University Hospitals of Leicester NHS Trust

Prevention for healthier lives: making it mainstream

UHL Prevention Annual Report 2022/23

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Chief Executive's Foreword

At UHL, our vision is to be leading in healthcare and trusted in communities. Our new strategic framework, published in November 2023, explains how we will achieve this and includes a commitment to embedding health equality and inclusion in all we do. Our growing focus on prevention is vital as we transform this intent into clear action.

Avoidable health inequalities and prevention are closely related. We serve one of the most diverse patient populations in the country. There is a life expectancy gap of 10 years between the most and least deprived wards in our city. Our most vulnerable patients are more likely to experience unhealthy environments, whether that is poor housing, low access to employment or poverty. These environments embed unhealthy behaviours that can be difficult for people to break out of without support.

The context for this is an urgent one that requires radical change in the way we work. As an integrated provider of health and care services for 1.1 million people in Leicester, Leicestershire and Rutland, we have a huge opportunity – and responsibility - to contribute to healthier lives for the future while responding to daily healthcare needs.

A range of partners play a role in supporting people to stay well and independent for longer and we are committed to working with General Practice, Local Authorities, community and mental health trusts and the voluntary sector, alongside communities themselves, to join services up around peoples' needs. We established our UHL Prevention Taskforce in 2022, recognising the difference that secondary care services can make in this area. The breadth of work taking place across our hospitals and communities demonstrates this.

Our first prevention annual report shows that this year, in UHL, our teams have:

- Provided smoking cessation services to over 3,000 people.
- Supported more than 1,450 people with alcohol intervention support, via targeted referrals from wards and our emergency care pathway.
- Worked with General Practice to offer tuberculosis testing and treatment to over 750 people who are registered as new entrants to the UK.
- Enhanced our approach to workforce prevention and wellbeing, recognising that the 18,000+ people who work with us at UHL are part of the communities we serve.

As well as improving quality of life and health outcomes, the business case for prevention has long been clear. What has been less clear is how every organisation can play a role in embedding it. There are two elements to our developing approach at UHL. The first is working with expert partners to establish the *Making Every Contact Count* framework across the Trust.

The second is building a social movement around health equality, inclusion and prevention that inspires everyone to understand their role and how they can make a difference. I hope that the information and evidence in this report will encourage colleagues and partners to ask what they could be doing differently, today, to make prevention mainstream.

Richard Mitchell, Chief Executive
University Hospitals of Leicester NHS Trust and University Hospitals of Northamptonshire NHS Group

Executive Summary

The University Hospitals of Leicester NHS Trust (UHL) is a large NHS teaching Trust providing integrated patient care. It is a national and regional centre for specialist treatment, a renowned biomedical research facility and the local hospital provider for 1.1 million people in Leicester, Leicestershire and Rutland.
The NHS Long Term Plan (LTP), published in 2019, set out the need for prevention to tackle the growing demand for health services driven by population growth, ageing and unmet health needs. Acute Trusts frequently see the impact that a lack of preventative care has – on patients' health outcomes, quality of life, and demand on services. Yet they can also play a strong role in making prevention mainstream, by embedding preventative frameworks into services and making every patient contact count.

In October 2023, UHL published its 2023 – 2030 strategy, with a vision to be *leading in healthcare and trusted in communities*, and preventative healthcare delivery forms a core element. UHL's Prevention Taskforce was launched in 2022 to provide dedicated focus to the area within the Trust. The Taskforce also supports coordination with primary care and community partners to meet the LTP requirements by 2023/24. Making Every Contact Count (MECC), smoking, alcohol, weight management, Latent Tuberculosis Infection (LTBI) screening, health inequalities and workplace wellbeing have been identified as key focal points for prevention, given their priority status within the LTP. Developing an Annual Prevention Report is part of UHL's commitment to demonstrating action on the prevention agenda. Although healthy weight is an important element of prevention nationally, it has not been a focus of this report as UHL is currently reviewing how it can be effectively embedded into the Trust.

In relation to this, UHL will be developing its first Prevention Strategy in the next 12-24 months to embed LTP elements into business as usual. The aim is to encompass other areas such as HIV screening and violence reduction once the strategy foundation is established. The Prevention Strategy will link directly to UHL's health inequalities programme, as well as the Prevention and Health Inequalities Board for the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB).

The aims and objectives of this UHL Annual Prevention Report 2023 are to:

- Provide stakeholders with an overview of how UHL is embedding prevention into its services as per the NHS Long Term Plan.
- Summarise service specification and utilisation in the areas of alcohol, smoking, Latent Tuberculosis Infection (LTBI) and workplace wellbeing within UHL.
- Summarise steps taken by UHL to address health inequalities.
- Outline how the Making Every Contact Count (MECC) approach has been implemented trust wide across UHL.
- Formulate recommendations for partners.

Overview of UHL Admissions

Inpatient admissions at UHL in 2022/23 (235,037) saw a 6% increase from that in 2021/22 (221.640), while there was a 1% decrease in emergency attendances in 2022/23 (258,336) compared to 2021/22 (260,146). Although most inpatients (72%) and emergency attendances (60%) were Whites, almost one-fifth of both inpatients (18.9%) and emergency attendances (23.6%) were from the Asian/Asian British group. The highest percentage of admissions are from quintile 4, at 23.5%.

Making Every Contact Count (MECC) in UHL

UHL is focusing on the benefits of smoking cessation and reduction of alcohol consumption by supporting staff to make every contact with their patients count, through a 'Train the Trainer' initiative with largely positive feedback from attendees. Of 224,723 UHL admissions between July 2022 to June 2023, 52% (115,901) had a MECC assessment, of which 7% (15,276) answered "YES" to the question, "do you smoke?" and were automatically seen by the UHL tobacco dependency service 'CURE', while 15% (33,766) answered "YES" to the question, "do you drink alcohol?" with no data on whether they were seen by the UHL Alcohol Care Team.

Alcohol: The Alcohol Care Team (ACT) at UHL by supporting patients with alcohol-related issues, contributes to the NHS LTP initiative of minimising admissions and bed days associated with alcohol. Of 6561 inpatients and emergency attendances at UHL with alcohol-related issues in 2022/23, 22.27% were referred to ACT. Referral rates are on the rise, but there is room for enhancement by focusing on staff recruitment for ACT and providing MECC training to colleagues, enabling them to effectively guide patients towards ACT.

Smoking: UHL employs an in-reach tobacco dependency service called CURE (Conversation, Understand, Replace, Expert & Evidence based treatments) for assisting patients in smoking cessation. 100% of inpatients identified as smokers between April 2022 to September 2023 were referred to CURE, with 34.31% of them being seen by a Tobacco Dependency Advisor (TDA), and 56.34% of those in turn setting a quit date in the community. Four week quit rates in community services achieved the national benchmark rates of over 50%. UHL also provides a free staff smoking cessation offer that was launched in 2022 with over 100 staff making a quit attempt using this service, improving the health and well-being of our workforce

Latent Tuberculosis Infection (LTBI): UHL employs a General Practitioner (GP)-led programme where immigrants registering with GPs are offered tests for LTBI which when positive are referred to UHL for further clinical assessments. In 2022/23, the total tests conducted by GPs in LLR was 780, out of which 96 (12.3%) were positive for LTBI. The number of patients treated for LTBI has decreased by just under a half from 2018 to 2022. The highest number of referrals from 2015-2023 were from contact screening (794), followed by migrant/new entrant screening (622).

Workforce Wellbeing: UHL as a trust offers a holistic approach to health and wellbeing of its employees. Of the 19000 staff employed by UHL, 57.3% belong to the White ethnic group followed by Asian/Asian British at 31.10%. Besides an in-house occupational health service, there is an in-house psychological-counselling service called Amica and health promotion activities such as badminton, yoga, Pilates etc. offered free of charge to all UHL employees. A free NHS digital weight management programme is available to staff with a BMI of over 30 and either diabetes or hypertension. This programme utilises weight management providers to provide bespoke, tiered levels of support over several weeks to individuals and has been demonstrated to be effective, with an average weight loss of 3-4 kilogrammes. This programme has not yet been launched to UHL staff.

Health inequalities: Leicester has more than 50% of the city's population belonging to an ethnic minority, while Leicestershire and Rutland have around 10% and 3% respectively belonging to ethnic minority groups (15-20% of the population are identified as being South Asians). Analysis of UHL outpatient data identified that access, experience, and outcomes are not universal across the population of Leicester, Leicestershire & Rutland. Patients from the lowest socioeconomic or BAME communities wait longer, are more likely not to attend and have care pathways end at the first Outpatient appointments. A pilot case study was conducted where a total of 5422 patients from the most deprived areas were proactively contacted prior to their appointments between April to September 2023. 'Did not attends'

(DNAs) were lower by almost three times in the patients proactively contacted (6.95%) compared to those not contacted (17%).

Overall recommendations

- MECC: Ensure healthcare professionals are trained to deliver brief advice and interventions on prevention topics during routine patient interactions.
- Data collection: Implement the recording of smoking status, alcohol consumption, and BMI for all patients admitted.
    - Ensure timely referrals to the Alcohol Care Team if patients have reported excessive alcohol intake or admitted with alcohol related complaint.
    - Review the existing process for recording smoking assessments and identify gaps.
    - Promote latent TB screening for high-risk groups and offer a combined testing programme for Latent TB infection and blood-borne viruses
- Enhance staff wellbeing and access to public health interventions through assertive outreach, awareness events and engagement.
- Ensure ongoing training opportunities and information to keep staff updated with prevention efforts and available services within UHL.
- Make prevention a priority for all healthcare professionals.

Background

Nationally within healthcare, the prevention of illness and promotion of health have become key priorities as outlined in recent national recommendations. The **2019 NHS Long Term Plan** highlights the growing demand for health services driven by factors such as population growth, ageing and unmet health needs[1]. To address this demand, the NHS will need to redesign healthcare delivery, improve upstream prevention of avoidable illnesses, and enhance supported self-management of long-term health conditions. Importantly, it acknowledges that for the prevention agenda to succeed, collaborative efforts from various stakeholders, community and acute will be needed.

In line with the NHS Long Term Plan, the **2023 Hewitt Review** emphasises the significance of prevention in reducing health inequalities.[2] The review highlights the costs of socioeconomic inequality on the NHS and underscores the importance of addressing wider threats to health through collective action. It provides a framework for acute trusts to develop effective prevention strategies and emphasises the need for collaboration with communities, local government, and other healthcare providers.

How the NHS Long Term Plan came into being

The NHS Long Term Plan, launched in January 2019, outlines how an additional £20.5 billion allocated to the NHS from taxpayers' contributions will be spent over the next 5 years. The additional funds ensure a secure and improved funding path for the NHS, averaging 3.4% a year over the next 5 years, compared with 2% over the past 5 years. The plan has been developed in partnership with frontline healthcare workers, patients and their families through over 200 separate events, over 2,500 separate responses. Insights offered by 85,000 members of the public and from organisations representing over 3.5 million people have been considered in developing this plan, which aims to improve quality of patient care and health outcomes across major diseases such as dementia, cancer and stroke.[3,4]

The NHS Long Term Plan sets out ways to overcome challenges faced by the NHS such as staff shortages and increasing demand for services. Integrated Care Systems (ICSs) which bring together primary care networks (GPs, their teams and other community services), other NHS organisations and local authorities to provide joined up healthcare services to meet local community needs, were proposed by the plan; accordingly, 42 ICSs were established across England in July 2022.[5]

The plan also sets out wider action for prevention to help tackle health inequalities. Funds will be allocated to local areas for local level evidence-based targeting of communities most affected by health problems. Some of the programmes include cutting down smoking, weight management, doubling enrolment in the successful Type 2 NHS Diabetes Prevention Programme, limiting alcohol-related Accident and Emergency (A&E) admissions and lowering air pollution.[6]

These interventions are designed to target individuals who are at increased risk of ill health because of their lifestyle – and other risk factors – with a particular focus on how we close the gap in inequality of health outcomes for individuals and communities in deprived areas.

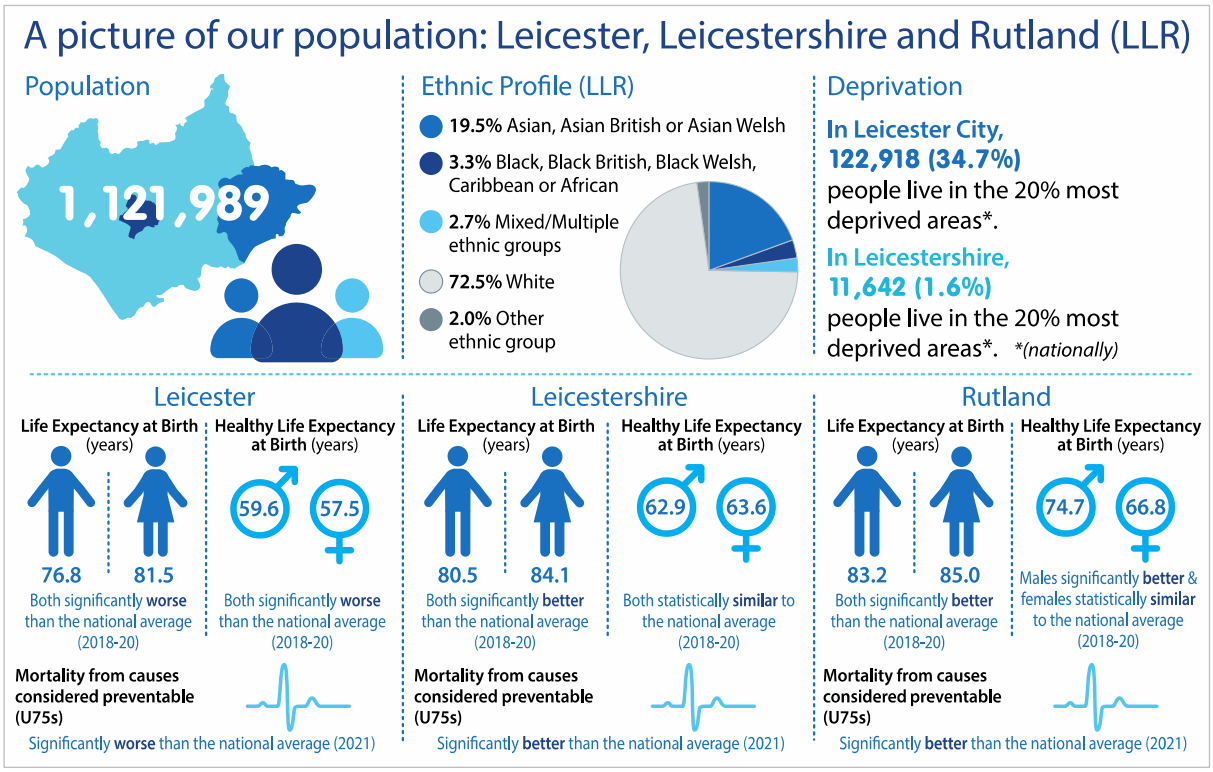
Improving the population's health and preventing illness and disease is key to reducing health inequalities and is at the heart of the NHS Long term Plan.

The Local Government Association describes the three levels of prevention as follows:[7]

Primary prevention	Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups
Secondary prevention	Systematically detecting the early stages of disease and intervening before full symptoms develop – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure.
Tertiary prevention	Softening the impact of an ongoing illness or injury that has lasting effects. This is done by helping people manage long-term, often-complex health problems and injuries (e.g., chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life and their life expectancy.

Population served by UHL

Figure 1: Facts and Figures for Leicester, Leicestershire and Rutland (LLR)



Source: Census 2021, Index of Multiple Deprivation 2019 (based on 2020 Mid Year Estimates) , OHID, Public Health Outcomes Profile

1. Overview of Admissions in UHL

The following data was provided by UHL Business Intelligence & Information Service. The data was sourced from UHL Data Warehouse. This section summarises the demographic profile of patients accessing UHL services.

This data is based on hospital spells which is defined as the total continuous stay of a patient using a hospital bed on premises controlled by a health care provider during which medical care is the responsibility of one or more consultants, or the patient is receiving care under one or more nursing episodes or midwife episodes in a ward.[8]

Inpatient admissions data includes both elective and non elective admissions (inpatient being elective inpatients, emergency being non elective inpatients and day cases elective day cases).

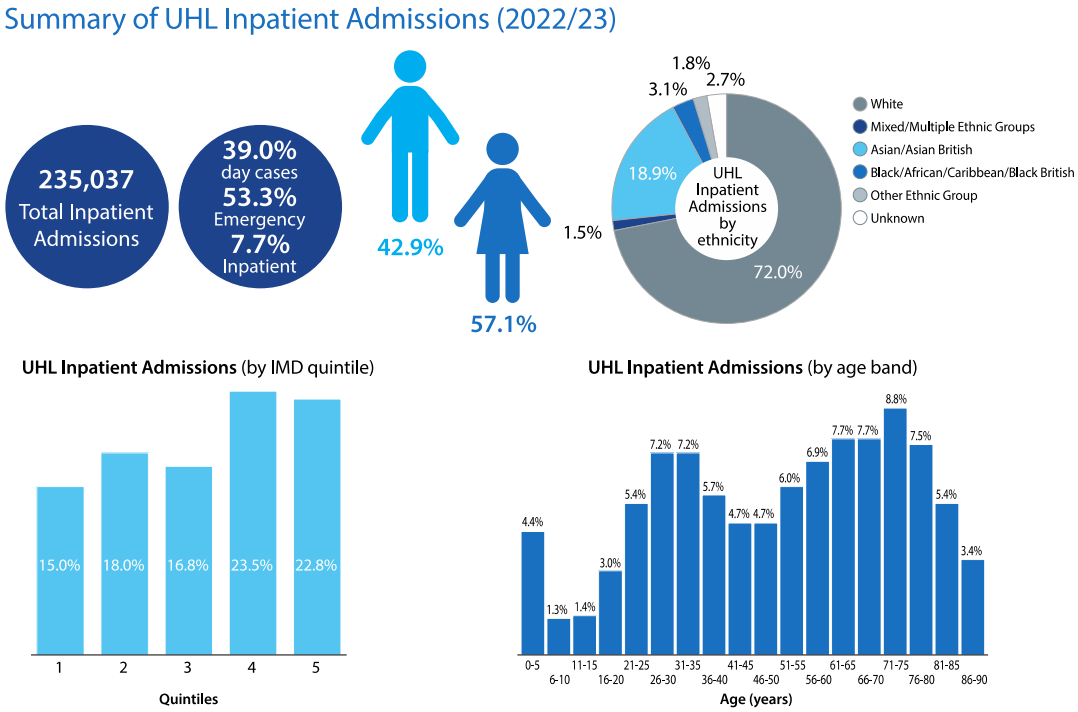
The Index of Multiple Deprivation (IMD) is a measure of relative deprivation in small, fixed geographic areas of the UK called Lower Layer Super Output Areas (LSOAs). These areas are divided into 5 quintiles based on relative disadvantage, with quintile 1 being the most-deprived and quintile 5 being the least-deprived.[9] It is important to note, the data presented below is based on the patient's residential postcode; besides, the IMD quintile could only be allocated to records that had a valid postcode.

Summary of Inpatient admissions and A&E attendances to UHL

In 2022/23, there were a total of 235,037 admissions (elective and emergency) to UHL, this is an 6.0% increase compared to 2021/22 (221,640). For A&E attendances into UHL, the total for 2022/23 were 258,366, this is an 1.0% decrease compared to 2021/22 (260,146).

1.1 Inpatient admissions

Figure 2: Summary of Inpatient Admissions to UHL, 2022/23

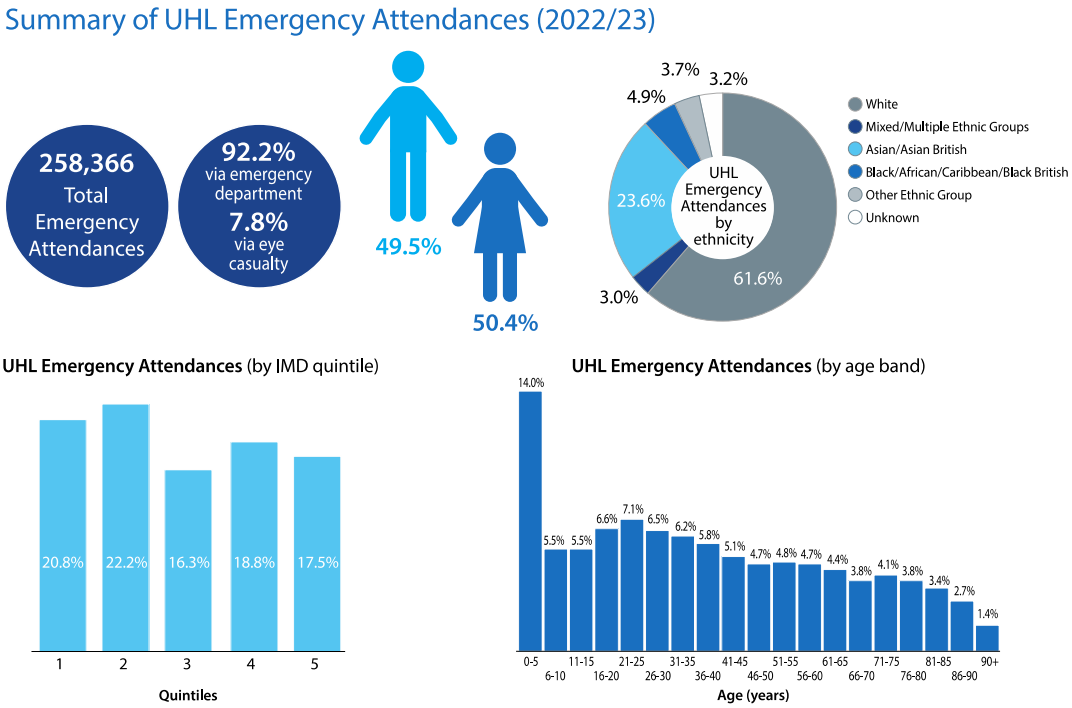


Source: UHL Business Intelligence and Information Service.

- Out of the total admissions, over half (53.3%) were emergency inpatients, 39% accounted for elective day cases and the remainder were elective inpatients (7.7%).
- Out of the total admissions to UHL in 2022/23, 42.9% were males and 57.1% were females.
- In 2022/23, admissions for children aged 5 years and under made up 4.4% of all admissions. The highest percentage of admissions were witnessed in the 71 to 75 years age group. Just over half of the total admissions were from those aged 16 to 60 years age group.
- Just over 70% of total admissions was comprised of patients of White ethnicity, followed by 18.9% belonging to Asian/Asian British ethnic group. The percentage of elective admissions were higher for patients of White ethnicity compared to emergency admissions.
- For all admissions at UHL, the lowest percentage of admissions were from patients residing in quintile 1 (most deprived) at 15.0% and the highest percentage from quintile 4, at 23.5%. It is noteworthy that this data is based on all patients attending UHL, therefore will include data for residents outside of LLR.

1.2 Emergency Department Attendances

Figure 3: Summary of Emergency Department Attendances to UHL, 2022/23



Source: UHL Business Intelligence and Information Service.

- Out of the total emergency attendances, a majority (92.2%) of them were via the emergency department, followed by 7.8% via the eye emergency department.
- Out of the total emergency attendances to UHL in 2022/23, 49.5% were males and 50.4% were females.

- In 2022/23, emergency attendances for children aged 5 years and under made up 14.0% of all attendances. Just over half of the total attendances were from those aged 16 to 60 years.
- Just over 60% of emergency attendances were by patients of White ethnicity, followed by 23.6% belonging to Asian/Asian British ethnic group.
- For emergency attendances at UHL, the lowest percentage of attendances were from patients residing in quintile 3 at 16.3% and the highest percentage from quintile 2, at 22.2%. Note this data is based on all patients attending UHL, therefore will include data for residents outside of LLR.

2. Prevention work in UHL

UHL's Vision for Prevention

Professor Sanjay Agrawal
(Consultant Respiratory Intensivist, UHL):

This Prevention Report describes the tremendous progress UHL has made over the past 3 years, in helping the LLR population we serve, to prevent ill health and reduce health inequality by implementing the NHS LTP pathways addressing the modifiable risk factors of tobacco and alcohol addiction, unhealthy weight and LTBI. These programmes of work will provide benefits to our patients and communities now and for years to come and we should be proud of these new treatment pathways between UHL and community partners.

A review of existing literature on prevention strategies in NHS acute trusts reveals that many have integrated prevention and population management into their overall strategies, with a focus on long term conditions, environmental sustainability and staff-wellbeing. However, few have developed a detailed specific prevention review and strategy. Nottingham University Hospitals NHS Trust produced a 2018 prevention strategy which looked to embed prevention and population health approach to all areas, with particular focus on physical activity, smoking, alcohol, mental health, and poor diet through structural and governance changes.

A whole systems approach is needed to promote prevention. UHL aims to implement a trust-wide strategy whilst working in collaboration with UHL Health Inequalities (HI) Board and the Prevention and Health Inequalities Board for the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB). Smoking, obesity, and alcohol have been identified as key focal points, given their priority status in the NHS long-term plan and their significant prevalence within UHL.

The National Health Service (NHS) delivers care for over 1,000,000 people in any given 24-hour period.[4] Within this number, are many individuals who are not currently systematically screened and treated for harmful addictions to tobacco and alcohol or for unhealthy weight. Where these conditions are identified, they are largely left untreated as they are considered 'lifestyle choices' and historically there have been no NHS-commissioned treatment pathways.

It is now recognised that left untreated, these conditions lead to substantial and wholly preventable demand on NHS hospital-emergency and elective services, GP services and widen health inequalities. In addition, leaving these conditions untreated, substantial burden is placed on the whole health and care system through sickness absence, loss of productivity, poverty, crime and family disruption.

Acknowledging the impact of smoking, alcohol, and unhealthy weight, together with a renewed focus on reducing health inequalities, the 2019 NHS Long Term Plan has

committed substantial financial investment and resources to focus on the treatment of tobacco and alcohol addiction in secondary care and increase the treatments available for unhealthy weight in primary and secondary care. The newly commissioned services include:

Tobacco dependency:

- Screen and treat every in-patient in acute trusts that smokes
- Screen and treat every in-patient in mental health trusts that smokes
- Screen and treat patients in the community with 'serious mental health disorders' (e.g., schizophrenia)
- Screen and treat pregnant mothers and their partners who smoke
- Support NHS staff who smoke to quit

The NHS Long Term Plan aims to support smoking cessation in people in contact with NHS services, based on the proven Ottawa Model for Smoking Cessation implemented in Canada and Manchester. The aim is to offer NHS-funded tobacco treatment services to all people admitted to hospital who smoke by 2023/24. The model will also be adapted for pregnant women and their partners through a new smoke-free pregnancy pathway inclusive of focused sessions and treatments. In addition, smoking cessation will also be offered as part of specialist mental health services.[10]

Alcohol dependency:

- **Provide 24/7 support to in-patients through Alcohol Care Teams**

As per the NHS Long Term Plan, the NHS Prevention Programme has aimed to establish specialist Alcohol Care Teams (ACTs) in 25% of hospital sites with the greatest rates of deprivation and alcohol-dependence-related harm in England. These hospitals will be supported to fully establish ACTs through funding from their clinical commissioning groups (CCGs) health inequalities funding supplement, working in partnership with local authority commissioners of drug and alcohol services. The optimal model for ACT services was published in November 2019, in collaboration with the then Public Health England, and is envisioned to prevent about 50,000 alcohol-related hospital admissions over 5 years. Evidence for optimised specialist alcohol interventions arises from a National Institute of Care and Excellence (NICE) case-study which found that ACTs significantly reduce avoidable bed days and readmissions. The 7-day-per-week ACT service in Royal Bolton Hospital saved 2,000 bed days in its first year of implementation, with a return on investment of £3.85 per £1 invested. Modelling approaches have found that an ACT in every non-specialist acute hospital will save 254,000 bed days and 78,000 admissions per year by the third year of implementation. ACTs support patients and families experiencing alcohol-related harm through specialist advice and interventions, including assessment, psychosocial intervention, abstinence advice, relapse protection and onward referral to community alcohol services and wider social support. The programme that started with 10 early implementer sites boasted of 22 sites up and running with the right mix of staff by the end of summer 2022.[11]

The items highlighted represent the commissioned pathways for delivery at UHL, however many of the treatment pathways require close integration with community services provided by primary care and local government. Specific areas of integration include: pharmacotherapy on hospital discharge, in-patient treatment records, on-going community treatment records, communication and treatment completion data and reporting outcomes via NHS Digital.

In addition to the areas highlighted above, the NHSE Prevention programme includes work programmes that encompass tuberculosis and antimicrobial resistance.

How does UHL prevention align with other strategies?

UHL co-created with colleagues, patients and partners a trust-wide strategy 2023-2030 **'Leading in healthcare, trusted in communities'**, of which preventative healthcare delivery forms a core element. However, UHL does not have a strategy dedicated solely to prevention yet. UHL has now committed to develop a Prevention Strategy over the next 12-24 months to embed NHS LTP elements of Smoking, Alcohol, Obesity and Tuberculosis into business as usual. The aim would be to encompass other areas such as HIV screening and violence reduction as well, once the strategy foundation is well established with time. The Prevention Strategy will not only be directly linked to the Health Inequality work within UHL but also with the Prevention and Health Inequalities Board for the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB).

The UHL Prevention Approach is in accordance with the prevention strategies outlined in the NHS Long Term Plan to help tackle health inequalities. The Making Every Contact Count (MECC) approach is at the heart of this report; the MECC strategy revolves around making the millions of daily life interactions that staff at UHL have worthwhile in encouraging people towards lifestyle change.[12] This is also in alignment with the National Institute for Health and Care Excellence (NICE) Guidelines for Behaviour Change.[13]

The UHL Approach towards reduction of alcohol consumption resonates with the Leicester City Alcohol Harm Reduction Strategy 2022-2027 and the Leicestershire County Council's Substance Misuse Strategy 2022-2023, both of which advocate early identification of individuals with harmful levels of alcohol consumption and referral to appropriate services through MECC.[14]

The UHL Prevention Strategy is also in line with the Leicester, Leicestershire and Rutland Integrated Care Board (LLR-ICB) Clinical Strategy that revolves around the key objective of tackling inequalities in outcomes, experience and access to healthcare, which in turn expands the objectives laid out in the LLR Health and Wellbeing Partnership Strategy 2022-2027 that ensures that prevention is at the forefront of local policy planning and is a fundamental part of all professionals' roles across LLR through MECC.[15]

The Leicester, Leicestershire & Rutland Health Inequalities Framework, as the UHL Strategy, also sets out a collaborative approach towards health and wellbeing bringing together a range of partners and people to work together based on local community engagement.[16]

The UHL Prevention goals also align with Health and Wellbeing Strategies of the three local authorities within LLR which focus on community engagement and partnership-working to reduce health inequalities, develop workforce and build healthy and active communities through behaviour change with respect to smoking and alcohol consumption.[17,18,19]
The UHL Prevention Taskforce was launched in 2022 for dedicated focus to prevention within UHL and coordination with primary care and community partners to meet the NHS Long Term Plan requirements by 2023/24. This forum will enable University Hospitals of Leicester to meet national and local objectives around prevention as well as ensure our population is given the tools to live as many healthy years as possible. The primary focus of the taskforce is to coordinate the UHL response to the NHS England/Improvement mandate and commitments.

3. Key areas for prevention in UHL

The following diagram shows the key areas of focus in terms of prevention in UHL. Although healthy weight is an important part of the prevention agenda in the NHS LTP, this has not been a focus of this report as UHL is currently reviewing how this element of prevention is embedded into the trust for patients accessing UHL services. Each area of focus covered in the infographic below will be reviewed in section 3.

Figure 4: Key areas for UHL prevention

**MECC Making Every Contact Count. **LTBI Latent Tuberculosis Infection*

3.1 MECC (Making Every Contact Count) in UHL

"MECC is an approach to behaviour change that uses the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing".[20]

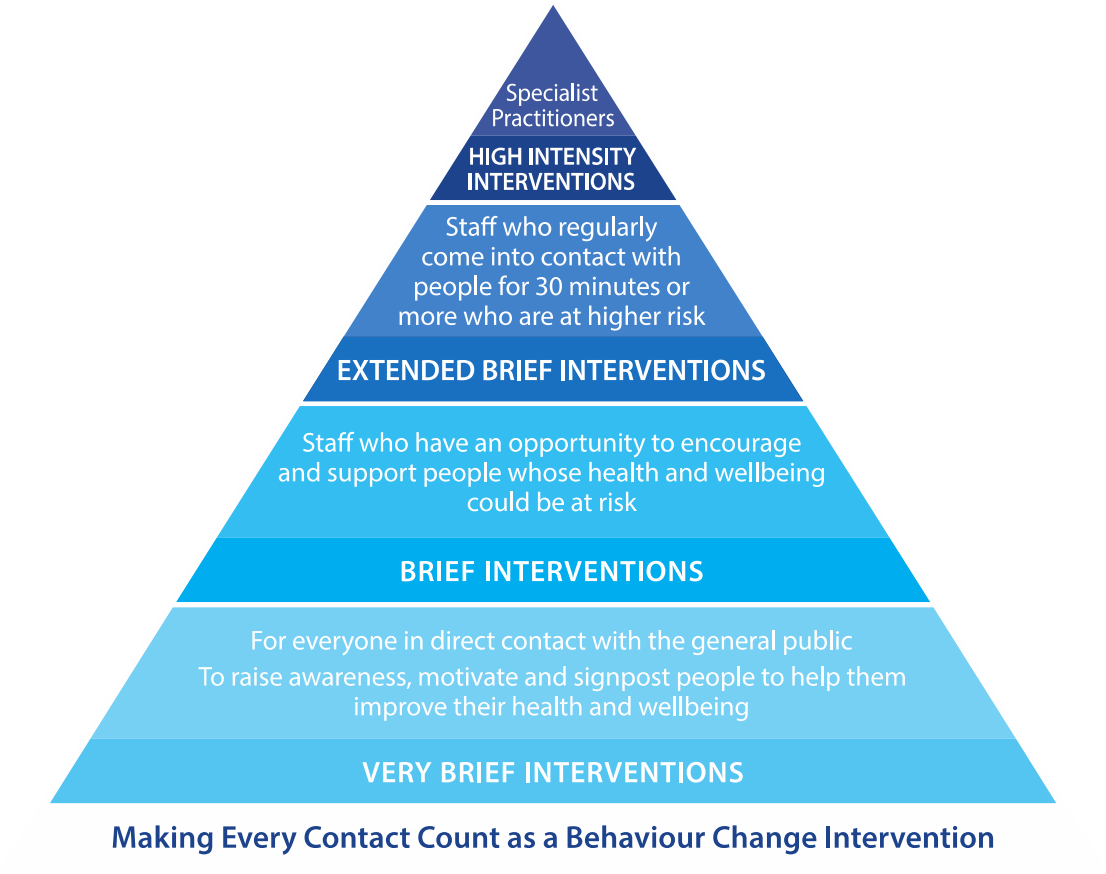
The MECC approach encourages health and social care staff to have conversations with their patients about how they might make positive improvements to their health and wellbeing by focussing on asking the right questions and listening effectively. Evidence suggests adoption of the MECC approach across health and care could have a significant impact on the health of our population.[20]

MECC activity is detailed in the two layers at base of the pyramid below.

MECC Level 1: Very brief intervention – a very brief intervention can take from 30 seconds to a couple of minutes. It enables the delivery of information to people, or signposting them to sources of further help. It may also include other activities such as raising awareness of risks, or providing encouragement and support for change.[20]

MECC Level 2: Brief intervention – a brief intervention involves oral discussion, negotiation or encouragement, with or without written or other support or follow-up. It may also involve a referral for further interventions, directing people to other options, or more intensive support.[20]

Figure 5: MECC Model



Source: Making every Contact Count: Consensus Statement

As an organisation, UHL have a responsibility to protect and improve the overall health and wellbeing of their patients and staff. UHL are focusing on the benefits of quitting smoking and reducing alcohol intake by supporting staff to make every contact with their patient count.

Staff are being encouraged to take the opportunity to ask our patients whether they are concerned about their smoking and drinking habits and providing them with support and simple brief lifestyle advice if they are as well as signposting their patients to existing services where appropriate.

Leicestershire County Council are working with UHL using the 'train the trainer' approach to train staff (domestic workers and porters) at UHL to then train others throughout the organisation.

MECC Implementation in UHL Data

In total, there were 224,723 admissions in UHL between the period of July 2022 to June 2023, out of these total admissions, 52% (115,901) of patients had a MECC assessment.

Out of the 115,901 MECC assessments completed, 7% (15,276) answered "YES" to the question, "do you smoke?" and were also automatically seen by a member of the CURE team. Moreover, MECC assessments for smoking do not include assessments which have not been linked to a Hospital Information Support System (HISS) inpatient spell.

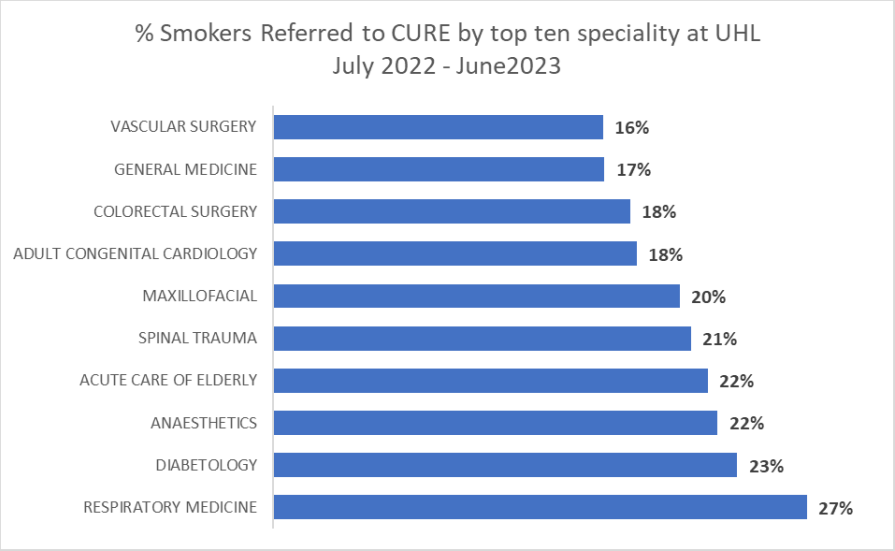
Out of the 115,901 MECC assessments completed, 15% (33,766) answered "YES" to the question, "do you drink alcohol?". there is no data to suggest that patients who answered

'yes' to alcohol consumption have been referred to the Alcohol Care Team at UHL. There is also no data on the units and frequency of alcohol consumed.

The top three admitting specialities for those smokers referred to the CURE team include Respiratory Medicine (27%), Diabetology (23%) and Anaesthetics (22%). The three admitting specialities ranked in the bottom three include, Gastro-Enterology, Clinical Haematology and Bone Marrow Transplantation

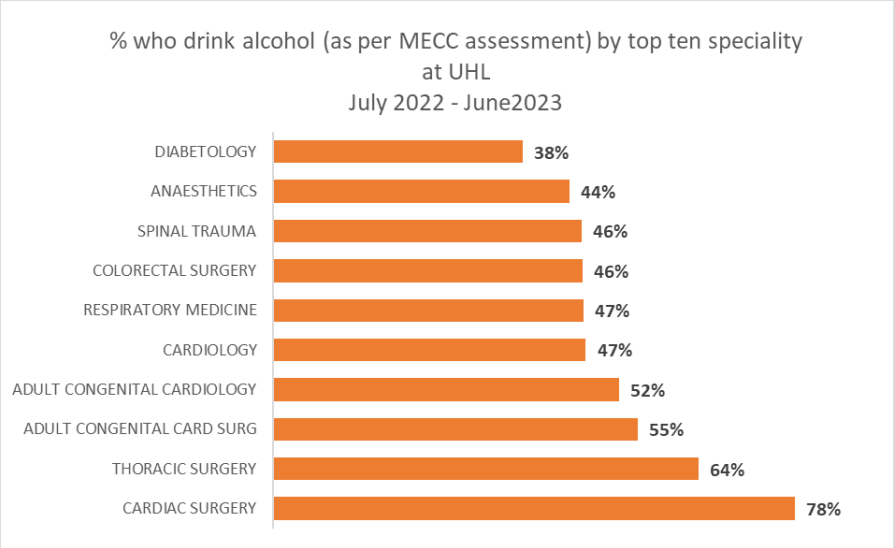
The top three admitting specialties for those responding yes to drinking alcohol include Cardiac surgery (78%), Thoracic surgery (64%) and Adult congenital cardiology surgery (55%). The three admitting specialities ranked in the bottom three include Obstetrics, Bowel Screening and Midwifery.

Figure 6: Percentage of smokers referred to CURE by top ten speciality at UHL, July 2022 to June 2023



Source: UHL MECC Data

Figure 7: Percentage of patients who drink alcohol, by top ten speciality at UHL, July 2022 to June 2023



Source: UHL MECC Data

MECC training for frontline staff

Leicestershire County Council Public Health Team have been working closely with UHL to deliver training to UHL staff (porters, catering, domestic, support and radiology) which will equip frontline staff with skills to have empowering, non-confrontational conversations to support people to make changes to their behaviour to improve their general health and well-being. In addition to this, the MECC/Healthy Conversation Skills Train-the-Trainer training further trains staff to deliver the training to others in their teams/departments in order to make the training scalable and sustainable.

Evaluation of the training (based on how staff would respond to four statements on diet, exercise, smoking and alcohol) revealed that staff had shifted from giving mainly Telling/Suggesting responses to using mainly Open Discovery Questions; these are questions generally beginning with “what” or “how” that explore someone’s world or perspective, supports them to identify solutions or new ways of acting and demonstrates that their views are valued and listened to. This leads to more effective, non-confrontational, empowering and person-centred conversations which is the aim of the training.[21]

Participants, at the end, were asked to rate the quality of training on a scale of 1 to 10 where 1 indicated the lowest level of quality and 10 the highest. 11 of the 13 participants scored a 10, resulting in a mean score of 9.8. With respect to participant suggestions on improvements, 50% of participants did not feel improvements were necessary, while the rest suggested inclusion of more examples from social care conversations for future sessions. Participants provided a variety of positive comments regarding the features on which the sessions were structured. These included active participation and engagement, inter-departmental liaison with colleagues, role play, garnering alternative perspectives and the training model of getting trained first before leading the activities.

3.2 Alcohol

Alcohol misuse is the biggest risk factor for death, ill-health and disability among 15-49-year-olds in the UK, and the fifth biggest risk factor across all ages. Alcohol is a causal factor in more than 60 medical conditions, including mouth, throat, stomach, liver and breast cancers, high blood pressure, cirrhosis of the liver, and depression. Alcohol use has health and social consequences borne by individuals, their families, and the wider community. Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and £21 billion per year to the society as a whole.[22]

3.2.1 Overview of Alcohol Related Admissions in Leicester, Leicestershire & Rutland (LLR)

Alcohol-related hospital admissions are used as a way of understanding the impact of alcohol on the health of a population. In LLR, the rate of alcohol related admissions in 2021/22, were either statistically similar (Leicester) or significantly better (Leicestershire and Rutland) in comparison to the national rate. This data is based on patients resident in LLR that have had an alcohol admission at any hospital.

Table 1: Admission episodes for alcohol-related conditions (*Broad) in Leicester, Leicestershire and Rutland (LLR), 2021/22

	Number	Rate per 100,000 population	LCL (95%)	UCL (95%)
Leicester	4,838	1,726	1,677	1,777
Leicestershire	10,561	1,428	1,401	1,456
Rutland	509	1,068	976	1,167
England	948	1,734	1,731	17,38

Source: Local Alcohol Profiles for England, OHID, 2023

**Broad - A measure of hospital admissions where either the primary diagnosis (main reason for admission) or one of the secondary (contributory) diagnoses is an alcohol-related condition.*

Better 95% | Similar | Worse 95%

3.2.2 Overview of Alcohol Care Team (ACT) at UHL

The Substance Misuse Liaison team based within the Leicester Royal Infirmary is a collaboration between the charity called Turning Point and University Hospitals Leicester NHS Trust, bringing together clinicians and non-clinicians with a variety of backgrounds and expertise. The team supports patients with any kind of drug or alcohol problem, from dependence, addiction, acute illnesses to chronic relapses. They also undertake interventions involving education, harm reduction strategies, relapse prevention, and motivational work, as well as clinical management of withdrawal. The team works with family members, with strong links with wider multi-disciplinary teams such as mental health, housing, safeguarding, and issue referrals as appropriate. They also seamlessly link patients seeking ongoing support into the Turning Point treatment pathways across Leicester, Leicestershire and Rutland.

The Alcohol Care Team, are part of the Substance Liaison Team at the University Hospitals of Leicester NHS Trust (UHL) and is part of the NHS Long Term Plan initiative mentioned earlier, aimed at reducing alcohol-related hospital admissions and bed days. It is a newly established service that provides support to patients in UHL with alcohol-related illnesses, mainly those who are alcohol dependent.

The ACT will assess patients presenting with acute intoxication, in acute alcohol withdrawal or with alcohol-related complications. The ACT service was developed as a partnership approach across all local partners and clinical leads. The adopted model demonstrates a multi-agency approach in the interests of patient care. The alcohol service at UHL will be provided 7-days a week to every inpatient ward and emergency department within UHL, with robust out of hours arrangements in place to support departments outside of normal business hours. The service aims to:

- Reduce avoidable alcohol-related admissions by reducing serve health risk among dependent drinkers
- Reduce the length of stay for inpatients by improving the management of [alcohol] withdrawal
- Provide appropriate, timely, meaningful education and support for those attending or being admitted with alcohol-related problems
- Facilitate integrated alcohol care between secondary, primary and community care providers

- Provide psychosocial interventions to support dependent drinkers to sustain abstinence following discharge
- Improve compliance with the trust's alcohol withdrawal guidelines
- Educate staff on alcohol use disorder and its management
- Improve information sharing between services (e.g., secondary care, primary care and community services)
- Improve data collection and opportunities for analysis

The service is slated to be operational 7-days a week from September 2023 once all nurses are recruited and their training is complete. The service at UHL is being delivered in partnership with Turning Point, and hence there is no delay in handover from the team within UHL or community services; this partnership approach also allows the team to identify known service users should they present to either the Emergency Department or the ward. The service target/outcomes have not been defined as the establishment, funding and service specifications were set by NHS England. Furthermore, the desired outcomes of reduced alcohol consumption occur downstream at community service level and would not be part of the ACT remit.

Operating Principles

- ACT staff will operate as a single multi-agency, multi-disciplinary team.
- Staff will not be redeployed to support other activities/duties except in the event of an emergency (operational pressures are not included as emergencies).

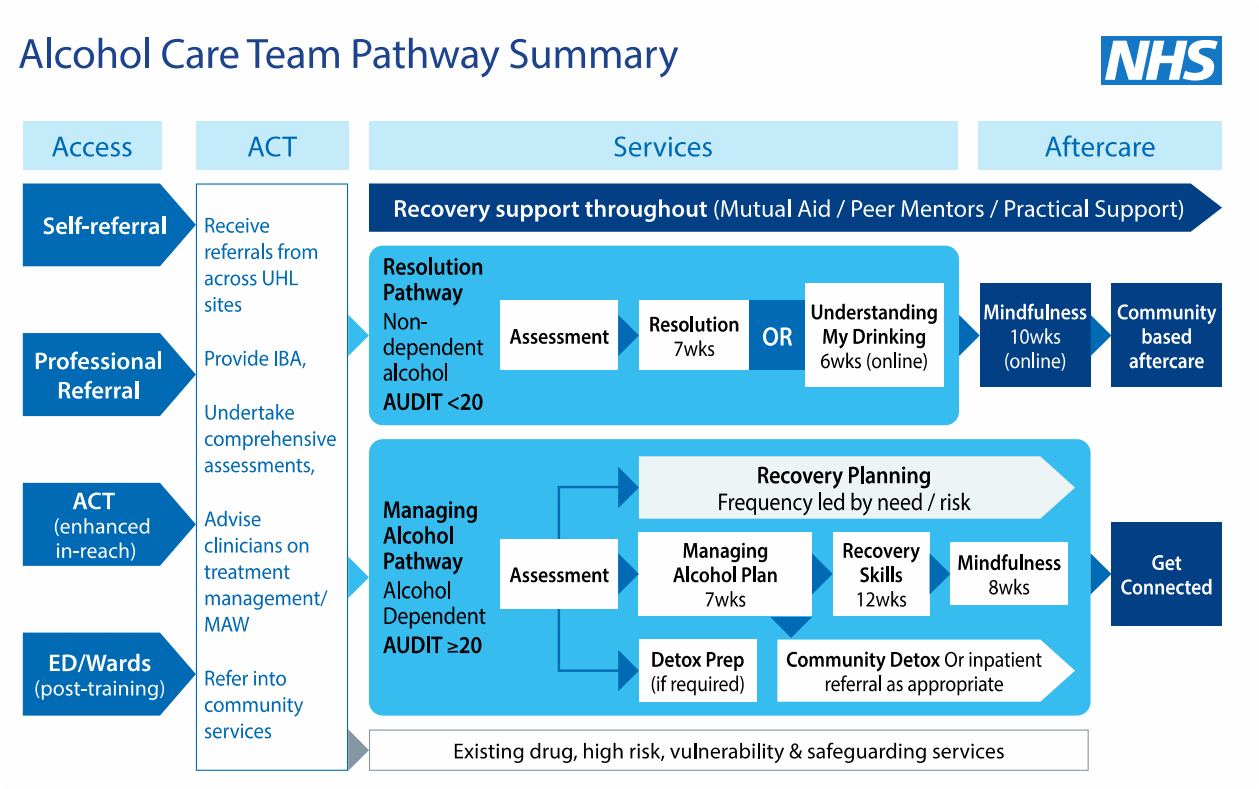
Emergency Department (ED)

- ACT will assess patients presenting with acute intoxication, in acute alcohol withdrawal or with alcohol-related complications.
- Where patients are not ready for a full assessment (e.g., still intoxicated), they should receive an initial assessment for risk and provide advice on admission need.
- Where patients in acute withdrawal are admitted the ACT will support ward staff to stabilise their condition and manage MAW as appropriate to the patient's needs.
- Patients presenting with other alcohol-related complications will be assessed by the ACT, who will contribute to their care plan.

Inpatients

- Routine screening to be used to identify any possible alcohol-dependent patients for referral to ACT for a comprehensive assessment
- ACT will contribute to the over-arching care plan with alcohol care interventions/support and advice including:
- Medically Assisted Withdrawal (MAW) regime advice, including post-discharge in the community where appropriate
- Medication advice to support sustained abstinence or consumption
- Screening for liver fibrosis
- Specialist Mental Health (MH) assessment + psychosocial interventions to support community alcohol-related treatment

Figure 8: UHL Alcohol Care Team Pathway Summary

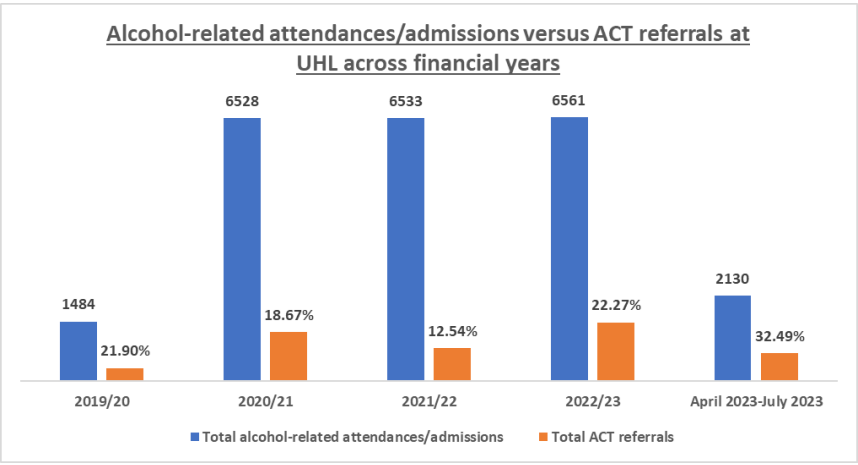


Source: UHL Alcohol Care Service

3.2.3 Alcohol Care Service Data

The following data has been provided by the alcohol services team at the University Hospitals of Leicester NHS Trust (UHL). The following figure denotes the total number of alcohol-related elective admissions as well as Emergency Department attendances at UHL across financial years. Of 6561 patients presenting to UHL with alcohol-related issues in 2022/23, 2301 were attendances at the Emergency Department and 4260 were inpatients. However, there is a minimal risk of the same patient being counted twice because a patient presenting at the Emergency Department naturally becomes an inpatient once admitted.

Figure 9: Number and Percentage of ACT referrals



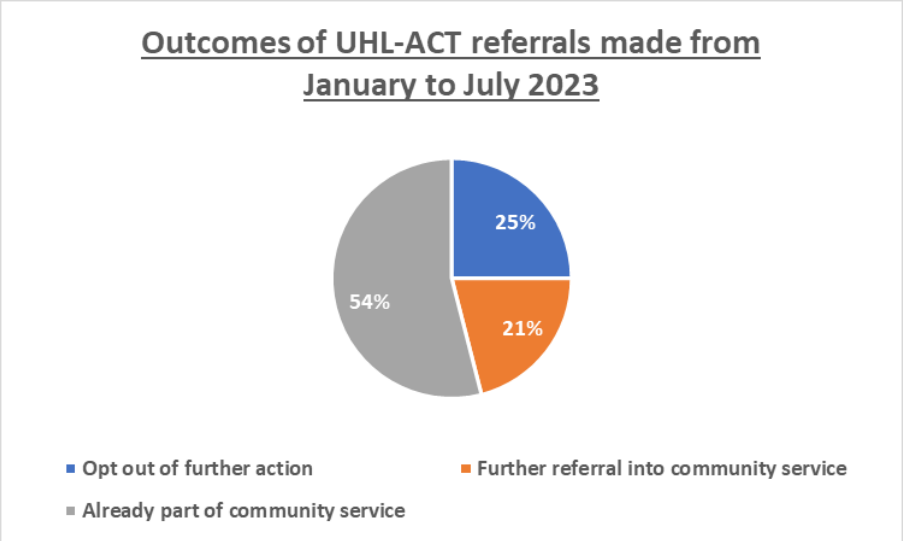
Source: UHL Alcohol Service Data

The above data shows that referral rates have been increasing, particularly after initiation of the Enhanced Turning Point service in July/August 2022. There has been a 50% increase in referral rates since the UHL-sponsored nurses began joining the team since April 2023. In addition, the team is looking to work with Nervecentre[1] to develop the MECC Assessment Tool for alcohol and automating the referral process for staff, thereby facilitating greater opportunity for prevention support and activities to take place.

The pathway is such that after referral by UHL staff, the ACT sees the patient, completes an initial assessment and where appropriate (in all cases currently), explain the support that can be provided to help improve their drinking behaviour or quit before harm occurs. The patients who opt out of support do so by choice and hence are given Brief Intervention Advice (BIA) and reminded that they can always self-refer if they change their minds in future and are handed information for help. Specific reasons given by patients for opting out are currently not being captured by UHL systems.

Outcome data is available only from January 2023. Of the total referrals made between January to July 2023, 25% opted out of further help after an initial assessment and Brief Intervention Advice (BIA), 21% agreed to be referred further to community services after initial assessment and BIA and the remaining 54% were identified by ACT as already part of community programmes. This 54% will already have an assigned caseworker who the ACT notifies immediately upon contact and discusses an approach with. The benefit here is that the caseworker can keep a track on the patient from admission and prioritise support on discharge. The opt-outs after initial assessment were by patient choice.

Figure 10: Summary of outcomes of ACT referrals at UHL

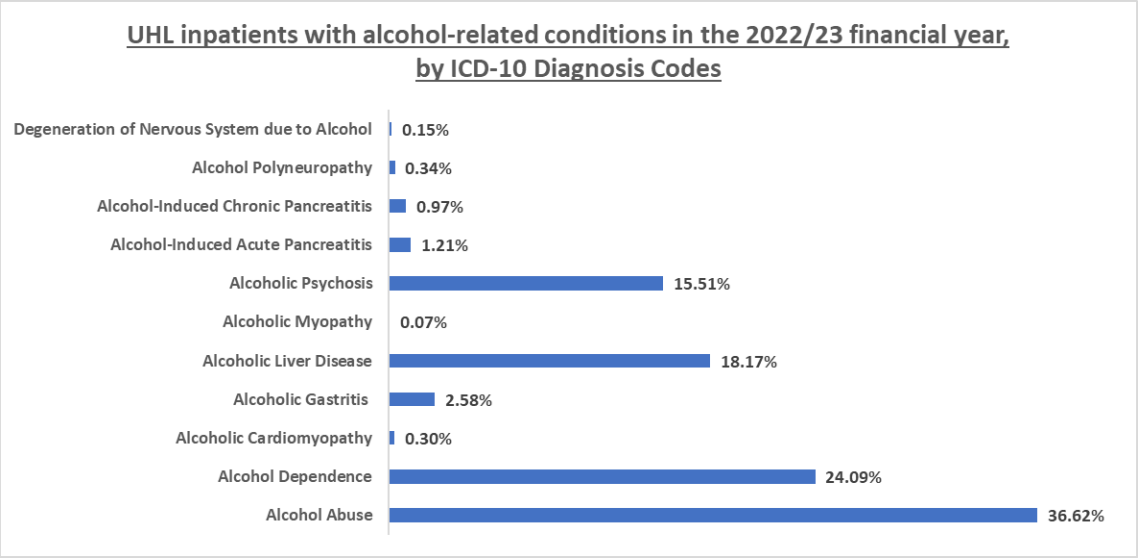


Source: UHL Alcohol Service Data

Please note that in the figure below for 2022/23, the total number of inpatients with ICD-10 diagnosis codes is 6093 although the total number of inpatients at UHL with alcohol-related conditions is 4260. This is because the same patient can have more than one ICD-10 diagnosis code. Alcohol abuse formed the most common diagnosis among inpatients at 36.62% (2231) followed by alcohol dependence at 24.09% (1468) and alcoholic liver disease at 18.17% (1107).

[1] Nervecentre is an electronic patient record management system used in the NHS.

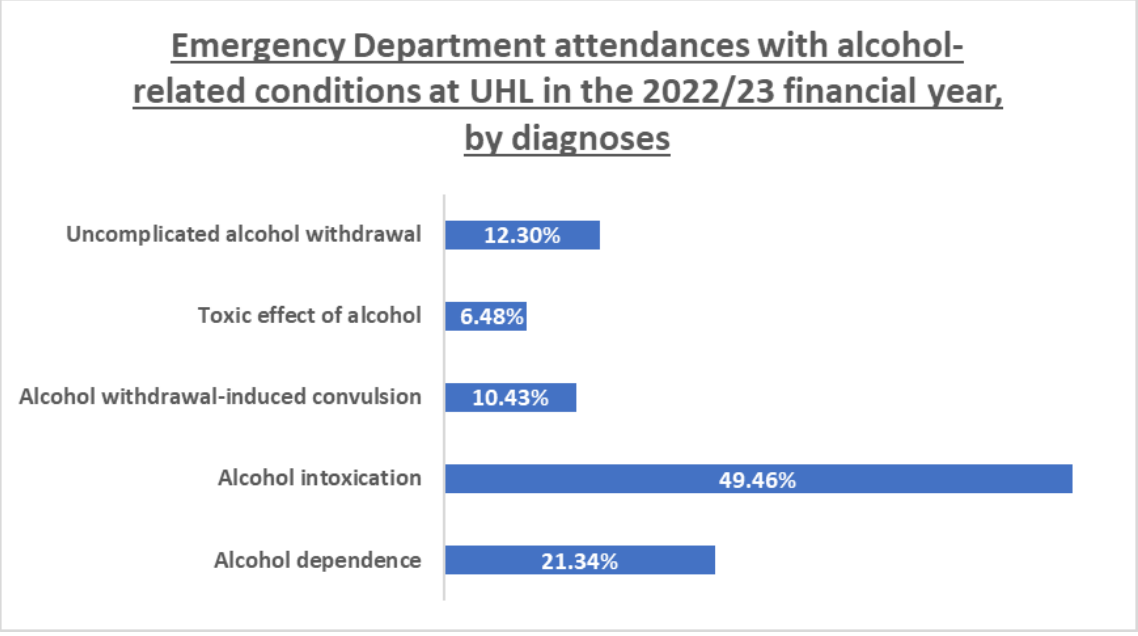
Figure 11: Alcohol-related conditions of inpatients in the 2022/23 financial year, by ICD-10 diagnosis codes



Source: UHL Alcohol Service Data

The most common diagnoses for the 2301 patients presenting with alcohol-related conditions at the UHL emergency department in 2022/23 were alcohol intoxication at 49.46% (1138), alcohol dependence at 21.34% (491) and uncomplicated alcohol withdrawal at 12.30% (283) respectively.

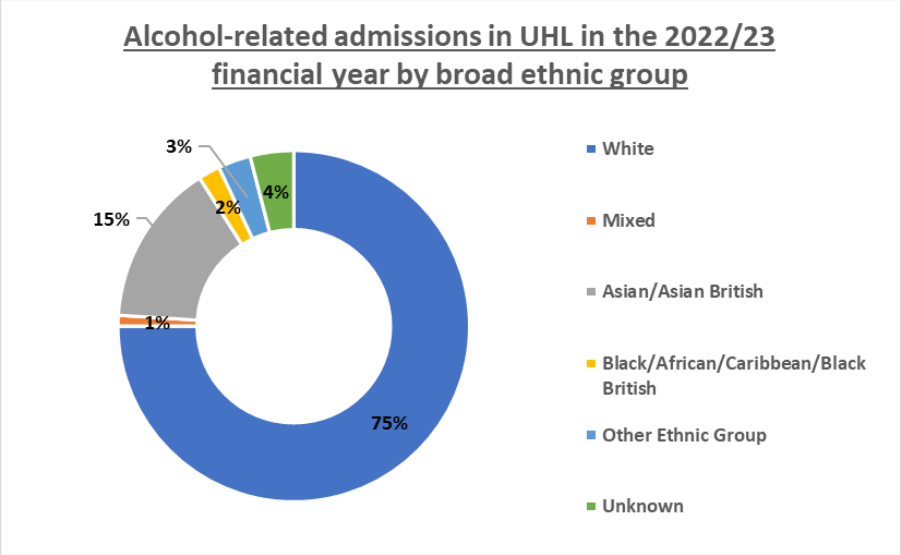
Figure 12: Emergency attendances at UHL for alcohol-related conditions



Source: UHL Alcohol Service Data

Among the total of 6561 patients presenting to UHL with alcohol-related issues either through the emergency department or inpatient admissions, the greatest number belonged to the White ethnic group at 75% (4952), followed by Asian/Asian British at 15% (976).

Figure 13: Alcohol-related attendances/admissions at UHL in the 2022/23 financial year, by ethnicity

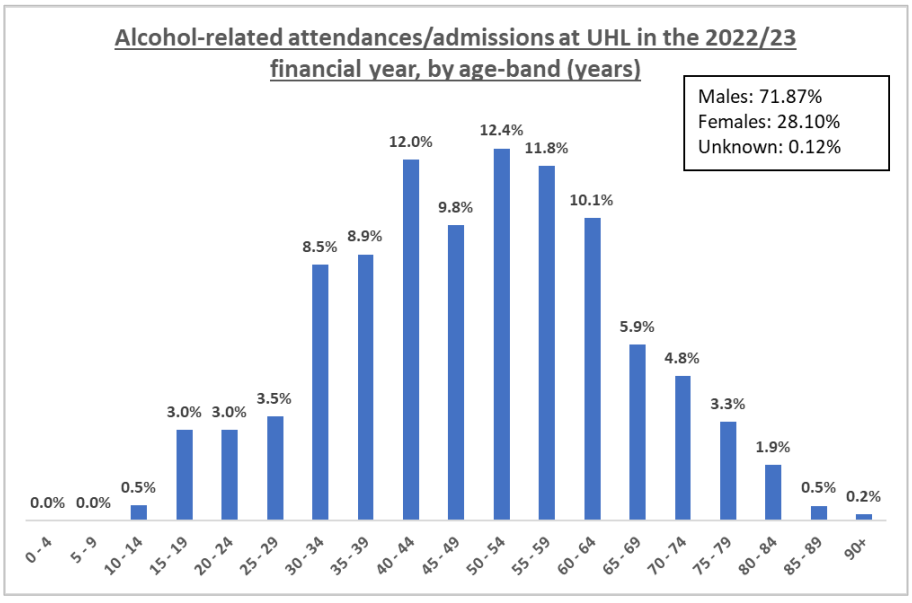


Source: UHL Alcohol Service Data

In terms of age, the greatest number of alcohol-related attendances/admissions at UHL (6561) in the 2022/23 financial year belonged to the 50-54 years age band at 12.4% (812), followed closely by the 40-44 years band at 12.0% (788) and the 55-59 group at 11.8% (774).

Males at 71.87% (4709) exceeded females at 28.10% (1844).

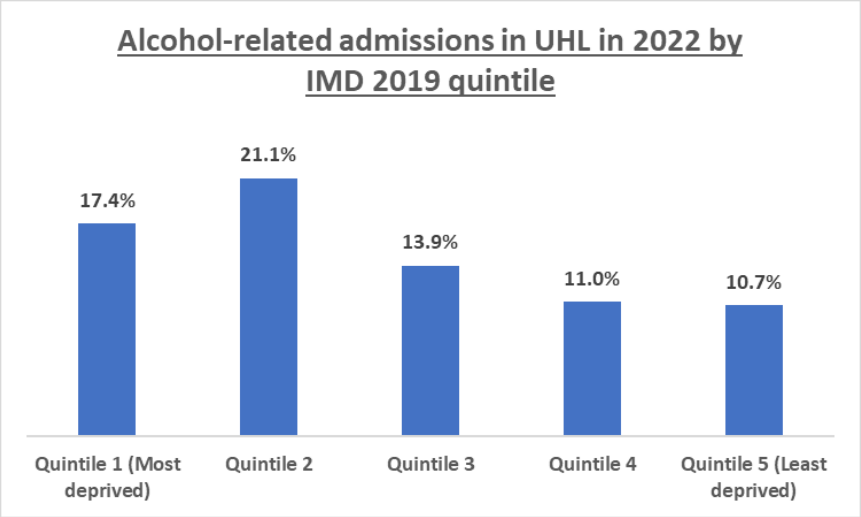
Figure 14: Alcohol-related attendances/admissions at UHL in the 2022/23 financial year, by age-band (years)



Source: UHL Alcohol Service Data

Among alcohol-related admissions at UHL in 2022, the largest proportion belonged to quintile 2 (21.1%) followed by quintile 1 (17.4%). IMD quintiles are not available for patients who are resident outside the Leicester, Leicestershire and Rutland region. It is important to note, this data is based on patients' residential postcode.

Figure 15: Alcohol related admissions in UHL by deprivation, 2022



Source: UHL Alcohol Service Data / IMD 2019

Among patients presenting to the UHL A&E with alcohol-related conditions in 2022, 74% (2217) belonged to the Leicester, Leicestershire and Rutland regions and 26% (778) to non-LLR areas.

Feedback and Case Studies on UHL Alcohol Service from Health Professionals and Service Users/Clients

The poor family had been fobbed off for years with him being continually discharged from either police custody or hospital, with no consideration to his mental health until the Turning Point Hospital Substance Misuse Team got involved.

Offender Manager, National Probation Service

I am glad that I agreed to alcohol treatment in the hospital. I am not sure where I would be now if I didn't. I would recommend treatment to anyone. I am happy to be alive and that I have not had to go back to the hospital.

Service User

I do believe that if one of their team did not prevent discharge and request an urgent mental health assessment - he would have been at a high risk of death and his family also at high risk.

Turning Point Recovery Worker

Case Study 1
Client AS

Dependent/chaotic drinker, consuming between 1-3 bottles of wine daily.

Attended A&E in crisis. Depressed, and had attempted suicide. Wife had kicked him out of the home due to his drinking.

Joint working between Mental Health Liaison and HLT to assess immediate risk, develop safety plan and undertake brief intervention around alcohol. We quickly gained a rapport with AS and helped him articultae his problems through the lens of his alcohol use. Intelligent and insightful, he could see that he should prioritise addressing his alcohol consumption. Together we worked out a stabilisation/reduction strategy, managing his expectations, answering any questions he had. We then facilitated seamless transfer into community services.

He remains in treatment with Turning Point, has massively reduced his alcohol intake to below the threshold of dependence and is reaping the benefits in all areas of his life. No longer suffers suicidal ideation, and he is working on rebuilding his relationship with his family.

Case Study 2
Client DT

DT saw the Turning Point team in the hospital who conducted a brief intervention, including advice on how to detox safely at home. Although he attempted this a number of times and did not achieve abstinence straight away, he had the tools that we gave him to reduce safely. Now he has achieved abstinence, and he is passing on his knowledge that he learnt to other alcohol dependent people that he comes into contact with at Unity House. He is an unofficial Peer Mentor at Unity house and continues to help others where he can.

3.2.4 Recommendations

- Increase in-hospital referrals to ACT from 40% - increase MECC capacity and awareness of ACT
- Ensure follow up and patient outcome data is recorded for patients needing alcohol misuse support on discharge.
- Patient level data outcomes should be reported to NHS England mandated dataset
- Capture reasons on UHL system given by patients for opting out the service.

3.3 Smoking

Smoking is a leading cause of preventable disease and premature death in England, the UK and globally. Smoking accounts for approximately 5.5% of the NHS budget. Admissions to hospital due to smoking-related conditions not only represent a large demand on NHS resources but can also be used as a proxy for variations in smoking-related ill health in the general population across England.[23]

Smoking in pregnancy has well known detrimental effects on the mother as well as the baby's growth and development. On average, expectant mothers who smoke have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption, premature rupture of membranes, increased risk of miscarriage, premature birth, still birth, low birth weight and sudden unexpected death in infants.[24]

Encouraging pregnant women to stop smoking during pregnancy may help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

3.3.1 Overview of Tobacco in Leicester, Leicestershire & Rutland (LLR)

According to the annual Population Survey (2021), smoking prevalence in adults (aged 18+) in Leicester (12.8%), Leicestershire (11.2%) and Rutland (13.0%) was statistically similar to the national rate (13.0%). The grid below, shows, Leicester City has significantly worse (higher) rates compared to England for smoking at time of delivery, smoking attributed mortality and smoking attributed hospital admissions. Leicester City has had significantly worse (higher) smoking attributed mortality rates compared to England since 2013-15 and since 2016/17 for smoking attributable hospital admissions. In comparison to England, Leicestershire and Rutland have statistically similar rates for smoking at time of delivery and significantly better (lower) rates for smoking attributed mortality and smoking attributed hospital admissions.

Figure 16: Smoking Prevalence in Leicester, Leicestershire and Rutland (LLR)

Indicator	Period	England	East Midlands region	Leicester	Leicestershire	Rutland
Smoking prevalance						
Smoking prevalence in adults (18+) – current smokers (APS)	2021	13.0	13.4	12.8	11.2	13.0
Smoking status at time of delivery	2021/22	9.1	11.8	10.0	8.3	6.8
Smoking attributable mortality (new method)	2017-19	202.2	213.8	254.2	172.3	122.6
Smoking attributable hospital admissions (new method). This indicator uses a new set of attributable fractions, and so differs from that originally published	2019/20	1398	1561	1701	1219	816

Source: Tobacco Control Profile, OHID, Fingertips.

Better 95% | Similar | Worse 95%

3.3.2 CURE (Conversation, Understand, Replace, Expert & Evidence based treatments) Tobacco Dependency Service

CURE is based on the Ottawa Model[25] for Smoking Cessation (OMSC). This model aims "to change healthcare practices so that smoking cessation treatment is provided as part of routine care to all patients who are tobacco users".

Figure 17: Summary of CURE

Source: UHL CURE Evaluation Report

CURE at UHL began at Glenfield hospital in 2021, followed by Leicester Royal Infirmary in early 2022. Implementation is currently underway for the final hospital, Leicester General Hospital. Manchester employs an in-house model. An in-house model is defined as a service where full care is provided by the same organisation. An in-reach model is defined as a service where a transfer of care takes place from one organisation to another. UHL has an in-reach service. Tobacco Dependency Advisors (TDAs) are employed by Leicester City Council and patients are referred to community services for their ongoing care. A full team of TDAs was established in March 2023. The in-reach service has advantages and disadvantages. Advantages include the ability spread the workload of implementation across multiple organisations; capitalising on the experience and expertise of community smoking cessation services and establishing strong partnerships. Disadvantages include the need for exceptional team working; difficulties with access to data and integration of systems and patient pathways across organisations and the possibility the hospital will feel less ownership over the project.[26]

The following data is collected in CURE:

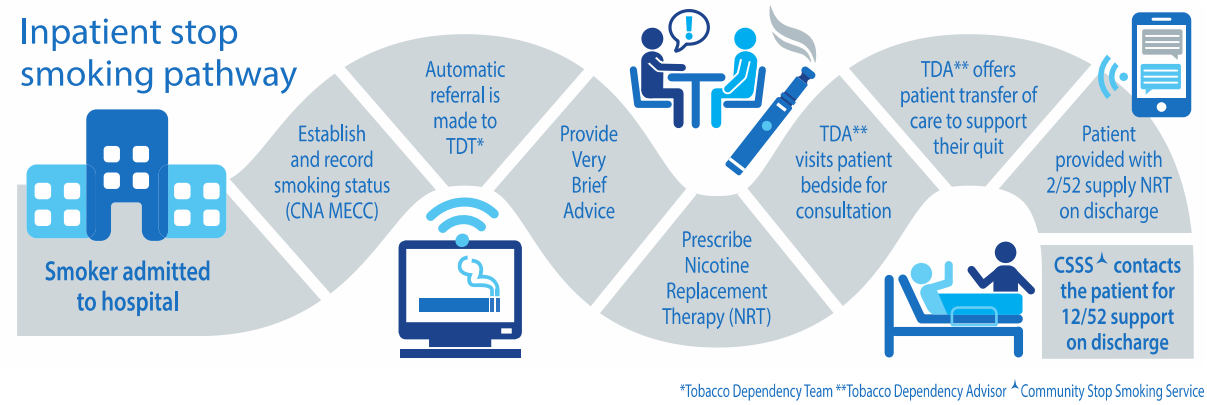
- Clinical staff input patient smoking status into Nervecentre[2] through the MECC assessment (not mandatory).
- The following day, data is sent from Nervecentre to administrator.
- Administrator manually inputs this data into an Excel spreadsheet.
- TDAs record patient outcome data onto same spreadsheet.
- Community smoking cessation services can retrieve patient records from shared spreadsheet.
- Further patient outcomes are collated in community smoking cessation service records.

Limitations with the current system include human error in inputting data, the process being time and labour-intensive, potential for patients being missed, limited capacity across all teams involved to manually input and extract data and no streamlined approach to data extraction (including hospital and community data).

[2] Nervecentre is an electronic patient record management system used in the NHS.

Upcoming changes include approval of a new case management system (QM) due to complete by the end of 2023, which community smoking cessation services will begin using. TDAs will be able to prescribe NRT through “Emeds prescribing”, which will improve access to medication for inpatients. Service budget review is underway to assess sustainability of service within current LTP allocation.[26]

Figure 18: Inpatient Smoking Pathway



Source: UHL CURE Service

3.3.3 Community Smoking Cessation Services:[26]

After patients are seen at UHL, a transfer of care takes place to community services. Patients are referred to one of three community services based on their home location and choice. The differences between the services are summarised in the table below.

Table 2: Comparison of Leicester City and Leicestershire and Rutland County Smoking Cessation Services*

	Livewell	Quit Ready
Location	Leicester City	Leicestershire County
Demographics	More deprived	Less deprived
Inception	2019	2017
Patient seen annually*	Up to 8000 (Whole integrated service)	Over 2000 (Smoking cessation service only)
Number of staff	8 stop smoking advisors (including new maternity TDA)	8 stop smoking advisors
Service structure	Part of larger healthy lifestyle service	Smoking cessation service
Service offered to smokers	Telephone appointments, face to face and home visits	Telephone appointments and home visits
Quit rate recording process	Recorded on case management system onto NHS digital template which is submitted to NHS digital each quarter	NHS Digital Submissions and internal Senior Leadership Team (SLT) submissions

Source: CURE Evaluation Report

*Like-for-like services have not been compared here: Livewell is a *large integrated healthy lifestyle service* that is operated by Leicester City Council, supporting up to 8000 individuals in the deprived areas of Leicester, while Quit Ready is a *smoking cessation service* operated

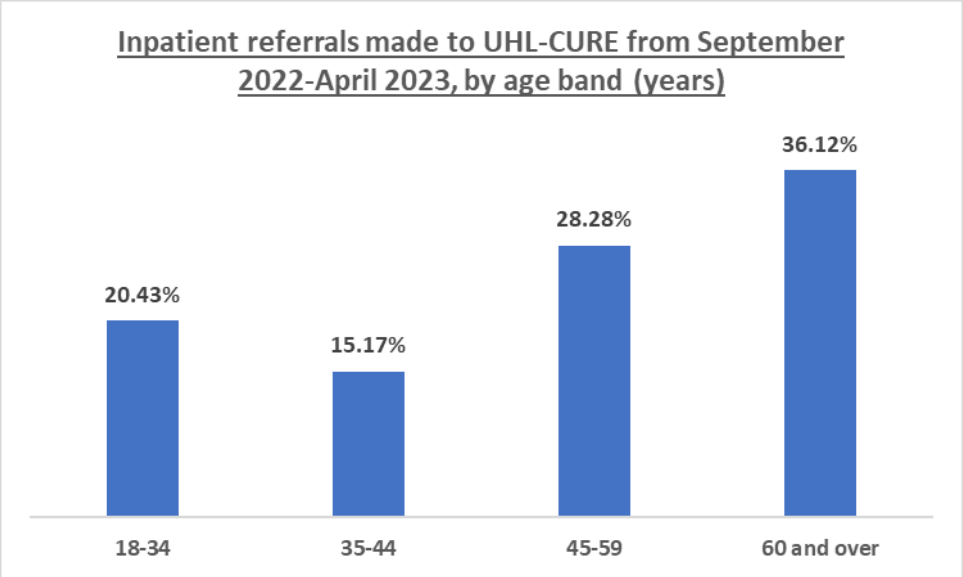
by Leicestershire County Council that sees over 2000 individuals every year. The services employ the same number of staff and offer mainly telephone appointments.

3.3.4 CURE Tobacco Dependence Service Data: September 2022 - April 2023

Data from the National Tobacco Dependence Services Dashboard from September 2022 to April 2023 showed that of all patients admitted to UHL during this period, 4940 were identified as smokers, 100% of whom were referred to CURE.

The figures below depict a demographic breakdown of referrals made to UHL CURE from September 2022 to April 2023. It is seen that the largest proportion of patients at 36.12% (1750) belonged to the age-band of 60 years and over followed by 28.28% (1370) of patients at the age band of 45-59 years.

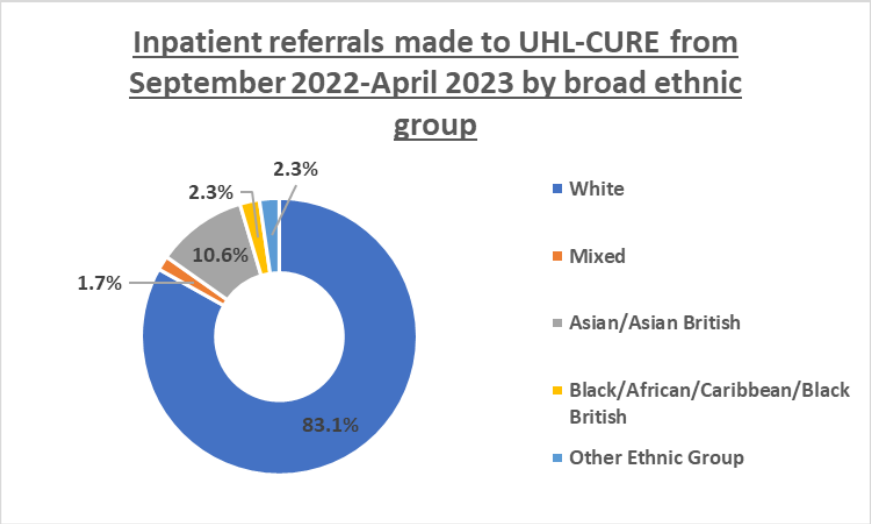
Figure 19: Inpatient referrals to UHL-CURE from September 2022-April 2023, by age band (years)



Source: National Tobacco Dependence Services Dashboard, August 2023

In terms of ethnicity, the maximum number of patients identified as smokers and referred to CURE were of White ethnicity at 83.11% (3960) followed by Asian or Asian British ethnicity at 10.60% (505). Males at 57.04% (2815) were greater in number compared to females at 42.96% (2120).

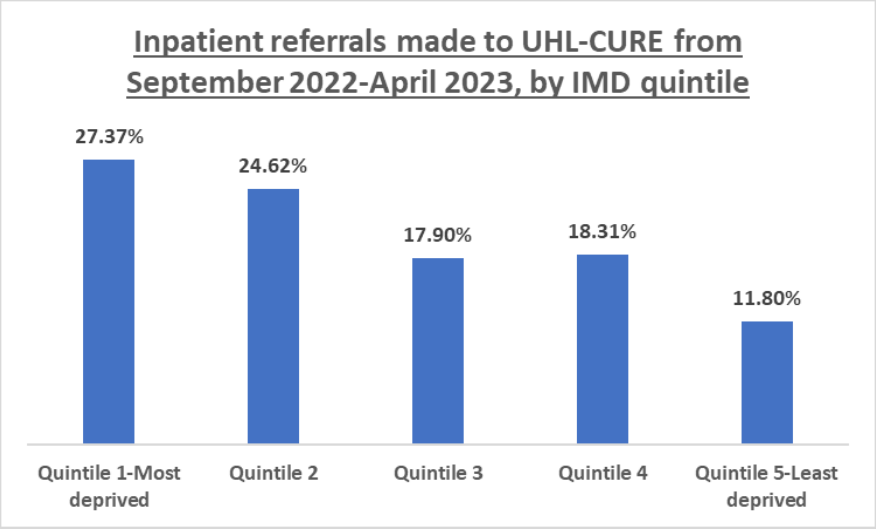
Figure 20: Inpatient referrals to UHL-CURE from September 2022-April 2023, by ethnicity



Source: National Tobacco Dependence Services Dashboard, August 2023

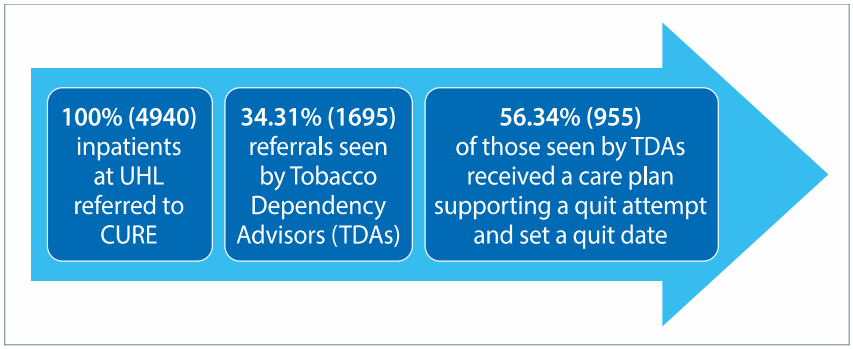
The highest number of patients at 27.37% (1345) who accessed the service were resident in the most deprived quintile (IMD quintile 1).

Figure 21: Inpatient referrals to UHL-CURE from September 2022-April 2023, by Index of Multiple Deprivation (IMD 2019) Quintile



Source: National Tobacco Dependence Services Dashboard, August 2023

Figure 22: Outcomes of patients seen by UHL TDAs from September 2022-April 2023

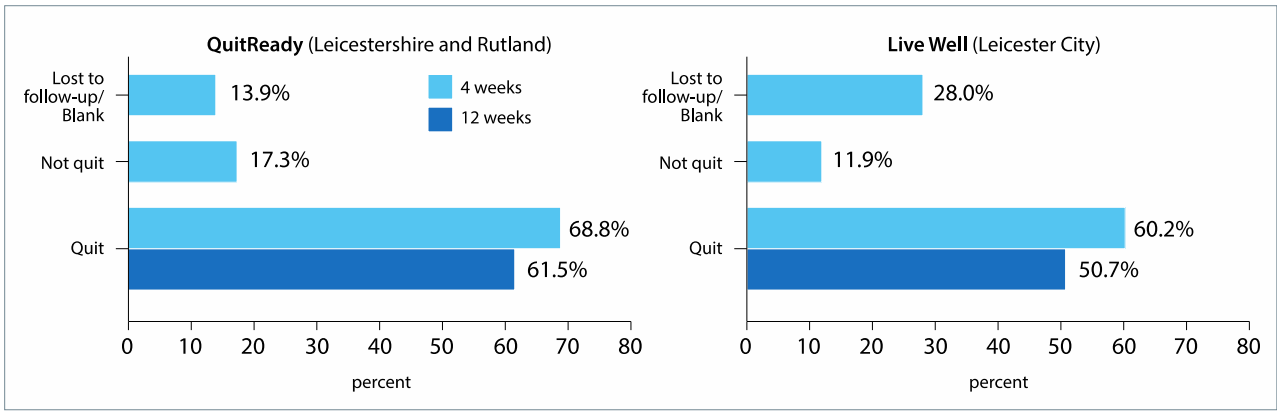


Source: National Tobacco Dependence Services Dashboard, August 2023

In terms of service effectiveness, aggregate-level data collected monthly from October 2022 to March 2023 through LiveWell and QuitReady Theseus systems showed that overall, of all CURE referrals received during this period, 56.3% achieved a 4-week quit and 58% of those individuals went on to achieve a 12-week quit status.

LiveWell (Leicester City)

Figure 23: The proportion of quit status by community service, October 2022 to March 2023.



Source: Acute Transfer of Care (TOC) Quit Data.

However, it is important to note, data on quit status in the community cannot be directly compared to patient-level data from the National Tobacco Dependence Services Dashboard because a small number of TOCs during this period would be day-cases and investigating report issues have been found in referrals received to setting a quit date, and the data includes only those referrals that have a recorded quit date.

Case Studies on UHL-CURE from Service Users

Case Study 1
Service User 1

I made the decision to quit smoking after a conversation with a nurse in hospital who helped me to realise how my genetic lung disease was negatively affecting my health. Following this wake-up call, I had a consultation with the tobacco dependency team on quitting; ***"they offered me nicotine patches and lozenges as a nicotine replacement".*** *I found these to be quite helpful on starting my journey to stay smoke-free as they helped to curb my cravings, then I switched to vaping once I joined the Live Well stop smoking service.*

The CURE and Live Well team have done a great job of helping me to quit as ***"I haven't had a cigarette since New Year's Eve"*** *whilst still using a vape as a substitute.*

If I were to give advice to others who want to quit smoking, ***"I would recommend calling The Live Well team and joining the programme".*** *In my experience, being referred to this programme was a key step in my journey to quit smoking. They provided the support and tools I needed to succeed.*

One thing I appreciated about the stop smoking service was their effective communication methods. They regularly reached out to me via phone calls on a weekly basis. What impressed me even more was their flexibility in accommodating my work schedule. ***"They would text me when I was working night shifts, allowing me to respond at my convenience",*** *which made it easier for me to stay engaged in the programme.*

Overall, my experience with the hospital tobacco dependency advisor and the Live Well stop smoking service has been positive. With their support, I have been able to quit smoking and make significant progress in improving my health. It hasn't been an easy journey, but their guidance and resources have made a significant difference.

Case Study 2
Service-User 2: Dannie. Smoke-free Dannie hasn't looked back

"I've been smoke-free for seven weeks and I haven't looked back," said Dannie Hardisty, a student midwife who has taken part in the UHL staff tobacco dependency programme that was lanuched in October.

Dannie started training as a midwife in September and wanted to quit before her first community placement, "I thought it would be hypocritical to be advising women to quit smoking during and after pregnancy when I was a smoker and vaper myself."

Dannie came across the Tobacco Dependency team at one of their outreach events in the restaurants and saw it as a sign that it was time to quit. As Dannie already vaped, she wanted to move away from the vaping pathway that the dependency team was offereing.

"I used the nicotine gum and patches pathway as I already vaped and wanted to quit that too." explained Dannie, "but I forgot to wear my patches a couple of times, so I phased them out completely and just used the gum to help combat the habit."

Dannie's first obstacle came just nine days after she quit as her supervisor was also a vaper, but Dannie persevered through.

"It was easier than I thought and I'm doing really well. I've also convinced my partner to quit smoking with me!".

Quote from Service Lead

I saw a man in PA today who you saw in July 40-60 cigarettes per day
Since you saw him he has not smoked one cigarette and has had no side effects other than feeling so much better in himself can taste things again
Thank you for all your support you are making a huge difference
Louise, CRM sister

3.3.5 Recommendations

- Aim to see all patients referred to CURE in line with national levels at 60%.
- NRT should be provided within 4 hours of admission to prevent nicotine withdrawal.
- NRT should be provided to patients on discharge to avoid relapse.
- In terms of transfer of care, ensure patients have ongoing quit support from local authority support services.
- Promote the use local authority stop smoking services in the community, especially for expectant mothers.
- Promote tobacco dependency service to UHL staff
- Collect patient level data, which should be optimised to the effectiveness of the service.
- Quality improvement methodology should be built into the service delivery, in order to sustain service and make sure it's effective.

3.4 Latent Tuberculosis Infection (LTBI)

Tuberculosis continues to be a significant problem in certain parts of LLR. Leicester City has amongst the highest rates of TB with certain groups at much higher risk. Implementing latent TB screening for high-risk groups is important as it identifies individuals with latent infection which may reactivate in the future. Individuals with a positive test for latent TB can be seen by specialists to ensure that they have not got active TB and offered appropriate therapy to reduce the risk of them developing TB in the future and transmitting to contacts. Moreover, the LTBI programme has allowed us in Leicester City to implement a combined testing programme for LTBI and blood-borne viruses so that we can identify serious infections at an early stage.

Professor Manish Pareek, Chair of Infectious Diseases, University of Leicester and Honorary Consultant in Infectious Diseases, Leicester Royal Infirmary

Tuberculosis is a serious infectious disease, which can be life-threatening without appropriate treatment. Tuberculosis (TB) is an infection which is caused by bacteria from the Mycobacterium tuberculosis complex (M. tuberculosis, M. bovis or M. africanum) and usually affects the lungs. It can be treated with antibiotics but can be serious if not treated. There's a vaccine that helps protect some people who are at risk from TB.[27] The main aim of LTBI testing is to try and treat the infection before it becomes active, therefore reducing the risk of spreading.

LTBI is when TB bacteria is present within the body, but no symptoms are present. Since 2015/16, there is a national LTBI testing and treatment programme, funded by NHS England, which aims to test new entrants to the UK, based on the following eligibility criteria:

- born or spent more than 6 months in a high TB incidence country (≥150/100,000 or Sub-Saharan Africa)
- entered the UK within the last 5 years (including entry via other countries)
- aged between 16 – 35 years.
- no previous history of TB or LTBI
- not previously screened for LTBI in the UK

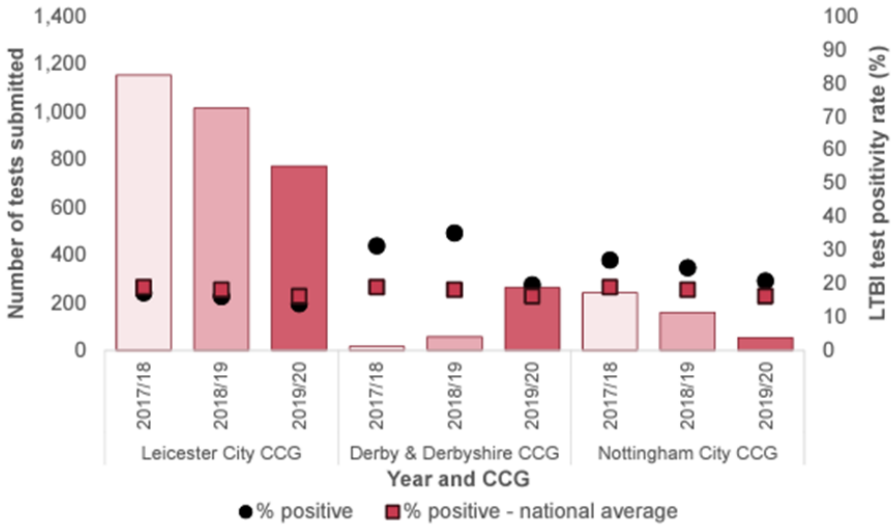
The LTBI programme was launched in 2015 in 59 high incidence CCGs (now known as ICBS) that had a TB rate of ≥20 per 100,000 population and/or ≥ 0.5% England's total TB notification numbers. The LTBI programme for migrants from high-incidence countries was heavily impacted by the COVID-19 pandemic. NHSE&I provided guidance on the provision of TB services in March 2020 which included pausing the national LTBI programme from April 2020.[28]

3.4.1 Overview of LTBI in Leicester, Leicestershire & Rutland (LLR)

Leicester City is considered one of the most diverse cities within the UK. Approximately, 41.3% of the population is born outside of the UK. According to the Census 2021 data, Asian, Asian British or Asian Welsh ethnic group (43.4%) accounts for the highest proportion of residents in Leicester City, compared to 9.7% nationally. The latest published LTBI data is from April 2015 to March 2020. Figure 24 below shows in Leicester City, the number of tests

submitted has decreased year on year from 1,152 in 2017/18 to 772 in 2019/20. The proportion of LTBI positive test out of confirmed tests, have decreased from 17% to 14%.

Figure 24: Number of tests and test positivity rate for CCGs in the East Midlands TBCB, England, 2017/18 to 2019/20

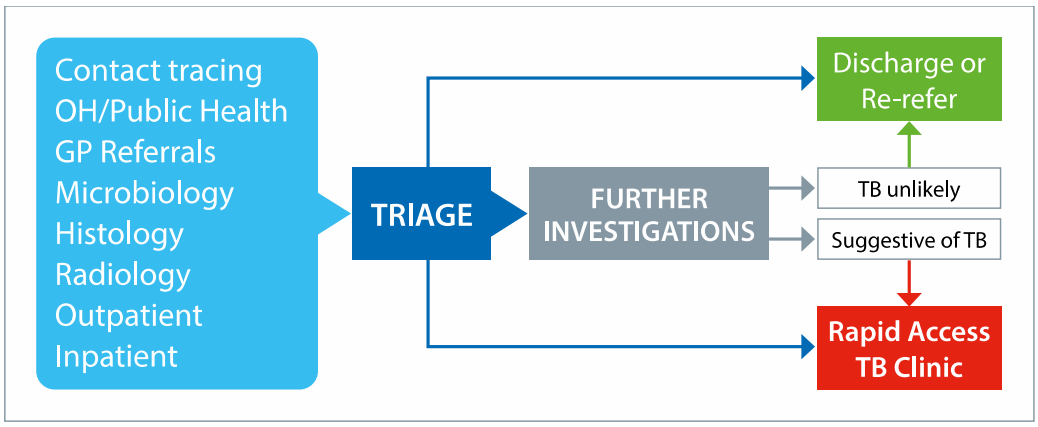


Source: Joint Health Security Agency - LTBI testing and treatment programme for migrants report

3.4.2 LTBI Service in UHL

In Leicester the model for testing for LTBI is a GP-led programme, where new arrivals who register with GPs are given a blood test to identify whether LTBI is present. If a patient is tested positive for LTBI, they will be referred to UHL and have further clinical assessment and scans. The course of treatment offered to those diagnosed with LTBI include a course of antibiotics over three months. All patients diagnosed with TB have a named TB specialist nurse as their case manager. TB is curable. It is usually treated with a six-month course of antibiotics, which must be completed in order to discourage recurrence of disease or drug resistance. See Figure 25 below which illustrates the pathway for TB patients.

Figure 25: Rapid access TB Pathway (based at Glenfield)

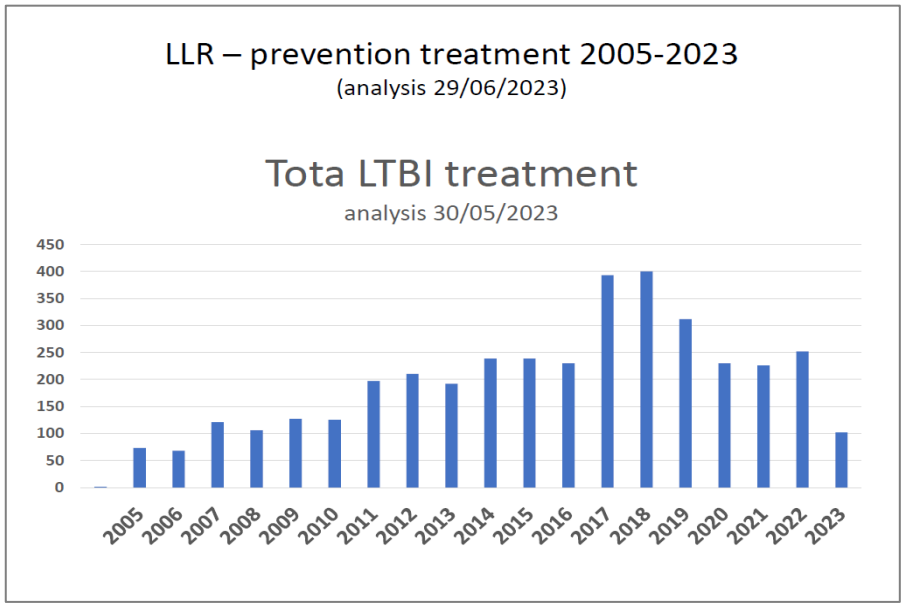


Source: TB Epidemiology Report, TB Service Lead, UHL.

3.4.3 LTBI Service Data in LLR

In 2022/23, the total tests conducted by GPs in LLR was 780, out of these, 96 (12.3%) were positive for LTBI. Figure 26 below shows numbers in treatment for LTBI has decreased just under a half since 2018 to 2022.

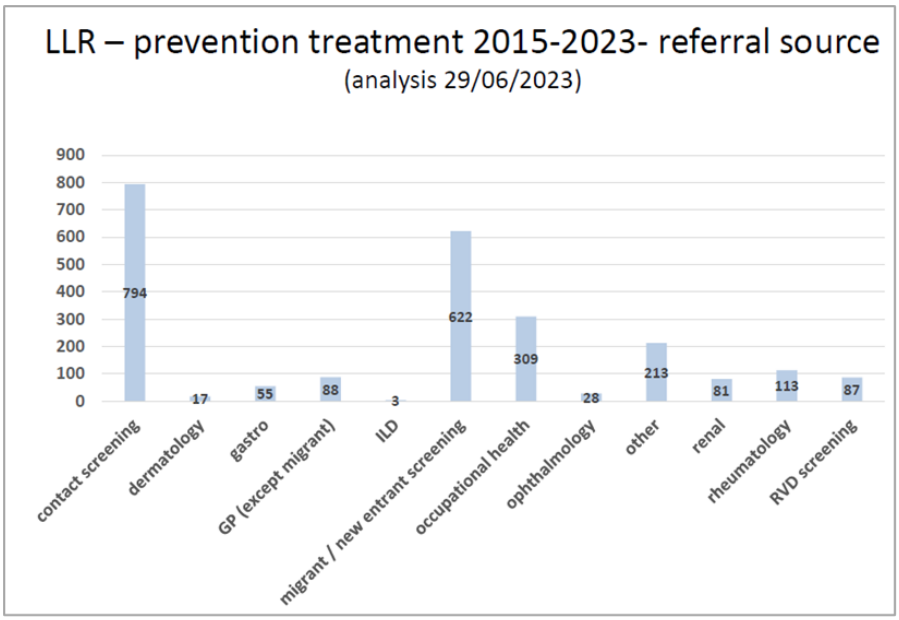
Figure 26: UHL LTBI Prevention treatment, LLR, 2005 to 2023



Source: TB Epidemiology Report, TB Service Lead, UHL

Figure 27 shows that the highest number of referrals are coming from contact screening (794), followed by migrant/new entrant screening (622).

Figure 27: UHL LTBI Prevention treatment, LLR, referral source, 2015-2023



Source: TB Epidemiology Report, TB Service Lead, UHL.

4. Workforce Wellbeing

UHL is one of the largest employers in LLR, currently employing approximately 19000 LLR residents. Although UHL employees represent only 50% of the overall total occupational departmental activity, they contribute to system prevention. For the purpose of this report, figures related to UHL employees only will be depicted. Among UHL-only employees, there is a greater percentage of female staff (75.9%) compared to males (22.6%). Employees in the age-band of 30-39 years (26.10%) form the greatest proportion. The White ethnic group (57.3%) forms the majority followed by the Asian/Asian British group (31.10%). The demographic profile of UHL-only employees, age-, sex- and ethnic group-wise is depicted in the graphs below.

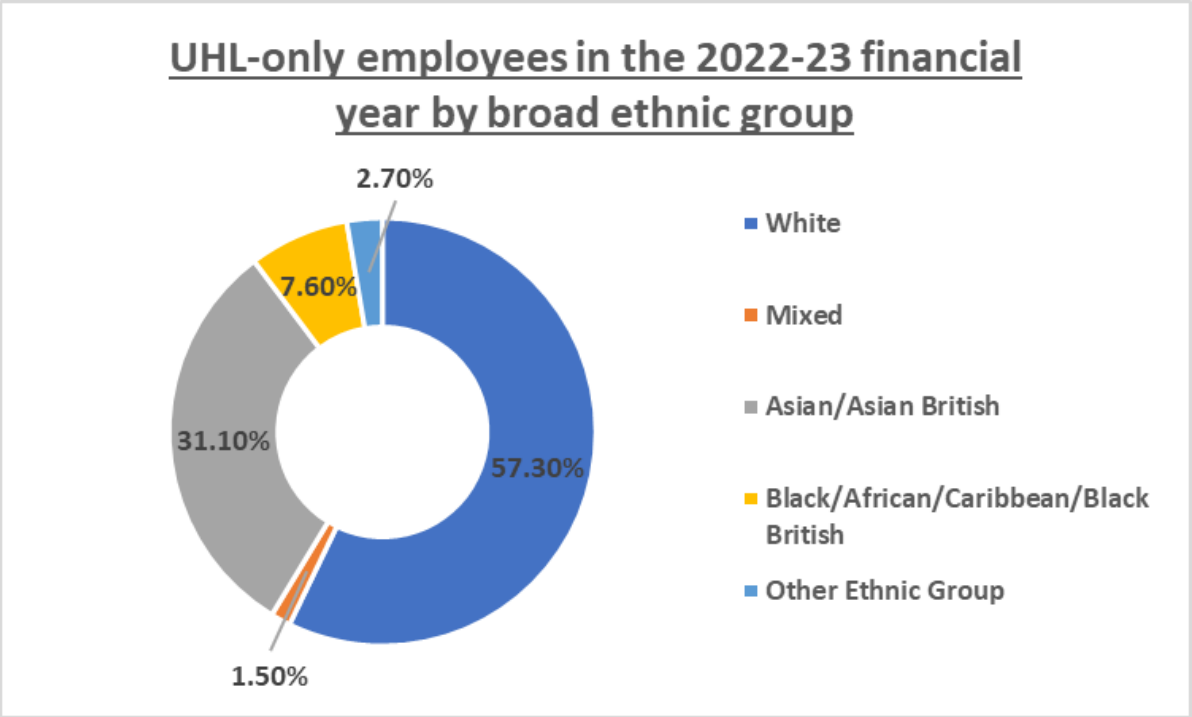
The workplace is our second home; we spend a third or more of our wake time and lives in the workplace context.

We contribute to and benefit from an environment that promotes, maintains and restores our good health, at work and at home.

UHL's commitment to preventing health deterioration in its workforce plays a major role in keeping the wider LLR community healthy; it's what makes UHL trusted.

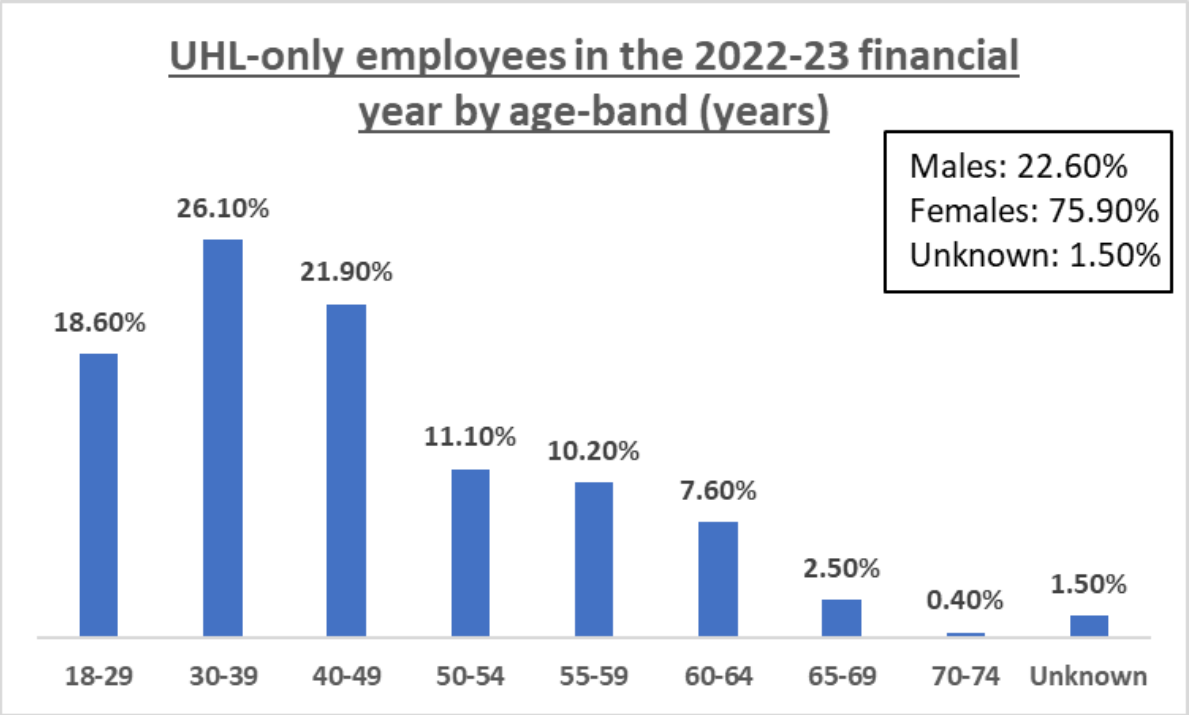
Vlad Iorga, Associate Director for Total Occupational Health, Mental Health and Wellbeing (OH-MH-WB)

Figure 28: UHL-only employees by ethnic group, 2022/23



Source: Occupation Health, Mental Health and Wellbeing, UHL.

Figure 29: UHL-only employees by age and gender, 2022/23



Source: Occupational Health, Mental Health and Wellbeing, UHL.

Workplace occupational health, mental health and wellbeing are critical drivers to the public health and prevention agenda. Active engagement in work has been identified as a driver for good mental well-being, however, specific to the health and care industry, in the context of night shift working, being in employment has been determined to be a barrier to accessing primary care health services and due to increased stigma, healthcare workers are less likely to access structured mental health therapy via the generic community mental health services. Good access to workplace-integrated health and wellbeing services not only acts as a primary driver to public health interventions but also increases awareness of own health, promoting engagement with public health initiatives such as screening and thereby contributing to population health improvement. Workplace health initiatives can directly impact the health and safety of employees. By improving working conditions, reducing workplace stressors, and encouraging health-promoting behaviours, Occupational Health (OH) can reduce the risk of chronic diseases and work-related illnesses.[29] Implementing occupational health strategies can result in less absence from work due to sickness, benefitting the UK economy by reducing a £15 billion estimated annual cost of sickness absence.[30]

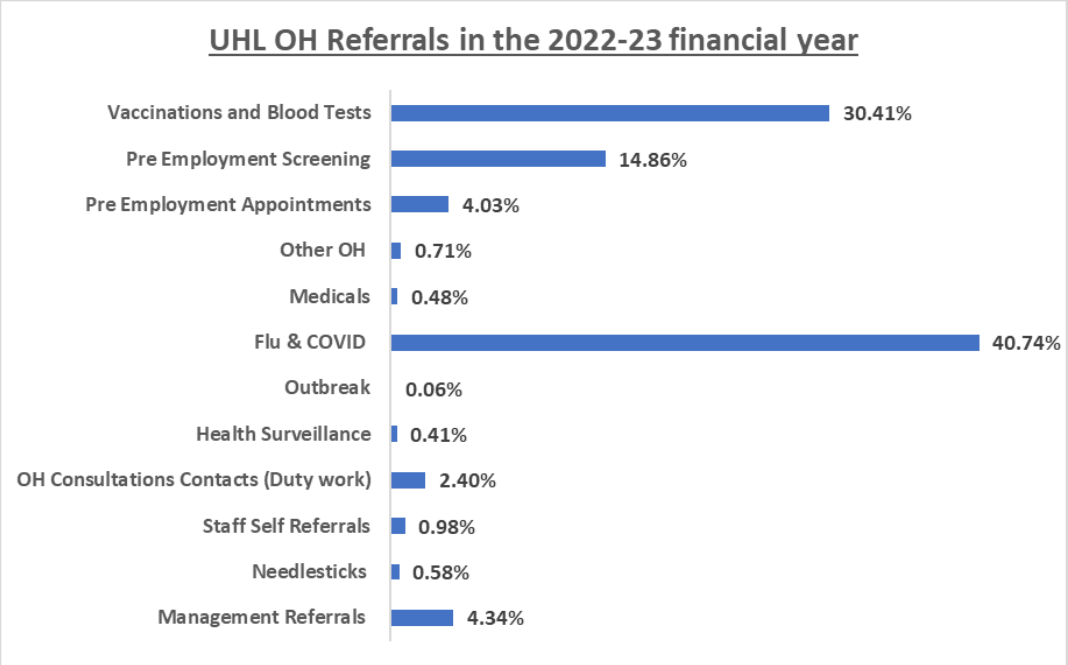
As an employer, UHL is committed to proactively supporting the holistic health, safety and wellbeing of all colleagues, grounded in compassion, best available clinical evidence and delivered in an accessible, personalised and inclusive way. UHL is one of the three NHS Trusts in England to have in-house physical and mental health services for staff. All UHL workers, including students receive mandatory occupational health checks upon placement, which include screening, blood tests, health assessment, immunisation against all known viruses, and recommended health-protecting adjustments or immunisation boosters, which have public health benefits at a population health level. In addition, UHL's Embedded Prevention Offer strives to provide access and engages all UHL workers to benefit from an

accessible in-house Occupational Health service, an in-house embedded psychological counselling and critical incident support service (Amica) and other public health promotion activities through assertive engagement and awareness events through a Health and Wellbeing (HWB) Team. The Trust's Employee Wellbeing Offer includes mandatory occupational health screening, immunisation, epidemiology and health surveillance, assertive outreach, initiative-taking support, health promotion, advice and guidance across the spectrum of health and wellness needs, and others such as menopause, men's health, emotional, physical and financial wellbeing.

In-house Occupational Health service

The following diagram illustrates the types of referrals received by the UHL OH department in the 2022-23 financial year. Among referrals received by the UHL OH department in the 2022-23 financial year, flu and COVID formed the majority at 40.74% followed closely by vaccination and blood test referrals at 30.41%. Pre-employment screening formed approximately 15% of OH referrals at UHL in 2022-23. Management referrals involve UHL OH advising managers on how best to support staff returning to work following sickness absence. Among key surveillance programmes are audiometry tests and monitoring and respiratory surveillance of workers exposed to certain risk factors, and confidential support and surveillance for staff members with blood borne viruses (BBVs). UHL OH also supports the trust response to outbreaks through contact tracing and appropriate follow-up, besides providing expert guidance to the trust with respect to outbreak policy creation and implementation. The term 'medicals' in the graph below indicates medical assessments for workers in particular roles such as food handling, driving, work in confined spaces and radiation exposure, in accordance with national Public Health (PH) and Health and Safety Executive (HSE) legislation and guidelines; UHL OH delivers these services with other support specialties such as pharmacy, histopathology or biochemistry departments.

Figure 30: UHL Occupational Health Referrals, 2022/23



Source: Occupational Health, Mental Health and Wellbeing, UHL.

Occupational Health services are also provided to an extensive list of external organisations within LLR on a contractual basis, further contributing to the wider prevention and public health agenda through access to population health immunisation and surveillance data.

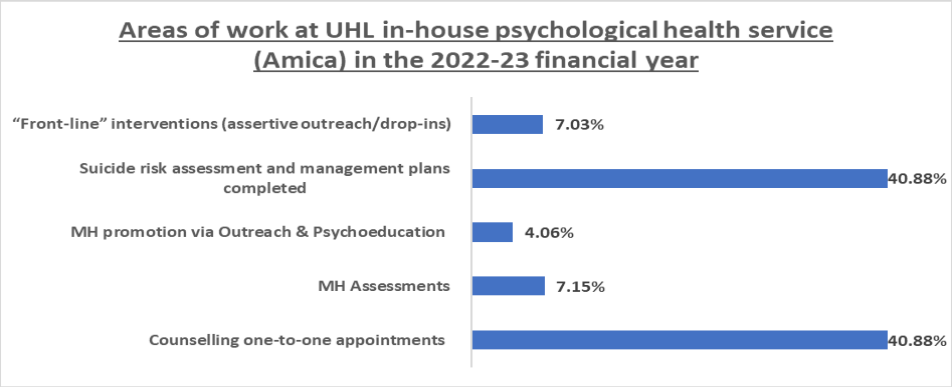
In-house embedded psychological counselling and critical incident support service (Amica)

UHL has been running its in-house staff psychological well-being service (Amica) for almost 30 years. The dedicated team consists of psychological wellbeing practitioners, cognitive behavioural therapists, counsellors, a psychological wellbeing practitioner, assistant, and clinical psychologists. Amica is an internal provider of staff counselling service to ensure staff members have access to a confidential support service. Counselling sessions are provided as part of an 8-sessions-model following an appropriate clinical assessment. The service is also provided to external organisations on a contractual basis. The service is operational 24*7 service and provides a necessary contact point to help support staff in improving their mental health and well-being. It also acts an important signposting opportunity to other pathways and support mechanisms.

A systematic review conducted by Zaman et al. in 2022 elicited that healthcare professionals encounter unique obstacles when seeking mental health support, as they fear that utilising services provided by their peers might lead to perceptions of vulnerability on their part.[31] Hence, to improve access, UHL funds a separate psychologically safe space for staff. The in-house service 'Amica' acknowledges and reassures UHL employees that confidentiality is paramount to the service and its users through use of an independent clinical recording system which ensures all support provided is discreet and completely confidential. Services at Amica are rapidly accessible and are evidence-based in line with NICE CG123 and NICE CG212 through provision of routine appointments, screening for suicidality and prevention through embedded suicide and self-harm risk assessments at each contact. When suicidal ideation is present, this is managed directly in session or referral is made to secondary mental health (MH) services in the community, preventing avoidable loss of life. Furthermore, Amica also provides psychoeducational sessions and access to computerised CBT. These programmes include healthy lifestyle behaviours, such as sleep improvement, stress management etc., personal benefits of which will also permeate to their families and communities.

Areas of work covered by Amica in the 2022-23 financial year are depicted below; counselling appointments and suicide risk assessments formed the majority of workstreams at 40.88% each.

Figure 31: Areas of work in UHL in-house psychological service (Amica)



Source: Occupational Health, Mental Health and Wellbeing, UHL.

Public Health Prevention and Promotion mapped to UHL Health and Wellbeing team

UHL promotes workers' wellbeing, health improvement and access to public health interventions through assertive outreach, awareness events and engagement. The various health promotion activities available for UHL staff are outlined below.

Making Every Contact Count (MECC)

- Manager's Wellbeing Conversations training includes MECC framework.

Smoking Cessation and Pulmonary Health

- The CURE (Conversation, Understand, Replace, Expert & Evidence based treatments) Tobacco Dependency Service is offered to UHL staff too, with signposting to quitting support

Reducing Obesity/Healthy Weight Management and Cardiovascular Health

- Half price Slimming World vouchers
- HIIT classes – weekly, live classes
- Cardio classes – weekly, live classes
- Pilates classes – weekly, live classes
- 5-a-side football – free to UHL colleagues
- Badminton – free court time for UHL colleagues
- Cricket – free to UHL colleagues
- Yoga – free for UHL colleagues
- Promoting "Step into health Programme" run by Loughborough College, developing greater understanding about key lifestyle areas - physical activity, nutrition and healthy eating and stress management.

Prevention of alcohol, substance misuse & gambling adverse consequences

- Signposting to Turning Point
- Signposting to Professional Bodies and Practitioner Health
- Signposting to NHS Gambling addiction hubs

Mental Health prevention through social prescribing and community resource activation

- TRiM (Trauma Risk incident Management) support
- REACT (Recognise, Engage, Actively listen, Check risk, and Talk about specific actions) MH training
- Compassion Fatigue training
- Mindfulness sessions free to UHL colleagues
- Signposting to "Mind Coaching" programme for:

- Emotional Release	- Motivation	- Interrupted Sleep
- Relaxation	- Stress Management	- Anxiety Release
- Work Worries	- Positive Thinking	

5. Health Inequalities

UHL is committed to providing healthcare that meets the needs of individuals and communities. We see the impact of failure to prevent in our patients and in our services every day; it is in the increasing numbers of patients living with complex multi-morbidity, it is in the increasing demand for outpatient services, it is in the increasing admissions to our hospitals. Added to this, avoidable health inequalities experienced by our most vulnerable populations are entrenched further when we approach healthcare reactively rather than preventatively.

Through the initial actions outlined in this report, UHL will begin a move towards meeting the daily healthcare needs of the population whilst focusing on building sustainabale, equitable healthcare services.

Ruw Abeyratne, Director of Health Equality and Inclusion, University Hospitals of Leicester

"Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. They arise because of the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can impact both our physical and mental health and wellbeing. Within this wider context, healthcare inequalities are about the access people have to health services and their experience and outcomes".[32]

The NHS Long Term Plan sets out key actions that would strengthen the contribution from the NHS to reducing healthcare inequalities. The NHS aims to tackle health inequalities in three ways:[32]

1. Influencing multiagency action to address social determinants of health via working with local authorities, Office for Health Improvement and Disparities and local communities.
2. The NHS is a significant economic actor in its own right in that choices made as an employer, purchaser and a local 'anchor institution' can help reduce inequalities.
3. Tackling inequalities in healthcare provision, which is a prime focus for the NHS. Identifying and tackling the disparities in access to services, patient experience and healthcare outcomes is key.

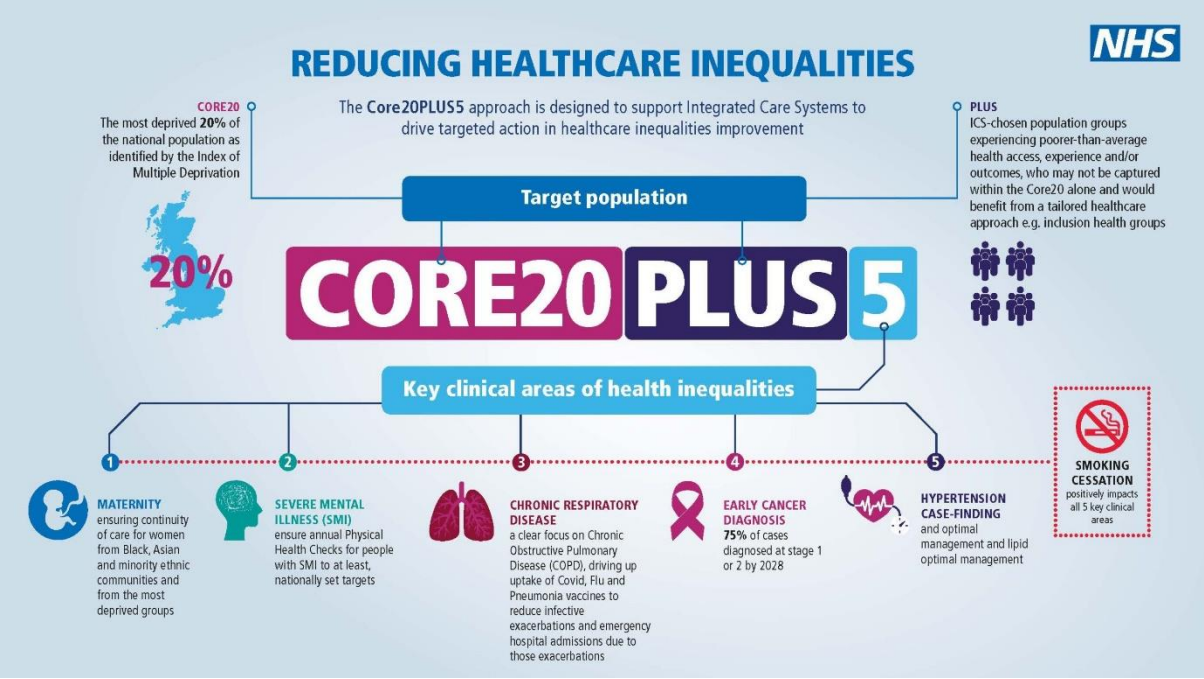
A national approach to inform action around reducing healthcare inequalities involves the Core20PLUS5 approach for both adults and children. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement, see table and infographics below

Table 3: Definition of CORE20PLUS5

Breakdown	Definition
CORE20	The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health
PLUS	PLUS population groups are determined locally and are those that experience poorer than average health access, experience and/or outcomes, for example; ethnic minorities, homeless community, people with a learning disability, vulnerable migrants etc
5	These are 5 clinical areas of focus which require accelerated improvement: **Adults** - Maternity, Severe Mental Illness (SMI), Chronic Respiratory disease, Early cancer diagnosis and Hypertension. **Children –** Asthma, Diabetes, Epilepsy, Oral Health and Mental Health.

Source: NHS England

Figure 32: CORE20PLUS5 - Adults



Source: NHS England

UHL Approach to tackling Health Inequalities in healthcare

UHL population serves 1.1 million residents of Leicester, Leicestershire, Rutland. In Leicester just over a third (35%) of residents live in the most deprived 20% of neighbourhoods; in Leicestershire and Rutland there are pockets of significant deprivation despite affluence for a proportion of the population, particularly in parts of Loughborough and Coalville. Leicester has more than 50% of the city's population belonging to an ethnic minority, while Leicestershire and Rutland have around 10% and 3% respectively belonging to ethnic minority groups (15-20% of the population are identified as being South Asians). Analysis of UHL access and outcome data associated with access to Cardiology services highlights a range of differentials based on ethnicity, gender, deprivation levels and disability status. This difference exists in relation to the formation of waiting lists, rates of non-

attendance, those discharged after first appointment, and differences in rates of prescription of key NICE drug (Rivaroxaban).

2021/22 non-attendance rates for a Cardiovascular Outpatient appointment were higher for Black Africans (16%) and Asians (13%) than the White British population (9.3%). In addition, the poorest populations had a non-attendance rate of 14% in 2021/22. Moreover, a large difference exists in prescription of Rivaroxaban: Black African (2%), Asian (15%) patients compared with White British patients (74%).[33]

UHL aims to launch an Innovation for Health Inequalities Programme by December 2023 to increase referrals from the BAME & poorest populations to UHL Cardiovascular services, reduce the differential in non-attendance rates within UHL Cardiovascular Outpatient services, and understand and reduce any differentials within NICE approved drug prescribing. There are three main components to the proposed intervention. The first will attempt to increase access to UHL Cardiology, Diabetes and Vascular services for those from the lower Indices of Multiple Deprivation and members from the BAME community through identification at the time of referral the form of communications non-English speaking/reading individuals would like their appointment information in (English letter, first language letter, English audio and first language audio). Members of the communities where access is looking to be increased will also be consulted to identify potential solutions. Secondly, a range of online videos, attendances at local radio stations, community specific materials will be produced to increase awareness of services and why accessing public services is important. Finally, sessions will be held with the Cardiology, Diabetes and Vascular consultant teams to understand differentials in prescribing practice and identify opportunities to change practice.

This project, by reducing differentials in relation to access, experience & outcomes will benefit patients of Leicester, Leicestershire and Rutland & those that support those individuals. These benefits will be underpinned by clear measurables, for which a 12-month baseline will be produced. Further benefits will also be experienced for UHL and the wider ICS.

Patient benefits range from earlier diagnosis, decreased waiting times, reduction in differences between discharge-at-first-outpatient rates, further disease prevention and reduction in clinically unnecessary hospital time for the 20% of most disadvantaged patients accessing cardiology services. Benefits to the system encompass reduction of non-attendance rates, increase in patient satisfaction and reduction in emergency service usage rates among these patients.

<u>Developing a Historical Understanding of Black Maternity and Motherhood Health Experiences in Leicestershire</u>

Maternity care in the Leicester area is marked by health inequalities, particularly among Black mothers, who have been found to have poorer maternal outcomes such as rates of pre-term birth, maternal mortality, and other pregnancy-related outcomes. UHL is embarking on a wide-reaching project of quality improvement in maternity services. This project will run 6 months from January 2024-July 2024.

This project aims to develop an historically contextualised understanding of experiences, initiatives and challenges in maternity and motherhood for Black women in Leicestershire under the NHS (i.e., since 1948), both from the perspective of Black women/mothers and healthcare practitioners involved in their care. Its objectives are:

- To undertake archival research in the University of Leicester archives (in particular, the Caribbean Midwives Oral History collection) and University Hospitals of Leicester archives on Black women's and Black healthcare professionals' historical experiences and challenges in maternity and motherhood.
- To conduct 5-10 oral history interviews with Black female long-term Leicestershire residents about their experiences of maternity, childbirth, and early motherhood care in local NHS services.
- To identify social and cultural determinants of maternal healthcare inequalities within this historical data and use this knowledge to inform maternity and public health service improvement for the Black community in local NHS services.
- To compile a historical profile of Black maternity and motherhood in Leicestershire, and present this at a public event within the local Black (African and Caribbean) community in Leicester, accompanied by representatives of local NHS services (public health and hospitals) to share the planned service improvements informed by this historical context.

Improving Equity of Access-UHL Pilot Case Study

Analysis of UHL outpatient data identified that access, experience, and outcomes are not universal across the population of Leicester, Leicestershire & Rutland. Patients from the lowest socioeconomic or BAME communities wait longer, are more likely not to attend and have care pathways end at the first Outpatient appointments.

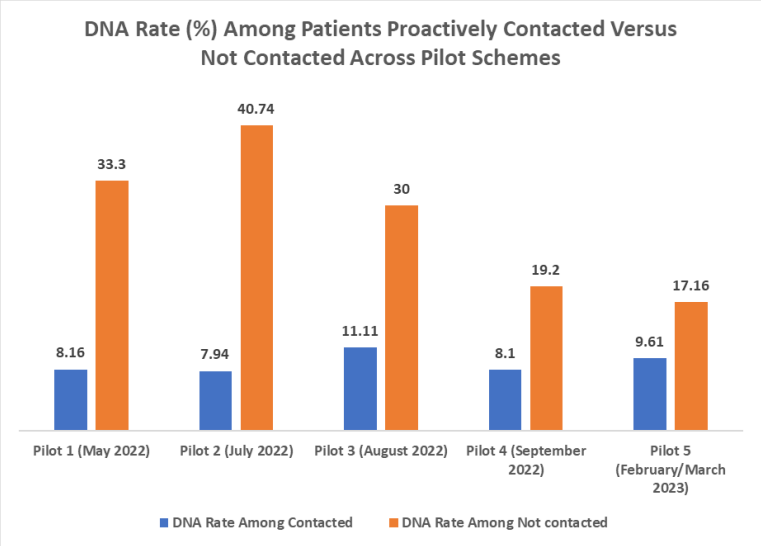
To address this, as part of the pilot, the booking centre proactively contacted patients from the most deprived areas (by Index of multiple deprivation IMD data) to remind them of their appointment and offer support with attendance e.g., travel costs and car parking, interpretation as well as longer appointments where needed. The outcome of the call was recorded, if patients needed any help was identified and actioned during or soon after the call, the final element was to then review the outcome of the attendances and what happened e.g. failure to attend (Did Not Attend/DNA), attended, cancelled etc. The results highlighted a significant difference in DNA rate of those contacted versus those not contacted. UHL undertook 5 pilot schemes since May 2022. A total of 1536 patients were contacted through over 3000 telephone calls.

Primary goals included:

- Identify patients at higher risk of not attending based on IMD decile
- Make calls and offer assistance to those patients
- Reduce health inequalities of these patients and improve equity of access
- Reduce DNA rate

UHL reviewed the DNA rates for patients in IMD groups 1 to 10 and identified higher DNA rates in Respiratory, Gastroenterology and pain management specialties which led to 5 pilot schemes from May 2022 to March 2023 whereby patients attending future appointments in those specialties in IMD groups 1 and 2 were called 2 weeks prior to the appointment with an offer of support call rather than a traditional reminder call. The graph below depicts that the DNA rates among patients proactively contacted was substantially lower than those not contacted.

Figure 33: DNA Rate Among patients proactively contacted and those not contacted



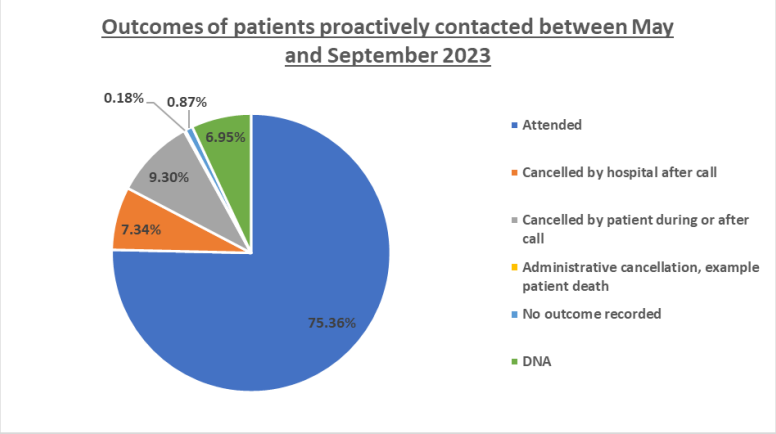
Source: UHL Pilot Study

Initial results have shown a significant difference in attendance for those contacted. This work has eliminated the differential in non-attendance between the most- and least-deprived populations. The trust average DNA rate overall is 8% so by calling IMD 1 patients, this has reduced their DNA rate to around the trust average.

The economic case for improving equity and inclusion within UHL services is clear. However, the priority for UHL is improving the quality of services for patients, enabling those in greatest need to access services and clinicians which are most likely to benefit them. The work of this pilot is easily transferrable to other services, which must form a key priority across all services' work on DNAs.

Considering the clear results of the pilot schemes, UHL has incorporated proactive pre-appointment telephone calls to patients into business as usual. All patients in IMD quintiles 1 and 2 over the age of 16 are routinely called and attendance results monitored. A total of 5422 patients were contacted between May to September 2023 and of that, 6.95% (377) did not attend, as shown below. On the contrary, of the 3427 patients who could not be proactively contacted during this period, 18.44% (632) did not attend.

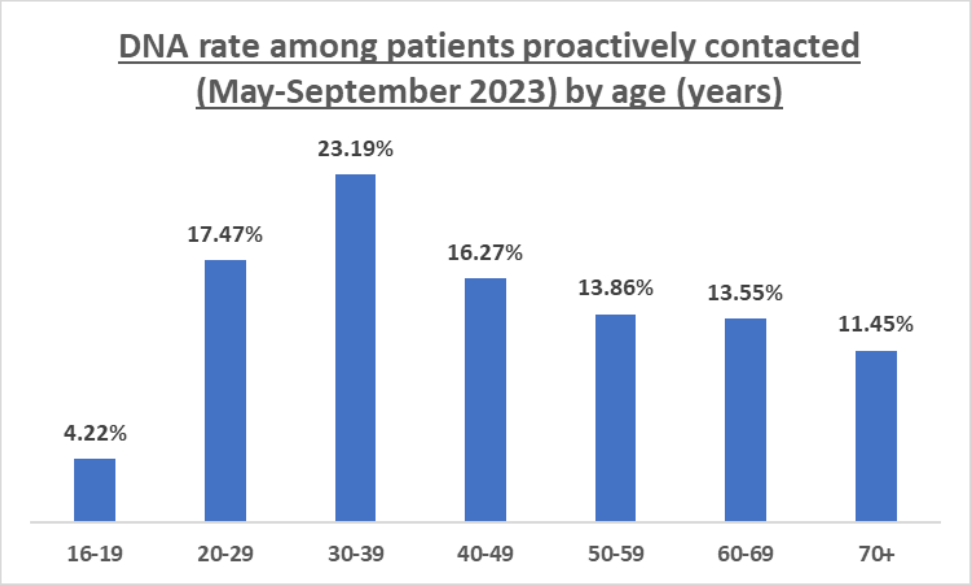
Figure 34: Outcomes of patients proactively contacted, May-September 2023



Source: UHL Outpatient Performance Data

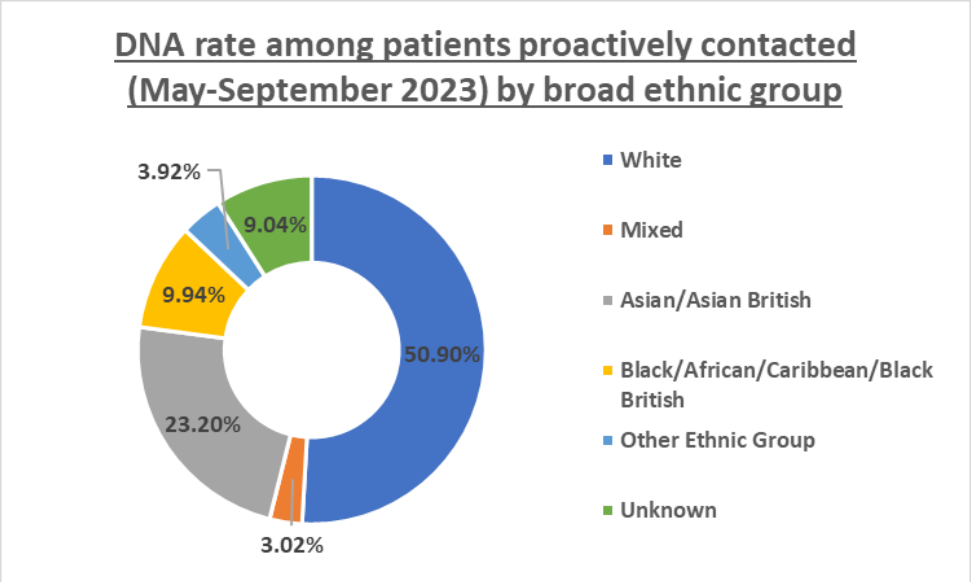
The following graphs show that among patients who did not attend after proactive contact between May and September 2023, the greatest number belonged to the 30-39 years age group at 23.19% (77) followed by the 20-29 years age group at 17.47% (58), and the White ethnic group formed the majority at 50.90% (169) followed by Asian/Asian British at 23.20% (77). It is worth noting that these figures are out of a total of 332 patients instead of 377 patients who DNA d, as only 4863 of the total 5422 patients contacted could be prospectively identified.

Figure 35: DNA rate among patients proactively contacted by age (years), May-September 2023



Source: UHL Outpatient Performance Data

Figure 36: DNA rate among patients proactively contacted by broad ethnic group, May-September 2023



Source: UHL Outpatient Performance Data

6. Summary of Recommendations and Opportunities

Based on the findings of this report, the following recommendations are proposed:

- **MECC:** Ensure healthcare professionals and other frontline staff are trained to deliver brief advice and interventions on prevention topics during routine patient interactions.
- **Data collection**:
  - Implement the recording of smoking status, alcohol consumption, and BMI for all patients admitted.
  - Ensure timely referrals to the Alcohol Care Team if patients have reported excessive alcohol intake or admitted with alcohol related complaint.
  - Review the existing process for recording smoking assessments and identify gaps.
- **Increase access to intelligence and relevant data on prevention efforts**
- **Promote latent TB screening** for high-risk groups and offer a combined testing programme for Latent TB infection and blood-borne viruses
- **Enhance staff wellbeing** and access to public health interventions through assertive outreach, awareness events and engagement
- **Training:** Ensure ongoing training opportunities and information to keep staff updated with prevention efforts and available services within UHL
- **Make prevention a priority for all healthcare professionals**

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اگر آپ کو یہ معلومات کسی اور زبان میں درکار ہیں، تو براہِ کرم مندرجہ ذیل نمبر پر ٹیلی فون کریں۔

ਜੇ ਤੁਸੀਂ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਗਏ ਨੰਬਰ 'ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ।

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