternatives to management in the acute hospital.

23. Building on this theme there is a lot more that UHL can do internally to offer different styles of clinics. Longer term we are planning for a new treatment centre as part of our reconfiguration plans. Acting on the Royal College of Physicians report will enable us to develop new models of care out of the acute setting, paving the way for different styles of clinics. One example of this is the recommendations in the GIRFT report (July 2018) on Urology services which focuses on how resources across this large specialty could be better used to improve the patient experience by reducing waiting times, enabling more care to be provided via outpatient settings and providing more effective pathways to definitive treatments. To do that, the report recommends changes to service configuration within trusts, changes to staffing arrangements, extending the role of specialist nurses including a better career structure for specialist urological nurses, to extend their role and help deliver more treatment in an outpatient setting.

24. Moving to a digital paperless outpatient service is a core part of the programme with developments in outpatients being considered as a priority in 2019/20. As part of this we continue to build our future vision for the paperless out patients. Requirements will be shaped by changes in the way in which Outpatient services will be delivered, as referenced in the recently published Royal College of Physicians report: New models of communication with our patients and healthcare partners will be explored as we scope the extent of opportunity and learn from other trusts who have already implemented their digital strategy. Opportunities for outpatient services are the development of a patient portal, the use of self-help and monitoring apps, self-check in, self-serve and selection of appointments, information sharing between parties, remote monitoring instead of face to face follow up appointments and a paperless environment. Into the wider system UHL is

seeking to make sure that there is interoperability between systems wherever possible to improve information sharing and reduce duplication of effort.

25. A population based health approach aimed at improving physical and mental health outcomes, promoting wellbeing and reducing health inequalities across an entire population coupled with information from GIRFT and the Model Hospital will continue to inform priorities for outpatient transformation across the health system. Priorities for the forthcoming year will be to develop:

- Referral support services for a number of specialities with referrals to these services being triaged through a central point. The number of clinics that can be delivered in alternative primary care settings will be increased in order to make better use of primary care, community hospitals and other facilities.

- UHL will work with partners to increase capacity and capability to deliver care from primary care practices as described in the Five Year Forward View plans. Emerging from this will be a different workforce looking at the use of GPs with a special interest (GPwSI), Pharmacists, Physiotherapists, High Street Optometrists and Specialist Nurses.

- A continued reduction in follow up attendances within secondary care supported in primary care and other settings through developing Optometry led services and delivering ENT services in a different way. Community services are being set up to support such changes in patient pathways.

- Diagnostic referral pathways will be developed to increase the number of referrals that support diagnostic decision-making, increase GP education, the introduction of advice and guidance for imaging plain film to inform proposals for future diagnostic referral hubs.

- Increasing uptake of the First Contact Practitioner (FCP) to ensure that, where appropriate, patients with musculoskeletal conditions are seen by the right person in a primary care setting and they receive appropriate care in a more timely manner. This involves a shift from traditional community or hospital based therapy services to physiotherapists being part of the General Practice team.

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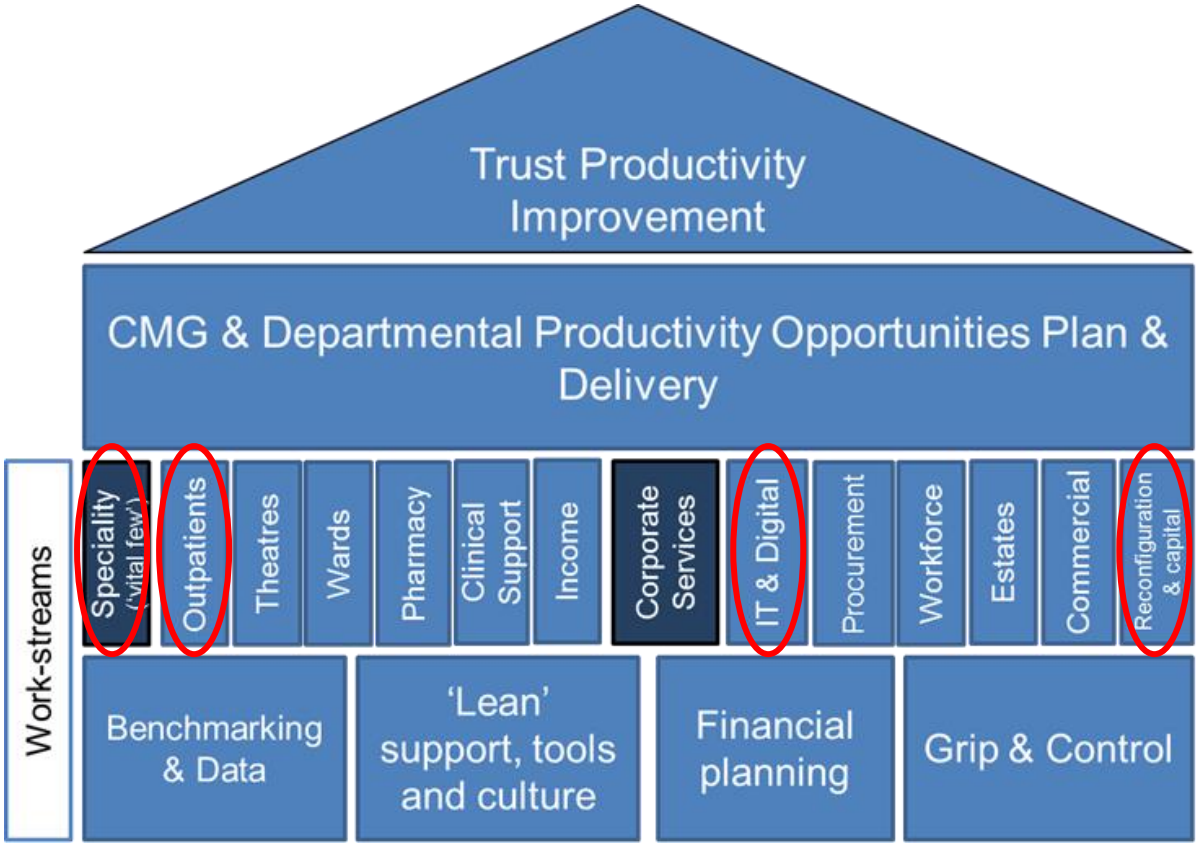
- In Ophthalmology, alongside other initiatives, CCGs/STPs are to undertake local eye health capacity reviews as part of the National Specification for High Impact Interventions. A draft plan has been developed which includes public health colleagues reviewing population needs and indicators, building a picture of demand and workforce across primary and secondary care, and agreeing priorities for pathway redesign with the Local Eye Health Network (LEHN).

Governance

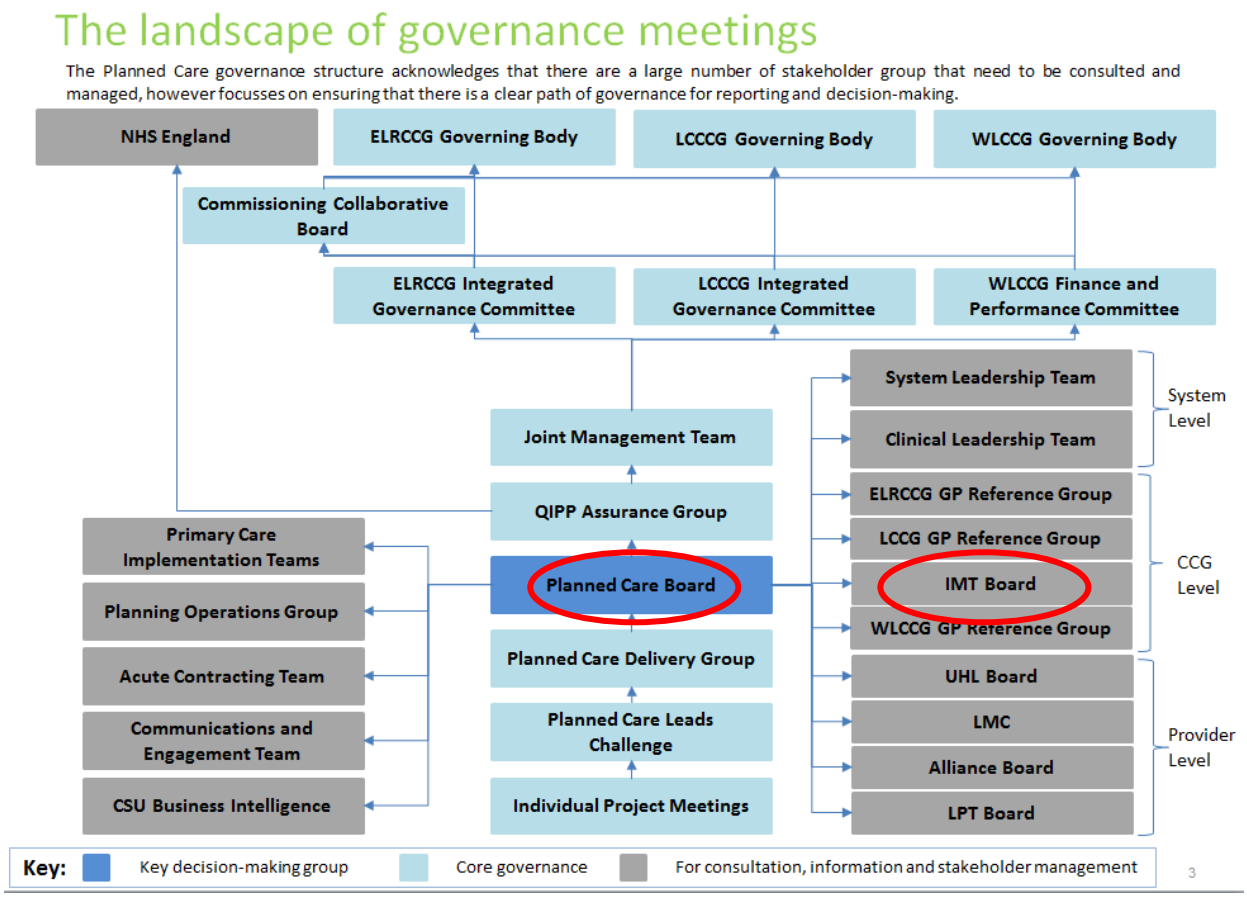
26. UHL's Outpatient Transformation activities are monitored through the Outpatient Transformation Programme Board with the Director of Strategy and Communications as the Executive Sponsor and Senior Responsible Officer. There are direct links with the wider LLR Planned Care Board, which has clinical and managerial representation from all partners and patient representation. The programme has joint SRO's at Director level

from LLR CCGs and UHL to demonstrate joint leadership and accountability. All programmes are supported by a team of Project Managers, Business Intelligence, Finance and Communications and Engagement with LLR support based in Leicester City CCG (hosted service). UHL's internal governance arrangements are illustrated in the diagram below:

Landscape of UHL's Productivity and Improvement Programme Governance



27. The role of local organisations and leaders within our BCT partnership is to develop new ways of working within the current statutory frameworks which enable us to operate in a more collaborative way as one system focused on doing the best for the health and care of local people, including those with planned care needs. The governance structure outlining decision-making, assurance and stakeholder engagement for the wider LLR STP Planned Care Programme is presented in the following diagram:



Conclusions

28. The report by the Royal College of Physicians is timely and welcomed by UHL and partners across the Health and Social Care System. The founding principles give key areas for improvement for the Trust as a provider of acute health care as well as system partners across LLR. There is agreement that the historic model of outpatient care is no longer fit for purpose and that continued rates of growth and use of the UHL services is not sustainable, neither is it right for patients going forward. Internal and external programmes of work are already in progress to reshape how we deliver care, putting patients at the centre of their care, valuing patient carer and staff time as well as making sure patients are managed in the most effective way by the right professional at the right time and in the right place.

29. Technology will have a significant part to play in terms of how we communicate with patients and train and guide them to manage their own healthcare. Connectivity between systems to assist care providers in delivering value adding care and eliminating waste is a challenge but forms a vital part of delivering high quality care in the most efficient way. Through our eHospital Programme and the wider LLR IM&T Board and new ways of working we will make it easier for patients to manage their own conditions and support improvements in planning and communication.

30. Whist the Royal College of Physicians sets out an ambitious roadmap; strong partnerships have been developed to ensure we take every opportunity to deliver sustainable integrated patient centred outpatient services in the future.

Background papers

The Royal College of Physicians *Outpatients: The Future - Adding value through sustainability.* London: RCP, November 2018
https://www.rcplondon.ac.uk/projects/outputs/outpatients-future-adding-value-through-sustainability

Circulation under the Local Issues Alert Procedure

Not applicable.

Officer to Contact

Name and Job Title: Jane Edyvean
Out Patient Transformation and Reconfiguration Programme Manager
Strategy Team
Level 3 Chief Executives Department, Balmoral Building, Leicester Royal Infirmary
LE1 5WW

Mobile: 07943 325017
Office: 01162 588662
E Mail: jane.edyvean@uhl-tr.nhs.uk

Relevant Impact Assessments

Equality and Human Rights Implications

31. An Equality and Human Rights Impact Assessment is currently being undertaken but as of yet no conclusions have been drawn.