Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **WEDNESDAY, 21 JUNE 2017**
TIME: **5:30 pm**
PLACE: **Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Commission

Councillor Cutkelvin (Chair)
Councillor Fonseca (Vice-Chair)

Councillors Cassidy, Chaplin, Corrall, Dempster and Sangster.

I unallocated Non-Group place.

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

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester

G. J. Carey

For Monitoring Officer

Officer contacts:
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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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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

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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 on the agenda.

3. MEMBERSHIP OF THE COMMISSION

To note the membership of the Commission for the municipal year 2017/18 appointed by the Annual Council meeting on 11 May 2017.

Councillor Cutkelvin– Chair
Councillor Fonseca – Vice-Chair
Councillor Cassidy
Councillor Chaplin
Councillor Corrall
Councillor Dempster
Councillor Sangster

1 unallocated Non-Grouped Place.

4. TERMS OF REFERENCE **Appendix A (Pages 1 - 2)**

To note the Terms of Reference of the Commission to be approved by the Annual Council at its meeting on 11 May 2017.

5. DATES OF COMMISSION MEETINGS

To note the dates for meetings of the Commission for the municipal year 2016/17 approved by the Annual Council meeting on 11 May 2017 as follows:-

Wednesday 23 August 2017
Wednesday 4 October 2017

Wednesday 29 November 2017
Thursday 11 January 2018
Wednesday 7 March 2018

6. MINUTES OF PREVIOUS MEETING **Appendix B (Pages 3 - 18)**

The minutes of the meeting held on 12 April 2017 are attached and the Commission will be asked to confirm them as a correct record.

The minutes can be found on the Council's website at the following link:-

http://www.cabinet.leicester.gov.uk:8071/ieListMeetings.aspx?CId=737&Year=0

7. CHAIR'S ANNOUNCEMENTS

8. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

9. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

10. LIFESTYLE SERVICES REVIEW **Appendix C (Pages 19 - 32)**

The Director of Public Health submits a report on the current range of lifestyle services commissioned or provided by Public Health in the City. There is a national drive towards developing integrated lifestyle or wellness services and significant savings will also need to be made in the 2019/20 budget. Members are asked to comment upon the questions asked in paragraph 3.3 of the report regarding the future direction of lifestyle services and prevention priorities.

11. INFANT MORTALITY IN LEICESTER **Appendix D (Pages 33 - 40)**

The Director of Public Health submits a briefing report that provides an introduction to Infant Mortality in Leicester and summarises the actions being taken to reduce level of infant mortality in Leicester.

12. WORK PROGRAMME **Appendix E (Pages 41 - 44)**

The Chair submits a document that outlines the Health and Wellbeing Scrutiny

Commission's Work Programme for 2017/18. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

13. ANY OTHER URGENT BUSINESS

SCRUTINY COMMITTEES: TERMS OF REFERENCE

INTRODUCTION

Scrutiny Committees hold the executive and partners to account by reviewing and scrutinising policy and practices. Scrutiny Committees will have regard to the Political Conventions and the Scrutiny Operating Protocols and Handbook in fulfilling their work.

The Overview Select Committee and each Scrutiny Commission will perform the role as set out in Article 8 of the Constitution in relation to the functions set out in its Terms of Reference.

Scrutiny Committees may:-

i. review and scrutinise the decisions made by and performance of the City Mayor, Executive, Committees and Council officers both in relation to individual decisions and over time.

ii. develop policy, generate ideas, review and scrutinise the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas.

iii. question the City Mayor, members of the Executive, committees and Directors about their decisions and performance, whether generally in comparison with service plans and targets over a period of time, or in relation to particular decisions, initiatives or projects.

iv. make recommendations to the City Mayor, Executive, committees and the Council arising from the outcome of the scrutiny process.

v. review and scrutinise the performance of other public bodies in the area and invite reports from them by requesting them to address the Scrutiny Committee and local people about their activities and performance; and

vi. question and gather evidence from any person (with their consent).

- **Annual report:** The Overview Select Committee will report annually to Full Council on its work and make recommendations for future work programmes and amended working methods if appropriate. Scrutiny Commissions / committees will report from time to time as appropriate to Council.

The Scrutiny Committees which have currently been established by the Council in accordance with Article 8 of the Constitution are:

- Overview Select Committee (OSC)
- Adult Social Care Scrutiny Commission

- Children, Young People and Schools Scrutiny Commission
- Economic Development, Transport and Tourism Scrutiny Commission
- Health and Wellbeing Scrutiny Commission
- Heritage, Culture, Leisure and Sport Scrutiny Commission
- Housing Scrutiny Commission
- Neighbourhood Services and Community Involvement Scrutiny Commission

SCRUTINY COMMISSIONS

Scrutiny Commissions **will**:

- Be aligned with the appropriate Executive portfolio.
- Normally undertake overview of Executive work, reviewing items for Executive decision where it chooses.
- Engage in policy development within its remit.
- Normally be attended by the relevant Executive Member, who will be a standing invitee.
- Have their own work programme and will make recommendations to the Executive where appropriate.
- Consider requests by the Executive to carry forward items of work and report to the Executive as appropriate.
- Report on their work to Council from time to time as required.
- Be classed as specific Scrutiny Committees in terms of legislation but will refer cross cutting work to the OSC.
- Consider the training requirements of Members who undertake Scrutiny and seek to secure such training as appropriate.

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: WEDNESDAY, 12 APRIL 2017 at 5:30 pm

P R E S E N T :

Councillor Dempster (Chair)

Councillor Chaplin	Councillor Sangster
Councillor Cleaver	Councillor Unsworth

In Attendance:

Councillor Dr Moore

Also Present:

Richard Morris, Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group.

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74. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Cassidy and Fonseca and Karen Chouhan, Chair, Healthwatch Leicester.

75. DECLARATIONS OF INTEREST

Councillor Dempster declared an Other Disclosable Interest in Minute No 83 (University Hospitals of Leicester Quality Accounts) as a patient of the Rheumatology Department UHL.

In accordance with the Council's Code of Conduct the interest was not considered so significant that it was likely to prejudice Councillor Dempster's judgement of the public interest. Councillor Dempster was not, therefore, required to withdraw from the meeting during consideration and discussion on the item.

76. MINUTES OF PREVIOUS MEETINGS

RESOLVED:

that the minutes of the meetings held on 4 January 2017, 2 March 2017 and 29 March 2017 be approved as a correct record.

77. PETITIONS

The Monitoring Officer reported that no petitions had been submitted in accordance with the Council's procedures.

78. CHAIR'S ANNOUNCEMENTS

The Chair announced that arrangements were being made to hold a further meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Meeting in late May. Members would be notified of the date when the arrangements had been finalised.

79. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions or statements of case had been submitted in accordance with the Council's procedures.

Mr David Bradley submitted the following representation:-

"Concerns were raised by myself 12 months ago about the care and treatment of autistic adults in Leicester both in terms of the lack of adequate and appropriate facilities within the NHS and a poorly managed process to return such patients back into the community.

At the time, the previous chair requested a report on the outcome of further discussions on the matter and questioned whether the policy could be changed to improve the care of people diagnosed with Asperger's or autism.

I am aware that a case study has been carried out by Mark Griffiths into particular failings in the CPA process, but I am not aware of any report or policy changes with regard to the care of adults with autism whilst held in hospital where there is a distinct lack of understanding or training in dealing with the complex issues of such cases. I note that the CQC also found deficiencies in providing necessary psychological therapies for such patients.

Similarly I would still like to question the effectiveness of the Care and Treatment Review process in achieving its aims of returning adults with learning disabilities or autism back into the community, where it is painfully obvious that there are not enough specialist residential establishments in Leicester to receive them. The result being that

patients are kept in hospital far longer than is beneficial for their health and wellbeing, or they are transferred out of the region again adding additional cost to their care and treatment.

When will this commission hold LPT to account for not providing appropriate care for autistic adults whilst in recovery and hold Social Services to account for not engaging with health services to prepare and provide appropriate care packages in the community?

I refer the Commission to the Statutory Guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy (March 2015) – page 31 – Local Authorities, NHS bodies with commissioning responsibility should JOINTLY – Develop and update local JOINT commissioning plans for services for adults with autism, based on effective JOINT strategic needs assessment, and review them annually, for example with the local Health and Wellbeing Board."

The Chair stated that the Adult Social Care Scrutiny Commission had considered several reports on Autism at its meeting in December 2016 and would receive a further update in August 2017. A number of issued raised by Mr Bradley were related to NHS issues and NHS colleagues would be asked to respond to them in writing directly to Mr Bradley with a copy to the Commission members.

The Strategic Director of Adult Social Care commented that whilst social services staff engaged in the discharge process, NHS Staff were responsible for taking the lead co-ordinating role for the patient's care whilst they remained in a hospital setting and it was identified that they continued to require clinical treatment or care. Social services could offer advice and guidance but NHS staff determined when a patient should be discharged and whether any social services were required to support the patient after discharge. It was also noted that the Council had planned to use capital monies and right to buy receipts of in the region of £7m last year to build 168 accommodation units to develop supported housing and extra care, which could support patients discharged from hospital. These plans had been put on hold following the Government's announcement that they had suspended the existing policy arrangements regarding the Local Housing Allowance and would be issuing a revised policy. The new policy had yet to be issued. The current indication was that it may be autumn 2018 before a revised policy was issued. This was frustrating to the Council in providing assistance to help people move from acute settings to a supported living setting.

Members commented that the Adult Social Care Scrutiny Commission aimed to make the City 'autistic friendly' and would be disseminating information to staff to increase their knowledge of the issues involved. It was hoped that both Commissions could work together on this topic in the future.

Mr Bradley commented that autism issues fell across many spectrums of service delivery and often fell between gaps in service as a result.

The Chair thanked Mr Bradley for raising the issue again. In addition to asking health colleagues to provide the information requested, the Chair felt that the Commission should write to the 3 City's MPs to raise the housing policy issue in parliament.

AGREED:-

1) That the representatives of the CCG be thanked for their presentation and responses to Members' questions.

2) That the Commission write to the City's MP requesting them to urge the Government to issue the revised policy on the Local Housing Allowance as soon possible.

80. CQC REVIEW OF HEALTH SERVICES FOR LOOKED AFTER CHILDREN AND SAFEGUARDING

Adrian Spanswick, Lead Nurse Adult Safeguarding, Leicester City CCG and Chris West, Director of Quality, Leicester City, CCG gave a presentation on behalf of the Leicester City Clinical Commissioning Group on the CQC review for Looked After Children and Safeguarding.

It was noted that:-

a) The Care Quality Commission (CQC) had undertaken a review of health services for Looked After Children and Safeguarding provision in Leicester City between 8th and 12th February 2016. The review covered services commissioned by both Leicester City Clinical Commissioning Group (CCG) and Leicester City Council. The CQC published its report on 5th August 2016. A copy of the report had previously been distributed to members.

b) The CQC report did not provide a rating, but had made 59 recommendations for improvements in health organisations involved in the review. The CQC had sent a separate letter for the attention of the Council's public health team where areas for improvement related to services provided by the NHS, but were commissioned by the Council,

c) A detailed action plan to address the recommendations in the CQC report had been developed and agreed with local partners involved in the review. Supplementary areas of concern brought to the attention of public health within the Council were not included in the CCG coordinated joint action plan. The action plan was submitted to the CQC on 3rd September 2016.

d) The implementation of the agreed action plan was being monitored by Leicester City CCG, Leicester Safeguarding Children Board (LSCB) with an oversight provided by NHS England. Progress against each recommendation is received from relevant organisations in accordance with a Quarterly reporting schedule.

e) The evidence for each quarter was received by the CCG Hosted Safeguarding Team and scrutinised by the Designated Nurses. Updates had been shared with the Leicester City CCG Governing Body and the Leicester City Children Improvement Board.

f) The CQC Action Plan was divided into 11 sections and attributable to the following organisations:
- Leicester City CCG
- NHS England
- Leicester City Local Authority
- Leicestershire Partnership Trust
- University Hospitals of Leicester NHS Trust
- SSAFA
- Leicester Recovery Partnership
- Staffordshire and Stoke on Trent NHS Partnership Trust

g) The 11 sections in the action plan covered the 59 recommendations highlighted by the CQC. However, there were 172 planned actions identified in the CCG plan to achieve improved outcomes following the CQC review.

h) Significant progress had been made by March 2017 against the delivery of the action plan. This included:
- 143 (of 172) planned actions had been completed.
- 28 planned actions were currently being implemented and were on track.
- 1 action, dependent on national work (Child Protection Information Sharing Project), was currently in progress but behind anticipated delivery.

i) The CCG continued to work with partner organisations to collate evidence of progress against actions relating to each recommendation. This involved detailed confirmation and challenge from the CCG Hosted Safeguarding Team on each provider's submission as part of the CCG quality monitoring process. The Quarter 4 submissions and updates were due to be received in April 2017.

In response to Members' questions the following comments were received:-

a) All evidence submitted as part of the action plan was reviewed with the provider by the quality lead for that action and the Lead Nurse for Adult Safeguarding. The evidence was also reviewed by each work stream and LPT and UHL's internal safeguarding committees and boards.

b) NHS England also had a role in overseeing the action plan and endorsing the improvements achieved against the action plan. In addition, the CQC could also make further planned and unplanned visits which focused attention on achieving the improvements required within the action plan.

c) Some of the services provided were shared with the other 2 CCGS in the LLR footprint and they had yet to be inspected.

d) Domestic Violence was a focus for the Safeguarding arrangements and a Domestic Violence Board was being created which would be chaired by the Police.

e) Each of the organisations involved in the responses to the improvements in the Action Plan had done what they said they would do. However, the CCG as the as safeguard lead, were also asking organisations to identify where further work was required to get better improvements.

f) A number of elements of children's health and wellbeing had been improved to become more resilient. For example a new GP Safeguarding Assurance Tool had been launched on 1 April and the initial feedback from GPs indicating it was working well in referring children to the access team. Phone access was available to respond to those in crisis and referrals could be made where appropriate. All children were now being assessed promptly and the service was committed to providing services to those who needed them most at the earliest possible time.

g) It was acknowledged that some areas were taking too long to achieve required standards. Often there was more than one organisation involved in working together to achieve the improvement. It was felt that the direction of travel in these instances was positive. LPT had made considerable progress in carrying out the Initial Health Assessments with the 13 week target. They were now working to reduce the time between the assessment and subsequent treatment. It should also be recognised that young people often failed to attend their appointments which caused further delays in lost appointments. Further work was needed to understand the reasons for this and to address increased access to the services.

h) Little was currently known about the demographic profiles of young people accessing the services and further work to providing information to determine, age, sex and rural/urban profiles would be helpful.

Members made comments and expressed concerns as follows:-

a) The backlog of children who had been assessed and were still awaiting treatment was still of concern.

b) Providing some support to looked after children after they became adults was considered desirable. Some looked after children still required assurance and support to access public health and GP services after losing the support of their looked after children nurses who helped them to arrange medical and dentists appointment etc. There were many

community/religious groups within communities and neighbourhoods that could provide support and help in these circumstances and it may be that those requiring the services were unaware of the pathways to access them. It was also recognised that many looked after children who had been fostered stayed in touch afterwards and it may only be a minority that felt they needed extra support when they reached adulthood.

c) Members were disappointed they had not been provided with a copy of the Action Plan. Whilst it was recognised that the Action Plan was being monitored by the Safeguarding Children's Board and the Improvement Board; reports made no reference to the involvement of the Council's scrutiny process. It was also felt that officers should involve Scrutiny Chairs (particularly the Chair of the Children, Young Peoples and Schools' Commission) in reports that were submitted to the Improvement Board.

The Strategic Director of Adult Social Care commented that the ongoing issue of providing support to individuals transitioning into adulthood who had traditionally received support from a wide network of services had always been a challenge, as there were inadequate resources to provide any support services post care where there was no ongoing statutory requirement to do so. He supported the suggestion of a community network pathway to offer community and peer support where there was no statutory requirement to provide support.

The Deputy Director of Public Health responded to the Chair's comments in relation to re-commissioning services for schools nurses and health visitors after budgets had been top sliced by a 10% reduction. He noted that this covered costs associated with locating NHS staff in children's centres which needed to be met and indicated that further updates could be submitted to a future meeting after the new Healthy Together programme goes live at the start of July. He also confirmed that the Director of Public Health was committed to ensuring that there was a continual and collective response covering both public health and safeguarding. A copy of the CQC's letter would be provided to the Commission; but it was noted that this letter had not yet been received from the CQC.
AGREED:

1) That the CCG representative be thanked for their attendance and their presentation.

2) That the Children, Young Peoples and Schools Scrutiny Commission and the Health and Wellbeing Scrutiny Commission work jointly to consider the quarterly update reports to satisfy themselves of the progress being made.

3) That a copy of the CQC's letter to the local public health team on services provided by the NHS, but commissioned by the local authority, be forwarded to the Scrutiny Policy Manager and sent

to members of the Children, Young Peoples and Schools and the Health and Wellbeing Scrutiny Commissions once this letter has been received.

81. ADJOURNMENT OF MEETING

At 18.35 pm the Chair adjourned for 10 minutes to enable those officers, councillors and members of the public who had attended for the previous item to leave the meeting.

At 18.45 pm the meeting reconvened with Councillors Dempster, Chaplin, Cleaver, Sangster and Unsworth present.

82. CQC INSPECTIONS OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST 2016

The Commission received a report from the University Hospitals of Leicester NHS Trust (UHL) providing an overview of the outcome of Care Quality Commission (CQC) comprehensive inspection of the Trust.

Julie Smith Director of Nursing UHL NHS Trust and Sharon Hotson Director of Clinical Quality, UHL NHS Trust, attended the meeting to present the report and respond to Member's questions.

It was noted that:-

a) The Inspection took place in June 2016 and the Inspection Report was published on 26 January 2017. The Inspection had been carried out at all 3 UHL sites. The Trust had received an overall rating of 'Requires Improvement'. However, a number of individual practices had been rated as outstanding; including the CHD service at Glenfield. It had also been rated as outstanding in the previous inspection in 2014 and had maintained making many improvements since then.

b) It was considered that good progress had being made in the general direction of travel since 2014 and the Trust acknowledged there was always more to do. There was a positive culture within the Trust and its leadership had made sure that staff knew about the challenges being faced and what was being done to address them.

c) The Trust had made a number of improvements since June 2016 and it had provided evidence to the CQC on these improvements. It was pleasing that the conditions previously imposed on the Trust's licence by the CQC in 2015 had been removed in November 2016.

d) The Trust had been highly praised for 'caring' by staff and there were still challenges around the emergency pathway. The Trust had been praised for its robust plans for the care of deteriorating patients. Sepsis had been an area of considerable focus and challenge and UHL had

made such considerable improvements in responding to the national performance indicators that it had been nominated for a national safety award. The Trust still had many challenges around its aging estate.

e) A Quality Summit had been held on 28 March 2017 and the initial feedback from the CQC indicated that they were satisfied with the progress being made and the Trust was making good progress to meet its aims of being rated 'Good' in future inspections.

Members made the following comments:-

a) It was not helpful when inspection regime criteria changed as this made comparisons with previous inspection reports difficult and the inspection process unsustainable.

b) The comments of 'outstanding' in relation to CHD services were extremely welcome; particularly in the context of the current national review which was seeking to close the service at Glenfield.

c) It was important to remember that the proposals to reduce acute care from 3 to 2 sites would not resolve all issues facing the Trust and the proposal still required public consultation before it could happen.

In response it was noted that:-

a) The new Emergency Department at the Royal Infirmary site was due to open on 26 April 2017 and that should allow considerable improvements to be made within the hospital. It provided a far larger space which should make the hand-over of patients from EMAS far easier and reduce the amount of waiting times of ambulances at the hospital so that they could return to active service much quicker than in recent times.

b) There should also be efficiencies for new models of care with the nearness of other services to the new emergency department. However, demand was still increasing and the department was seeing 200 more patients per day than when work started on building the new facility.

c) Improvements were also being introduce to provide hot food out of regular hours, especially when a patient had missed a meal through going to another appointment in the hospital or their bed had been moved. In some instances staff were feeling empowered to keep patients until they have eaten their meals. The hospital had taken back the provision of meals and different processes were now in place. Further work was being undertaken to see what further improvements could be made within the current financial resources.

The Chair commented that it would be relatively simple with the current inspection regime to concentrate on outliers of poor performance and lose sight of the fact that UHL is one of the largest acute Trusts in the Country facing

huge and complex issues. It was important to focus on the Trust's recognition of the challenges being faced and the steps being taken to address them. 'Requires Improvement' was a disappointing term to use in the current inspection regime when compared to the previous equivalent rating of 'adequate'; which as considered a far less emotive term. At times of rising need and lack of resources, 'adequate' could be considered to be good enough. 4 NHS Trusts had been placed in special measures during the week and the performance 'bar' was constantly moving which was not considered to be helpful.

It was felt the Trust could do more to engage with the public on the possible reduction from 3 acute sites to 2. People generally became concerned when there were proposals to 'close' facilities but if the transfer of services led to better and improved care, then this needed to be clearly explained in the communications strategy for the proposal.

AGREED:

1) That the representatives of the UHL be thanked for their report and response to Members' questions

2) That a further report providing an update on the improvement under the Action Plan be submitted in a year's time together with a commentary of any barriers that have hindered progress.

83. UNIVERSITY HOSPITALS OF LEICESTER QUALITY ACCOUNTS

The University Hospitals of Leicester NHS Trust submitted a report on the Draft Quality Account for 2016/17. The Commission was invited to review the draft Quality Account and provide feedback by Monday 1 May 2017, as part of the statutory Quality Account process.

The Chair commented that it was not an easy report to read and suggested that in future years council officers could give advice on style and format for a covering report so that it would be more meaningful for Members to make comments. It was fully recognised that the current report was written to an NHS formula.

In response it was stated that:-

a) The structure of the report was pre-scripted by a NHS toolkit. Trusts had asked for some time for it to be written in a more relaxed style because it was recognised that it was not an easy format to be readily understood by the public. The Trust was in the process of preparing a more accessible and easier to read report for the public.

b) Any response from the Council had to be included in its entirety (unedited) in the comments section of the report. The Council could comment on any item in the report or on any other issues which were of concern to the Council.

c) Comments made in previous years had been taken into account in the production of this year's report but there were still difficulties in presenting the quality matrix in an easier format.

d) The report provided an account of the Trust's performance to the public, its partners and its Board. It was intended to reflect upon the quality of services provided but it should also provide a balanced picture to include and recognise the challenges being faced, together with commentary on the improvements the Trust wished to achieve in the following year. It was particularly pleasing that the Trust performance on infection control was one of the best nationally. There were still challenges to be faced especially around capacity and the Emergency Department but there were plans to achieve improvement.

e) The final draft would be submitted to the Trust's Board in June, following the inclusion of comments received and then it would be audited by the KPMG for quality assurance against the NHS checklist and data requirements.

AGREED:

That the draft Quality Accounts be received and that the Chair of the Commission be given delegated authority in conjunction with the Scrutiny Policy Manager to prepare a response to the draft Quality Accounts and circulate it to members of the Commission for comment prior to them being submitted to UHL.

84. SHARED CARE AGREEMENTS

The Leicester City Clinical Commissioning Group submitted a report on Shared Care Agreements. Dr Danahar, GP Lead for Prescribing and Lesley Gant, Head of Medicines Optimization attended the meeting to present the report and respond to members' questions.

It was noted that:-

a) Shared Care Agreements (SCAs) aimed to facilitate the seamless transfer of an individual patient from secondary care to general practice to allow patients with complex conditions and drugs treatment regimes to be cared for closer to home. The full range of medical conditions where SCAs could be used were outlined in the report.

b) The process and monitoring requirements surrounding SCAs were robust and provided safeguards for the patient. An SCA was an agreement and, if the patient's GP agreed to take on the care in the agreement, the shared care arrangements would start and monitoring would take place between the GP and the secondary care commissioners via e-mail. Not all GP practices accepted SCA's and where this was refused by the GP, the patient's care continued to be

provided by the secondary care sector. In these instances the CCG worked with the GP to provide support aimed at enabling the GP to work towards accepting SCA's in the future. From October to December 2016 103 SCA's had been refused by GPs in the LLR area. The refusal in the City was approximately a third of the total refusals and this equated, on average, to less that I per practice per quarter. More than half of the refusals by GPs were of a temporary nature until further support or training could be provided. It was thought that the total number of refusals not accepted altogether was in the region of 40 for the quarter.

In response to Members' questions the following responses were received:-

a) In instances where the SCA was refused by the GP, the secondary care commissioner would try to resolve the issues. The responsibility for the patient's care would remain with the specialist practitioner in the secondary care sector. Very few SCA's involved patients who were already in hospital, so this did not impact directly upon patients' length of stay in hospital. A number of SCA's involved patients with rheumatoid conditions and GP's would monitor any side effects the patient may have to the medication they received and would discuss changes to the medication with the specialist practitioner where appropriate.

b) Should a GP practice close the patient could transfer to another practice, which could then consider taking over the patient's SCA. If not then the patient's care would revert to the secondary care specialist.

c) The secondary care specialist would first discuss the possible use of an SCA with a patient before any referral was made to a GP. If a patient refused to have treatment in a safe environment then the treatment could be withdrawn. Equally if the patient did not fully comply with the monitoring arrangements with the GP then this would be flagged on the system and the patient would be called in for testing and monitoring on a quarterly basis.

d) Approximately 2,500 SCA's were agreed in a year compared to the 120 overall refusals in a year.

e) The responsibility for the patient's care rested solely with the secondary care clinician until a GP took on the responsibility for the patient's care under the SCA.

Members felt that many patients did not fully understand the process and suggested that it would be helpful if the CCG provided patients with FAQ sheet to explain the pathways involved in the process and to provide contact details in the event that there problems are encountered in the pathway.

The Head of Medicines Optimization stated that the CCG would look into specific cases where patient's felt there was an issue with SCAs and invited Members to provide details of any known cases after the meeting.

AGREED:

1) That the report be received and the CCG representatives be thanked for their presentation on the report.

2) That the CCG consider providing patients with a FAQ sheet to explain the pathways involved in the process and to provide contact details in the event that problems are encountered in the pathway.

85. ORAL HEALTH UPDATE

The Director of Public Health submitted a report providing an update in Oral Health in Leicester. Tiffany Burch, Specialty Registrar Public Health, presented the report and responded to members questions.

During the presentation of the report the following comments were noted:-

a) Since the introduction of the Oral Health Promotion Strategy 2014-17, the Council had made dramatic improvements in the oral health of 5 year olds. The intention of the strategy was to see a 10% increase in the number of 5 year olds who were decay free by 2019. At the time the strategy was launched, the Council had the worst performance in the county. Dental health survey results released by Public Health England in May 2016 showed an 8% improvement in just 2 years moving the Council from bottom to 4th worst performer in country. The scale of the improvements would normally be expected to take much longer to achieve. It was hoped that the initial target of 10% improvement would be achieved when the next survey results were released in 2017.

b) The Council had received an award from the Royal Society of Public Health for its programme of oral health improvement and the Chief Dental Officer was also looking at how the Leicester model could be fed into a national programme.

c) 18 primary schools, 84 nursery and playgroups and I special school were now participating in the Supervised Brushing programme.

d) 50,000 Oral Health Resources Packs (free toothbrushes and toothpaste) had been distributed in the last two years by schools, Health Visitors, Family Nurses Partnership and Travelling Families Team.

e) The supervised toothbrushing pilot for special schools carried out at Ellesmere College had now been completed and the Happy Teeth Happy Smiles Team were using the success of the pilot to roll out the programme to other special schools.

f) 4 dental practices have received the Happy Teeth Happy Smiles accreditation with a further practice close to accreditation.

g) Staff were working with the Leicester Pharmaceutical Committee to incorporate oral health in the Healthy Living Pharmacy Accreditation Scheme.

h) The use of social media had been found to be highly successful and would continue to be used.

Members welcomed the improvement achieved in such a relatively short space of time and made the following suggestions to continue the good progress made:-

a) The Oral Health Resource Pack could be included in the food bank distribution.

b) Consideration should be given to running Supervised Toothbrushing at Community Centres during school holiday periods so that parents can be involved with their children.

c) Consider attending a street party for children being organised in Highfields on 12 August 2017.

d) Consider contacting working men's clubs in the city as most club committees work with families and encourage them to use the clubs.

The Chair commented that she hoped there would be no budget cuts to oral health budget as it needed to be increased by inflation to keep on track. It was important to maintain funding as significant improvements had been made but there was still much more to achieve.

AGREED:

That the report be received and all staff involved be congratulated in helping to make the considerable improvements the oral health of 5 year olds in such a relatively short timescale.

86. WORK PROGRAMME

The Scrutiny Support Officer submitted a document that outlined the Health and Wellbeing Scrutiny Commission's Work Programme for 2014/15.

AGREED:

That the Work Programme be noted and that the suggestion of adding autism to the Work Programme and also working jointly with the Adult Social Care Scrutiny Commission on this be noted.

87. CLOSE OF MEETING

The Chair closed the meeting at 8.06 pm.

APPENDIX C

Health Overview and Scrutiny

Date:
21st June 2017

Title: Lifestyle Services Review: Background

Lead director: Ruth Tennant Director of Public Health

City Mayor

Useful information

- Ward(s) affected: All
- Report author: Jo Atkinson, Public Health Consultant
- Author contact details: Jo.Atkinson@leicester.gov.uk
- Report version number: 1

1. Summary

The city council funds a range of public health services as part of its responsibility to improve health in the city. This includes a number of lifestyle services, including stop smoking, weight management and physical activity programmes. These services account for around 11% of divisional spend or £2 million each year. A rolling programme of review of public health services is underway. This includes a review of lifestyle services which is the focus of this paper.

Leicester has high levels of disease related to lifestyle factors e.g. cardiovascular disease and respiratory disease. Levels of smoking, physical inactivity and poor diet are also high. There is clear evidence that outlines the health (and other) benefits of stopping smoking, increasing physical activity, eating healthily and losing weight. There is also research evidence behind many interventions aimed at supporting people to stop smoking, lose weight and increase physical activity levels.

A range of lifestyle services are commissioned or provided by public health in the city. Nationally there is a drive towards developing integrated lifestyle services or wellness services. This is recognition of the fact that many people do not have only one risk factor for developing poor health but have multiple risk factors. In addition, integrated services are expected to be more efficient.

A further context for the discussion regarding lifestyle services is the need to make significant savings to this budget by 2019/20. Debate is therefore needed to inform the decision making about where savings are made, the scope of the new integrated service and prevention priorities.

2. Recommendations

To consider the information presented about the current lifestyle services provided in the city and the savings to be made by 2019/20.

To consider the questions posed at the end of the report regarding the future direction of lifestyle services and prevention priorities.

3. Supporting information

3.1 Background

3.1.1 Context

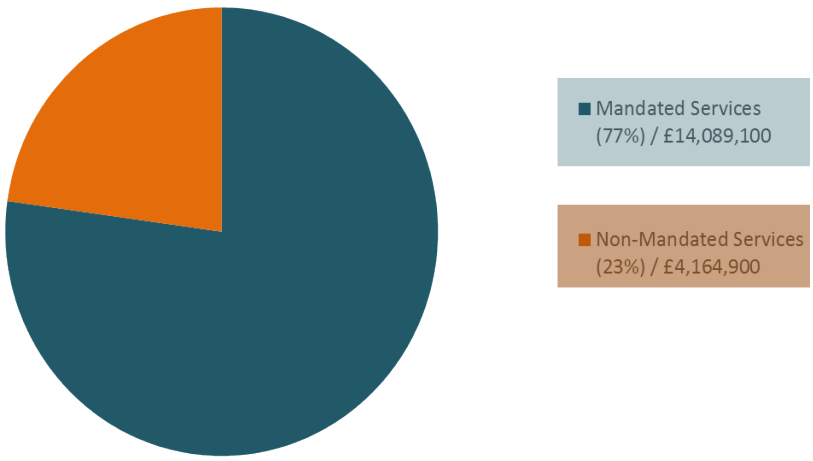
Since 2012 local councils have had a responsibility to take steps to improve and protect public health with a grant given to all upper tier councils to support this. Certain responsibilities are mandated:

- Open access sexual health services, including contraception
- Elements of the 0-19 Healthy Child Programme, which includes the city's health visiting & school nursing service and the national child weight management programme.
- The NHS Health-checks programme which screens adults for preventable illnesses including heart disease and diabetes.
- Oral health prevention and promotion
- Taking steps to protect the health of the public

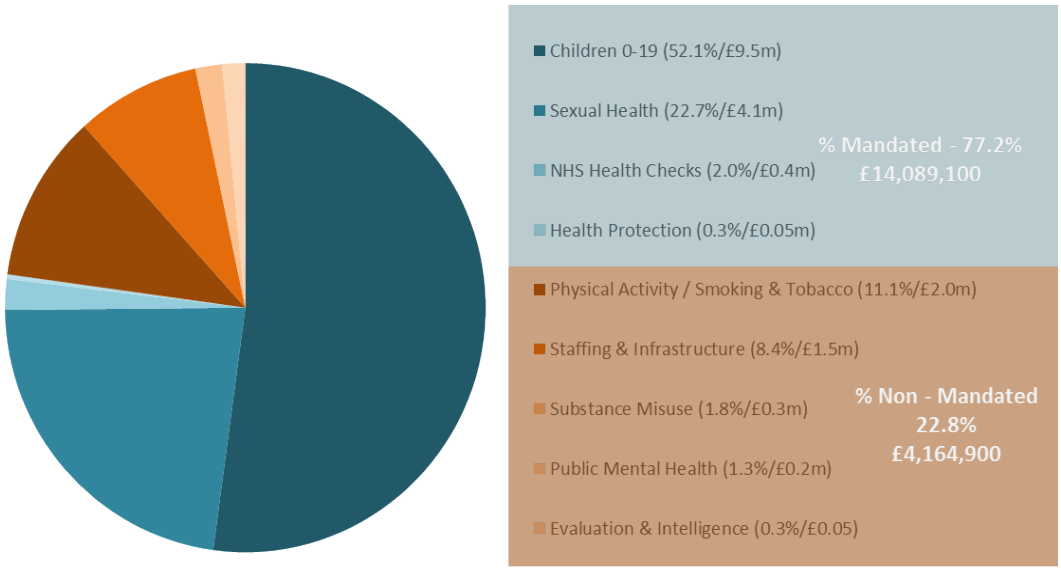
Other services are not mandated but councils are expected to demonstrate how they are using the grant to improve health outcomes locally and to report spend against a number of key areas including physical activity, obesity, smoking and mental health. Drug and alcohol treatment services are not mandated but councils are expected to consider the number of people using these services and local recovery rates in determining how the grant is used.

In 2016/17, mandated services accounted for 77% of divisional spend, or £15.3 million with non-mandated services costing £4.5 million (see table below). The council also spends a further £5.2 million on drugs and alcohol services (within Adult Social Care) and £3.4 million on sports and leisure service which has recently been brought under the Division of Public Health.

Mandated and non-mandated service spend



Spend by service area



This chart shows how spend is allocated to specific services. Lifestyle services (which includes services to reduce obesity, smoking and increase physical activity) accounts for 11% of divisional spend or just over £2 million each year in 2017/18.

Public Health Spending Reviews

Since May 2015, when in-year cuts to the public health grant were announced, there has been an annual reduction in the grant allocation. To meet this, there has been a rolling programme of spending reviews of public health services to achieve efficiencies (see below) across these services and to make sure that money is spent in a way that reflects the specific health challenges in the city and complies with statutory responsibilities.

Service area	Review
NHS Health-checks	Reviewed in 2017
Children's 0-19 services	Review in 2016: new service goes live July 2017
Drugs and alcohol (ASC)	Reviewed in 2015. New service went live in 2016.
Organisational Review of divisional staffing	Completed in March 2017
Sexual Health services	Review underway: new service to be recommissioned in January 2018.
Lifestyle services	Review underway

The rest of this paper focuses on our current lifestyle services.

3.1.1 Lifestyle services: the case for investment

Life expectancy, in particular, healthy life expectancy is significantly lower in Leicester than in England. Overall life expectancy for women is 81.8 years but only 57.8 years are spent in good health, compared with 64 years in England. Men live on average 77.3 years with 58.5 years spent in good health, compared with 63.4 years nationally.

Leicester has high levels of disease related to lifestyle factors e.g. cardiovascular disease, respiratory disease and diabetes. Estimates of the number of Leicester residents who have unhealthy lifestyle behaviours suggest that the situation is worse in Leicester compared to the national average for England. 21.5% of adults in Leicester smoke, 20% are obese and over 30% are inactive.

Tobacco use is the single greatest cause of preventable deaths in England. Half of regular smokers are killed by tobacco and half of these will die before the age of 70, losing an average 10 years of life. Obesity is a major public health issue and is associated with a range of health problems including type 2 diabetes, cardiovascular disease and cancer. Diet has a wider impact on health than the link with obesity. Even in the absence of obesity a poor diet is linked with a range of diseases including heart disease, strokes and some cancers. Oral health is also associated with diet. Physical inactivity is known to be the fourth leading cause of global mortality. In the UK, physical inactivity has been attributed to 11% of coronary heart disease cases, 19% of colon cancer cases, 18% of breast cancer cases, 13% of type 2 diabetes cases and 17% of premature all-cause mortality.

There are significant health inequalities in relation to smoking, obesity, physical inactivity and diet according to age, gender, ethnicity and socio-economic status. In particular, those living in the most disadvantaged areas have higher levels of smoking and obesity, are more likely to be inactive and have poorer diets.

There is a clear evidence base that outlines the health and wider benefits of stopping smoking, increasing physical activity, eating healthily and losing weight. There is also research evidence behind many interventions aimed at supporting people to stop smoking, lose weight and increase physical activity levels.

Poor health resulting from smoking, obesity and inactivity impacts not only on length of life but also length of healthy life. This translates into costs not only for the NHS but also ultimately for adult social care. Leicester has a younger care home population than in the rest of the country and preventable long-term conditions such as diabetes, COPD and CVD are more common in care home residents.

Lifestyle services are just one part of a complex picture about what needs to be done to improve people's health. National policy (such as the Sugar Tax, plain packaging for cigarettes and fiscal policy such as alcohol duty or taxes on cigarettes) is key. Patterns laid down at home or at school in the early years are also crucial. Making environments healthy – for example, through smoke-free hospitals, promoting healthier schools or encouraging people to use parks and open spaces to get more active is crucial and is an important part of the division's work programme, working with other parts of the council. People are aware of the health risks of smoking, obesity and physical inactivity, and many will make positive changes without external support.

But we also know that healthy behaviours tend to get picked up quicker by people in more affluent areas. For example, smoking rates have dropped faster in higher social groups and have remained much more static in lower socio-economic groups. The effect of this is to widen the health gap between social classes, placing further strains on other services including social care.

To address this, the lifestyle services and programmes that the city currently provides

focus on people who need this support most and are, in most cases, heavily targeted on people living in the more deprived parts of the city.

3.1.2 Lifestyle Services: what do we provide?

Our lifestyle services include smoking cessation, weight management, an exercise referral scheme, health trainer services and a healthy lifestyle hub. Although there is communication and some referral between services, integration is fairly limited. The first stage to address this has been the development of the healthy lifestyles hub which started delivering fully in April 2015. Nationally there is a drive towards developing integrated lifestyle services or wellness services. This is recognition of the fact that many people do not have only one risk factor for developing poor health but have multiple risk factors e.g. they smoke, drink excessively, have a poor diet and are inactive.

The review of lifestyle services needs to be considered within the context of a significant savings targets across the council and within the division. This includes a spending review target against these services of around half the current budget.

3.2 Current performance of lifestyle services

Smoking Cessation Services (Stop) (provider- public health, LCC)
(£970k, year)

The service

The service focuses on the following:

- providing an effective smoking cessation service particularly targeting those from disadvantaged communities, pregnant women and other vulnerable groups
- protecting children and young people from the impact of smoking through its smoke free homes work
- providing leadership to the tobacco control agenda in the city

The Stop Smoking Service offers proven behavioural support and medication to help smokers quit smoking. The length of treatment is 12 weeks and clients are encouraged to attend weekly/ fortnightly appointments with a specialist advisor for the duration of their treatment. This service is also offered by16 pharmacies and 6 practice nurses that are trained and supported by the Stop Smoking Service.

A new less intensive service has been piloted in workplaces whereby clients are seen face to face at the assessment and offered nicotine replacement therapy or other support and then followed up at 4 weeks. This is working well particularly amongst those using e-cigarettes as their chosen aid to quitting.

Tobacco Control

The service carries out work with a wide range of settings and staffing groups to support them to reduce smoking rates. For example, stop smoking advisors support many settings e.g. UHL, LPT and care homes to develop smoking policies and become smokefree. Training is provided to help staff to give brief advice to smokers that they come into contact with and encourage them to stop and to accept referral into smoking cessation services.

A comprehensive smokefree homes programme has been developed in the city, led by

the smoking cessation team, with a range of partners involved e.g. children's centres, midwives, health visitors and the neonatal unit. The programme aims to raise awareness about the dangers of second hand smoke and to encourage people to sign up to a 'Step Right Out' pledge to keep their home smokefree for the benefit of family health.

The team carry out extensive marketing and awareness-raising regarding the consequences of smoking and offer support for smokers who wish to quit.

Performance

3718 smokers in Leicester set a quit date with Stop in 2015/16. Numbers using the service have risen from around 4,200 in 2006/07 to a peak of nearly 6,200 in 2011/12 but there has been a decline more recently primarily as a result of the increased use of e-cigarettes. Leicester achieves higher quit rates than many of our comparator authorities with 52% quitting at 4 weeks.

Smoking services have differing approaches to engagement. Leicester's service aims to engage as many smokers as possible even if a proportion of them do not seem highly motivated to quit initially. A high number of people set a quit date per 100,000 population and the number of successful quitters per 100,000 population is the highest amongst our comparator authorities. Some other smoking cessation services will only engage with clients that are very highly motivated to quit and may therefore achieve high quit rates but do not achieve as high number of quitters per 100,000 population. It is estimated that the service engages nearly 7% of Leicester smokers per year to set a quit date, anything over 5% is considered good penetration of the smoking population.

A Health Equity Audit of the smoking cessation service is undertaken regularly, this enables the service to review how effectively they are reaching their target population. The last audit has shown that the service is successfully targeting the most deprived areas of the city with the majority (87%) of clients coming from the most deprived areas of the city. The white population have the highest uptake of the service with 8% of white smokers setting a quit date. The lowest uptake of the service is found in Mixed and Black ethnic groups. The 4 week quit rate amongst BME groups however has increased considerably between 2014/15 and 2015/16 from 49% to 56%.

The smoking service sees over 200 pregnant women per year and achieves a quit rate of nearly 45%, comparable to the national average.

Leicester's service costs approximately £409 per quitter, which is lower than the East Midlands and national average.

The Stop Service has been accredited by the NCSCT (National Centre for Smoking Cessation and Training) which is a marker of quality. This confirms that interventions offered are based on the current evidence base and that staff are appropriately trained and supervised.

The service is providing leadership to other smoking cessation services on the use of e-cigarettes, including an understanding that e-cigarettes can be used both for harm reduction and abstention. Stop is currently one of three services involved in a research trial of e-cigarettes, with more participation in research planned.

In relation to the Smokefree Homes programme, nearly 9000 people have pledged to make their homes smokefree and nearly 1800 frontline staff have been trained to deliver the message. An independent evaluation was carried out which reported that

the Step Right Out campaign was achievable for those signing up and motivated the majority of individuals (over 80%) who previously allowed smoking in their home, to stick to the pledge to keep them smokefree.

Healthy Lifestyles Hub (provider – Parkwood Healthcare Ltd)
(up to 400k/ year)

The service

The Healthy Lifestyle Hub consists of telephone-based assessment and advice from which clients can then be referred on to the appropriate lifestyle support service. Clients in need of support to address lifestyle risk factors (including smoking, poor diet, physical inactivity, alcohol misuse and obesity) will be referred to the hub by GPs, and other health and social care professionals. Appropriately trained staff assess the needs of each client, provide motivational support, identify key health goals and refer/ signpost clients into relevant lifestyle services. The hub has been running fully for nearly 2 years, but ran as a pilot for over a year prior to this. The hub is partly funded by the local NHS.

Performance

Over 5000 referrals per year are made to the healthy lifestyles hub, the majority of which are made by practice nurses in GP practices. Since the contract started in April 2015 the service has worked hard to engage with GPs and other relevant organisations in order to ensure appropriate referrals. The service has ensured appropriate uptake of the service from clients in the most disadvantaged areas, BME groups and men. The hub refers over 80% of clients to at least one lifestyle service.

Health trainer service – (provider – Parkwood Healthcare Ltd)

The Health Trainer service provides a more intensive support service for clients who need additional help to achieve and support behavioural change. If it is apparent during the initial contact, or at the 6 week follow up, that the client requires additional support, a referral to the Health Trainer service can be made for those clients that meet the eligibility criteria. In order to be eligible people must come from one of the most disadvantaged areas of the city and have multiple and complex risk factors that require more intensive support to address. Health trainers should come from the local communities, they are “lay workers” often without qualifications but are trained for approximately 6 months in order to carry out the role.

Health Trainers take their clients through a staged process: lifestyle assessment, decision making and goal setting, personal health planning, referral and review. The minimum period of contact agreed with an individual client will be three months and the maximum period should be 12 months. A maximum of 6 ‘contacts’ per client is recommended as the purpose of the health Trainer Service is to encourage independence. The most common reasons for accessing the service are to improve diet, increase physical activity and lose weight.

Performance

The health trainer service has been running in Leicester since 2010 and was formally evaluated in 2013. The service was meeting its targets and out-performing the national data set. Economic analysis of the service suggested that the service was cost-

effective. Over 900 clients set a personal health plan per year. During 2016/17, over 60% of clients achieved/ partially achieved their personal health plan.

The service is accessing the appropriate clients i.e. those from the most disadvantaged areas and BME groups. Targets relating to weight loss, increasing fruit and vegetable consumption and increasing physical activity levels have also been achieved. User satisfaction with the service is good, with 94% of those completing surveys rating the service as very good or good.

Probation Health Trainer Service (provider – Inclusion Healthcare)
(75k/ year)

The service

The Probation Health Trainer service follows a similar model to the community health trainer service described above. However, the health trainers are all ex-offenders who consequently have a clear understanding of the needs of the offenders that they support. Health trainers often start as volunteers in order to gain experience, then get the opportunity to apply for paid positions.

Probation Health Trainers take their clients through the same staged process as community health trainers i.e. lifestyle assessment, decision making and goal setting, personal health planning, referral and review. Clients accessing the service commonly receive support with registering with GPs and dentists, accessing drug, alcohol and mental health services, accessing benefits and housing advice and are provided with advice and support to stop smoking, eat more healthily and become more physically active.

Performance

Initial assessments were carried out for 536 clients in the city in 2015/16. Nearly 400 clients developed a personal health plan with nearly 90% achieving their targets. 56 clients were supported to register with GPs and 69 to register with dentists.

Adult weight management
Targeted and enhanced service (provider - Leicestershire Partnership Trust)
(up to 230k per year)

The targeted weight management service is aimed at those who do not normally engage with commercial weight management services e.g. Weightwatchers/ Slimming World e.g. men, some BME populations, people with mental health conditions and people with learning difficulties. The service operates in a range of settings that are accessible to the targeted client groups.

The enhanced service is dietician-led and supports people with a BMI of 30+ (obese) or (BMI 28+ for South Asians) with significant health issues(e.g. heart disease, diabetes and those that are morbidly obese (BMI 40+).

Both programmes are 12 weeks long and include healthy eating advice and physical activity interventions. It is based on a behaviour change model and includes motivational support and support to maintain weight loss long term.

Performance

In 2015/16, 439 people attended the weight management programmes, with over 80% completing the programmes. 60% achieved a weight loss of at least 3% of their body weight by the end of the 12 week programme, with over 20% achieving a 5% weight loss. The appropriate groups i.e. BME groups and men are being successfully targeted. Rates of weight loss are good compared to national rates and satisfaction levels with the service are high.

Active Lifestyle Scheme (provider – Sports Services, LCC)
(175k/ year)

The service

The exercise referral scheme is for Leicester City residents, with specific health problems, who need a GP referral qualified exercise instructor to undertake an assessment and recommend a personalised exercise plan. Clients are followed up at 6 weeks, 3, 6 and 12 months and offered further assessment and support. The service has been redesigned during 2016 and in collaboration with the CCG the referral criteria have been refined, so those with multiple risk factors for heart disease, stroke and type 2 diabetes are prioritised. Patients with a lower level of risk or who are sedentary and inactive but otherwise in good health are directed to universal provision.

The separate Heart Smart group is the end stage of the cardiac rehabilitation pathway, and is operated as a closed group just for people who have had a cardiac event. The main referral route is from the UHL cardiac rehabilitation pathway.

Performance

The service receives approximately 4000 referrals per year, plus 200 referrals per year for Heart Smart. Retention rates on the programme have increased dramatically with 70% of those referred attending their first appointment. 82% of these attended the subsequent appointment. Increasing numbers of clients are also attending group-based sessions such as walking football, group circuit sessions and other classes for Active Lifestyle Scheme clients.

Food for Life Programme in schools - (provider – Soil Association)
(75k in 2017/18)

The service

Food for Life Programme has been running in schools since April 2015. All schools in the city will be offered the opportunity to take part in the programme over the 3 year contract period. This offers face to face support to schools to adopt a whole school approach and create a positive food culture. Training courses are provided to give teachers the confidence and capacity to offer practical cooking, food growing and develop farm links. Training supports the curriculum and helps promote knowledge of healthy eating amongst pupils, parents and the wider community. Other courses are designed to support school cooks and lunchtime supervisors and develop the pupil voice.

Schools work towards Food for Life awards which are an independent endorsement for schools that serve nutritious, fresh, sustainably sourced food and support pupils to eat well and enhance their learning with cooking, food growing and farm links.

Performance

There are nearly 70 schools enrolled onto the Food for Life programme currently, 6 have already achieved the bronze award. Food for Life has supported the City Catering service to achieve the Bronze Catering Mark Award for school meals and are working towards the Silver award. City Catering supply bronze standard meals to 79 schools in Leicester City.

Food for Life in the City work in partnership with the Leicestershire Nutrition and Dietetics Service. They work with schools and parents to improve lunch boxes. They have also run cook and eat programmes in schools targeted at those most in need and involve both pupils and parents. In the previous academic year, 151 teachers and support staff received training from Food for Life.

Food for life have a clear evidence base regarding their impact e.g. they can demonstrate:
- an average increase in uptake of school meals of 13% after 2 years
- pupils in food for life schools are twice as likely to eat 5 or more portions of fruit or vegetables per day
- there is a £3 social return on investment for every £1 invested
- FFL catering mark Gold menus have up to 47% lower climate impact than standard school menus
- research evidence points towards FFL's potential to contribute helping close the gap for disadvantaged children in terms of their health and academic attainment (NFER, 2011)

Evaluation is currently being carried out to ensure that these outcomes have also been demonstrated locally.

School-based physical activity programme - (provider - School Sport and Physical Activity Network)
(67k/ year)

The service

The aim of the commissioned service is to target inactive children in primary schools and encourage them to become more active. The team deliver a range of physical activity sessions and training for school staff. Delivery includes: physical literacy sessions in primary schools, physical activity sessions within Change4Life clubs, balanceability (balance bike training), extension of the WISPA project to target year 5 and 6 girls and whole school training on Klmbles (a music and movement programme) and physical literacy and training on playground supervision for lunchtime supervisors and young leaders.

In addition the service works with schools and offers advice and support regarding how best to increase physical activity levels, meeting Ofsted requirements and best use of the school sport premium.

Performance

There is a clear set of performance targets and the service is delivering on all of these.

Satisfaction amongst those attending training is high, both school staff and pupils

attending young leaders training.

Contribution to Leicestershire and Rutland County Sports Partnership (LRS)
(45k/ year)

The service

The council has a partnership agreement with the County Sports Partnership which outlines the support and priorities which are key to ensuring that the Sport and Physical Activity offer across the city is cohesive and robust and that the work that LRS do is in keeping with the identified priorities as determined by City colleagues.

County Sports Partnerships (CSPs) work across the sporting landscape, actively supporting partners to increase participation in sport and physical activity. LRS brings additional strategic support and expertise to Leicester. LRS have led and supported the development of successful bids bringing additional resource, introductions to other partners and their projects such as Street Games and The Dame Kelly Homes Trust. LRS have built on the early years physical activity research previously undertaken in Leicester, and supported the production of resources and training for purposeful physical play in early years settings.

Performance

A detailed action plan is reported against to the LeicesterShire and Rutland Sport board quarterly. Leicester City Council is represented on the board by the Sports Development manager.

Nationally LRS is considered to be a high performing CSP and many of its initiatives, products and services are now being rolled out nationally.

The effectiveness of CSP can be considered in relation to some of the projects it has led on and/or delivered. One local example is Get Healthy, Get into Sport, a Sport England funded project aimed at getting inactive people more active. The local project in New Parks and Greenhill (in Coalville, Leicestershire) has achieved targets, within budget.

LRS bring additional resource through externally funded programmes, partnership projects and contribution in kind. LRS calculate that for every pound invested in LRS by Leicester City Council there has been a minimum of £17 partner funding.

Support to Food Growing Projects - (providers - Saffron Acres and British Trust of Conservation Volunteers (BTCV))
(20k/ year)

The Service

A food growing support programme has run for the past 2 years and has been extended for a further year. The two voluntary sector organisations commissioned support small scale growing projects in schools, early years' settings and in the wider community. The aim is to develop knowledge, skills and resilience in new and existing groups.

Additionally for the past 2 years £1000 grant per ward has been available to small groups to bid for to enable them to start growing. Further grants will be available in 2017/18. Additional grants have also been awarded to schools, early years' settings

and other community growing projects to fund equipment and other growing resources.

Performance

Over 90 packages of support have been provided. The Get Growing Grant scheme has funded over 30 community groups and an evaluation process is being developed to identify value and benefit of this programme.

Food growing courses and bespoke training has been offered and delivered to community groups. Over a quarter of food growing projects funded by the Get Growing grant programme are now part of the It's Your Neighbourhood award scheme.

3.3 Next Steps

Workshops, one of which is focussed on prevention and lifestyle services, are being conducted during June/ July to engage with key stakeholders in discussions about the future shape of our lifestyle services before proposed options are taken to the Executive in the Autumn.

Scrutiny members are requested to consider the following questions which will also be discussed at the workshops this summer:

- What is the role of the public sector in prevention? To what extent should the state intervene?
- In the context of a reducing budget for prevention, what are the priorities? Should the public sector pay for people to be supported to e.g. stop smoking or lose weight or should individuals have to pay?
- Should we prioritise early years investment over support for adults?
- Should individual support only be available to certain disadvantaged or high risk groups? If so, which groups should we focus on?
- Should we continue to develop more integrated lifestyle services so that people can access advice and support in one place?

4. Details of Scrutiny

21st June 2017 meeting of Health and Wellbeing Scrutiny Commission

5. Financial, legal and other implications

5.1 Financial implications

None yet – to be considered when preparing options for the future of lifestyle services

5.2 Legal implications

None yet – to be considered when preparing options for the future of lifestyle services

5.3 Climate Change and Carbon Reduction implications

None yet – to be considered when preparing options for the future of lifestyle services

5.4 Equality Impact Assessment

N/A

5.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

N/A

6. Background information and other papers:

None

7. Summary of appendices:

None

8. Is this a private report (If so, please indicated the reasons and state why it is not in the public interest to be dealt with publicly)?

No

9. Is this a "key decision"?

No

APPENDIX D

Infant Mortality in Leicester: briefing note

Report for : Health & Wellbeing Scrutiny Commission

Report Date: 21st June 2017

Lead Director : Ruth Tennant, Director of Public Health

Useful information

- Ward(s) affected: All
- Report author: Clare Mills
- Author contact details: clare.mills@leicester.gov.uk, 0116 454 4617

Suggested content

1. Purpose of report

This is the first report to the Health & Wellbeing Scrutiny Commission and provides:

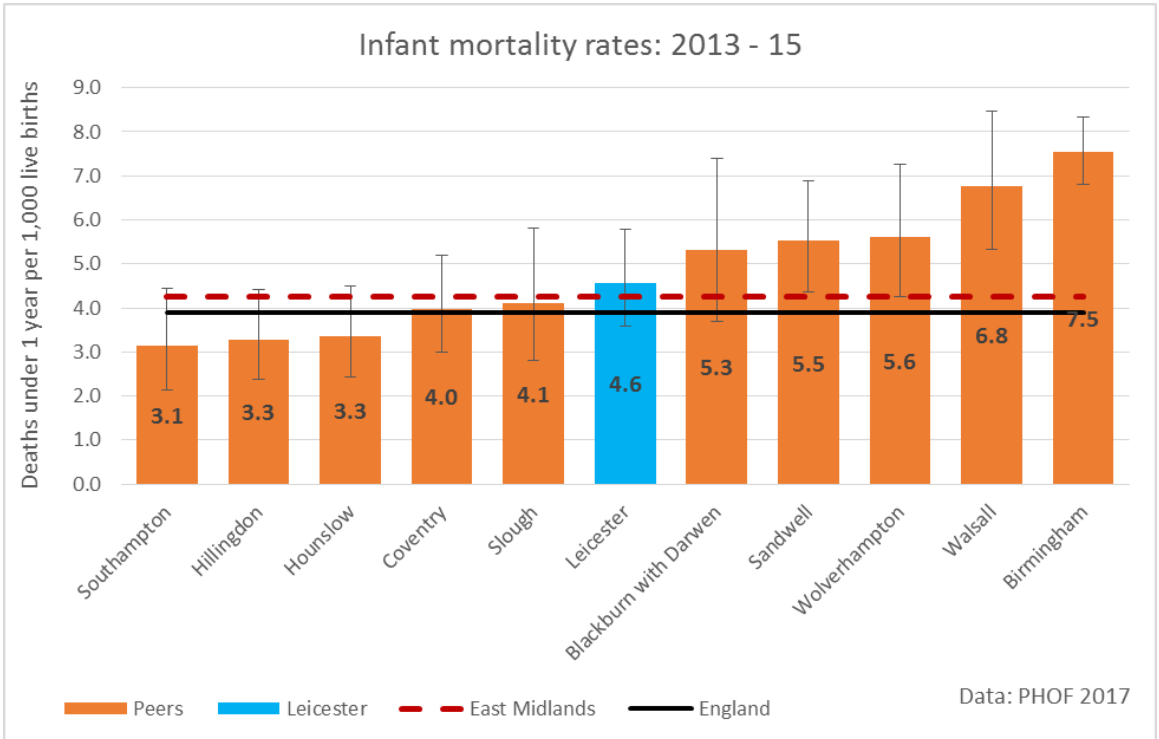
- An introduction to Infant Mortality in Leicester City (a more detailed picture is available in the strategy **Reducing Infant Mortality In Leicester, Leicestershire and Rutland:2016 – 2019).**
- A summary of actions being taken to reduce infant mortality in Leicester.

2. Summary

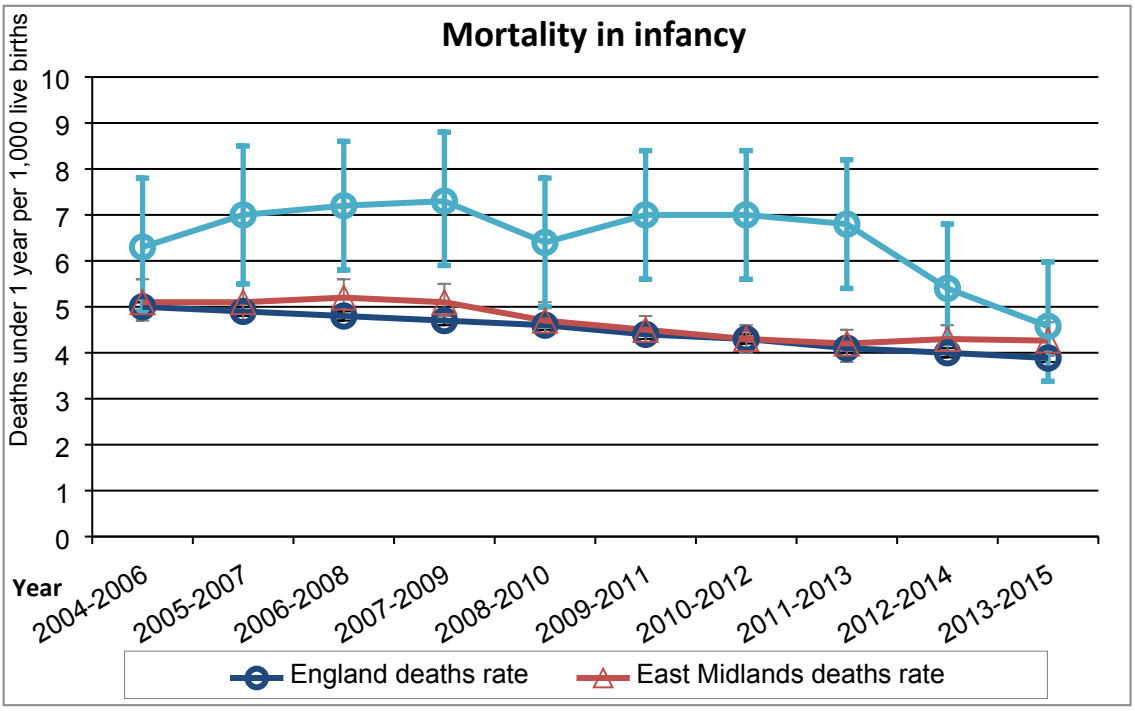
The loss of any baby has a devastating effect on family, friends and the community and while infant mortality is low, this continues to be an important area of focus for public health, working with partners.

2.1 The context

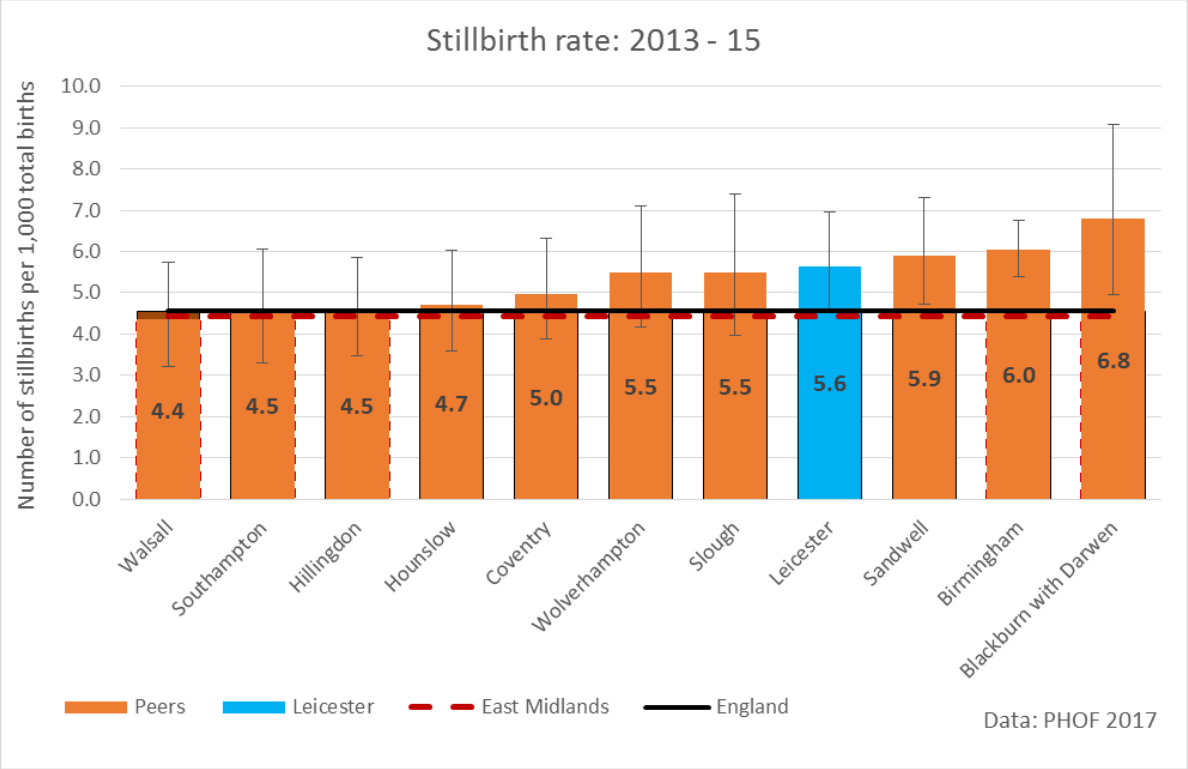
Infant mortality is defined as the number of deaths before the age of 1 per 1,000 live births. The graph below shows that the Leicester City rate (4.6 per 1,000 live births) is not significantly higher than the national and regional rates (3.9 and 4.3 respectively). In comparison with peer comparators, most of the local authorities are similar to Leicester with the exception of Birmingham which is significantly higher.



The graph below depicts the trend in infant mortality rate in Leicester City over a ten year period. It shows that over the period Leicester's infant mortality rate has been significantly higher than nationally, improving in the last 2 periods to show a rate similar to England. Because of the small number of deaths in each year, rates are reported as pooled over 3 years. Since the high point in 2007-2009, where there was an average of 34 deaths per year, this figure has fallen and between 2013-15 there was an average of 24 deaths per year.



Many of the modifiable and preventable risk factors for infant mortality also have an impact on still births. The rate of stillbirth in Leicester was 5.6 deaths per 1,000 total births in 2013-15, equivalent to an average of 29 stillbirths per year. This is not significantly higher than the national average rate of 4.6 per 1,000 and the regional average of 4.4 per 1,000 births. The chart below shows that Leicester has the fourth highest rate of stillbirths when compared with its peer comparators



2.2 The causes

Factors related to the mother:

- **Maternal age:** high rates of infant mortality are among women aged 40 and over and women under the age of 20. Reducing under-18 conceptions would decrease the infant mortality gap by 1%. Teenage pregnancy rates have shown a continued decline but this decline is showing some signs of levelling off.
- **Smoking:** it is well documented that smoking in pregnancy has serious consequences including stillbirth and low birth weight. Reducing the smoking in pregnancy rates would decrease the gap by 2%. It is important to note that passive smoking also contributes to infant deaths. The prevalence of smoking during pregnancy in Leicester in 2015/16 was 11.4%, which is comparable to the national rate
- **Maternal obesity:** is associated with increased risk of congenital anomalies and increased rate of infant deaths. Reducing the prevalence of obesity would decrease the infant mortality gap by 2.8%. There is not reliable information on local maternal obesity rates but anecdotal information suggests this is increasing.
- **Maternal education:** there is clear association between mother's education and infant mortality. Improving maternal educational attainment reduces the risk of infant mortality.
- **Domestic violence:** it is estimated that 30% of domestic violence cases start or escalate during pregnancy and domestic violence is associated with increases in rates of miscarriage, low birth weight, premature birth, foetal injury and foetal death.
- **Maternal ethnicity:** Mothers from the Asian or Asian British ethnic groups are reported to have significantly higher proportions of low birth weight births and infant deaths.

Factors related to the infant:

a. **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.

b. **Breastfeeding:** increasing the rate of breastfeeding initiation in the Routine and Manual (R&M) group to nationally recommended levels would reduce the infant mortality gap by 4%.
c. **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.
d. **Congenital anomalies:** serious birth defects are not always preventable. However, there are some measures that can increase the chances of having a healthy baby, such as folic acid intake and avoiding smoking during pregnancy.

Wider determinants related to infant mortality:

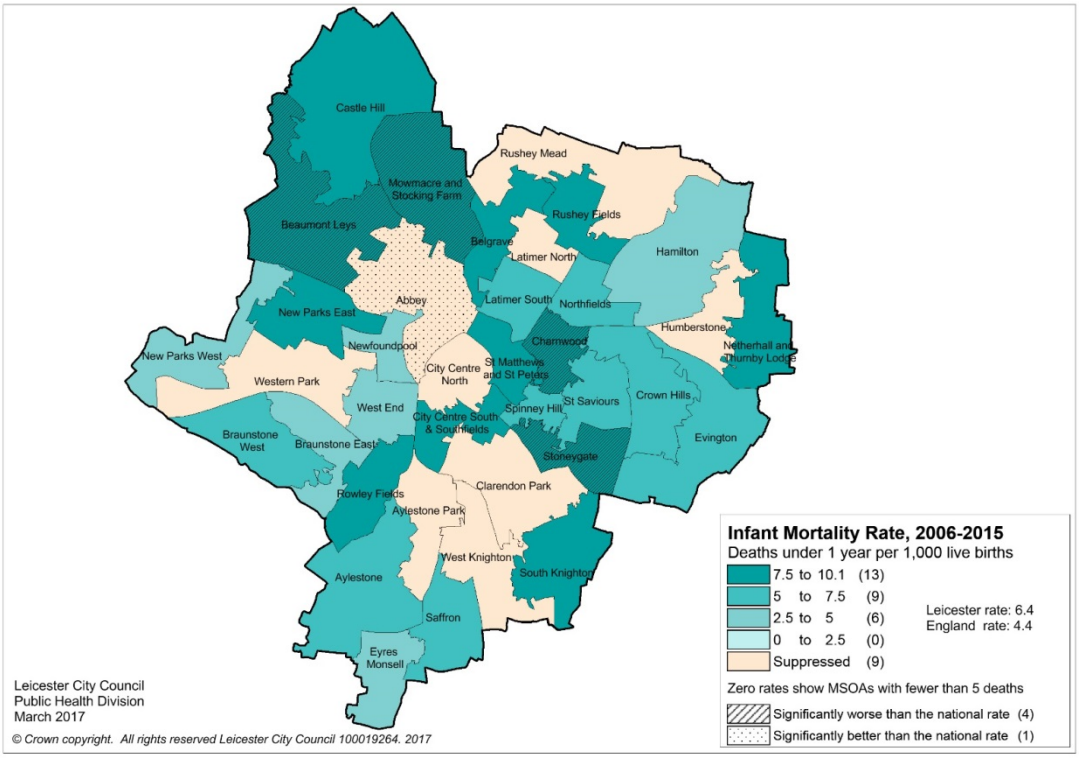
a. **Poverty and deprivation:** reducing child poverty would reduce the infant mortality gap by 3%.
b. **Housing and overcrowding:** improving housing conditions and reducing overcrowding would reduce the infant mortality gap by 1.4%.
c. Targeted interventions to **prevent SIDS** would decrease the gap by 1.4%.

Factors related to preconception care, pregnancy and delivery:

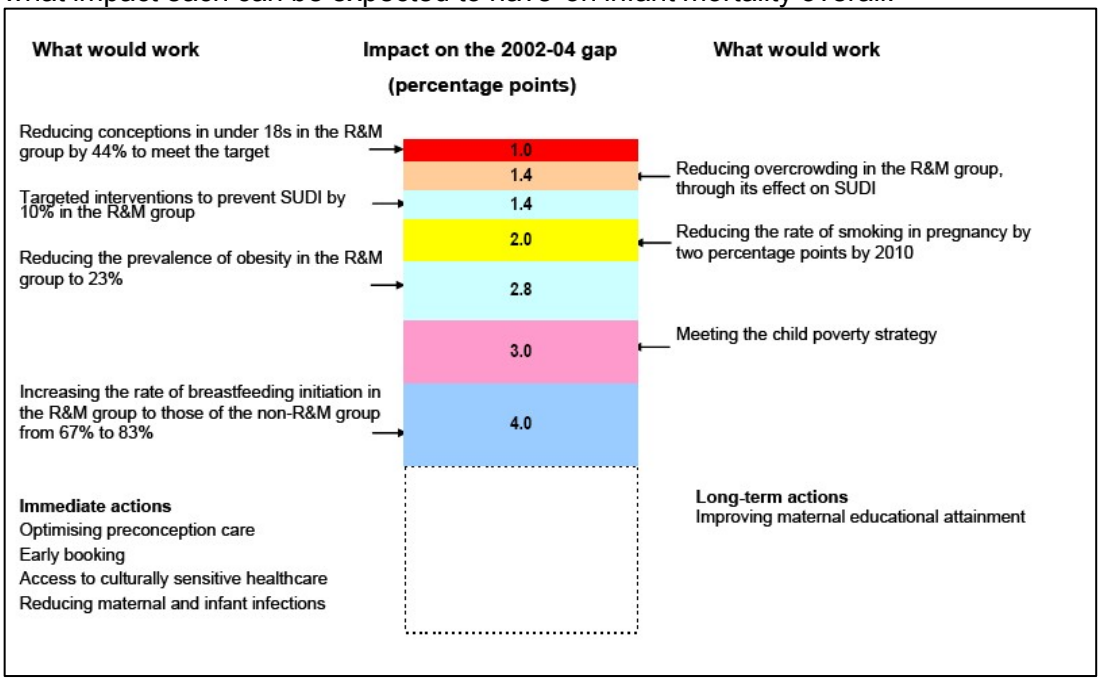
a. Early booking for antenatal care
b. Screening for infections and congenital anomalies
c. Maternal immunisation, such as MMR, whooping cough and flu vaccination
d. Medical conditions during pregnancy, such as diabetes and hypertension
e. Nutritional status, such as folic acid supplements
f. Difficult and complex labour, such as use of instruments

Infant mortality and deprivation

Infant mortality is more likely to occur in households living in poverty and national research has shown that there are higher rates in families from some ethnic minority groups such as Pakistani, Bangladeshi and Black Caribbean groups. Leicester City currently has the ninth highest level of child poverty in the country with 37% of children living in poverty.. However, the graph below shows that there is no significant difference in the rates of infant mortality in Leicester by deprivation quintiles



The diagram below shows the key causes of infant mortality, what actions can be taken, and what impact each can be expected to have on infant mortality overall.



2.3 The way forward

Reducing infant mortality requires a combination of health interventions and actions on the wider social determinants of health by the NHS, local authorities and voluntary organisations, charities and social enterprises. These interventions must start before birth. Giving every child the best start in life through interventions to reduce health inequalities in infancy is central to reducing health inequalities across the life course.

The IMSG (Infant Mortality Strategy Group) work to reduce the incidence of infant mortality and stillbirth in Leicester, Leicestershire and Rutland. The work is guided by the following principles:

- to make it everybody's business to support reduction in infant mortality and stillbirth
- to provide strategic leadership and accountability for the delivery against the agreed actions
- to ensure a multi-agency partnership approach across the region is used to deliver the action plan
- to promote the safety and welfare for all children and young people – implementing sound safeguarding practices and procedures and always adhering to the Local Safeguarding Children's Board Child Protection Procedures

The regional Infant Mortality Strategy and Action Plan was launched in October 2016, with the endorsement of the City's Health and Well-being Board. Since then a range of work has taken place to:

- Promote safe sleeping through a local campaign run with the Lullaby Trust.
- Share messages about smoking and increase referrals to the smoking service, including playing a STOP (smoking) DVD in GP surgeries.
- Develop links between infant feeding clinics and STOP.

The IMSG reports to the Health and Well-being Board and further updates on what action is being taken to reduce infant mortality can be provided to future Scrutiny meetings.
'

3. Recommendations

Health & Wellbeing Scrutiny Commission are asked to note the contents of this update and support the work taking place.

4. Financial, legal and other implications

4.1 Financial implications

N/A

4.2 Legal implications

N/A

4.3 Climate Change and Carbon Reduction implications

N/A

4.4 Equalities Implications

N/A

4.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

N/A

5. Background information and other papers:

NA

6.Summary of appendices:

None

7. Is this a private report (If so, please indicated the reasons and state why it is not in the public interest to be dealt with publicly)?

No

8. Is this a "key decision"?

No

Health and Wellbeing Scrutiny Commission

Work Programme 2017 – 2018

Meeting Date	Topic	Actions arising	Progress
21st Jun 17	1. Lifestyle Services Review 2. Infant Mortality Rates		
23rd Aug 17	1. Sexual Health Review 2. STP – Mental Health		
4th Oct 17	1. Drugs & Alcohol Reconfiguration of Services – CQC inspection report 2. Accident & Emergency Services at UHL – progress report on new facilities 3. STP – Acute Hospital Sites		
29th Nov 17	1. STP – Maternity Services 2. STP – Primary Care		
11th Jan 18			
7th Mar 18			

APPENDIX E

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee

Meeting Date	Topic	Actions arising	Progress
29th Sep 16	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust 2) UHL NHS Trust's View on NHS England's Proposals for Congenital Heart Disease Services 3) Other Viewpoints on NHS England's Proposals	Contact NHS England to inform them that the committee would like the review process to be stopped but if it is to go ahead then they will need to attend another joint meeting once the consultation is announced.	
14th Dec 16	1) Sustainability and Transformation Plan	All three council scrutiny committees agreed to consider elements of the STP separately based on local concerns. Another joint meeting will convene when each council has had separate consideration.	
14th Mar 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust	It was agreed to have a further meeting of the committee before the consultation ends to hear views from Members of the public and other stakeholders.	
27th Jun 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust		

Forward Plan Items

Topic	Detail	Proposed Date
Anchor recovery hub	Developments of a permanent site	
Dementia, Dental Care, Diabetes, GPs, Obesity, Smoking, COPD and Substance Misuse	Progress to individual strategies/services	
Patient experience of the system	Work with Healthwatch to gain an understanding of how patients feel about health services	
Public Health Performance Report	Annual/Six monthly?	
CQC Inspection of LPT	Update since the last meeting and an updated action plan to improve performance	
CQC Review of Health Services for LAC and Safeguarding (Joint with CYPS Scrutiny)	Updated action plan and indicators that suggest the current performance.	
Children Young People Joint Strategic Needs Assessment JSNA (Joint with CYPS Scrutiny)		
CCG Annual Report		
LPT Annual Report		
Air Quality Action Plan	Update to be considered jointly with EDTT Scrutiny	
Impacts of Brexit on staffing in NHS	What has the immediate impact been? What will continue to happen when we exit the EU? What contingencies are being put in place? Where will the biggest impacts be?	