LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: MONDAY, 10 OCTOBER 2016

Time: 3:00 pm

Location:
MEETING ROOM G.01, GROUND FLOOR, CITY HALL,
115 CHARLES STREET, LEICESTER, LE1 1FZ

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

G. J. Carey

For Monitoring Officer

NOTE:

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MEMBERS OF THE BOARD

Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Adam Clarke, Assistant City Mayor, Energy and Sustainability

Councillor Piara Singh Clair, Assistant City Mayor, Culture, Leisure and Sport

Councillor Abdul Osman, Assistant City Mayor, Public Health

Councillor Sarah Russell, Assistant City Mayor, Children, Young People and Schools

City Council Officers:

Frances Craven, Strategic Director Children's Services

Steven Forbes, Strategic Director of Adult Social Care

Andy Keeling, Chief Operating Officer

Ruth Tennant, Director Public Health

NHS Representatives:

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

Trish Thompson, Locality Director Central NHS England – Midlands & East (Central England)

Healthwatch / Other Representatives:

Karen Chouhan, Chair, Healthwatch Leicester

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Chief Superintendent, Andy Lee, Head of Local Policing Directorate, Leicestershire Police

Matthew Cane, Group Manager, Leicestershire Fire and Rescue Service

STANDING INVITEES: (Not Board Members)

Kaye Burnett, Chair, Better Care Together Programme
Toby Sanders, Senior Responsible Officer, Better Care Together Programme
Richard Henderson, Acting Chief Executive, East Midlands Ambulance Service NHS Trust

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- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed at the meeting.

3. MINUTES OF THE PREVIOUS MEETING **Appendix A (Pages 1 - 20)**

The Minutes of the previous meeting of the Board held on 18th August 2016 are attached and the Board is asked to confirm them as a correct record.

4. SUSTAINABILITY AND TRANSFORMATION PLAN

To receive a presentation from Toby Sanders, Senior Responsible Officer for the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan.

1. STP Plan Overview

2. STP Governance Arrangements

3. STP Patient and Public engagement

5. INFANT MORTALITY STRATEGY **Appendix B (Pages 21 - 32)**

Clare Mills, Lead Commissioner (Healthy Child Programme), Public Health and Nicola Bassindale, Service Manager (Strategy, Quality & Performance), Education & Children's Services to present a report outlining the new strategy to reduce infant mortality in Leicester, Leicestershire and Rutland. The Board is requested to approve the recommendations in the report.

6. FINAL REPORT ON THE DELIVERY OF THE JOINT HEALTH AND WELLBEING STRATEGY (2013-16)

Appendix C (Pages 33 - 70)

To receive a report that presents final information on progress in delivering the Joint Health and Wellbeing Strategy: 'Closing the Gap'. The responsibility for ensuring effective delivery of this strategy has been devolved to the Leicester City Joint Integrated Commissioning Board (JICB).

The Board is asked to note progress on the delivery of the Joint Health and Wellbeing Strategy and the areas of concern highlighted in the report and the response of the JICB to these (section 3.7).

7. ADULTS JOINT STRATEGIC NEEDS ASSESSMENT 2016

Appendix D (Pages 71 - 88)

To receive a report from the Director of Public Health on the progress in updating the Joint Strategic Needs Assessment 2016 (JSNA). The JSNA is predominantly web-based and iterative in nature, with annual reviews of sections planned. It is produced by a multi-agency team overseen by the JSNA Programme Board.

A summary document, Snapshots: Health and Wellbeing in Leicester has been prepared to both accompany the briefings and promote use of the web pages. This is attached as Appendix A. The infographics in the Snapshots document will be made available on the web pages for downloading and use in presentations of various types.

8. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

9. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will be held on the following dates:-

Thursday 15th December 2016 – 5.00pm
Monday 6th February 2017 – 3.00pm
Monday 3rd April 2017 – 2.00pm

Meetings of the Board are scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

10. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 18 AUGUST 2016 at 4.00pm

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
Karen Chouhan	–	Chair, Healthwatch Leicester.
Councillor Piara Singh Clair	–	Assistant City Mayor, Culture, Leisure and Sport, Leicester City Council.
Councillor Adam Clarke	–	Assistant City Mayor, Energy and Sustainability, Leicester City Council.
Chief Inspector Lou Cordiner	–	Local Policing Directorate
Frances Craven	–	Strategic Director, Children's Services, Leicester City Council.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group.
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
Dr Peter Miller	–	Chief Executive, Leicestershire Partnership NHS Trust.
Superintendent Mark Newcombe	–	Adviser to the Police and Crime Commissioner, Office of the Police and Crime Commissioner.
Councillor Abdul Osman	–	Assistant City Mayor, Public Health, Leicester City Council.
Sarah Prema	–	Director Strategy and Implementation, Leicester City Clinical Commissioning Group.
Councillor Sarah Russell	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council.

Ruth Tennant	–	Director of Public Health, Leicester City Council.
Mark Wightman	–	Director of Marketing and Communications, University Hospitals of Leicester NHS Trust

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

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16. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

John Adler, Chief Executive, University Hospital of Leicester NHS Trust.
Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner.
Andy Keeling, Chief Operating Officer, Leicester City Council.
Chief Superintendent Andy Lee, Head of Local Policing Directorate, Leicestershire Police.
Sue Lock, Managing Director, Leicester City Clinical Commissioning Group.
Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group.
Trish Thompson, Locality Director Central NHS England – Midlands & East – (Central England).
Professor Martin Tobin, Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester.

17. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting. No such declarations were made.

18. APPOINTMENTS TO THE BOARD

The Board noted that the Council had made the following appointments to the Board at its meeting on 14 July 2016:-

Councillors

Councillor Piara Clair Singh – Assistant City Mayor, Culture Leisure and Sport.

NHS Representatives

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

Healthwatch / Other Representatives

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Steve Robinson-Day, Collaboration Manager, Leicestershire Fire and Rescue Service

A representative of the city's sports community – to be appointed

A representative of the private sector/business/employers – to be appointed

In addition the Chair has also issued a standing invitation to the following to attend meetings as non-voting members of the Board.

Kaye Burnett, Chair, Better Care Together Programme
Toby Sanders, Senior Responsible Officer, Better Care Together Programme
Richard Henderson, Acting Chief Executive, East Midlands Ambulance Service NHS Trust
A representative of the Primary Care Sector – to be appointed.

The Local Policing Unit had also informed the Monitoring Officer that their representative on the Board is now Chief Superintendent Andy Lee, Head of Local Policing Directorate, following Chief Superintendent Sally Healy's retirement. Supt Kerry McLernon has also been nominated to attend the Board in Chief Superintendent Lee's absence.

The revised Terms of Reference for the Board reflecting these changes were received by the Board.

19. MINUTES OF THE PREVIOUS MEETING

AGREED:

That the Minutes of the previous Board meeting held on 6 June be confirmed as a correct record.

20. NHS ENGLAND'S PROPOSALS FOR CONGENITAL HEART DISEASE SERVICES AT UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

NHS England presented a report on their proposals for the future provision of congenital heart disease services with particular reference to University Hospitals of Leicester NHS Trust.

Will Huxter, Senior Responsible Officer for the Congenital Heart Disease (CHD) Implementation Programme and Regional Director of Specialised Commissioning (London), NHS England and Dr Geraldine Linehan, Regional Clinical Director, Midlands and East for Specialist Commissioning, NHS England, attended the meeting to present the report.

The Board also received a copy of the Deputy City Mayor's letter to the Secretary of State on 13 July 2016 requesting the decision to be reviewed and reversed. Copies of the decisions already taken by Leicester City Council and Leicestershire County Council on Children's Heart Surgery at Glenfield Hospital following NHS England's announcement had also been submitted for information.

The Chair welcomed the representatives of NHS England to the meeting, together with Mr E White CC, Chair of Leicestershire County Council's Health and Wellbeing Board and Councillor V Dempster, Chair of the Leicester City Council's Health and Wellbeing Scrutiny Commission.

The Chair invited members of the public to indicate if they would like to contribute to the discussion on this item and four members of the public asked to speak to the meeting.

Mr Huxter, NHS England, thanked the Chair for the opportunity to present the report and to set out the proposals for change and the basis upon which they had been made. He was also keen, as the Senior Responsible Officer for congenital heart disease work across the country; to listen to the Board's and the public's questions and concerns and have the opportunity to address them.

He also introduced Dr Linehan Clinical Director for specialist commissioning for the Midlands and East region. Dr Linehan stated that she was a GP by training, not a specialist in Congenital Heart Disease (CHD); but did have an overall remit for quality of services in the region.

In presenting the report, Mr Huxter stated he wished to set out the context of the proposals and their rationale and then outline the next steps in the debate and consideration of the proposals. During the presentation of the report he made the following comments:-

a) NHS England had not made any final decision yet on Glenfield or any other providers of CHD.

b) The proposals were based upon assessments of whether trusts currently met the standards or were likely to do so in the time frame set out in NHS England's standards.

c) NHS England were meeting University Hospitals of Leicester NHS Trust (UHL) on 16 September 2016 to discuss in detail their assessment and the trust's response.

d) There would be formal public consultation on the proposals later this year, and NHS England would want to come back to the area to talk to the Joint Health Overview Scrutiny Committee once the consultation was launched.

e) Much of the debate about CHD services was focused on the standards, their development and how they fitted in with the overall approach NHS

England were taking. After discussions with stakeholders over a wide range of areas, a new CHD review had been established in July 2013. The aims of the review were fundamental to what NHS England were trying to achieve and these were:-

- Secure the best outcomes for all patients. This was not just about the lowest rates of mortality but also about reduced disability and improved opportunity for survivors to lead better lives.
- Tackling variation. To ensure services across the country consistently meet national standards and were able to offer resilient care 24/7; so the care required was available at all times when needed day and night.
- Improve patient experience. To provide information to patients and families and consideration of access and support for families when they are away from home.

The standards can be found on the NHS England website at the following link:-

https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/

f) The standards were lengthy but they did demonstrate they were not just focused in the clinical aspects of care; but also about support and services for families. The standards were central to the review and described what constituted an excellent CHD service, and had been used to assess Leicester and other provider centres across the country.

g) The standards had been developed with the CHD service and experts in CHD, patients, professional bodies and charities. They had received strong consensus before going to public consultation. The standards were formally agreed by the NHS England Board in July 2015. There had been strong representations from patient groups supporting the standards but also supporting NHS England, as the commissioner of services, to ensure the standards were met.

There were three levels of service set out in the paper –

- Specialist Surgical Centres (Level 1)
- Specialist Cardiology Centres (Level 2) - which NHS England was proposing for Leicester in the future
- Local Cardiology Centres (Level 3)

h) NHS England considered two areas of the standards were particularly important determinants of service, quality and safety. These were:-

– Surgery All surgeons should be at least part of a team of 4 surgeons, with on call commitments no worse than 1 in 3 from April 2016. Each surgeon must undertake a minimum of 125 operations per year and, from April 2021, a minimum on call commitment of a 1 in 4 rota. This was to ensure that there were

surgeons with the right level of expertise and experience across a range of operations which CHD may require. Also making sure that the system had resilience to have staff to cover 24 hrs.

- Surgery from sites having service interdependencies. This was not a technical abstract issue, but was fundamental to having expertise available when patients were very unwell and all services were on the same site 24/7 to be at the bedside when required.

i) NHS England were convinced that the standards would make a real difference in ensuring that services were safe, of high quality and were available 24/7 by teams of professionals working closely together in an integrated way.

j) The numbers of operations were not just important for the surgeon but also for the wider clinical team, theatre nursing and other clinical staff, to provide much greater resilience and stability within providers to attract and retain surgical and other clinical staff.

k) The assessment process had taken some time. The assessment had been based upon on evidence submitted by UHL. NHS England considered that the UHL had not meet minimum 125 operations per surgeon and a total of 375 cases spread across 3 surgeons and did not meet the full range of other services required to be provided on the same site.

l) After considering the evidence from UHL and all other providers, NHS England were proposing to cease commissioning specialist services (surgery and interventional cardiology) from UHL but were looking to continue to provide level 2 specialist cardiology services in Leicester. It was stressed that there were no proposals to close Leicester as a provider of CHD services, apart from surgery and intervention cardiology. Patients would continue to access services locally in Leicester. NHS England wished all patients across the country to have access to excellent CHD services, and the proposal, if implemented, would transfer some patients currently receiving treatment from Leicester to Birmingham. There were already close links between the two centres and some complex cases were already referred to Birmingham. Most of the care patients received was not surgical and that non-surgical care would continue to be provided at Leicester. NHS England accepted that some patients would have to travel further for surgery and intervention cardiology but considered that people already chose to travel for excellent care; and the greater part of treatment provided for CHD was not emergency surgery but elective planned work.

m) During the pre-consultation engagement on the proposals, NHS England wanted to talk and listen to concerns and questions from Health and Wellbeing Boards and other stakeholders. NHS England would also be talking to UHL about the proposals and their implications for other

paediatric services within the trust if these proposals were taken forward.

n) Both ECMO, which is a large and important service within Leicester, and paediatric intensive care services (PICU) were being looked at as part of national reviews being carried out by NHS England to ensure that they took a joined up approach to specialised paediatric services.

o) The high level timetable was set out in the report; with a final decision after consultation being taken in spring 2017. It was emphasised that nothing would change overnight. NHS England would consult on the proposals and, if agreed, would implement them carefully in a measured way. The primary concern was for patients to have access to best possible services.

In summing up Mr Huxter reiterated that most CHD care would still be provided at Leicester; the proposals solely moved surgery and interventional cardiology to Birmingham and the greater part of CHD work was not emergency but elective surgery. NHS England believed passionately that implementing these standards would deliver better outcomes for children's and adult's CHD services. They were conscious that there had been a long period of uncertainty in CHD dating back to Bristol in 2001, but believed these proposals, if taken forward, would end that uncertainty and ensure there were resilient services available to Leicester, the East Midlands and the area beyond for the future.

The Chair invited, Mark Wightman, Director of Communications, University Hospital of Leicester NHS Trust (UHL) to respond to NHS England's report. Mr Wightman stated that:-

a) He was representing UHL Trust Board and the 300 staff working in the in East Midlands Congenital Heart Centre unit. He introduced two staff present in the public gallery to answer clinical questions if necessary. Dr Frances Bu'Lock – Consultant Paediatric Cardiologist and Elizabeth Aryeetey, Lead Nurse for the East Midlands Congenital Heart Centre

b) The East Midland Congenital Heart Centre at Glenfield had made excellent progress over recent years. It had expanded bed numbers and staff, improved outcomes, invested in staffing, created a new adolescent unit and briefed architects to create new single site children's hospital which would meet the NHS England's co-location standard. This had been done against a backdrop of uncertainty following the Secretary of State's statement on the flawed decision to stop surgery in Glenfield 4 years ago.

c) UHL disagreed that to cease commissioning children's heart surgery in the East Midlands was "in the best interest of patients with CHD and their families." UHL failed to see how leaving the East Midlands as the only region without a specialist centre was equitable.

d) UHL already provided one of the best performing surgical centres in

England. They were confident that when latest NICOR data was published in October, Glenfield's clinical outcomes for patients would be amongst the best in the country. Despite seeing more children than ever, there had been no deaths within 30 days of surgery for 15 months. The same day cancellation rates and un-planned re-operation rates within 30 days were significantly better than the national average. The patient and families satisfaction rates were currently 99%. This was supported by the CQC's initial feedback of their recent inspection in observing "the excellent clinical outcomes for children following cardiac surgery at Glenfield Hospital" UHL felt this should alert NHS England that to implement their decision would be a grave mistake.

e) UHL were on target to meet surgical numbers. They had carried out 280 surgical cases in 2014/15 and had increased this to 332 in 2015/16. They expected to meet 375 cases per year with 3 surgeons within the next 3 years. This had been achieved by 31% increase in beds, including the adolescent unit and a short stay bay after approx. £1 m investment

f) UHL felt that the standards they had been consulted upon changed after the clinical engagement exercise from a commitment to achieve 3 surgeons and 375 operations from the introduction of the standards in April 2016 to a retrospective 3 surgeons and 375 operations by APRIL 2016. NHS England had effectively shortened the timescale for delivery by 3 years and must have known that it would exclude Leicester and yet had still stated, in a report to the NHS England National Board, that a major reconfiguration of specialist services with the associated risk and upheaval could probably be avoided.

g) UHL quoted NHS England's own words that the magical 125 cases per surgeon was "arbitrary". The School for Health and Related Research in Sheffield, had stated that "whilst a relationship between volume and outcome exists this is unlikely to be a simple, independent and directly causal relationship, i.e that no cut-off relating to surgical volume and better outcomes was identified. There was never any indication of the number of minimum or maximum cases which should be done each year by an individual surgeon."

h) UHL considered that the NHS England were proposing to close a top quality service despite clinicians working in the service being confident to achieve the required number of procedures; and this was compounded by NHS England applying the standards retrospectively. The decision was also based upon an arbitrary number of cases for which the NHS England's own reviewer had said there was no scientific evidence. UHL therefore encouraged NHS England to look again at UHL's outcomes, zero mortality rates and actual results.

i) EMCHC (East Midland Congenital Heart Centre) supported 12 PICU (Peadiatric Intensive Care Unit Service) beds which would be lost if NHS England ceased to commission CHD surgery at Glenfield. Losing the

Glenfield PICU beds would also result in the viability of the Leicester Royal Infirmary PICU beds being compromised, as the paediatric intensivists worked across both units. These specialists were attracted to Leicester by the diverse caseload that working across the two sites offered and this would be lost if more than half the PICU beds disappeared at Glenfield. Glenfield provided 30 % of the PICU capacity across Birmingham, Leicester and Nottingham. The National PIC Directors meeting in July had unanimously expressed the view that the NHS England's proposals made proper evaluation and response impossible and presented a significant destabilising pressure on PIC services; which may be further destabilised through the PIC national review at a time when there was a national crisis in PICU capacity.

j) There would be a domino effect if Glenfield PICU capacity was lost and LRI's PICU capacity was compromised; as it would have a knock effect on other specialist paediatric services which required intensive care to function safely. This included children's general surgery, ear nose and throat surgery, metabolic surgery, fetal and respiratory medicine (children who received long term ventilated care) children's cancer and neonatal units. In addition, neighbouring hospitals supported by specialist teams in Leicester would not be able to look for support for their more complex patient care from their nearest specialist trust, UHL. This would affect Burton, Coventry, Kettering, Northampton and Peterborough hospitals. Therefore closing Glenfield CHD surgery would ultimately undermine other specialist services across the wider East Midlands.

k) The ECMO facility at Glenfield was the largest paediatric respiratory ECMO unit in the country and provided 50% of the national capacity. Leicester had pioneered ECMO and the unit was used in the swine flu pandemic in 2010. The Glenfield ECMO unit was the only service to provide a national transport service by stabilising patients before moving them to a specialist centre. The proposals to cease CHD surgery at Glenfield would also result in the loss of the ECMO unit as staff also worked in ECMO and the service would lose decades of staff experience, knowledge and innovation. The standards stressed the importance of numbers, and UHL questioned why this had not been applied to ECMO as well.

l) UHL felt that if NHS England wanted to support centres they should broker conversations that meant patients are treated in their nearest hospitals and not support the existing system where patients in Northampton are referred to Southampton for no real evident reason. If commissioning took place to the nearest centre, then Glenfield achieving 375-500 cases per year would be simple. Patient choice was not the reason for these apparent perverse patient flows. It was considered that any parent faced with dealing with a very sick child would send them to wherever their referring doctor suggested. They felt this was effectively a clinician choice and not patient choice that was being applied. If patient choice was important to NHS England, UHL questioned why they

were removing that choice from 300 patients a year that considered Leicester as their local centre.

m) Given all the above views, UHL had been incensed when NHS England had said they would work with Bristol and other centres to achieve the standards in full on the same day they indicated that UHL's CHD service would be closed. Bristol's Children's Heart Unit had triggered an investigation in 1990's when 35 children had died through poor clinical practice and more children suffered poorer outcomes than expected. A further review was carried out in 2014 related to concerns of mortality rates and the second review report for Bristol was published the same day as Glenfield were informed that their unit was identified for closure.

n) UHL failed to understand why NHS England was responding to a centre with quality concerns elsewhere when indicating to close a service with no concerns.

o) Many things had changed since the original review of the Bristol unit. There were now 5 fewer centres and mortality data for each centre was published annually, which was better than peer centres in other developed health economies. The mortality rates had halved in the last 10 years for this type of surgery.

p) UHL considered their position to be uncomfortable and unwelcomed. It seemed that NHS England were offering a new solution to old problem that no longer existed. UHL wanted to continue to do the best for their patients and families. UHL stressed that they were not being parochial in their views but they could not, in all consciousness, let a well performing service be destroyed.

Mr Ernie White CC – thanked the Chair for the invitation to take part in the Board's consideration of this issue. He stated that everyone was determined to fight UHL's case in partnership with the city council and other local stakeholders. He considered UHL's presentation completely demolished NHS England's position. The County Council's Health & Wellbeing Board had met in July which resulted in the County Council's Cabinet passing a strong and robust resolution in support of UHL. He felt it would be helpful if the joint health scrutiny committee could meet soon; as scrutiny had the power to refer decisions to the Secretary of State for Health. He considered that the position taken by NHS England was unconvincing and that they were offering an old solution to problem that had gone away. He felt they had got it wrong and hoped that, by a combined effort of everyone, a change of mind could be achieved.

Councillor Vi Dempster, Chair of the City Council's Health and Wellbeing Scrutiny Commission, supported Mr White's comments and felt that UHL's statement was a convincing demolition of the argument for ceasing to close the CDH unit at Glenfield. She indicated that she would have discussions with officers to see how members of the public could be best involved in the process of the joint scrutiny health committee.

Karen Chouhan, Chair of Leicester Healthwatch expressed the support of patient groups all over Leicester Leicestershire and Rutland for UHL and the CHD centre. The Leicester Mercury Patient's Panel and other patient groups would fight hard to support UHL and to reverse the decision. Healthwatch would like to see the decision reversed now. They also wished to make sure that the consultation proposed was framed in such a way that it empathised with the patient and not NHS England; as consultations had a habit of being framed in such a way to get the answers wanted by those issuing the consultation. They would like to know that there was independent expertise in framing the questions and patients were involved in that process. They would also like assurances that there would be independent scrutiny of that consultation and no decision would be taken without that. Full reasons of any decision taken in the future should also be made available.

The Chair commented that the Board had a role to understand and analyse the submission made to them. The Board needed to fully understand the 'magic' number of cases; particularly in relation to the validity that some people were placing upon it. This also included understanding the detail of why these were so important and what and where the evidence was to support this case.

In response to the Chair's question on how many current centres across the country met the current April 2016 standards at the moment; Mr Huxter confirmed that none of the centres had met the standards at the time of the assessment by NHS England.

The Chair commented that the basis of the proposals seemed to be a judgement about the trajectory of centres to meet those standards. It was important, therefore, that further clarity was required around the difference in amber/green and amber/red markers that had been used to make that judgement. He felt the clarity about the dividing lines and judgements made were critical in understanding the recommendations because UHL had indicated a strong, credible and ambitious vison for a single site children's hospital with all interdependencies NHS England had outlined and UHL's surgical numbers were on track. Given all the clinical and surgical inter-dependencies involved, he asked what analysis had been carried out or commissioned by NHS England of the implications for wider children's medical services if the proposals to cease commissioning in these centres were progressed. NHS England could not look at CHD surgery in isolation, and they needed to be mindful of whole breadth of children's medicine services in different parts of the country. The Board would require assurances from NHS England's analysis of how children's medicine services would look in Leicester, Leicestershire and Rutland and the wider East Midlands should the proposals be implemented.

In response to the Chair's comments, Mr Huxter and Dr Linehan stated that:-

a) Leicester's assessment had been included in the report. The centres in the amber/ green category all had plans to achieve the standards being delivered in this calendar year. This was different to those providers in

the amber/red category. Further details of these could be shared with Board.

b) The national review around PICU and ECMO services, in advance of going to public consultation, was to understand the potential impact of these proposals on other children's services and other broader services

c) The standards had taken two years to develop in consultation with large number of experts, patients, parents and different organisations and had been the subject of a huge amount of debate. There was a need to remember that CHD was pretty rare and within it there were rarer conditions which were managed within a centre. It was important, therefore, that the NHS had experts with the breadth of surgical experience to operate and look after those cases.

d) NHS England's efforts were designed to do the right thing for patients and the objective of the standards was to improve care and deliver excellent care; taking it to an extra level. In order to have a safe and sustainable service it was necessary for surgeons to undertake a good volume of operations.

e) It was acknowledged that the number of operations per year was arbitrary in the sense that they had been arrived at as a judgement after lengthy discussions. NHS England offered to provide the evidence in support of the standards; including the number of cases per surgeon and total caseload per centre.

The Chair sought an explanation in laymen's terms of how much better a surgeon was in undertaking 125 operations per year compared to one who did 120 operations.

In reply, Dr Linehan stated that specifically in relation to CHD being a rare condition, it was difficult to get enough cases of rare forms of CHD to provide data to prove the number operations that were needed before you had no problems; so there was an element of extrapolation involved. However, it was known in other areas, such as centralised stoke and vascular services, that better outcomes correlated to the number of interventions that were done in a centre. Whilst the number of operations to become expert was unknown, the concept of doing more operations to achieve more expertise was an established principle. The size of teams was also important in having sustainability and to have 'fresh' surgeons to undertake the operations.

Mr Huxter added that sustainability was not just about surgeons but the whole clinical team. Although the minimum standard was 125 operations per year, there were surgeons currently doing more than 200 operations per year. Whilst the 30 day mortality data shows no statistical difference between providers, NHS England believed surgical volumes to be a key assurer of quality and safety.

Councillor Osman felt it was unfortunate that NHS England had issued their

statement in July the day after the Brexit referendum. He reported on a recent meeting of East Midlands Councils which had overwhelmingly expressed support for retaining the services at Glenfield. He felt that having a helipad at Glenfield added to its ability to carry out the services. He also questioned whether the proposed changes to the service were about standards or financial savings.

Councillor Russell commented that if the clinical standards data showed no difference in mortality rates for different levels of operations, what data should the Board be looking at in its consideration of the issue?

The Chair then invited members of the public to address the Board meeting.

Eric Charlesworth, Leicester Mercury Patient's Panel stated that he had been involved with Bristol's inquiry, safe and sustainable, the IRP review and the process for the current standards. When the standards had been approved, there had been no mention of changing the rules afterwards. He also felt that some statements made by NHS England were causing damage in this, and other areas, as they implied that patients did not receive excellent service at the centres identified for closure. He urged NHS England to look again at the evidence and data provided by Glenfield and reconsider their proposals.

He also submitted the following question:-

"In line with Governments requirements for openness candour and patient involvement throughout all change processes and to ensure that you and we avoid the repeated serious flaws highlighted in the safe and sustainable review why have you not listen to what Lord Ribeiro said in his IRP when he made his recommendations which some of them you have not even bothered to take up it would appear. Would you please give the names of the patient and public involvement representatives; can you give me assurance that they have found out local data and have consulted with local people and, by local, I mean the east midlands, before they can contribute to whether the statement that you are making about the mindfulness to withdraw this commissioning has been made? And I would like to know why there has been no apparent recent involvement of PPI when all the previous agreements were that nothing would be done without it coming back for consultation before items were issued or alterations made?"

Heather Rawlings stated that family members had received CHD surgery in October and fully praised the CHD unit at Glenfield. She felt that she had heard an excellent case of why Glenfield should stay open and endorsed UHL's statement. She expressed reservations about the review and asked how much it would cost to close centres. She also felt that the implications for families had been underestimated. Many people were living in austerity, on '0' hour contracts or on benefits, and were facing financial difficulties every day. This impacted upon their ability to travel distances to receive treatment, look after other family children and to keep their employment. These factors also affected the health of individuals.

Ms Sally Ruane – Chair of Leicester Mercury Patient's Panel re-iterated that

NHS England had stated that the 125 figure for operations was not evidence based. She commented that standards were inputs which were designed to achieve the outputs desired for a service. Standards in themselves were not an end, but a means to an end; which were excellent outcomes. She stated that the meeting had heard that Glenfield patients get excellent care at the moment; so it appeared that NHS England wished to close an excellent service on the basis of a non-evidenced based standard. This raised the question of whether the standards were being set deliberately high that they were likely to result in closures somewhere across the country. She felt there was a danger that the public confidence in NHS England would be undermined by these judgements. It was of concern that an announcement had been made that was very destabilising of the service and would have huge knock on effects on other children's services in this area and affecting children across the region; and yet no impact assessment has been undertaken.

Elaine Murray Stated that a petition had already received 26,000 signatures. The Unit was not failing in any shape or form and ECMO, in particular, received world-wide acclaim. She questioned what would happen if Birmingham could not cope with referrals from the East Midlands. The service belonged in Leicester and the East Midlands and felt that the efforts of Keep the Beat and HeartLink and all other research money that had gone into the Unit belonged to Leicestershire and the Unit should stay operational.

In response Mr Huxter stated that:-

a) There was no requirement to achieve savings in the review and no savings would be achieved. The review was driven by standards.

b) The information requested by Mr Charlesworth could be provided.

c) All parties involved had a responsibility to demonstrate transparency and openness.

d) Details of the public consultation and the PPI involvement could be made available.

e) The review was not about cost or privatisation of the NHS and the impact on families travelling to obtain intervention surgery was noted.

f) The Standards had not been set too high for achieving excellent care.

g) The public announcement was not timed to coincide with the Brexit referendum.

h) The views expressed at the meeting had been heard and he wanted to listen and to have a debate in Leicester about the proposals. He felt that the meeting had been useful to hear these views and NHS England genuinely believed that the proposals would improve services.

The Chair thanked everyone for their contributions and attendance at the

meeting and for NHS England setting out their proposals and for listening to the views expressed in the meeting.

AGREED:-

1) That the given the comments and statements made at the meeting, the Board supports UHL in its challenge to NHS England's proposal to cease commissioning Level 1 CHD services from UHL and that all partners and stakeholders be strongly encouraged to do so as well.

2) That NHS England's offer to provide details of the full assessment of all the other centres be accepted to allow the Board to understand the precise methodology used to assess those centres; including the categorisation within the NHS England's traffic light indicators.

3) That NHS England provide the Board with an analysis/impact assessment of how children's medicine services would look in Leicester, Leicestershire and Rutland and the wider East Midlands should the proposals be implemented; particularly in relation to ECMO, PICU and the other children's services mentioned in UHL's statement to the Board.

4) That NHS England provide further evidence, and details of the analysis and research, around the 125 cases per year for surgeons and that scrutiny be recommended to consider in detail this particular aspect of the review.

5) That the joint health scrutiny committee be encourage to meet as soon as possible, in order to exercise its powers in relation to health scrutiny and to provide a further arena for public discussion and accountability.

The Chair adjourned the meeting for 5 minutes at 5.12 pm to allow members of the public and others to leave the meeting if they wished to do so.

The meeting recommenced at 5.17pm.

21. PRIMARY CARE STRATEGY

Professor Farooqi, Co-Chair Leicester City Clinical Commissioning Group (CCG) and Sarah Prema, Director, Strategy and Implementation, (CCG) gave a presentation on the challenges faced by primary care in the city and the plans being developed for a Primary Care Strategy to address these. The strategy would be finalised once the local Sustainability and Transformation Plan was completed in September 2016; which included work around general practice. In addition, it would be informed by the Primary Care Summit that had been organised for 9 September 2016.

During the presentation it was noted that:-

a) The number of single handed practices in the City had decreased from 26 to 6 in recent years as a result of some GPs retiring and others

merging with other practices.

b) There were 59 practices in city of which 14 were training practices. The average list size of a practice was 6,531. This was slightly lower than the national average of 7,225.

c) There were a large number of Alternative Provider Medical Services (APMS) contracts; 13 practices out of the total number of 59 practices in the City. This was in contrast to the county area where there were no APMS contracts. This was an indicator of the difficulty in ensuring services in the City.

d) More practices in Leicester were rated as good by the CQC compared to the England and Midlands and East averages.

e) The number of primary sector consultations had increased continually over the last 13 years. Applicants to GP training had dropped by 15% and in 2014 one in ten slots for new GP trainees remained vacant. The number of unfilled GP posts nationally had quadrupled in the last 3 years.

f) The average funding for a GP in the city was approximately 10% below the national average.

g) The city had been divided into 4 Health Need Neighbourhoods to enable a locality delivery of primary and community care. These would include extended hours provision, urgent care services (including diagnostics), community nursing and therapy services, social services, voluntary service, self-care and patient education. The focus of the Health Need Neighbourhoods would be on prevention and mobilising community "assets" as well as the development of integrated teams to support patients with the most complex needs.

h) The CCG were also developing a HUB within 2 Health Need Neighbourhoods to provide patients with access to wider services. The strategy also included a number of initiatives (outlined in the presentation) to improve access to the services.

i) There was raft of initiatives to improve the recruitment and retention of staff in primary care. These were listed in full in the presentation.

j) The 59 GP practices were delivered from 60 main premises and 12 branch sites. There were a number of practices operating from converted houses and the CCG supported practices to apply to the NHS England Estates and Technology Fund and 5 developments to the fund were made in 2016.

k) The CCG supported the development of Federations which supported practices to become more sustainable, combine back office functions, provide uniform delivery of services, share staff across practices and

provide the potential to deliver a wider range of services.

l) There was a need for some changes in patient expectations as not all services in the future may be provided by one practice and patients may be 'referred' to a HUB for specialist services such as diabetes etc. Also patients needed to understand that minor ailments such as sore throats, colds and flu and sprained ankles etc did not require appointments with GPs; as treatment could be safely provided by other qualified health professionals. This would reduce the burden on GPs time to concentrate on patients with more serious illnesses.

The strategy would continue to evolve and comments were welcomed.

The Chair commented that it would be helpful to have milestones for the initiatives. It was recognised that some solutions were easier than others to implement and some would be more popular than others. It was, therefore essential to develop these through engagement and discussion and the forthcoming Primary Care Summit would provide a good opportunity to begin this process. He also asked what the impact of having 1 federation and Health Needs Neighbourhoods would have on the financial viability of GP practices.

Members of the Board commented that:-

a) Primary care was critical to the success and sustainability of health services and there was a real challenge in the city to achieve this. A more ambitious strategy to achieve national averages of performance in the primary care services would be welcomed. Given the intention to transfer significant activity from UHL and LPT in the future to the primary care sector through BCT and STP, it would be essential to have a robust primary care sector in place to achieve this.

b) Integrated teams already made differences to the ways in which patients were presenting to the acute sectors and were transforming services for better patient experiences.

c) Continuity of care was the prime consideration of patients and this should be linked to BCT and STP

At 5.57pm the Chair was called away from the meeting on other Council business and Assistant City Mayor Piara Singh Clair took the Chair.

In response to the Chair's and Board Members' comments, Professor Farooqi stated that:-

a) The CCG recognised that the strategy needed to be ambitious and link in with the government's initiative to recruit an additional 5,000 GPs.

b) Retention of GPs was still challenging. A number GPs recruited from aboard eventually move to Canada, Australia and America after a period of training in the UK.

c) Providing a portfolio of experiences for GPs would lead to making careers more attractive.

d) There was a challenge in breaking the circle of heavier workloads for GPs which were exacerbated in some practices by a GP leaving and the practice being unable to recruit a replacement.

e) There was scope within the integrated teams for UHL and LPT staff to work part time in the community.

f) Continuity of care was fully recognised and the planning of long term or complex conditions would require stable teams to be in place.

g) There would be consultation with the public as it was essential for them to be involved in designing the services for the future.

h) Currently 30% of GPs were aged over 50 years old which could lead to 50 GPs being recruited in the next 5 year to maintain the status quo of current number of GPs.

AGREED:

That Professor Farooqi and Sara Prema be thanked for their presentation and the Boards comments be taken into account in developing the Primary Care Strategy.

22. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public present at the meeting.

23. DATES OF FUTURE MEETINGS

It was noted that future meetings of the Board would be held on the following dates:-

Monday 10th October 2016 – 3.00pm

Thursday 15th December 2016 – 5.00pm

Monday 6th February 2017 – 3.00pm

Monday 3rd April 2017 – 2.00pm

Meetings of the Board were scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

24. ANY OTHER URGENT BUSINESS

There were no items to be considered.

25. CLOSE OF MEETING

The Chair declared the meeting closed at 6.05pm

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Appendix B

LEICESTER CITY HEALTH AND WELLBEING BOARD
10 October 2016

Subject:	Regional strategy to reduce infant mortality
Presented to the Health and Wellbeing Board by:	Clare Mills, Lead Commissioner (Healthy Child Programme), Public Health Nicola Bassindale, Service Manager (Strategy, Quality & Performance), Education & Children's Services
Author:	Nicola Bassindale

EXECUTIVE SUMMARY:

This report presents the new strategy to reduce infant mortality in Leicester, Leicestershire and Rutland (LLR).

The strategy runs from 2016 to 2019 and has an associated action log that records current and planned actions across a range of risk factor areas. Progress against this log will be monitored by the LLR Infant Mortality Strategy Group (IMSG), with scrutiny and oversight provided by the Maternity Services Liaison Committee (MSLC).

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- support UHL's application to achieve UNICEF Baby Friendly level 3 accreditation
- support staff within the H&WB member organisations to engage with the Health Needs Assessment initiated by Leicestershire County Council to investigate needs across LLR regarding the maternal obesity priority
- support the frontline practitioners in their organisations responsible for designing and delivering interventions to reduce maternal obesity
- cascade information regarding this work to their staff reminding them that reducing infant mortality is 'everybody's business' and that their role is important in identifying risk
- support their staff to develop joint working opportunities that enhance outcomes for families

MAIN REPORT:

Background and Development Process

1. The development of this strategy started in Public Health and was led by a former consultant Bayad Abdalrahman, in conjunction with the IMSG. This initial work was to address infant mortality only, and covered Leicester city only.

2. From November 2015 the lead for this work in Public Health was handed to Clare Mills and a decision was made for Nicola Bassindale from Education & Children's Services to jointly work on the strategy and take on the role of Deputy Chair for the IMSG.

3. The work undertaken to write a strategy was reviewed by the IMSG and. after much discussion, a decision was made to include the issue of stillbirth within the strategy, principally because many of the risk factors for infant mortality are common to those for stillbirth.

4. Extensive consultation, including a multi-agency workshop held during Safer Sleep week in March 2016, developed and refined the strategy and action log. Conversations during this period led to the decision to integrate the work with Leicestershire colleagues, whose Public Health function includes Rutland.

5. Leicester City Council's Public Health and Education & Children's Services' Departmental Management Teams have each signed off the strategy. Leicestershire County Council's Public Health team (covering Rutland) is also taking the strategy through its parallel scrutiny route. The MSLC reviewed and signed off the strategy on 8 August 2016.

Next Steps

6. The IMSG has identified a number of priorities for the coming months. The group meets quarterly and will focus on a key issue at each meeting, as well as receive reports on the progress of actions recorded in the action log.

7. H&WB members are asked to support the principles of this strategy and enable this support to be cascaded throughout their organisations, ensuring staff are aware of the issues, risks and evidence-based interventions proven to reduce the incidence of infant mortality and stillbirth.

8. H&WB members are also asked specifically to:
    - support UHL's application to achieve UNICEF Baby Friendly level 3 accreditation
    - support their staff to engage with the Health Needs Assessment initiated by Leicestershire County Council to investigate needs across LLR regarding the maternal obesity priority
    - support the frontline practitioners responsible for designing and delivering interventions to reduce maternal obesity

- cascade information regarding this work to their staff reminding them that reducing infant mortality is ‘everybody’s business’ and that their role is important in identifying risk
- support their staff to develop joint working opportunities that enhances outcomes for families

no.	Issue	Detail /Rationale	Action: What are we going to do about this?	Outcome: What change do we want to see?	Accountability: Who is responsible?	How are they reporting back?	Date for "deep dive"	Date to be completed
	1. Miscellaneous Actions							
1.1	Local data and knowledge	Ascertain the main causes of infant death in LLR	Gather information via: • CDOP Annual Report • CDOP cumulative report 2009-14 • MBRRACE-UK data & report (due May 2016) • UHL/NHS Perinatal Mortality Review report (due May 2016) • Data can be cross-referenced with the results of the Health & Wellbeing Survey and data from ASH • Use data on ethnicity collected by the Perinatal Mortality Review Group (stillbirths) to identify themes • Use information recorded by CDOP low birth weight and infant deaths to identify key groups • CDOP record smoking in pregnancy as part of the review and this information could be audited • CDOP record known domestic violence, and this could be crossed referenced with other factors they collect (such as birth weight) to create a local picture	A better evidenced-based understanding of local causes of infant deaths	Lisa Hydes, Julia Austin, Rob Howard and Lucy Smith	Cross-reference data and report back in Nov 16	Nov-16	Review regularly
1.2	Learning from others	Research actions taken in areas that have reduced infant mortality	Gain insight from peer comparator areas that have significantly reduced infant mortality rates (e.g. Barking and Dagenham)	A better evidenced-based understanding of actions that will reduce infant mortality and stillbirth	Infant Mortality Steering Group (IMSG) –	each member to share information at IMSG meetings		Ongoing
1.3	Review of previously identified actions	Review National Strategy Team recommendations (2010)	Undertake a full audit against all the NST recommendations	Report back to Infant Mortality Strategy Group	Clare Mills, Public Health		Nov-16	Nov-16
	2. Maternal characteristics & risk factors							
2.1	All risk factors	See below	Create a calendar of events to highlight key issues	Raising awareness of what parents can to reduce the risk of infant mortality and stillbirth	Infant Mortality Steering Group	update/planning at each IMSG meeting		Review Quarterly
2.2	Maternal age	Mothers under 20 are 1.4 times more likely and mothers over 40 are 1.7 times more likely to have a stillbirth. Mums under 20 are 4 times more likely to have a SIDS compared to the over 20's The teenage conception rate in Leicester has significantly reduced from a baseline in 1998 of 64.6 per 1,000 to in 29.7 in 2013. Reducing under-18 conceptions would decrease the infant mortality gap by 1%	Work with and commission partners and schools to create tailored Relationships & Sex Education (RSE) packages that meet the needs of individual schools and children across LLR	Young people making positive health choices about their own sexual health and relationships	Liz Rodrigo, Clare Mills, Public Health and partners		Feb-17	Feb-17

no.	Issue	Detail /Rationale	Action: What are we going to do about this?	Outcome: What change do we want to see?	Accountability: Who is responsible?	How are they reporting back?	Date for "deep dive"	Date to be completed
		Looked-after teenage girls are 2.5 times more likely to become pregnant than other teenagers	Have a particular focus on meeting the needs of LAC children	As above	TBC		Feb-17	Feb-17
2.3	Maternal ethnicity	Mothers of Black ethnic origin are more than twice as likely and mothers of Asian ethnic origin are 1.5 times more likely to have a Stillbirth	Raise staff awareness across partner organisations and flag as a potential vulnerability. Staff to be made particularly aware of accumulating risk factors	Parents receiving required support to have a healthy pregnancy and birth, and positive experience of child's early life	All partners	by exception	accumulating risk factors 01/02/2018	on going
		Mothers from the Asian or Asian British ethnic groups are reported to have	Target support and services appropriately (Staff to be made aware of accumulating risk factors)		All Partners	by exception	accumulating risk factors 01/02/2018	on going
			Introduction of GROW protocol at UHL to identify small babies by personalised growth charts		UHL; training and roll-out	update Nov 16, and then by exception		Training to begin Sep 2016
2.4	Maternal smoking	Smoking in pregnancy doubles the risk of stillbirth and is a significant risk factor for SIDS	Contract mandatory delivery of brief intervention training and referral of smokers into NHS Stop Smoking Services for new HCP	More babies born to non-smoking mothers	Public Health	by exception	May-17	on going
		NICE recommends that prospective parents are advised prior to pregnancy and that smokers are identified as early as possible by midwives and referred to specialist stop smoking services.	Record the smoking status of each pregnant woman	Increase in the number of women with Smoking status recorded CO reading being taken	Health Visitors and Midwives.	by exception	May-17	Ongoing
		'Saving Babies' Lives' care bundle identifies that reducing smoking in pregnancy would reduce the incidence of stillbirth and early neonatal death.	Continue to record the Carbon Monoxide (CO) reading for pregnant woman who smoke – with a view to a gold standard of recording readings for <u>all</u> pregnant women		UHL.	by exception	May-17	Ongoing
		The smoking in pregnancy rate is similar to both the national rate and our peer comparator local authorities. However, large variations exist across LLR.	Ensure new mums know about and have the opportunity to be referred to STOP Smoking Service (opt out) at 28-36 week HV visit	Referrals being made to STOP at 28 weeks.	Clare Mills, HCP provider, STOP	by exception	May-17	Ongoing
			Create a robust referral system from the point of discharge		STOP, Midwifery	by exception	May-17	Ongoing
2.5	Second-hand smoke (passive smoking)	'Passive Smoking and Children' report concluded that; maternal smoking after birth was associated with a three-fold increased risk of sudden unexpected death in infancy and that having one or more smokers living in the household more than doubled the risk of sudden unexpected death in infancy.	Increase the number of parents being given advice on protecting their baby from second-hand smoke (SHS)	More babies born and living in smoke free homes	a)Maternity Care Assistants and Maternity Support Workers at health visit	by exception	May-17	Ongoing

no.	Issue	Detail /Rationale	Action: What are we going to do about this?	Outcome: What change do we want to see?	Accountability: Who is responsible?	How are they reporting back?	Date for "deep dive"	Date to be completed
			Provide training/guidance to all appropriate staff in partner organisations to enable them to advise prospective parents and parents on the risks of SHS to their baby or unborn child. Link to NICE guidance 48.	Training sessions delivered to all relevant staff. Staff feeling confident and competent at discussing second-hand smoke with parents	b) STOP (Karen House and Louise Ross) & Rod Moore UHL	by exception	May-17	Dec-16
			Ensure that all parents are given advice on protecting their baby or unborn child from SHS at each maternity visit, post-natally (in line with requirements of HCP spec) and during episodes of treatment at UHL Children's Hospital (in line with PH48 Recommendation 5)	Second-hand smoke advice given and recorded on paperwork. returns of Step Right Out sign ups (as appropriate)	c)Midwives (and MCAs/MSWs) STOP	by exception	May-17	Ongoing
2.6	Maternal obesity	Women with a pregnancy BMI >35 increase the risk of stillbirth	Provide information and advice about healthy eating in "Bumps to Babies"	Women receive advice on health eating in pregnancy as per PH guidance	a)HCP Provider, LCC staff	by exception via Assurance and Development Group		Ongoing
		Reducing the prevalence of obesity would decrease the infant mortality gap by 2.8%	Look at data and costings to continue and possibly expand Maternal Obesity clinics for women (currently women with 40+BMI are seen at UHL)	Women are supported to have a healthy pregnancy	Undertake a health needs Assessment (Ben Rush, LeicestershireCC)	Update at each meeting	May-17	May-17
		In 2010/11, 25% of pregnant women in Leicester were recorded as overweight and 19% as obese (higher than the national rate of 15.6%)	Map what is currently happening via PH funding (and audit against NICE Guidance PH27)	Identification of gaps and planning for future services	Undertake a health needs Assessment (Ben Rush, LeicestershireCC)	Update at each meeting	May-17	May-17
2.7	Maternal immunisation, such as MMR, whooping cough and flu vaccination	NICE recommends that prospective parents are advised prior to pregnancy that influenza in pregnancy is a risk factor for stillbirth	All Health Visitors and Midwives to check immunisations and refer to GP as required	All mothers fully vaccinated as appropriate	GPs Midwifery HCP Provider	by exception		Embedded and Ongoing
			Increase uptake of flu vaccination by frontline staff		Dave Giffard to investigate CQUINS			
2.8	Nutritional status, such as folic acid supplements	Folic acid intake can increase the chances of having a healthy baby. NICE recommends that prospective parents are advised prior to pregnancy and provide guidance for vitamin D and folic acid supplements	All Health Visitors, Midwives and Children Young People and Families (CYPF) Centre staff to promote use of appropriate nutrition, supplements and healthy diet throughout pregnancy at all contacts	All mothers eating well and taking the right supplements during pregnancy	HCP Provider Midwifery	by exception		Ongoing
			Revisit Vitamin D and Healthy Start Vitamins		Clare Mills and Jane Roberts	report at each meeting		Aug-17
2.9	Domestic violence	Domestic violence is associated with increases in rates of miscarriage, low birth weight, premature birth, foetal injury and foetal death	All relevant professionals to be confident to have discussions about domestic abuse and protecting children. [Achieved by core mandatory training and HV care plans]	More mothers and babies living free from domestic abuse	CYPF Centre staff, Midwifery and Health Visiting	by exception	Aug-17	Ongoing

no.	Issue	Detail /Rationale	Action: What are we going to do about this?	Outcome: What change do we want to see?	Accountability: Who is responsible?	How are they reporting back?	Date for "deep dive"	Date to be completed
		NICE recommends social care support – to identify and support women with complex social factors, including vulnerable parents, children in need and those at heightened risk of domestic violence	b)All professionals able to give relevant advice and to identify accumulating risk factors			by exception	Aug-17	Ongoing
2.10	Poor mental health	Poor mental health of either, or both parents has been found to be a compounding characteristic in cases of sudden unexplained infant deaths	All relevant professionals to be confident to have discussions about mental health and emotional wellbeing	More parents of babies managing their mental health well	Health Visiting and Midwifery	by exception	Aug-17	Ongoing
			All professionals able to give relevant advice and to identify accumulating risk factors			by exception	Aug-17	Ongoing
2.11	Substance misuse	NICE recommends that prospective parents are advised prior to pregnancy of the risk of substance misuse	All relevant professionals to be confident to have discussions about substance misuse and protecting children	More parents of babies living free from substance misuse	Health Visiting and Midwifery	by exception	Aug-17	Embedded and Ongoing
			All professionals able to give relevant advice and to identify accumulating risk factors and act as appropriate Specialist Midwife in post			by exception	Aug-17	Embedded and Ongoing
2.12	Parents who have difficulty reading or speaking english	NICE Guidance (2010) highlights complex social factors that may adversely impact on pregnancy outcomes and increase the risk of infant/maternal death	Identify accumulating risk factors and put support in place to help parents		All partners	by exception	accumulating risk factors 01/02/2018	Ongoing
			b)CDOP to work with Local Safeguarding Children's Board on access to emergency services		Lisa Hydes	by exception	accumulating risk factors 01/02/2018	Complete by June 2017
			Promote use of Lullaby Trust downloadable material in 20 languages		All partners	by exception	accumulating risk factors 01/02/2018	Ongoing
2.13	Preparation for parenthood	NICE Guidance currently highlights the need for antenatal education classes to improve: • Breastfeeding rate • Healthy behaviours • Contact with services • Support for anxiety and depression • Satisfaction with birth This should be provided in the community, as close as possible to the family home. Pregnant women with health, emotional or social needs should be referred to specialist care.	Evaluate the current local offer "Bumps to Babies" programme and implement recommendations to the programme.	Increased parenting confidence and capacity	Children, Young People & Family Centres HCP provider			Ongoing
			Follow-up people who have used Bumps to Babies (journey mapping)		Liz Mair			Jun-18
			Increased number of parents attending "Bumps to Babies", and identify vulnerable mothers who don't attend, and target them. Working Group to be reconvened; link to Early Help.		Julia Pilsbury/Clare Mills Update November 16		Feb-17	on going
	3. Factors related to the infant							

no.	Issue	Detail /Rationale	Action: What are we going to do about this?	Outcome: What change do we want to see?	Accountability: Who is responsible?	How are they reporting back?	Date for "deep dive"	Date to be completed
3.1	Breastfeeding	Increasing the rate of breastfeeding initiation and prevalence in the Routine and Manual group would reduce the infant mortality gap by 4%	Please see Infant Feeding Strategy for actions	Increased number of mothers initiating breastfeeding, and more mothers breastfeeding for longer	Clare Mills on behalf of Infant Feeding Strategy Group and Infant Feeding Network	by exception		Infant Feeding Strategy consultation to be launched by July 2016
		Breastfeeding rates in Leicester are significantly higher with levels consistently above national averages, particularly at 6-8 weeks, although there are areas that are lower than the average – particularly in deprived areas	Health Visitors ensure mothers are fully supported to breastfeed for as long as they chose, and that information about support is made available to mothers.		HCP provider	by exception		Ongoing
			Bumps to Babies, session 3, covers infant feeding and the value of breastfeeding		HCP provider	by exception		Ongoing
			NCT's Breastfeeding Peer Support service is able to provide volunteers on UHL wards		NCT, midwifery			Ongoing
3.2	Safer sleep	Targeted interventions to prevent Sudden Infant Death Syndrome (SIDS) would decrease the gap by 1.4%	Raise awareness of safer sleep messages and families/babies vulnerable to SIDS and consider how a range of non-NHS colleagues (voluntary sector, CYPF Centre staff and GPs) can help spread the message about the risks of bed sharing and consider developing a concerted campaign around preventing SIDS (National Support Team 2010)	More babies sleeping safely because key Public Health messages are delivered, encouraging early access to provision of formal services and promoting attachment and emotional wellbeing	CONI leads	by exception		Ongoing
			b)Support development of LLR wide Baby Box project, that includes Lullaby Trust safer sleep and Little Lullaby leaflets to ensure safer sleep messages are delivered to younger parents		b)Voluntary Action Leicestershire Public Health	update from VAL/Untapped me as required		
			Health Visitors to support breastfeeding at night, including an open discussion around safer sleeping practices		HCP Provider	by exception		Ongoing
			UHL including safer sleep in the mandatory training for all midwives		UHL	by exception		Ongoing
3.3	"Vulnerable Families" – Identified as having multiple characteristics that might increase risk of stillbirth or infant mortality	(Evidence provided under each characteristic or risk factor heading)	Look at adapt Rotherham card "Child at risk of SIDS" for use by professionals	Professionals being aware, identifying and guarding against the accumulation of risk factors		by exception	accumulating risk factors 01/02/2018	
			Provide training to Paediatric Liaison Staff to raise awareness of characteristics and risk factors		UHL CONI coordinator	by excpetion	accumulating risk factors 01/02/2018	Ongoing
			Adapt current Paediatric Liaison referral form adding a box entitled "vulnerable families"		UHL CONI coordinator	by exception	accumulating risk factors 01/02/2018	Ongoing
			Identifying and guarding against accumulation of risk factors			by exception	accumulating risk factors 01/02/2018	

no.	Issue	Detail /Rationale	Action: What are we going to do about this?	Outcome: What change do we want to see?	Accountability: Who is responsible?	How are they reporting back?	Date for "deep dive"	Date to be completed
3.4	Poverty and deprivation	Low socioeconomic status of mother is a risk factor for still birth Improving maternal educational attainment reduces the risk of infant mortality Reducing child poverty would reduce the infant mortality gap by 3%	Create more targeted and tailor interventions	More parents supported to reduce the risk of SIDS in their family environment	Infant Mortality Strategy Group		accumulating risk factors 01/02/2018	Ongoing
3.5	Housing and overcrowding	Improving housing conditions and reducing overcrowding would reduce the infant mortality gap by 1.4%	No action identified at this date	n/a	n/a		Nov-17	n/a
	4. Other factors relating to preconception care, pregnancy and delivery							
4.1	Early booking for antenatal care	In Leicester, the proportion of women booking before 12 weeks is significantly lower than the national average (Quarter2, 2014/15)	No action identified at this date	n/a	n/a			n/a
4.2	Screening for infections and congenital anomalies	NICE Pre-existing familial conditions - genetic counselling, screening and support if needed	Develop a strategic delivery model for screening that ensures services are commissioned, contracted, performance managed and governed for health outcomes. Ensure that sonographers are recruited, trained and supported to implement the first trimester combined screening for Down's screening (National Support Team 2010)					
	5. Important issues which are relevant to the IM Strategy, and are discussed at IMSG, but are core business for partners and reported to other forums (e.g. CCG or CQC)							
5.1	Foetal growth restriction	'Saving Babies' Lives' care bundle identifies that improved death	Identify the local approach to antenatal detection of foetal growth restriction	Reduced number of stillbirth and neonatal deaths of SGA babies	Midwifery	update Feb 27		
		risk assessment and surveillance for foetal growth restriction would reduce the incidence of stillbirth and early neonatal	Identify whether UHL calculates and publishes their antenatal detection of Small for Gestational Age (SGA) babies rates		Midwifery	update feb 17		
			Identify whether UHL audits SGA cases that are not detected antenatal in order to identify the reasons why, learn from them and improve future detection		Midwifery	update feb 17		
5.2	Reduced foetal movement	'Saving Babies' Lives' care bundle identifies that raising awareness of reduced foetal movement would reduce the incidence of stillbirth and early neonatal death	Provide information and advice to pregnant women on reduced foetal movement (RFM) and how they should respond by 24th week of pregnancy, and discussed at every subsequent contact	Reduced number of stillbirths following awareness raising regarding RFM	Midwifery and Health visiting	by exception	accumulating risk factors 01/02/2018	Ongoing
			Use the provided checklist to manage the care of pregnant women who report RFM		Midwifery	by exception	accumulating risk factors 01/02/2018	Ongoing
5.3	Issues during labour	'Saving Babies' Lives' care bundle identifies that effective foetal monitoring during labour would reduce the incidence of stillbirth and early neonatal death	Identify whether UHL provide annual training and competency assessment for all staff who care for women in labour in cardiotocograph (CTG) interpretation and use of auscultation	Reduced number of stillbirth and neonatal deaths	Midwifery	by exception		Ongoing

no.	Issue	Detail /Rationale	Action: What are we going to do about this?	Outcome: What change do we want to see?	Accountability: Who is responsible?	How are they reporting back?	Date for "deep dive"	Date to be completed
5.4	Medical conditions during pregnancy, such as diabetes and hypertension	NICE recommends that prospective parents are advised prior to pregnancy and that pregnant women with specific medical conditions such as diabetes, hypertension, epilepsy, renal/cardiac and mental health needs to be identified and offered specific support tailored to their needs	Ensure services screen all pregnant women and offer appropriate support to manage these conditions	More mothers experiencing these conditions during pregnancy managing them well	GPs and Midwifery; report to CCG	by exception		Ongoing
			Specialist midwives in post for diabetes and hypertension		GPs and Midwifery; report to CCG			Ongoing
5.5	Low birth weight	The main risk factors associated with low birth weight include: maternal age, multiple birth, smoking (including passive) in pregnancy, language barriers and delay in accessing the antenatal care pathway, maternal infection, and poor maternal nutrition.	GROW programme to be implemented to support early IDE notification and identification of growth retarded babies		Midwifery	by exception	accumulating risk factors 01/02/2018	Ongoing
5.6	Infections	Childhood immunisations reduce the risk of infections in infancy. Leicester has a good uptake of childhood immunisation of more than the recommended 95% coverage.	HVs to promote vaccinations	Increased take up of childhood immunisations	HCP provider	by exception		Ongoing

Appendix C

LEICESTER CITY HEALTH AND WELLBEING BOARD

10 October 2016

Subject:	**Final Report on Delivery of the Joint Health and Wellbeing Strategy (2013/16)**
Presented to the Health and Wellbeing Board by:	**Sue Lock**
Author:	**Adam Archer**

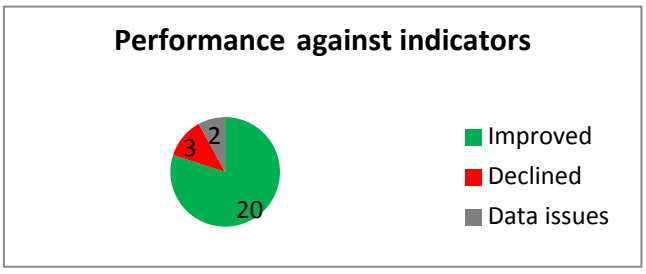
EXECUTIVE SUMMARY:

This report presents final information on progress in delivering the Joint Health and Wellbeing Strategy: 'Closing the Gap'. Responsibility for ensuring effective delivery of this strategy has been devolved to the Leicester City Joint Integrated Commissioning Board (JICB).

This is the seventh and final progress report to the Health and Wellbeing Board. It serves two related purposes: providing assurance that actions identified in the strategy have been delivered; and, reporting on the final position for the performance indicators set out in Annex 2 of the strategy.

This is a high level monitoring report; it acknowledges that both the actions and performance indicators in the strategy are subject to separate monitoring and reporting through the governance arrangements of those partner organisations coming together through the Health and Wellbeing Board.

While improvements could be seen against specific measures throughout the life of the strategy, the evidence available to us at the close of the strategy suggests that the desired impact on the health and wellbeing of the city's residents has largely been achieved.



RECOMMENDATIONS:
The Health and Wellbeing Board is requested to:

(i) Note the largely very positive outcome of the delivery of the Joint Health and Wellbeing Strategy;
(ii) Note the residual areas of concern highlighted in the report.

Final Report on Delivery of the Joint Health and Wellbeing Strategy 2013-16

Report on behalf of the Leicester City Joint Integrated Commissioning Board

1. Introduction

This report presents final information on the delivery of the Joint Health and Wellbeing Strategy: 'Closing the Gap'.

The strategy aimed to reduce health inequalities, delivering against the five strategic priorities:

- Improving outcomes for children and young people
- Reducing premature mortality
- Supporting independence for older people, people with dementia, long term conditions and carers
- Improving mental health and emotional resilience
- Addressing the wider determinants of health through effective use of resources, partnership and community working

For each priority a number of focus areas are identified, and the strategy included key performance indicators to measure progress. Data is available to show progress, with direction of travel indications for 23 of the 25 measures.

2. Monitoring the key performance indicators in the Health and Wellbeing Strategy

The majority of performance indicators in the strategy are outcome measures. They were designed to provide evidence that the actions identified in the strategy (and indeed the wider efforts of partners under the Board's "call to action") have the desired impact.

The indicators do not have specific targets, but rather reflect the ambition of the strategy to improve on the baseline positions for all our priorities.

The baseline position for each indicator is given at Appendix 1a, alongside an indication of the direction of travel of performance relative to this.

Many of these are outcome measures and will show improvement only after the successful completion of actions being delivered through the strategy. While improvements could be seen against specific measures throughout the life of the strategy, the evidence available to us at the close of the strategy suggests that the desired impact on the health and wellbeing of the city's residents has largely been achieved.

Measures showing particular improvement relative to the baseline in the strategy include:

Breast feeding at 6-8 weeks: Performance against this measure has shown further improvement, with the latest data showing a rate of 62.1% compared to the baseline of 54.9%.

Smoking in pregnancy: The latest data shows that the decline in performance experienced in 2013/14 has been addressed, with a rate of 11.8% in 2014/15 and the early part of 2015/16. This now shows an improvement from the baseline figure.

Teenage conception rates: The latest data shows that the decline in performance experienced in 2012 (increase from 30.0 to 32.9) has been reversed, with rates of 29.7 in 2013 and 25.3 in 2014. Position now significantly improved from the baseline.

Diabetes: Management of blood sugar levels has improved from 62% to 69.7%.

Carers' receiving needs assessments …: 2015/16 data (45.4%) shows an improvement of over 140% from the baseline (18.8%).

Older people who are still at home 91 days after discharge from hospital into reablement: Performance improved from 77.2% at baseline to 91.5% in 2015/6.

Older people admitted on a permanent basis to residential or nursing care: The rate of admissions has fallen from 763 per 100,000 to 653 per 100,000 sine the baseline was established.

Dementia diagnosis rates: The percentage of patients diagnosed with dementia against the expected prevalence for the population has increased from the 2011/12 baseline of 52% to 88.2% in November 2015.

Measures showing deterioration from the baseline in the strategy are:

Obesity in children in Year Six: Positive improvements through 2009/12 have not been sustained. Indeed, our performance in 2014/15 has fallen below the previous 'worst' position in 2009/10. However, our performance remains better than our comparator group average (experiencing a similar decline in 2014/15), but below the England average.

Smoking cessation - 4 week quit rates: 2014/15 outturn data and year to date information for 2015/16 confirms previously reported concerns about this measure. This deterioration reflects a national decline in quit rates, largely attributed to: limited national marketing; the increased usage of e-cigarettes; and, difficulties in reaching / working effectively with entrenched smokers. Although, Leicester continues to out-perform its comparator authorities.

Coverage of cervical screening in women: This was considered as an area of concern by the Board previously. Data published in November 2015 confirms a year on year decline from the baseline in the strategy. The marked decline in 2014/15 can in part be attributed to a change in recording methodology. Although, the drop in the England average was 4.3% with Leicester experiencing a 4.9% drop. We continue to under-perform against both the England and our comparator averages.

In this report we have included benchmarking data, where it is available, to help us understand our performance and rate of improvement (or decline) in relation to other similar local authorities. We have used the most appropriate benchmarking group for each measure (e.g. National Foundation for Educational Research benchmarking group for children's and young people's measures see Appendix 1c). We have also been able to include trend analysis in graph form for most of our measures. This information is set out in Appendix 1b.

A summary of the current position on the 25 indicators in the strategy is shown below. The full report on the indicators is set out in Appendix 1a of this report.

Direction of travel against baselines in the strategy:

	Performance has improved from the baseline in the strategy	**20**
	Performance is the same as the baseline in the strategy	**0**
	Performance has worsened from the baseline in the strategy	**3**
	There are data quality / comparability issues (see below)	**2**

Data Issues

With the adoption of the replacement measure for dementia and completion of the 2015 Health and Wellbeing Survey providing data on smoking prevalence, there are now only two outstanding data issues. These relate to the changed definition for '*Readiness for school at age 5*' and historic data quality issues for the '*Proportion of adults in contact with secondary mental health services living independently with or without support*'. These both impact on our ability to judge performance against the baselines set in the strategy.

3. Progress on implementing the actions in the Health and Wellbeing Strategy

The overall approach we have taken to monitoring progress against the actions set out on the strategy has been 'light touch' in order to give a broad overview of progress, and in keeping with the high level and extensive scope of the strategy itself.

Each of the five strategic priorities of the strategy consists of a number of sub-sections. Strategic priorities 1 to 5 contain 19 sub sections, and we have asked contacts for those sub sections to provide a progress statement and RAG rating on each one.

Overall, the RAG ratings that contacts gave to the 19 areas were:

Red	Little or no progress has been made.	**0**
Amber	Some progress has been made, but we have not met our expectations.	**7**
Green	Good Progress has been made. Our expectations have been met or exceeded.	**12**

Some of the main achievements to support delivery of the outcomes include:

Improve readiness for school at age five: The Children's Centre teachers lead group work sessions with parents and their children based on a nationally accredited programme; Peers Early Education Project that aims to provide parents with information about how to support primarily their child's language development but also encourage personal, social and emotional and physical development. Parents' evaluation of the groups shows that they have gained knowledge, confidence and changed their behaviours as a result of attending.

Teenage pregnancy: The integrated sexual health service is rolling out a C-Card (Condom Card) scheme across Leicester. This scheme will make it easier for young people to get free condoms and sexual health advice. The scheme aims, to encourage longer-term sexual health awareness, change in behaviour and better use of other services. The scheme will be provided in pharmacies, GP surgeries and in community settings.

Increase physical activity and healthy weight: The Healthy Lifestyles Hub has been rolled out across GP practices in the city, jointly funded by the city council and CCG. Between April 2015 and end March 2016 over 5000 patients have been assessed by the service and referred into appropriate lifestyle services e.g. weight management, exercise referral and the health trainer service.

Long-term conditions (respiratory disease management): The CCG has been working with practices to deliver a quality assured COPD detection and diagnostic service. Leicester City CCG has been commissioning a COPD telehealth and health coaching programme. It realised a 72% reduction in the number of emergency admissions for those patients within the service.

Older People: A successful bid to the Big Lottery brought £5m into Leicester to combat loneliness and isolation in older people. The work is being led by the Leicester Ageing Together Partnership, who are now implementing a programme with 21 projects and 19 providers.

Dementia: Locally a Dementia Action Alliance has been established jointly chaired by Leicester City Council and Leicestershire Police. This brings together a range of stakeholders with the primary aim of making Leicester, Leicestershire and Rutland dementia friendly communities. The Alliance has also been leading on a range of local events to celebrate the annual national dementia awareness week.

Promote the emotional wellbeing of children and young people: Health and social care partners have collaborated to develop and implement mental health Crisis Care Concordat Action Plan, including provision of an appropriate place of safety for young people.

The 19 statements of progress, together with RAG ratings are set out at Appendix 2.

Appendix 1(a)

‘Closing the Gap’: Leicester’s Health and Wellbeing Strategy – 2013/16 Indicators				
Improve outcomes for children and young people				
Indicator (For information on activity in support of each measure please see the sections of Appendix 1)	**Baseline as published in strategy**	**Latest data as at May 2016**	**Direction of travel against Baseline**	**Notes**
Readiness for school at age 5 (Section 1.3)	2011/12 – 64% (old definition)	**2014/15 – 50.7%** (new definition)		Current performance not comparable with baseline data. Under the new definition our performance has improved significantly from a very low base (12/13 – 27.7% and 13/14 – 41.0%)
Breastfeeding at 6-8 weeks (Section 1.1)	2011/12 – 54.9%	**2014/15 - 62.1%** **2015/16 (Q1) – 62.6%**		Significant improvement from baseline.
Smoking in pregnancy (low is good) (Section 2.1)	2011/12 – 12.7%	**2014/15 – 11.8%** **2015/16 (Q3) – 11.8%**		
Conception rate in under 18 year old girls (per 1,000) (low is good) (Section 1.2)	2011 – 30.0	**2014 – 25.3**		Significant improvement from baseline.

Reduce obesity in children under 11 (bring down levels of overweight and obesity to 2000 levels, by 2020) (low is good) (Section 1.4)	Reception: 2010/11 – 10.6%	Reception: **2014/15 – 10.5%**		Note the long-term ambition associated with this indicator.
	Year 6: 10/11 – 20.6%	Year 6: **2014/15 - 22.1%**		Increase in obesity levels for children in Year Six.
Reduce premature mortality				
Indicator (For information on activity in support of each measure please see the sections of Appendix 1)	**Baseline as published in strategy**	**Latest data as at May 2016**	**Direction of travel against Baseline**	**Notes**
Number of people having NHS Checks (Section 2.4)	2011/12 – 8,238	**2014/15 - 13,967** **2015/16 (Q3) – 8,278**		
Smoking cessation: 4 week quit rates (number and rate per 100,000 adult pop.) (Section 2.1)	2011/12 – 2,806 (1,153 per 100,000)	**2014-15 - 2,008** (757.2 per 100,000) **2015/16 (Q3) – 1,357**		Marked downturn in performance reflecting national trend.
Reduce smoking prevalence (low is good) (Section 2.1)	10/11 – 23.4% (Household survey)	**2015 - 21.4%** (Health & Wellbeing survey)		
Adults participating in recommended levels of physical activity (Section 2.2)	Oct 2011 – 27.8%	**Oct 2015 – 32.5%**		Original definition and baseline (17.7%) amended prior to first reporting on strategy.

Alcohol-related harm (rate per 100,000) (low is good) (Section 2.3)	2011/12 - 719.1 (new definition)	**2014/15 – 708.3** **(new definition)** **2015/16 (Q2) – 364.8**		The definition of the alcohol-related hospital admissions measure has changed. The narrow definition indicator has been adopted for this report, roughly equating to 'alcohol specific' admissions.
Uptake of bowel cancer screening in men and women (Sections 2.4 & 3.1)	11/12 – 43%	**2014/15 – 46.2%**		
Coverage of cervical screening in women (Sections 2.4 & 3.1)	2011/12 – 74.7%	**2014/15 – 67.7%**		Year on year decline in coverage.
Diabetes: management of blood sugar levels (Sections 2.4 & 3.1)	2011/12 – 62%	**2014/15 – 69.7%**		Significant improvement from baseline.
CHD: management of blood pressure (Section 2.4)	2011/12 – 88.3%	**2014/15 – 89.5%**		
COPD: Flu vaccination (Section 2.4)	2011/12 – 92.3%	**2014/15 – 96.5%**		

Support independence				
Indicator **(For information on activity in support of this measure please see the sections of Appendix 1)**	**Baseline**	**Latest data as at May 2016**	**Direction of travel against Baseline**	**Notes**
People with Long Term Conditions in control of their condition (Section 3.1)	2011/12 – 60.8% *Revised baseline*	**2014/15 - 61.5%** **Jan - Sept 2015 – 61.6%**		Data is based on weighted survey results from GP Access Survey. Data quality issues have been resolved; the original baseline was incorrect and has subsequently been amended.
Carers receiving assessment or review and a carers service or advice and information (Section 3.4)	2011/12 – 18.8%	**2015/16 – 45.4%**		Provisional 2015/16 outturn. Significant improvement from baseline.
Proportion of older people (65 +) who are still at home 91 days after discharge from hospital into reablement. (Section 3.2)	2011/12 – 77.2%	**2015/16 – 91.5%**		Provisional 2015/16 outturn. Significant improvement from baseline.
Older people (65+), admitted on a permanent basis to residential or nursing care per 100,000 pop. (low is good) (Section 3.2)	2011/12 – 763.20 (revised Feb 2014)	**2015/16 – 653.7**		Provisional 2015/16 outturn. Significant improvement from baseline.
Dementia diagnosis rates: the percentage of patients diagnosed with dementia against the expected prevalence for the population. (Section 3.3)	11/12 – 52%	**14/15 – 72%** **November 2015 – 88.2%**		The intention was to use a national measure planned to be introduced in 14/15, however, it remains a placeholder in ASCOF. As such, a proxy measure has been used. This shows significant improvement from baseline.

Carer-reported quality of life (Section 3.4)	2009/2010 – 8.7 2012/2013 – 7.1	**2014/2015 – 7.2**		Rating judgement based on 12/13 data (not available when strategy published) rather than 9/10 as this better reflects performance over the life of the strategy.
The proportion of carers who report that they have been included or consulted in discussion about the person they care for. (Section 3.4)	2009/2010 – 70% 2012/2013 – 63.5%	**2014/2015 – 68.5%**		As above
Improve mental health and emotional resilience				
Indicator **(For information on activity in support of this measure please see the sections of Appendix 1)**	**Baseline**	**Latest data as at May 2016**	**Direction of travel against Baseline**	**Notes**
Self-reported well-being: people with a high anxiety score (low is good). (Section 4.2)	11/12 – 41.99%	**2014/15 – 40.7%**		
Proportion of adults in contact with secondary mental health services living independently with or without support. (Section 4.3)	2011/12 – 68.1%	**2015/16 - 62.1%**		Data issues have persisted with this measure, including 2015/16 data only being available for the first eight months of the year.

Appendix 1(b)

Performance Trends and Benchmarking

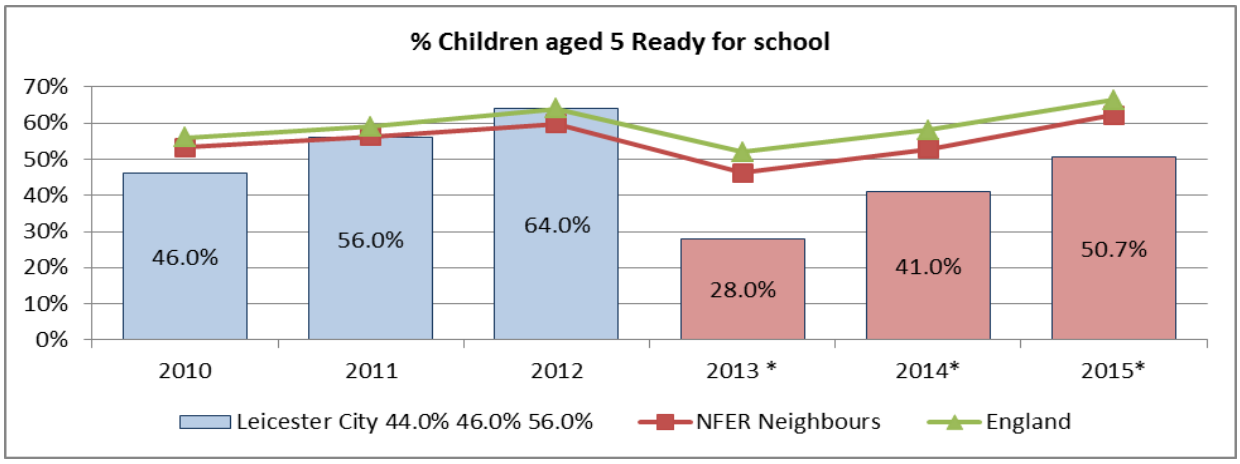
Key for Graphs
NFER Neighbours = National Foundation for Educational Research Statistical Neighbour Group
ONS = Office for National Statistics Neighbour Group
CIPFA = Chartered Institute for Public Finance and Accountancy Statistical Neighbour Group

(See appendix 1c for membership of comparator groups)

Historical data up to and including the baseline	**Data released since the publication of the strategy**

Priority: 1 Improve outcomes for children and young people

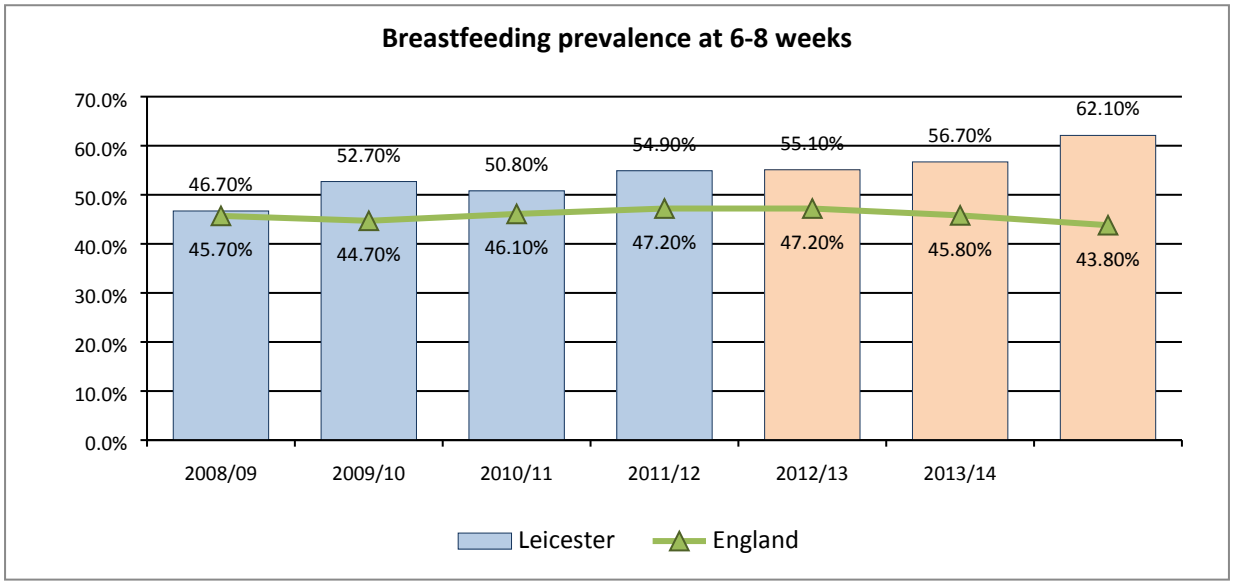
Readiness for school at age 5



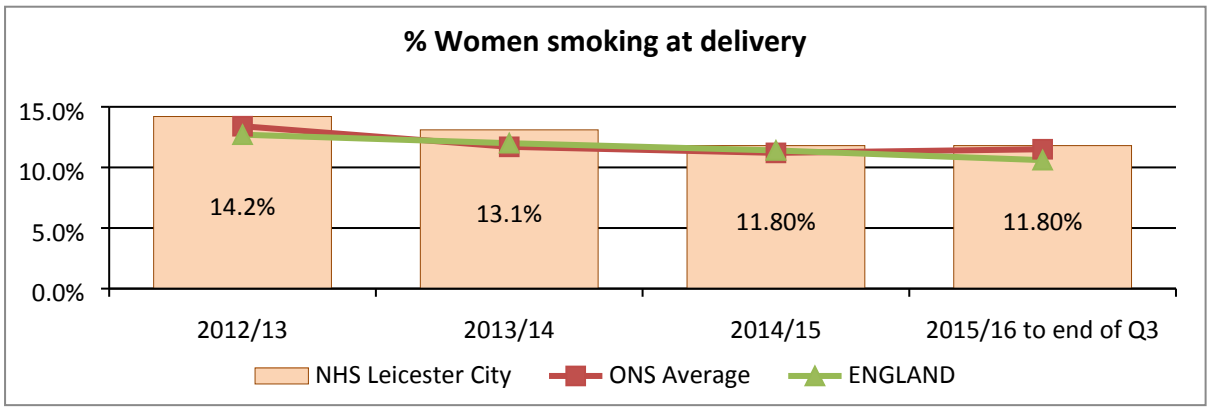
N.B. trend graph shows historical trend for the old measure of "Achieving a good level of development at Early Years Foundation Stage for 2009-2012. The first year of results for the new Foundation Stage Profile was 2013.

Historical trend for the old EYFS profile "School Readiness measure	**Trend for new EYFS profile "School Readiness measure**

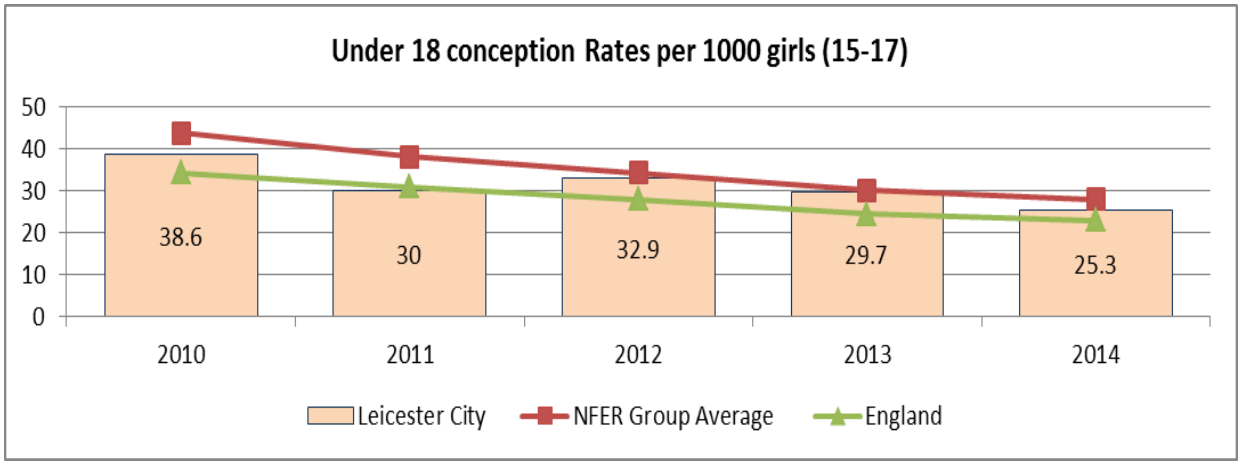
Breastfeeding at 6-8 weeks



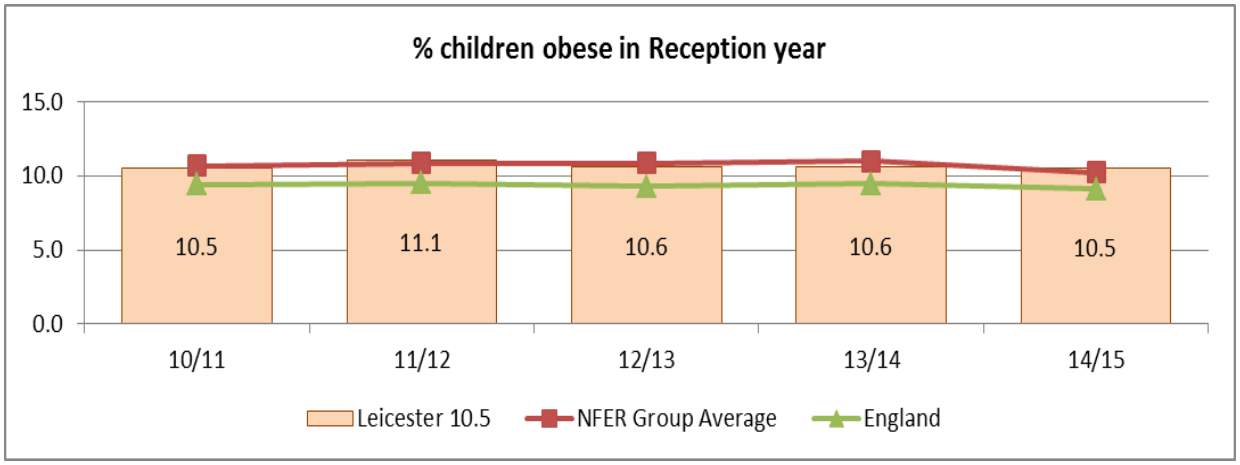
Smoking in pregnancy



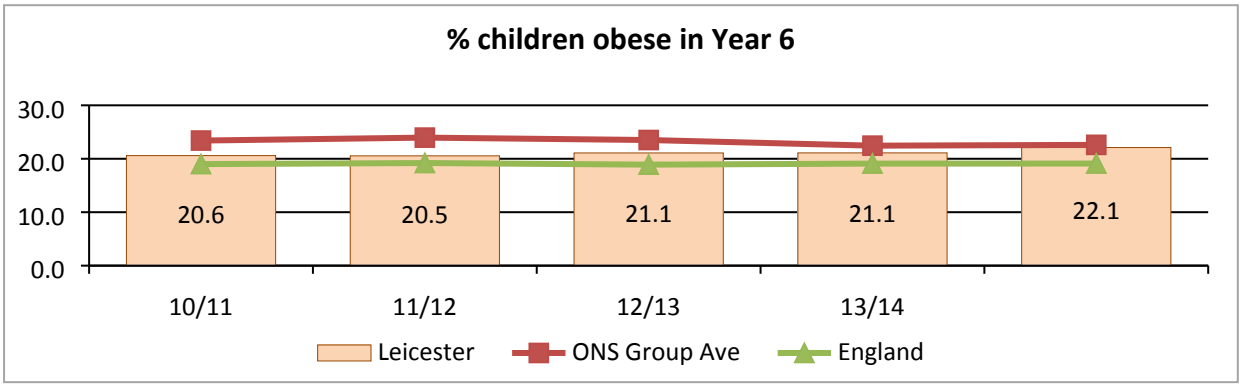
Under 18 conception Rates per 1,000 girls (15-17)



% children obese in Reception year

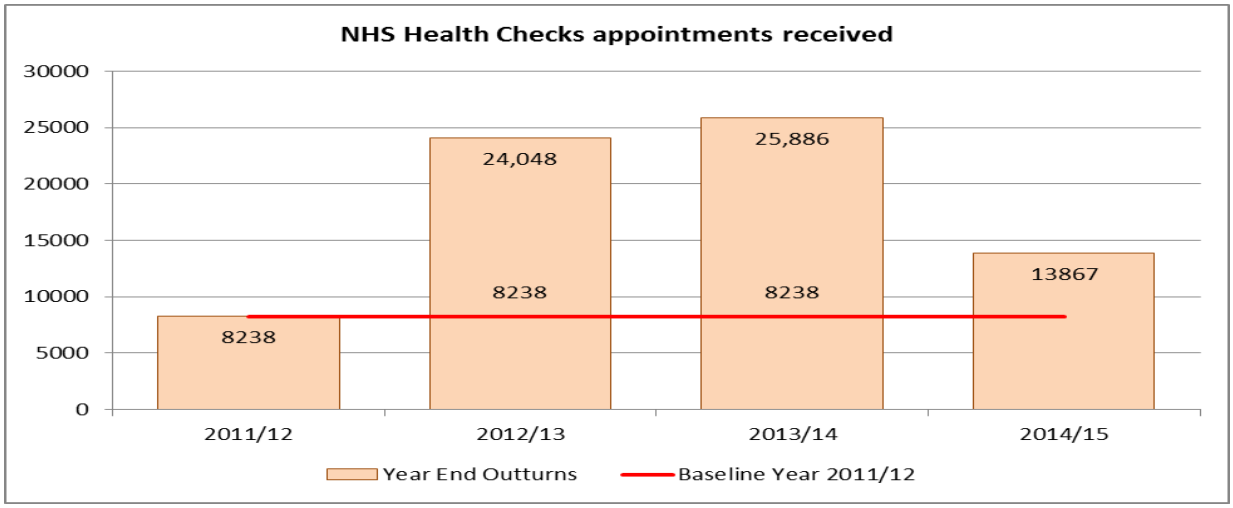


% children obese in Year 6

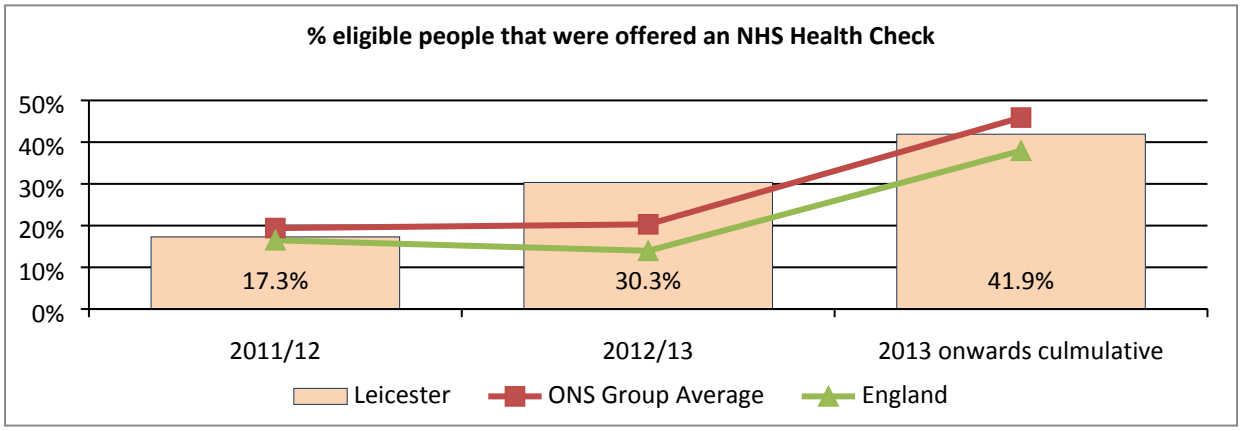


Priority 2: Reduce premature mortality

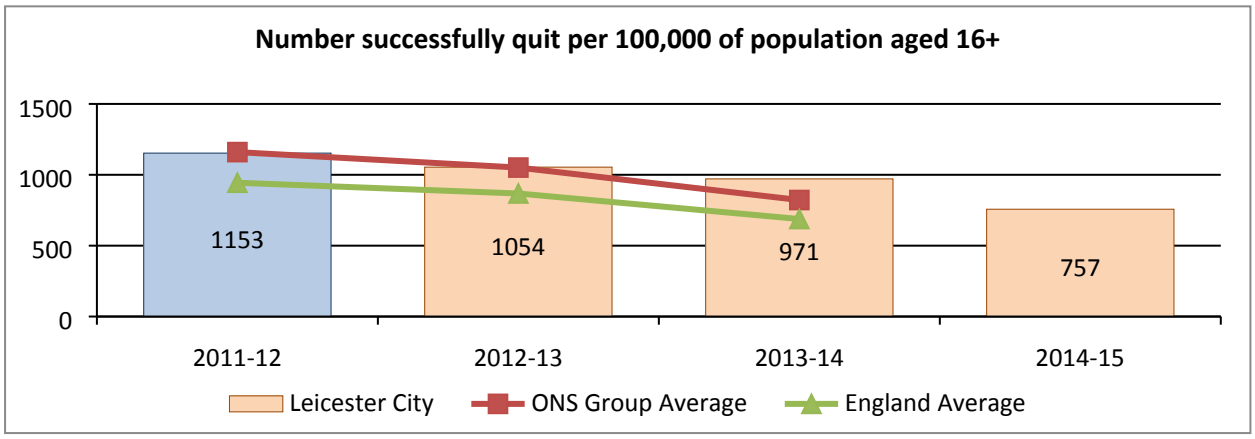
Number of people having NHS Checks



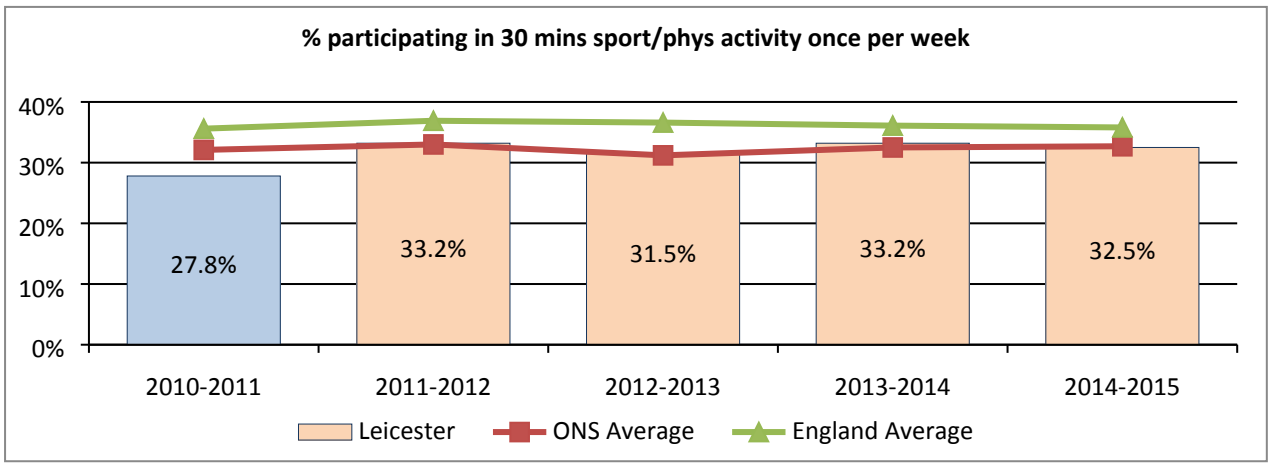
Proxy measure: % eligible people that were offered a NHS Health Check (used because it enables meaningful comparisons between different sized areas)



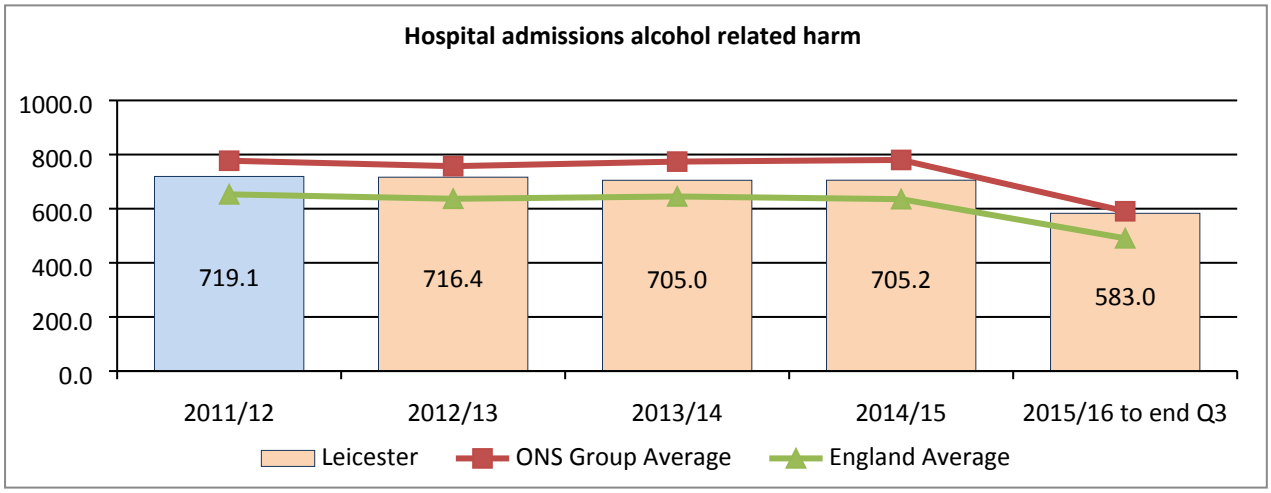
Number successfully quit (self-report) per 100,000 of population aged 16 and over



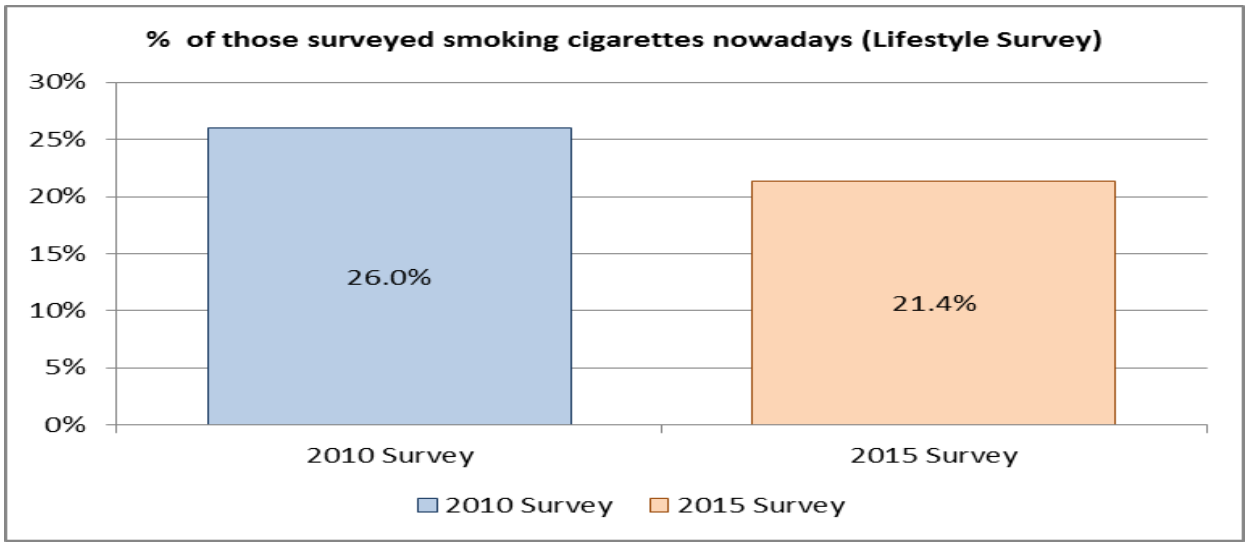
% participating in 30 minutes of sport/physical activity per week



Hospital admissions for alcohol related harm, new narrow definition measure

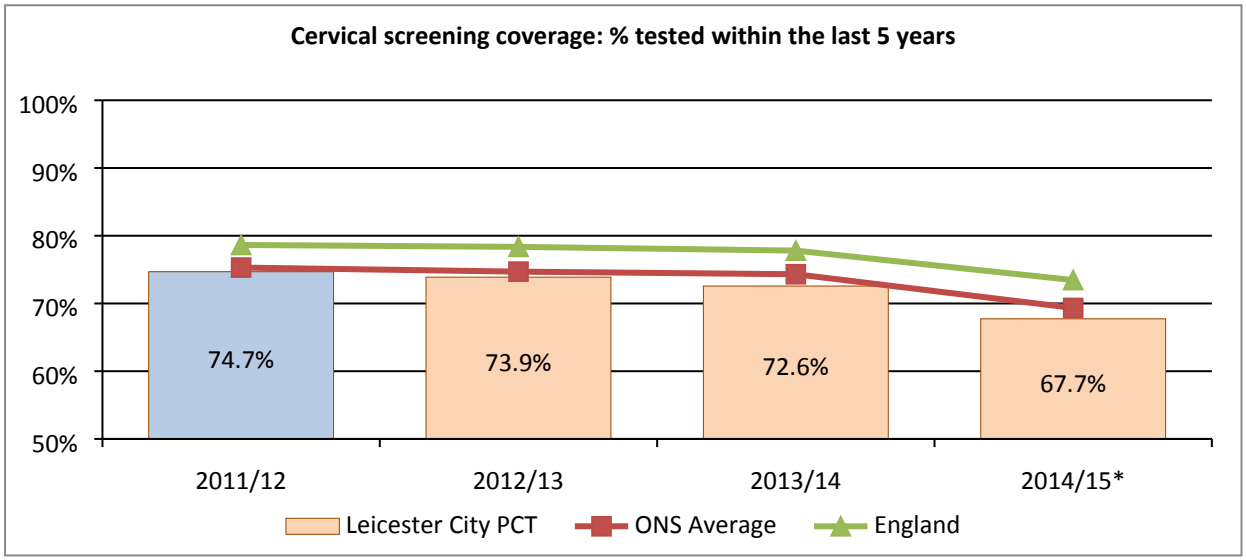


Reducing smoking prevalence:

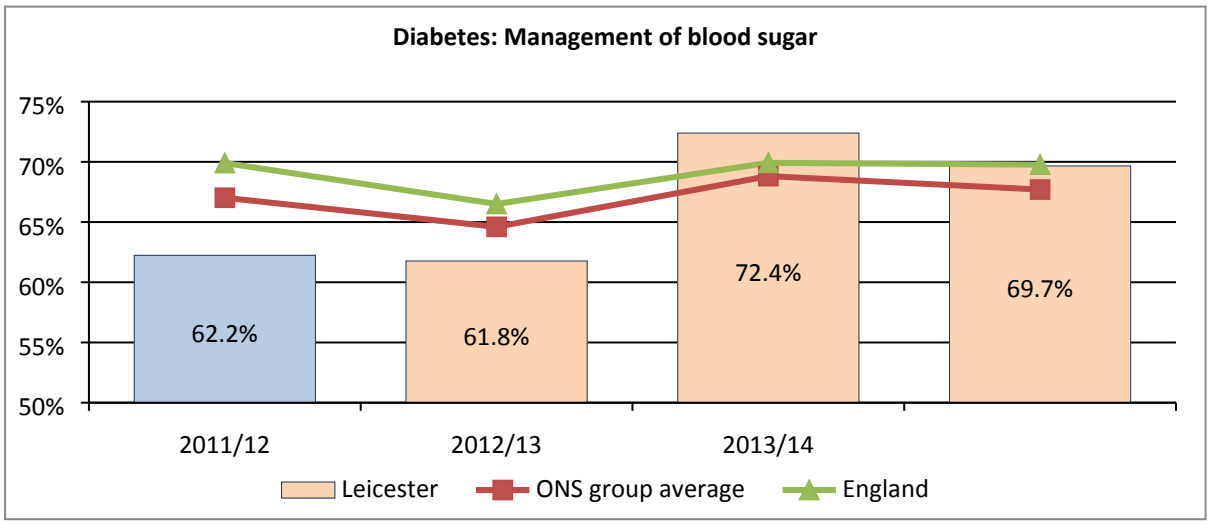


Uptake of bowel cancer screening
Data not published nationally

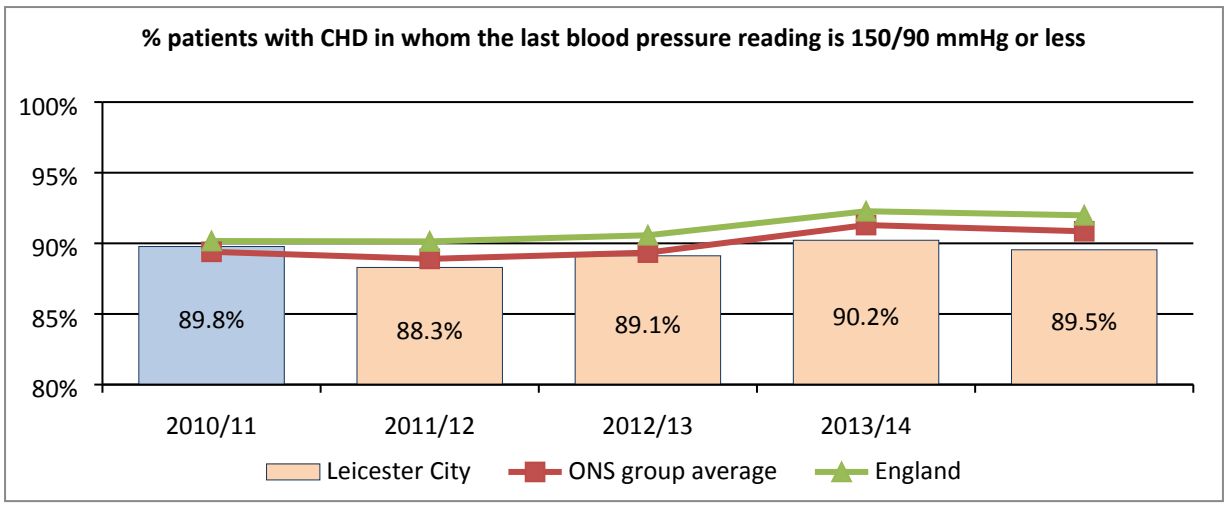
Cervical screening coverage



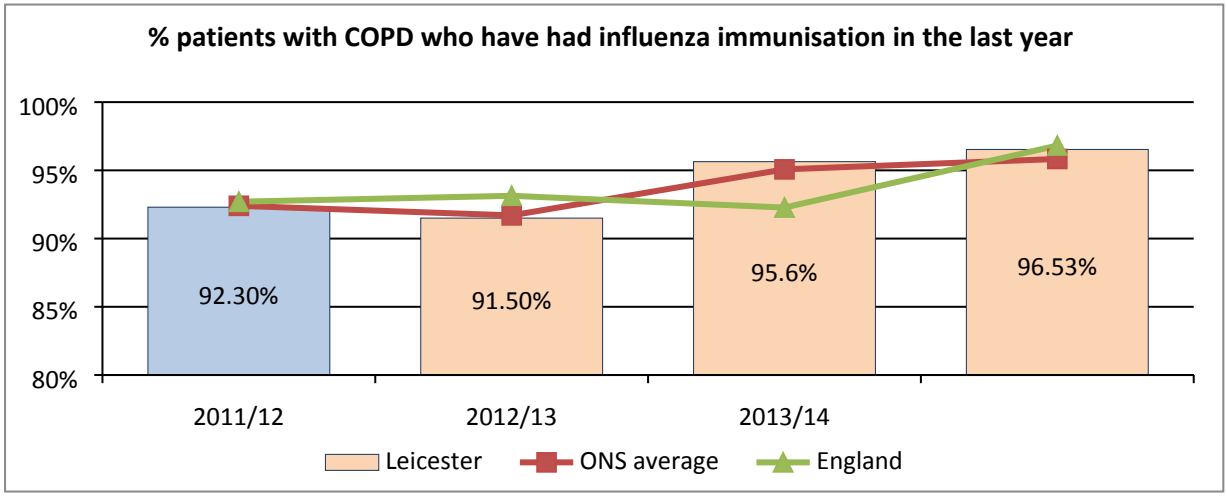
Diabetes: Percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol in the preceding 15 months.



Coronary Heart Disease: Percentage of patients with coronary heart disease in whom the last blood pressure reading is 150/90 or less.

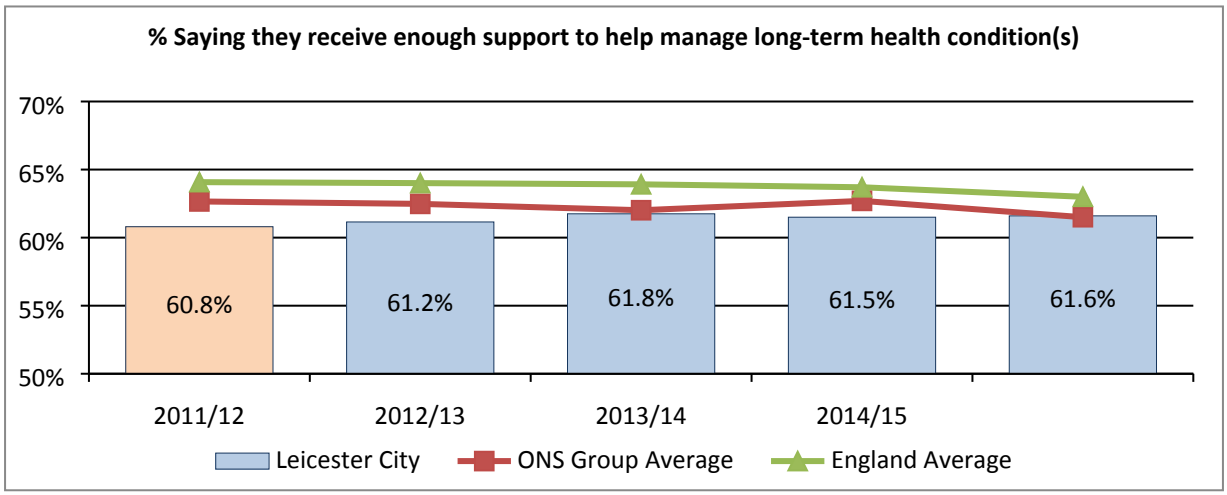


Chronic Obstructive Pulmonary Disease: Percentage of patients with COPD who have had influenza immunisation

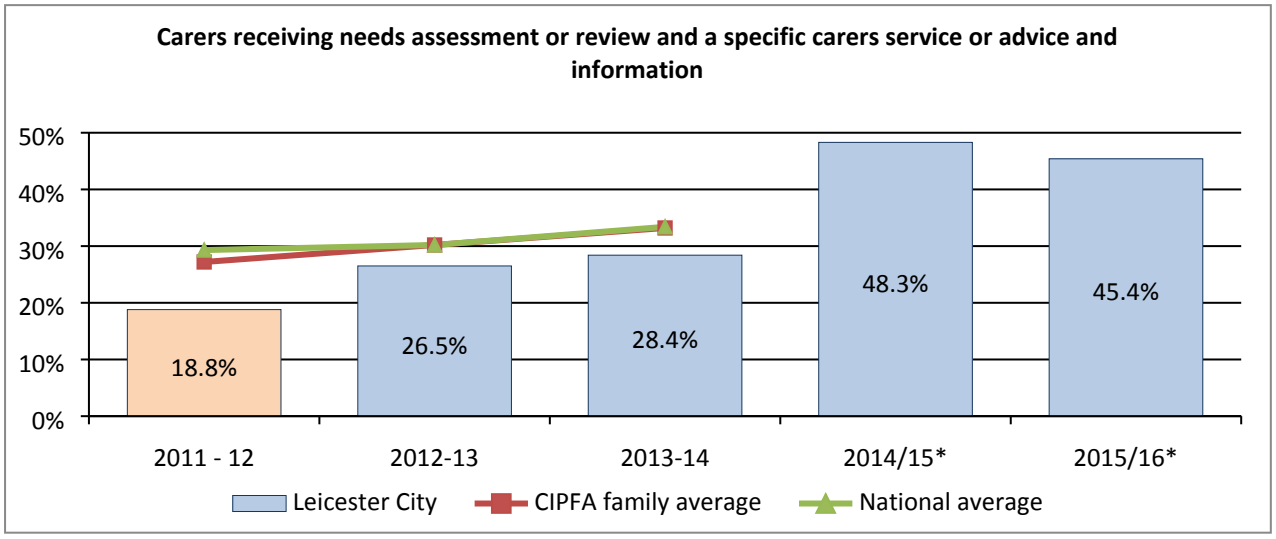


Priority 3: Promoting Independence

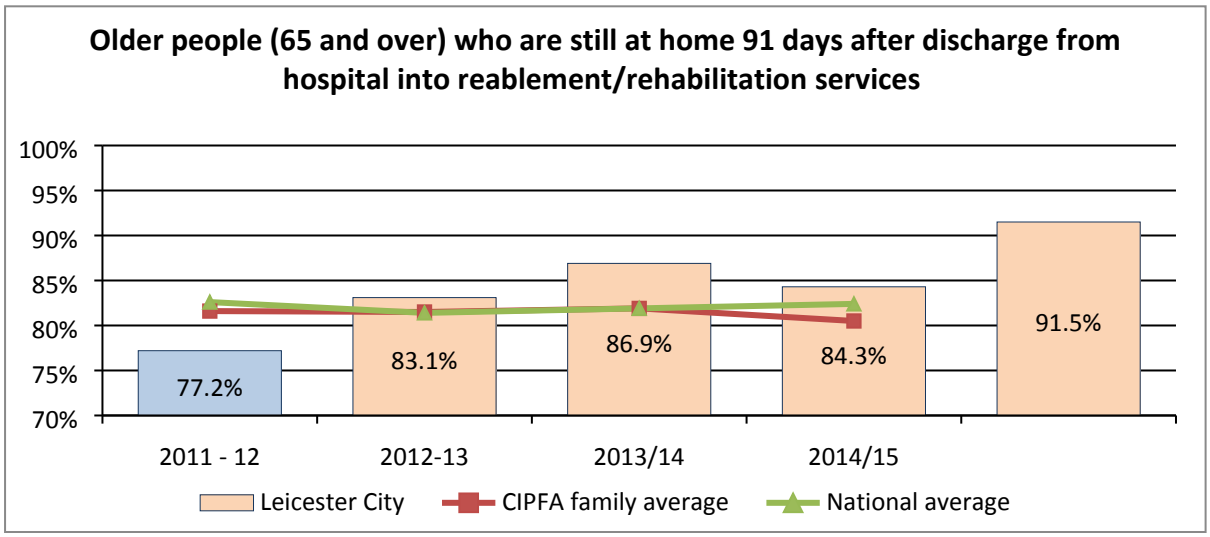
Long term conditions: People with Long Term Conditions in control of their condition



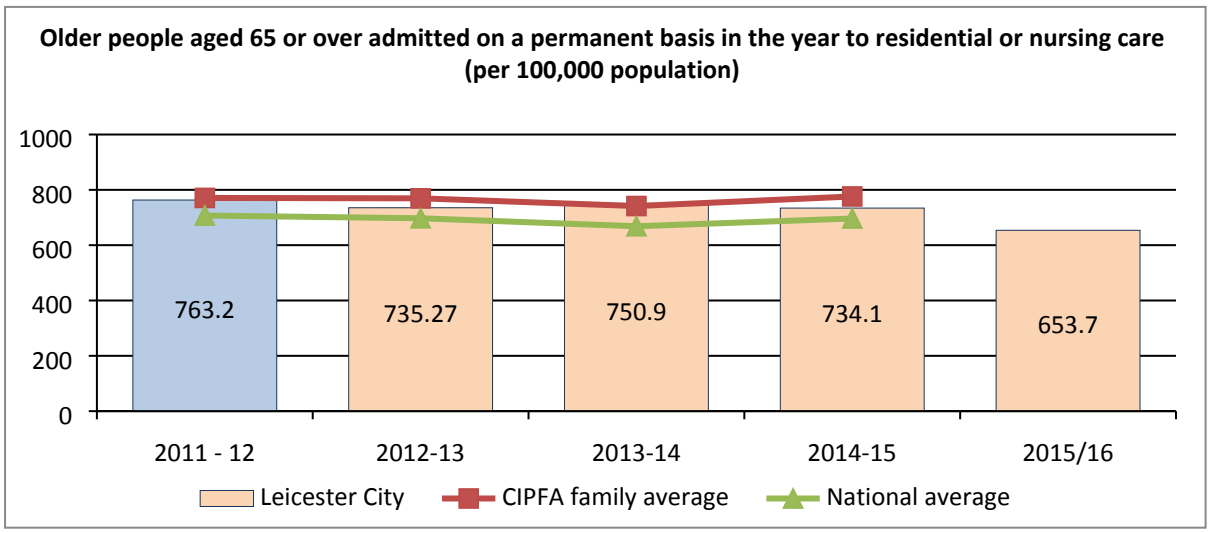
Carers receiving needs assessment or review and a specific carers service or advice and information (formerly NI135) **local measure only from 2014/15 onwards*



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

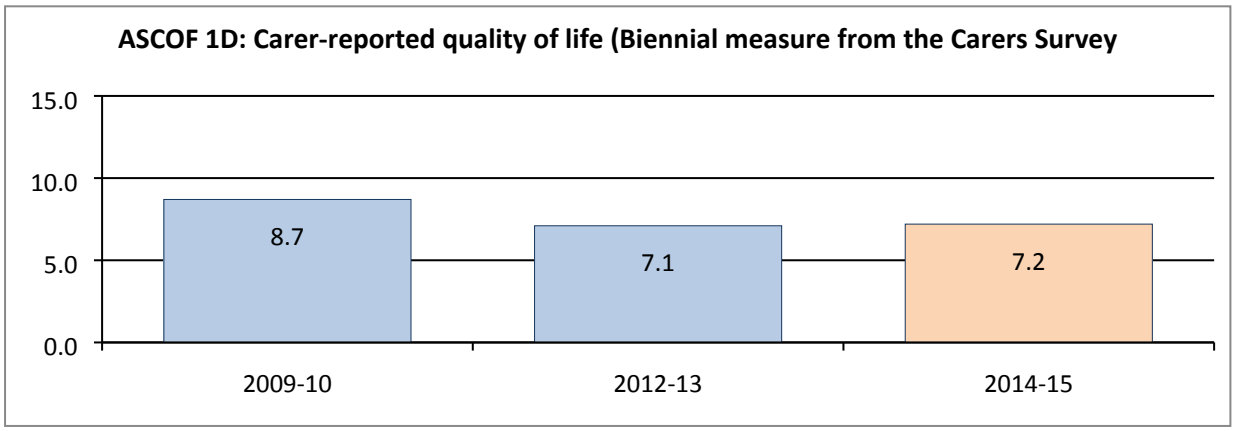


Older people aged 65 or over admitted on a permanent basis in the year to residential or nursing care (per 100,000 population)

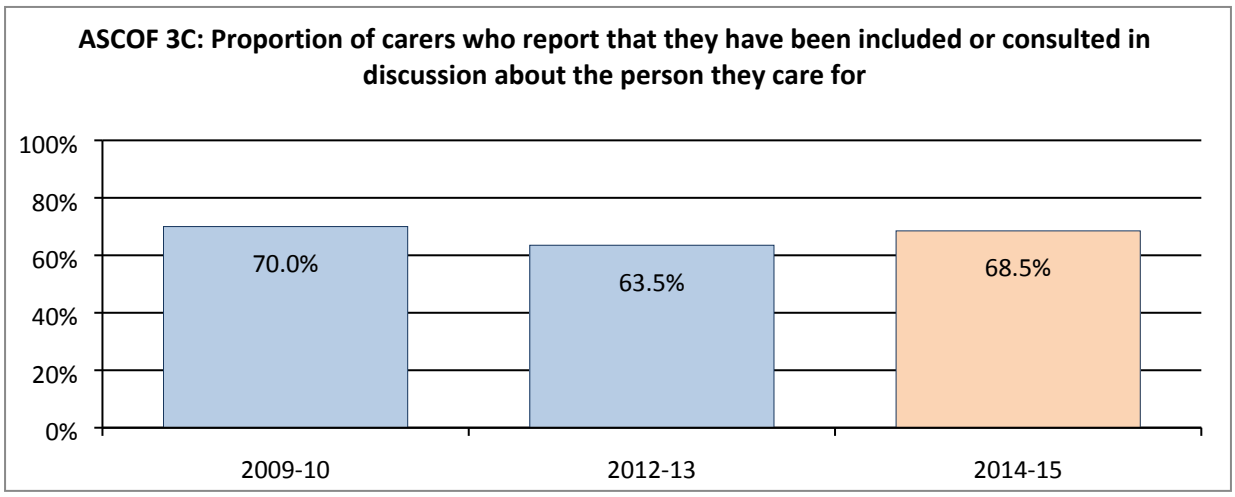


Dementia effectiveness – post dementia care:
No data will be available this measure during the life of the strategy.

Carer-reported quality of life (ASCOF 1D)

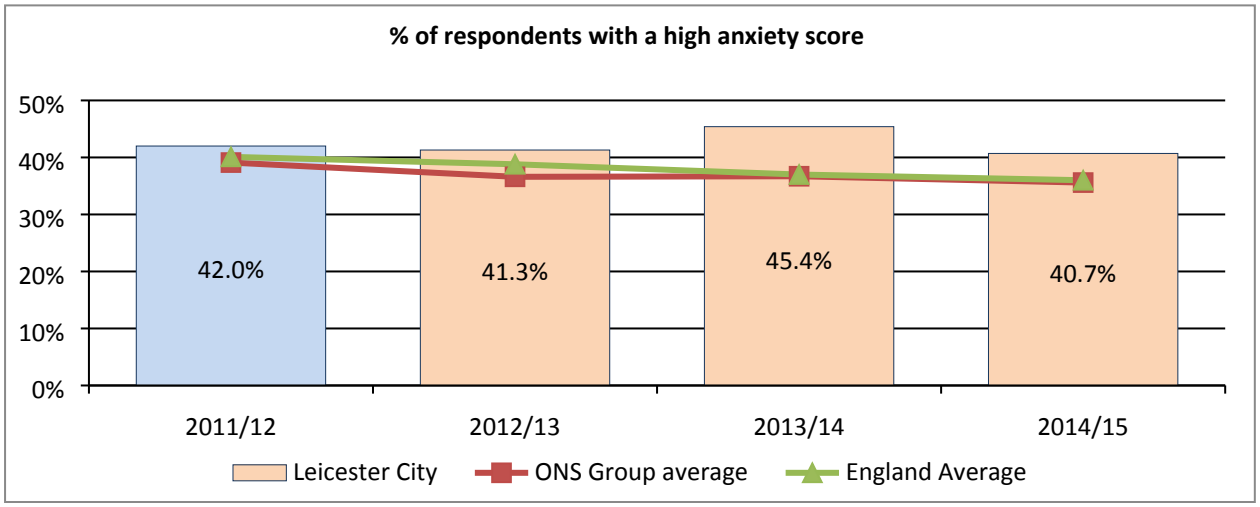


Proportion of carers who report that they have been included or consulted in discussion about the person they care for (ASCOF 3C)

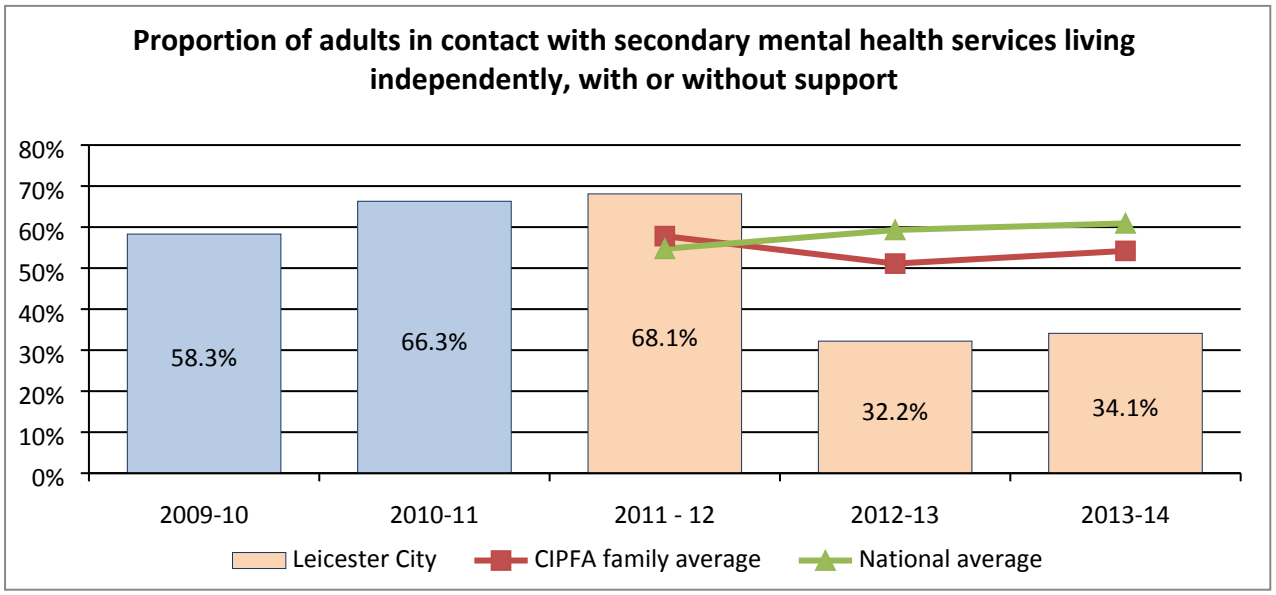


Priority 4: Improve mental health and emotional resilience

Self-reported wellbeing: % of respondents with a high anxiety score:



Proportion of adults in contact with secondary mental health services living independently, with or without support – *Please note there is no new data for this measure due to ongoing data quality issues*



Appendix 1(c)

Technical Notes

Benchmarking:

This report includes benchmarking against relevant comparator authorities, where possible. The comparator groups used to benchmark different measures are shown below.

Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbours Model	**National Foundation for Educational Research (NFER) benchmarking group**	**Office for National Statistics (ONS) benchmarking group**
Luton	Wolverhampton	**Manchester**
Wolverhampton	Hounslow	NHS Central Manchester CCG
Nottingham	Sandwell	NHS South Manchester CCG
Coventry	Blackburn with Darwen	NHS North Manchester CCG
Sandwell	Slough	**Barking And Dagenham**
Bradford	Coventry	NHS Barking And Dagenham CCG
Peterborough	Hillingdon	**Nottingham**
Blackburn with Darwen	Walsall	NHS Nottingham City CCG
Kingston upon Hull	Birmingham	**Birmingham**
Derby	Southampton	NHS Birmingham Crosscity CCG
Middlesbrough	**Leicester**	NHS Birmingham South And Central CCG
Liverpool		**Sandwell**
Oldham		NHS Sandwell And West Birmingham CCG
Newcastle upon Tyne		**Wolverhampton**
Slough		NHS Wolverhampton CCG
Leicester		**Leicester**
		NHS Leicester City CCG

Appendix 2

'Closing the Gap: Leicester's Joint Health and Wellbeing Strategy 2013-16'

Implementation of actions

Final Statements: April 2016

Strategic Priority 1: Improve outcomes for children and young people

Section	**1.1 Reduce Infant Mortality**
Contact(s)	Clare Mills, Leicester City Council Nicola Bassindale, Leicester City Council

Action underway in the City to Reduce Infant Mortality since the last update include:

- Children and Young People JSNA is being developed and will be completed this year
- 0-5 Strategy has been completed
- The multi-agency infant mortality strategy group has drafted an Infant mortality strategy and evidence based Action Plan
- UNICEF Baby Friendly Initiative stage 3 accreditation - LPT have achieved Stage 3 of the assessment and are still working towards Stage 3 (the final stage)
- UNICEF Baby Friendly Initiative stage 3 accreditation – UHL have achieved Stage 2 of the assessment and are working towards Stage 3 (the final stage) – due to be assessed in October
- Maternal obesity service was de-commissioned and ended in April 2016
- Bumps to Babies is the City's multi-agency offer around anti/post-natal education and delivers clear health related messaged
- The 0-19 Health Child Programme (formally Health Visiting and School Nursing) is currently being re-commissioned and is due to begin provision 1st July 2017
- Breastfeeding Peer Support Service is now delivering, moving forward this will form part of the 0-19 Health Child Programme
- Participation in a study conducted in Nottingham about pregnant women's attitudes to e-cigarettes during pregnancy and post-partum continues

RATING Amber	Some progress has been made but we have not met our expectations.

Section	**1.2 Reduce Teenage Pregnancy**
Contact(s)	Liz Rodrigo, Public Health Principal, Leicester City Council David Thrussell, Head of Young Peoples Service, Leicester City Council Kim Knight, Operational Manager, Integrated Sexual Health Services, Staffordshire and Stoke On Trent NHS Partnership Trust

The rate of under-18 conceptions in Leicester continues to fall. The latest data is for 2014 and shows that Leicester has a rate 25.3 per 1000 15-17 year olds. This is still statistically higher than the English rate of 22.8 per 1000 15-17 year olds. There has been a fall each year for the last 10 years.

The Young people's service provided by Staffordshire and Stoke On Trent NHS Partnership Trust provides a young people specific service. This has had limited attendance at the Connexions service at New Walk. Both the Connexions Service and Youth Service are part of the C Card Scheme and PA's and Youth Workers have been briefed on this offer. The Choices service is promoted to all young people in the NEET group.

Community Based Public Health Services for Young People covering emergency hormonal contraception, chlamydia screening and long-acting reversible contraception is being provided and there has been an increase in demand in the last quarter.

The integrated sexual health service is rolling out a C-Card (Condom Card) scheme across Leicester. This scheme will make it easier for young people to get free condoms and sexual health advice. The scheme aims, to encourage longer-term sexual health awareness, change in behaviour and better use of other services. The scheme will be provided in pharmacies, GP surgeries and in community settings.

The remodelled Youth Service is also providing a more integrated youth offer including improved access to contraception and sexual health services. Workforce training for both city council and commissioned youth service providers includes targeting vulnerable young people including those at risk of underage conception or poor health outcomes.

Phase 2 of the THINK Family Programme will support additional targeting of young people and families at risk of poor health outcomes including both mental and physical health. This will build upon the success of the current programme focussed on improving school attendance, ETE engagement, and reduction in crime and anti-social behaviour.

Public Health is commissioning some RSE provision via the Sexual Health and HIV prevention tenders. This includes some coordination and development of a core offer to secondary schools and FE colleges. This started on 1st April 2015. A programme of support is being developed for schools, governors and parents, and this will be reviewed in the next year.

The review of the 0-19 offer for the Healthy Child Programme and the recommissioning of service will include an offer to support young parents which has been shown to reduce repeat pregnancies.

RATING Green	Good Progress has been made. Our expectations have been met or exceeded

Section	**1.3 Improve readiness for school at age five**
Contact(s)	Julia Pilsbury, Early Help Targeted Services, Leicester City Council

The Early Help Children's Centre Teachers have continued to work with providers of early years (preschool) providers across the city to offer support on aspects of teaching and learning with the view to improving quality. Research shows that children attending good quality preschool settings make better progress. There are now fewer settings in the city judged "Inadequate" or "Requires Improvement"
The Children's Centre teachers also work with carers and other professionals to ensure children looked after in city placements have a Personal Education Plan, that ensures their learning and development is at the forefront of people's minds when planning for their future and that carers have a clear direction for to support their learning. Most LAC in City placements have a PEP.

The Children's Centre teachers lead group work sessions with parents and their children based on a nationally accredited programme Peers Early Education Project (PEEP) that aims to provide parents with information about how to support primarily their child's language development but also encourage personal, social and emotional and physical development. Parent's evaluation of the groups shows that

they have gained knowledge, confidence and changed their behaviours as a result of attending.

The Children's Centre teachers work with local providers of preschool and schools on transition, which includes identifying a cohort of children transferring to school and holding a series of workshops for the child and parent looking at how the parents can support the transition and their child's learning. In some situations they hold workshops of this kind in the children, young people and family centres with a focus on children who have not had any preschool experience, for families with boys and or children born in the summer all of whom the early Years Foundation Stage profile shows do least well.

The Children's Centre teachers also organise forums in the cluster to share good practice and develop working practice with preschool settings and Foundation Stage coordinators in school.

The child learning team also work with other agencies like health and midwifery to deliver an anti-natal programme delivering messages early to parents about health, feeding, attachment and play.

The Children's Centre teachers have piloted and are now rolling out across the city a home visiting programme aimed at increasing parents' interaction with their child, looking at their level of development and what they can do to support their child's learning.

Early help family support teams are trading with some schools and provide a family support facilitator for the school who works with parents presenting in school with challenges that effect the child, thus supporting the parent to deal with issues like housing, finance or challenging behaviours that have an effect on the child's emotional health and or attendance and ability to learn.
Family support through the children, young people and family centre service provide advice point aimed at offering immediate and short term interventions for parents and/or provide information for other professionals that support parents ability to manage difficult situations i.e. housing issues, financial difficulties and focus on the child to improve parenting and the child's emotional development.

The early learning team provide Stay and Play sessions that are a universal service that provide a variety of learning experiences for preschool children and their parents and deliver key messages about learning through play, using books and rhymes and health messages that all contribute to school readiness.

The childcare team also work in the home with individual families where developmental delay has been identified by other professionals or through stay and play. A childcare learning facilitator will hold sessions in the home that focus on the child's level of development and plan stimulating activities that will extend the child's learning and that parents can continue in order to ensure the child progresses to the expected level of development for his/her age or is referred on, or signposted on to appropriate specialist services.

The children, young people and family centres work with the library service and promote book start, to encourage parents to use the library and use books with their children for enjoyment and reading. To develop a love of books and stories that supports their language and listening skills.

RATING Amber	Some progress has been made but we have not met our expectations.

Section	**1.4 Promote healthy weight and lifestyles in children and young people**
Contact(s)	Jo Atkinson, Consultant in Public Health, Leicester City Council

- The city still has significantly higher rates of childhood obesity in both reception year and year 6 compared to the national rates. Leicester is following the national trend with steadily increasing levels of obesity in year 6 but stabilising levels in reception year.

- The Food for Life Programme has been running in schools since April 2015. 36 schools have so far enrolled in the programme which supports schools to develop a whole school approach to healthy eating and food sustainability, including practical cooking, food growing and embedding these in the curriculum. By the end of March 2017, it is expected that at least 70 schools will be enrolled in the programme.
- A healthy eating initiative in children's centres and other early years' settings has also been running since April 2015 with over 60 settings signed up so far. The programme supports these settings to provide healthy, nutritious food to the children that they care for and provides training to early years' staff. Community-based "Cook and Eat" programmes also run which support parents to cook healthy food for their families and teach practical cooking skills.
- Investment has been made in the delivery and co-ordination of physical activity interventions in primary schools particularly targeting the most inactive children. The team deliver a range of physical activity sessions and training for school staff. In addition the service works with schools and offers advice and support regarding how best to increase physical activity levels, meeting Ofsted requirements and making best use of the school sport premium funding.
- A child weight management service has been running in the city for 2 years. 75 families have attended the programme each year with positive outcomes including children (and parents/ siblings) becoming a healthier weight, measurably improving the families' diet and increasing their levels of physical activity.

RATING Amber	Some progress has been made but we have not met our expectations.

Strategic Priority 2: Reduce premature mortality

Section	**2.1 Reduce smoking and tobacco use**
Contact(s)	Rod Moore, Public Health Consultant, Leicester City Council

The STOP Smoking Cessation Service transferred to the City Council from 1st April 2015 to strengthen links with other key council services and at the same time maintain partnerships with the wider health community.

The number of quitters at four weeks has continued to fall reflecting changes in smoker's behaviour due to the further impact of e-cigarettes, decline in national messaging regarding quitting smoking and having to address more embedded smoking behaviour as prevalence rates overall have reduced. Note that the final 2015/16 performance data will not be available until later in 2016 (the data submission period closes in June 2016). Despite the fall the Leicester service continues to be among the best at attracting smokers to the service and helping them to quit. Work has continue on the basis of the recovery plan, which included further promotional campaigns. Work has also continued to promote and support smoking cessation with communities, hospitals, primary care, maternity services and other settings. The CCG has funded some additional pilot work in strengthening smoking cessation efforts in UHL, which has been reviewed and is informing developments within the Better care Together Long-term conditions workstream.. Work is also in place supporting improvements to smoking cessation at LPT assisting LPT to address high smoking rates in patients with mental health issues. The service continues to make smoking cessation available to younger smokers and supports work to reduce smoking in pregnancy – where the rates of smoking at time of delivery have fallen, but still slightly above the national average

The service is participating in a National Institute for Health Research (NIHR) clinical trial regarding the

effectiveness of e-cigarettes versus standard NRT and behavioural support. The Royal Society of Public Health has noted the innovative approach of Leicester in addressing and supporting smokers seeking to quit from e-cigarettes. Like other services around the country local targets have been reviewed to reflect the national decline in smoking cessation quits and to identify a set of appropriate targets. The introduction of these has been offset by budget reductions

The Step Right Out Campaign to reduce exposure to second hand smoke in homes and cars continues and has been part of a number of promotional campaigns during the year.

RATING Amber	Some progress has been made but we have not met our expectations.

Section	**2.2 Increase physical activity and healthy weight**
Contact(s)	Jo Atkinson, Public Health Consultant, Leicester City Council

- The Healthy Lifestyles Hub has been rolled out across GP practices in the city, jointly funded by the city council and CCG. Between April 2015 and end March 2016 over 5000 patients have been assessed by the service and referred into appropriate lifestyle services e.g. weight management, exercise referral and the health trainer service.
- The health trainer service (one to one lifestyle advice) continues to operate in the most disadvantaged areas of the city. The service works with 900 people each year to agree a personal health plan (focused on e.g. weight loss, healthy eating, increasing physical activity, increasing self-confidence or reducing alcohol consumption) and provides motivational support to enable people to achieve their goals.
- Adult weight management services continue to be provided across the city, particularly targeting those areas and groups with the highest level of need. Patients referred by their GP can be referred into Weight Watchers. A service is also delivered by Leicestershire Partnership Trust for specific communities with additional needs and for people with other health problems, such as heart disease.
- The Active Lifestyle Scheme continues to see a high level of demand and has a waiting list. The service is being redesigned in order to reduce the waiting list and will give people a wider range of physical activity opportunities to access.
- A review of lifestyle services in the city is currently being undertaken and a new integrated lifestyle service is being developed. The new integrated lifestyle service will launch in 2017.

RATING Amber	Some progress has been made but we have not met our expectations.

Section	**2.3 Reduce Harmful Alcohol Consumption**
Contact(s)	Julie O'Boyle, Consultant in Public Health Chief Inspector Donna Tobin-Davies, Leicestershire Police Karly Thompson, Divisional Director East Midlands Ambulance Service Paul Hebborn, Leicestershire Fire and Rescue Service Justine Denton, Leicester City Council Trading Standards Mike Broster, Head of Licensing Leicester City Council Rachna Vyas, Head of Strategy and Planning, Leicester City CCG

A new model of managing problematic street drinking rolled out from April 2015 has seen a marked decrease in the number of complaints about street drinking, the number of sightings of street drinkers and

the number of recorded incidents on the Police STORM reporting system. An outreach co-ordinator post (funded by the Police and Crime Commissioner through the Safer Leicester Partnership) has been established since the middle of July 2015.

There are ongoing issues relating to the wet centre which if not resolved could have an adverse impact on the progress being made with regard to street drinking.

Treatment services performance has shown a marked improvement with latest figures demonstrating that 35% of alcohol clients are achieving a successful completion (national average 40%)

RATING Green	Good Progress has been made. Our expectations have been met or exceeded

Section	**2.4 Improve the identification and clinical management of cardiovascular disease, respiratory disease and cancer** **3.1 People with long term conditions**
Contact(s)	Hannah Hutchinson, Senior Strategy and Implementation Manager, Leicester City CCG

Context

A key priority for Leicester City CCG is improving long term condition management and the CCG is working closely to with the Better Care Together programme to improve outcomes for patients. Leicester City CCG has the highest CVD premature mortality in the East Midlands and there is still work to be done around stroke admissions and Atrial Fibrillation; those with undiagnosed hypertension and chronic kidney disease prevalence, heart failure and diabetes management. These are being address by the CCG Operational Plan for 2016-2017 but improvements have already taken place in numerous ways to manage patients with LTC. Progress has included:

Clinical Leadership

The CCG invests in clinical leadership across the LTC strategic agenda. A total of 5 GP mentors work across the diabetes and anti-coagulation programmes to support the development, implementation and delivery of the LTC programmes and work to increase prevalence detection and improve quality of care provided to patients.

Cardiovascular Disease Management

A number of inter-dependent developments to improve the clinical outcomes for people with Cardiovascular Disease related conditions have been embedded within primary care since April 2013. These included pathways for atrial fibrillation, heart failure, warfarin management and diabetes.

Atrial Fibrillation and Heart Failure

The ethos of this development is to (i) increase the recorded prevalence in AF and HF, (ii) increase the number of patients diagnosed with AF prescribed anticoagulation therapy in line with NICE and best practice and (iii) increase the number of patients diagnosed with HF being reviewed and therapy optimised in line with best practice.

The programme has demonstrated significant clinical outcomes for patients and reduced clinical variation in general practice, through improving knowledge and skills to detect and diagnose, improving care and outcomes for our patients and reducing avoidable hospital admissions and prevention of strokes. We are working on the prevention of strokes for our local population through identifying patients requiring anticoagulation therapy and initiating the treatment plans. This has been delivered as part of an upskilling package for staff involved in the management of these patients and over 500 clinicians have been trained

in AF, HF, Anticoagulation and Diabetes to support our patients.

The CCG has implemented and trained HCP to use a National Anticoagulation Initiative reporting tool called INR Star. This is being utilised by 52/60 practices and helps to identify populations where strokes can be prevented. The use of this tool and the lives saved from its utilisation resulted in the CCG being the winner of the Excellence in Healthcare Business Analytics EHI award in October 2015 and being shortlisted for finalists at the Healthcare IT Award in December 2015.

Some of the **outcomes and progress** achieved by the CCG to date are:

- 11% reduction in strokes compared to the same time last year (January 2016 data)
- A 50% reduction in cardiac arrhythmia and 13% reduction in heart failure
- An increase in prevalence recorded for AF from 0.97% when the programme started to 1.02% in January 2016
- An increase in prevalence recorded for AF from 0.97% when the programme started to 1.02% in January 2016
- Number of AF patients initiated on an ODI has increased by over 700 since the programme commenced.
- Out of the 52 practices participating the Number and % of AF register patients prescribed anticoagulation therapy has risen from 64% to over 85%

Diabetes

Leicester City CCG has the highest rate of increase in diabetes prevalence in the last five years compared to CCGs in the East Midlands. Approximately one third of all primary care practices have been trained and accredited to deliver enhanced care for complex patients with diabetes to ensure care local to home and out of the acute setting. To support this new pathway, there has been investment in training for all practices for core diabetes skills and an accreditation training package for the primary care providers to be eligible for enhanced diabetes provider status.

Some of the **outcomes and progress** achieved by the CCG to date are:

- Leicester City CCG is the highest achieving CCG in the East Midlands for % of diabetic patients meeting 3 targets – blood pressure, HbA1C and cholesterol.
- Since 1st April 2015 the CCG has seen:
    - An increase in diabetes patients on QoF registers by 752
    - An additional 2795 diabetes patients with a care plan
    - 63 more Housebound patients being managed in the community
    - 257 complex diabetes patients (HbA1c>8%) being managed in primary care
- A procurement has been undertaken to continue to commission diabetes structured patient education which has resulted in Spirit Healthcare offering this provision from April 2016 after Desmond delivered the service throughout 15/16.

Respiratory Disease Management

The CCG has been working with practices to deliver a quality assured COPD detection and diagnostic service. Leicester City CCG has been commissioning a COPD telehealth and health coaching programme. It realised a 72% reduction in the number of emergency admissions for those patients within the service. This offer has now been optimised and through BCT new projects are being commissioned to further improve care for patients through spirometry in primary care and breathlessness clinics at UHL as two examples.

RATING Green	Good Progress has been made. Our expectations have been met or exceeded

Strategic Priority 3: Support independence

Section	3.1 People with long term conditions
Contact(s)	Sarah Prema, Leicester City Clinical Commissioning Group
See 2.4 above	
RATING Green	Good Progress has been made. Our expectations have been met or exceeded

Section	3.2 Older People
Contact(s)	Bev White, Leicester City Council

A successful bid to the Big Lottery brought £5m into Leicester to combat loneliness and isolation in older people. The work is being led by the Leicester Ageing Together Partnership, who are now implementing a programme with 21 projects and 19 providers. National and local evaluation will ultimately inform on-going developments in this important area.

The number of older people who are supported to live at home continues to grow thanks to support received from a range for agencies such as the Royal Voluntary Service's Hospital to Home service, which was funded by the Cabinet Office. This is being considered for on-going funding by the CCG. The Red Cross also have a similar project funded through the Cabinet Office and this has also proven to be successful in enabling people to return home safely.

The City Council continues to offer a range of services that support the independence of older people. These include the increased take up of assistive technology solutions, the further development of extra care housing, commissioning of domiciliary support, low level preventative services such as lunch clubs, community meals and advice and information have been and continue to be well used by older people.

During the period, closer working between adult social care staff and primary care teams has been facilitated through a number of initiatives including Better Care Together and this is resulting in a more enhanced customer focus.

RATING Green	Good Progress has been made. Our expectations have been met or exceeded

Section	3.3 People with Dementia
Contacts	Bev White Leicester City Council Alison Brooks Leicester City CCG

The LLR Joint Dementia Strategy ended in 2014 but implementation continued with the Better Care Together programme picking this up and continuing to make dementia a local priority. The BCT Dementia Delivery Group (DDG) started to meet in early 2016 with a view to refreshing the strategy, agreeing joint priorities and a delivery programme.

Locally diagnosis of dementia in primary and secondary care has continued to increase over the life of this strategy. From a starting point of 65% diagnosis rate it has now risen to 82%. Whilst this is something to celebrate it also brings challenges around capacity of services to respond to this increase but responses to this are being considered by the DDG.

A range of community services have been and continue to be commissioned. These include a hospital support service for which on-going funding is currently being sought, memory cafes and peer support groups, advice, information and advocacy, and training for carers.

Locally a Dementia Action Alliance has been established jointly chaired by Leicester City Council and Leicestershire Police. This brings together a range of stakeholders with the primary aim of making Leicester, Leicestershire and Rutland dementia friendly communities. The Alliance has also been leading on a range of local events to celebrate the annual national dementia awareness week.

Leicester City Council's Dementia Care Advisor service has been and continues to be greatly valued by people living with dementia and their carers for its advice, information and care management service.

RATING Green	Good Progress has been made. Our expectations have been met or exceeded

Section	**3.4 Carers**
Contacts	Bev White, Leicester City Council

Over the life of the strategy, the number of carers assessments carried out has continued to increase overall. The introduction of the Care Act in April 2015 introduced a new carers' assessment form and staff training.

Leicester City Council agreed a Memorandum of Understanding between its adults and children's divisions which clarifies staff roles and responsibilities in cases where young carers are present.

Take up of training by carers has increased over the life of the strategy and this continues to be commissioned in a new carer's service which was implemented in April 2016. This contract also includes advice and information, opportunities for support, including peer support, advocacy and short breaks.

The LLR Joint Carers Strategy continues to be implemented with partner agencies each having their own delivery plan. Oversight of this now comes under the Better Care Together programme and the carers Delivery Group began meeting in early 2016. The strategy will be refreshed once the new National carers' strategy is published.

RATING Green	Good Progress has been made. Our expectations have been met or exceeded

Strategic Priority 4: Improve mental health and emotional resilience

Section	**4.1 Promote the emotional wellbeing of children and young people**
Contacts	Jasmine Murphy, Consultant in Public Health, Leicester City Council Mark Wheatley, Public Health Principal, Leicester City Council

Under *Closing the Gap* the Health and Wellbeing Board held a mental health seminar and workshop. As a result a Mental Health Action Plan was developed, highlighting the importance of protecting childhood mental wellbeing to improve future mental health in Leicester.

These plans are linked to the manifesto pledge to work with partners to ensure an effective Children and Adolescents Mental Health Service for young people in Leicester. Under *Closing the Gap* progress on this work was made in the following ways:

- **Children's Joint Strategic Needs Assessment:** currently in progress.
- **Future in Mind and Transformational Plan :** The report of the Children and Young People's Mental Health and Wellbeing Taskforce to enhance timely access to mental health support for children, young people, parents and carers. Leicester City Council and local Clinical Commissioning Groups are working to improve commissioning and provision of children and young people's mental health services under a local Transformational Plan, with key priority areas including resilience to mental illness, early help and improved CAMHS provision.
- **Improved care for children and young people in mental health crisis:** Health and social care partners have collaborated to develop and implement mental health Crisis Care Concordat Action Plan, including provision of an appropriate place of safety for young people.
- **Work with local schools and other educational settings to promote healthy lifestyles and positive activities:** Encourage use of on-line healthy living and mental wellbeing resources, such as Health for Kids http://www.healthforkids.co.uk/ and Health for Teens http://www.healthforteens.co.uk/; investigate potential mental health promotion activity with local schools.
- **On-line counselling pilot:** Leicester City Council, Leicestershire County Council and local CCGs have commissioned a pilot for on-line counselling for young people through Kooth.

RATING Amber	Some progress has been made but we have not met our expectations

Section	**4.2 Address common mental health problems in adults and mitigate the risks of mental health problems in groups who are particularly vulnerable.**
Contacts	Yasmin Surti, Lead Commissioner Mental Health, Leicester City Council Julie O'Boyle, Consultant in Public Health, Leicester City Council Mark Wheatley, Public Health Principal, Leicester City Council

There has been some progress with improving mental health and emotional resilience under *Closing the Gap*. The Health and Wellbeing Board held a seminar and workshop on mental health, which generated a Mental Health Action Plan to underpin the strategy. As well as providing structure to *Closing the Gap* initiatives, this plan is likely to form the basis of future work on emotional wellbeing.

The general approach has a wider mandate because the work on mental health is linked to manifesto pledges, such as:

- Continuing to promote good mental health and wellbeing through the City Council's public health priorities.
- Ensuring every member of frontline council staff will complete mental health awareness training and autism awareness training.
- Delivering commitments the City Council has made in signing the Local Authorities Mental Health Challenge.

Progress on supporting mental health has been made in the following ways:

- **Promoting key mental health and wellbeing messages, including Five Ways to Wellbeing:** Five ways to wellbeing poster campaign March 2015; Better Care Together (BCT) mental health Resilience and Recovery work plan; Staff wellbeing event May 2015.

- **Challenging stigma and discrimination by promoting Mental Health First Aid (MHFA) in the workplace and in faith groups:** 4 sessions held January-March 2015 in faith groups: Instructor Training Taster Session August 2015; Mental Health First Aid 2 day and half day courses for Leicester City Council staff.
- **Raising awareness of suicide and self-harm risks as part of local Suicide Prevention Strategy and Action Plan:** Suicide Awareness Training and suicide awareness films https://www.youtube.com/user/findinghopeleicester; Real Time Surveillance Pilot for deaths from suicide with Leicestershire Police; work in progress on Zero Suicide Approach with Leicestershire Partnership Trust.
- **Evaluating the impact of the whole Crisis Care pathway for adults, including impact on levels of mental health crisis:** Improve LPT Crisis Team responses times for people in mental health crisis who need urgent care; Refocus role of Community mental health teams by moving stable patients to primary care; Increase capability and capacity of primary care to ensure all Leicester practices can support step down of stable patients from Community Mental Health Teams. Work with partners to develop a Crisis House. Enabling links to the Crisis Care Concordat.
- **Strengthen Voluntary and Community Sector (VCS) role in Recovery Network:** Review existing CCG and Leicester City Council VCS mental health provision, to ensure that the provision reflects the recovery and resilience agenda
- **Strengthen Recovery services:** Agree further Recovery College sites, to include a city centre site; increase VCS involvement to support recovery; review and develop existing social prescribing pilots (Eyres Monsell and 2 county sites); develop proposal for VCS contribution to Recovery Network to reduce pressure on other parts of MH pathway.
- **Accepting the Mental Health Challenge**: Through this Leicester City Council aims to support an integrated approach to mental health care, ensuring that mental wellbeing underpins traditional universal services and encouraging the delivery of a broad spectrum of services across the city and where necessary across the region. This includes a commitment to listen to the concerns of people with mental illness and their carers; protect the mental wellbeing; collaborate in the prevention of mental illness; promote early intervention in mental health and develop personalisation and social care services for people with mental illness.
- **The Joint Specific Needs Assessment on Mental Health** in Leicester was accepted and put onto the Leicester City Council JSNA Website in September 2014.
- **The Joint Commissioning Strategy on Mental Health in Leicester** was developed in the context of *Closing the Gap*, the Joint Specific Needs Assessment on Mental Health and Better Care Together. Leicester City Council (Adult Social Care and Public Health) and Leicester City CCG are working together to deliver the strategy. The strategy covers housing, employment, education, personalisation, transition to adulthood as well as health.
- **Parity of Esteem:** A key element of the work across LLR under BCT to develop parity of esteem between mental and physical health problems. People with mental illness are more at risk of premature mortality than the population generally. It is important that mental and physical health care is integrated at every level, with commissioners working to improve standards of physical health care within mental health facilities and primary care, to ensure earlier diagnosis of illnesses.
- **There have been other important initiatives**, such as the Triage Car, in which the Police and Leicestershire Partnership Trust collaborate to provide alternative care and support for someone with a mental health problem.

RATING Green	Good Progress has been made. Our expectations have been met or exceeded

Section	**4.3 Support people with severe and enduring mental health needs**
Contacts	Sarah Prema, Chief Strategy and Planning Officer, Leicester City CCG

	John Singh, Strategy and Implementation Officer, Leicester City CCG

The BCT Strategy 2014-19 prioritises Mental Health, with an overall aim to improve the acute care pathway, strengthen rehabilitation services and strengthen resilience and recovery support within primary care and community settings.

Some progress has been made against these priorities including:

- Improved response times from crisis and home treatment services (2015)
- Opening of a LLR mental health Crisis House in 2015
- Doubling number of primary care Mental Health Facilitators to support a greater number of number of patients with severe and enduring needs supported within primary care (2015)
- Plans for primary care to support stable patients within primary care rather than secondary care Community Mental Health teams (2016)
- Advanced plans to develop joint health and social care funded locality resilience and recovery hubs (2017)
- More timely recovery by refocusing LPT inpatient rehabilitation services (2014)
- Development of Mental Health First Aid training for professionals, employers, communities and faith groups (ongoing)

However it is acknowledgment more needs to be done particularly in relation to promoting a better understanding of mental health to reduce stigma and improving the acute care pathway associated patient experience. Work will continue to be progressed through:

- The LLR Better Care Together Mental Health Work stream
- Leicester City Joint Mental Health Strategy 2015-2019 (monitored through the Leicester City Mental Health Partnership Board)

Rating Amber	Some progress has been made but we have not met our expectations

Strategic Priority 5: Focus on the wider determinants of health

Section	**5.1 Understand local health inequalities and what is effective in reducing them**
Contacts	Ruth Tennant, Director of Public Health, Leicester City Council Sue Cavill, Public Health, Leicester City Council

Leicester's Joint Strategic Needs Assessment is currently being refreshed and due to be completed in the summer. This will give an updated picture of health and wellbeing in the city and identify specific areas for action. Joint Specific Needs Assessments are also periodically carried out – the most recent is on mental health, and this has provided information for the Health and Wellbeing Board's current focus on mental health. The Board fosters an ongoing debate about what is effective in reducing health inequalities and this helps to develop appropriate programmes of intervention.

The Health and Wellbeing Board also seeks assurance from members (eg Clinical Commissioning Group, NHS England) that their commissioning intentions include Equality Impact Assessments, to ensure that health inequality issues are addressed as part of commissioning planning.

RATING Green	Good Progress has been made. Our expectations have been met or exceeded.

Section	**5.2 Explore with health and social care professionals and wider groups within the city council, the NHS and the voluntary and community sector how to work in a co-ordinated and integrated way to improve health and wellbeing through effective deployment of resources, partnership working, engagement and community development.**
Contacts	Ruth Tennant, Director of Public Health, Leicester City Council Sue Cavill, Public Health, Leicester City Council

The Deputy City Mayor is leading work on further plans to help improve community engagement in implementing the strategy and assessing the equality impacts of decisions.

Since October, Health and Wellbeing Board meetings have included updates from council departments about how they are contributing to the aims of the Health and Wellbeing Strategy in terms of the wider determinants of health. So far this has included: Planning, Transportation and Economic Development; Housing; and Sports, Arts, Culture and Neighbourhoods.

The recent Pharmaceutical Needs Assessment public consultation, which was led by the Health and Wellbeing Board, included engagement with a variety of community groups and their feedback will be incorporated into the final Assessment.

The Joint Strategic Needs Assessment includes engagement with stakeholders representing a wide variety of groups.

The work on the Better Care Fund has involve close partnership working between the City Council's adult social care team and the Clinical Commissioning Group, and this will continue as the measures in the Better Care Fund plan for joint working are implemented.

The Health and Wellbeing Board is continuing with a programme of development sessions which will focus on turn on key priorities, and has so far held two workshops/seminars about mental health, aiming to find opportunities for joint working.

The Board is currently holding a series of development sessions at which members are working on the development of the new Joint Health and Wellbeing Strategy, and this includes consideration of how to involve the public in both plans and future implementation of the strategy.

RATING Green	Good Progress has been made. Our expectations have been met or exceeded.

Section	**5.3 Assess the health/health inequality implications of decisions made that will change service provision to local residents.**
Contacts	Ruth Tennant, Director of Public Health, Leicester City Council Sue Cavill, Public Health, Leicester City Council

The Health and Wellbeing Board seeks assurance from members (eg Clinical Commissioning Group, NHS England) that their commissioning intentions include Equality Impact Assessments, to ensure that health inequality issues are addressed as part of commissioning planning.

The Board carries out engagement with local people and community groups in order to understand

health and health inequality implications of decisions made or planned. Initial engagement on the Joint Strategic Needs Assessment is currently underway. The Board is currently developing a new Joint Health and Wellbeing Strategy and as part of this is seeking new sources of data to understand the impact of the planned strategy on particular groups. This may lead to the Strategy focusing on particular geographical areas of the city.

RATING Green	Good Progress has been made. Our expectations have been met or exceeded.

Section	**5.4 Encourage local professionals to explore with seldom heard and community groups how to improve two way communication, fostering better understanding and leading to improved perceived access to health and social care services.**
Contacts	Ruth Tennant, Director of Public Health, Leicester City Council Sue Cavill, Public Health, Leicester City Council

The engagement and consultation described in connection with 5.1, 5.2 and 5.3 provides information about the perceived communication needs of the seldom heard and community groups which will help foster better relationships and perceived access. More work needs to be done working with all partners in the Health and Wellbeing Board to understand how these perceived communication needs can be met within current financial parameters.

RATING Green	Good Progress has been made. Our expectations have been met or exceeded.

Appendix D

LEICESTER HEALTH AND WELLBEING BOARD

10 OCTOBER 2016

Title of the report:	Joint Strategic Needs Assessment (JSNA) 2016
Author:	Rod Moore, Consultant in Public Health, Leicester City Council
Presenter:	Rod Moore, Consultant in Public Health, Leicester City Council

Purpose of report:

For information - to update the Health and Wellbeing Board on progress on the high-level Joint Strategic Needs Assessment (JSNA) 2016.

Key points to note:

The JSNA 2016 is designed to be predominantly web-based and iterative in nature, with annual reviews of sections planned. It has been produced by a multi-agency team overseen by the JSNA Programme Board.

A summary document, *Snapshots: Health and Wellbeing in Leicester* has been prepared to both accompany the briefings and promote use of the web pages. This is attached as Appendix A. The infographics in the *Snapshots* document will be made available on the web pages for downloading and use in presentations of various types.

The first block of the Adults' section of JSNA 2016 is the final stages of delivery and will be live on the City Council website shortly. Subjects that will be covered in the first block are listed in Appendix B. The web-pages provide a brief summary of the topic (as a web page), links to a further (PDF) briefing on the topic and to links within, and also external to the council, to relevant plans, profiles and data sources. There are introductory pages which explain the purpose and use of the web-pages. The intention is that each section of the JSNA will be reviewed at least annually.

There will further sections published in a second block within 2016/17 and those planned so far for this, are listed in Appendix C.

The Children and Young People's (CYP) section of JSNA 2016 is also nearing completion. It too will be published on the JSNA web-pages. There are nine chapters in this CYP section (see Appendix D). There will be a separate briefing on these sections.

Both the Adults' and Children and Young people's JSNA sections have involved two sets of engagement with stakeholders. Both sets of engagement have been delivered by VAL, following formal procurement.

As further sections are added to the JSNA web-pages the *Snapshots* document will be updated. It is intended that it will retain its 'infographic' approach to presenting information.

Actions required by the Health and Wellbeing Board members:

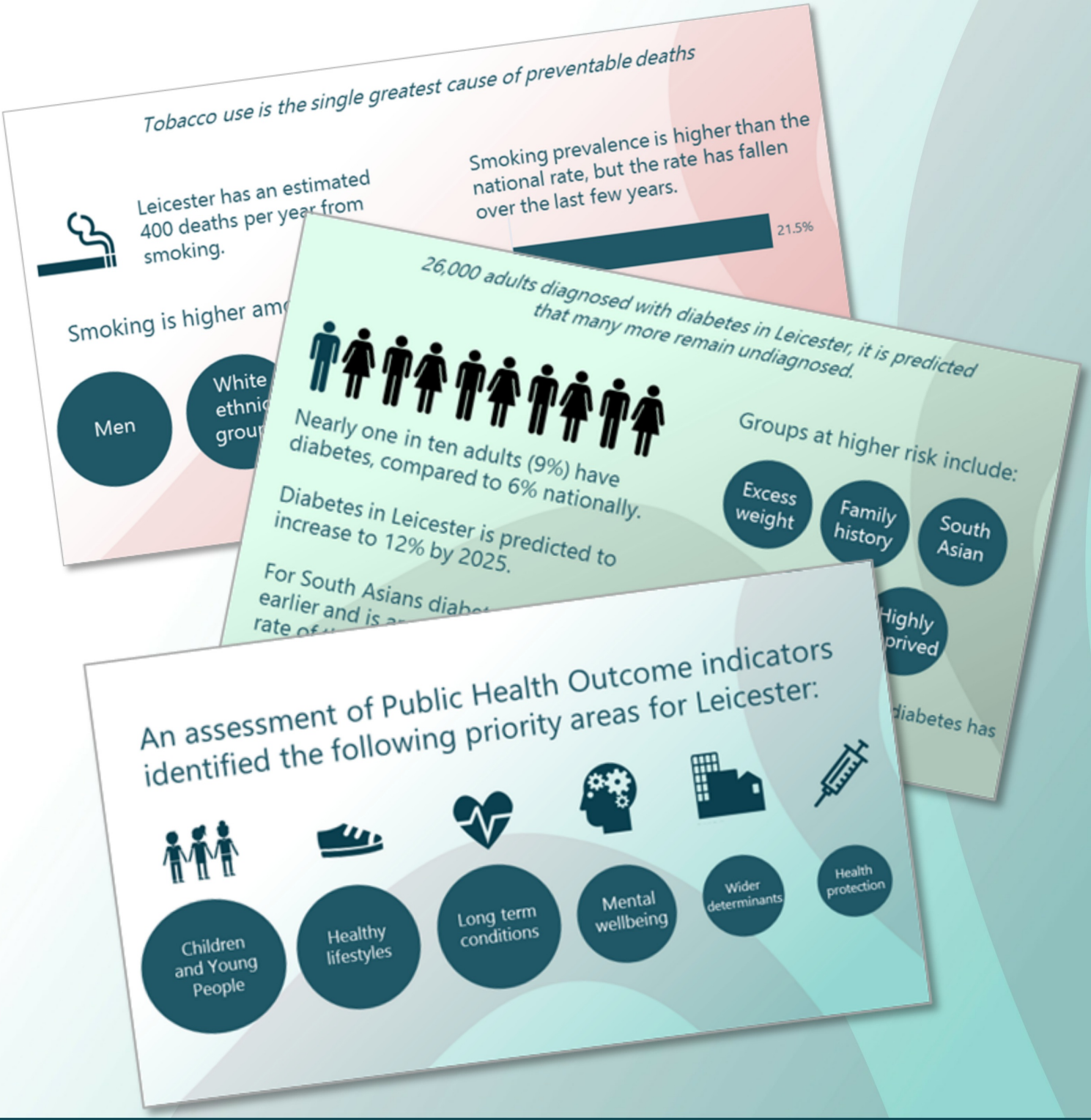
NOTE the progress made and deliverables planned.

Summary of appendices:

Appendix A: *Snapshots: Health and Wellbeing in Leicester*
Appendix B: JSNA 2016 – Adults: Topics in the 1st block
Appendix C: JSNA 2016 – Adults: Topics planned for the 2nd block
Appendix D: JSNA 2016 – Children and young people: section topics

Snapshots:

Health and wellbeing in Leicester



Leicester
Joint Strategic
Needs Assessment
Version 1.0

NHS
Leicester City
Clinical Commissioning Group

Leicester
City Council

JSNA 2016

This short report accompanies the Joint Strategic Needs Assessment (JSNA) pages on the Leicester City Council website www.leicester.gov.uk/JSNA

What's available and why?

The JSNA 2016 is a series of briefings, available at the above web address, which give an overview of topics related to the health and wellbeing of people in Leicester. These briefings are intended as starting points for discussion and consideration which can lead to action. Each briefing provides information on the topic it covers and links to further information, strategies and statistics as appropriate. These links include the more detailed and narrowly focused need assessments (JSpNAs) on specific topics, services, communities or conditions. Beside their relevance to health, social care and public health organisations, it is intended that the briefings will be helpful to those in the voluntary and community sector (and more widely) and supportive of combined efforts to improve health and wellbeing.

These briefings are not therefore a statement of policy of either Leicester City Council or NHS Leicester City Clinical Commissioning Group, or the Leicester Health and Wellbeing Board. The Leicester Health and Wellbeing Strategy presents the priorities for action to improve health and wellbeing which have been approved by the Health and Wellbeing Board and is available from: http://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/health-and-wellbeing-board

Publication

The JSNA 2016 is being put on its web pages in two blocks, the first covering the following.

- Alcohol
- Drugs
- Tobacco
- Obesity
- Sexual health
- Oral health
- Cardiovascular disease
- Diabetes
- Cancer
- Respiratory disease
- Dementia
- Mental health and wellbeing
- Learning disabilities
- End of life care
- Adult social care
- New arrivals

A second block will be added later in 2016 and will include the following.

- Children and young people
- Physical and sensory disabilities
- Physical activity
- Lesbian, gay, bisexual and transgender populations
- Homelessness

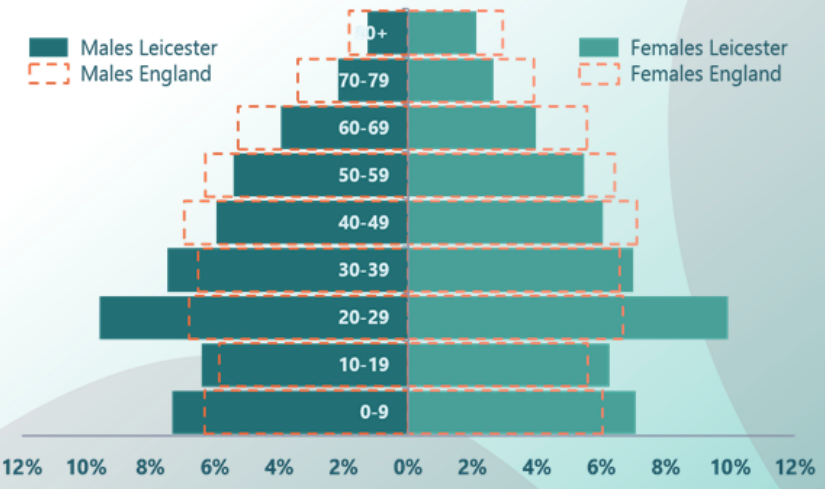
Your feedback is welcomed

The briefings on the web pages, and this document, will be reviewed at least annually and we welcome your comments and suggestions for improvement of specific briefings. Please send your comments to jsna@leicester.gov.uk or telephone 0116 454 2023.

Leicester has a younger age profile when compared to England

Leicester population: 337,653

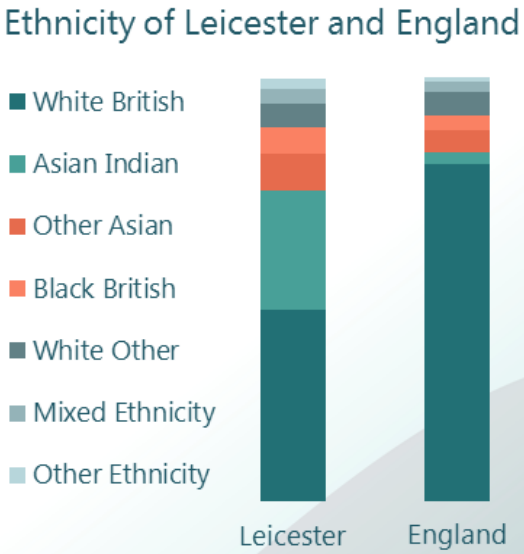
Age	2014	2038
< 19	27%	26%
20-64	61%	58%
65+	12%	16%



The population is forecast to rise at a faster rate than England, reaching 404,000 by 2038.

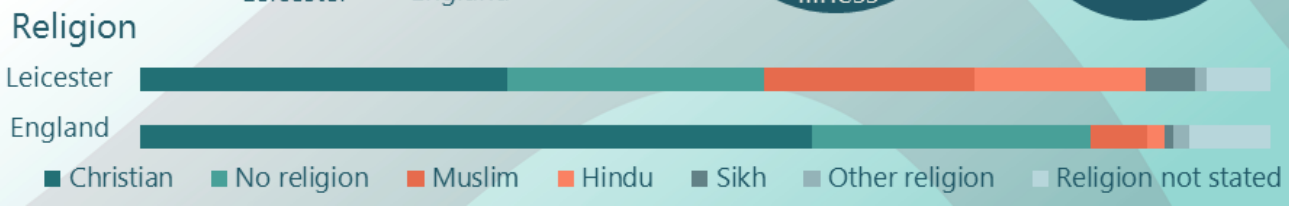
The proportion of people aged over 65 is forecast to increase.

Leicester is diverse

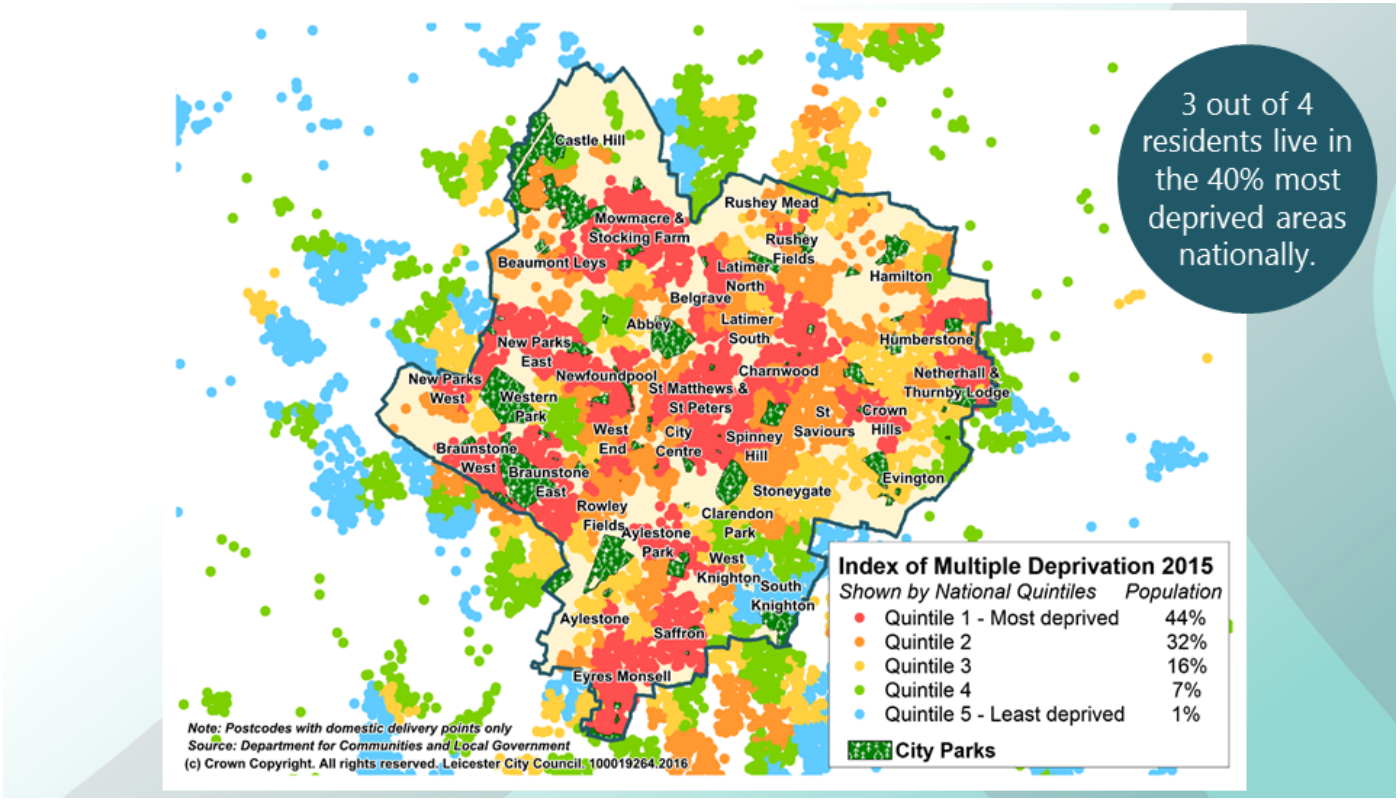


One in four households include someone with a disability or longterm illness

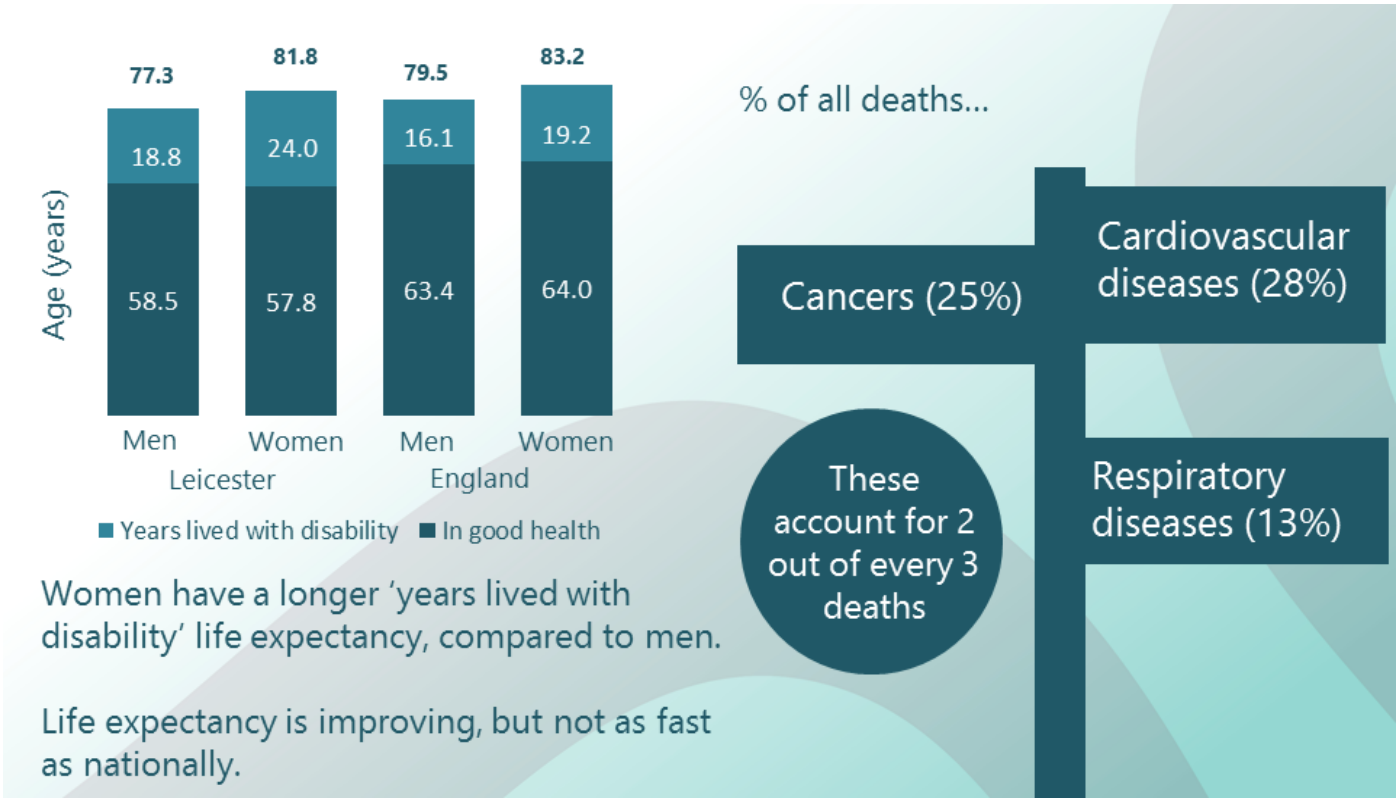
Leicester's LGBT community is estimated at 4%



Leicester has areas of high deprivation



Leicester has a lower healthy life expectancy



Key issues

The key areas for improving health and wellbeing in the city are:

Children and young people. Addressing the health and wellbeing issues faced by children and young people which have a significant impact on all areas of their development and life chances.

Lifestyles and prevention. Addressing the modifiable behaviour (e.g. smoking, poor diet, inactive lifestyle) and beliefs, which increase the likelihood of poorer health and wellbeing, long term conditions, increased use of health and social care services and which can lead to higher risk of premature death in mid- and later life.

Long term conditions. Reducing the impact of chronic health conditions which are, in large part, related to the major causes of early death in the city, through prevention, management and care.

Mental wellbeing. Addressing the actions which support health and wellbeing through the development of personal resilience, the ability to enjoy life and to adapt positively in the face of personal and social adversity.

Wider determinants of health and wellbeing. Addressing factors, beyond individual lifestyles, which drive poorer health and wellbeing and which require solutions based on the organised efforts of the community and wider society.

Health protection. Ensuring that systems which protect the public from threats to their health and wellbeing are in place and are effective.

Overview of briefings available on: www.leicester.gov.uk/jsna

Children and young people

Children and young people under 20 years old make up a quarter of Leicester's population

Over two thirds of Leicester's school children are from minority ethnic backgrounds.

What's going well?	What needs improving?
Higher rates of childhood immunisations	Infant mortality and low birthweight
Higher rates of breastfeeding	Obesity amongst primary school children
Lower hospital admissions for injury, mental health and self-harm	School readiness of children at end of reception

When compared with England

The Children and Young People's JSNA will be released later in 2016.

Lifestyle factors: Tobacco

Tobacco use is the single greatest cause of preventable deaths

Leicester has an estimated 400 deaths per year from smoking.

Smoking prevalence is higher than the national rate, but the rate has fallen over the last few years.

Smoking is higher amongst:

- Men
- White ethnic groups
- Routine & manual workers

The Stop Smoking Service has a higher quit rate than nationally.

Local services include

- Stop Smoking Service aims to support people to stop smoking successfully, which includes targeted support for pregnant smokers and those with infants.
- Other actions include addressing cheap and illicit tobacco, encourage smoke-free homes, provide support to lifelong smokers with long-term conditions, and deliver treatment for smokeless tobacco.

Obesity

Obesity is a high risk factor for type 2 diabetes, stroke, heart disease and cancer

% Excess weight* in adults

% Eating 5 fruit & veg a day

% Exercise for 150 minutes + a week

*Excess weight refers to those overweight or obese

Leicester has a better rate for excess weight but a worse rate for fruit and veg consumption.

The population achieving at least 150 minutes physical activity is worse but improving.

Obesity is higher among:

Women

Black British

35-64 age group

Local services include

- Services include universal services, lifestyle interventions, specialist interventions and bariatric surgery.
- Related lifestyle services include physical activity services in Leicester and the planned Healthy Leicester lifestyle hub.

Alcohol

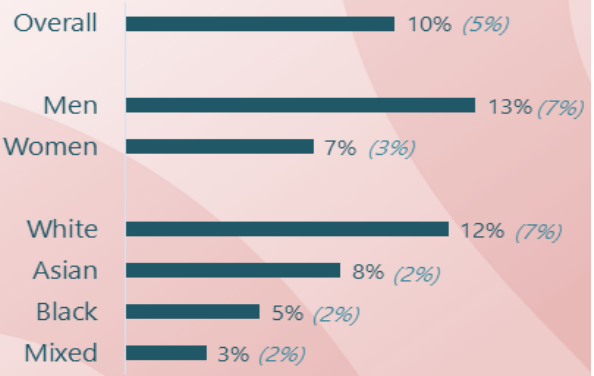
Alcohol misuse is the third biggest lifestyle risk factor after smoking and obesity.

On average, half of Leicester's adult population drink less alcohol than nationally.

Harm is significantly higher than nationally, demonstrated by alcohol related hospital admissions, mortality and crime.

There has been a reduction in hospital admission rates related to alcohol since 2010/11.

% of Leicester adult drinking population drinking above the recommended units *(as a % of all Leicester adults)* :



Local services include

- Awareness raising activities, brief interventions, and specialist treatment and support services.
- Specific services for vulnerable populations such as young people, those with dual diagnosis, treatment resistant drinkers, those in the criminal justice system and those in recovery.

Sexual health

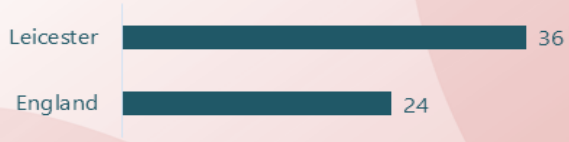
Includes contraception, and testing and treatment of sexually transmitted infections.

The two most common sexually transmitted infections are chlamydia and genital warts.

Those at highest risk of poor sexual health include:

- Men who have sex with men
- Sex workers
- Victims of domestic violence

Higher rate of newly diagnosed HIV cases than England (per 10,000 aged 15-59).



Over half of HIV diagnoses in Leicester are late, but this is improving.

Local services include

- The Integrated Sexual Health Service provides contraception, sexually transmitted infection testing and treatment, outreach work, psychosexual counselling and a young people's service.
- GP's provide contraception, while pharmacies provide free emergency hormonal contraception to under 25s.
- A sexual assault and rape centre is available to support men and women.
- Specific 'at risk' targeted services are also available.

Oral health

Oral health is an integral part of overall health and wellbeing.

Adults in Leicester report significantly poorer oral health than England.

Oral health problems are largely preventable.

Risk factors for oral disease include:

- High frequency of sugar in diet
- Smoking or chewing tobacco
- Excessive consumption of alcohol
- Poor oral hygiene
- Irregular dental attendance

Oral health issues in the city include...

- Higher incidence of oral cancer
- Fewer adults going to dentist
- Lower satisfaction with dental services
- Affordability of NHS dental charges is an issue

Local services include

- Leicester has an oral health promotion service.
- NHS dental practices deliver the majority of oral health services.

Drugs

Drug misuse is responsible for 1 in 7 deaths among people in 20s and 30s (2014)

Leicester has a higher rate than England of Opiate/Cocaine users and only half are in treatment.

Overall, drug use in the population is low and has reduced in the last 10 years.

Successful completion of treatment for both opiate and non opiate drug use is similar to national rates.

Groups more likely to misuse drugs:

- Men
- Younger people
- Mixed ethnicity
- Un-employed

Groups less likely to access treatment:

- Cannabis users
- Prescription drug users
- Younger people
- BME people

Local services include

- A community based service and another for those in the criminal justice system.
- Specialist detoxification and residential rehabilitation for a small number of local users each year.
- A housing related service supports those at risk of homelessness.
- Peer support and mutual aid programmes to encourage healthier lives, and supporting abstinence.

Conditions: Cardiovascular disease (CVD)

CVD include stroke and disorders of the heart, and accounts for a third of all deaths nationally.

Over one in four deaths (28%) are from CVD in Leicester.

About 10,000 people in Leicester have diagnosed coronary heart disease.

4,600 people are recorded as having had a stroke or transient ischaemic attacks (TIA).

CVD is a major contributor to the Leicester and England life expectancy gap.

Risk is higher for:

- Men
- Older people
- BME
- Family history
- Highly deprived

Modifiable risk factors include:

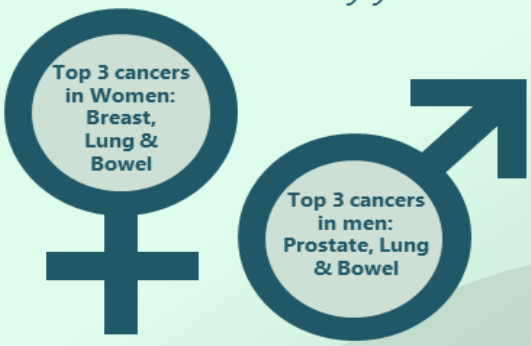
- Poor diet
- Physical inactivity
- Excess weight
- Smoking & alcohol
- Stress

Local services include

- Three main service areas include prevention, early diagnosis and management.
- NHS health checks help ascertain cardiovascular conditions in the 40+ population in Leicester.
- Integrated Cardiovascular Service which develops capability within primary care to seek out, detect, diagnose and treat adult patients who are at higher risk of atrial fibrillation and heart failure.

Cancer

Cancer is the second most common cause of death in Leicester. Every year over 1,100 people are diagnosed.



4,800 cancer patients on GP registers, 1.3% of the population.

Cancer accounts for 25% of all deaths in Leicester and a third of deaths for the under 75s.

Cancer issues in the city include:

- Low survival rates, but rising
- 50% of cancer diagnoses are late
- Uptake of screening is lower than national rates
- Breast and Bowel cancer survival is low

There has been a reduction in cancer mortality rates in under 75s.

Local services include

- Prevention, early diagnosis and treatment are the main focus.
- Prevention activity involves tackling modifiable risks such as smoking and obesity, and raising awareness of non-modifiable risks such as family history.
- Early diagnosis via breast, bowel and cervical cancer screening programmes and GP referrals.

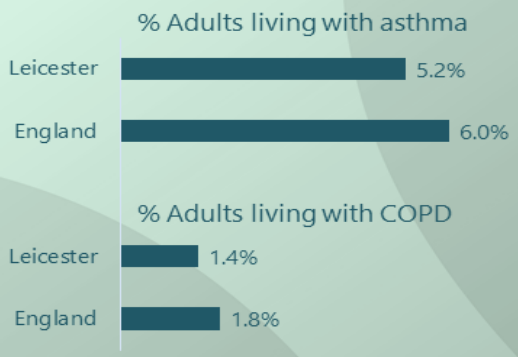
Respiratory disease

1 in 7 in the UK are affected by a respiratory disease, such as chronic obstructive pulmonary disease (COPD) or asthma.

About one in seven deaths (13.7%) are attributed to respiratory diseases.

Asthma affects all ages.

COPD more likely to affect men and the over 40s.



There has been a reduction in the under 75 mortality rate from respiratory disease.

Local services include

- Prevention activity through the Stop Smoking Services.
- Ascertainment involves diagnosis, mainly in primary care, with a focus on detection of chronic obstructive pulmonary disease (COPD) and asthma.
- Specialist nursing service delivered by the local, community trust, serving housebound patients and providing clinics in community hospitals.

Diabetes

26,000 adults diagnosed with diabetes in Leicester, it is predicted that many more remain undiagnosed.

Nearly one in ten adults (9%) have diabetes, compared to 6% nationally.

Diabetes in Leicester is predicted to increase to 12% by 2025.

For South Asians diabetes develops earlier and is around four times the rate of the white population.

Groups at higher risk include:

- Excess weight
- Family history
- South Asian
- Older people
- Highly deprived

Prevalence of recorded diabetes has increased.

Local services include

- GP practices provide diabetes services, a specialist service is offered to those with complex needs.
- Specialist services include in-patient care, insulin pumps, renal, foot, children/adolescents, pregnancy-related, Type 1 and rare/complex diabetes care.
- There are also local health professional and patient educational programmes.

Dementia

Dementia is caused by a number of diseases that affect the brain.

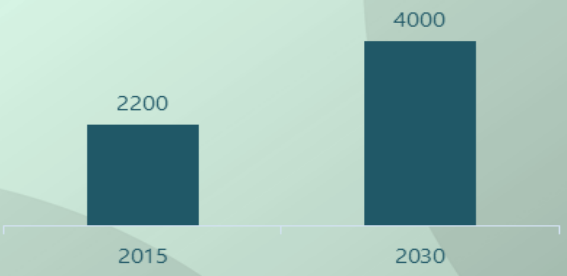
Dementia Friendly

Dementia cases are set to rise in the future, a reflection of our ageing population.

It is important to:

- Diagnose cases early
- Improve support for carers
- Personalise care plans

Diagnosed and expected dementia cases in Leicester



It is expected that there will be 800 new cases a year.

More people over 65 have dementia but younger people get dementia too.

Local services include

- Memory assessment, secondary care at the acute and community trusts, primary and community health and social care services and local nursing and residential homes.
- Increasingly, services are designed on the basis of need, following the patient journey from early diagnosis to end of life care.

Mental health and wellbeing

Common mental health problems are set to increase by 10% over the next 10 years.

18-64 year olds

Over 65 year olds

One in four working age adults and one in ten older people have a common mental health problem.

About 1 in 100 have a serious mental health illness.

Mental health issues in the city include:

- Under diagnosis of depression
- Higher rates of hospital admission for mental illness
- Worse than average outcomes

Local services include

- Service providers include Child and Adolescent Mental Health Services, Open Mind Improving Access to Psychological Therapies, in-patient and specialist mental health services, GPs.
- Services range from initial recognition and assessment, advice, support and treatment of complex disorders.

End of life care

End of life care helps all those with advanced, progressive or incurable illness to live as well as possible until they die.

About three quarters of deaths in Leicester (1,725 - 2,050 people) will require palliative care.

An additional 400 deaths forecast each year, of which 250 may use palliative care services.

Caring for someone can be:

- Physically demanding
- Mentally challenging
- Highly stressful

Patients on the palliative care register with a care plan

70%

Patients with a care plan who died in their preferred place.

88%

Local services include

- Adult end of life care services are distributed across primary and secondary healthcare, local authority adult social care services and the voluntary and independent sectors.
- Community care, supporting people in the last days of life, include specialist palliative care provided by LOROS, the Hospice At Home service delivered by Marie Curie, Macmillan Nurses, LOROS specialist nursing and community nurses.

Learning disabilities

National estimates are that 20 in every 1,000 people have a mild to moderate learning disability with an additional 3-4 people in every 1,000 having severe learning disabilities.

In Leicester, nearly 2,000 people are registered with learning disabilities (LD) through their GP.

However, in 2015 it was estimated that the real figure is over 6,000.

Life expectancy is lower for people with learning disabilities, but increasing.

Prevalence is higher amongst:

- 15-19 year olds
- 40 – 59 year olds
- White ethnic groups

Support available for people with LD to live in their own home

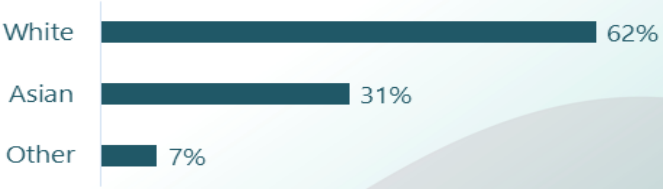
Local services include

• Personalised services, for example, personal budgets, allowing client purchasing of services; different supported living options.
• Employment-Plus, a specific Council-based employment service aimed at supporting people with learning disabilities into employment; health and social care support for transition from children's to adults' services; and support of carers.

Adult social care

Over 5,000 adults receive long term support provided by Leicester City Council

Services are personalised to support independence, and ability to live in own home where possible.



Primary support reasons include:

18-64	65+
• Learning disabilities • Physical support • Mental health	• Physical support • Mental health • Memory/Cognition

Future challenges

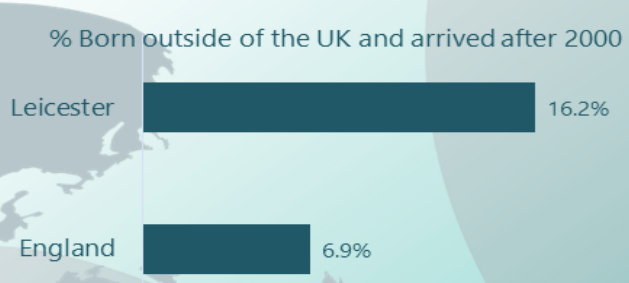
- A reducing budget
- Care Act requires support for carers
- Higher demand for social care support
- Increasing and ageing population

Local services include

• Support for nutritional, personal care, home habitational, social, safety, work, education and training, and caring needs.
• People eligible include older people (65+), people with physical and/or sensory disabilities, learning disabilities, mental health difficulties, HIV/AIDS, drug or alcohol problems; long-term or terminal illness or those caring for people who are in any of these groups.

New arrivals

New arrivals are a substantial mix of populations with differing health and social care needs.



Currently there are about 1,000 asylum seekers in Leicester, and this number is increasing.

The stressful circumstances by which asylum seekers arrive in the UK means that the prevalence of mental ill health is high.

Being younger, healthier, with fewer children, economic migrants tend to be infrequent users of healthcare.

However, the use of emergency care is higher among this group.

Local services include

• Services offer accommodation, emergency support and provisions, support in accessing services, information, advocacy, skills enhancement and training, and particular support to young people, notably unaccompanied young asylum seekers.

Sources

Leicester population	ONS mid-year estimates, 2014, ONS population forecasts (2014 based), Census 2011, Leicester Health and Wellbeing Survey 2015
Leicester deprivation	Department for Communities and Local Government, IMD 2015.
Life expectancy and mortality	Office for National Statistics mortality data 2012-14, Life expectancy and Healthy Life expectancy at birth 2012-2014
Children and Young People	Children's JSNA briefings 2016 (forthcoming)
Tobacco	Local Tobacco Control Profiles, Public Health England (PHE), 2015, Health and Social Care Information Centre: Statistics on Smoking, 2015
Obesity	Active People Survey, Sport England, 2015.
Alcohol	Health and Wellbeing Survey 2015, Local Alcohol Profiles for England: Public Health England 2015
Sexual Health	JSNA online briefing: Sexual health, Sexual and Reproductive Health Profiles: Public Health England, 2015
Oral Health	Leicester Dental Survey 2015
Drugs	Crime Survey for England and Wales 2013/14, Public Health Outcomes Framework Indicators 2015
Diabetes	NHS Quality Outcomes Framework data March 2015, Diabetes prevalence model; Yorkshire and Humber Public Health Observatory
Coronary Heart Disease	NHS Quality Outcomes Framework data March 2015, Public Health Outcomes Framework Indicators 2015
Cardiovascular disease	NHS Quality Outcomes Framework data March 2015, Public Health Outcomes Framework Indicators 2015
Cancer	NHS Quality Outcomes Framework data March 2015, Health and Social Care Information Centre, Office for National Statistics mortality data
Respiratory disease	NHS Quality Outcomes Framework data March 2015, Public Health Outcomes Framework Indicators 2015
Dementia	NHS Quality Outcomes Framework data March 2015, Dementia UK, The full report 2007
Mental health	Projecting Older People Population Information, Projecting Adult Needs and Service Information, http://www.leicester.gov.uk/media/178811/mental-health-jspna.pdf
End of life care	PHE: End of Life Care Profiles, Where people die (1974–2030): past trends, future projections and implications for care B. Gomes and I. Higginson, Palliat Med 2008; 22; 33
Learning disabilities	NHS Quality Outcomes Framework data March 2015, Age-specific standardised mortality rates in people with Learning Disability. Journal of Intellectual Disability Research
Adult Social Care	Leicester City Council, Service data.
New arrivals	ONS Census 2011, Future Vision Coalition, 2009
Infographics	Gurjeet Rajania, Public Health Analyst, Division of Public Health, Leicester City Council and Noun Project.

Stay involved

If you would like to join the JSNA email group and be kept up to date with changes and additions to the JSNA web pages, please contact jsna@leicester.gov.uk

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Appendix B: JSNA 2016 – Adults: Topics in the 1st block

- Lifestyle Factors
    - Alcohol
    - Drugs
    - Tobacco
    - Obesity
    - Sexual health
    - Oral health
- Conditions, Populations and Services
    - Mental Health and wellbeing
    - Dementia
    - Learning disabilities
    - New Arrivals
    - Cardiovascular Disease
    - Diabetes
    - Cancer
    - Respiratory disease
    - End of life care
    - Adult social care

Appendix C: JSNA 2016 – Adults: Topics planned for the 2nd block

- Lifestyle Factors, Conditions, Populations and Services
    - Children and young people
    - Physical and sensory disabilities
    - Physical activity
    - Lesbian, gay, bisexual and transgender (LGBT) populations
    - Homelessness

Appendix D: JSNA 2016 – Children and young people: section topics

- Introduction
- Demography
- Families of interest
- Pre-conception and pregnancy
- Early years (0-4 years)
- School years (5-9 years
- Adolescence (10-14 years)
- Young adulthood (15-19 years)
- Adulthood (20-24 years)