MEETING OF THE HEALTH AND COMMUNITY INVOLVEMENT SCRUTINY COMMISSION

DATE: MONDAY, 31 OCTOBER 2011
TIME: 2:00 pm
PLACE: THE TEA ROOM - FIRST FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER

Members of the Commission

Councillor Cooke (Chair)
Councillor Sangster (Vice-Chair)

Councillors, Dr Chowdhury, Fonseca, Gugnani, Kamal, Naylor and Westley
(One vacancy)

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

Elaine Baker

For Director of Corporate Governance

Officer contact: Elaine Baker
Democratic Support, Leicester City Council
Town Hall, Town Hall Square, Leicester LE1 9BG
(Tel. 0116 229 8806 Fax. 0116 229 8819)  
(e-mail elaine.baker@leicester.gov.uk)
INFORMATION FOR MEMBERS OF THE PUBLIC

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There are certain occasions when the Council's meetings may need to discuss issues in private session. The reasons for dealing with matters in private session are set down in law.

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If there are any particular reports that you would like translating or providing on audio tape, the Democratic Services Officer can organise this for you (production times will depend upon equipment/facility availability).

INDUCTION LOOPS
There are induction loop facilities in meeting rooms. Please speak to the Democratic Services Officer at the meeting if you wish to use this facility or contact them as detailed below.

General Enquiries - if you have any queries about any of the above or the business to be discussed, please contact Elaine Baker, Democratic Support, on (0116) 229 8806 or email elaine.baker@leicester.gov.uk or call in at the Town Hall.

Press Enquiries - please phone the Communications Unit on 252 6081
PUBLIC SESSION

AGENDA

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda, and/or indicate that Section 106 of the Local Government Finance Act 1992 applies to them.

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 20 September 2011 are attached and the Commission is asked to confirm them as a correct record.

4. PETITIONS

The Director of Corporate Governance to report on the receipt of any petitions submitted in accordance with the Council’s procedures.

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Director of Corporate Governance to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council’s procedures.

6. LOROS QUALITY ACCOUNT 2010/11

Representatives from LOROS will be at the meeting to present the LOROS Quality Account for 2010/11. (Appendix B1).

The Department of Health (DoH) requires a Quality Account to be produced for various providers. This Account must include any written statements sent to those providers from the appropriate commissioning primary care trust, Local Involvement Network and/or overview and scrutiny committee in relation to their view of the provider’s Quality Account. Space has been provided at the end of the Account for this Commission’s statement.

It should be noted that the DoH requires both prescribed and mandatory terminology to be contained in the Account, which LOROS has endeavoured to follow.

Regulations state that any statement given by the Commission should be no longer than 500 words.
When the final version of the Quality Account is published, it should include an explanation of any changes made to the final version that were made subsequent to (and possibly as a result of) the statements provided.

The Quality Accounts Toolkit provides best practice advisory guidance for providers of NHS services to make use of during the production and publication of Quality Accounts in 2010. Regulations 5, 8, 9 and 10 explain the information which should be contained in a statement. These regulations are attached for information. (Appendix B2).

If Members are interested in viewing the full Quality Accounts Toolkit, it can be accessed at the following location:

The Commission is recommended to consider the LOROS Quality Account for 2010/11 and whether it wishes to provide a statement on its view of this Account.

7. PRESENTATION BY MALCOLM LOWE-LAURI, CHIEF EXECUTIVE OF UNIVERSITY HOSPITALS NHS TRUST

Malcolm Lowe-Lauri, (Chief Executive, University Hospitals Leicester Trust), will provide an overview of his role and discuss how the Trust can work with the Commission.

8. HEALTHWATCH

Leicester Local Involvement Network (LINk) has been invited to the meeting to explain how LINk will develop in to Healthwatch as part of the forthcoming reforms to the National Health Service.

9. REVIEW OF WORKING AGE ADULT MENTAL HEALTH SERVICES

a) Representatives of the Akwaaba Mental Health Project will be at the meeting to talk about the services provided by the Project and how they benefit the residents of Leicester. (See Appendix C1)

The Commission is asked to receive the presentation and consider how the issues raised can inform the review proposed under b) below.

b) The Commission’s first scheduled review is to re-visit the 2010 scrutiny review of mental health services for working age adults. A draft scoping document for this review is attached. (Appendix C2)

The Commission is asked to consider this, making any comments and/or amendments considered necessary, and to determine how this review should proceed.
10. **WORK PROGRAMME**

The Members’ Support Officer submits a document that outlines the Health and Community Involvement Scrutiny Commission’s Work Programme. The Commission is asked to consider the programme and make comments and/or amendments as it considers necessary.

11. **UPDATE ON ITEMS ON THE FORWARD PLAN OF KEY DECISIONS**

The Director of Corporate Governance submits an update on the progress of items relevant to this Commission that are included on the Council’s Forward Plan of Key Decisions. The Commission is recommended to note this update and comment as appropriate.

12. **ITEMS FOR INFORMATION**

The Commission is recommended to receive and note the following items, which are submitted for information only:-

<table>
<thead>
<tr>
<th>Title</th>
<th>Item</th>
<th>Appendix (where applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update on National Health Service Reforms</td>
<td>The Director of Public Health will provide a brief update on progress with the National Health Service reforms</td>
<td></td>
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<tr>
<td>Shadow Health and Wellbeing Board – Terms of Reference</td>
<td>This paper was requested at the meeting of this Commission held on 20 September 2011</td>
<td>F1</td>
</tr>
<tr>
<td>Shadow Health and Wellbeing Board – Public Health Priorities &amp; Expectations of Health Providers</td>
<td>This paper was requested at the meeting of this Commission held on 20 September 2011</td>
<td>F2</td>
</tr>
<tr>
<td>Health Inequalities Improvement Plan</td>
<td>This paper was requested at the meeting of this Commission held on 20 September 2011</td>
<td>F3</td>
</tr>
<tr>
<td>Glossary of National Health Service Terms</td>
<td>This was requested at the meeting of this Commission held on 20 September 2011. Appendix F4 is taken from information</td>
<td>F4 &amp; F5</td>
</tr>
<tr>
<td>Centre for Public Scrutiny (CfPS): Newsletter for Health, Care and Wellbeing Scrutiny</td>
<td>produced by the Department of Health in July 2003. (Taken from: Overview and Scrutiny of Health – Guidance) Appendix F5 also was produced by the Department of Health for use within the National Health Service, but may be of use to Members. (Taken from: Quality Accounts Toolkit 2010-11)</td>
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<td>13. ANY OTHER URGENT BUSINESS</td>
<td>If Members would like to receive this electronic newsletter, they can register for it via the following link: <a href="http://www.cfps.org.uk/news/e-newsletters/">http://www.cfps.org.uk/news/e-newsletters/</a> If preferred, the newsletter can be read on the CfPS website, by following the same link.</td>
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Minutes of the Meeting of the
HEALTH AND COMMUNITY INVOLVEMENT SCRUTINY COMMISSION

Held: TUESDAY, 20 SEPTEMBER 2011 at 2.30 pm

PRESENT:

Councillor Cooke – Chair
Councillor Sangster – Vice Chair

Councillor Dr Chowdhury
Councillor Fonseca
Councillor Gugnani
Councillor Kamal
Councillor Naylor

Also present:

Councillor Alfonso
Councillor Sood (Assistant City Mayor (Health and Community Involvement)

IN ATTENDANCE:

Eric Charlesworth – Leicester Local Involvement Network
Laura Dennis – Communications Team, University Hospitals of Leicester NHS Trust
Ben Smith – Voluntary Action Leicester

*** * * ***

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Westley and from Michael Smith of the Leicester Local Involvement Network.

2. DECLARATIONS OF INTEREST

Councillor Naylor declared a personal interest in the general business of the
meets in that he was a Shadow Governor on the Leicester Partnership Trust.

3. WELCOME AND INTRODUCTIONS

Councillor Cooke welcomed all present to the first meeting of this Commission. He explained that it was hoped to develop a two-year work programme and that members of the Commission would fully participate in in-depth scrutiny of the issues identified.

All present then introduced themselves.

Councillor Cooke explained his intention to explore how the range of organisations that the Commission liaised with could be maximised. Any suggestions of relevant organisations for inclusion in this would be welcome.

4. PETITIONS

The Director of Corporate Governance reported that no petitions had been received.

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Director of Corporate Governance reported that no questions, representations, or statements of case had been received.

6. PRESENTATION BY THE ASSISTANT CITY MAYOR WITH RESPONSIBILITY FOR HEALTH AND COMMUNITY INVOLVEMENT

Councillor Sood, Assistant City Mayor with responsibility for Health and Community Involvement, thanked the Commission for inviting her to address the meeting and for providing the opportunity to explore how everyone could work together for the benefit of the health and involvement of the people of the City.

Councillor Sood drew attention to the following points:

- The information circulated with the agenda on this item formed the basis of her portfolio, but her actual responsibilities changed as needs arose;

- It was recognised that the population of Leicester had very high health needs, with more disadvantaged communities having poorer levels of health. There was a diverse range of communities in the City, many of which had their own health problems;

- Local authorities would have responsibility for public health from 2013, at which time Primary Care Trusts would cease to exist. In preparation for this, public health staff would be physically located in City Council offices at New Walk Centre from Autumn 2011 and a Shadow Health and Wellbeing Board had been established;
• The City Council was monitoring progress with the establishment of Public Health England and the disestablishment of the Public Health Agency that it was replacing;

• The wide range of issues that had implications for health and wellbeing meant that an integrated approach was needed with the holders of all Cabinet portfolios;

• There were various performance indicators against which the Council had to monitor performance and show that changes had been made that improved life for people in the City. This would be achieved in various ways, such as through the Healthy Heart campaign that recently had been launched by the City Mayor;

• Closer working partnerships were needed between the National Health Service, the City Council and local organisations;

• It was hoped that young people could be encouraged to look after their own physical and mental health, for example through increased participation in sport;

• The City Mayor had included various pledges in relation to health and community involvement in his 100 Days programme. Issues raised at the regular Meet the Mayor events across the City would supplement these;

• The Council wanted to work closely with the voluntary sector to deliver its programmes. There was a well-established voluntary sector in the City, but some issues and concerns remained, so a Compact Steering Group had been set up to address these.

Various points were then raised during discussion on this item:-

• Responsibility for health issues was shared between Councillor Sood and the City Mayor. For example, the City Mayor chaired the Shadow Health and Wellbeing Board, which would set priorities and consider how the Council’s public health responsibilities would be delivered when the forthcoming National Health Service reforms were implemented;

• All Members had been given a profile of health issues for their own Wards and were welcome to suggest issues arising from these for consideration and, where appropriate, investigation;

• The future role of the voluntary sector in the work of this Commission could be a suitable review topic. This could include issues such as how these groups operated and where leadership on certain issues should come from. It was important though to recognise the scale of the voluntary sector and celebrate all its elements while working closely with it;

• A fair procurement system was needed, to ensure that services and
expertise offered by these organisations was not lost;

- Some people felt more comfortable working with the voluntary sector than with a body such as the National Health Service or the Council, so it was important to ensure that this sector was maintained;

- The inclusion of other groups in the work of this Commission could extend to organisations such as the Youth Council, (which was chaired and run by young people and discussed issues raised by the young people themselves), and older people, (for example through the Forum for Older People);

- Without carers, pressures on organisations would increase significantly, but carers often did not get the consideration they needed and deserved. For example, as well as giving day-to-day care, they could have to cope with the side effects of medication taken by those being cared for. This could have implications for carers’ physical and mental health and wellbeing. Organisations such as CLASP (the Carers of Leicestershire Advocacy and Support Project), also were concerned with these issues;

- Although many aspects of the portfolio currently were described in very general terms, it would be useful to have ways of measuring the impact made by the work being done through this portfolio. However, it was recognised that outcomes of work in relation to public health related to lifestyle factors, which could be difficult to quantify, although some measures were available, such as the number of people who smoked;

- It would be beneficial to have a Meet the Mayor event in each Ward, as all Wards were different. It was recognised that it was not possible to hold such an event in every Ward during the first year of the City Mayor’s term of office but, as a compromise, when a Meet the Mayor event was held in a particular Ward, the Ward Councillors for adjoining Wards were invited to the event;

- It was important to work with other organisations and groups to add value to the Commission’s direction of travel and to hold each party to account, particularly when an action or priority had not been delivered. To enable efficient work programming to be undertaken, the Commission needed to be aware of when issues arose, for example from the Council’s Forward Plan of Key Decisions;

- Links needed to be established with the Shadow Health and Wellbeing Board, as its work programme would be a useful aid in developing the Commission’s own work programme.

7. PRESENTATION BY THE DIRECTOR OF PUBLIC HEALTH

Deb Watson, Director of Public Health, explained that the Director of Public Health was required to produce an annual report of the state of public health in
the area they served.

Deb Watson then gave a presentation on the Health Agenda in Leicester and the forthcoming National Health Service Reforms, a copy of which is attached to these minutes for information, drawing particular attention to the following points:-

- Life expectancy was not increasing as quickly in Leicester as it was nationally. Therefore, the gap between national life expectancy and life expectancy in Leicester was widening. However, this was not uniform across the whole City, with life expectancy for those in the most deprived quartile being significantly lower than for the most affluent people;

- The index of deprivation showed that the majority of Leicester had greater levels of deprivation than the rest of the country. This was very significant in terms of the health of the residents;

- A national review had suggested a model that showed the factors that influenced health. Although influences in themselves, lifestyle factors were deeply embedded in social and community networks. For example, influences could include eating habits, whether someone came from a household containing smokers, or whether a person’s parents played sport. The review had found that influences benefitting health tended to be more positive amongst more affluent people and more negative amongst those who were less affluent;

- It was important to encourage people to take up preventative care. The City Council was in a position to promote this, through its directly provided services and its partnerships with other groups and organisations;

- The Health Inequalities Improvement Plan aimed to accelerate improvements in public health. This recognised that it was not possible to take action on all issues and that things could take a long time to change. The Plan therefore sought to identify where value could be added to services already being provided; and

- Evidence showed that people’s health could deteriorate after a recession such as that currently being experienced, as unemployment and reduced income could have a detrimental effect on people’s health.

The following points were made in discussion and in response to questions from the Commission:-

- The best way to make big changes to people’s health was to motivate them to look after themselves during their lifetime. Approaches to this that were very tailored to individual needs were very successful, (for example, such as Fit and Active Braunstone);

- The number of obese people was of concern. One reason for current levels of obesity had been identified as that people did not know how to
prepare fresh food. Although cooking skills were being reintroduced in to schools because of this, other factors, such as doing less physical activity and the marketing of high calorie food, also were influences on obesity levels;

- The possibility of extrapolating information by ethnicity would be easier in some wards than others, as more data had been collected in some wards than others. This data was very important, given the City’s demographic profile and the lack of it from some areas highlighted shortcomings in data collection methods, as many communities were spread across the City, rather than being focussed in particular wards;

- Data on drug and alcohol misuse was collected from a variety of sources. For example, surveys and data on alcohol-related admissions to hospitals and deaths could be used to help identify underlying trends;

- A range of processes were in place through which the City Council currently worked with the voluntary sector. This not only included listening to, and consulting with, such organisations, but involved them in high level work, such as assessing the health needs of groups such as asylum seekers and travellers as part of the Strategic Needs Assessment. Some services also were commissioned from the voluntary sector and it provided advice on commissioning;

- Work was done in specific localities and/or communities to help people address issues that affected their own lives. Some of this was done by staff based in some of the more deprived areas of the City. It included things such as working with employers that had a large number of manual or unskilled workers to address health issues, as it had been found that there tended to be a high incidence of certain types of health issues amongst these workers, (for example, high levels of smoking and the problems this created);

- At present, there were no plans in the health authorities’ budgets to reduce the number of development workers, but responsibility for them would transfer to councils in 2013 and it was not known at this stage at what level funding would continue; and

- Currently, it was only possible to work intermittently on Health Impact Assessment Plans, so it could be useful for the Commission to examine what stage these were at and how they could be developed.

Deb Watson then gave a presentation outlining the current position on the forthcoming reforms to the National Health Service, a copy of which is attached at the end of these minutes for information. Particular attention was drawn to the following points:-

- Primary Care Trusts currently bought services from hospitals (which were independent trusts) and held the hospitals to account. Other providers included GPs, mental health services and ambulance services;
• Local Involvement Networks would develop in to locally based Healthwatch organisations;

• Although National Health Service funding for health care services, such as medicines, was likely to remain at its current level, changes to the population meant that an increase of approximately 4% per year was needed to continue to provide health care services at their current level. These costs would remain with the National Health Service following the reforms to be implemented in 2013, so it would need to increase clinical efficiency in order to cover the increased costs;

• It originally had been proposed that, following the reforms to be implemented in 2013, health care would be commissioned by GPs, but this had now changed, so they would not be the only commissioners. Instead, health care services would be commissioned by Clinical Commissioning Groups. These still would be clinically led, (for example, by doctors and nurses). The Director of Public Health was a non-voting member of the Board of the Leicester City Clinical Commissioning Group;

• Much of the detail of the transition of public health services to local authorities was not known yet, so it was not clear exactly which services would be transferred; and

• As a start to the process of transition, public health staff would be relocated to New Walk Centre in October 2011, although they would remain employed by the National Health Service until 2013.

RESOLVED:
that the following documents be presented to the Commission for consideration:-

a) the Health Inequalities Improvement Plan;

b) the terms of reference and priorities for the Shadow Health and Wellbeing Board; and

c) details of the priorities identified by the Shadow Health and Wellbeing Board for accelerating improvements in public health.

8. WORK PROGRAMME

The Commission received a draft work programme for 2011/12.

It was noted that it was suggested that a public meeting should be held in the autumn, at which the experiences and views of users of health services could be obtained. Information on the issues that were important to them could then be used to inform the work programme and set priorities.
The following points were made in discussion on this item:-

- Due to the nature of some of the issues suggested for inclusion in the work programme, it was envisaged that the programme would be a rolling one, covering the next two years;

- It was important to maintain an overview of the forthcoming reforms to the National Health Service;

- It would be useful to identify timescales for reports to meetings of the City Mayor and Cabinet, so that the Commission’s work programme could reflect these;

- An informal meeting had been held to consider how the current arrangements for the joint overview and scrutiny of health by this Council, Leicestershire County Council and Rutland County Council could be reviewed, but no decisions had been taken to date; and

- In addition to the items already listed in the work programme, it would be useful for the Commission to consider the following items:-
  
  o the failure of some GPs to make home visits;
  
  o the Primary Care Trust’s Fit for Purpose programme. This had been established following the ending of the Local Improvement Finance Trust (LIFT) programme as, of the 19 GP surgeries that were not fit for purpose, only 8 would be rebuilt; and
  
  o the stigma that was still attached to many things such as mental health issues, diabetes and epilepsy.

RESOLVED:

1) that a discussion meeting be held at 2.00 pm on Wednesday, 23 November 2011 with service users and health organisations to find out what issues are important to these groups, this information to be used to inform the Commission’s work programme and set priorities;

2) that the Health and Community Involvement Scrutiny Commission’s work programme be approved, subject to the inclusion of the items listed above; and

3) that the Chair and Vice-Chair of the Health and Community Involvement Scrutiny Commission liaise with officers to prioritise the issues included in the work programme.

9. DATES OF FUTURE MEETINGS

RESOLVED:

1) that, at least initially, meetings of the Health and Community
Involvement Scrutiny Commission be held 6-weekly; and

2) that the next meetings of the Health and Community Involvement Scrutiny Commission be held at 2.30 pm on Monday, 31 October 2011 and Wednesday, 14 December 2011.

10. ANY OTHER URGENT BUSINESS

PAEDIATRIC CONGENITAL CARDIOLOGY CARE REVIEW

The Chair agreed to accept this item as urgent business in accordance with Scrutiny Procedure Rule 15, (Part 4F of the Council’s Constitution), to enable it to be considered before a final decision was taken on this matter.

Eric Charlesworth, of the Leicester Local Involvement Network (LINk), updated the Commission on progress with the government review of paediatric congenital cardiology care. He explained that the government had decided to reduce the number of hospitals providing this service, but Glenfield Hospital, where the service currently was located, had only been included in one of the four options for the new arrangements, (Option A).

A campaign had been mounted to persuade the government to favour Option A and there had been very strong public support for this. However, the outcome of the review had been the recommendation that the unit at Glenfield Hospital should close and the services transferred to Birmingham.

Mr Charlesworth explained that there were some concerns about the way in which the review had been conducted and that the views of the public had not been taken in to account. For example, two public consultation sessions had been held in the City, but at both the Chairman of the review had stated that he felt that the services should transfer to Southampton, even though the review had not been completed at that stage. The Chairman had been challenged very strongly about this at the events and a formal complaint had been lodged with the Department of Health. The Department’s response had been very disappointing, only stating that these were the personal views of the Chairman.

Comments could be made on the published recommendations by 5 October 2011. Leicestershire County Council had convened a meeting of its Adults, Communities and Health Overview and Scrutiny Committee to consider comments and had asked a representative from the Working Group that had undertaken the review to attend the meeting.

Mr Charlesworth advised the Commission that the Chief Executive of the University Hospitals of Leicester NHS Trust had offered to make a presentation to the Scrutiny Commission on his concerns about the recommendations made following this review.

RESOLVED:

that the Chair and Vice-Chair of the Health and Community
Involvement determine what action should be taken in response to the findings of the review of paediatric congenital cardiology care.

11. CLOSE OF MEETING

The Chair thanked everyone for attending and closed the meeting at 4.51 pm
The Health Agenda in Leicester

Health and Community Involvement Scrutiny Commission
Leicester City Council
20 September 2011

Deb Watson
Director of Public Health and Health Improvement
NHS Leicester City and Leicester City Council

Improving Health in Leicester
Annual Report of the Director of Public Health and Health Improvement 2010
Outline

Part 1
- Overview of Health Inequalities in Leicester
- Role of the Council in improving health
- Health Inequalities Improvement Plan
- Key Challenges

Part 2
- NHS Reforms – Headline changes
- Healthy Lives, Healthy People – Implications of the Public Health White Paper
- Conclusions, questions and discussion

Life Expectancy

What is Known:
- Life expectancy in Leicester is lower than England for both males and females.
- Male LE in Leicester has increased by 2 years from 73.4 (1997-99) to 75.4 (2007-09); MLE in England has increased by 3.16 years from 1997-09 to 2007-09.
- Male LE gap between Leicester and England has risen from 1.7 years from 1997-09 to 2.8 years in 2007-09.
- Female LE in Leicester has increased by 1.3 years from 78.7 in 1997-09 to 82.0 in 2007-09; FLE in England has increased by 2.3 years from 80.0 years 1997-99 to 82.3 years in 2007-09.
- Female LE gap between Leicester and England has increased from 1.3 years in 1997-99 to 2.3 years in 2007-09.

Implications:
- Life expectancy in Leicester is increasing at a slower pace than nationally, increasing the gap between Leicester and England.
What is known:
Life expectancy is related to deprivation.
Life expectancy (LE) in Leicester is 2.9 years lower than the England average for males and 2.4 years lower for females.
LE varies across the city, with generally lower rates in the west of the city; there is a gap of around 8 years for males and 6 years for females between wards with the highest and lowest life expectancy.

Implications:
Although life expectancy in Leicester has improved, levels of deprivation have meant that it has improved more slowly than nationally, resulting in a widening of the health inequalities gap.
This is a key summary measure for the state of health in Leicester.

Health and Deprivation

Life Expectancy at birth (years) in Leicester City by deprivation quintile, 2005-2009

Local population deprivation groups

Male Female
Index of Deprivation 2010

Factors which influence health

Dahlgren & Whitehead 1991
Health Issues – summary

- Poor health is a big strategic issue for Leicester
- More people dying young, esp. in more deprived communities.
- Inequalities gap is not narrowing. Leicester vs England or within Leicester
- Important to accelerate improvements in:
  - Lifestyle factors - smoking, physical activity, diet, healthy weight, alcohol. Higher rate of deaths caused by smoking in Leicester
  - Care services – access, take-up and quality of services, esp. preventative care provided by GPs and early treatment
  - Wider determinants of health - educational attainment, skills, employment, housing, transport, crime etc
- Priorities with short term impact = smoking and more preventative care, esp by GPs
- Priorities with medium and longer term impact = other lifestyle factors and all wider determinants of health
- Priorities agreed at 1st shadow H&WB Board meeting in August

2. Health Inequalities Improvement Plan

STOP! HELP & ADVICE 0116 295 4141 www.phleicester.org.uk
Role of the Council in Improving Health

- The NHS cannot tackle poor health alone. Health is less about medicine and more about the social, environmental and economic circumstances of people’s lives.
- Local Authorities already have many of the levers to sustain and improve health through directly provided services that are vital for health and wellbeing
- Many partnerships that the Council leads are very important for health and wellbeing
- Important to consider the impact on health inequalities of key decisions re policies and plans

Role of the Council in Improving Health (2)

- Councils have always had a key role in protecting and improving health and led on public health until 1974
- NHS Reforms signal more local authority responsibilities for health, including the lead for Public Health from April 2013
- Council will have the lead role for the new Health and Wellbeing Board including understanding health needs/priorities (via JSNA) and developing a long-term strategy with partners (Joint H&WB Strategy)
- Holding partners and service providers to account through scrutiny
- Community leadership – the role of elected members as role models and in leading local work to improve health within communities.
Health Inequalities Plan and Progress

- Health Inequalities Improvement plan in place since May 2010.
- Good progress on actions. Some improvements in short term indicators.
- Revised plan in draft for 2011/12. Identifies some 70 actions across NHS and LCC with short to medium term impacts in the following areas:
  - Smoking cessation and tobacco control
  - Healthy eating, healthy weight and physical activity
  - Reducing alcohol related harm
  - Reducing teenage pregnancy
  - Increasing access to early maternity services
  - Increasing the percentage of babies who are breastfed
  - Increasing up-take of childhood immunisations
  - Preventative care for older people
  - Health checks for people with learning disabilities
  - Housing-related health improvement
  - Primary care (GPs) improvement, including NHS Health Checks and improved primary care for people with serious respiratory illness
  - Expanding cancer screening and improve up-take
- Does not include longer term actions on wider determinants of health
- Shadow Health and Wellbeing Board to have oversight

Key Challenges

- Recession & reductions in public funding
- Time lags between action and outcome
- Targeting towards the people/places where need and benefits are greatest. Ensure take up of services by people who need them most.
- Empowering communities to take action on health
- ‘Industrial scale’ needed
- Making healthy choices easy as part of everyday life
- Long term continuous improvement of the wider determinants of health (educational attainment, skills, employment, housing, transport, crime etc) for better health in the longer term
- There is no quick fix.
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Health Transition - Background

- Abolition of Primary Care Trusts and Strategic Health Authorities in April 2013 (SHA's to clusters by Oct 2011)
- NHS Care services to be commissioned locally by Clinical Commissioning Group overseen by the new NHS Commissioning Board that will also commission some specialist services
- Provider NHS organisations to become Foundation Trusts with greater autonomy
- Specific health responsibilities transferring to Local Authorities are:
  (a) public health and
  (b) responsibility for health strategy and partnership through new Health and Well Being Board arrangements
  (c) Development of local Healthwatch
- Need to strengthen partnership through transition and beyond
- Period of significant growth in NHS funding has ended
- Demographic change, plus new medicines and technologies = approx 4% cost pressure each year for the NHS - To be found through efficiency savings across the NHS. Risks of cost-shifting
NHS Reforms
Commissioning Healthcare

- Health and Social Care Bill ‘paused’ following Health Select Committee recommendations. ‘Listening exercise’ concluded on 13th June 2011
- Government response to listening exercise published on 14th June 2011
- Creation of Clinical Commissioning Groups (CCGs) to commission healthcare - (responsible for the whole population within their boundaries. New name reflects that membership is broader than GPs)
- CCG Board to include two lay members (one patient and public involvement champion) plus at least one registered nurse and one doctor who is a secondary care specialist not employed locally)
- CCGs have new duty to promote integrated health and social care. Also new duty to promote research
- PCT Clusters to be reflected in local arrangements for NHS Commissioning Board. This will be established by October 2012 to authorise CCGs ensuring that CCGs have robust governance
- There is one shadow Clinical Commissioning Group for Leicester City. This is established as a sub-committee of the PCT
- After April 2013 Local Authorities will be mandated to ensure that NHS commissioners receive the public health advice, expertise and analysis they need

NHS Reforms
Health and Wellbeing Board

- Creation of Health and Wellbeing Boards to co-ordinate Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JH&WBS)
- The purposes of H&WB Boards is to:
  - Lead on improving the strategic coordination of commissioning across NHS, social care, and related children’s and public health services
  - Bring together the key NHS, public health and social care leaders in each local authority area to work in partnership
  - Provide a key forum for public accountability of NHS, public health, social care for adults and children
  - Deep and productive partnerships, that develop solutions to commissioning challenges...
  - Based on mutuality and co-creation. Collaboration as the norm.
  - Elected representatives, with other key local stakeholders, to be engaged in early conversations about how local services can best meet needs rather than reacting as commentators and critics
NHS Reforms
Health and Wellbeing Board (2)

- A new (and stronger) role for local government to facilitate joined up commissioning plans across the NHS, social care, public health and other local partners via Health and Well Being Boards
- H&WB Boards will have a duty to involve users and the public – strengthening of the public voice via Healthwatch
- H&WB Board to be involved in development of CCG’s commissioning plans for health care services and a stronger expectation that these will be in line with H&WB Strategy. No veto but H&WB Board can refer plans back to CCG or up to NHS Commissioning Board
- H&WB Boards will have a formal role in authorising CCGs. H&WB Board view will be taken into account in annual assessment of Clinical Commissioning Groups
- H&WB Boards will discharge executive functions of local authorities after 2013. LA to determine precise number of elected members on the H&WB Board, free to insist on having a majority of elected Councillors
- H&WB Board subject to oversight and scrutiny by existing statutory structures for Overview and Scrutiny
- First shadow Health and Wellbeing Board in Leicester on 11th August 2011, chaired by the City Mayor
NHS Reforms
Public Health Transition

- *Healthy Lives Healthy People* white paper Consultation closed 31st March 2011 with lots of uncertainties and more detail to come
- Little on Public Health in Govt Response to NHS ‘listening exercise’
- Local government to be responsible for Public Health locally from April 2013, backed by ring-fenced budgets, plus an incentivised ‘health premium’
- A new dedicated, professional public health service – Public Health England – to be set up as an executive agency of the Dept of Health, ensuring independent expert scientific advice
- Directors of Public Health employed by local authorities will be strategic leaders of these efforts (DsPH to be jointly appointed by PHE and Local authority)
- Best evidence and evaluation will be used, supporting innovative approaches to behaviour change. New research nationally
- Public Health Policy paper on 14th July 2011 clarified some important points (e.g. Public Health support to healthcare commissioning) but some aspects not yet clear - more detail to come- Policy papers through the Autumn

Public Health Transition (2)
Local progress and issues

- Important to maintain momentum in existing work and seize new opportunities that arise through changes.
- Managing local progress on Health transition is the responsibility of the PCT Cluster but this will also be overseen by the H&WB Board
- Regional DsPH leading on PH transition nationally. PH Transition assurance visit to Leicester on 28th July with good feedback. Detailed PH transition plans needed from PCTs by March 2012.
- DPH is remains a member of the PCT Exec Team, PCT Board and PCT Cluster Board through the transition as well as being a statutory member of the shadow H&WB Board and a non-voting member of the shadow Leicester City Clinical Commissioning Group Board.
- Accommodation in New Walk Centre now identified for proposed change of base for PH staff
- No change of employer until responsibilities and arrangements are clear
- ‘HR Concordat’ to be developed nationally between the Local Government Group and the NHS for staff transferring from PCTs to Local Authorities
- 3-year performance targets for public health in place during transition – important to stay focused on delivery.
Public Health Transition(3)
Local Progress and issues

- Steady investment in public health locally since 2008/09
- PCTs have lead responsibility for Public Health until April 2013 and fund public health activities and services required nationally and/or in response to local need
- Specific responsibilities transferring to LAs still to be confirmed
- Local Authority Public Health Grant to begin in 2013/14 and will be ring-fenced. Plus ‘Health Premium’ to incentivise improvement
- LA grant to be based on an allocation formula being developed by DoH. Formula and level of funding not yet known.

Conclusions

- Poor health is an important strategic issue for Leicester
- Gap is not narrowing – social justice implications
- Health is likely to worsen in light of recession
- Poor health is largely driven by deprivation and exacerbated by lifestyle factors embedded within communities
- Health Inequalities Improvement Plan in place – Good progress. Important to maintain momentum across all services and partners
- New opportunities in light of NHS Reforms.
- The Council already holds many of the levers
For more info....

- Current and previous Annual Reports of the Director of Public Health in Leicester. Also ward health profiles. Go to [www.phleicester.org.uk](http://www.phleicester.org.uk)
LOROS
Hospice Care for Leicestershire & Rutland

Quality Account
2010-2011

LOROS Sites:

LOROS Hospice
Groby Road
Leicester
LE3 9QE
Tel: 0116 231 3771
Fax: 0116 232 0312

Manor Croft Day Therapy Unit
147 Ratcliffe Road
Stoneygate
Leicester
LE2 3TE
Tel: 0116 270 7339

Website:  www.loros.co.uk

Registered Charity No:  506120
Registered company in England and Wales:  1298456
CQC Provider ID:  1-101728486

This Quality Account was endorsed by the LOROS Board of Trustees
“We think LOROS is fantastic. Staff and volunteers are amazing. We are thankful for the care of our Granddad pre and post death”
Extract from “Have Your Say”
April 2011

“The CNS has been kind, supportive and understands the difficulties we are facing. She has provided practical help and finds the time to talk through various problems we are encountering. We have every confidence in her”
Extract from “Have Your Say”
April 2011

“The highlight of my week is coming to Manor Croft. The kindness and friendship shown to me is wonderful”.
Extract from Manor Croft “Have Your Say”
April 2011
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<td>Scrutiny Committee says about the organisation</td>
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Part 1

Statement on Quality from the Chief Executive

LOROS is an independent local charity providing palliative care and support to around 2,500 people each year across Leicester, Leicestershire and Rutland. Patients are offered our care services based upon medical need and independent of gender, race, colour, creed or the ability to pay. In fact all of the care services are provided free of charge as a consequence of about 1/3 of the cost being funded by NHS and 2/3 from the generosity of the local community.

LOROS has an excellent track record of delivering outstanding care over the last 25 years and a reputation as an extremely worthwhile and valued local charity. This is based upon a clear purpose and focus and an enduring commitment to quality. LOROS staff and volunteers are passionate about their roles and the organisation and seek constantly to capture and act on feedback to improve further.

There are specific examples of commitment to such improvements in quality in this document in terms of better processes and equipment, investing in a new patient records system, enhanced partnership working and a thorough review of different models of care.

LOROS is actively engaged with the NHS and other stakeholders in determining how the quality of End of Life Care can be developed in the future.

A large number of people have contributed to the creation of this Quality Account, most notably the Clinical Governance Lead.

The LOROS Board of Trustees reviewed and approved this Quality Account at a meeting on 3 October 2011.

To the best of my knowledge, the information contained in this document is accurate.

Simon Proffitt
Chief Executive

October 2011
Part 2

Priorities for Improvement 2011/12 – Future Planning

The Hospice has a number of ongoing initiatives to enable us to offer a more comprehensive service to the local community, whilst working within the limitations of the current financial constraints. All plans for improvement have been discussed with, and have been influenced by staff, volunteers, patients, carers and the community we serve.

Priority 1 - Patient Record System

Following a thorough evaluation of different options, LOROS is in the process of implementing SystmOne which is a patient record system already in use by a majority of GPs in Leicester, Leicestershire and Rutland. This system is due to go-live at LOROS on 1 February 2012 and should enhance patient care and the organisation’s effectiveness and efficiency. It will not only provide LOROS with a modern IT system for processing and storing patient information but will also provide an opportunity to share such information between healthcare professionals, subject to approval of individual patients.

Priority 2 - Partnership Working

LOROS already works closely and effectively with a number of other organisations involved in providing health and social care. The implementation of the Health and Social Care Bill will result in palliative care services being commissioned by GP led local Clinical Commissioning Groups as opposed to PCTs. Consequently, LOROS is seeking to establish very close working relationships with these CCGs in order to enhance end of life care.

Furthermore, effective education and training of healthcare professionals is increasingly being regarded as a requirement to improve the quality of end of life care. LOROS will enhance its provision in this area, as well as in research, by partnership working with De Montfort University to create jointly a Centre for the Promotion of Excellence in Palliative Care (CPEP).

Priority 3 - Day Care

As part of a broad strategic review, LOROS is currently conducting a specific review of day care with the objective of ensuring that the model for the future best meets the needs of patients. This will be within the context of other services offered by LOROS and other providers. A wide range of stakeholders are being consulted, including patients, carers, family members and referrers.
Priority 4 – Syringe Driver Replacement Programme

In December 2010 the National Patient Safety Agency identified patient safety issues associated with the use of certain types of syringe pump, including the Graseby pump currently used in LOROS.

In response to this, working alongside hospital and community services, the Graseby pumps currently used will be replaced, in October 2011, by syringe pumps that incorporate the necessary safety features stipulated within the NPSA Rapid Response Report.

Consultation between palliative care providers, within the hospital and community settings, is ongoing in order to minimise risks to patient safety and maintain quality of care across care settings during the transition period.
Statements of Assurance from the Board

The following are a series of statements that all providers must include in their Quality Account. Many of these statements are not directly applicable to palliative care providers. Please note that the wording of these statements is prescribed.

Review of Services (Mandatory Statement)
During 2010/11, LOROS has provided for the NHS:
- In-patient Unit
- Day Care Unit
- Outpatients and domiciliary palliative medicine consultant visits
- Care in the community palliative care nurse specialist service
- Home visiting
- Counselling
- Lymphoedema Clinic service (cancer and non-cancer)
- Complementary therapy
- Education service

LOROS has reviewed all of the data available to them on the quality of care in all of these services (NHS services). The income generated by the NHS services reviewed in 2010/11 represents one third of the total expenditure incurred in the provision of services by LOROS for the reporting period 2010/11.

Participation in Clinical Audits (Mandatory Statement)
There have been no national clinical audits and no national confidential enquiries that LOROS participated in during 2010/11 due to LOROS being ineligible to participate.

All reports of local audits were reviewed by LOROS during 2010/11. LOROS intends to take the following actions to improve the quality of healthcare provided:
- The dignity audit highlighted some minor shortfalls in our documentation. This was reviewed at a Clinical Governance meeting. The action plan included changing the demographic page of the shared notes to include age, gender and religious beliefs.
- Hand hygiene audit. Action plan includes raising staff awareness. Our IPC lead nurse has established a hand hygiene campaign which is located at the hospice and our satellite day unit. The campaign regularly runs throughout the year.
- LOROS uses audit tools developed by Help the Hospices National Audit Tool as appropriate.

Research (Mandatory Statement)
The number of patients receiving NHS services or sub-contracted services by LOROS in 2010/11 was 21 in 5 studies. These were recruited during the period to participate in research approved by a research committee.

LOROS is actively developing opportunities to question and challenge the provision of palliative care from its broadest perspective. Research in 2010/11 has included:
1. IMPACT (Improving Palliative Care for Tomorrow) – Researching the impact of a Foundation Degree in palliative and supportive care.
2. A study exploring the value and impact of seeking feedback from patients and carers to students on the Foundation Degree.
3. Three students looking at the use of different technologies in the management of lymphoedema.
4. The donation of tissue samples post mortem for pharmaceutical and other research.
5. Care in the last days of life for people with cancer: Aspects of decision making: A qualitative study of the perspectives of clinical staff and bereaved relatives.

LOROS has adopted the Research Governance Framework for the NHS and has robust research governance processes including a research committee underpinned by a contractual relationship with the University Hospitals of Leicester research management and governance department.

Goals Agreed with Commissioners (Mandatory Statement)
LOROS’ income in 2010/11 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation Payment Framework, because LOROS is not contractually part of the CQUIN scheme. We do provide an annual care report for each of our PCTs. Key Performance Indicators have been agreed with the PCT for the period 2011/12. For the reporting period 2011/12, payment will not be related to KPI compliance.

What Others Say About Us (the Provider) (Mandatory Statement)
LOROS is required to register with the Care Quality Commission, currently the hospice and Manor Croft Day Therapy Unit are registered separately which is a requirement of the CQC, however Manor Croft is part of LOROS and its current registration is as a provider of the following regulated activities:

The Leicestershire & Rutland Organisation for the Relief of Suffering has the following conditions of registration that apply:

1. Diagnostic screening procedures
   1. The Registered Provider must ensure that the regulated activity, diagnostic and screening procedures is managed by an individual who is registered as a manager in respect of the activity, as carried on at or from the locations, The Leicestershire and Rutland Hospice and Palliative Day Therapy Unit – Manor Croft.
2. Treatment of disease, disorder or injury
   2. The Registered Provider must ensure that the regulated activity treatment of disease, disorder or injury is managed by an individual who is registered as a manager in respect of the activity, as carried on at or from the locations LOROS The Leicestershire & Rutland Hospice and LOROS Palliative Day Therapy Unit – Manor Croft.

3. Nursing Care
   1. The Registered Provider must ensure that the regulated activity nursing care is managed by an individual who is registered as a manager in respect of the activity, as carried out at or from the locations LOROS The Leicestershire & Rutland Hospice and LOROS Palliative Day Therapy Unit – Manor Croft.

   Additional conditions that apply at LOROS Hospice:
   1. The Registered Provider must only accommodate a maximum of 32 service users at LOROS The Leicestershire & Rutland Hospice.

   Additional conditions that apply at Manor Croft:
   1. The Registered Provider must only provide a maximum of 25 service users at LOROS Palliative Day Therapy Unit – Manor Croft.

The Care Quality Commission has not taken any enforcement action against LOROS during 2010/11.

LOROS is subject to periodic reviews by the Care Quality Commission and its last inspection was on 12th December 2008. One area identified for improvement was the arrangements for analysis and learning from incidents. As a result of this, LOROS reviewed the Risk Management policy and investigating incident form.

Manor Croft Day Therapy Unit’s last inspections were on 14th and 19th August 2009. All standards were met. Both inspections related to the Care Standards Act 2000.

In June 2010 LOROS and Manor Croft Day Therapy Unit were required to be registered with the Care Quality Commission against the Health & Social Care Act of 2008. Both applications were successful.

Data Quality (Mandatory Statement)
LOROS did not submit records during 2010/11 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.
Information Governance Toolkit (Mandatory Statement)
LOROS’ score in 2010/11 for information quality and records management was not assessed using the Information Governance Toolkit. This toolkit is not applicable to palliative care.

Clinical Coding Error Rate
LOROS was not subject to the Payment by Results clinical coding audit during the period 2010/11 by the Audit Commission.
Part 3

Report on Review of Quality Performance 2010/11

Priority 1
A strategy & Business Plan for the Education Team
The Hospice has been hugely successful in developing a whole range of education and learning opportunities for health and social care professionals. We have been successful in obtaining money to support End of Life Care education and communication skills training. Indeed, we are part of a national (Department of Health) programme which is reviewing the efficacy of different methods of communication skills training. This year, we are seeking support from one of our Hospice medical consultants and De Montfort University business school placement to further develop a business plan which will strengthen and potentially enable the future development of a learning centre for Palliative Care with a national reputation. This will indirectly impact on clinical effectiveness and patient experiences.

Update
The LOROS Education Department continues to flourish and to expand its education and evaluation activity across all health and social care settings. Successful bids through End of Life Care Monies for education have allowed the department to develop programmes of education which have been specifically developed to meet the needs of the workforce across all care settings.

In addition to formal delivery of education, a Practice Development Team has been established and has been very successful in enabling practitioners in the workplace to embed theoretical knowledge into practical application in their place of work. Evaluation of this initiative has demonstrated measurable changes in practice through skills, knowledge and confidence development.

An education strategy with a 3-5 year focus has been developed and has recently been approved in principle by the LOROS Board of Trustees. Plans are now underway to undertake a scoping exercise and further impact analysis in order to progress implementation of the strategy.

Centre for the Promotion of Excellence in Palliative Care: CPEP
Informing Practice, Transforming Care
LOROS has a long history of partnership working with De Montfort University which includes provision of undergraduate nursing placements and a Masters in Palliative Care programme. DMU’s School of Nursing and Midwifery and LOROS now plan to extend this partnership by creating the Centre for the Promotion of Excellence in Palliative Care (CPEP).
The new centre, which will have a physical base at De Montfort University, aims to enhance the skills and knowledge of practitioners dealing with people with advanced illnesses and to make sure that they are given respect and dignity in the last stages of their lives.

The importance of palliative and end of life care has been recognised in a number of Government publications including the End of Life Care Strategy which was published in 2008; education and research are key in promoting high quality end of life care across all care settings.

DMU and LOROS will not only work together to provide education to professionals from the health and social care sector but also volunteers and other staff who deal with advanced illnesses.

Research will also be carried out to improve care and practice development in the future.

**Priority 2**

**A strategy to review the Hospice patient administration system (SystmOne)**

The Hospice already has a sound IT system to support patient demographics and data collection. The roll out of a national IT patient administration system (SystmOne) is currently underway in our locality. The Hospice must complete a feasibility, cost, and quality benefit study to inform decisions that the Board will need to make in relation to LOROS transferring to this system. There would be undoubted benefits in terms of communication about patient care, which should enhance patient safety and clinical effectiveness.

**Update**

The Hospice has recently conducted an options appraisal in order to evaluate the feasibility of implementing a replacement patient administration system. Three options were considered:

1. Remain with current system;
2. Implement SystmOne;
3. Implement Infoflex.

Each option was reviewed with the appropriate costs, feasibility and quality benefits all documented. This information was presented to the Hospice Senior Management Team in order for them to make a final decision on which system to implement. The decision was then made that we will implement SystmOne with a planned ‘go live’ on 1st February 2012. It is envisaged that this will enhance patient care by improving our ability to communicate electronically with GPs.
Priority 3
Developing a strategy for engagement with BME

An application has been submitted to the “volunteering fund for health and social care” to fund a project worker to support volunteers to assist in the development of our strategy for BME population in our locality.

Currently, the population of those who use our services is not entirely representative of our resident population in terms of BME mix. The project worker would aim to deliver a number of outcomes through the use of volunteers:

1. To raise awareness with the public of Hospice services (including schools)
2. To enable the BME population to have an understanding of how services may be accessed
3. Potentially to see a change in our BME mix/population within our organisation

Update

The application details above were successful. The “Broadening Horizons” project has been awarded £35,000 and will run over two years. A project worker has been recruited and commenced in post in January 2011, working 15 hours per week. The overall purpose of the project is to increase awareness and understanding of specialist palliative care services among the BME population in Leicester City and to recruit a team of volunteers to promote this. This project fits well with the End of Life Care Strategy which encourages choice over preferred place of care. Raising awareness will enhance the probability of informed choice once families realise the scope and support offered by specialist palliative care services. The project worker has identified Key Performance Indicators which will be monitored closely by the fund. These include:

- Number of new volunteers recruited over the project lifetime
- Number of hours (volunteer) carried out over the project lifetime
- Number of service users who will benefit from the project over its lifetime
- Number of training courses run over the project lifetime
- Number of resources produced

A steering group has been established and has held its first meeting. Terms of Reference for the group have been agreed. The group plan to meet approximately every 6-8 weeks. Networking and gathering of information has begun to determine which groups to target in order to begin reaching out, and begin to find out what the BME group know about specialist palliative care services.
Priority 4
Medicine Management Review
A major review of the medicine management processes on the ward began in January 2010. This was necessary because of the increasing complexity of patients on the ward and the ever broadening range of drugs used. A further driver for change is safety, and ensuring that patients receive their medication correctly. Process management tools have been used and full engagement of staff and patients has been sought. Changes to our systems will be developed and evaluated towards the end of this year.

- Update
This has been a large piece of work which has continued to be progressed during the year. A total of 33 issues were raised following the mapping process. Areas of change include:
  - Improved communication between ward staff and the community team sharing information in patient notes
  - The ward pharmacist ensures that all staff doctors and nurses are given guidance on medicine safety and practice
  - To prevent duplication, only doctors take the patient drug history
  - Implementation of daily controlled drug orders
  - Healthcare Assistants have extended their role to enable them to support and care for patients with tube feeding administration of medicines
  - The nurses are wearing red tabards during drug rounds, which are an alert to staff and visitors not to interrupt them
  - The layout of the medicine chart has been reviewed and is more user friendly
  - A new, larger medicine trolley has been purchased
  - The hours of the Pharmacy Technician have been increased
  - The IPU is piloting the use of bedside lockers for patient’s medications
Quality Overview - Review of Quality Performance

LOROS is a specialist palliative care provider – we also provide an education and training service to ensure as many people as possible can benefit from the specialist knowledge and experience LOROS has developed around palliative and end of life care.

In accordance with the Department of Health, LOROS submits a National Minimum Dataset (MDS) to the National Council for Palliative Care.

The Minimum Data Set Report for 2009/10 (see below) is the 15th report to be produced. The most recent National Minimum Data Set which covers the period 2009/10 compares LOROS against the published results.

### Inpatient Unit:

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<thead>
<tr>
<th>Age (All Patients)</th>
<th>Nat Survey 09/10</th>
<th>LOROS 09/10</th>
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<tbody>
<tr>
<td>Under 25</td>
<td>0.5%</td>
<td>1%</td>
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<tr>
<td>26 – 65</td>
<td>32%</td>
<td>37%</td>
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<tr>
<td>66 – 84</td>
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<td>Over 84</td>
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<th>Ethnicity (New Patients)</th>
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<tr>
<td>White British</td>
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<th>Diagnosis (New Patients)</th>
<th>Nat Survey 09/10</th>
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<tbody>
<tr>
<td>Cancer</td>
<td>90%</td>
<td>91%</td>
</tr>
<tr>
<td>Non-Cancer</td>
<td>9% (excl unknowns)</td>
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</tbody>
</table>

- Average Length of Stay: 14.4 (Units with over 25 beds) | 12
- Admissions Ending in Discharge: 49% | 61%
- % Bed Occupancy (midnight): 73% | 76%
- Throughput (Adm per bed per year): 23.3 | 24.4
- Turnover (Interval between adms): 4.1 | 3

### Day Care:

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<tr>
<th>Nat Survey 09/10</th>
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<tbody>
<tr>
<td>Average number of new patients</td>
<td>97</td>
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<tr>
<td>Average total no of patients attending</td>
<td>148</td>
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<th>Age (All Patients)</th>
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<tr>
<td>Under 25</td>
<td>0.3%</td>
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<tr>
<td>26 – 65</td>
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<td>66 – 84</td>
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<tr>
<td>Over 84</td>
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<td>Male</td>
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<td>Ethnicity (New Patients)</td>
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<td>White British</td>
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<tr>
<td>Cancer</td>
<td>86%</td>
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<tr>
<td>Non-Cancer</td>
<td>14%</td>
<td>11%</td>
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</table>

| Average length of care | 172 days (6M) | 160 days |
| Avg no of sessions per year per unit | 199.1 | 150 |
| Avg no of places per session | 14.5 | 20 |
| % use of available places | 74% | 67% |

1Of the 149 services responding, over a quarter had more than 20% patients with a non-cancer diagnosis.

256% of patients attended for 90 days or fewer while 24% attended for more than 180 days. (LOROS 58% 90 days or fewer/24% greater than 180 days).

Community Services:

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<th>Nat Survey 09/10</th>
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<td>Number of new patients</td>
<td>520</td>
<td>487</td>
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<tbody>
<tr>
<td>Under 25</td>
<td>0.4%</td>
<td>0.6%</td>
</tr>
<tr>
<td>26 – 65</td>
<td>30%</td>
<td>32%</td>
</tr>
<tr>
<td>66 – 84</td>
<td>56%</td>
<td>58%</td>
</tr>
<tr>
<td>Over 84</td>
<td>14%</td>
<td>9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity (New Patients)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>76%</td>
<td>86%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis (New Patients)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>89%</td>
<td>96%</td>
</tr>
<tr>
<td>Non-Cancer</td>
<td>10% (excl unknowns)</td>
<td>4%</td>
</tr>
</tbody>
</table>

| Average number of visits per patient | 4.2 | 4.2 |
| Deaths as a % of deaths and discharges | 59% | 66% |
| Homes deaths as a % of all deaths | 43% | 51% |
| Average length of care | 119 days | 124 days |
| Average caseload per team | 213 | 221 |

3The number of ‘All other non-cancer’ was higher than might have been expected with over 30% of new home care patients in this category.

4The proportion of people dying at home increased while the proportion dying in hospital decreased – (LOROS figures show home deaths have increased and hospital deaths have stayed the same. Hospice deaths decreased 2009/10 from 2008/09).

565% of patients had a length of care of less than 90 days and 19% for more than 180 days.
Outpatients:
The total number of specialist palliative care services providing an outpatient service is not accurately known, but from previous surveys it is thought to be about 300. Using this as a baseline there was a 52% response rate.

<table>
<thead>
<tr>
<th>Age (All Patients)</th>
<th>Nat Survey 09/10</th>
<th>LOROS 09/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>1.2%</td>
<td>2%</td>
</tr>
<tr>
<td>26 – 65</td>
<td>48%</td>
<td>59%</td>
</tr>
<tr>
<td>66 – 84</td>
<td>44%</td>
<td>36%</td>
</tr>
<tr>
<td>Over 84</td>
<td>6%</td>
<td>3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity (New Patients)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White British⁶</td>
<td>63%</td>
<td>91%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis (New Patients)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Non-Cancer</td>
<td>20%</td>
<td>50%</td>
</tr>
</tbody>
</table>

⁶A total of 30% of new patients were not recorded. Of the non-white categories 34% were recorded under ‘Other’.
⁷A quarter of new patients and over a third of all patients seen in outpatients were diagnosed with Breast Cancer.

Of all the services surveyed the outpatient service has the highest % of patients with a diagnosis other than cancer. It also had the highest proportion of ‘All other conditions’ diagnoses at 55%. (LOROS included Lymphoedema/Counselling/Comp Therapy in this years return – if these were included by other units this may explain the high proportion).

Inpatients:
Of the 113 services seeing people with a primary diagnosis of MND, 94% saw 10 patients or fewer. Five Independent and 2 NHS units saw more than 10 patients (LOROS more than 10 patients).

Day Care:
Of the 110 services who see people with primary MND, 95% saw 10 patients or fewer. No NHS services saw more than 10 patients and one service alone saw 26 patients – which accounted for 5% of people seen (LOROS 10 patients or fewer).

Community Care:
Community Care services were the only setting where the majority of services saw more than 10 people. Of the 119 services who reported seeing people with primary MND, 72% saw 10 or fewer and 7% saw more than 20 people. LOROS Community CNS Team did not see any MND patients during this period as there are MND Community CNSs locally.
Outpatients:
34% of services did not see anyone with MND, of those that did 87% saw 10 of fewer. One unit alone saw 59 people with MND – 16% of the total number of people *(LOROS saw 59 people with MND)*.

Local Quality Measures
In addition to the quality measures in The National Data Set for Palliative Care, LOROS has chosen to measure performance against the following data. This is compared internally to data obtained in previous years.

Quality Improvement Programme (QIP)
A Quality Improvement Programme (QIP) continues to evolve and develop. All staff share this responsibility and join with these objectives; many of which were embedded within their own Personal Development Plans. This year LOROS will need to ensure that the QIP embraces the organisations KPIs, the PCT End of Life Care Service Specifications (see below), and any actions as a result of the Strategic Review.

LOROS Care Service
Quality Improvement Programme 2011/2012

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>▪ Further engage with staff to enhance the safety of the environment</td>
</tr>
<tr>
<td></td>
<td>▪ Potentially reduce untoward drug incidents</td>
</tr>
<tr>
<td>Clinical Cost Effectiveness</td>
<td>▪ Keep cost of care services within budget and where possible make savings</td>
</tr>
<tr>
<td></td>
<td>▪ Seek ways to maintain services within constraints of current economic climate</td>
</tr>
<tr>
<td>Governance</td>
<td>▪ Define patient outcome measures for all clinical services</td>
</tr>
<tr>
<td></td>
<td>▪ Engage with the PCTs and the emerging GP Consortia</td>
</tr>
<tr>
<td>Patient Focus</td>
<td>▪ Continue to seek patients and carers views potentially using IT and the website</td>
</tr>
<tr>
<td></td>
<td>▪ Explore and pilot SKIPPS</td>
</tr>
<tr>
<td>Accessibility and Responsive Care</td>
<td>▪ Monitor KPIs in line with PCT Quality Outcomes</td>
</tr>
</tbody>
</table>

LOROS Chief Executive, Lead Consultant and previous Matron/Director of Care Services, met with Commissioners earlier this year and agreed KPIs which have been agreed with the PCT for the period 2011/12 (payment is not related to KPI compliance).
### Local Quality Measures Continued.... Clinical Data

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2010/11</th>
<th>2009/10</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of new referrals</td>
<td>1697</td>
<td>1574</td>
<td>1581</td>
</tr>
<tr>
<td>Total number of patients admitted to Inpatient Unit (IPU)</td>
<td>730</td>
<td>659</td>
<td>752</td>
</tr>
<tr>
<td>% of admissions ending in discharge</td>
<td>54%</td>
<td>45%</td>
<td>41%</td>
</tr>
<tr>
<td>Number of beds</td>
<td>31</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>% occupancy</td>
<td>73 (M)/80</td>
<td>76(M)/82</td>
<td>67(M)/75</td>
</tr>
<tr>
<td>Medical outpatient attendances including Manor Croft and Domiciliary</td>
<td>528</td>
<td>649</td>
<td>722</td>
</tr>
<tr>
<td>Lymphoedema outpatient attendances incl Consultant clinics</td>
<td>2623</td>
<td>2197</td>
<td>2221</td>
</tr>
<tr>
<td>Enablement Team Therapy Clinic attendances including Acupuncture sessions</td>
<td>117</td>
<td>151</td>
<td>128</td>
</tr>
<tr>
<td>Complementary Therapy Outpatient sessions not including Ward activity</td>
<td>937</td>
<td>690</td>
<td>1014</td>
</tr>
<tr>
<td>Attendances by patients at Day Therapy Unit</td>
<td>1830</td>
<td>2010</td>
<td>2112</td>
</tr>
<tr>
<td>Contacts with patients by the CNS Team</td>
<td>3394</td>
<td>3044</td>
<td>2750</td>
</tr>
<tr>
<td>Hospice at Home sessions provided</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Complaints that were founded</td>
<td>9</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Complaints which were unfounded</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Serious patient safety incidents (excl falls)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Patients known to be infected with MRSA on admission to the IPU</td>
<td>5</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Patients infected with MRSA whilst on the IPU</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Patients known to be infected with Clostridium difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia on admission</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Patients who contracted these infections whilst on the IPU</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Average Length of stay on the IPU (days)</td>
<td>13</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Complaints</td>
<td>11</td>
<td>8</td>
<td>10</td>
</tr>
</tbody>
</table>
The Hospice cares for over 2,500 patients and relatives each year. We received 11 complaints during the period April 2010 – March 2011. All were resolved.

All complaints are taken seriously. All are reported to the Clinical Governance Steering Group and are investigated and acknowledged to the person making the complaint. Once the investigation has been completed the findings are shared with the person and the appropriate actions taken with the relevant staff. A register of compliments and complaints is kept.

During the past 12 months, the number of incidents reported has increased on the previous year. This should be seen as positive: Staff have received training around incidents and the importance of reporting near misses has particularly been encouraged.

During the year 2010/2011, a total of 2 incidents have been reported to the Care Quality Commission and the Health and Safety Executive, in relation to the incidents which have happened to patients. All patient incidents are thoroughly investigated and copies of all findings and the report are held on the patient file. These two incidents related to falls resulting in fractures. The patients were on the In-patient Unit, and had significant underlying health problems. Learning from these incidents was to stress to staff the importance of continual assessment of patients, whilst understanding the need for patients to be empowered and independent.

Over the last year, 25 (3.4%) patients have developed pressure sores. In all of these cases, patients were particularly frail and their skin was vulnerable in all cases, appropriate care and pressure relieving devices were used to prevent further damage.

<table>
<thead>
<tr>
<th>Slips, trips and falls (patient only)</th>
<th>115</th>
<th>82</th>
<th>79</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who experience a fracture or other serious injury as a result of a fall</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Patients who developed pressure sores whilst on the IPU</td>
<td>25</td>
<td>22</td>
<td>40</td>
</tr>
</tbody>
</table>

Note: Number of Outpatient Attendances includes Hospice (incl Pain, Zoledronate & MND)/Manor Croft and Domiciliary Visits Day Therapy Attendances does not include first assessments carried out in patient’s home.
Local Quality Measures Continued....

Hospice Activity for the year Apr 09 – Mar 10

No of Patients supported for the year Apr 09 – Mar 10

Total contacts 12837

Total number of patients supported across all services = 2530

Average time inpatients stayed with us was 12 days 2009/10 and 13 days 2010/11

Hospice Activity for the year Apr 10 – Mar 11

No of Patients supported for the year Apr 10 – Mar 11

Total contacts 13016

Total number of patients supported across all services = 2667
## Local Quality Measures Continued....

**LOROS**
Hospice Care for Leicestershire & Rutland

Service Specification 2011/12
7. Quality and Performance Indicators - Figures correct at date of submission

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 PPD Achieved IPU(^1)</td>
<td>60%</td>
<td>86%</td>
<td>72%</td>
<td>83%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPD Achieved CNS(^1)</td>
<td>60%</td>
<td>62%</td>
<td>63%</td>
<td>85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Advance Care Plan IPU (evidenced by completed EMAS and/or DNARCPR)</td>
<td>50%</td>
<td>89%</td>
<td>97%</td>
<td>92%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Advance Care Plan v.12 documentation. IPU only – DN’s responsible for documentation in the community.</td>
<td>Evidenced in medical records</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>v.12 documentation used in IPU from June 2011</td>
</tr>
<tr>
<td>2.1 Advance Care Plan CNS</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Available within S1 once fully functional</td>
</tr>
<tr>
<td>2.6 Training Plan</td>
<td>Evidence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Progress against Action Plan evidenced and available in end of year audit</td>
</tr>
<tr>
<td>2.7 Training Courses</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Annual Audit to be completed at year end</td>
</tr>
<tr>
<td>2.8 Supervision</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Annual Audit to be completed at year end</td>
</tr>
<tr>
<td>3.2 IPU patients on LCP</td>
<td>85%</td>
<td>92%</td>
<td>83%</td>
<td>85%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 The IPU provides a response to the initial request within 2 hours.</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patients admitted to the IPU within 48 hrs of request being made if required clinically and enough resources available to do so.  

<table>
<thead>
<tr>
<th></th>
<th>90%</th>
<th>84%</th>
<th>90%</th>
<th>90%</th>
</tr>
</thead>
</table>

4.4 The CNS service provides a response to the request within 2 working days and undertakes a visit within 5 working days (or at a timescale at the patient’s request)  

<table>
<thead>
<tr>
<th></th>
<th>90%</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
</tr>
</thead>
</table>

4.8 CNS patients on LCP\(^2\)  

<table>
<thead>
<tr>
<th></th>
<th>85%</th>
<th>80%</th>
<th>73%</th>
<th>71%</th>
</tr>
</thead>
</table>

6.1 Organisational Plan  

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Action Plan evidenced and available in end of year audit</th>
</tr>
</thead>
</table>

6.2a&b Service User Survey response rate\(^3\)  

<table>
<thead>
<tr>
<th>% Satisfaction</th>
<th>40%</th>
<th>66% (May 2011)</th>
<th>90%</th>
<th>100% (May 2011)</th>
</tr>
</thead>
</table>

Other Indicators:  

<table>
<thead>
<tr>
<th>No of Incidents (Patients)</th>
<th>12</th>
<th>29</th>
<th>18</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>No of Serious Incidents(^4)</th>
<th>0</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
</table>

| No of PU Grade 3 & 4\(^5\) | 0 | 0 | 2 |

1. PPD calculated includes figures for PPD achieved, not achieved and unknown.  
2. From available data – there will be some missing data as LOROS CNS not always responsible for initiating LCP.  
3. Currently undertaking Service User Questionnaire 6-monthly.  
4. Reported to PCT immediately.  
5. Investigated by LOROS and also reported separately to the PCT who will add onto the STEIS system (as per Meeting with Nikki Beacher 15/6/11)
Participation in Clinical Audit
To make sure that we are providing a consistently high quality service, we undertake our own clinical audits. As appropriate, we use the national audit tools developed specifically for Hospices. This allows us to monitor the quality of care being provided in a systematic way and creates a framework where we can review this information and make improvements where needed.

Through the Annual Care Report, the Board of Trustees is kept fully informed about the audit results and any identified shortfalls. Through this process, the Board has received an assurance of the quality of the services provided.

Examples of Audits Year 2010/11

Self Assessment by accountable officer
Hospice fully compliant. Audited twice per year

Management of non controlled drugs
A few minor shortfalls around documentation. Discussed at Therapeutics Committee meeting. Audited twice per year.

Day Care Admission Initial Assessment
Demonstrated - generally good compliance in most areas

Demonstrating Patient Outcomes
Outcome measurement has a major role to play in improving the quality, efficiency and availability of the services we provide.

We are aware that the recent NHS reforms place greater emphasis on demonstrating outcomes. As an organisation we are keen to develop this aspect.

The Director of Care Services chairs the LOROS internal clinical data meeting; outcome measures is an agenda item. Our aim is to gather information on existing tools to assist in this process.

St. Christopher’s Hospice and Southampton University have collaborated on a piece of work (SKIPPS) and developed a tool to measure patient outcomes. Three departments within the hospice are currently piloting this questionnaire to see if we can adopt this.
A future piece of work that is ongoing is around service review/development: The LOROS Board of Trustees Strategic Review. The following is taken from the Terms of Reference for the Strategic Review:

- **Community Services**
  To consider the extent to which LOROS should expand the current range and reach of care services in the community.

- **Day Care**
  To ensure that the model of day care provided by LOROS complements other LOROS services and is responsive to the changing health and social needs of patients in our community, in the most effective manner.

- **Education & Research**
  To establish a clear vision and strategy for the continuing contribution of LOROS to education, training and research.

- **Inclusivity**
  To ensure that all adults in Leicester, Leicestershire and Rutland have equal opportunity to access the care services provided by LOROS based on medical need.

- **Marketing**
  To maximise the awareness of LOROS across Leicester, Leicestershire and Rutland - its brand, role, and need for support.

- **NHS Reform & Funding**
  To ensure that LOROS influences where possible, and adapts to, the significant changes in the NHS in order to manage any threats and take advantage of any opportunities.

- **Non Cancer Palliative Care**
  To determine how best to respond to the growing expectation that palliative and end of life care will be commissioned based on need and not diagnosis.
Feedback from Patients/Families

What Our Patients Say about the Organisation
LOROS values the views of our patients and carers and actively engages with users of our services in a number of ways. Patients are encouraged to give feedback through Patient Satisfaction Questionnaires, “Have Your Say” cards, and Patient and Carer Forums. Further detail can be found below:

Patient Satisfaction Questionnaires
November 2010 saw the introduction of the 1st generic questionnaire used for all LOROS services. Previously, individual departments carried out questionnaires for their own cohort, this new format standardises the questions across all services and our surveys are anonymous.

Surveys are distributed twice a year. A total of 126 questionnaires were handed out to patients/carers during November 2010. Results are set out below:
Service User Questionnaire—November 2010

This is the first generic questionnaire used for all LOROS services. Previously individual departments carried out questionnaires for their own cohort and this new format standardises the questions across all services.

Questionnaires were distributed to 126 patients and/or carers during November 2010. 78 completed questionnaires were received giving a 62% response rate and achieving a 100% satisfaction rate. The following gives a synopsis of the results.

Of the completed surveys received 54 were completed by patients, 17 by Next of Kin, 5 by Carers and 6 by Relative/Friends

- 74% of those questioned received a LOROS leaflet.
- 96% felt that the leaflets were given at the right time.
- 100% felt that the leaflet was easy to understand and
- 100% found the leaflets helpful.

The following questions were asked about the care received from the Hospice:

<table>
<thead>
<tr>
<th>N/A</th>
<th>Never</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>72</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>68</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>60</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>72</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>62</td>
</tr>
</tbody>
</table>

- 93% of respondents felt that they had confidence and trust in the staff.
- 91% felt that they were given enough privacy and dignity when discussing their condition or being examined always or most of the time.

Dissatisfaction

If you are unhappy with any aspect of our Services would you know how to complain?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>4</td>
<td>14</td>
</tr>
</tbody>
</table>

Did you feel the staff member explained the reasons for treatment or action in a way that you could understand?

<table>
<thead>
<tr>
<th>N/A</th>
<th>Never</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>67</td>
</tr>
</tbody>
</table>
CATERING (completed if applicable)

✓ 98% of respondents found the hospitality of the catering staff good or excellent.
✓ 93% felt the variety of food offered was good or excellent.
✓ 90% felt the quality of the food was good or excellent.
✓ The remainder of respondents felt that all categories above were acceptable.

100% of people who had special dietary needs felt that these were met.

Did you find the Hospice and/or Manor Croft easy to get to?

Examples of comments made:
“Sometimes difficult to park”
“Always very welcoming”
“LOROS is 25 miles away”
“Easy access and always someone to help you”
“Not applicable as transport provided”
“Only because my partner brought me and lifted me into a wheelchair”
“Very well signposted from main roads”

100% of respondents found the cleanliness of the premises and overall environment good/excellent.

Do/Did you have a Key Worker?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>13</td>
<td>11</td>
</tr>
</tbody>
</table>

OVERALL 100% OF PEOPLE RESPONDING RATED THE CARE AND SUPPORT RECEIVED AS GOOD/EXCELLENT

Additional comments received on improving the services accessed:
1. Wider variety of food at counter.
2. Fold down beds for relatives to stay in rooms.
3. More seating with shade (there was only one parasol and no shade anywhere).
4. More communication from consultants and relatives:
   a. Allotted time slots
   b. Family meetings
5. Lymphoedema team need more regular sessions with patients to keep them up to date.

Only second day here. Feel this questionnaire not really appropriate at this moment in time.
Given my reduced mobility I would have expected appointments with MIND nurse to be home based rather than at LOROS. I was referred for respite at LOROS early November 2010 and have still not heard anything - this is required urgently for carer support reasons.

More information in Hospital about what LOROS has to offer.

There were a lot of positive comments made about the level of services in this section.

Participants were asked whether there was anything good about the services that they would wish to highlight:

Feeling that you are amongst friends.
All of the services were excellent. If any, I would highlight the Hospice nurses who could not do enough. They were brilliant and always there for my husband and me. Also, the Counselling Service, which I am still using, has been invaluable and very supportive.
A fantastic caring atmosphere combining a mixture of professionals and caring volunteers. Well done.
The amount of time the consultant was able to give me in my appointment meant that full discussion could take place.
The HCAs were very attentive.
Patient Carers Forums
Two forums took place in 2010/11.

Care and Support provided for Visitors and Carers
All attendees of the Forum had accessed one or more of the Hospice services. For them it was a positive experience whichever service was used. Overall it was felt that all hospice teams provided consistency in their approach and manner which gave carers/relatives confidence and reassurance. In addition, they felt they could get involved as much as they wanted to be in the patient’s care.

Two of the recommendations made as a result of this Forum were to see if it was feasible to provide Complementary Therapy seven days a week and the need for privacy for patients/families in the bay when important consultations are taking place.

With some staff re-organisation and within the limited resources, Complementary Therapy has now been made available on alternate Saturdays on the ward.

With regard to privacy on the bay, it was agreed that where possible and practical, patients/families will be offered the opportunity for important discussions to take place in a private room. This information has been disseminated to all relevant staff.

What Our Staff Say about the Organisation
Staff are involved in our organisation through our Heads of Department forum, “Have Your Say” leaflets, and through staff surveys. This year we will be participating in a survey through Help the Hospices which will enable us to benchmark ourselves against other Hospices. LOROS staff survey was carried out in 2010: 75% of staff completed the anonymous 'Birdsong' Charity Consulting Survey, which enables LOROS to benchmark themselves against other hospices. In relation to each section, LOROS responses generally were as follows:

1. The organisation and communication: Very positive and all better than benchmark.

2. Morale and work/life balance: Positive and better than benchmark, other than questions regarding stress at work, flexible working and excess hours, which were slightly worse than benchmark.

3. People management: Positive and mostly better than benchmark, but some equal to it.

4. Development and reward: Positive and better than benchmark with respect to use of skills, adequacy of training and career development, but some concerns with regard to pay level and process.
With regard to an action plan:

1. Morale and work/life balance: Concerns will be reviewed within each department.

2. Levels of pay and process for review will be addressed for the whole organisation by the Senior Management Team.

3. One immediate action is that LOROS will participate in the Help the Hospices salary survey.

4. The data for each job family/department will be shared with the relevant department manager and departmental action plans will be developed. Staff will be requested to complete the survey again in 2011 in order to monitor whether the actions in areas of concern have led to improvement and the positive areas have been maintained.

Examples of comments made by staff:

- What is the best thing about working for your hospice?
  
  *A good working environment, with well-trained and dedicated staff.*

  *I feel that I make a difference to patients and their families.*

  *I feel valued and feel that my job is worthwhile, in terms of supporting the work of the hospice.*

- If you could change one thing about working for your hospice what would it be?

  *Pay scale to reflect the work done within the department.*

  *More office space.*

  *More consideration for management about the stress nursing staff are under when nursing patients who are so ill. Help to de-stress.*

(A team is looking at developing a designated area for staff, to facilitate this).

- Other comments:

  *It is a lovely place to work and is very rewarding.*

  *The LOROS hospice is a wonderful charity of which I am proud to be a part of.*
The Board of Trustees Commitment to Quality
The Board is fully committed to provide the best service for our patients in order to achieve our aims. The Hospice has an established governance structure, with members of the Board having an active role in ensuring that LOROS provides a high quality service in accordance with its Statement of Purpose. This has recently been updated and is located on the intranet, and is also displayed in hard copy format at both the Hospice and Manor Croft.

Every six months, a member of staff who is not involved with the day to day running of the Hospice or Manor Croft completes an unannounced inspection on behalf of the Chief Executive.

Trustees play an active role as a critical friend at key Hospice forums, Heads of Department meetings, and the Clinical Governance Steering Group meetings.

The Trustees are involved in Thanksgiving and Remembrance events and meet with bereaved families. In this way, they hear first hand about the quality of the service provided.

The Board is confident that the treatment and care provided by LOROS is of a high quality and is cost effective.
Written statements by other bodies

What NHS Leicester City say about the organisation

What Leicestershire County and Rutland PCT say about the organisation:

What Leicester LINks say about the organisation

What Leicestershire LINks say about the organisation:

What the Leicester, Leicestershire and Rutland Health Overview and Scrutiny Committee say about the organisation:
This page is left blank intentionally.
The schedule attached to the regulations for Quality Accounts sets out, in column 1, a description of the data to be included in the statement (prescribed information) and, in column 2, the format in which you should write the statement (form of statement). A provider should complete the statement that is relevant to their organisation (two options are given for each statement). The completed statements should be included in Part 2 of the Quality Account.

**Regulation 5 – Written statements by other bodies**
This regulation sets out the requirement for a Quality Account to include any written statements sent to the provider from the appropriate commissioning primary care trust (PCT), Local Involvement Network (LINk) and/or Overview and Scrutiny Committee (OSC) in relation to their view of the provider’s Quality Account. Each statement should be no longer than 500 words (this will be increased to 1000 words). The Quality Account should also include an explanation of any changes made to the final version of the Quality Account that were made subsequent to (and possibly as a result of) the statements being provided.

**Regulation 6 – Signature by senior employee**
This regulation sets out the requirement for a senior employee (for example, the Chief Executive) of an organisation to sign a written statement (Part 1), thus declaring their accountability for the content of the Quality Account.

**Regulation 7 – Priorities for improvement**
This regulation sets out additional information that should be included in a Quality Account. Providers should include a section which confirms that the organisation has identified key areas for improvement and has in place plans to monitor and report on progress. This section should include:
- at least three priorities for improvement and how they were identified;
- report progress from previous priorities;
- how progress to achieving priorities will be monitored and measured by the provider; and
- how and when this progress will be reported back to others in the future.

**Regulation 8 – Document assurance by commissioning primary care trust**
This regulation sets out the legal requirements for both providers of NHS services and their commissioning PCTs or strategic health authority (SHAs). It sets out:
- the requirement for a provider to send a copy of their Quality Account to their commissioning PCT or SHA within 30 days beginning with 1 April at the end of the reporting period (i.e. by 30 April each year);
- the requirement for a commissioning PCT or SHA to check the accuracy of the information contained in the provider’s Quality Account in relation to the services provided to it; and
the requirement for the commissioning PCT or SHA to then provide a written statement (maximum 1000 words) for publication in the provider’s Quality Account. The statement should confirm whether or not they consider the provider’s Quality Account to contain accurate information and include any other comments they consider relevant – for instance, whether or not they believe it is a balanced report of the quality of healthcare services provided. This statement should be returned to the provider within 30 days of receipt.

The provider should send their Quality Account to one commissioning PCT (or SHA if the provider is a PCT or is not commissioned by a PCT). Where a provider has more than one commissioning PCT, they should send their Quality Account to the coordinating commissioning PCT.

Where the provider provides services to more than one coordinating commissioning PCT, they should send their Quality Account to the coordinating commissioning PCT in the SHA area in which the provider is located.

Where the provider provides services to more than one coordinating commissioning PCT in the SHA area in which it is located, they should send their Quality Account to the coordinating commissioning PCT which is responsible for the largest number of patients that the provider has provided NHS services to during the reporting period.

Where there is no coordinating commissioning PCT, they should send their Quality Account to the commissioning PCT which is responsible for the largest number of patients that the provider has provided NHS services to during the reporting period.

Where a provider is commissioned by more than one SHA (and no PCT), they should send their Quality Account to the SHA which is responsible for the largest number of patients that the provider has provided NHS services to during the reporting period.

**Regulation 9 – Document assurance by appropriate Local Involvement Network**

This regulation sets out the requirement for a provider to send a copy of their Quality Account to their appropriate LINk within 30 days beginning with 1 April at the end of the reporting period (i.e. by 30 April each year).

To fulfil this obligation, the provider should send their Quality Account to the LINk or LINks in the local authority area in which the provider's principal office is located. The method of communication (post, email etc) is not specified in the regulation and should be left to local determination.

**Regulation 10 – Document assurance by appropriate Overview and Scrutiny Committee**

This regulation sets out the requirement for a provider to send a copy of their Quality Account to their appropriate OSC within 30 days beginning with 1 April at the end of the reporting period (i.e. by 30 April each year).

To fulfil this obligation, the provider should send their Quality Account to the OSC in the local authority area in which the provider's principal office is located. The method of communication (post, email etc) is not specified in the regulation and should be left to local determination.
THE AKWAABA AYEH MENTAL HEALTH ADVOCACY PROJECT

The Akwaaba Ayeh (formally known as the Mental Health Shop) was the initiative of a group of local community workers who called together those involved or interested in the field of mental health. They discussed issues, which surround black people and their experience of the mental health services. The group went on to provide information, advice and support on a range of issues such as police involvement, housing, after care and advocacy.

Post a research report in 1999 ‘Sadness In My Heart’ the group finally obtained funding from the local authority and the Mental Health Shop was born. Akwaaba Ayeh offers advice, information and support to people experiencing mental health problems and their carers. Priority is given to African, African Caribbean and Asian people living in the Highfields area of Leicester, although we assist people resident in psychiatric hospitals and wards outside of this catchment area.

The Akwaaba Ayeh Project is an Advocacy Project. Our service aim to promote help in the way that our clients want to be helped e.g. psychiatric, social workers, housing benefits etc.

Referrals are accepted from people experiencing mental health problems, relatives, carers, social services, health authority staff, GP’s housing organisation and voluntary and community groups.

Research after Research has revealed that Black people are over represented in social care and psychiatric systems. Akwaaba Ayeh is unique. Not just because we are one of the first black advocacy project’s in the UK but, because we have helped to shape mental health services locally, regionally and nationally by fighting racial inequalities in health and social care services on behalf of our service user. That is, helped breakdown barriers such as, language, race, culture, gender, diagnosis, divides between East and Western Culture, appropriate medical/social care assessments. Our fight against racial inequality in mental health must remain unique as otherwise it will become dissolved i.e. black people would not be given priority and routinely processed via service provision as they would be no challenge to racial inequality at any level. In Leicester we are unique. We are the only black advocacy provider therefore it must remain unique.
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**Background to scrutiny reviews**

Getting the right topics for scrutiny reviews is the first step in making sure scrutiny provides benefits to the Council and the community.

The scoping template has been designed to assist in thinking through the purpose of a review. This scoping document needs to be completed by the member proposing the review.

In order to be effective, every scrutiny review must be properly project managed. This is to make sure that the review achieves its aims and has measurable outcomes. One of the most important ways to make sure that a review goes well is to ensure that it is well defined at the outset. This way the review is less likely to get sidetracked or be overambitious in what it hopes to tackle. The task group’s objectives should, therefore, be as SMART (Specific, Measurable, Achievable, Realistic & Time-bound) as possible.

This template includes a section for the Department to complete to allow OSC to consider any additional factors that may influence the proposed review.

Scrutiny reviews will be facilitated by a Members Support Officer.

**Evaluation**

Reviewing changes that have been made as a result of a scrutiny review is the most common way of assessing effectiveness. This will, in part, be done through the Scrutiny Annual Report which is produced yearly and which will include departmental feedback on which, if any, recommendations from task group reports have been taken forward as well as providing an explanation where they have not been implemented. However, any scrutiny review should consider whether an on-going monitoring role for the task group is appropriate to the topic under review.

For further information please contact the Members Support Team on (0116) 229 8824
1. Title of Proposed Scrutiny Review

To re-visit the 2010 scrutiny review of Mental Health Services (working age adults)

Proposed by - Councillor Michael Cooke, chair of Health and Community
Involvement Scrutiny Commission

2. Rationale

In 2010 the Health Scrutiny Committee completed a scrutiny review on how Mental
Health Services are delivered in Leicester.

The review in 2010 achieved the following:
   1) Identified the current provision of adult mental health services across the city
   2) Benchmarked users and carers perceptions of that service
   3) Highlighted any gaps in current and planned provision of the service
   4) Identified potential improvements to the service

The new Health and Community Involvement Scrutiny Commission is to re-visit this
review to measure what improvements have been made to the service in Leicester.

3. Purpose and Objectives of Review

The purpose of this review is to find out:
   1) what actions have been carried out by the service in relation to the
      recommendations made.

   2) How this service will be delivered in the future
4. Outcome

- To gain a clear understanding of how mental health services in Leicester have improved since the last review.
- To comment on how mental health services in Leicester will be delivered in the future.
- To produce a report with recommendations

5. Methodology/Approach

- Take evidence from officers and stakeholders, including external organisations.
- Take the recommendations from the last review report and investigate what actions have been taken.
- Take evidence from users and providers of the mental health service in Leicester.
- The possibility of a visit to see how mental health services are delivered.

6. Time Management

- This review will start November 2011 and aim to finish by January 2012
7. Resource Requirements

This review will require officer time from Adult Social Care services.

The review will be supported by Member Support Officer time.

8. Risks

- Insufficient time to complete the review
- Availability of people from whom to take evidence

9. Publicity

- Publicity will be through the commission meetings held and information sent to users of the mental health service.
- Information about this review will be publicised on LCC website

10. Further Supporting Evidence

You may feel you would like to add further information to support your case for an inquiry. Please feel free to do so in the space below.
11. Departmental Comments

Scrutiny’s role is to influence others to take action. It is, therefore, important for OSC to understand the department’s view of the proposed review. Please ensure that the following box is filled in by a relevant officer in the department.

This review is supported by the Adult Social Care Service.

Departmental Comments Completed by

Job Title
### CURRENT / ONGOING ISSUES – October 2011

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>PRESENTED BY:</th>
<th>DATE FOR</th>
<th>THEME / COMMENTS</th>
</tr>
</thead>
</table>
| The broad issues around the forthcoming changes to the NHS & Public Health White Paper | Deb Watson | On going | - GP Commissioning collusion  
- Patient choice  
- 18 week target  
- Healthwatch  
- Transition  
- Personal Health Budgets |
| Public Health Work by the City Council | Cabinet Lead | On going | To receive update /progress at each commission meeting |
| Revisit the Adult Mental Health Services Review conducted last year | Tracie Rees, Director of Commissioning | To be confirmed | |
| Review the Joint Health Scrutiny arrangements | Cllr Cooke, Chair | September 2011 | Initial discussions taken place |
| Autumn – Plan a public meeting to invite people’s views/concerns and ideas for future reviews | Cllr Cooke, Chair | October 2011 | It is planned that a discussion meeting will be held with service users and health organisations to find out what issues are important to them. This information will then be used to inform the work programme and help set priorities.  
The meeting will be held at 2.00 pm on Wednesday, 23 November 2011 in the Tea Room at the Town Hall.  
Suggestions for invitees and the format that the meeting could take are invited.  
Voluntary Action LeicesterShire has agreed to help with publicity for this event |

### Possible items for future scrutiny

<table>
<thead>
<tr>
<th>TOPIC / ISSUE</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Health Inequalities / Health Promotion</td>
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</table>
### Health & Community Involvement Scrutiny Commission
#### Draft Work Programme 2011/12

<table>
<thead>
<tr>
<th>TOPIC / ISSUE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalisation Care Agenda &amp; Budgets</td>
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<tr>
<td>University Hospitals of Leicester Stabilisation Plan</td>
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<td>Healthy Heart Programme</td>
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<td>Integrated Intermediate Care and Reablement</td>
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<td>Integrated Health and Social Care Services</td>
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<td>Social Marketing</td>
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<td>Health Through Warmth</td>
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<td>Drug Use and Users</td>
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<td>Maternity Services</td>
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<td>Annual Health Check</td>
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<td>Mental Health Services (Children’s)</td>
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<td>PCT funding linked to Social Care</td>
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<td>Health and Wellbeing Board</td>
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<td>Progress on Public Health Implementation</td>
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<tr>
<td>Dementia Services / Strategy</td>
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<td>Hospital Discharges</td>
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<td>GP Visiting (Home visits by GPs)</td>
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<tr>
<td>Condition of GP Practices following the ending of the NHS “Fit for Purpose” programme</td>
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**Possible item – Discussion Meeting with Key Stakeholders**
## LEICESTER CITY COUNCIL

### EXTRACT FROM FORWARD PLAN OF KEY DECISIONS

**FOR THE PERIOD: 1 OCTOBER 2011 TO 31 JANUARY 2012.**

<table>
<thead>
<tr>
<th>KEY DECISION</th>
<th>REASON</th>
<th>DECISION MAKER</th>
<th>PERIOD WITHIN WHICH DECISION TO BE TAKEN</th>
<th>THOSE TO BE CONSULTED AND HOW</th>
<th>RELEVANT REPORTS</th>
<th>TO WHOM REPRESENTATIONS SHOULD BE MADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS AND SOCIAL CARE RE-ABLEMENT PATHWAY To consider the development of an integrated health and social care re-ablement pathway.</td>
<td>Is significant in terms of its effect on communities living or working in an area comprising more than one ward.</td>
<td>Cabinet/City Mayor</td>
<td>November 2011</td>
<td>Following consultation with UHL, LPT and PCT.</td>
<td></td>
<td>Director of Public Health, <a href="mailto:Deb.Watson@leicester.gov.uk">Deb.Watson@leicester.gov.uk</a></td>
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<tr>
<td>LLR DEMENTIA STRATEGY</td>
<td>Is significant in terms of its effect on communities living or working in an area comprising more than one ward</td>
<td>Cabinet Lead Member for Adults</td>
<td>Between 1 Oct 2011 and 31 Jan 2012</td>
<td>TBC.</td>
<td>Director of Public Health, <a href="mailto:Deb.Watson@leicester.gov.uk">Deb.Watson@leicester.gov.uk</a></td>
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<tr>
<td>NHS WHITE PAPER TRANSPORT PLAN, LEICESTER CITY COUNCIL</td>
<td>Is significant in terms of its effect on communities living or working in an area comprising more than one ward</td>
<td>Cabinet/City Mayor</td>
<td>Between 1 Oct 2011 and 31 Jan 2012</td>
<td>TBC</td>
<td>Director of Public Health, <a href="mailto:Deb.Watson@leicester.gov.uk">Deb.Watson@leicester.gov.uk</a></td>
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NOTES

* Key decisions are defined as:

An executive decision which is likely:-

- to result in the Council incurring expenditure which is, or the making of savings which are significant having regard to the Council’s budget for the service or function to which the decision relates; or

- to be significant in terms of its effects on communities living or working in an area comprising one or more Wards in the City.

Expenditure or savings will be regarded as being significant if:-

- in the case of revenue the expenditure/savings are outside the approved revenue budget and are greater than £250,000

- in the case of capital, the capital expenditure/savings are £1,000,000 or more.

Not all decisions to be taken by the Cabinet will be key decisions.
Shadow Health and Well Being Board
Terms of Reference
Leicester City

Introduction
The Shadow Health & Well Being (SH&WB) Board will be an advisory body to Leicester City Council Cabinet, the One Leicester Clinical Commissioning Group and Leicester, Leicestershire and Rutland Primary Care Trust Cluster.

The SH&WB Board will run in shadow form through 2011 and 2012. It is expected that legislation will be passed to allow the SH&WB Board to become an Executive Committee of Leicester City Council from April 2013.

From April 2013 onwards, the board will become statutory with new scrutiny regulations in place supporting democratic involvement, accountability and transparency.

These terms of reference will be tried and tested by the board whilst it is in shadow form, therefore this document is subject to change. There will be a specific review of these terms of reference after the first 6 months of working in Shadow form (i.e. in February 2012)

1. Aim
To achieve better health, Well Being and social care outcomes for Leicester City’s population and a better quality of care for patients and other people using services.

2. Key Role
2.1 lead on improving the strategic coordination of commissioning across NHS, social care, and related children’s and public health services

2.2 bring together the key NHS, public health and social care leaders in each local authority area to work in partnership

2.3 provide a key forum for public accountability of NHS, public health, social care for adults and children and other commissioned services that the health and Well Being board agrees are directly related to health and Well Being.

3. Responsibilities
3.1 Identify current and future health and Well Being needs with the One Leicester Clinical Commissioning Group across Leicester City through revising the Joint Strategic Needs Assessment (JSNA) as and when required.

3.2 Develop and agree the priorities for improving the health and Well Being of the people of Leicester and tackling health inequalities

3.3 Prepare and publish a Joint Health and Well Being Strategy (JHWS) that is evidence based through the work of the Joint Strategic Needs Assessment (JSNA)
and supported by all stakeholders. This will set out our objectives, trajectory for achievement and how we will be jointly held account for delivery.

3.4 Develop solutions to complex challenges outlined in the JSNA and JHWS.

3.5 Facilitate partnership working across health and social care to ensure that services are joined up around the needs of service users. Encourage persons who arrange for the provision of health-related services in its area to work closely with the health and Well Being board.

3.6 Join up partnership working across Leicester City, particularly linking to the Strategic Partnership and ensure there are appropriate links with the Local Safeguarding Children’s Board and Safeguarding Adults Board.

3.7 Ensure governance arrangements, strategic partnerships and relationships are in place to progress the JHWS and address any barriers to success.

3.8 To have oversight of the use of relevant public sector resources across a wide range of services and interventions, with greater focus and integration across outcomes spanning health care, social care and public health.

3.9 Make use of flexibilities available such as pooled budgets and lead commissioning arrangements to provide more integrated commissioning across health and social care.

3.10 Focus resources on the agreed set of priorities for health, Well Being and social care (as outlined in the JSNA and JHWS).

3.11 Ensure that the One Leicester Clinical Commissioning Group and other NHS commissioners demonstrate how the JHWS has been implemented in their commissioning decisions.

3.12 Ensure that other commissioners of services relevant to health and Well Being demonstrate how the JHWS has been implemented in their commissioning decisions.

3.13 Ensure that all relevant partners have regard to the JHWS when exercising commissioning functions.

3.14 Review performance against key outcome indicators and be collectively accountable for outcomes and targets specific to performance frameworks within the NHS, Local Authority and Public Health.

3.15 Ensure that the work of the board is aligned with policy developments both locally and nationally.

3.16 Ensure robust arrangements are in place for smooth transition into the Statutory Board in time for April 2013.

3.17 Provide an annual report from the Shadow Health and Well Being Board to the Leicester City Council Cabinet and to the Board of NHS Leicester City (or its successor)
4. Communication and Engagement

4.1 Develop and implement a Communications and Engagement plan, outlining how the board will be influenced by stakeholders and the public, and how the board will disseminate specific duties required by the board, including consultation on service changes.

4.2 Communicate and engage with local people in how they can achieve the best possible quality of life and be supported to exercise choice and control over their personal health and Well Being.

4.3 Represent Leicester City in relation to health & wellbeing issues at local, regional and national level.

5. Membership

5.1 Initial members:

Elected Members (3)
- The City Mayor (Chair of the shadow Health and Well Being Board) (1)
- The Assistant Mayor, Health Portfolio (1)
- The Deputy City Mayor (1)

One Leicester Clinical Commissioning Group (3)
- The Chair of the One Leicester Clinical Commissioning Group (or a representative as nominated by the Chair of the One Leicester Clinical Commissioning Group) (1)
- The ‘Director Buddy’ supporting the development of One Leicester Clinical Commissioning Group (1)
- One further representative from the NHS: During the transition period, this will include the Chief Executive of the Primary Care Trust (PCT) Cluster or a representative as nominated by the Chief Executive of the PCT cluster (1)

Officers (3)
- The Director of Public Health and Health Improvement, (NHS Leicester and Leicester City Council) (1)
- The Strategic Director for Adults and Communities (Leicester City Council) (1)
- The Strategic Director, Children (Leicester City Council) (1)

Local Health Watch and other representatives (3)
- One representative of the local health watch organisation for the area of the local authority, i.e. currently Leicester Local Involvement Network (LINK) (1)
- Such other person(s) as the local authority and/or health and Well Being board thinks appropriate.

Note: The board’s membership reflects the anticipated statutory provisions and the main funding partners. Arrangements will be made to establish a structure that supports the work required by the board (to include stakeholders and providers).

6. Quorum
6.1 For a meeting to take place there must be at least one representative from each of the groups present, that is:

- Leicester City Council (Elected member)
- One Leicester Clinical Commissioning Group
- Director of Public Health
- Local Health watch

7. Voting

7.1 Decisions will be reached through a majority vote of members; where the outcome of a vote is impasse the chair will have the casting vote.

8. Chair

8.1 The chair of the Shadow Health & Well Being Board will be the City Mayor.

9. Meetings

9.1 Administration support will be provided by Leicester City Council.

9.2 There will be standing items on each agenda to include:

- Declarations of Interest
- Minutes of the Previous Meeting
- Matters Arising
- Updates from each of the formal subgroups of the Health & Well Being Board,

9.3 Meetings will be held approximately every quarter (4 times a year) or more frequently until the Board is formally established

Version 2 Amended at point 3.2 following discussion at the first meeting of the shadow Health and Wellbeing Board on 11th August 2011
1. Introduction

Sir Peter Soulsby, Leicester’s elected City Mayor, has set out a programme of immediate priorities to be delivered within the first 100 days following his election to office on 5th May 2011. This includes a pledge relating to the new Health and Well Being Board as follows:

“In our first 100 days, we will …… set out our public health priorities and expectations of local health service providers through the new Health and Well Being Board and ensure Leicester’s transition arrangements are on track with clear public accountability arrangements in place for the NHS.”

This paper provides proposals for discussion relating to (a) public health priorities in Leicester and (b) expectations of local health service providers.

2. Public Health Priorities

2.1 Statement of Priorities

Poor health is an important strategic issue for Leicester. People in the city die early, particularly from circulatory diseases (heart disease, stroke and diabetes), cancers and respiratory diseases. Poor health is largely driven by deprivation and exacerbated by lifestyle factors embedded within communities. The inequalities gap in health between Leicester and England is not narrowing and limited progress has been made to reduce the gap between the more deprived and the more affluent communities within Leicester.

We recognise that there will be no quick fixes and that what is required is sustained efforts for both short and longer term improvement. This will require:

- the engagement of individuals and communities
- the use of best evidence of effectiveness to guide what we do
- targeting of efforts to where they can have greatest effect
- evaluating what we do to ensure best use of resources.

Addressing the issue is a combination of health improvement initiatives, better health care and improvements in the social, economic and environmental circumstances influencing better health.

Our priorities for public health are therefore to accelerate improvements in:
• Lifestyle factors
  – Reducing smoking
  – Improving physical activity, diet, healthy weight
  – Reducing harmful consumption of alcohol.

• Care services
  – Improving access, take-up and quality of services, especially preventative care provided by GPs and primary care and early treatment, immunisation and screening

• Wider factors that influence health over the long term
  – Including educational attainment, skills, employment, housing, transport and crime.

In addition to the developmental priorities outlined above, constant surveillance and vigilance is also required to ensure that the health of the population is protected from communicable disease and any new or emerging threats to health.

It is important that we seize the new opportunities provided by the new relationship between the City Council and the commissioners of health care through the Health and Well Being Board and the council’s scrutiny processes.

The important support work that the voluntary and community sector does to improve health and wellbeing is explicitly recognised.

2.2 Rationale

These priorities outlined above are proposed based on:
  • the annual report of the Director of Public Health
  • recent presentations of Leicester’s health needs and priorities to:
    ➢ the City Mayor on 11th May 2011
    ➢ One Leicester Clinical Commissioning Group Development Day on 17th May
    ➢ Leicester City Council Cabinet on 25th May 2011; and
    ➢ the ‘Health in Leicester’ presentation and debate at full Council on Health in Leicester on 29th June 2011,
  • the Leicester Ward Health Profiles 2011,
  • the Health Profile of Leicester 2011.

Public Health priorities for will be reviewed annually following the publication of the independent report of the Director of Public Health and Health Improvement. Priorities may also change in response to significant new or emerging threats to population health.
2.3 Notes re Public Health priorities

The public health priorities for Leicester are set out at a very high level above but can also be articulated in more detailed plans and performance indicators.

2.3.1. Plans

There is an existing Health Inequalities Improvement Plan for Leicester which includes detailed actions within the NHS and local authority to accelerate progress on issues that can be expected to have impact in the short to medium term (i.e. improving lifestyle factors and improving access to and take up of preventative care services).

In relation tackling the wider social determinants of health, it is important that evidence recently provided by Professor Sir Michael Marmot in ‘Fair society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010’ is used to influence the development of local plans and actions reduce health inequalities by maximising positive impacts on health and mitigating risks to health throughout life. ‘Fair society, Healthy Lives’ adopts a life course framework which aims to build people’s self-esteem, confidence and resilience right from infancy, with stronger support for early years.

2.3.2 Performance Indicators

The new national Public Health Outcomes framework is currently awaited and is expected to be published in Autumn 2011 following consultation as part of the Public Health White Paper, ‘Healthy Lives, Healthy People: Our Strategy for Public Health in England’. The new Public Health Outcomes framework will complement the new Outcomes Frameworks for the NHS and for adult social care.

In the meantime, to avoid loss of momentum in relation to existing Public Health indicators, Strategic Health Authorities have agreed targets with PCT Clusters for existing NHS public health indicators over the next three years.

3. Expectations of Health Service Providers

3.1 Statement of expectations

Through strategic oversight of health and social care commissioning the Shadow Health and Well Being Board will ensure that health service providers

- uphold the NHS Constitution
- develop services in accordance with the health needs of the local population
- ensure that service provision is informed by the needs of service users and addresses the needs of minority and vulnerable groups.
- provide services in a way that is informed by best clinical evidence and with regard to considerations of health care efficiency.
• support partnership working with other agencies to ensure delivery of services in the most effective and efficient way
• meet the standards of the NHS Outcomes Framework

3.2 Rationale

The expectations articulated in the statement above move through first addressing the rights and obligations of individuals as laid out in the NHS Constitution to ensuring that services are developed in relation to local need and delivered with respect to the particular needs of users. These should be of the highest clinical standard and delivered effectively and efficiently through engagement with partners. Health service providers should meet the standards of the NHS Outcomes Framework.

3.3. Notes re Expectations of health Service Providers

Health needs of the local population as jointly identified in Joint Strategic Needs Assessments, Annual Reports of the Director of Public Health and other public health advice and in line with the Leicester Joint Health and Well Being Strategy (to be developed through the Health and Well Being Board).

Informed by the needs of service users is seeking a responsiveness to the particular needs of individuals and particular vulnerable groups in the population so that there is equitable access, take up and outcomes of health care – this can be demonstrated through audits (including health equity audits) and evaluations in key service areas.

Informed by best clinical evidence particularly NICE guidance and other expert systematic reviews of evidence of effectiveness and cost effectiveness.

Partnership working including the development of joint commissioning arrangements between the council and the One Leicester Clinical Commissioning Group.

The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of the NHS Constitution in their decisions and actions.


The NHS Outcomes Framework is a national (England) statement of the expectations of the NHS. During 2011/12, the framework will be finalised nationally, baselines will be identified and levels of ambition will be negotiated for the NHS nationally against the indicators. During 2012/12, the Secretary of State will use the outcomes framework to hold the NHS Commissioning Board
to account and in turn, the NHS Commissioning Board will use the framework to hold local NHS Commissioner to account. 

Deb Watson
Director of Public Health and Health Improvement
NHS Leicester City and Leicester City Council
14 July 2011.

(Amended following discussion at the shadow Health and Wellbeing Board on 11th August 2011)
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LEICESTER HEALTH INEQUALITIES IMPROVEMENT PLAN 2011/2012

ALL ACTIONS FOR JULY 2011 WELLBEING AND HEALTH PRIORITY BOARD

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<td>7.1</td>
<td>1. Early Intervention &amp; Prevention:</td>
<td>One hundred first time vulnerable mothers aged under-19 from across the city, from early pregnancy until the child is two years old</td>
<td>David Thrussell, Head of Service for YOS &amp; Interim HoS for Youth Support, Leicester City Council (LCC)</td>
<td>Specific dates in action plan</td>
<td>TBC Sept 2011</td>
<td>Family Nurse Partnership to be commenced in Leicester. Supervisor recruited June 2011. Consultation on the core offer is to be completed by 8th July.</td>
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<td>7.2</td>
<td>2. Raising Aspirations</td>
<td>Four I..ME programmes delivered and evaluated</td>
<td>Adam Suddaby, 13-19 Lead for EET, LCC</td>
<td>Specific dates in action plan</td>
<td>TBC Sept 2011</td>
<td>SRE senior strategic lead is leading on this agenda and plans are in place to get further leadership through the Leicester’s Schools &amp; Colleges Alliance. I ME programme is being delivered in four secondary schools.</td>
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<td>wards. Raising aspiration is central to the Children’s Trust effectively meeting a range of targets, including the reduction of teenage pregnancy and improving outcomes for teenage mothers and young fathers</td>
<td>Eight schools involved in the action research knowledge centre on RSE</td>
<td>Bill Morris, Director for the Education Improvement Partnership &amp; SRE Strategic Lead</td>
<td>Specific dates in action plan</td>
<td>TBC Sept 2011</td>
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<td>7.3</td>
<td>3. Relationships &amp; Sex Education: National and international research shows that good quality SRE has a protective function as young people who have had good SRE are more likely to choose to have sex for the first time later. There is no evidence that SRE hastens the first experience of sex.</td>
<td>One member of staff trained in PSHE CPD in all 18 schools &amp; PRUs</td>
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<td>5 speakeasy programmes delivered by July</td>
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<td>7.4</td>
<td>4. Contraception &amp; Sexual Health for young people A review by the Government's Teenage Pregnancy Unit found the provision of young people focused contraception and sexual health services had the biggest impact on conception rate reductions in high performing areas</td>
<td>15 additional professionals LAQRC trained by April 2012</td>
<td>Liz Rodrigo, Public Health Lead for Sexual Health, NHS Leicester City (NHSLC)</td>
<td>Specific dates in action plan</td>
<td>TBC Sept 2011</td>
<td>Weekender service reduced due to lack of use on Sundays and Mondays. Revised hours commenced 26 April 2011 and will be reviewed in 6 months. Youth advisors to be recruited to assess local sexual health provision and needs – report due end September 2011.</td>
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<td>support for teenage parents to increase their employability through access to education, training and employment (ETE). Paid employment is the single most important factor in reducing the risk of poverty</td>
<td>teenagers and young parents&lt;br&gt;One hundred first time vulnerable mothers aged under-19 from across the city, from early pregnancy until the child is two years old</td>
<td>Parents Coordinator, Connexions</td>
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<td>7.6</td>
<td>6. Workforce Training: Workforce training is a key priority for the Teenage Pregnancy Partnership as it is a sustainable approach to ensuring that children, young people and families have access to professionals who can effectively support them</td>
<td>Eleven teenage pregnancy training courses delivered by Oct 2011&lt;br&gt;Two training courses delivered in each locality April 2012</td>
<td>Gill Stacey, Head of Workforce, LCC</td>
<td>Specific dates in action plan</td>
<td>TBC Sept 201</td>
<td>Interim training programme has been developed. Children and Young People learning and development plan evaluation form adopted. E:Learning basic level RSE awareness course is being developed</td>
</tr>
<tr>
<td>7.7</td>
<td>7. Communications: Clear and consistent messages to young people through media campaigns can also impact positively on young people’s attitudes and behaviour. For example, surveys with young people have showed that those who recalled hearing the teenage pregnancy strategy media adverts were more likely to say that they would: access advice and support; discuss contraception with their partner; use contraception; resist pressure from friends; and say no to sex if they did not feel</td>
<td>LARC city &amp; county campaign targeting 16-19 year olds – Sept 2011&lt;br&gt;LARC campaign targeting 18-25 year olds&lt;br&gt;Christmas campaign Dec2011 /Jan 2012</td>
<td>Melanie Shilton, NHSLC, Marketing Manager &amp; Shaun Knapp, Senior Marketing Officer, LCC</td>
<td>Specific dates in action plan</td>
<td>TBC Sept 2011</td>
<td>LARC YouTube video is available. Vox pop video and relationships and sex education toolkit for FE is being trialled at two colleges. Launch is still planned for Sept.</td>
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### Ref Objective Outputs Operational Lead Review Date RAG Progress (As at 12 July 2011)

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<td>7.8</td>
<td>8. Data: Detailed, accurate and up-to-date data and information are essential for determining need, planning, commissioning and performance managing appropriately targeted programmes. Additional local information is required to identify young people most at risk to allow effective targeting.</td>
<td>6 bi-monthly data reports presented at the TP Executive Board Evidence for two JPAB planning sessions</td>
<td>Rowan Smith, Public Health Data Analyst, NHSLC</td>
<td>specific dates in action plan</td>
<td>TBC Sept 2011</td>
<td>Data reports are presented to the Teenage Pregnancy Executive Board to identify trends and inform commissioning priorities.</td>
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Section 16: Healthy eating, healthy weight and physical activity

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<tr>
<td>16.1</td>
<td>Increase levels of physical activity in adults and target interventions to have the greatest impact on inequalities.</td>
<td>Development of the Let's Get Moving Physical Activity care pathway to best suit local needs.</td>
<td>Sumina Azam, Steph Dunkley</td>
<td>October 2011</td>
<td>Amber</td>
<td>Funding for Let's Get Moving withdrawn in 2010/11, but available for 2011/12. Included in Leicester Sport Partnership Trust and the Healthy Weight Strategic Group's physical activity action plan. Pathway development work underway. Discussions are beginning with partners that may be able to help with delivery of the pathway.</td>
</tr>
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<td>16.2</td>
<td>Increase levels of physical activity in adults and target interventions to have the greatest impact on inequalities.</td>
<td>Work with local dance co-ordinators to increase physical activity levels in adults / families (non-recurrent funding).</td>
<td>Sumina Azam, Steph Dunkley</td>
<td>October 2011</td>
<td>Green</td>
<td>Work with dance co-ordinators is on track. Dance 4 are developing a project brief to deliver a programme of dance to targeted groups in Leicester (the elderly, those from BME communities and those with Learning Disabilities).</td>
</tr>
<tr>
<td>16.3</td>
<td>Increase levels of physical activity in adults and target interventions to have the greatest impact on inequalities.</td>
<td>Work in partnership with Local Authorities to increase uptake of the Active Lifestyle Scheme and increase the number of adults making the 3x30 Pledge.</td>
<td>Sumina Azam, Steph Dunkley</td>
<td>November 2011</td>
<td>Green</td>
<td>Partnership with Local Authorities is on track.</td>
</tr>
<tr>
<td>16.4</td>
<td>Increase levels of physical activity in adults and target interventions to have the greatest impact on inequalities.</td>
<td>Work in partnership to integrate walking activities into physical activity pathway and increase the numbers of health walks.</td>
<td>Sumina Azam, Steph Dunkley</td>
<td>October 2011</td>
<td>Amber</td>
<td>Nominated walking lead to be agreed. Walking task and finish group established. Walking Week 4 - 12 June. 2 additional walk leader trainers trained. 'Healthy Hearts' Walking challenge launched weekend 4th June at Riverside Festival.</td>
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<td>16.5</td>
<td>Increase levels of physical activity in adults and target interventions to have the greatest impact on inequalities.</td>
<td>Work in partnership with Sustainable Transport cycling team to integrate cycling activities into physical activity pathway.</td>
<td>Sumina Azam</td>
<td>October 2011</td>
<td>Green</td>
<td>Cross-intervention opportunities established e.g. cycling is being promoted as an exit route for those taking part in the Active Lifestyles Scheme.</td>
</tr>
<tr>
<td>16.6</td>
<td>Increase levels of physical activity in adults and target interventions to have the greatest impact on inequalities.</td>
<td>Work with Sports Services to deliver physical activity related initiatives to areas of deprivation (non-recurrent funding)</td>
<td>Sumina Azam</td>
<td>November 2011</td>
<td>Green</td>
<td>Planning for delivery of projects underway.</td>
</tr>
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<td>16.7</td>
<td>Promote healthy weight through increasing healthy eating and physical activity behaviours in children and Early Years and target interventions to have the greatest impact on inequalities.</td>
<td>Increase nutrition knowledge and skills of children attending primary schools and their families through participation with the Food Routes programme</td>
<td>Sumina Azam</td>
<td>October 2011</td>
<td>Green</td>
<td>On track</td>
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<td>16.8</td>
<td>Promote healthy weight through increasing healthy eating and physical activity behaviours in children and Early Years and target interventions to have the greatest impact on inequalities.</td>
<td>Work with local professional sports clubs to increase physical activity levels in school children (non-recurrent funding).</td>
<td>Sumina Azam</td>
<td>September 2011</td>
<td>Green</td>
<td>Project planning currently underway, with delivery planned to start Autumn 2011.</td>
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<tr>
<td>16.9</td>
<td>Promote healthy weight through increasing healthy eating and physical activity behaviours in children and Early Years and target interventions to have the greatest impact on inequalities.</td>
<td>Work with local physical activity experts to deliver out of school physical activity opportunities.</td>
<td>Wayne Allsopp</td>
<td>Sept 2011</td>
<td>Green</td>
<td>Intervention options being considered informed by social marketing insight (see 16.10)</td>
</tr>
<tr>
<td>16.10</td>
<td>Promote healthy weight through increasing healthy eating and physical activity behaviours in children and Early Years and</td>
<td>Complete social marketing insight work in Braunstone and New Parks targeting families</td>
<td>Sumina Azam, Melanie Shilton</td>
<td>November 2011</td>
<td>Green</td>
<td>Results of social marketing work has been fed back to the Healthy Weight Strategic Group and the information has been used to further develop interventions in the health and wellbeing strategy.</td>
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<td>target interventions to have the greatest impact on inequalities.</td>
<td>with children under 5 years and use insight work to inform delivery of current services and commissioning decisions.</td>
<td>Steph Dunkley</td>
<td></td>
<td></td>
<td>Braunstone and New Parks area. Further insight work has been agreed with BME communities, in view of high levels of overweight and obesity in the adult population.</td>
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<td>16.11</td>
<td>Promote healthy weight through increasing healthy eating and physical activity behaviours in children and Early Years and target interventions to have the greatest impact on inequalities.</td>
<td>Work with partners at LCC e.g. Children’s Services, Education to develop links between healthy weight strategies and partnership work.</td>
<td>Sumina Azam Steph Dunkley</td>
<td>January 2011</td>
<td>Green</td>
<td>On track</td>
</tr>
<tr>
<td>16.12</td>
<td>Promote healthy weight through increasing healthy eating and physical activity behaviours in children and Early Years and target interventions to have the greatest impact on inequalities.</td>
<td>Ensure that delivery of training to children’s workforce e.g. HENRY is effectively targeted and that interventions are evaluated.</td>
<td>Sumina Azam Steph Dunkley</td>
<td>October 2011</td>
<td>Green</td>
<td>Delivery of HENRY core training has begun. Further training is being purchased for community health staff. Facilitated e-learning is also in development.</td>
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<td>16.12a</td>
<td>Promote healthier eating and healthy weight through increased uptake of school meals. Ensure that all families who are eligible for free school meals register for them, and that children and young people understand the benefits of choosing a nutritionally balanced meal at lunchtime.</td>
<td>City Mayor 100 Days Programme commitment to make sure school meals in Leicester remain affordable and nutritional. Effective delivery of the action plan produced as a result of recommendations from the Children &amp; Young People’s Scrutiny Committee Task Group ‘Review of School Meals’.</td>
<td>Trevor Pringle Annie Vesty</td>
<td>tbc</td>
<td>Green</td>
<td>Action plan completed and agreed and actions / recommendations are progressing.</td>
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<td>16.13</td>
<td>Ensure that adult weight management interventions are targeted at and accessible to populations with greatest need i.e. those with highest levels of overweight and obesity and deprived communities</td>
<td>Food and Activity Buddies (FAB) is targeted at areas of highest deprivation and highest overweight and obesity levels. A new service model (adult weight management model supported by the B-active coaching and volunteering project) has an increased target of 2000 participants per year from Jan 2011, compared with previous target of 700 participants.</td>
<td>Sumina Azam Rob Melling Steph Dunkley</td>
<td>November 2011</td>
<td>Green</td>
<td>FAB has commenced a new adult weight management model in January 2011, which is currently undergoing formal evaluation.</td>
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<td>16.14</td>
<td>Ensure that adult weight management interventions are targeted at and accessible to populations with greatest need i.e. those with highest levels of overweight and obesity and deprived communities</td>
<td>Diet, Health and Activity in Leicester (DHAL) is targeted at the South Asian Community, who have higher levels of adult overweight and obesity and higher levels of obesity related disease.</td>
<td>Sumina Azam Gulshinder Chatta Steph Dunkley</td>
<td>November 2011</td>
<td>Green</td>
<td>DHAL is underway and delivering to target.</td>
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<td>16.15</td>
<td>Ensure that children's weight management interventions are targeted at and accessible by populations with greatest need i.e. those with highest levels of overweight and obesity and deprived communities</td>
<td>Fit and Active Football is open to children aged 8 - 14 years old and their families who are overweight. The service is currently delivered in New Parks, Belgrave, Saffron/Eyres Monsell and Highfields to</td>
<td>Sumina Azam Chloe Jones Steph Dunkley</td>
<td>September 2011</td>
<td>Green</td>
<td>Meetings are currently being held with the service in order to maximise uptake and ensure that those taking part in the programme are benefitting from a high quality service.</td>
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<tr>
<td>16.16</td>
<td>Ensure that children’s weight management interventions are targeted at and accessible by populations with greatest need i.e. those with highest levels of overweight and obesity and deprived communities</td>
<td>Commission a weight management service for children aged under 8 years, as no service is currently available for this age group.</td>
<td>Sumina Azam, Steph Dunkley</td>
<td>September 2011</td>
<td>Amber</td>
<td>Tender specification is being written. The Competition Panel agreed that the service could be procured through going through a competition process in proportion with the size of the relatively small contract.</td>
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<td>16.17</td>
<td>Ensure that there is effective use of data and intelligence to support targeting of services to populations with greatest need.</td>
<td>Data from the NCMP programme to be disseminated to partners and used to inform commissioning and target interventions.</td>
<td>Sumina Azam, Steph Dunkley</td>
<td>November 2011</td>
<td>Green</td>
<td>The 2009/10 NCMP data has been disseminated to partners, including to schools. More detailed analysis of the data has been undertaken. The 2010/11 NCMP programme is currently underway.</td>
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<td>16.18</td>
<td>Ensure that there is effective use of data and intelligence to support targeting of services to populations with greatest need.</td>
<td>Use other data e.g. data from local Social marketing and national data sets effectively to target interventions effectively.</td>
<td>Sumina Azam, Steph Dunkley</td>
<td>November 2011</td>
<td>Green</td>
<td>Social marketing data is being disseminated and used to inform provision of services.</td>
</tr>
<tr>
<td>16.19</td>
<td>Build the evidence base for interventions aimed at preventing or managing overweight and obesity, to ensure delivery of effective services.</td>
<td>Work with St Mary’s University to undertake a research project to develop an effective method of implementing new DH early years physical activity guidelines.</td>
<td>Sumina Azam, Steph Dunkley</td>
<td>September 2011</td>
<td>Amber</td>
<td>A research project is in the planning stages, implementation planned to start September 2011</td>
</tr>
<tr>
<td>16.20</td>
<td>Build the evidence base for interventions aimed at preventing or managing overweight and obesity, to improve service quality and ensure services are provided effectively.</td>
<td>Use information from service evaluations to improve service quality and ensure services are provided effectively.</td>
<td>Sumina Azam, Steph Dunkley</td>
<td>November 2011</td>
<td>Green</td>
<td>Four service evaluations are complete or currently underway. A fifth service may also be commissioned, after a review of budgetary constraints.</td>
</tr>
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</table>
| 16.21 | Projects to improve physical activity through active travel (HI £) | Pedometers – to be used for health walks, 3x30 and as part of personalised travel plans  
Walking promotion – this is for the promotion of Walkit.com e.g. at corporate events with schools  
StarWalker training – funding is to allow staff to go into school to increase involvement and monitor progress  
Scootability – the Scootability pilot project is currently being evaluated. This money will be used according to the recommendations and priorities that arise from the evaluation.  
Adult Cycle Training – This currently takes part in Abbey Park. Funding will be used to help roll out to other areas. | Jeff Miller  
Sally Slade | tbc | tbc | The PCT already contributes to walking and cycling interventions through the Active Lifestyles Scheme. Therefore, these interventions have been chosen as they add value to what has previously been agreed/is already underway. |
<table>
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<tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Skyride – this will contribute to the traffic management of the event.</td>
<td>Liz Blyth, Paul Edwards</td>
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<td></td>
<td></td>
<td>Four health days to be held at leisure centres in targeted deprived areas to be attended by 1000 people.</td>
<td></td>
<td>March 2012</td>
<td>Amber</td>
<td>The funding for each of these projects is to be agreed in May. Some of the projects are likely to continue to the 2012/13 financial year to increase the impact of the interventions and build sustainability.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop health walks across the city one from each the seven leisure centre areas.</td>
<td></td>
<td>March 2012</td>
<td>Amber</td>
<td>Facility managers at identified leisure centres have been informed that funding is available for health days, to be held October/November 2011 and early 2012</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Walking co-ordinator to co-ordinate and develop walking activities in Leicester City. Seven health walks.</td>
<td></td>
<td>September 2011</td>
<td>Red</td>
<td>Health walk training opportunity has been sent out to all children centre managers, five names put forward for training. Once walking co-ordinator in post, training opportunity will be promoted further.</td>
</tr>
<tr>
<td>16.22</td>
<td>Sports services to increase opportunities for people to become more active through a range of initiatives all funded through non recurrent funding</td>
<td>Sports Taster Sessions – 6 week taster sessions and link this in with the 3x30 pledge. Target one week at council staff, two weeks within companies in Leicester and three</td>
<td></td>
<td>March 2012</td>
<td>Amber</td>
<td>Four sessions of fitness classes held over one week, week commencing 30/06/11 for council staff, 66 participants. Email sent out to all participants for feedback, planning now to offer a weekly lunch time Pilates class to staff.</td>
</tr>
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<td></td>
<td>Have commenced work with Pepsico, over 200 staff members signed up to 3x30 pledge, company are interested in offering taster sessions to staff and then developing regular activities to include a health walk.</td>
</tr>
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<td></td>
<td>260 families signed up for free family swim pass. Letters sent to families’ week commencing 05/07/11 to collect passes from leisure centres.</td>
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<td></td>
<td>Health event being held at St Barnabas library on 30/07/11</td>
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</table>
## Section 11

### Smoking cessation and tobacco control

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<tr>
<th>Ref</th>
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</tr>
</thead>
</table>
| 11.1 | To carry out enforcement operations and targeted communications campaigns to reduce under-age sales of cigarettes. These actions will be targeted in areas where tobacco-related harm is highest and where intelligence indicates under-age selling by specific businesses.  
(\(H1 \ £\)) | 60 under age sales test purchases using "mystery shoppers" spread throughout the year, based on intelligence collection. Success will be measured by reference to a non-compliance target rate of < 12%. Programme to raise awareness of increasing use of false ID by under 18s. (Q2) | Adrian Russell  
John Fox | April 2012 | Green | Q1 (Apr-Jun):  
- 31 test purchases  
- 4 offences  
- Non-compliance rate = 12.9% |

| 11.2 | To gather intelligence, investigate and disrupt the supply of illicit tobacco sales (all forms of non-duty paid)  
(\(H1 \ £\)) | Establish joint working arrangements with EM HMRC Inland Tobacco Team. Planned outputs from operations are estimated to include: seizure and confiscation of illicit tobacco, 6 operations will result in formal enforcement actions | Adrian Russell  
John Fox | April 2012 | Green | June 2011: Joint working based on national HMRC/Trading Standards protocol established. Applies also to 12.3 below. First operation in Q2. |
<table>
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<tbody>
<tr>
<td>11.3</td>
<td>Inspection and sampling of Shisha smoking mixtures on sale at retailers and Shisha Cafes to assess compliance with UK statutory health warning regulation and payment of excise duty. (HI £)</td>
<td>25 compliance checks 10 samples taken for analysis Enforcement action for non-compliance: By TS for health warning law. By HMRC if non-duty paid.</td>
<td>Adrian Russell John Fox</td>
<td>April 2012</td>
<td>Green</td>
<td>June 2011: Programme initiated. Product with no health warnings discovered. Investigations into point of entry into UK and payment of duty; ongoing.</td>
</tr>
<tr>
<td>11.4</td>
<td>Inspection visits to Shisha Cafes to ensure compliance with the 2007 Smoke Free premises regulations and under age sales law. Covert monitoring targeted at suspected/known offenders. (HI £)</td>
<td>40 smoke-free compliance monitoring inspections (overt and covert) Intelligence-led UAS mystery shopper operations at 5 cafes (Q2)</td>
<td>Adrian Russell John Fox Gov Mandora</td>
<td>April 2012</td>
<td>Green</td>
<td>Q1 (Apr-Jun): • 10 inspections • 5 non-compliant</td>
</tr>
<tr>
<td>11.5</td>
<td>Formal, legal action in the forms of prosecutions in the criminal courts, simple cautions, reviews of premises licences, and orders suspending sales, will be taken as a proportionate response to the level of seriousness of non-compliance. (HI £)</td>
<td>tbc</td>
<td>Adrian Russell John Fox</td>
<td>April 2012</td>
<td>tbc</td>
<td>Q1: • Three businesses reported for prosecution; decision awaited. • Two further offenders; investigations continuing.</td>
</tr>
</tbody>
</table>

Section 12
Helping individual to stop smoking
Strategic Lead: Deb Watson
<table>
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<tr>
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<tbody>
<tr>
<td>12.1</td>
<td>Motivate and assist smokers to quit, using high quality combination of behavioural support and pharmacotherapies.</td>
<td>The 2011-12 target is 2,536 four-week quitters Q1 702 four-week quits (report due 9/9/11) Q2 516 four-week quits (report due 9/12/11) Q3 551 four-week quits (report due 14/3/12) Q4 767 four-week quits (report due 18/6/12)</td>
<td>Louise Ross</td>
<td>First review Sept 2011</td>
<td>Amber</td>
<td>The Q1 target carries a risk to achievement, due to front-loading The service exceeded the 2010-11 target by 135 four-week quits, reporting 2,605 to DH 255 four-week quits have been recorded in Q1 to date (4/7/11)</td>
</tr>
<tr>
<td>12.2</td>
<td>Reduce smoking in pregnancy</td>
<td>Smoking at time of delivery 13.9% by end Q4 2011-12, with a 1% reduction in each of the 6 priority wards. Freemen 25% from 26% Braunstone Park &amp; Rowley Fields 24% from 25% New Parks 34% from 35% Eyres Monsell 35% from 36% Westcotes 15% from 16%</td>
<td>Louise Ross Clare Mills</td>
<td>July 2011</td>
<td>Green</td>
<td>To be measured at end of each Quarter and reported via Tobacco Control Coordination Group</td>
</tr>
<tr>
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<tr>
<td></td>
<td></td>
<td>Humberstone &amp; Hamilton 9% from 10%</td>
<td></td>
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<td></td>
<td></td>
<td>NB Wide confidence intervals due to small numbers of births</td>
<td></td>
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<td></td>
<td></td>
<td>Consolidate contribution of Community Health Development Coordinators in supporting this workstream by July 2011</td>
<td></td>
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</table>

**Section 13**  
Denormalise smoking  
*Linkage to reducing infant mortality*

13.1 Increase the number of smoke free homes in Leicester  
Develop realistic plans to increase numbers of smoke free homes, involving a range of key partners. Report progress to the Tobacco Control Coordination Group.  
Louise Ross  
Karen House  
End July 2011  
Green  
Report outlining plan due end July 2011 and quarterly thereafter.

**Section 14**  
Evaluation of effectiveness of tobacco control actions

14.1 Evaluate impact of STOP! smoking service  
Programme of audit and evaluation to include:  
a) survey of smoking status at 52 weeks;  
Louise Ross  
August 2011  
Green  
Evaluation programme to be agreed by Tobacco Control Coordination Group by end August 2011.  
Progress to date:
<table>
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</table>
|     |           | b) audit of compliance with NICE guidance in at least one key area of the service; and  
|     |           | c) Health Equity Audit |              |         | a) Monthly survey of 52 week success demonstrates 38.4% of all eligible service users are still smokefree  
|     |           |         |                  |             |     | b) Audit of compliance with NICE guidance on smoking in pregnancy demonstrates almost full compliance  
|     |           |         |                  |             |     | c) Health Equity Audit can be started now that full 2010-11 dataset is ready for analysis  
| 14.2 | Evaluate at least one aspect of The SmokeScreen project aimed at young people in Leicester schools & colleges | Report end July 2011 on:  
Total number of sign-ups by students aged 11-19  
Number of assemblies where the presentation was delivered  
Number of schools/colleges which participated/did not participate  
To include:  
• testimonials from staff and students  
• recommendations for development in next academic year | Louise Ross  
Qasim Chowdary | August 2011 | Green | Analysis of outcomes to be considered by end August 2011. Plans for further development of strategy to reduce numbers of young people starting to smoke (ACTION) to be agreed by key stakeholders via Tobacco Control Coordination Group.  
Prevention of the uptake of smoking among young people is in the current NICE development programme; QC is on the stakeholder list  

## Appendix F

### Glossary and useful terms or jargon buster

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<tr>
<td>ACPC</td>
<td>Area Child Protection Committee</td>
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<tr>
<td>Acute services</td>
<td>Medical and surgical treatment and care provided typically in hospitals</td>
</tr>
<tr>
<td>Advocacy (in the context of ICAS)</td>
<td>Where a person supports someone making a complaint against the NHS</td>
</tr>
<tr>
<td>ALG</td>
<td>Association of London Government</td>
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<tr>
<td>Ambulatory Care Centre</td>
<td>See walk-in centre</td>
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<tr>
<td>APH</td>
<td>Association for Public Health</td>
</tr>
<tr>
<td>ASH</td>
<td>Action on Smoking and Health</td>
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<tr>
<td>BBV</td>
<td>Blood borne virus</td>
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<tr>
<td>BDA</td>
<td>British Dental Association or British Dietetic Association</td>
</tr>
<tr>
<td>Bed blocking (also known as delayed discharge)</td>
<td>Where patients that are fit for discharge remain in acute hospital beds when other more suitable forms of care are not being provided</td>
</tr>
<tr>
<td>Best Value</td>
<td>System of quality improvement in local government which sets a duty to deliver services of a clear standard, covering cost and quality by the most effective, economic and efficient means available. It is not currently applied to NHS services</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association – professional association of doctors, acting as a trade union, scientific and educational body and publishing house</td>
</tr>
<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>Booked admissions scheme</td>
<td>An airline-style booking system which makes arranging NHS appointments easier and more convenient for patients. Piloted in 24 areas</td>
</tr>
<tr>
<td>BPAS</td>
<td>British Pregnancy Advisory Service</td>
</tr>
<tr>
<td>BTS</td>
<td>Blood Transfusion Service</td>
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<tr>
<td>Caldicott guardian</td>
<td>All NHS organisations are required to appoint a Caldicott guardian – a person who has responsibility for policies that safeguard the confidentiality of patient information</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
</tbody>
</table>
Care trust  
PCT or NHS trust which includes social services commissioning on delegated authority from local government

CDS  
Community dental service

Centre for Public Scrutiny New organisation established to share good practice and innovation in all forms of public scrutiny

CHC  
Community Health Council

CHD  
Coronary heart disease

CHI  
Commission for Health Improvement. A national body to support and oversee the quality of clinical governance and clinical services

Clinical governance  
A framework through which NHS organisations and individual health professionals are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish

Clinical negligence  
A breach of duty by healthcare practitioners in the performance of their duties

Clinical network  
A network of health professionals from different NHS organisations working together across institutional and local boundaries, to provide optimum care for a particular disease or patient group

CMO  
Chief Medical Officer

CNO  
Chief Nursing Officer

Cochrane collaboration  
An international network of nine centres whose role is to build, maintain and disseminate up-to-date information from systematic reviews of healthcare trials

Collaborative  
Established regional partnership to develop and provide services to address a specific medical condition, e.g. cancer collaboratives check/verify

Commissioning  
The process of deciding what local people need from the NHS and buying those services with public money from the most appropriate providers. This can range from large contracts commissioning acute care from hospitals to smaller contracts with voluntary sector providers for a range of services to provide care and improve health. PCTs are responsible for commissioning the majority of health services
Community care
Services provided by a county council or unitary authority social services department, the NHS and volunteers, designed to keep people independent, and to support elderly people, or people with mental health problems or learning difficulties who might previously have been in a long stay hospital.

Community Health Services
NHS services provided outside a hospital. This includes district nurses, health visitors, community midwives, district dieticians, chiropodists, and community psychiatric nurses. Many community health staff are attached to GP practices and health centres.

Contract (NHS)
Agreement between two health service bodies for provision of goods or services eg a PCT and a provider (such as a hospital trust), by which health care, or in some places, social services care is bought for local people.

County Council
Upper tier authority in shire areas responsible for strategic services including education, social services, highways, trading standards. Counties provide around 80% of services (by value) in the two-tier areas.

CPPIH
Commission for Patient and Public Involvement in Health. Commission established to set national standards for patient and public involvement, and to support patient forums at a local level.

CSR
Comprehensive spending review.

Councillors
 Democratically elected community representatives. Elected by local people for a term of four years.

CVD
Cardiovascular disease.

DAT
Drug Action Team.

DEFRA
Department for Environment, Food and Rural Affairs.

DfES
Department for Education and Skills.

DGH
District General Hospital.

DH
Department of Health.

District Council
Lower tier authority in two-tier shire areas responsible for local service provision including housing, environmental health and development planning.

DPH
Director of public health.

DTI
Department of Trade and Industry.

DfT
Department for Transport.

DWP
Department for Work and Pensions.
EAZ  Education Action Zone: national government initiative aimed at building on the roles of schools by using partnerships and raising levels of educational attainment

EHR  Electronic Health Record

ENB  English National Board of Nursing, Midwifery and Health Visiting

ENT  Ear, nose and throat

EPR  Electronic Patient Record

Equality  The degree to which a resource is equally distributed

Equity  Concerned with how fairly resources are distributed throughout a group of people according to population, not individual need. Initiatives to address health equity tries to distribute resources, opportunities, access, etc, fairly (according to need) not equally

ESF  European Social Fund

Feasibility Study  A project to identify whether a certain action should be carried out

Foundation Trust  NHS Foundation Trusts will be established as new public interest organisations accountable to local people and free from Whitehall control. Drawing on models from co-operative societies, mutual organisations and charities in Britain and abroad, NHS Foundation Trusts will work for NHS patients and the wider public benefit. Each NHS FT will have a Board of Governors, including governors elected by members from the local community and NHS staff, to provide accountability to local stakeholders

FPA  Family Planning Association

FPC  Family Planning Committee

GDC  General Dental Committee

GDP  General Dental Practitioner

GMC  General Medical Council

General Medical Services  Services provided by local doctors

GLA  Greater London Assembly

GOC  General Optical Council

GP  General Practitioner. A doctor who works from a local surgery or health centre providing medical advice and treatment to patients who have registered on his/her list. A GP is usually an independent contractor providing services to patients through a contract with the local PCT. Practice nurses based at the surgery usually support the doctor
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<tr>
<th>Acronym</th>
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<tbody>
<tr>
<td>GUM</td>
<td>Genito urinary medicine</td>
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<tr>
<td>HAZ</td>
<td>Health Action Zone. An initiative to bring together organisations within and beyond the NHS to develop and implement a locally agreed strategy for improving the health of local people</td>
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<tr>
<td>HCHS</td>
<td>Hospital and Community Health Services. These are all the services provided from hospitals and PCTs (such as operations, out-patient services, community and district nursing)</td>
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<td>HDA</td>
<td>Health Development Agency</td>
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<tr>
<td>Health inequality</td>
<td>Generally refers to variations in health that relate to variations in socio-economic status</td>
</tr>
<tr>
<td>HES</td>
<td>Hospital Episode Statistics</td>
</tr>
<tr>
<td>HFEA</td>
<td>Human Fertilisation and Embryology Authority</td>
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<tr>
<td>HI</td>
<td>Health improvement</td>
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<tr>
<td>HIMP</td>
<td>Health Improvement Modernisation Programme</td>
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<tr>
<td>HMR</td>
<td>Hospital Medical Record</td>
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<tr>
<td>HLC</td>
<td>Healthy Living Centre</td>
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<td>HP</td>
<td>Health promotion</td>
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<td>HSG</td>
<td>Health Service Guidelines</td>
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<td>HV</td>
<td>Health visitor</td>
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<td>HWI</td>
<td>Healthy workplace initiative</td>
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<td>ICAS</td>
<td>Independent Complaints Advocacy Service</td>
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<tr>
<td>ICU</td>
<td>Intensive care unit</td>
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<tr>
<td>IDeA</td>
<td>Improvement and Development Agency. Provides information, training and support to local authority councillors</td>
</tr>
<tr>
<td>IMT</td>
<td>Information management and technology</td>
</tr>
<tr>
<td>Independent Reconfiguration Panel (IRP)</td>
<td>Independent panel established to provide the Secretary of State with advice when issues of substantial variation or development have been referred to him for a decision. Issues are referred to the IRP only by the Secretary of State and the panel has no direct role with either NHS bodies or overview and scrutiny committees</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>JCVI</td>
<td>Joint Committee on Vaccination and Immunisation</td>
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<tr>
<td>LA</td>
<td>Local authority</td>
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<tr>
<td>LAC</td>
<td>Local Authority Circular</td>
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<tr>
<td>LGA</td>
<td>Local Government Association</td>
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</table>
LDP Local delivery plan: Under the new three year planning framework for health and social care (see PPF), LDPs will show how the NHS, working with social services and other partners, will make visible improvements in health, including a reduction of health inequalities, and expand and reform services over the next three years. LDPs will be produced by strategic health authorities and informed by PCT led local plans

London Borough Council A single, all purpose authority in the Greater London area which became the unitary tier of local government when the Greater London Council was abolished in 1986 and the Inner London Education Authority in 1990

LSP Local strategic partnership

Metropolitan District Council A single, all purpose authority in the areas of the former metropolitan county councils which became the unitary tier of local government when the MCCs were abolished in 1986

M(H) Minister of Health

MH Mental health

MDO Mentally disordered offender

MHAC Mental Health Act Commission

MMR Measles, mumps and rubella

Morbidity A diseased condition or state; the incidence of a disease or all of a disease in a population

Mortality The number of deaths in a population, including overall deaths and comparisons of several types of deaths

MRC Medical Research Council

NAO National Audit Office

NDC New Deal for Communities

NGO Non-Government Organisation

NHS National Health Service

NHS trusts Provide most NHS services, through contracts with primary care trusts (PCTs). A board of a lay chair, non-executive directors and executive directors (the senior staff of the trust) manages them. An NHS Trust may run one or several hospitals. Ambulance trusts run the emergency and routine ambulance transport services under contracts with purchasers. Acute trusts run the district and specialist hospital services
<table>
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<tr>
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<tbody>
<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence. A national body created to ensure every NHS patient gets fair access to quality treatment. It sets clear national standards of what patients can expect to receive from the NHS. It promotes clinical and cost effectiveness through guidance and audit to support front-line staff</td>
</tr>
<tr>
<td>NPSA</td>
<td>National Patient Safety Agency. Established to run a mandatory reporting system for logging errors across the NHS, so as to improve safety by reducing the risk of harm. The aim is to create a more blame-free NHS where lessons are shared and learnt</td>
</tr>
<tr>
<td>NSF</td>
<td>National Service Framework. National plan, including national targets, to address service improvements to address specific issues, e.g. coronary heart disease, or services for older people</td>
</tr>
<tr>
<td>OATs</td>
<td>Out of area treatments. Agreements for patient treatments that are outside the standard contracts negotiated with local hospitals and other providers and need special approval from the appropriate PCT (i.e., the one covering the area in which the patient lives)</td>
</tr>
<tr>
<td>ODPM</td>
<td>Office of the Deputy Prime Minister – responsible for policy relating to local authorities</td>
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<tr>
<td>OHN</td>
<td>Our Healthier Nation – national strategy for health improvement</td>
</tr>
<tr>
<td>OSCs</td>
<td>Overview and scrutiny committees established by local authorities</td>
</tr>
<tr>
<td>PALS</td>
<td>Patient Advice and Liaison Services. Provided within NHS trusts and PCTs to provide on the spot help and advice to patients and carers</td>
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<tr>
<td>Pathfinder</td>
<td>The first of a programme that acts as a pilot and uses new approaches</td>
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<tr>
<td>PCT</td>
<td>Primary Care Trusts. Organisations on which health and social care professionals and lay members are represented and which commission and, in some cases, provide, health services for their area, including acute and specialised services and family health services (e.g. GPs, dentists) PCTs typically cover about 100,000 patients. They are responsible for the local health planning, public health at a local level, and have a budget reflecting their population's share of the available resources for almost all local health care needs. They assess the needs of the local population and determine local targets and standards to improve quality and efficiency</td>
</tr>
<tr>
<td>PDS</td>
<td>Personal Dental Services</td>
</tr>
<tr>
<td>PFI</td>
<td>Private Finance Initiative. A government led programme to enable the private sector to become involved in the provision of public sector facilities</td>
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</table>
PHel | Public health electronic library
---|---
PPF | The Priorities and Planning Framework guidance 2003-06 sets out the national priorities and targets for health and social care that will need to be built into local planning over a three year planning cycle
PPI | Patient and Public Involvement
Public Health Observatory | There are 9 regional Public Health Observatories across the country. They aim to improve access to, and analysis of, routine population-based health data. All are linked via a national association in order to share knowledge, develop external collaborations, support national agencies and avoid duplication of work
Procurement | The securing of funding or resources
Quantitative | Information about the numbers of something, used for statistics
RCGP | Royal College of General Practitioners
RCN | Royal College of Nursing
Red Book | The conditions under which GPs are paid
Regeneration | Upgrading an area through social, physical and economic improvements
RTA | Road traffic accidents
Secondary care | Care provided by hospitals
Section 31 Arrangements | Section 31 of the Health Act 99 enables local authorities and NHS bodies to delegate commissioning of particular health-related functions to a lead partner, to integrate the provision of services, and to pool budgets in order to improve the coordination and delivery of services that increasingly cross the traditional boundaries of 'health' and 'social care'
SHA | Strategic Health Authority. Renamed former Health Authorities with the role of performance managing NHS trusts and PCTs
SLA | Service level agreement
SMR | Standardised mortality ratio
Social exclusion | Excluded or alienated from society
SoS | Secretary of State
Stakeholder | A group or individual with an interest in an initiative, project or activity and its outcomes
Statutory | Having its basis in statute i.e. an Act of Parliament
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Telemedicine</td>
<td>The use of communications systems to provide remote diagnosis, advice, treatment and monitoring.</td>
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<tr>
<td>Terms of service (GPS)</td>
<td>Terms and conditions to which GPs work (National Contract)</td>
</tr>
<tr>
<td>Tertiary care</td>
<td>Care provided by specialist hospitals or departments (e.g. cancer centres) for patients referred from district hospitals</td>
</tr>
<tr>
<td>Unitary authority</td>
<td>A single, all purpose local authority created by local government reorganisation after 1992</td>
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<tr>
<td>Walk-in Centres</td>
<td>Centres which deliver accessible services on a drop-in basis. Offer free consultations and provide treatment for minor injuries and illnesses, general health information, self-treatment advice, information about out of hours GP and dental services and local pharmacy services. They are nurse-led, though a number of other health professionals and social care staff may be involved</td>
</tr>
<tr>
<td>Working time directive</td>
<td>The European working time directive regulations came into force in 1998, and apply to all directly employed NHS workers except junior doctors. They set a working time limit of an average of 48 hours per week</td>
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</tbody>
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Annex B: Glossary

Acute trust
A trust is an NHS organisation responsible for providing a group of healthcare services. An acute trust provides hospital services (but not mental health hospital services, which are provided by a mental health trust).

Ambulance trusts
There are currently 12 ambulance services covering England, providing emergency access to healthcare. The NHS is also responsible for providing transport to get many patients to hospital for treatment. In many areas it is the ambulance trust that provides this service.

Association of Public Health Observatories
The Association of Public Health Observatories (APHO) represents a network of 12 public health observatories (PHOs) working across the five nations of England, Scotland, Wales, Northern Ireland and the Republic of Ireland. They produce information, data and intelligence on people’s health and health care for practitioners, policy makers and the wider community.
http://www.apho.org.uk

Audit Commission
The Audit Commission regulates the proper control of public finances by local authorities and the NHS in England and Wales. The Commission audits NHS trusts, primary care trusts and strategic health authorities to review the quality of their financial systems. It also publishes independent reports which highlight risks and good practice to improve the quality of financial management in the health service, and, working with the Care Quality Commission, undertakes national value-for-money studies. Visit: www.audit-commission.gov.uk/Pages/default.aspx

Board (of trust)
The role of the trust’s board is to take corporate responsibility for the organisation’s strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief executive is responsible for ensuring that the Board is empowered to govern the organisation and to deliver its objectives.

Care Quality Commission
The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: www.cqc.org.uk

Clinical audit
Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.
Commissioners
Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Primary care trusts are the key organisations responsible for commissioning healthcare services for their area. They commission services (including acute care, primary care and mental healthcare) for the whole of their population, with a view to improving their population’s health.

Commissioning for Quality and Innovation

Community services
Health services provided in the community, for example health visiting, school nursing and podiatry (footcare).

Department of Health
The Department of Health is a department of the UK government but with responsibility for government policy for England alone on health, social care and the NHS.

Foundation Trust
A type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. NHS Foundation Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public and staff, and are governed by a board of governors comprising people elected from and by the membership base.

Health Act
An Act of Parliament is a law, enforced in all areas of the UK where it is applicable. The Health Act 2009 received Royal Assent on 12 November 2009.

Healthcare
Healthcare includes all forms of healthcare provided for individuals, whether relating to physical or mental health, and includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition, for example cosmetic surgery.

Healthcare Quality Improvement Partnership
The Healthcare Quality Improvement Partnership was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. It is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices.
Hospital Episode Statistics
Hospital Episode Statistics is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere.

Indicators for Quality Improvement
The Indicators for Quality Improvement (IQI) are a resource for local clinical teams providing a set of robust indicators which could be used for local quality improvement and as a source of indicators for local benchmarking. The IQI can be found on the NHS Information Centre website at: www.ic.nhs.uk/services/measuring-for-quality-improvement

Learning disability trusts
Learning disability trusts provide a range of healthcare and social support services for people who have learning disabilities and other long-term complex care needs.

Local Involvement Networks
Local Involvement Networks (LINks) are made up of individuals and community groups which work together to improve local services. Their job is to find out what the public like and dislike about local health and social care. They will then work with the people who plan and run these services to improve them. This may involve talking directly to healthcare professionals about a service that is not being offered or suggesting ways in which an existing service could be made better. LINks also have powers to help with the tasks and to make sure changes happen.

Mental health trusts
There are currently 60 mental health trusts covering England, which provide health and social care services for people with mental health problems.

Monitor
The independent regulator responsible for authorising, monitoring and regulating NHS Foundation Trusts.

National Institute for Health and Clinical Excellence
The National Institute for Health and Clinical Excellence is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Visit: www.nice.org.uk

National Patient Safety Agency
The National Patient Safety Agency is an arm's-length body of the Department of Health, responsible for promoting patient safety wherever the NHS provides care. Visit: www.npsa.nhs.uk

National patient surveys
The National Patient Survey Programme, coordinated by the Care Quality Commission, gathers feedback from patients on different aspects of their experience of recently received care, across a variety of services/settings. Visit: www.cqc.org.uk/usingcareservices/healthcare/patientsurveys.cfm
National Research Ethics Service
The National Research Ethics Service is part of the National Patient Safety Agency. It provides a robust ethical review of clinical trials to protect the safety, dignity and well-being of research participants as well as ensure through the delivery of a professional service that it is also able to promote and facilitate ethical research within the NHS.

NHS Choices
The first port of call for the public for all information on the NHS.

NHS East of England
NHS East of England is the strategic health authority for the east of England, covering Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. NHS East of England is the regional headquarters of the NHS, and provides strategic leadership for all NHS organisations across the six counties.

NHS Information Centre
The NHS Information Centre are England’s central, authoritative source of health and social care information. Acting as a ‘hub’ for high quality, national, comparative data for all secondary uses, they deliver information for local decision makers to improve the quality and efficiency of frontline care. www.ic.nhs.uk

Overview and scrutiny committees
Since January 2003, every local authority with responsibilities for social services (150 in all) have had the power to scrutinise local health services. Overview and scrutiny committees take on the role of scrutiny of the NHS – not just major changes but the ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

Pacesetters programme
The Department of Health funded Pacesetters programme is a transformational change programme in which the Department supports strategic health authorities and NHS trusts to work with their local communities, to reduce health inequalities arising out of discrimination and disadvantage for both patients and staff. Pacesetters is the only Department of Health equality programme that works across all equality strands, and additionally focuses on innovation in the field of equality and diversity. The programme tests innovations and identifies good practice and learning in order to share, spread and sustain them throughout the NHS – to make a permanent positive difference to people and communities.

Primary care trust
A primary care trust is an NHS organisation responsible for improving the health of local people, developing services provided by local GPs and their teams (called primary care) and making sure that other appropriate health services are in place to meet local people’s needs.

Providers
Providers are the organisations that provide NHS services, for example NHS trusts and their private or voluntary sector equivalents.
Quality reports
Monitor and NHS East of England required all NHS Foundation Trusts in England and all NHS providers in the East of England region to produce Quality Reports in spring/summer 2009. The term quality report has been used to distinguish it as part of the testing process, in comparison to a Quality Account, for which there is a legal requirement.

Registration
From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC).

Regulations
Regulations are a type of secondary legislation made by an executive authority under powers given to them by primary legislation in order to implement and administer the requirements of that primary legislation.

Research
Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both.

Secondary Uses Service
The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development. Visit: www.ic.nhs.uk/services/the-secondary-uses-service-sus/using-this-service/data-quality-dashboards

Special review
A special review is a review carried out by the Care Quality Commission (CQC). Special reviews and studies are projects that look at themes in health and social care. They focus on services, pathways of care or groups of people. A review will usually result in assessments by the CQC of local health and social care organisations. A study will usually result in national-level findings based on the CQC's research. Visit: www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/specialreviews/specialreviewsandstudies2009/10.cfm
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