Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 11 September 2019 at 2.00 pm**

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

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. J. Morgan CC
Mr. T. Gillard CC	Mrs B. Seaton CC
Mrs. A. J. Hack 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 5 June 2019.	(Pages 3 - 10)
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.	Healthwatch Leicester and Leicestershire Annual Report.	Healthwatch Leicester and Leicestershire	(Pages 11 - 40)
9.	Healthwatch Leicester and Leicestershire report on Hospital Discharge.	Healthwatch Leicester and Leicestershire	(Pages 41 - 50)
10.	Health Performance Update.	Chief Executive and CCG Performance Service	(Pages 51 - 72)
11.	Draft Leicestershire Substance Misuse Strategy 2020-2023.	Director of Public Health	(Pages 73 - 90)

12. Date of next meeting.

    The next meeting of the Committee is scheduled to take place on 13 November 2019 at 2:00pm.

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

Agenda Item 1

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 5 June 2019.

PRESENT

Mr. T. Barkley CC
Mr. D. C. Bill MBE CC
Dr. R. K. A. Feltham CC
Mr. T. Gillard CC
Mrs. A. J. Hack CC
Dr. S. Hill CC
Mr. J. Morgan CC
Mrs B. Seaton CC
Mrs. M. Wright CC

In attendance
Mr. L. Breckon CC, Cabinet Lead Member for Health and Wellbeing
Micheal Smith, Healthwatch Leicester and Leicestershire
John Edwards, Associate Director for Transformation, Leicestershire Partnership NHS Trust (minute 10 refers)
Spencer Gay, Chief Finance Officer, West Leicestershire Clinical Commissioning Group (minute 11 refers)
Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland Clinical Commissioning Group (minute 12 refers)

1. Appointment of Chairman.

RESOLVED:

That Dr. R. K. A. Feltham 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 2020.

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

2. Election of Deputy Chairman.

RESOLVED:

That Mrs. M. A. Wright CC be elected Deputy Chairman of the Health Overview and Scrutiny Committee for the period ending with the date of the Annual Meeting of the County Council in 2020.

3. Minutes.

The minutes of the meeting held on 13 March 2019 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.

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.

Mrs. A. J. Hack CC declared a personal interest in agenda item13, development of a new model for homelessness and housing support, as she was employed by a housing provider.

8. Declarations of the Party Whip.

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

9. Presentation of Petitions.

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

10. All Age Mental Health Transformation.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided an update on the All Age Transformation Programme. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Committee welcomed John Edwards, Associate Director for Transformation, Leicestershire Partnership NHS Trust to the meeting for this item.

Arising from discussions the following points were noted:

(i) It was not expected that the appointment of Angela Hillery as the new Chief Executive for LPT would have a radical impact on the All Age Transformation Programme though it was possible that the phasing could be altered and other minor elements could change. Angela Hillery was also Chief Executive of Northamptonshire Healthcare Foundation Trust and good practice from Northamptonshire had already been implemented in the Programme.

(ii) In response to concerns raised by members regarding whether LPT had the workforce capacity to implement the All Age Transformation Programme, it was acknowledged by LPT that the draft workforce model required further work and reassurance was given that affordability testing would take place which could lead to refinement of the proposed model.

(iii) Members raised concerns regarding the lack of governance for the scheme, how the programme would be co-ordinated, and the reliance of the programme on Local Area Co-ordinators which did not exist in every area of the county. In response it was confirmed that these issues were being taken into account through the development of the model.

(iv) The peer support workers that were being introduced through the transformation programme were employed workers rather than volunteers, although they could be recent service users. Training was currently being provided and supervisory arrangements would be put in place. Members emphasised the importance of monitoring the effectiveness of the role.

(v) In response to a query from Members it was explained that the outcomes of the All Age Transformation Programme linked in well with the outcomes of the Action Plan which had been created in response to the Care Quality Commission (CQC) report of February 2019. To address cultural and behavioural issues identified by CQC workshops had been held with LPT staff and an NHS Improvement Tool had been used. A targeted cultural programme was now being used alongside the transformation programme.

(vi) Outpatient care would be delivered through geographically aligned local teams set around groups of GP practices known as Primary Care Networks (PCN) though it was unlikely that there would be a team for every PCN. It was felt that this alignment would help to reduce the gap between primary care and secondary care.

(vii) A new and improved website for LPT had been commissioned and it was expected to be online imminently.

RESOLVED:

(a) That the aims of the All Age Mental Health Transformation Programme be welcomed;

(b) That the Committee's concerns regarding LPT's capacity to implement the programme be noted;

(c) That LPT be urged to ensure that the All Age Mental Health Transformation Programme addresses the concerns that have been raised by the Care Quality Commission.

11. <u>QIPP end of financial year.</u>

The Committee considered a joint report of West Leicestershire Clinical Commissioning Group and East Leicestershire and Rutland Commissioning Group which provided an update on the 2018/19 Quality, Innovation, Productivity and Prevention (QIPP) programme and the planned 2019/20 QIPP programme. A copy of the report, marked 'Agenda Item 11', is filed with these minutes.

The Committee welcomed Spencer Gay, Chief Finance Officer, West Leicestershire Clinical Commissioning Group (CCG) to the meeting for this item.

Arising from discussions the following points were noted:

(i) The primary aim of QIPP schemes was quality improvement rather than financial savings. To ensure there was no negative impact on service users, quality impact assessments were carried out on all QIPP schemes and Key Performance Indicators were monitored. The schemes did not represent cuts to service, rather they were efficiencies offset by a backdrop of investment.

(ii) Whilst the QIPP achievement for both Leicestershire County CCGs for 2018/19 had been very close to the £40.145m target, the CCGs were not fully confident that the 2019/20 QIPP target of £49.020m would be reached. So far £37,782m of QIPP savings had been identified for 2019/20 but a further £11,238m needed to be identified and work was being undertaken with providers to ascertain where the additional savings could come from. The 2019/20 QIPP scheme assumed that there would be £700,000 savings delivered from the CCG management team restructure and there was an overall requirement to reduce running costs by 20% by 2021. The 2019/20 Scheme also made allowances for the expected impact from the introduction of Primary Care Networks (PCNs). It was clarified that whilst the budget for PCNs would still belong to the CCGs who would have oversight of how the money was spent, CCGs would have less control over it than they did over other budgets.

(iii) A longer term financial plan had been drafted based on the expected future funding and the plan was to be updated in summer 2019. Consideration would then be given by the CCGs to what solutions could be found to address the financial problems raised in the plan. The CCGs were also expected to publish their response to the NHS Long Term Plan in the autumn of 2019 and they would share this response with the Committee. Healthwatch Leicester and Leicestershire was also conducting a piece of work relating to the public response to the NHS Long Term Plan the results of which would also be shared with the Committee and the CCGs.

RESOLVED:

(a) That the update on Quality, Innovation, Productivity and Prevention (QIPP) Savings Schemes be noted;

(b) That officers be requested to submit a further report on QIPP schemes and the CCG response to the NHS Long Term Plan to the Committee's meeting in November 2019.

12. Primary Care Networks.

The Committee considered a joint report of East Leicestershire and Rutland Clinical Commissioning Group and West Leicestershire and Rutland Clinical Commissioning Group which provided an update on the development of Primary Care Networks (PCNs) across Leicester, Leicestershire and Rutland. A copy of the report, marked 'Agenda Item 12', is filed with these minutes.

The Committee welcomed Tim Sacks, Chief Operating Officer, ELRCCG to the meeting for this item.

Arising from discussions the following points were noted:

(i) Each PCN was to be provided with funding for the 2019/20 year to recruit physiotherapists and social prescribing practitioners; job advertisements had already been circulated for the first 26 posts. By 2023 it was expected that PCNs would have approximately 13 new members of staff, excluding doctors and nurses, per 50,000 people for carrying out primary care services. The intention behind the new staffing requirements was to address the shortage of doctors and nurses by providing the services in other ways. The CCGs recognised there could be difficulties recruiting to these additional posts given existing issues with staffing and recruitment and the fact that there would be national competition for the posts. There was a need to make primary care in Leicestershire a more attractive place to work. There had been a national drive to recruit more GPs from overseas and LLR had gained 14 international GPs. However, there were still gaps and more medical school places had also been created in Lincoln.

(ii) A requirement of the Long Term Plan was a large increase in the number of pharmacists for each PCN area and the CCGs were working on a programme for pharmacists, including support and career development advice, to ensure that there was adequate provision across all areas in LLR.

(iii) In response to a concern raised by a member that the phrase 'neighbourhood', which was used in relation to the geographical area covered by PCNs, did not accurately describe an area of between 30,000 and 50,000 patients, it was explained that this was national terminology which the LLR CCGs had no control over.

(iv) One of the aims of PCNs was to help reduce avoidable A&E attendances and members raised concerns that there was confusion amongst the public regarding whether they could attend Urgent Care Centres without an appointment. Some patients were being turned away because they had not booked an appointment through NHS 111. In response it was acknowledged that there were problems with the system of patients booking into Urgent Care Centres and work needed to take place with the provider of the service to improve clarity and communication to the public. In LLR appointments at Urgent Care Centres were 15 minutes in length. NHS England required commissioners of Urgent Care Services to provide 30 minutes per 1000 patients; the current provision in LLR was more than double with 67 minutes per 1000 patients.

(v) In response to concerns regarding whether the primary care infrastructure would be able to meet the housing growth in Leicestershire reassurance was given that this was being considered as part of development of the Primary Care Estates Strategy and mapping was taking place to analyse the condition of buildings and what they could be used for. Local Plans were being taken into account when carrying out estates planning. It was confirmed that funding received under Section 106 of the Town and Country Planning Act 1990 could not be used for GP salaries as it was capital funding. However, revenue funding would increase with growth as it was based on the number of patients.

RESOLVED:

(a) That the update on Primary Care Network development across Leicester, Leicestershire and Rutland be noted;

(b) That officers be requested to produce a report on the Primary Care Estates Strategy for a future meeting of the Committee.

(c) That details of the Primary Care Networks for Leicester, Leicestershire and Rutland, including geographical areas and names of Accountable Clinical Directors, be circulated to all members of the Committee once available.

13. Development of a new model for homelessness and housing support.

The Committee considered a report from the Director of Public Health which explained the proposals to develop a new model for homelessness and housing support which were being consulted on. A copy of the report, marked 'Agenda Item 13', is filed with these minutes.

The existing model for homelessness and housing support comprised of the Falcon Centre in Loughborough which was a 30 bed hostel, and The Bridge in Loughborough which provided sustainable housing support, advice and solutions for homeless and vulnerable people in Loughborough and Leicester. The Cabinet at Leicestershire County Council had resolved not to withdraw support and funding for the Falcon Centre as this would place the centre at risk of closure. Members were provided with written representations from Oadby and Wigston Borough Council which raised concerns regarding the proposed discontinuing of the existing 'Housing Matters' services and the consequent impact on local residents. It was noted that Oadby and Wigston Borough Council would be submitting further representations as part of the consultation process and the Director of Public Health stated that he would give their concerns full consideration.

The proposed new model would focus on working with individuals with substance misuse problems and mental health issues rather than the more general housing support service which was currently provided. The Director of Public Health acknowledged that there could be an impact on District Councils as a result of this which was an inadvertent consequence. One of the advantages of bringing the service in house was that the Public Health Department had a network of organisations that could be used to facilitate the work. The model would build on the capability of First Contact Plus and Local Area Co-ordinators. In response to a question the Director of Public Health stated that he had no concerns that First Contact Plus staff would be overworked as extra capacity had been added to the First Contract Plus service. Although not all areas of Leicestershire had Local Area Co-ordinators, Local Area Coordinators would assist people that resided outside of the area they covered. First Contact Plus would also provide support to people in those areas without LACs. A further advantage was that the service could be more equitably distributed across Leicestershire rather than being focused on Loughborough.

The Committee recognised that the proposal represented a reduction in service, made necessary by the financial situation faced by the Council. It was felt that the proposal was the best possible in the circumstances.

RESOLVED:

(a) That the update on the proposed new model for homelessness and housing support be noted;

(b) That the comments now made be submitted to the Cabinet for consideration at its meeting on 22 October 2019.

14. Dates of future meetings.

RESOLVED:

It was agreed that future meetings would take place on the following dates all at 2:00pm:

11 September 2019;
13 November 2019;
15 January 2020;
4 March 2020;
3 June 2020;
9 September 2020;
11 November 2020.

2.00 - 3.35 pm CHAIRMAN
05 June 2019

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Agenda Item 8

healthwatch Leicestershire

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 11TH SEPTEMBER 2019

REPORT OF HEALTHWATCH LEICESTERSHIRE

HEALTHWATCH LEICESTERSHIRE ANNUAL REPORT 2018-19

Purpose of report

1. The purpose of this report is to present Healthwatch Leicestershire's Annual Report for 2018/19 which provides a summary of the activity it has undertaken in its first contract year as a jointly commissioned contract with Healthwatch Leicester.

Policy Framework and Previous Decisions

2. The County Council, following the Health and Social Care Act 2012, is required to directly commission a local Healthwatch. The local Healthwatch in turn has a set of statutory activities to undertake, such as gathering local views and making these known to providers and commissioners, monitoring and scrutinising the quality of provision of local services and a seat on the Health and Wellbeing Board.

Background

3. The purpose of Healthwatch Leicestershire is to promote improvements in local health and social care services – improving outcomes for local people in Leicestershire. HWL believes that the best way to do this is by designing local services around the needs and experiences of local people.

4. The Annual Report contains details on the statutory activities undertaken over the last year and demonstrates the impact that these activities have made on the commissioning, provision and management of local health and social care services.

5. The report gives examples of the work done with statutory partners and illustrates how Healthwatch has worked to support the public in accessing information about Health and Social Care services.

Recommendation

6. It is recommended that Healthwatch Leicestershire's Annual Review 2018 -19 be noted.

Officer to Contact

Micheal Smith - Manager
0116 2518313
Micheal.Smith@healthwatchll.com

List of Appendices

Healthwatch Leicestershire's Annual Review 2018-19

Relevant Impact Assessments

Equality and Human Rights Implications

15. HWL is aware that the Public Sector Equality Duty (PSED) applies to all functions of public authorities that are listed in Schedule 19 Equality Act 2010. Schedule 19 list does not include Healthwatch England or Local Healthwatch organisations, however as bodies carrying out a public function using public funding we are subject to the PSED general duty.

16. ECS/ Healthwatch Leicestershire is committed to reducing the inequalities of health and social care outcomes experienced in some communities. We believe also that health and social care should be based on a human rights platform. We will utilise the Equality Act 2010 when carrying out our work and in influencing change in service commissioning and delivery.

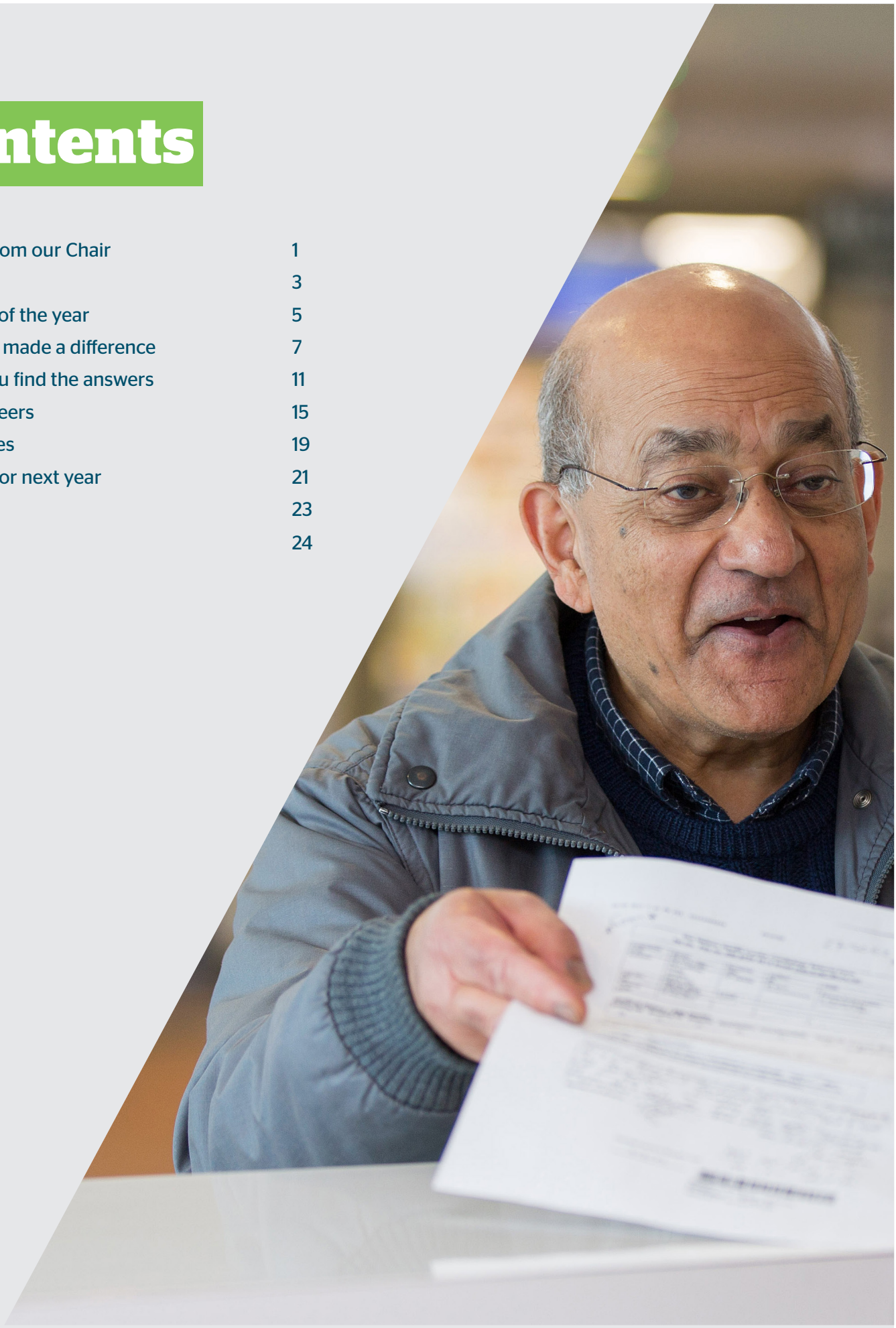
healthwatch Leicester

healthwatch Leicestershire

Healthwatch Leicester and Leicestershire

Annual Report 2018-19

Contents



Message from our Chair

I am delighted to be presenting my first Healthwatch Leicester and Leicestershire report. Patient voice has always been important to me. I started my journey 10 years ago when I was elected as Chair of my local Patient Participation Group (PPG). Since then I have been involved in numerous projects to ensure that the patient's perspective is counted when decisions are made about health provision in the City.

Being Chair of Healthwatch Leicester and Leicestershire has given me the opportunity to champion the service user's voice in social care as well as the NHS, with a wider reach in the county. Leicestershire is very diverse, and the patient's needs vary from area to area.

Acting in the role of Chair of not one but two Healthwatches has been an interesting challenge this year due to trying to ensure we have a meaningful relationship across two councils (of different political groups) and three Clinical commissioning groups. This has been both a blessing and a curse. We are able to represent patients with a stronger and clearer voice across Leicester City and Leicestershire County, but we also need to make sure we are engaging with the different communities across our patch.

In Healthwatch, our staff and board members have worked hard to maintain the relationships with key partners, from the previous contracts, and to ensure we are where we need to be as the Health and Care landscape has changed around us.

We have worked closely with our Healthwatch Rutland colleagues even if we have not always approached a situation from the same direction.

Through 2018-19 I feel we have challenged the Health and Care system when it was appropriate, and we have also looked to find opportunities to inform and educate members of the public on how to engage with services more effectively.

This year is likely to see as such change in how services are delivered, and we will continue to champion patients and the public are involved in changes and kept informed on how changes will affect them.

Our priorities for the next 12 months are;

- Medicines Management – Relationship between GP's, Hospitals and Patients
- Personal Budgets
- Social Prescribing
- Access to Secondary Mental Health Care
- Supported Living services
- Lifestyle services

Harsha Kotecha

Chair, Healthwatch Advisory Board

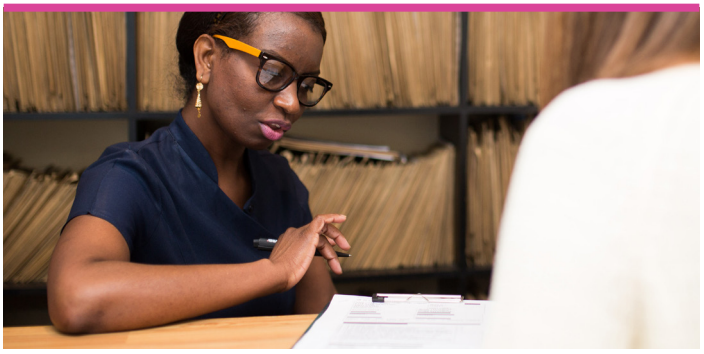
Changes you want to see

Last year we heard from 483 people who told us about their experience of a number of different areas of health and social care. Here are some examples of the changes that you want to see.

+ Make it easier to see a doctor or nurse quickly

+ Healthcare professionals should have a positive attitude and be empathetic

+ Staff should take the time to speak to people about what to expect next



+ Services should provide information so that people can make informed decisions about their care

About us

Healthwatch is here to make care better

We are the independent champion for people using local health and social care services. We listen to what people like about services and what could be improved. We share their views with those with the power to make change happen. People can also speak to us to find information about health and social care services available locally.

Our sole purpose is to help make care better for people.

As Chair of Healthwatch England, it's my role to make sure your Healthwatch gets effective support and that national decisions are informed by what people are saying all over England.

If you were one of the 400,000 people who shared their experiences with us last year, I want to say a personal thank you. Without your views, Healthwatch wouldn't be able to make a difference to health and social care services, both in your area and at a national level. One example of this is how we shared 85,000 views with the NHS, to highlight what matters most, and help shape its plans for the next decade.

If you're part of an organisation that's worked with, supported or responded to Healthwatch Leicester and Leicestershire, thank you too. You've helped to make an even bigger difference.

None of this could have been possible without our dedicated staff and volunteers, who work in the community every day to understand what is working and what could be better when it comes to people's health and care.

If you've shared your views with us then please keep doing what you're doing. If you haven't, then this is your chance to step forward and help us make care better for your community. We all have a stake in our NHS and social care services: we can all really make a difference in this way.

Sir Robert Francis QC
Healthwatch England Chair

Our vision is simple

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

Our purpose

To find out what matters to you and to help make sure your views shape the support you need.

Our approach

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

People at the heart of everything we do

We play an important role bringing communities and services together. Everything we do is shaped by what people tell us. Our staff and volunteers identify what matters most to people by:

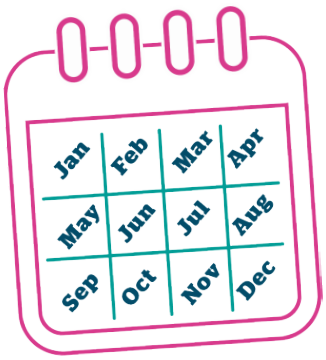
- Visiting services to see how they work
- Running surveys and focus groups
- Going out in the community and working with other organisations

Our main job is to raise people's concerns with health and care decision-makers so that they can improve support across the country. The evidence we gather also helps us recommend how policy and practice can change for the better.

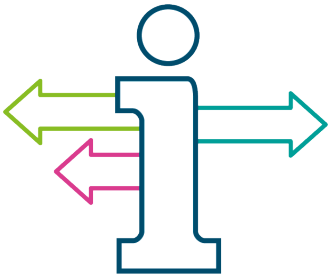
Highlights from our year

Find out about our resources and the way we have engaged and supported more people in 2018-19. **Our resources:**

483 people shared their health and social care story.



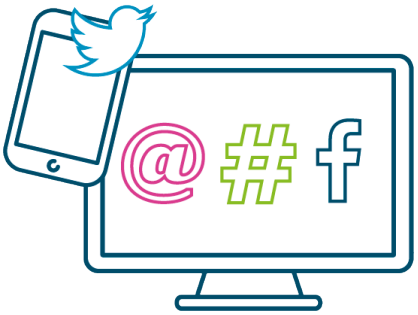
We have **35** volunteers helping to carry out our work. In total, they gave up **1045** of hours.



193 people accessed Healthwatch advice and information online or contacted us with questions about local support.

We visited **11** services and **165** community events to understand people's experience of care. From these visits, we made **47** recommendations for improvement.

18 improvements we suggested were adopted by services to make health and care better in our community.



9115 people engaged with us through our website and social media.

How we've made a difference

Changes made to your community

Find out how sharing your views with your local Healthwatch has led to positive changes to health and social care services in Leicester and Leicestershire. We show when people speak up about what's important, and services listen, care is improved for all.

Take a look at an example of a local Healthwatch demonstrating how they have made a difference in their community.

Maternity Workstream

Across Leicester, Leicestershire and Rutland there is a plan in place to transform and improve maternity and neonatal services. NHS organisations and local authorities are working together to put this plan into action.

We have representation on both the Local Maternity Systems (LMS) Board and the Maternity Voices Partnership (MVP) Group. The LMS has a focus on delivering high quality, safe and sustainable maternity services and improved outcomes and experience for woman and their families.

The MVP brings together new mums and their families from across Leicester, Leicestershire and Rutland to create a new social space where they can meet other mums and discuss their experience before, during and after birth with the people directly involved in the running of the services. There are currently 18 members of the group. Regular meetings are held, and a virtual group has been set up so that the people who are unable to meet in person can feed into discussions.

Some of the achievements of the MVP:

- Attendance at a regional event to meet other MVPs within the region.
- A local leaflet was developed and devised to advertise our Maternity Voices Partnership- distributed through several avenues including 'walking the patch'.
- A 'frequently asked questions', 'terms of reference' and an 'MVP one pager' was developed.
- Advertised our MVP on the UHL Maternity Services website, Facebook pages for the birth centres, leaflets distributed within the hospitals, children's centre, through word of mouth and the Leicester City CCG website.
- We hold bi-monthly meetings in children's centres (requested by the users that attend).
- The MVP attends a regional forum which meets every six months to share practice and tips, usually with user representation as well as our communications and engagement team.
- Good engagement from the Head of Midwifery and hospital trust.
- Healthwatch engagement and presence at all our meetings.
- Engagement from the Perinatal Mental Health team and Public Health with our MVP to develop their pathways and actively engage with our users and co-produce our services locally.

We have also been commissioned by the MVP to organise an away day for the members to celebrate the achievements of the group, to show appreciation for their engagement and enable them to meet the wider MVP team.

"Healthwatch Leicester and Leicestershire have been extremely supportive of Leicester, Leicestershire and Rutland (LLR) Maternity Voices Partnership (MVP). They have supported the MVP through excellent representation by Healthwatch at all MVP meetings as well working in partnership with Leicester City Clinical Commissioning Group to deliver a Team Building Day for the valued users or our MVP. Gemma Barrow has been brilliant with her engagement with our MVP."

Jasmine Cajee - Midwife Programme Support Officer for Better Births

Public views of access to GPs in Leicester and Leicestershire

Building on the survey work completed by Healthwatch Leicestershire (Your views about GP services – Nov 2017) we wanted to understand the public support for how GP services will change in the coming years. A survey was created by Healthwatch Leicester and Healthwatch Leicestershire to gather people's experiences of accessing GP services.

Our overarching aims were to assess; access to appointments, patient choice and to look at ways to improve the service for patients. During July – September 2018, we attended meetings, festivals and events across the city and county to speak to people about their GP services and to complete the survey.

The survey was made available online and cascaded to all Healthwatch contacts and other networks. The survey was also promoted via social media. 211 surveys were completed.

Key Findings

Booking appointments was predominantly carried out by telephone with almost 75% of respondents using telephone booking. Perhaps as a result of the dominance of telephone booking, improvements to the telephone systems of practices were a common theme suggested by respondents with comments about being cut off and being on hold for long periods of time. There were also comments about the difficulties of getting through and then there being no appointments left.

There was a relative lack of online booking and suggested improvements were around making more appointments available including next day appointment. 45% of respondents said that they were not offered a choice of practitioner when they booked an appointment, but continuity of care was an area for improvement for a number of respondents, particularly in relation to those with ongoing health conditions such as mental health concerns.

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Although 62% of respondents said that they were either completely satisfied or satisfied with their practice opening times, there were some that raised opening times as an area for improvement. Suggestions were generally in relation to practices being open for longer in the evenings and opening at weekends in order to accommodate the working patterns of some patients and make appointments more accessible.

When accessing out of hours primary care, respondents opted for a range of services. Promisingly less than 5% said that they would turn to A&E rather than using another primary care service.

Improvements suggested by respondents other than in relation to the process of booking appointments or accessing a preferred practitioner covered a range of issues, including increasing staff at all levels to improve services, providing better training for reception staff to provide better customer service and environmental improvements such as increased car parking.

The report findings were shared with the CCGs and GP Practices across Leicester and Leicestershire.

We developed a poster to be displayed in all GP Practices highlighting our findings.

"We valued the support that Healthwatch Leicester and Leicestershire provided to health and care partners to involve patients, carers, staff and the public in the redesign of community services. Their expertise in gathering insights and experiences from people and understanding what matters, means we have a reach seam of qualitative information, that is helping us to shape and improve the health and care services delivered."

Sue Venables - Head of Communications, Engagement and Involvement for Better Care Together

Have your say

Share your ideas and experiences and help services hear what works, what doesn't, and what you want from care in the future.

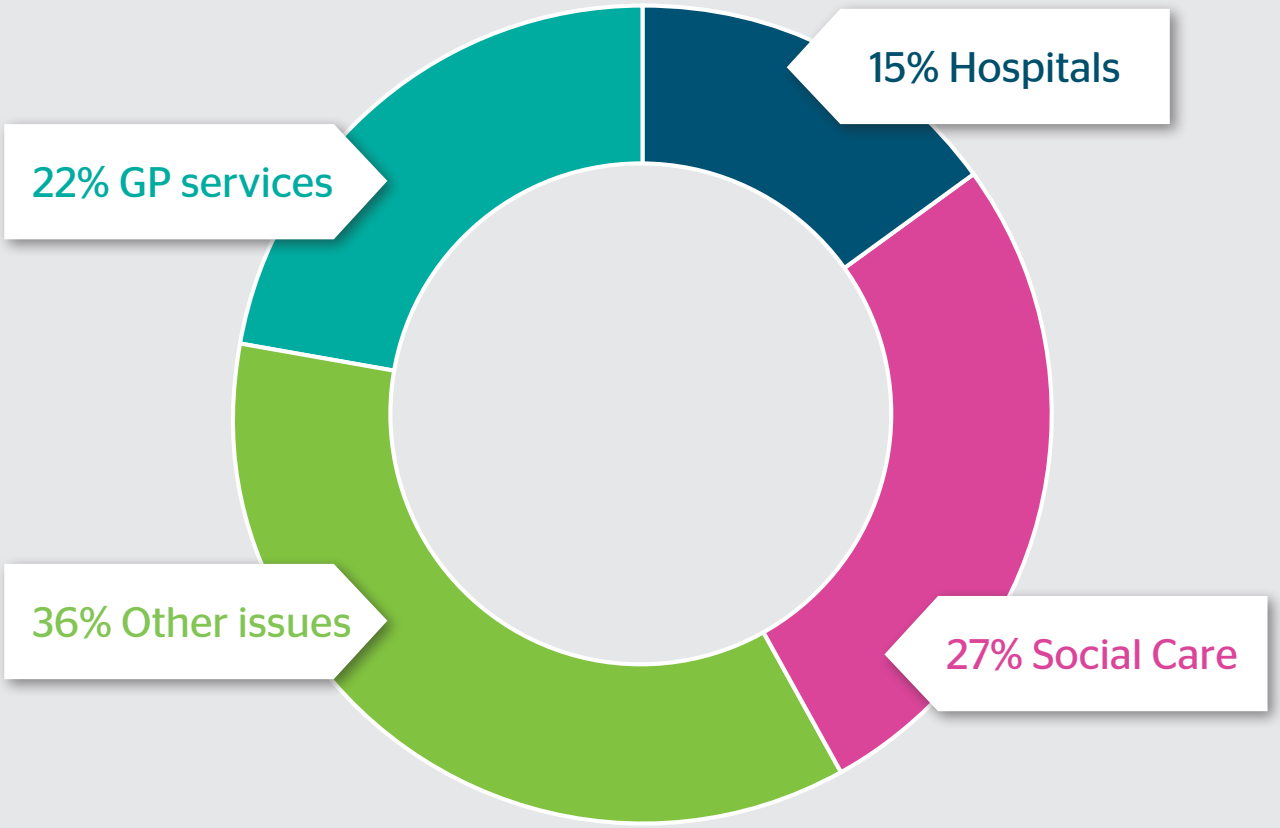
w: www.healthwatchll.com
t: 0116 2518313
e: enquiries@healthwatchll.com

Helping you find the answers

What services do people want to know about?

People don't always know how to get the information they need to make decisions about their own health and care. Healthwatch plays an important role in providing advice and pointing people in the right direction for the support they need.

Here are the most common things that people ask us:



How we provide people with advice and information

Finding the right care or support can be worrying and stressful. There a number of organisations that can provide help, but people don't know where to look. Last year we helped 193 people access the advice and information they need.

You can come to us for advice and information in a number of ways including:

- Specific advice and information blogs online
- Our contact us form
- At community events
- Promoting helpful services across our social media channels
- Over the phone

Charles's story :

I was really worried that my brother was going to be moved to a hospital far away from my family and I was worried that there was nothing we could do to stop it. So, I contacted Healthwatch Leicestershire to find out what my options might be.

'Thanks to Healthwatch Leicestershire for your advice and I'm glad it was sorted out at the first point of call, but I'm also pleased that you provided further options for us if that wasn't successful.'

Winter Health Messages

We identified winter health messages as one of our work priorities. We wanted to consider the messages that members of the public have seen and their effectiveness in supporting people to look after their health in winter.

Three focus groups were undertaken during December 2018 and January 2019, with two being undertaken in Leicester City Centre and one taking place in Loughborough.

Focus groups were chosen as they give an opportunity to explore the experiences and opinions of the participants in more depth than is possible using quantitative survey methods. Over the three focus groups there were 17 participants.

Some of the themes discussed were flu vaccinations, keeping warm and the use of pharmacies. The most common themes that participants discussed related to the flu vaccine. This suggests that the messages about having the vaccine have been amongst the most effective winter health messages.

However, participants raised issues that suggest that whilst the message about having the flu vaccine has been broadly effective there are other issues with the information that the public receive about the flu vaccine. Participants spoke of past campaigns that they were aware of including 'keep warm, keep well'. Keeping warm was a key point for participants in terms of what they could do to keep well in the winter, and most were aware that there was an optimum temperature for their homes to be kept to.

The use of pharmacies instead of the GP in the first instance was recognised as a message that a number of participants had seen and acted upon. However, the feedback on their experiences of using the pharmacists instead of the GP was mixed.

Library Drop-Ins – Leicester City

Leicester City Council has a total of 22 Libraries across the City one for each of the 22 wards they have in the City.

During the months of October – December 2018 we visited and held Drop-Ins at all 22 libraries Some of them were stand-alone libraries but with the decline in the interests in libraries over the last 20 years and the increases in technology, a lot of the libraries have now been incorporated into Leisure and Community Centres across the City.

One particular Library in Leicester which has a bit of a following is what they call the "Pork Pie Library" which sits on the edge of two of the largest council estates in Leicester City and is a classic 1930's style building now recognised as a listed building along with another which is in another area of the city called St Barnabas Library.

At more than one there were groups of people who meet there on a regular basis whom we had good conversations with and whilst promoting Healthwatch, also picked up some issue, mainly around their local GPs.

With Leicester being such a diverse City, we met lots of people from different communities all with different experiences. The most prolific in terms of numbers was the City Centre Library where we met with more than 20 people, but generally we would engage with anything from 6 up to 20 over the time we would be there.

Every Leicester City Library now has Healthwatch information available.

Are you looking for help?

If you have a query about a health and social care service, or need help with where you can go to access further support, get in touch. Don't struggle alone. Healthwatch is here for you.

w: www.healthwatchll.com
t: 0116 2518313
e: enquiries@healthwatchll.com

Our volunteers

How do our volunteers help us?

At Healthwatch Leicester and Leicestershire we couldn't make all of these improvements without the support of our 35 volunteers that work with us to help make care better for their communities.

- Raise awareness of the work we do in the community
- Visit services to make sure they're meeting people's needs
- Support our day to day running e.g. governance
- Collect people's views and experiences which we use in our reports

Volunteers work with local services to highlight patient concerns with GP services

Following on from several concerns raised by members of the public, Healthwatch working alongside the quality team of the Clinical Commissioning Group in Leicester City undertook a visit to talk to patients based at a City GP practice. Through speaking to patients, we were able to identify several improvements – from changes to the telephone service used to changes to the waiting area of the practice.

Meet our volunteers

We caught up with a couple of our fantastic volunteers to show you how their work truly makes a difference to the lives of people in our area.

Kim Marshal-Nichols

Kim

My name is Kim Marshal-Nichols I started volunteering many moons ago and I have been with Healthwatch since the change over from Local involvement Networks (LINks – Healthwatch predecessor) in Leicester 2010 I enjoy my role as an Authorised Rep and like the way in which it has evolved over the last 13 months with the Engaging Community Staffordshire take over, which collected Leicestershire en route, it has enriched my role making it challenging and rewarding, I love speaking to people and I certainly do that I engage with people from 16 - 101 ! On a regular basis, and sometimes my team friends have to drag me away! I have made many friends volunteering and would encourage everyone to do it.

It certainly has enriched my life.

Mark

I have always been driven by wanting to help other people to have their say about public services. As a Healthwatch Board Member, it is my role to represent the views of service users, carers, family and friends to NHS and Social Care. At a strategic level, I am currently involved with Leicestershire Partnership NHS Trust and the Learning Partnership Board for the City.

Leicestershire and Leicester are very diverse communities, so I am also driven by wanting to help engage traditionally unheard communities have their say, for example, championing the voice of LGTBQI people or those experiencing social isolation due to rural poverty. I work to ensure those voices are heard and what they say is acted upon.

In my role at Healthwatch, I can effect positive changes to NHS policies and services. I really enjoy getting out and about to meet people to better understand what they want from service providers, policy setters and commissioners. Volunteering with Healthwatch has therefore given me a positive boost to my self-confidence and self-worth.

Mark Farmer

Volunteer with us

Are you feeling inspired? We are always on the lookout for more volunteers. If you are interested in volunteering get in touch at Leicester and Leicestershire.

w: www.healthwatchll.com
t: 0116 2518313
e: enquiries@healthwatchll.com

‘The views and stories you share with us are helping to make care better for our local community’

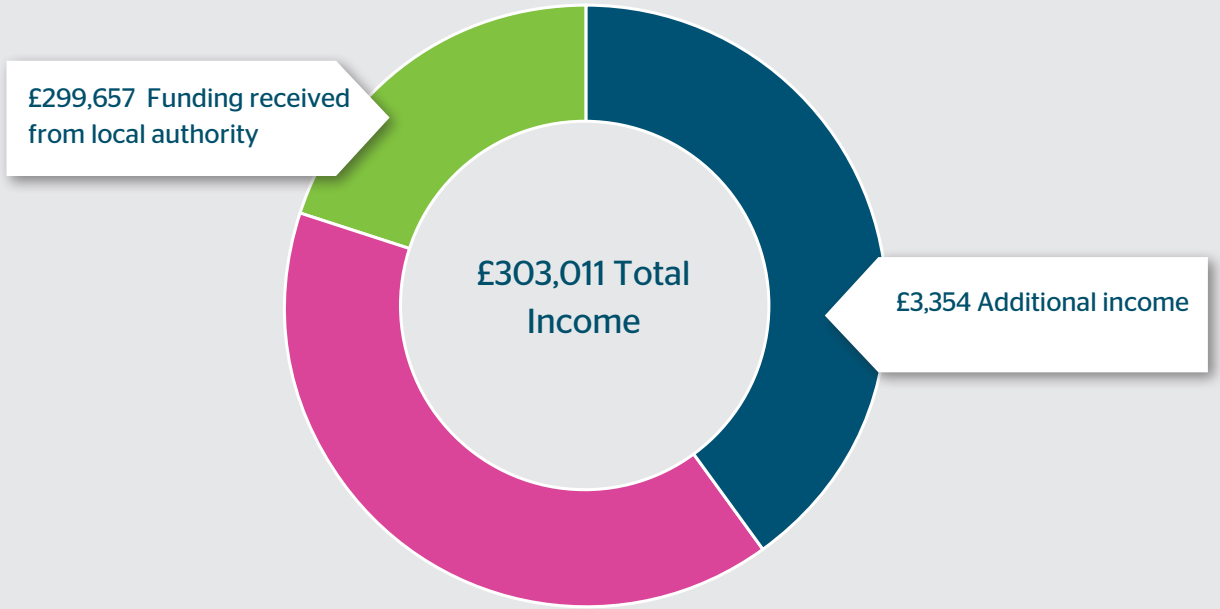
Mike Smith
Healthwatch Volunteer

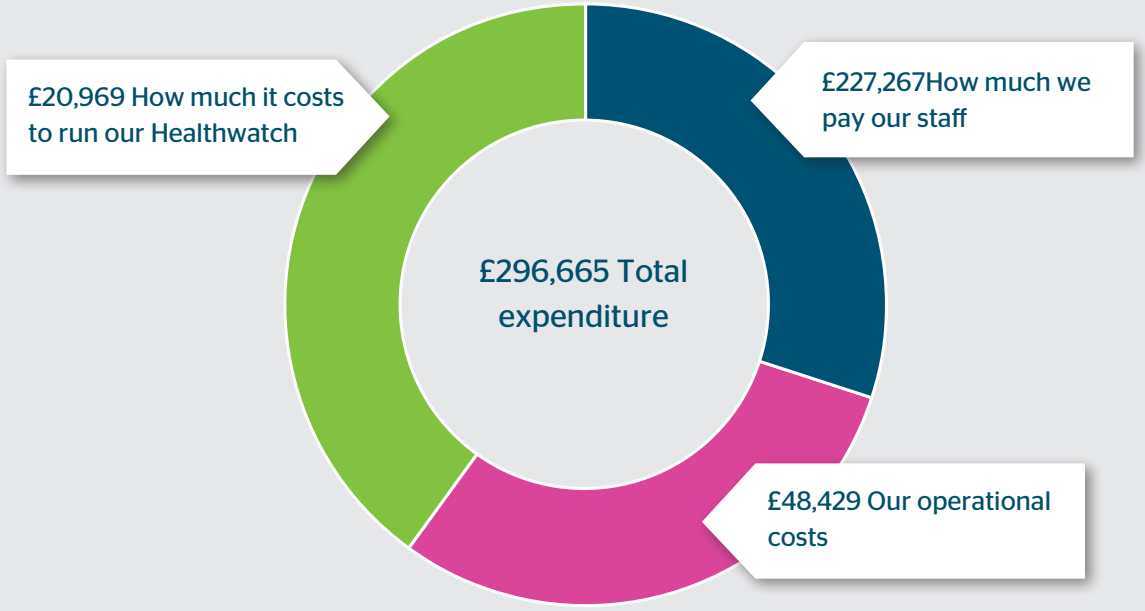
Our finances

How we use our money

To help us carry out our work, we are funded by our local authority. In 2018-19 we spent £296,665.

We also received £3,354 of additional income from other sources.





Our plans for next year

Message from our Manager

Looking back

Through 2018-19 has been an "interesting" year with delivering two Healthwatch contracts and acting on behalf of patients in the two very different areas. This was coupled with moving to a different way of working under Engaging Communities Staffordshire, however through the hard work and effort of our Advisory Board, Authorised Representatives and staff team we have maintained and built on the work of the separate Healthwatch organisations.

Looking ahead

Our role of the voice of local people is only going to be more important as the pace of service review and change. As well as the voice we need to act as the eyes and ears of the public and ensure they are kept up to date with how changes will affect their "patient experience"

Often, we are challenging Health and Care services to set clearer expectations to those using services. Some areas of focus for us next year will be –

- Community Mental Health Services
- What does "Social Prescribing" mean to the person on the street?
- Personal Budgets – Have they improved the lives of those on the

Barriers and opportunities

With a changing staff team, it has been difficult to build up the momentum we would have hoped but we have been lucky to have had wonderful team members. They have moved onto new pastures and we wish them the very best in the future.

A challenge going forward is to ensure we keep a constructive and meaningful relationship with those delivering, commissioning and scrutinising services. As we hear more from patients and their families about how services are struggling, we need to make sure their lived experience is passed on in the most effective way possible.

As the services change, we are presented with the biggest barrier as well as the biggest opportunity, to ensure we are in the right place to have the biggest impact.

Thank you

To our Advisory Board – Harsha Kotecha (Chair), Mark Farmer, Shireen Bharuchi, Rita Patel and Colin Norman (Resigned). I would like to thank them for their continued efforts in representing the public in an ever-growing number of meetings, absorbing all the different issues raised by members of the public and turning that into priorities.

To our Authorised Representatives – Who have taken the change of pace and deliver of Enter and View visits in their stride. They have done everything we've asked of them and more.

To our staff team – TUPE'd or not TUPE'd...that is the question. Well not quite but to all staff members who have moved across into the new contract and to those who have joined us since then. It is only through their passion and commitment to what Healthwatch can achieve and how much they care about patient and public involvement that we have delivered what we have this year. Each one is a credit to our ongoing mission.

Micheal Smith
Healthwatch Leicester and Leicestershire

Thank you

Thank you to everyone that is helping us put people at the heart of health and social care, including:

- Members of the public who shared their views and experience with us
- All of our amazing staff and volunteers
- The voluntary organisations that have contributed to our work
- We want to thank everyone across the Health and social care services and the voluntary sector who have supported us in our work

"Healthwatch in Leicester and Leicestershire has established a strong and productive working relationship with the University Hospitals of Leicester in many different ways in 2018-19.

Be it through the regular meetings between senior UHL board members to share the lived patient experience or across the table in scrutiny meetings challenging how services are changing across Health and Social Care services. Healthwatch in Leicester and Leicestershire continues to act in the best interested of patients and the public. Their meaningful contribution to shaping and influencing local services demonstrates why patient and public involvement remains so important in the times ahead. "

Mark Wightman - Director of Strategy and Communications University Hospitals of Leicester NHS Trust

Contact us

Address and contatct as of 31/03/2019.

» **Contact number:** 0116 2518313

» **Email address:** enquiries@healthwatchll.com

» **Social media:** @HealthwatchLeic

» **Website:** www.healthwatchll.com

Healthwatch Leicester and Leicestershire

Clarence House

46 Humberstone Gate

Leicester

LE1 3PJ

Contract holder's address and contact details of as of 31/03/2019.

Engaging Communities Staffordshire CIC (ECS)

Unit 42, Staffordshire University Business Village

Dyson Way

Stafford

ST18 0TW

» **Contact number:** 01785 887809

» **Email address:** www.ecstaffs.co.uk

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you need this in an alternative format please contact us.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LEICESTER
HINCKLEY AND
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Agenda Item 9

healthwatch Leicestershire

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 11TH SEPTEMBER 2019

REPORT OF HEALTHWATCH LEICESTERSHIRE

HOSPITAL DISCHARGE REPORT

Purpose of report

1. The purpose of this report is to highlight the patient experience of being discharged from hospital, locally. Through patient interviews common themes and issues are presented, with recommendations which will be taken forward with University Hospitals of Leicester (UHL) and other stakeholder partners.

Policy Framework and Previous Decisions

2. The County Council, following the Health and Social Care Act 2012, is required to directly commission a local Healthwatch. The local Healthwatch in turn has a set of statutory activities to undertake, such as gathering local views and making these known to providers and commissioners, monitoring and scrutinising the quality of provision of local services and a seat on the Health and Wellbeing Board.

Background

3. The purpose of Healthwatch Leicestershire is to promote improvements in local health and social care services – improving outcomes for local people in Leicestershire. HWL believes that the best way to do this is by designing local services around the needs and experiences of local people.

4. Following patient insight being shared on frustrations being discharged from Hospital and also due to partnership working on the discharge from hospital process, the Healthwatch Advisory Board set this issue as a substantive work issue. Working with senior staff in UHL, Healthwatch staff interviewed patients waiting to be discharged from Leicester Royal Infirmary and Glenfield Hospital. The report sets out the patient experiences shared through the interviews. These experiences were reviewed to identify any common issues or trends and to set recommendation to be raised with UHL.

Recommendation

5. It is recommended that Healthwatch Leicestershire's Hospital Discharge report be noted.

Officer to Contact

Micheal Smith - Manager
0116 2518313
Micheal.Smith@healthwatchll.com

List of Appendices

Healthwatch Leicester and Healthwatch Leicestershire - Hospital Discharge Report

Relevant Impact Assessments

Equality and Human Rights Implications

6. HWL is aware that the Public Sector Equality Duty (PSED) applies to all functions of public authorities that are listed in Schedule 19 Equality Act 2010. Schedule 19 list does not include Healthwatch England or Local Healthwatch organisations, however as bodies carrying out a public function using public funding we are subject to the PSED general duty.

7. ECS/ Healthwatch Leicestershire is committed to reducing the inequalities of health and social care outcomes experienced in some communities. We believe also that health and social care should be based on a human rights platform. We will utilise the Equality Act 2010 when carrying out our work and in influencing change in service commissioning and delivery.

healthwatch Leicester

healthwatch Leicestershire

Hospital Discharge Report

July 2019

Introduction

Healthwatch Leicester and Healthwatch Leicestershire are the public champions for health and social care. We collect feedback from the residents of Leicester and Leicestershire who have used health and social care services about their experiences. The feedback is used to influence health and social care commissioners and providers to share good practice and develop service improvements.

On this occasion Healthwatch Leicester and Healthwatch Leicestershire decided to undertake a project to understand the experiences of patients being discharged from hospital. The project wanted to understand how involved patients were in planning their discharge, if they were happy with the process of being discharge, and how comfortable they were with what was decided for their discharge in terms of where they were discharged to. The project also sought to understand what staff were involved in discharge planning and how they communicated with the patients about what was going to happen at their discharge.

Methodology

This project used semi-structured interviews to collect feedback from people who were being discharged from hospital to understand their experience of the discharge process.

Interviews took place in the discharge lounge at The Royal Infirmary and Glenfield Hospital and all participants gave their signed consent to take part in the project.

The feedback has been analysed and organised into themes and these are presented in the findings below. There were a limited number of participants and the nature of data collection means that the findings are a snapshot of the experiences of those individuals that were willing to take part and are therefore, not necessarily representative of all people who are discharged from hospital in Leicester and Leicestershire.

There is no breakdown in the feedback between people who are normally resident in the City or the County. Although respondents were to be asked for the first part of their postcode in order to differentiate between localities, many failed to provide it and so no meaningful distinctions can be made.

Findings

There were ***18 interviews*** undertaken with patients who were waiting in the discharge lounge. In addition to this we received comments from one family member of a patient and comments from three members of staff.

The feedback from the participants has been collated and organised into themes in order to understand where there have been common experiences.

Themes

Urgent admissions

The way that the participant came to be admitted to hospital was discussed with them and how many times in the last twelve months they had been admitted.

From the feedback that was received it was apparent that most admissions were unplanned or emergency admissions. This would mean that their discharge planning would take place whilst they were in hospital and that no planning could take place prior to their admission as could happen with a planned admission.

Patient involvement

A recurring theme was that patients often did not feel that they had been involved in their discharge planning. This included simple receiving of information about what was happening with their discharge.

For others, they felt that the planning had been done without them and that they would have liked ***'to be more involved'*** in the plans for their discharge. One participant commented that their discharge plan had been ***'done without my involvement'*** whilst another said that they had 'talked over my head.' Another said that they had '***not spoken to anyone'*** about their discharge. The lack of involvement in their discharge planning meant that some of the participants had concerns about their return home with one saying that they had ***'no forward plan'*** and another saying that they ***didn't 'know what would happen'*** when they '***got home'***.

However, others felt that they had been involved with one commenting that they had been ***'totally involved'*** and another saying that they had been 'listened to' and the discharge had been done '***more his way'***.

On the day delays

A key theme was that patient were experiencing delays on the day of discharge. This made patients feel ***'annoyed'*** and ***'frustrated'*** with one participant telling us that they had been ***'waiting all bloody day'*** in the discharge lounge. Another said that ***'up until the discharge lounge'*** their discharge had ***'gone really well'*** whilst another participant described themselves as ***'absolutely livid'*** because they had been waiting for four hours to leave.

Communication about the causes of delays on the day were seen as an issue for some of the respondents. This was particularly the case in respect of having indicative timescales on when they might be able to leave the hospital.

Although it was observed by one of the Healthwatch Staff carrying out the interviews that one participant was given information about the reason for the delay in their discharge this was not the case for many. One patient said that they had been in the discharge lounge for ***'eight hours'*** and ***'no-one had come and said when' they 'were going home.'*** By this point the patient said they were ***'tired and fed up.'*** Another commented that they did not ***'know what the hold up was.'*** Being kept informed of the reasons for delays and when they might expect to go home was suggested as an improvement with one participant saying ***'it's a plus to know what's happening.'***

Waiting for medication was a major cause of delays on the day and left participants in the discharge lounge for long periods of time. One respondent said that ***'waiting for medication was the cause of today's delay'*** whilst another said that they had been ***'waiting for medication 9am until 9pm. 12 hours'***.

A member of staff commented that *'if the only thing that is needed is a signature by the doctor, and then he has to deal with an emergency, there can be a long wait for the signature needed for medication. '*

Improving the process for obtaining medication for discharge was a key point made by participants when they were suggesting how the discharge process could be improved. Comments included general suggestions that they should *'speed up medication'* to more specific suggestions of having *'more pharmacists.'*

Waiting for hospital transport was also a cause of delay in the discharge lounge. One participant commented that they were *'waiting for an ambulance'* before going on to say *'I could get a taxi but why should I pay?'* Another said that they were *'going home in an ambulance'* but had been *'waiting for four hours.'*

One staff member commented on how medication delays and transport delays could be interconnected saying that *'sometimes medication has a hold up and the ambulance allocated to the patient is re-allocated to someone whose medication has been arranged.'*

Waiting for discharge paperwork could also be a cause of delays once discharge had been confirmed for that day. Some of the participants said that they were delayed because they were *'waiting for a discharge letter.'* Another said that they were 'waiting for a letter about my care.'

The long wait in the discharge lounge and lack of entertainment there was mentioned by two of the participants who both commented that there was no television available and having one could improve the discharge experience where there are delays.

Late notification of discharge

For some participants there was little awareness of when they were going to be discharged prior to being told it was that day. One participant was informed *'40 minutes prior'* to the interview taking place for this project. Another said that they were *'not told'* when they were going to be discharged and they were *'told on the morning'*. The last notification suggests that there was little patient involvement in the planning for their discharge.

For one of the participants their discharge had needed to be delayed by a day because they had had no prior notification that they may be discharged at that point and they had not got any clothes to leave hospital in.

Family support

Most participants were leaving hospital to return to their own homes. It was notable that many of those spoke about their family members supporting or caring for them. There were a range of different arrangements spoken about including family members *'caring'* for them, or family members *'popping in'* to check on them, as well as families where there are formal carers and families were also checking in. For some of the participants there was a reliance on spouses to care for them on their discharge from hospital.

It was also commented on that for one family, they were not involved or kept informed of discharge plans that were made for their relative. They commented that when they had arrived to visit their relative they were not on the ward but had been moved to the discharge lounge. The decision to discharge had not been discussed with any family members.

Staff involved in discharge planning

Nobody mentioned having had any discussions or involvement with social workers about their discharge or care following discharge.

Only one participant mentioned that they were going to go into residential care for a short while after they were discharged and they said that they had arranged this themselves. It was planned in advance and *'had always been the case.'*

Others said that they had spoken to the *'doctor on the ward'* and had had *'no discussions with nurses' or had discussed it with a 'surgeon'* but there were *'no nurses'* involved *'in discharge'*.

Others said that they had spoken to a range of medical professionals including *'physios'* and *'nurses'*. For one participant though, they had only spoken to *'the nurses on the discharge lounge. No others.'*

Conclusions

The number of participants in this project were small and the feedback they have given is a snapshot of their experience in a short time period. However, there were some common themes found within the feedback.

There was little patient involvement in planning for discharge. Most of the participants had not been consulted on their discharge and some would have welcomed more say in what happened around their discharge.

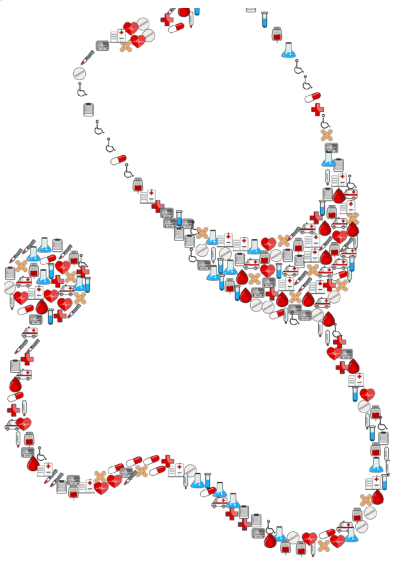
On the day delays were a key theme for the participants in the project. For some there were issues in relation to a lack of communication about the reasons for the delays. For others, the issues were in relation to the process of being discharged, including delays with paperwork and particularly waiting for medication. Waiting for transport home was also seen as a reason for delays and there was potentially a link between delays in medication and long waits for transport home.

As there were long reported delays waiting in the discharge lounge the lack of any entertainment, such as a television was an issue for some participants.

Last minute or on the day notification of discharge was common. This meant that participants had not necessarily been able to make arrangements for their return home and also points towards a lack of planning for the discharge of patients and their ongoing recovery at home.

All but one of the participants was being discharged back to their own homes. Most had commented that they were going to be receiving care or support from their family members. It became clear that the support of families was key to the ongoing care of participants. However, it was not clear how much involvement families had in the discharge process and making decisions on longer term care.

None of the participants indicated that they had spoken to anyone from social care in relation to their discharge. Those that had spoken to anybody about their discharge said that they had spoken to medical staff. For some of those the only staff they had spoken to were doctors or surgeons with no nursing involvement. Again this, suggests that there is a lack of planning and understanding of the circumstances that the patients are returning home to.



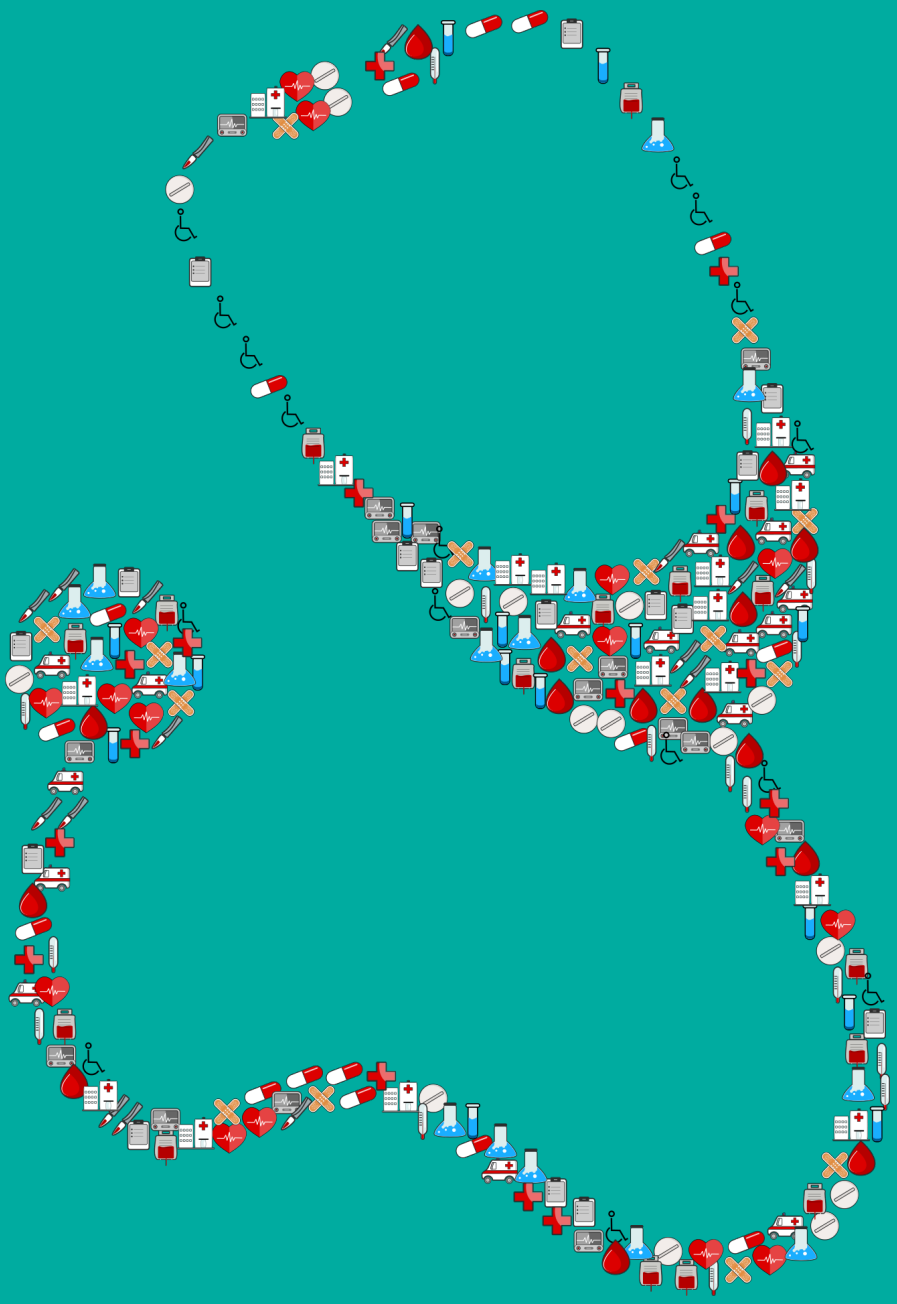
Recommendations

The following recommendations are made based on the report findings.

- In view of the key themes being concerned with on the day delays it is recommended that consideration is given to how to reduce the time spent in the discharge lounge, including a reduction in waits for medication.
- Participants felt that they would benefit from more information on the day timescales for leaving hospital. It is recommended that consideration should be given to providing information on timescales for leaving the hospital on the day of discharge.
- On the day notification was a common occurrence. Therefore, it is recommended that it is ensured that patients are kept involved and informed on plans for their discharge and likely dates for discharge in advance. This would reduce the instances of patient's being given little notice of their discharge and ensure that they can make suitable arrangements for returning home.
- Family support when returning home was a key theme for our participants. However, it was not always the case that families had been involved in plans for discharge. Therefore, it is recommended that when planning for discharge health and social care providers ensure that families are involved and consulted with.

healthwatch Leicester

healthwatch Leicestershire



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Agenda Item 10

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 11 SEPTEMBER 2019

REPORT OF THE CHIEF EXECUTIVE AND CCG PERFORMANCE SERVICE

HEALTH PERFORMANCE UPDATE AT AUGUST 2019

Purpose of Report

1. The purpose of the report is to provide the Committee with an update on health performance in Leicestershire and Rutland based on the available data at August 2019.

Background

2. The Committee has, as of recent years, received a joint report on health performance from the County Council's Chief Executive's Department and the CCG Commissioning Support Performance Service. The report aims to provide an overview of performance issues on which the Committee might wish to seek further reports and information, inform discussions and check against other reports coming forward.

NHS Constitution

3. At a national level the health performance reporting model is influenced by the Government's mandate to NHS England. A revised mandate was issued relating to the period 2017-18. There are also a wide range of separate clinical and regulatory standards that apply to individual services and providers. The Public Health Outcomes Framework (PHOF) sets out metrics on which to help assess public health performance and there is a separate framework for other health services. Adult social care outcomes are covered by the Adult Social Care Outcomes Framework (ASCOF) and the Better Care Fund is subject to separate guidance.

Changes to Performance Reporting Framework

4. A small number of changes have been made to the way performance is reported to the Committee to reflect comments at previous meetings, including inclusion of a wider range of cancer metrics and Never Events and Serious incidents related to UHL. The overall framework will continue to evolve to take

account of the above developments as well as any particular areas that the Committee might wish to see included.

5. The following 4 areas therefore form the current basis of reporting to this committee: -

a. Performance against the key metrics/targets set out in the Better Care Fund plan, in relation to health and care integration;
b. Clinical Commissioning Group (CCG) performance for both West Leicestershire and East Leicestershire and Rutland CCGs;
c. Quality - UHL Never Events/Serious Incidents; and
d. An update on wider Leicestershire public health outcome metrics and performance.

Better Care Fund Performance

6. BCF planning guidance, released in July 2017, reduced the number of BCF metrics from six to four. The guidance contained a requirement for all areas to reduce the number of delayed transfers of care (DToCs).

7. A refresh to the BCF Policy Framework for 2019/20 was published in April 2019. The delayed BCF guidance was published in July 2019 along with final financial allocations. There was an expectation that the target for delayed transfers for end of September 2018 would be maintained or exceeded thereafter. A review of other BCF outcome metrics has been carried out and these have been updated accordingly.

8. The four BCF outcome metrics for 2019/20 remain the same as in previous years. The **non-elective admissions** target is based on the CCG operating plans. As in previous years this includes a small percentage of bordering CCGs. The target for the Leicestershire BCF plan is to achieve no more than 72,313 non-elective admissions during 2019/20.

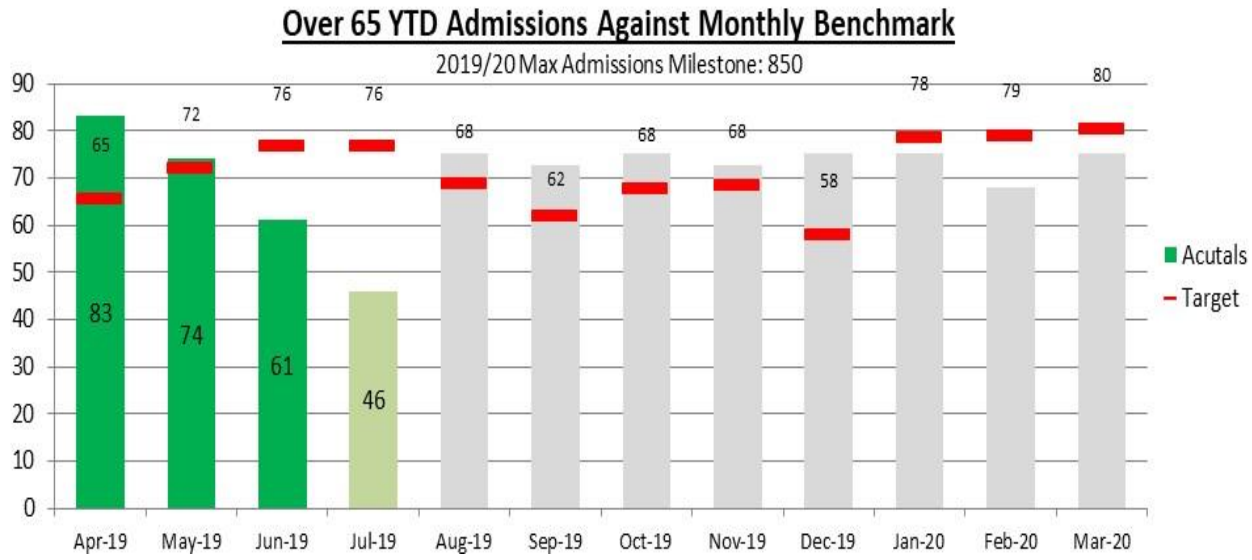
9. The **delayed transfers of care (DTOC)** target has been set by NHS England. The national target remains to achieve below 4,000 delays per day across England. For Leicestershire, the DTOC target is to achieve no more than 42.8 delays per day. Which equates to 7.88 average days delayed per day per 100,000 population.

10. The two BCF social care metrics were refreshed in Q4 2018/19 during the main BCF refresh process. The target for the number of **permanent admissions of older people (aged 65 and over) into residential and nursing care homes** is for fewer than 850 admissions during 2019/20. The target for the **proportion of older people who were still at home 91 days after discharge** has been set at 88%.

11. The first wave of Care Quality Commission local system reviews were undertaken during quarter 3 2017/18, which covered 12 areas across England. The second wave of local reviews was published in December. Leicestershire has not been included in this list, which is reflective of the good overall comparative performance. The final end of year position in relation to delivery against BCF metrics and targets for 2018/19 is set out in Appendix 1. The position shows generally good performance in delivering against targets last year.

Metric 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population, per year

12. The BCF target for permanent admissions to care for those aged 65+ during 2019/20 is a maximum of 850 admissions. There were 218 permanent residential admissions between April 2019 and June 2019. The current full year forecast of 853 is predicted, a full year variance of +3. Performance is RAG-rated amber and is statistically similar to the target.



Metric 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

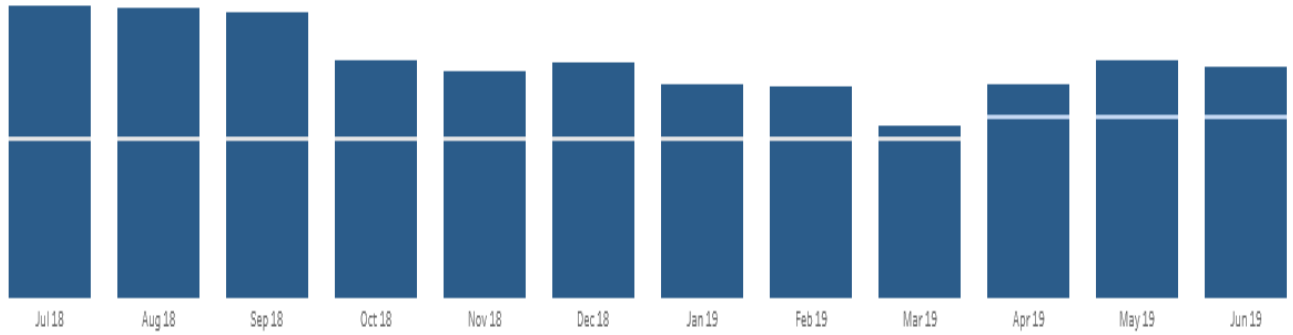
13. For hospital discharges between April 2019 and June 2019, 90% of people discharged from hospital into reablement/rehabilitation services were still at home after 91 days. This is above the 2019/20 target of 88%. Performance is RAG-rated green and is statistically similar to the target.

ASCOF2B - Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement / rehabilitation services.

	Feb 2018 to Apr 2018	Mar 2018 to May 2018	Apr 2018 to Jun 2018	May 2018 to Jul 2018	Jun 2018 to Aug 2018	Jul 2018 to Sep 2018	Aug 2018 to Oct 2018	Sep 2018 to Nov 2018	Oct 2018 to Dec 2018	Nov 2018 to Jan 2019	Dec 2018 to Feb 2019	Jan 2019 to Mar 2019
Hospital Discharges Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home	519	540	541	538	535	523	532	538	561	571	582	581

	May 2018 to Jul 2018	Jun 2018 to Aug 2018	Jul 2018 to Sep 2018	Aug 2018 to Oct 2018	Sep 2018 to Nov 2018	Oct 2018 to Dec 2018	Nov 2018 to Jan 2019	Dec 2018 to Feb 2019	Jan 2019 to Mar 2019	Feb 2019 to Apr 2019	Mar 2019 to May 2019	Apr 2019 to June 2019
Living at home 91 days later Of those above, those who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital	481	500	500	486	481	472	475	480	491	510	526	523

ASCOF2B - Monthly Results

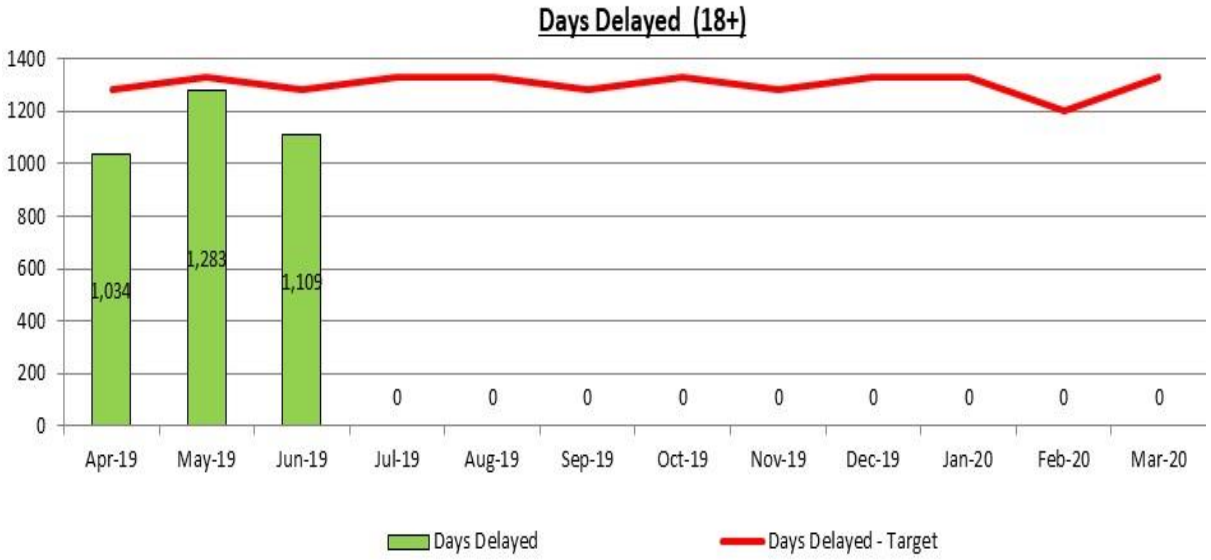


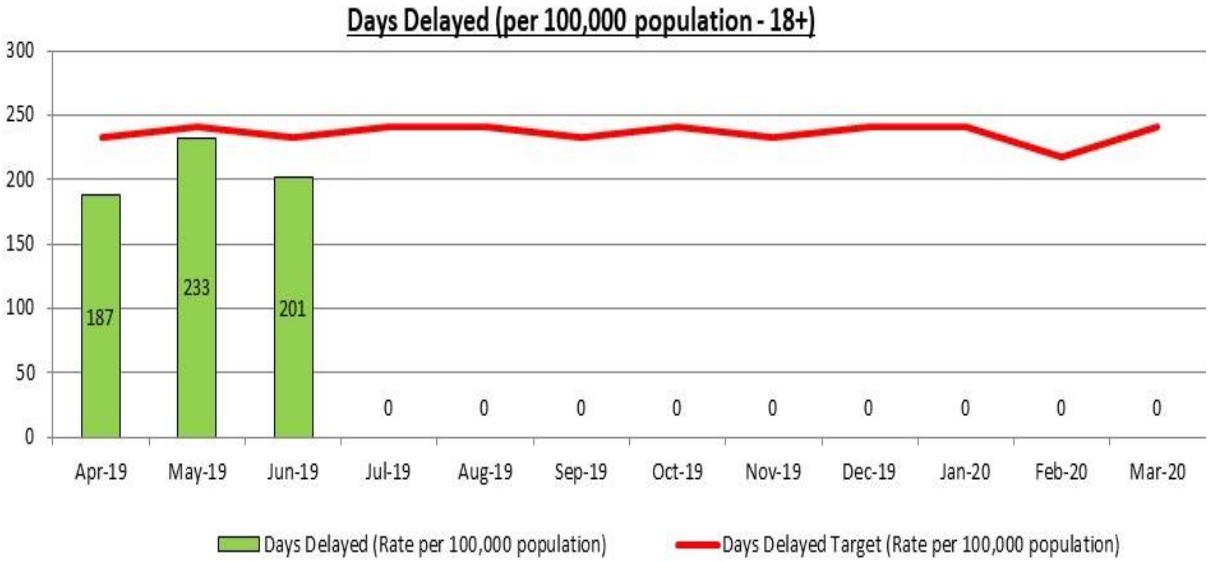
Discharge Date	Feb 2018 to Apr 2018	Mar 2018 to May 2018	Apr 2018 to Jun 2018	May 2018 to Jul 2018	Jun 2018 to Aug 2018	Jul 2018 to Sep 2018	Aug 2018 to Oct 2018	Sep 2018 to Nov 2018	Oct 2018 to Dec 2018	Nov 2018 to Jan 2019	Dec 2018 to Feb 2019	Jan 2019 to Mar 2019
91st Date	**May 2018 to Jul 2018**	**Jun 2018 to Aug 2018**	**Jul 2018 to Sep 2018**	**Aug 2018 to Oct 2018**	**Sep 2018 to Nov 2018**	**Oct 2018 to Dec 2018**	**Nov 2018 to Jan 2019**	**Dec 2018 to Feb 2019**	**Jan 2019 to Mar 2019**	**Feb 2019 to Apr 2019**	**Mar 2019 to May 2019**	**Apr 2019 to June 2019**
Total SU's NOT at home	38	40	41	52	54	51	57	58	70	61	56	58
SU Deceased	23	19	17	26	30	29	31	32	44	33	30	29
SU in Hospital	10	15	18	22	21	20	21	23	24	22	23	25
SU in Permanent Care	5	6	6	4	3	2	5	3	2	6	3	4

Metric 3: Delayed transfers of care (DTOCs) from hospital per 100,000 population

14. The Government's mandate to the NHS for 2018-19 has set an overall ambition for reducing delays to around 4,000 hospital beds occupied by patients delayed without discharge by September 2018. For Leicestershire this equated to DTOCs not exceeding 7.88 in every 100,000 population per day. This target is to be maintained during 2019-20.

15. Overall there were 3,426 days lost to delayed transfers of care in Leicestershire between April and June 2019; a 28% increase on the same period last year. For delays attributable to adult social care there were 542 days delayed an increase on the same period last year, with UHL down but both LPT and out of county significantly higher. There were 232 delayed days attributable to ASC during June 2019 – the highest number of days delayed in a month since October 2017. Delays have steadily increased from 49 in November 2018.

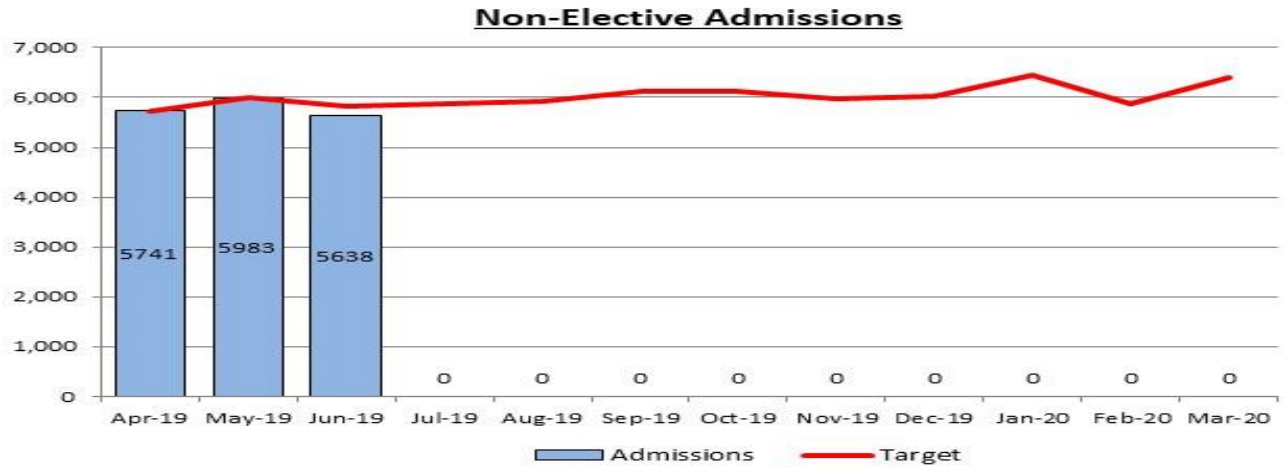


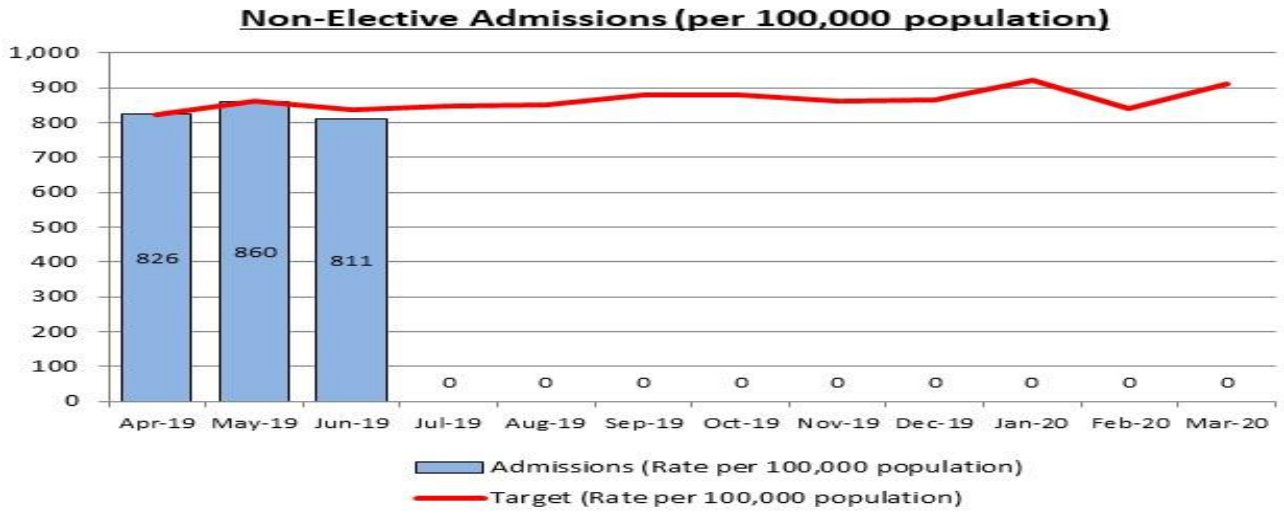


Metric 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, per month

16. Secondary User Statistics data for April 2019 to June 2019 shows 17,362 non-elective admissions. This is a variance of -180 against a month 3 target of 17,542. The target has been achieved in 2 out of 3 months. A full year forecast of 72,133 has been predicted – variance of -180 and rag rated green. Non-elective admissions are prominent within 65+ adults at 50.2% compared with 39.2% for 18-64 and 10.5% for children.

17. We also have a local metric on injuries due to falls in people aged 65 and over. There were 639 non-elective admissions for falls related injuries between April 2019 and June 2019. This a variance of +27 against the Q1 target of 612 and an increase of 3.2% compared to the same period last year.





CCG Performance Dashboard - Appendix 2

18. NHS England's CCG Improvement and Assessment Framework (IAF) was introduced in 2016/17, it aligns key objectives and priorities and informs the way NHS England manages relationships with CCGs. In November 2018 NHS England (NHSE) refreshed the Improvement and Assessment Framework for CCGs for 2018/19. There is currently no update available from NHSE on a 2019/20 CCG IAF.

19. The framework provides a greater focus on assisting improvement alongside statutory assessment functions and is based on 4 areas of assurance for each CCG - Better Health, Sustainability, Leadership and Better Care. The full dashboards, as published in July 2019 by NHS England, showing CCG performance across all 4 domains, are reported in Appendix 2 for ELRCCG and WLCCG. The dashboard within the appendix of this report mirrors the format of the 2018/19 IAF.

20. Each year NHSE publish CCG ratings based on assessment against the IAF. Ratings range from Outstanding, Good, Requires Improvement and Inadequate. In 2017/18 ELRCCG and WLCCG were assessed as 'Requires Improvement'. Results for the 2018/19 assessment were published in July, and both CCGs achieved 'Good' status. NHSE cited several areas of strength; smooth transition of WL leadership changes, progression of some corporate functions, positive engagement with the STP and system level activity planning.

21. The following table provides an explanation for the key IAF constitutional indicators not being achieved. Up-to-date data has been provided in the table where available. Details of local actions in place in relation to these metrics are also shown.

NHS Constitution metric and explanation of metric	**Most recent local data**	**Local actions in place/supporting information**
Cancer 62 days from referral to treatment The indicator is a core delivery indicator that spans the whole pathway from referral to first treatment covering the length of time from urgent GP referral, first outpatient appointment, decision to treat and finally first definitive treatment. Shorter waiting times can help to ease patient anxiety and, at best, can lead to earlier diagnosis, quicker treatment, a	**National Target >85%** **Latest Performance** **ELR** (All Providers); June 2019 – 74% **WL** (All Providers); June 2019 – 76% **UHL** (All patients); May 2019 – 75%	Late tertiary referrals are still affecting the backlog and account for some of the exceptional long waiters. Other factors impacting on backlog and 62 day performance continues to be theatre and HDU/ITU capacity constraints. Cancer patients continue to be tracked until treated and the CCG are appraised daily on the latest status. Local UHL Actions • Shadow reporting commenced for the new 28 day faster diagnostic standard • Urology; increased use of Derby robotic sessions (staffing dependent), improved patient booking process, patient video developed • Head & Neck; two locums recruited to mitigate staffing constraints, NGH/KGH consultants providing additional clinics, when possible, liaising with Trusts to explore if there is any free capacity across the patch

lower risk of complications, an enhanced patient experience and improved cancer outcomes.		• Lung; optimal lung pathway progressing, improved tracking and actions for long waiters, increased rapid access to lung clinic resource • Weekend process to ensure the Director on call and Silver on call have a list of cancer patients, who are expected to ensure they are prioritised • UHL weekly review is now including patients on the 31day list to ensure that patients are booked on next steps and any delays are managed
A&E admission, transfer, discharge within 4 hours A&E waiting times form part of the NHS Constitution. This measure aims to encourage providers to improve health outcomes and patient experience of A&E. The standard relates to patients being admitted, transferred or discharged within 4 hours of their arrival at an A&E department.	**19/20 National Target > 95%** **UHL A&E + UCC's local Target July 2019 - 88.3%** **UHL ED + UCCs** July 2019 - 81% **<u>UHL A&E only local Target July 2019 83.9%</u>** **UHL ED only** July 2019 - 72% **LLR Urgent Care Centres only** July 2019 - 99.6%	Summarised below are actions which are being taken by UHL and across the LLR system as a whole to improve performance against the 4-hour emergency care standard: UHL • Increased overnight clinical support to injuries stream • Same Day Emergency Care accelerator programme membership focusing on extension of GP and Ambulatory Care Unit at the LRI site in September • Emergency Care Improvement Support Team support focusing on the flow out of the Clinical Decisions Unit at Glenfield site • Further Multi-Agency Discharge Events will take place throughout the year, leading into Winter • Ward 7 Acute Medical Unit extension with additional discharge co-ordinator and junior doctor cover overnight • Out of Hours service to support GP streaming (DHU) LLR • Pilot redirection of Ambulance Category 3&4 calls to Clinical Navigation Hub. • Mandated conveyance by EMAS to Loughborough Urgent Care Centre for appropriate patients • Increased offer for access for diagnostics and direct access to clinics in line with out of hospital Same Day Emergency Care pathways • Managing non-elective demand with a key focus on nursing homes, mental health and patients aged between 18 -25.
18 week Referral To Treatment (RTT)	**Latest Performance**	The longest waits for patients are those waiting an admitted procedure with shorter waits for non-admitted patients.

The NHS Constitution sets out that patients can expect to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions if they want this and it is clinically appropriate. 2019/20 National Target >92% of patients to start treatment with 18 weeks from referral In 2019/20 the national ambition is also that the Waiting List should be sustained at March 2018 levels in March 2020.	**ELR (All Providers)** June 2019 – 86% 20,661 patients waiting at the end of March 2018 20,950 patients waiting at the end of June 2019. **WL (All Providers)** June 2019 – 85% 23,384 patients waiting at the end of March 2018 24,794 patients waiting at the end of June 2019 **UHL (All Patients)** UHL are not expecting to meet the national standard of 92% in 2019/20. June 2019 – 84% 64,751 patients waiting at the end of March 2018. 64,721 patients waiting at the end of June 2019.	UHL are planning to reduce the overall waiting list in 2019/20 however they have forecast 85.5% performance against the RTT standard at the end of March 2020. The level of cancer referrals into UHL has increased which has meant that capacity has been diverted to support the 2ww standards. The Trust is uprating the theatre productivity programme to increase admissions and FourEyes are providing external validation to support this and undertake clinical engagement. Specific areas of concern are in Neurology, Allergy, ENT, Urology and Gynaecology. Actions are in place to improve performance and include: - Recruitment, additional weekend list, reviewing capacity modelling and exploring use of IS via subcontract arrangements. Delivery of the Referral Support Services to reduce system demand on UHL and Alliance. Improved outpatient and theatre utilisation as managed by the Outpatient and Theatre Program Boards.

Other Cancer Metrics

22. The latest performance (June 2019) for the Cancer Wait Metrics is below: -

Metric	Period	National Target	East Leicestershire and Rutland CCG	West Leicestershire CCG
Cancer Waiting Times				
% Patients seen within two weeks for an urgent GP referral for suspected cancer	Jun-19	93%	91%	90%
% of patients seen within 2 weeks for an urgent referral for breast symptoms	Jun-19	93%	94%	85%
% of patients receiving definitive treatment within 1 month of a cancer diagnosis	Jun-19	96%	94%	96%
% of patients receiving subsequent treatment for cancer within 31 days (Surgery)	Jun-19	94%	89%	86%
% of patients receiving subsequent treatment for cancer within 31 days (Drug	Jun-19	98%	100%	100%
% of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy	Jun-19	94%	98%	96%
% of patients receiving 1st definitive treatment for cancer within 2 months (62 days)	Jun-19	85%	74%	76%
% of patients receiving treatment for cancer within 62 days from an NHS Cancer	Jun-19	90%	85%	80%
% of patients receiving treatment for cancer within 62 days upgrade their priority	Jun-19	N/A	81%	89%

UHL Never Events and Serious Incidents

23. There has been one Never Event at UHL in 2019/20, which occurred in June 2019, and 9 Serious Incidents between April 2019 – June 2019. Actions undertaken by UHL are to share learning from Never Events and Serious Incidents through the CMG Quality & Safety Boards, CQRG, Patient Safety Portal and learning bulletins. Incidents are used in training programmes such as the Patient Safety Essentials, Step Up course MSc and Medical School Years 1 and 2. Any themes identified are triangulated so that chief issues of concern can be understood.

Areas of Improvement

24. There are several areas which are worth commenting on, that have shown recent improvement;
    - Diagnostic 6 week wait standard has been achieved for 10 consecutive months at UHL.
    - 52+ weeks wait has been compliant for 12 consecutive months at UHL.
    - Single Sex Accommodation Breaches, no breaches have been reported for 3 consecutive months at UHL.
    - Cancelled Operations (on the day), 1.0% reported in June 2019 at UHL.

- Delayed Transfers of Care levels remain within tolerance levels at UHL, and ELRCCG is in the highest performing quartile across England CCGs.
- ELRCCG were in the highest performing quartile for injuries from falls in people over 65yrs.
- ELRCCG were in the highest performing quartile for smoking at the time of delivery.
- 100% of the ELRCCG & WLCCG population have access to the Primary Care extended access service.
- ELRCCG and WLCCG continue to achieve the national standard that over 67% of the expected number of dementia patients now have a dementia diagnosis within primary care.

Public Health Outcomes Performance – Appendix 3

25. Appendix 3 sets out current performance against a range of outcomes set in the performance framework for public health. The Framework contains 38 indicators related to public health priorities and delivery. The dashboard sets out, in relation to each indicator, the statistical significance compared to the overall England position or relevant service benchmark where appropriate. A rag rating of 'green' shows those that are performing better than the England value or benchmark and 'red' worse than England value or benchmark.

26. Analysis shows that of the comparable indicators, 18 are green, 11 amber and 4 red. There are 5 indicators that are not suitable for comparison or have no national data.

27. Of the 18 green indicators, the following indicators, under 18 conceptions, new sexually transmitted infections and smoking status at time of delivery have shown significant improvement over the last few years. Breast cancer screening coverage and cervical cancer screening coverage has shown a significant declining (worsening) performance over the last five years. This declining trend, for both indicators, is witnessed nationally.

28. Of the 11 indicators that are amber, successful completion of drug treatment for opiate users has shown a trend of worsening performance. There are no significant changes for successful completion of drug treatment for non-opiate users.

29. Of the four red indicators chlamydia detection rate shows Leicestershire has declined to be worse than the benchmark goal and is ranked 9th out of 16 of the CIPFA nearest neighbours (1 being the best). For Take up of NHS health checks for the time period 2014/15-2018/19, Leicestershire is ranked 14th out

of 16. The percentage of physically active adults in Leicestershire is ranked 15th out of 16. Further work is underway to progress improvement across the range of indicator areas. Further consideration will be given to actions to tackle these areas as part of Health and Wellbeing Strategy implementation and the public health service plan development process.

30. HIV late diagnosis (%) for 2015-17 for Leicestershire has no value presented as the data is supressed due to disclosure issues. Breastfeeding initiation for Leicestershire has no value presented due to data quality reasons. Self-reported wellbeing – people with a low worthwhile score for 2017/18 for Leicestershire has no value due to the number of cases being too small.

31. Leicestershire and Rutland have combined values for the following three indicators - smoking status at time of delivery, successful completion of drug treatment (opiate users) and successful completion of drug treatment (non-opiate users).

List of Appendices

Appendix 1 – BCF End Year 2018/19 Metric Position
Appendix 2 – CCG Performance Dashboard
Appendix 3 – Public Heath Performance Dashboard

Background papers

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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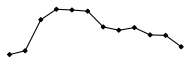
Metric	Target	Latest Data	RAG-rated data	Data RAG	Trend	Aim / Polarity	DOT	Commentary
METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population, per year	624.1	51.9	615.0	G		Good performance is represented by a fall in the figures	⇔	The RAG-rated data shows the year end actuals for 2018/19, based on CPLIs. The BCF target for 18/19 is a maximum of 890 admissions. The current actual position is 877 admissions (or 615 per 100,000 population), please note this position will increase with any late recordings. Performance is RAG-rated green and is statistically similar to the target.
METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	87.0%	n/a	87.7%	G		Good performance is represented by a rise in the figures	⇔	For hospital discharges between Oct and Dec '18, 87.7% of people discharged from hospital into reablement / rehabilitation services were still at home after 91 days. This is above the 18/19 target of 87%. Performance is RAG-rated green and is statistically similar to the target.
METRIC 3: Delayed transfers of care from hospital per 100,000 population	244.38	n/a	217.44	G		Good performance is represented by a fall in the figures	⇔	In March there were 1,182 days delayed, a rate of 217.44 per 100,000 population against a target of 244.38. This is RAG-rated as green and is statistically better than the target. For the different attributable organisations (NHS, social care, and jointly attributable), 78% of these delays were attributable to the NHS, 17% attributable to Social Care and 5% Jointly attributable.
METRIC 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, per month	868.67	819.53	857.20	G		Good performance is represented by a fall in the figures	⇔	For the period Apr-18 to Mar-19 there have been 68,012 non-elective admissions, against a target of 70,569 – a variance of -2,557. This is RAG-rated as green. For the month of March there has been 5,961 non elective admissions, against a target of 6,041 - a variance of -80. The monthly rate is 857.20 against a monthly target of 868.67 and this is RAG-rated green. The RAG methodology is green if non-elective admissions/rate is less than or equal to the monthly target, amber if non-elective admissions/rate is between the monthly target and monthly minimum, and red if non-elective admissions/rate is greater than the monthly minimum.

RAG Methodology Metrics 1 to 3:

RED if target is not met but performance is significantly worse than the target
AMBER if target is not met but performance is statistically similar to the target
GREEN if the target is met

RAG Methodology for Metric 4 is different to keep in line with other NEA reporting to LLR where targets have been set in consideration of the CCG operating plans:

RED if performance is greater than the monthly minimum
AMBER if non elective admissions/rate is between the monthly target and monthly minimum
GREEN if performance is less than or equal to the monthly target

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Appendix 2 – NHSE Improvement & Assessment Framework July 2019

Bandings

- Highest performing quartile
- Interquartile range
- Lowest performing quartile

NHSE Better Health Dashboard

	Area	Indicator	Period	Target	New data this release	03W: NHS East Leicestershire and Rutland CCG	04V: NHS West Leicestershire CCG
	Annual assessment	999a: Annual assessment	2018-19		✓	GD	GD
Better Health	Child obesity	102a: Percentage of children aged 10-11 classified as overweight or obese	2015-16 to 2017-18		✓	29.4%	32.6%
	Diabetes	103a: Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) ..	2017-18			38.6%	38.1%
		103b: People with diabetes diagnosed less than a year who attend a structured education course	2017-18 (2016 cohort)			2.59%	2.16%
	Falls	104a: Injuries from falls in people aged 65 and over	18-19 Q3			1645	1720
	Personalisation and choice	105b: Personal health budgets	18-19 Q4		✓	57	48
	Health inequalities	106a: Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions	18-19 Q2			1939	1995
	Antimicrobial resistance	107a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	2019 02	0.965	✓	0.953	0.962
		107b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	2019 02	10%	✓	10.4%	9.51%
	Carers	108a: The proportion of carers with a long term condition who feel supported to manage their condition	2018	1.000		0.54	0.60

NHSE Better Care Dashboard

Area	Indicator	Period	Target	New data this release	03W: NHS East Leicestershire and Rutland CCG	04V: NHS West Leicestershire CCG
Provision of high quality care	121a: Provision of high quality care: hospital	18-19 Q3			54	54
	121b: Provision of high quality care: primary medical services	18-19 Q3			66	66
	121c: Provision of high quality care: adult social care	18-19 Q3			62	63
Cancer	122a: Cancers diagnosed at early stage	2017		✓	52.0%	51.0%
	122b: People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	18-19 Q4	85%	✓	77.3%	72.8%
	122c: One-year survival from all cancers	2016	75%		73.4%	71.9%
	122d: Cancer patient experience	2017			8.8	8.8
Mental health	123a: Improving Access to Psychological Therapies – recovery	18-19 Q3	50%		48.8%	46.5%
	123b: Improving Access to Psychological Therapies – access	18-19 Q3			3.70%	3.80%
	123c: People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	2019 03	53%	✓	70.5%	75.0%
	123e: Mental health crisis team provision	2017-18			0.00%	25.0%
	123f: Mental health out of area placements	2019 02		✓	28	98
	123g: Proportion of people on GP severe mental illness register receiving physical health checks	18-19 Q4	50%	✓	26.1%	27.2%
	123i: Delivery of the mental health investment standard	18-19 Q4		✓	Green	Green
	123j: Ensuring the quality of mental health data submitted to NHS Digital is robust (DQMI)	2019 01		✓	0.85	0.85
Learning disability	124a: Reliance on specialist inpatient care for people with a learning disability and/or autism	18-19 Q4		✓	56	56
	124b: Proportion of people with a learning disability on the GP register receiving an annual health check	2017-18			50.1%	49.4%
	124c: Completeness of the GP learning disability register	2017-18			0.38%	0.41%
Maternity	125a: Neonatal mortality and stillbirths	2016			5.15	3.88
	125b: Women's experience of maternity services	2018		✓	83.0	80.6
	125c: Choices in maternity services	2018		✓	60.9	55.9
	125d: Maternal smoking at delivery	18-19 Q3	6%		5.33%	10.6%

Area	Indicator	Period	Target	New data this release	03W: NHS East Leicestershire and Rutland CCG	04V: NHS West Leicestershire CCG
Urgent and emergency care	127b: Emergency admissions for urgent care sensitive conditions	18-19 Q2			2084	2205
	127c: Percentage of patients admitted, transferred or discharged from A&E within 4 hours	2019 03	95%		77.1%	85.1%
	127e: Delayed transfers of care per 100,000 population	2019 03		✓	6.3	6.6
	127f: Population use of hospital beds following emergency admission	18-19 Q2			537	575
End of life care	105c: Percentage of deaths with three or more emergency admissions in last three months of life	2017		✓	8.99%	9.16%
Primary care	128b: Patient experience of GP services	2018			84.0%	84.9%
	128c: Primary care access – proportion of population benefitting from extended access services	2019 03		✓	100.0%	100.0%
	128d: Primary care workforce	2018 09			1.29	1.02
	128e: Count of the total investment in primary care transformation made by CCGs compared with the £3 head commitment made in the General Practice Forward Vi..	18-19 Q4		✓	Green	Green
Elective access	129a: Patients waiting 18 weeks or less from referral to hospital treatment	2019 03	92%	✓	85.3%	86.3%
7 day services	130a: Achievement of clinical standards in the delivery of 7 day services	2017-18		✓	2	3
NHS Continuing Healthcare	131a: Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting	18-19 Q4	15%	✓	6.06%	2.63%
Patient safety	132a: Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by the CCG	2018		✓	Amber	Amber
Diagnostics	133a: Percentage of patients waiting 6 weeks or more for a diagnostic test	2019 03	1%	✓	1.01%	0.86%

NHSE Sustainability and Leadership

Area	Indicator	Period	Target	New data this release	03W: NHS East Leicestershire and Rutland CCG	04V: NHS West Leicestershire CCG
Financial sustainability	141b: In-year financial performance	18-19 Q4		✓	Green	Green
Paper-free at the point of care	144a: Utilisation of the NHS e-referral service to enable choice at first routine elective referral	2019 03	100%	✓	100.0%	100.0%
Probity and corporate governance	162a: Probity and corporate governance	18-19 Q4		✓	Fully compliant	Fully compliant
Workforce engagement	163a: Staff engagement index	2018		✓	3.77	3.59
	163b: Progress against the Workforce Race Equality Standard	2018		✓	0.17	0.17
Quality of leadership	165a: Quality of CCG leadership	18-19 Q4		✓	Amber	Amber
CCGs local relationships	164a: Effectiveness of working relationships in the local system	2018-19		✓	67.3	64.6

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Public Health and Prevention Indicators in Leicestershire

Prevention	Indicator	Time Period	Polarity	Value	NN Rank	England	DoT	RAG
All	0.1i - Healthy life expectancy at birth, (F)	2015 - 17	High	65.7	9/16	63.8	—	Green
	0.1i - Healthy life expectancy at birth, (M)	2015 - 17	High	65.2	7/16	63.4	—	Green
	0.1ii - Life expectancy at birth, (F)	2015 - 17	High	84.1	8/16	83.1	—	Green
	0.1ii - Life expectancy at birth, (M)	2015 - 17	High	80.8	5/16	79.6	—	Green
	0.2iii - Inequality in life expectancy at birth, (F)	2015 - 17	Low	5.5	9/16	7.4	—	Grey
	0.2iii - Inequality in life expectancy at birth, (M)	2015 - 17	Low	6.6	5/16	9.4	—	Grey
Primary	1.16 - Utilisation of outdoor space for exercise/health reasons, (P)	Mar 2015 - Feb 2016	High	20.8	3/16	17.9	—	Yellow
	2.02i - Breastfeeding initiation, (F)	2016/17	High	Null	Null	74.5	—	Grey
	2.02ii - Breastfeeding prevalence at 6-8 weeks after birth - current method, (P)	2017/18	High	45.0	6/11	42.7	—	Green
	2.03 - Smoking status at time of delivery, (F)	2017/18	Low	9.5	3/16	10.8	▼	Green
	2.04 - Under 18s conception rate / 1,000, (F)	2017	Low	12.3	4/16	17.8	▼	Green
	2.06i - Reception: Prevalence of overweight (including obesity), (P)	2017/18	Low	24.3	15/16	22.4	▲	Red
	2.06ii - Year 6: Prevalence of overweight (including obesity), (P)	2017/18	Low	32.7	12/16	34.3	▲	Green
	2.12 - Percentage of adults (aged 18+) classified as overweight or obese, (P)	2017/18	Low	60.6	4/16	62.0	—	Yellow
	2.13i - Percentage of physically active adults, (P)	2017/18	High	64.3	15/16	66.3	—	Red
	2.13ii - Percentage of physically inactive adults, (P)	2017/18	Low	23.3	13/16	22.2	—	Yellow
	2.14 - Smoking Prevalence in adults (18+) - current smokers (APS), (P)	2018	Low	13.2	8/16	14.4	—	Yellow
	2.23ii - Self-reported wellbeing - people with a low worthwhile score, (P)	2017/18	Low	Null	Null	3.6	—	Grey
	4.02 - Proportion of five year old children free from dental decay, (P)	2016/17	High	77.7	15/16	76.7	—	Yellow
	2.18 - Admission episodes for alcohol-related conditions (Narrow), (P)	2017/18	Low	556.3	4/16	632.3	—	Green
Primary/Secondary	4.01 - Infant mortality, (P)	2015 - 17	Low	3.7	10/16	3.9	—	Yellow
	4.04i - Under 75 mortality rate from all cardiovascular diseases, (P)	2015 - 17	Low	62.1	7/16	72.5	—	Green
	4.05i - Under 75 mortality rate from cancer, (P)	2015 - 17	Low	119.8	2/16	134.6	—	Green
	4.06i - Under 75 mortality rate from liver disease, (P)	2015 - 17	Low	13.7	6/16	18.5	—	Green
	4.07i - Under 75 mortality rate from respiratory disease, (P)	2015 - 17	Low	27.0	7/16	34.3	—	Green
	4.10 - Suicide rate, (P)	2015 - 17	Low	7.9	4/16	9.6	—	Green
	4.15iii - Excess winter deaths index (3 years, all ages), (P)	Aug 2014 - Jul 2017	Low	18.8	4/16	21.1	—	Yellow
	4.15iv - Excess winter deaths index (3 years, age 85+), (P)	Aug 2014 - Jul 2017	Low	26.5	5/16	29.3	—	Yellow
Secondary	2.15i - Successful completion of drug treatment - opiate users, (P)	2017	High	5.5	14/16	6.5	▼	Yellow
	2.15ii - Successful completion of drug treatment - non-opiate users, (P)	2017	High	34.7	7/16	36.9	▶	Yellow
	2.17 - Estimated diabetes diagnosis rate, (P)	2018	High	79.4	6/16	78.0	—	Yellow
	2.20i - Cancer screening coverage - breast cancer, (F)	2018	High	81.3	1/16	74.9	▼	Green
	2.20ii - Cancer screening coverage - cervical cancer, (F)	2018	High	77.0	4/16	71.4	▼	Green
	2.20iii - Cancer screening coverage - bowel cancer, (P)	2018	High	63.6	4/16	59.0	—	Green
	2.22iv - Cumulative % of eligible pop aged 40-74 offered and received an NHS Health Check, (P)	2014/15 - 18/19	High	42.8	14/16	48.1	—	Red
	3.02 - Chlamydia detection rate / 100,000 aged 15-24, (P)	2018	High	1,702.7	9/16	1,974.9	▲	Red
	New STI diagnoses (exc chlamydia aged <25) / 100,000, (P)	2018	Low	486.7	4/16	850.6	▼	Green
	3.04 - HIV late diagnosis (%), (P)	2015 - 17	Low	Null	Null	41.1	—	Grey

Statistical Significance compared to England or Benchmark: Better, Similar, Not compared, Worse

Direction of Travel: ▼ Decreasing; ▼ Decreasing and getting better; ▼ Decreasing and getting worse; ▲ Increasing; ▲ Increasing and getting better; ▲ Increasing and getting worse; ▶ No significant change; — Cannot be calculated

Nearest Neighbour Rank: 1 is calculated as the best (or lowest when no polarity is applied)

Source: PHE, August 2019

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Agenda Item 11

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 11 SEPTEMBER 2019

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

DRAFT LEICESTERSHIRE SUBSTANCE MISUSE STRATEGY 2020-23

Purpose of report

1. The purpose of this report is to consult the Health Overview Scrutiny Committee on the draft Leicestershire Substance Misuse Strategy 2020-23.

Policy Framework and Previous Decisions

2. A condition of the public health grant requires local authorities to provide an accessible drug and alcohol treatment and recovery system while having regard to reducing health inequalities.

3. The priorities that form the Substance Misuse Strategy are informed by the Leicestershire Joint Strategic Needs Assessment chapters on alcohol misuse and drug misuse in adults which were published in March 2019.

4. The priorities align with the following outcomes from the Leicestershire County Council's Strategic Plan 2018-22 which was approved by the County Council on 6 December 2017:

   - **Wellbeing and opportunity:** The people of Leicestershire have the opportunities and support they need to take control of their health and wellbeing.
   - **Keeping people safe:** People in Leicestershire are safe and protected from harm.
   - **Great communities:** Leicestershire communities are thriving and integrated places where people help and support each other and take pride in their area.

5. The draft strategy seeks to build on elements of the Health and Wellbeing Strategy and to build on the work already underway to strengthen the links between health and wellbeing and community safety. The strategy also builds on the overarching public health responsibility to take steps to improve the health and wellbeing of Leicestershire residents by focusing on the broader issues surrounding substance misuse.

Background

6. Drug and alcohol misuse impacts on people's lives in many ways. Providing treatment and support to people with alcohol and/or drug problems can have a

significant beneficial impact not just for the individual, but for their families and their community. Preventing people from developing alcohol and drug problems and reducing their dependency on alcohol and drugs not only improves their individual health and wellbeing but also reduces the burden on health and social care services.

7. It is known that growing up in an environment where there is substance misuse is a significant factor impacting on childhood adversity and trauma, which itself leads to a higher risk of those children developing alcohol and drug problems and engaging in health harming behaviours in adulthood.

8. A comprehensive Leicestershire Joint Strategic Needs Assessment for drug misuse and alcohol misuse in adults was completed in March 2019. The reports highlight that considerable progress has been made over recent years in reducing the harm caused by drug and alcohol misuse in Leicestershire. However, the changing landscape of substance misuse needs in the local population coupled with increasing financial pressures faced by commissioners and partner organisations means there is a need to review the existing approach to substance misuse service provision to ensure the ongoing provision of appropriate, accessible and equitable services to our local population.

9. The proposed Leicestershire Substance Misuse Strategy 2020-23 utilises evidence from the needs assessments to recognise achievements made thus far across the Council and outlines the key priorities for the next three years to further reduce the harm caused by substance misuse. The Strategy also recognises the need to continue to utilise existing partnerships such as the Health and Wellbeing Board and the Leicestershire Safer Communities Strategy Board in developing a partnership approach to tackling the problems associated with drug and alcohol misuse in Leicestershire.

Proposals

10. The draft Leicestershire Substance Misuse Strategy 2020-23 is appended to this report. There are five priorities that form the Strategy. These are set out below:

    i. **Raise awareness and prevent the harms of drug and alcohol misuse particularly for those at greatest risk.** This will be delivered by developing a sustainable prevention offer in relation to drug and alcohol misuse and by developing a coordinated approach to communications and campaigns relating to drugs and alcohol across local partners.

    ii. **Develop a coordinated approach to early identification of individuals exposed to the harmful effects of drug and/or alcohol misuse.** This will be delivered by ensuring that LCC Public Health and Children and Family Services continue to work together to strengthen the whole family approach to those exposed to the harmful impact of drug and/or alcohol misuse. There is also an opportunity to optimise the link between the commissioned drug and alcohol treatment service and local hospital alcohol care teams once they are established.

    iii. **Develop an approach to the provision of treatment and recovery services that is responsive to the changing trends in drug and alcohol**

addiction among residents of Leicestershire. This will be delivered through an agreed approach to commissioning substance misuse services over the next 3 years with endorsement from all relevant commissioning organisations (e.g. NHS England).

iv. **Reduce ill health and deaths as a result of alcohol and drug misuse.** This will be delivered by ensuring harm reduction interventions form an ongoing component of substance misuse treatment provision and by developing a partnership approach (e.g. with Leicestershire Police) to the review of drug related deaths among Leicestershire residents.

v. **Ensure a joined up and timely response to changing patterns of substance misuse and emerging issues relating to substance misuse.** This will be delivered by setting up a substance misuse partnership group involving local service providers, voluntary sector organisations, commissioning organisations and partners. This group will meet regularly and feed into strategic groups such as the Health and Wellbeing Board, Leicestershire Safer Communities Strategy Board and the Strategic Partnership Board.

Consultation

11. Following Cabinet approval of the draft strategy on 25 June 2019, a public consultation commenced on 8 July 2019 and ran for 8 weeks, ending midnight on 2 September 2019. The consultation sought feedback regarding the proposed priorities through various means including focus groups and via the Have Your Say webpage on the council website. Stakeholders who were consulted included: local Clinical Commissioning Groups, Leicestershire Police, Office of the Police and Crime Commissioner, departments across the council, local hospitals, members of the Leicestershire Safer Communities Strategy Board and the Health and Wellbeing Board, district health leads, Healthwatch, Voluntary Action Leicestershire, substance misuse service providers and service users.

12. Analysis of the consultation findings shows strong support for having a strategy and for the priorities identified within the strategy. The consultation feedback placed strong emphasis on the importance of a partnership approach (Priority 5 of the Strategy). Feedback also indicated the need for more detail on how each priority will be implemented.

Resource Implications

13. There are no immediate resource implications arising from the strategy which will be progressed utilising existing resources.

Timetable for Decisions

14. The outcome of the consultation will be used to inform a final version of the strategy to be presented to the Cabinet for approval in November 2019. Following this, Public

Health will develop an implementation plan which details the specific actions required to achieve each priority, and the lead department/person responsible for each priority/action.

Conclusions

15. Following completion of a comprehensive Leicestershire Joint Strategic Needs Assessment for drug misuse and alcohol misuse in adults, the reports highlight that considerable progress has been made over recent years in reducing the harm caused by drug and alcohol misuse in Leicestershire. However, the changing landscape of substance misuse needs in the local population coupled with increasing financial pressures faced by commissioners and partner organisations means there is a need to review the existing approach to substance misuse service provision.

16. The proposed Leicestershire Substance Misuse Strategy 2020-23 utilises evidence from the needs assessments to outline the key priorities for the next three years to further reduce the harm caused by substance misuse and to ensure the ongoing provision of appropriate, accessible and equitable services to our local population.

17. An 8 week public consultation commenced on 8 July 2019. The consultation findings show support for the priorities identified within the strategy. A final version of the strategy will be presented to the Cabinet for approval in November 2019. Following this, Public Health will develop a detailed action plan to implement the Strategy.

Background papers

Report to Cabinet – Draft Leicestershire Substance Misuse Strategy 2020-23 – 25 June 2019
http://politics.leics.gov.uk/documents/s146576/Leicestershire%20Substance%20Misuse%20Strategy%202020-23.pdf

Leicestershire Joint Strategic Needs Assessment 2018-21: Substance Misuse in Adults
http://www.lsr-online.org/uploads/substance-misuse-in-adults.pdf

Leicestershire Joint Strategic Needs Assessment 2018-21: Alcohol Misuse in Adults
http://www.lsr-online.org/uploads/alcohol-misuse-in-adults.pdf

Report to the County Council – 6 December 2017 – Strategic Plan 2018 – 22
http://politics.leics.gov.uk/ieListDocuments.aspx?CId=134&MId=5104&Ver=4

Circulation under the Local Issues Alert Procedure

18. A copy of this report will be circulated to all members under the Members' Digest.

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List of Appendices

Appendix - Draft Leicestershire Substance Misuse Strategy 2020-23

Relevant Impact Assessments

Equality and Human Rights Implications

19. As part of the development of the final strategy, an Equality Human Rights Impact Assessment (EHRIA) will be undertaken to identify equality issues which need to be considered. The outcome of the assessment will be presented to the Cabinet alongside the final strategy in November.

Crime and Disorder Implications

20. Substance misuse has far reaching impacts on individual health, families and communities. There are clear links between substance misuse, crime and community safety. Meeting the health needs of people in contact with the criminal justice system can help to achieve reductions in crime, reduce offending and improve the individual's health.

Partnership Working and associated issues

21. The draft strategy outlines a partnership approach to tackling the problems associated with drug and alcohol misuse in Leicestershire. The priorities identified within this strategy have been developed based on an understanding of needs in relation to substance misuse and will be refined following widespread consultation with stakeholders.

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Leicestershire County Council

Substance Misuse Strategy 2020 - 2023

Introduction

Drug and alcohol misuse impacts on people's lives in many ways. Providing treatment and support to people with alcohol and/or drug problems can have a significant beneficial impact not just for the individual, but for their families and their community. Preventing people from developing alcohol and drug problems and reducing their dependency on alcohol and drugs not only improves their individual health and wellbeing but also reduces the burden on health and social care services.

There are around 600,000 dependent drinkers in England and around 200,00 children living with an alcohol dependent parent or carer. We know that growing up in an environment where there is substance misuse is a significant factor impacting on childhood adversity and trauma, which itself leads to a higher risk of those children developing alcohol and drug problems and engaging in health harming behaviours in adulthood.

These issues are not bound by geography, individual circumstances or age, and therefore at the heart of our strategy is the need to take a coordinated, whole system, life-course approach.

National evidence suggests that specialist drug and alcohol interventions for young people contribute to improvement in health and wellbeing, educational attainment, attendance at school and reduces risky behaviour. In monetary terms, young people's drug and alcohol interventions result in annual savings of £4.3m for health services and £100m for crime. If a 10% reduction in the number of young people continuing their dependency into adults is achieved, the lifetime societal benefit of treatment is estimated to be £159m which equates to £8 benefit for every £1 invested.

For Leicestershire, it is estimated that investment in treatment services for individuals with drug misuse reduces crime by 23% and for alcohol misuse is 48%, with total financial benefits to social care of £1.3million per annum and economic benefits of £7.5million per annum. Alcohol treatment provides a return on investment of £3 for every £1 invested. Drug treatment provides a return on investment of £4 for every £1 invested.

We have made considerable progress over recent years in reducing the harm caused by drug and alcohol misuse in Leicestershire. However, the changing landscape of substance misuse needs in the local population coupled with increasing financial pressures faced by the County Council and partner organisations means there is a need to review the existing approach to substance misuse service provision to ensure we continue to provide appropriate, accessible and equitable services to our local population.

This strategy takes stock of achievements made thus far and outlines the key priorities for the next 3 years to further reduce the harm caused by substance misuse in Leicestershire. These priorities align with the following outcomes from the Leicestershire County Council's Strategic Plan 2018-22 which has a focus on making life better for people in Leicestershire:

- **Wellbeing and opportunity:** The people of Leicestershire have the opportunities and support they need to take control of their health and wellbeing.
- **Keeping people safe:** People in Leicestershire are safe and protected from harm.
- **Great communities:** Leicestershire communities are thriving and integrated places where people help and support each other and take pride in their area.

Vision

People of Leicestershire are able to make informed healthy lifestyle choices to reduce the harms caused by alcohol and drug misuse and improve their wellbeing.

Priorities for Leicestershire

This strategy outlines a partnership approach to tackling the problems associated with drug and alcohol misuse in Leicestershire. The priorities identified within this strategy have been developed based on an understanding of needs in relation to substance misuse and following widespread consultation with stakeholders.

Priority 1:

Raise awareness and prevent the harms of drug and alcohol misuse particularly for those at greatest risk.

Where are we now?

Leicestershire has a significantly higher proportion of adults who drink more than 14 units per week, compared to England (29.8% and 25.7% respectively). A significantly higher proportion locally also reported binge drinking compared to the national average (21% and 16.5% respectively).

The Modern Crime Prevention Strategy 2016 refers to evidence that:

- Good quality Personal, Social and Health Education (PSHE) and school-based interventions designed to improve behaviour (e.g. by building confidence, resilience and effective decision-making skills) can have a preventative impact on substance misuse.
- Brief interventions (including motivational interviewing techniques) at early contact points with health, criminal justice and social care services can help prevent escalation for those in the early stages of substance misuse.

Evidence also indicates that identification and brief advice can reduce weekly drinking by between 13% and 34% which reduces the risk of alcohol-related conditions by approximately 14%, and risk of lifetime alcohol related death by approximately 20%.

Within Leicestershire County Council, the Public Health department provides a robust prevention offer centred around a social prescribing model. The offer focuses on developing community capacity, and on providing information, advice and referral through Local Area Coordinators and First Contact Plus.

Public Health also funds and supports the Leicestershire Healthy Schools Programme. One of the four key themes within the programme is the delivery of Personal, Social and Health Education (PSHE) which includes an emphasis on drugs and alcohol education. All 285 schools within Leicestershire participate in the programme.

Public Health also commissions the evidence-based 'Alcohol Risk Reduction Scheme' which is delivered by over 75 GP practices and 35 pharmacies across the county. It is an evidence-based preventative approach aimed at identifying individuals whose drinking might impact their health, now or in the future. Staff from these primary care services are trained to deliver a simple structured intervention based on an assessment using a validated alcohol screening tool, followed by brief advice, information on the harm of alcohol, and written information on reducing the risk from drinking alcohol. A similar approach is also delivered in the local hospitals via hospital liaison workers. Currently these are the only formal setups for assessment of alcohol intake and delivery of alcohol brief interventions. This limits the reach of this evidence-based prevention intervention.

What do we want to achieve?

- Empower young people to make positive choices when it comes to alcohol and drug use.
- Increase the number of adults receiving brief interventions and harm minimisation advice for drug and alcohol misuse.
- Clear and consistent communication messages in relation to drugs and alcohol to ensure people receive the right messages at the right time. This includes local implementation of national campaigns.

How will we get there?

- Utilise a partnership approach to provide a sustainable prevention offer to schools in relation to drug and alcohol misuse.
- Review the Alcohol Risk Reduction Scheme and its outcomes and utilise the findings to develop a revised offer that has a greater reach.
- Develop a coordinated and consistent approach across relevant partners to communications relating to drugs and alcohol.

Priority 2:

Develop a coordinated approach to early identification of individuals exposed to the harmful effects of drug and/or alcohol misuse.

Where we are now?

Adverse Childhood Experiences (ACEs) are events that have a traumatic and lasting effect on the physical and/or mental health of young people which subsequently impact on the health and wellbeing of these individuals in adulthood. Examples include abuse, neglect, substance misuse within the household and bereavement. The evidence suggests that 4 or more adverse childhood experiences results in a 4-fold increase in the likelihood that a person will use illicit drugs and a 7-fold increase in the probability that a person will develop an alcohol addiction. Locally, over half (54%) of adults in treatment have and/or live with children. The Leicestershire Children and Families Partnership Plan (2018-21) focuses on 5 priorities, one of which is to keep children safe and another is to enable children to have good physical and mental health with an emphasis on developing an approach to ACEs.

In recognition that support is better delivered by considering the needs of the whole family, the Children and Family Services Department provides early help support through the Children and Family Wellbeing Service. The Services delivers a range of support to families including group work and one to one support according to the assessed needs of the family.

Alongside this, Public Health commissions the 0-19 Healthy Child Programme which includes the provision of support through Public Health Nurses (Health Visitors and School Nurses) and through digital communications (text messaging service and a website of information for parents and young people). A range of support is provided based on the level of need. This includes a multi-agency approach to support children and young people and their families where substance misuse is identified.

There is clear evidence that a large amount of work is taking place to support children, young people and their families during the early stages of difficulties, including drug and alcohol misuse. Further work is required to ensure join up between these different offers to ensure our residents receive the right support at the right time from the right professionals, and to minimise duplication of provision.

The evidence shows that 85% of individuals within Leicestershire who may benefit from specialist treatment for alcohol misuse are not in treatment and 51% of opiate users and 68% of crack users are not in treatment. This evidence indicates a gap in identifying individuals with alcohol and/or drug dependency and a gap in referring these individuals into treatment services. For many individuals misusing drugs and/or alcohol, engaging in treatment can be the catalyst for getting the help they need to address other issues such as their physical health, mental health, housing and financial issues which can have a significant impact on the individual and on wider society.

The NHS Long Term Plan makes reference to establishing Alcohol Care Teams in hospitals that have the highest rate of alcohol dependence-related hospital admissions. If made available locally, these teams have the potential to enhance local provision by working in partnership with local authority commissioned drug and alcohol services.

What do we want to achieve?

- A reduction in the impact of parental alcohol and/or drug misuse on children.
- An increase in the number of individuals referred into substance misuse treatment services.
- A reduction in the number of hospital admissions for alcohol related ill health.

How will we get there?

- LCC Public Health and Children and Family Services to continue to work in partnership to strengthen the 'whole family' approach to those exposed to the harmful impact of drug and/or alcohol misuse.
- Optimise the link between the commissioned drug and alcohol treatment service and local alcohol care teams once they are established..

Priority 3:

Develop an approach to the provision of treatment and recovery services that is responsive to the changing trends in drug and alcohol addiction among residents of Leicestershire.

Where we are now?

The evidence shows that there is an increasing problem of misuse and dependence associated with some prescription and over-the-counter medicines. Nationally, the number of individuals in drug treatment for problems with prescribed, or over-the-counter medicines has increased year on year since 2009 with opioids cited as the most common cause. Locally, it is estimated there are in the region of 10,000 long-term prescribed opioid users across Leicester, Leicestershire and Rutland. This cohort represents a large number of individuals who are at-risk of developing dependency on prescribed drugs. Also, in 2017/18, there were 112 individuals in treatment services who cited addiction to a prescription only medicine or an over-the-counter medicine in Leicestershire, which accounts for 8% of those in treatment.

Other new patterns of drug use and health risk behaviour are also becoming established, including drug use alongside high-risk sexual behaviour (often referred to as Chemsex). This practice is more common in men who have sex with men and can have an adverse impact on their health and wellbeing. Currently, very little information is known on the prevalence of Chemsex amongst the population of Leicestershire. Another emerging pattern of drug misuse is the misuse of anabolic steroids which has increased year on year since 2007/08.

There are also specific cohorts of the population who are disproportionately affected by substance misuse. Locally, 1 in 5 individuals accessing treatment services are referred from criminal justice services. Meeting the health needs of people in contact with the criminal justice system can help to achieve reductions in crime, reduce offending and improve the individual's health. Locally, NHS England commissions a substance misuse treatment service within HMP Leicester which is provided by the same treatment provider as that of the community treatment service.

This setup has strengthened continuity of care for those released from prison with engagement exceeding national figures (64% vs 32%).

An additional at-risk cohort is those who are homeless. Evidence suggests an increase in the use of new psychoactive substances among those who are homeless and that a third of all deaths of homeless people in 2017 were due to drug poisoning.

The HM Government Drug Strategy (2017) places emphasis on facilitating a joined-up approach to commissioning a wide range of drug and alcohol services. The strategy also places emphasis on helping people attain wider social and personal resources which promote recovery. These include employment, housing, financial security, social networks and good health and wellbeing. Data from the local treatment service indicates that:

- 64% of individuals in treatment report being unemployed or on long-term sick
- 16% of individuals in treatment report a housing problem
- 50% of adults in treatment report a mental health treatment need and out of these, 13% are not receiving treatment for their mental health need.
- 32% of young people in treatment report a mental health treatment need and out of these, 24% are not receiving treatment for their mental health need.
- 49% of adults and young people in treatment report smoking tobacco and only 0.3% received a smoking cessation intervention. Smoking prevalence among Leicestershire residents accessing substance misuse treatment services is significantly higher than that of the general population of Leicestershire (12%).

It is likely that the above data is an underestimate as it does not capture information on those who are not in treatment. For example, there are large numbers of individuals accessing Adult Social Care Services who have a dual diagnosis of substance misuse and mental health issues who find it difficult to maintain engagement with treatment services and therefore place a heavy burden on public sector services.

Historically, the responsibility for local drug and alcohol services fell to Drug and Alcohol Action Teams which were funded predominantly by a Pooled Treatment Budget via the National Treatment Agency for Substance Misuse (A special health authority within the NHS). Following the Health and Social Care Act 2012, the functions of the National Treatment Agency transferred to Public Health England and in 2015/16, a condition was added to the public health grant which required local authorities to provide an accessible drug and alcohol treatment and recovery service as part of their duty to reduce health inequalities and improve the health of the local population.

Alongside this change, NHS England has the responsibility for commissioning healthcare across all secure and detained settings which includes the provision of substance misuse treatment services in prisons, and Clinical Commissioning Groups have the responsibility for commissioning healthcare services.

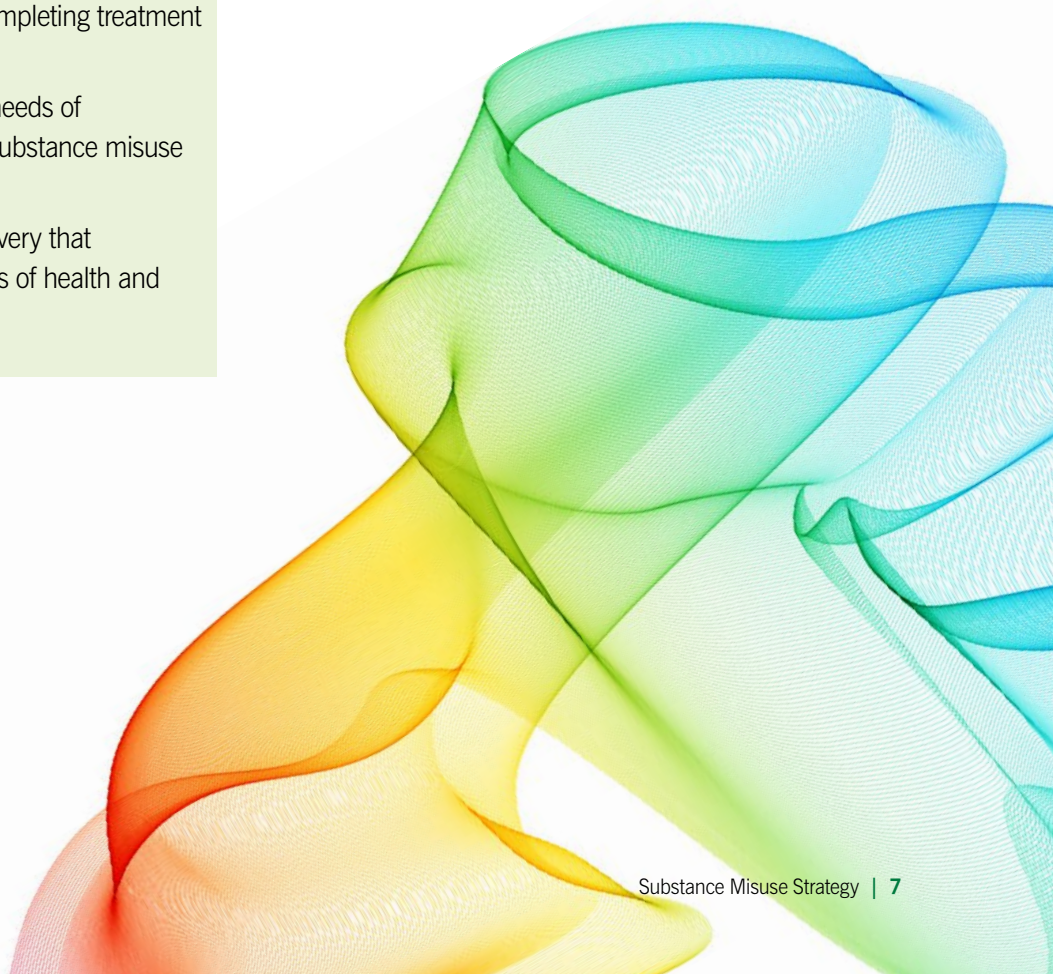
Considering the ongoing financial pressures placed on individual organisations and a risk of fragmentation of services, further work is needed to explore opportunities to integrate substance misuse service provision across all commissioners to ensure that the system is responsive to the needs of the local population and meets the physical and mental health needs of individuals while also placing a strong emphasis on recovery. This also has the potential to reduce the burden on public sector services from people who are frequent users of these services.

What do we want to achieve?

- Joined up commissioning of substance misuse services, including across organisational boundaries, that is patient-centred, equitable, takes a life-course approach and is evidence-based.
- Seamless pathway for individuals accessing support for substance misuse issues leading to an increase in those successfully completing treatment and maintaining recovery.
- A strengthened response to the needs of individuals with dual diagnosis (substance misuse and mental health issues).
- A strengthened approach to recovery that addresses the social determinants of health and wellbeing

How will we get there?

- An agreed approach to commissioning substance misuse services over the next 3 years with endorsement from all commissioning organisations.



Priority 4:

Reduce ill health and deaths as a result of alcohol and drug misuse.

Where we are now?

The local treatment service provides an array of harm reduction interventions. For example, individuals receiving treatment support for opioid addiction (e.g. heroin addiction) are encouraged by the treatment service to keep an accessible supply of naloxone which is crucial in reversing the effects of opioid overdose. Family members are also encouraged to do the same should the need arise for this treatment to be administered. Other harm reduction interventions available locally include:

- Blood borne virus screening (e.g. Hepatitis C testing), immunisation and support
- Needle and syringe exchange programmes
- Safer injecting information and support
- Sharps bins for the safe disposal of used injecting equipment

Harm reduction also encompasses mental health support. Leicestershire County Council has recently launched a campaign (Start a Conversation) to help break the stigma around suicide, encouraging people to be more open about their worries and showing them where to seek help. The campaign includes the provision of a website that gives people information on where to get help in a crisis, as well as providing information on how to maintain good mental health and how to support others in need.

In addition to harm reduction interventions, the local substance misuse treatment service conducts a thorough review of all drug-related deaths of its service users to identify lessons learned and implement any changes required to service provision. However, there isn't currently a coordinated approach to reviewing drug related deaths for those not accessing treatment services. Drug misuse is a significant cause of premature death and is entirely preventable. Locally, during the period 2015-17 there were almost 4 times more deaths from drug misuse in males compared to females which highlights a need for a coordinated approach to the review of drug-related deaths in Leicestershire.

What do we want to achieve?

- Reduce the risk of drug-related harm among Leicestershire residents
- Reduce the number of drug-related deaths occurring among Leicestershire residents.

How will we get there?

- Ensure that harm reduction interventions form an ongoing component of substance misuse treatment provision.
- Develop a partnership approach to the review of drug related deaths among Leicestershire residents to identify lessons learned and respond to these in a systematic way.

Priority 5:

Ensure a joined up and timely response to changing patterns of substance misuse and emerging issues relating to substance misuse.

Where are we now?

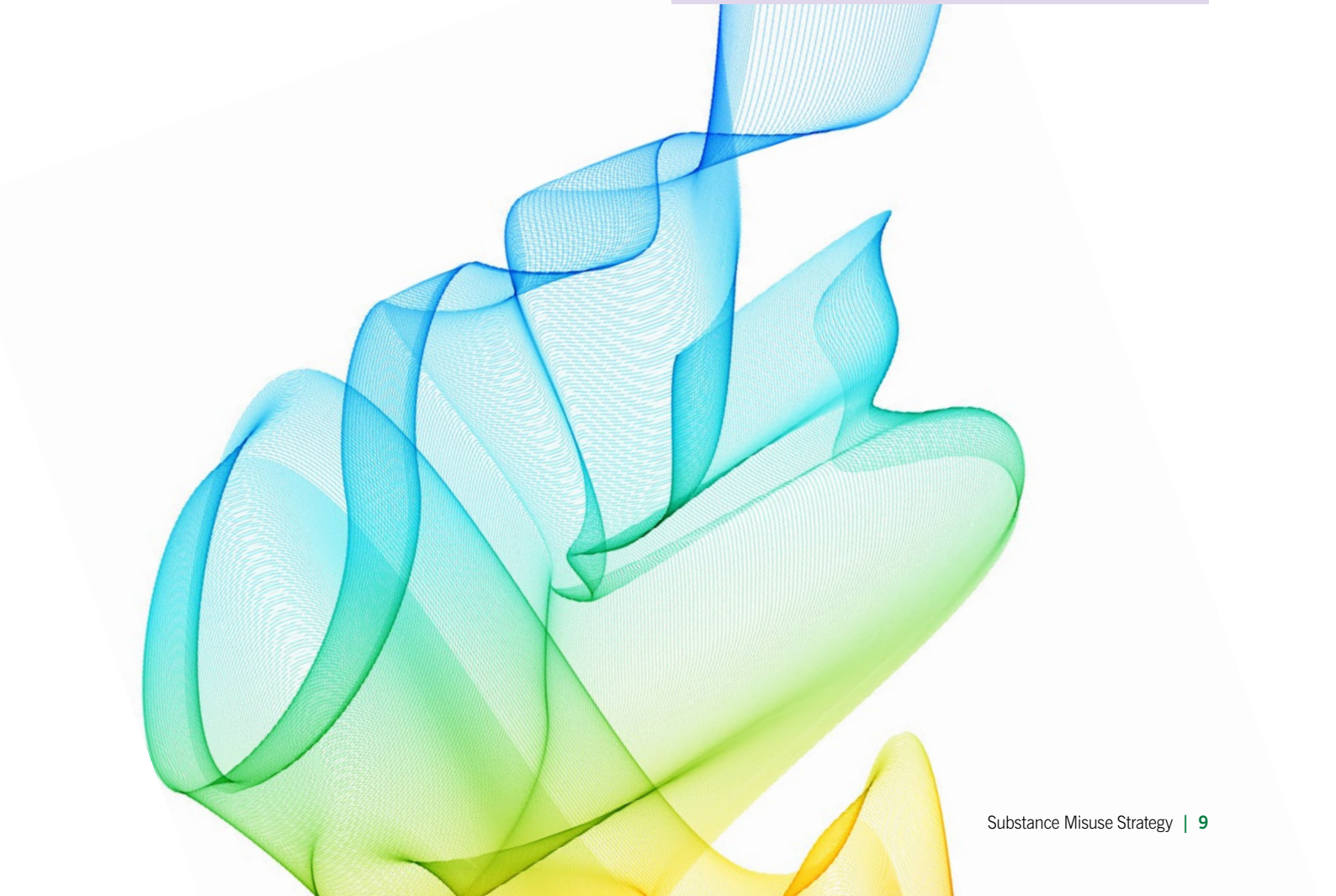
Currently, there is not a forum for local service providers, commissioning organisations and partners to jointly discuss and manage changing patterns of substance misuse (e.g. New Psychoactive Substances) and emerging issues specifically relating to substance misuse such as County Lines (gangs and organised criminal networks involved in exporting illegal drugs into small towns, usually exploiting children or vulnerable adults to conduct their activity). This has the risk of impeding the development of a timely response to issues and could also lead to fragmentation and duplication of work delivered across all partners.

What do we want to achieve?

- Close monitoring of and timely response to the changing patterns of substance misuse and substance misuse related issues using a multi-agency approach.

How will we get there?

- Develop a substance misuse partnership group involving local service providers, voluntary sector organisations, commissioning organisations and partners, that meets quarterly and can feed effectively into strategic groups such as the Health and Wellbeing Board, Leicestershire Safer Communities Strategy Board and the Strategic Partnership Board.



Key activities to deliver this approach

To ensure the strategic approach is delivered we will;

- **Develop new ways of partnership working**. An approach to this has been described under priority 5.
- **Keep partners informed of progress.** We will develop a detailed implementation plan which will be regularly reviewed and updated to track progress. The strategy's implementation and progress will be monitored by the Director of Public Health within LCC and regularly communicated to key stakeholders via substance misuse networks and relevant meetings/Boards.
- **Monitor performance through delivery of the implementation plan and development of a substance misuse dashboard.** The key public health indicators to assess whether this strategy has made a difference are presented as part of the Public Health Outcomes Framework. These include: proportion of individuals with substance misuse issues who are not in treatment, parents in drug treatment, successful completion of treatment, hospital admissions due to substance misuse, deaths from drug misuse and waiting times for accessing treatment services. Information will be collated to produce an annual progress update against the implementation plan and to review how this has translated to improved outcomes across Leicestershire.

Notes

Leicestershire County Council