Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **THURSDAY, 11 JANUARY 2018**
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 Chaplin, Corrall, Osman, Sangster and Waddington.

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

JHarget

For Monitoring Officer

Officer contacts:
Julie Harget (Democratic Support Officer):
Tel: 0116 454 6357, e-mail: Julie.harget@leicester.gov.uk
Kalvaran Sandhu (Scrutiny Policy Officer):
Tel: 0116 454 6344, e-mail: Kalvaran.Sandhul@leicester.gov.uk)
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Information for members of the public

Attending meetings and access to information

You have the right to attend formal meetings such as full Council, committee meetings & Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

Dates of meetings and copies of public agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk, from the Council's Customer Service Centre or by contacting us using the details below.

Making meetings accessible to all

Wheelchair access – Public meeting rooms at the City Hall are accessible to wheelchair users. Wheelchair access to City Hall is from the middle entrance door on Charles Street - press the plate on the right hand side of the door to open the door automatically.

Braille/audio tape/translation - If you require this please contact the Democratic Support Officer (production times will depend upon equipment/facility availability).

Induction loops - There are induction loop facilities in City Hall meeting rooms. Please speak to the Democratic Support Officer using the details below.

Filming and Recording the Meeting - The Council is committed to transparency and supports efforts to record and share reports of proceedings of public meetings through a variety of means, including social media. In accordance with government regulations and the Council's policy, persons and press attending any meeting of the Council open to the public (except Licensing Sub Committees and where the public have been formally excluded) are allowed to record and/or report all or part of that meeting. Details of the Council's policy are available at www.leicester.gov.uk or from Democratic Support.

If you intend to film or make an audio recording of a meeting you are asked to notify the relevant Democratic Support Officer in advance of the meeting to ensure that participants can be notified in advance and consideration given to practicalities such as allocating appropriate space in the public gallery etc.

The aim of the Regulations and of the Council's policy is to encourage public interest and engagement so in recording or reporting on proceedings members of the public are asked:

- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ 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 Julie Harget**, Democratic Support on (0116) 454 6357 or email julie.harget@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

PUBLIC SESSION

AGENDA

FIRE / EMERGENCY EVACUATION

If the emergency alarm sounds, you must evacuate the building immediately by the nearest available fire exit and proceed to the area outside the Ramada Encore Hotel on Charles Street as directed by Democratic Services staff. Further instructions will then be given.

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. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 29 November 2017 have been circulated 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

4. CHAIR'S ANNOUNCEMENTS AND UPDATE ON PROGRESS ON MATTERS CONSIDERED AT PREVIOUS MEETINGS

To receive updates on matters that were considered at previous meetings of the Commission.

5. PETITIONS

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

6. 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.

7. REPORT ON THE CARE QUALITY COMMISSION (CQC) INSPECTION OF GP PRACTICES

Appendix A (Pages 1 - 72)

The Commission will receive a report on the Care Quality Commission's inspections of G.P. Practices in Leicester City.

8. TURNING POINT CARE QUALITY COMMISSION (CQC) REPORT

Appendix B (Pages 73 - 106)

The Director of Public Health submits a report that provides the Commission with an update on the Care Quality Commission's (CQC) inspection of Turning Point. The report also details the activity of the Contracts and Assurance Service (CaAS) to monitor the service.

The Commission is recommended to note the contents of the report and provide any comments necessary.

9. UPDATE ON THE ANCHOR RECOVERY HUB

The Commission will receive an update and visual presentation on the new Anchor Recovery Hub on Hill Street, Leicester.

10. PUBLIC HEALTH PERFORMANCE REPORT

Appendix C (Pages 107 - 174)

The Director of Public Health submits a report that brings together information on key dimensions of Public Health performance in the second quarter of 2017/18. The Commission is asked to note the areas of positive achievement and areas for improvement.

11. DRAFT REVENUE BUDGET 2018/19

Appendix D (Pages 175 - 224)

The Director of Finance submits a report setting out the City Mayor's proposed budget for 2018/18 to 2020/21. The Commission is recommended to pass any comments to the Overview Select Committee as part of its consideration of the report before it is presented to the Council meeting on 21 February 2018.

12. WORK PROGRAMME **Appendix E (Pages 225 - 230)**

The Scrutiny Policy Officer 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

Appendix A

Leicester City Clinical Commissioning Group

Report on Care Quality Commission (CQC) inspections of GP practices

January 2018

Summary

1. Fifty-one out of fifty seven general practices in the city have received a CQC inspection under the current CQC inspection regime.

2. The current situation is that 1 practice is rated as outstanding, 43 practices rated good, and 7 practices require improvement. The CCG is pleased with the results to date, which benchmark well against other 'peer' areas with England.

3. The CCG has a process in place to support practices that may require improvement and to share learning across all city CCG general practices. This has helped a number of practices make significant improvements where needed.

Background

4. GP practices have been part of the CQC inspection regime since 2013. Following a review of inspections carried out, the CQC introduced a new higher level inspection regime for GP practices during 2015. To date over 900 GP practices across England have been visited under this enhanced level of inspection.

5. There are 57 practices in Leicester City and so far 51 have been subject to an inspection.

6. Registration with the CQC is a mandatory requirement for any provider of primary medical services, underpinned by legislation, as well as being contractually mandated.

7. Practices are required to register the services they provide and to nominate a registered manager who is responsible for ensuring that CQC standards are met and maintained.

8. If practices fail to maintain registration, or fail to notify CQC of any changes to the registered manager or clinicians, they are liable to legal action or fines.

9. The CQC has the ultimate power, if services are found to be sufficiently poor, to close a practice down.

Inspection regime

10. Where inspections are announced practices will usually be given two weeks' notice. During this time the practice will be asked to complete a Provider Information Return (PIR). This includes information such as their statement of purpose, and information about complaints received from patients or any serious incidents. The CQC will send the practice a supply of 'comment cards', which they need to make available to patients so they can also share their views with the inspection team.

11. Unannounced visits will take place if the CQC has any concerns about a practice or if they are responding to a particular issue or concern. As the name suggests, practices have no advanced notice of this type of inspection.

12. Each inspection team is led by a CQC inspector or CQC inspection Manager and may also include additional expert advisors. This can include a clinician (either a nurse or doctor), experts by experience or other specialist advisors, e.g. practice managers.

13. The practice is asked to ensure that at least one clinician and the registered manager are available on the day of the inspection. The practice will generally present an overview to the inspectors first. Following this, the individuals then continue with the inspection with each looking at specific areas with the relevant nominated member of staff.

14. The inspection days are normal days for the practice. This means that they continue work seeing patients during the visit. The clinical practice staff, such as GPs or practice nurses, should be available for an in-depth interview with inspectors if needed, and this can be up to an hour long. The inspectors will also often ask to speak to non-clinical staff (such as receptionists or administrative staff) for a shorter interview.

15. The CQC will usually ask to meet a representative from the practice's patient participation group. This individual will be interviewed by either the expert by experience or inspector in order to give a patients' perspective of the practice and the services that it provides. Patients attending the practice on the day may also be asked for their views of the surgery.

16. Once they have concluded the inspection, the inspector will offer the practice some initial informal feedback on what they have found. However, this is not necessarily representative of the final report as the CQC will consider further findings and information.

17. A draft report will then be written by the CQC which will go through its quality control and assurance mechanism. Following these quality assurance checks, the CQC will send the practice a draft report for a factual accuracy check. Once this is completed the final report is published on the CQC website. This can take a number of months from the date of the initial inspection.

18. The report may have a number of actions identified. If so, these are contained within the report and are defined either as areas the service *must* improve or areas the service *should* improve. If the areas of concern are sufficiently serious and may cause harm to patients then the practice is issued with an improvement notice. This means that the practice is legally required to undertake the improvement within the stipulated timescales. Timescales vary depending on the nature of change and improvements required but are typically in the region of two to three months.

What is assessed?

19. There are five key questions that the CQC asks about services at an inspection visit. These are:

    - Are services safe?
    - Are services effective?
    - Are services caring?
    - Are services responsive to patient needs?
    - Are services well led?

20. These questions are then broken down during the visit to form key lines of enquiry, or KLOEs. These focus on those areas that may need further investigation. Generally these are determined on a case-by-case basis and depend on any issues uncovered during the course of an inspection.

21. In addition the inspectors look at services for six population groups and rate those as well. The six population groups are:

    - Older people
    - Families, children and young people
    - People with long term conditions
    - Working age people
    - People whose circumstances make them vulnerable
    - People experiencing poor mental health.

22. It is important to recognise that any inspection is undertaken at a point in time with inspectors assessing what they see and hear on the day. Additionally, the CQC has powers under the Health and Social Care Act 2008 to access medical records for the purposes of exercising their functions (which includes checking that registered providers are meeting the requirements of registration).

Assessment and practice ratings

23. Practices are rated Outstanding, Good, Requires Improvement or Inadequate against each of the five key questions as well as for services provided to each of the population groups. These scores are then aggregated to provide an overall rating for each practice.

24. The following table provides a numerical break down of the overall ratings for practices so far inspected within the Leicester City CCG area. Appendix A provides a breakdown for all general practices that have been inspected and for whom the results are currently publicly available.

Rating	Number of practices
Outstanding	1
Good	43
Requires Improvement	7
Inadequate	0

25. It should be noted that this number is not static and does fluctuate as practices are re-inspected, CQC inspection reports are archived by the CQC or there are contractual change within the general practice. For example, this may include if a new provider takes over the running of the practice as has been the case with a number of city practices over the course of the last three months.

26. It is recognised that the vast majority of GPs do their utmost to provide the best possible care and, whilst there is always room for improvement, we are pleased with the outcomes of inspections to date. It is reassuring to note the high percentage of practices rated as ‘good’ and the increase in a good rating at re-inspection for those practices that required improvement or were inadequate. The CCG will continue to support practices to provide high quality services for patients.

27. The following table highlights the overall rating at first inspection for Leicester City general practices compared to the national data. While the city has slightly fewer

outstanding and good rated practices than the national average, it also has fewer inadequate practices. It should also be noted that the city benchmarks well against other similar cities in the country in which health need is likely to be higher and services in greater demand than in more rural and affluent areas.

First inspection	Outstanding	Good	Requires Improvement	Inadequate
National (May 2016)	4%	79%	13%	4%
Leicester City CCG	1.96%	74.5%	21.5%	1.96%

28. There are currently 6 general practices which have not yet been inspected. These are:

    - Asquith Surgery
    - Leicester City Assist practice
    - Shefa Medical practice
    - Bowling Green street surgery
    - Walnut Street Surgery
    - Heron Medical Practice/St Matthews Medical Centre.

29. No inspection date is yet known for these practices. It is worth noting that three of these practices have recently undergone a procurement process and are under new management as of 1st October 2017, while a further practice will be under a new provider from 1st February 2018.

Supporting general practices following CQC inspection

30. The CCG has a process in place to review all general practice CQC inspection reports when they are issued. Key Governing Body members are provided with a summary of all reports issued and they are also on the agenda at key CCG meetings such as its Risk Sharing Group. Appropriate and proportionate action is determined following review by the CCG teams at an operational group. This may include a meeting with the practice to explore particular issues or, where the inspection has been successful, sending a letter of congratulations.

31. Where themes are identified from the reports these are highlighted to all practices in various ways. This includes, for example, at protected leaning time events (which bring together all City GPs), in our practice level newsletters or other appropriate meetings. This process also includes the sharing of identified areas of good practice.

32. Themes from CQC inspection reports in the city have changed over time. For example, two years ago a common theme was around risk assessments and in particular lack of risk assessment for legionella.

33. Following an intensive awareness campaign by the CCG, we now rarely see the lack of a legionella risk assessment as an area for improvement. More recently themes are around the need to improve systems for the identification of carers, the need to establish effective systems to review and update procedures and guidance with a view to ensuring that information reflects the current requirements of the practice, and to continue to monitor patient satisfaction results in relation to the issues highlighted in the national GP patient survey.

34. Some reports show that processes do exist but are inconsistent in implementation. For example, reports highlight systems in place to identify the training needs for staff but these were not effective as there were gaps found in some staff training records. Inconsistent record keeping has been identified as an issue and this includes maintaining records of staff training, staff immunity status and emergency equipment checks. Overall the themes are reasonably similar to the national picture.

35. For practices where the CQC has identified some form of improvement the CCG will utilise a range of mechanisms to support a practice proportionate to the nature of the actions and the risk to patients. This involves a range of CCG teams including board GPs, nursing & quality team, health needs neighbourhood managers, medicines management team and commissioning contract teams coming together to work with the practice on interventions based upon the improvements required.

36. The CCG has a specific process in place to support practices which receive an overall rating of inadequate or enter special measures – the instigation of an oversight group. This group, chaired by the Director of Nursing & Quality and attended by the CQC, covers the initial review of the report to understand the level of risk and what this means to patients and the public. This group will work with the practice to develop a remedial improvement plan and risk mitigation strategies, along with an agreement of a process to monitor and oversee the implementation of the improvement plan itself.

37. For all general practices the CCG will monitor progress, working with and supporting the general practice until the identified actions are completed. There is a process of reporting and escalation in place via the CCG's Risk Sharing Group and from there to the CCG's Primary Care Commissioning Committee (which has overall board level oversight of the commissioning of general practice in the city).

38. CQC inspection reports form one part of the quality assurance process of general practices used by the CCG. The overall process is currently under review, but essentially consists of a number of levels of assurance monitoring and support. The first level is around routine assurance and evidence monitoring and practices would move up in stages if there was increasing risk or lack of assurance to, ultimately, the final stage of regional escalation and monitoring.

39. At a level one stage information and intelligence is reviewed and triangulated to identify if there are any potential risks/concerns or unwarranted variations. The CQC report would be reviewed alongside other data including prescribing information, complaint and serious incident information, performance and activity data such as emergency admissions, outpatient appointments, Quality & Outcomes Framework data and public health information such as childhood vaccinations. Additionally, general practice contract information is also reviewed. This would include opening times, appointment information and patient experience information from NHS Choices or the national patient survey.

40. Where concerns are identified further examination would take place including practice visits and specific quality and contract reviews. Where issues are more widespread and/or more prolonged and/or diverse in their nature a formal enhanced monitoring and support improvement plan would be required. If performance has not improved, despite a period of support and intervention, formal contractual actions may be considered. As already alluded to there is a process of reporting, monitoring and escalation in place via the CCG's Risk Sharing Group and from there to the CCG's Primary Care Commissioning Committee.

41. It is important to note that if the concerns relate to specific individual practitioner performance this will be the responsibility of NHS England. Where the CCG becomes aware of an issue that is related to an individual practitioner this will be escalated to NHS England.

42. A public and confidential report is on the agenda at each Primary Care Commissioning Committee which highlights all CQC reports and any actions agreed.

Informing commissioning decisions

43. The CCG takes the inspection ratings of practices very seriously, and is always keen to support practices to attain the best possible quality of care for its patients.

44. The information gained from the CQC reports provides a good indicator of practice quality and is used in triangulation with other information. This can include things such as Patient Experience Scores, Quality and Outcome Data and other quality markers (prescribing rates, ED attendances and screening uptake rates, for example).

45. CQC information is also used when considering whether practices would be suitable for providing additional or enhanced services, or whether practices need enhanced support through resilience or other funding streams that may be available to them.

Future CQC inspection regimes

46. There has been some criticism of CQC inspection regimes, particularly around the bureaucracy of visits, and the time impact it has for practices. With this in mind the General Practice Forward View describes a revised inspection regime that is less bureaucratic and focusses on certain service areas, as opposed to a full and comprehensive inspection.

47. In October 2017 the CQC issued a document entitled *How CQC monitors, inspects and regulates NHS GP practices*. This describes the how they will monitor general practices going forward. A summary formed part of the general practice exception report at the Primary Care Commissioning Committee at its December 2017 meeting, and is attached for your information as appendix B. This information is being discussed with practices in a variety of ways including at the protected leaning time event in January 2018.

Conclusion

48. We are pleased with outcome of CQC inspections so far however we are not complacent. We recognise that there is still much work to be done to improve the overall quality of primary care services in the city.

49. There is a process for monitoring CQC inspection reports and for supporting practices to make any identified improvements. This includes sharing learning from each other and ensuring any risks to patient and the pubic are minimised so patients receive as high quality standard of care as is possible.

APPENDIX A

		Initial Inspection Outcome							Latest Inspection Outcome						
	Practice	Date Report Published	Overall rating for this service	Are services safe	Are services effective	Are services caring	Are services responsive to people need's	Are services well-led	Date Report Published	Overall rating for this service	Are services safe	Are services effective	Are services caring	Are services responsive to people need's	Are services well-led
C82060	Sayeed Medical Centre	07/04/16	🟡	🟡	🟢	🟡	🟢	🟢	21/11/16	🟢	🟢	🟢	🟢	🟢	🟢
C82667	The Charnwood Practice	31/05/16	🟡	🔴	🟡	🟢	🟢	🟡	09/08/16	🟢	🟢	🟢	🟢	🟢	🟢
C82030	Downing Drive	21/10/16	🟢	🟡	🟢	🟢	🟢	🟢	17/11/16	🟢	🟢	🟢	🟢	🟢	🟢
C82084	Dr B Modi	24/02/16	🟢	🟡	🟢	🟢	🟢	🟢	26/05/16	🟢	🟢	🟢	🟢	🟢	🟢
C82626	Pasley Road Health Centre (Dr TK Khong)	04/07/16	🟡	🟢	🟢	🟡	🟡	🟡	31/01/17	🟢	🟢	🟢	🟢	🟢	🟢
C82037	East Park Medical Centre	22/07/16	🟢	🟡	🟢	🟢	🟢	🟢	23/02/17	🟢	🟢	🟢	🟢	🟢	🟢
C82676	St Elizabeth's Medical Centre	19/09/16	🟢	🟡	🟢	🟢	🟢	🟢	10/02/17	🟢	🟢	🟢	🟢	🟢	🟢
C82094	Beaumont Lodge Medical Practice	07/10/16	🟢	🟡	🟢	🟢	🟢	🟢	09/03/17	🟢	🟢	🟢	🟢	🟢	🟢
C82671	Belgrave HC - Dr R Kapur & Dr Sharma	31/05/16	🟢	🟡	🟢	🟢	🟢	🟢	07/11/16	🟢	🟢	🟢	🟢	🟢	🟢
Y00280	Belgrave Surgery (Dr S Bapodra)	23/04/15	🟡	🟢	🟡	🟢	🟢	🟡	28/01/16	🟢	🟢	🟢	🟢	🟢	🟢
C82005	Groby Road Health Centre	04/08/16	🔴	🔴	🔴	🟡	🟢	🔴	04/05/17	🟢	🟢	🟢	🟢	🟡	🟢
C82116	Highfields Surgery	04/02/16	🟢	🟢	🟢	🟢	🟢	🟡	07/02/17	🟢	🟢	🟢	🟢	🟢	🟢
C82624	The Practice Beaumont Leys	13/10/16	🟢	🟡	🟢	🟢	🟢	🟢	10/05/17	🟢	🟢	🟢	🟢	🟢	🟢
C82063	East Leicester Medical Practice	05/03/15	🟢	🟢	🟢	🟢	🟡	🟢	28/09/17	🟡	🟡	🟢	🟢	🟡	🟡
C82124	Victoria Park Health Centre	24/02/17	🟡	🟡	🟢	🟢	🟢	🟡	30/10/17	🟢	🟢	🟢	🟢	🟢	🟢
C82053	Hockley Farm Medical Practice								17/12/15	🟢	🟢	🟢	🟢	🟢	🟢
C82019	The Health Centre - Dr G Singh								11/02/16	🟢	🟢	🟢	🟢	🟢	🟢
C82008	Oakmeadow Surgery								17/12/15	🟢	🟢	🟢	🟢	🟢	🟢
C82105	Ar Razi Medical Centre								16/05/16	🟢	🟢	🟢	🟢	🟢	🟢
C82614	Asquith Surgery								05/02/15	🟡	🟡	🟡	🟢	🟢	🟢
C82092	Aylestone Health Centre (LMG)														
C82107	Brandon Street Surgery								25/04/17	🟢	🟡	🟢	🟢	🟢	🟢
C82122	Clarendon Park Medical Centre								18/07/16	🟢	🟢	🟢	🟢	🟢	🟢
C82099	Dr KA Choudhry (Al-Waqas Medical)								10/08/16	🟢	🟡	🟢	🟢	🟢	🟢
C82651	Dr KS Morjaria								30/06/16	🟢	🟢	🟢	🟢	🟢	🟢
C82659	Dr R Kapur (Melbourne Road Health Centre)								11/07/16	🟡	🟡	🟢	🟢	🟢	🟡
C82114	Dr UK Roy								28/05/15	🟡	🟡	🟡	🟢	🟢	🟢
C82620	Dr Shafi (Briton Street Surgery)								11/07/16	🟢	🟢	🟢	🟢	🟢	🟢
C82018	Dr D Jawahar & Partners								08/10/15	🟢	🟢	🟢	🟢	🟢	🟢
C82088	Evington Medical Centre								09/04/15	🟢	🟢	🟢	🟢	🟢	🟢
C82086	Fosse Medical Centre								19/11/15	🟢	🟢	🟢	🟢	🟢	🟢
C82623	Heatherbrook Surgery								26/11/15	🟢	🟢	🟢	🟢	🟢	🟢
C82642	Highfields Medical Centre								07/01/16	🟢	🟢	🟢	🟢	🟢	🟢
C82033	Humberstone Medical Centre								07/09/16	🟢	🟢	🟢	🟢	🟢	🟢
C82670	Inclusion Healthcare								05/02/15	★	★	★	★	★	★
C82031	Johnson Medical Practice								21/05/15	🟢	🟢	🟢	🟢	🟢	🟢
Y00344	Leicester City Assist Practice														
C82073	Merridale Medical Centre								07/12/16	🟢	🟢	🟢	🟢	🟢	🟢
C82680	Spirit Rushey Mead								02/07/15	🟢	🟢	🟢	🟢	🟢	🟢
C82046	Saffron Health *previously Saffron Group Practice*								19/02/15	🟢	🟢	🟢	🟢	🟢	🟢
C82080	Shefa Medical														
C82024	Spinney Hill Medical Centre								08/05/15	🟢	🟢	🟢	🟢	🟢	🟢
Y02469	Heron GP Practice and Primary Care Centre														

C82660	St Peter's Health Centre		08/05/15						
C82020	Student Health Centre - De Montfort Surgery		21/05/15						
C82643	The Community Health Centre		08/08/16						
C82100	The Hedges Medical Centre		02/06/16						
C82610	The Parks Medical Centre		11/02/16						
Y02686	The Practice Bowling Green Street								
C82669	The Surgery @ Aylestone		07/06/17						
Y00137	The Willows Medical Centre		02/08/17						
C82662	Walnut Street Surgery								
C82059	Westcotes GP Surgery 1		23/11/16						
C82653	Westcotes GP Surgery 2		23/11/16						
C82639	Westcotes Health Centre Dr Hazeldine		19/11/15						
Y03587	Westcotes Health Centre - Dr Lawrence		21/04/17						
C82029	Willowbrook Medical Centre		07/04/16						

Please Note: When CQC registration changes the CQC will sometimes archive previous inspection reports and therefore this list is indicative and provides an indication of outcomes at a point in time
Also note that some GP practices have had a contract change and therefore for CCG monitoring purposes we do use locations as well as providers names interchangeably

Key

★	Outstanding
●	Good
●	Requires improvement
●	Inadequate

Status
Archived
Live
Live
Live
Live
Live
Live
Live
Archived
Live
Live
Live
Archived
Live
Live
Live
Live
Live
Live
Live
Live
Archived
Not inspected
Live
Live
Live
Live
Archived
Archived
Archived
Live
Live
Live
Archived
Archived
Live
Live
Live
Not inspected
Live
Archived
Archived
Not inspected
Live
Not inspected

Archived
Live
Live
Live
Live
Archived
Live
Archived
Not inspected
Archived
Archived
Live
Live
Live

NHS
Leicester City
Clinical Commissioning Group

Guide to how the CQC monitors, inspects and regulates NHS GP practices

November 2017

CQC Insight

NHS
Leicester City
Clinical Commissioning Group

- Monitor potential changes to the quality of care provided
- Bring together information about a practice in one place
- Compare information against local and national data
- Updated throughout the year
- Will help CQC to plan when and what they inspect
- Data comes from a verity of sources including
  - Quality and Outcomes Framework (NHS Digital)
  - GP Patient Survey (NHS England)
  - NHS Business Services Authority
  - Public Health England
- Work with national partners e.g. NHS England, GMC, NMC, GPC, Healthwatch, CCGs, LA, voluntary and community sector
- Provider specific information and documents prior to an inspection visit e.g. patient population, staffing, polices & procedures, complaints, incidents – **Providers have 5 working days to respond**

Frequency of Inspection

	Maximum interval between inspection
Inadequate	Six months
Requires improvement	12 months
Good or outstanding	Five years

- Aim is to deliver an intelligence driven approach to regulation
- CQC will inspect a proportion of practices rated as good or outstanding per year
- CQC may inspect any service at any time, irrespective of rating, for example when monitoring information indicates a potential movement or deterioration in the quality of care
- Inspections will usually be announced – **2 weeks notice**
- Unannounced inspections will take place in response to concerns about a practice or something identified at a previous inspection.
- Inspection will be led by a CQC inspector or CQC inspection manager and may include additional expert advisors.

NHS
Leicester City
Clinical Commissioning Group

Types of inspection

Comprehensive

- Comprehensive inspections will address all five key questions, and ask is the service safe, effective, caring, responsive and well led?
- Will always be undertaken for services that have not yet been inspected, or if a service has an overall rating of inadequate or requires improvement.

Focused

- Used when there is a need to follow up on an area of concern. This could be a concern identified during a comprehensive inspection that has resulted in enforcement action, or concerns that have been raised with the CQC by the public, staff or stakeholders.
- Focused inspection do not usually look at all five key questions. They usually focus only on the areas indicated by the information that triggers the inspection

6 Population Groups

NHS
Leicester City
Clinical Commissioning Group

1. Older people
   - aged 75 years and over regardless of health needs or where they live – focus is on a proactive and personalised programme of care

2. People with long term conditions
   - Does not include those aged 75 and over
   - Does not include children and young people

3. Families, children and young people
   - Expectant and new parents, prenatal and antenatal care
   - Young people up to their 18th birthday

4. Working age people
   - Working age and those recently retired (up to age of 75)
   - Students age 18 years and over
   - Focus on how these people an access appointments and services at the practice

5. People whose circumstances make then vulnerable
   - Includes a number of different group – hard to access, vulnerable, gypsies, travellers, vulnerable migrants
   - The groups CQC will focus on is determined by the practice population but will always include learning disability and homeless
   - Focus generally on access to GP service generally including registration, ability to book appointments and receive services

6. People experiencing poor mental health (including people with dementia)
   - Covers the spectrum of mental health

Site Visits

NHS
Leicester City
Clinical Commissioning Group

- Usually one day
- Where managed from more than one location likely to visit a number of sites during a comprehensive inspection
- Gather views of patients, families and carers
- Speak with a range of staff
- Track a patient journey through their care pathway, Check policies, review records and registers etc

Practice Presentation

NHS
Leicester City
Clinical Commissioning Group

- No longer than 30 minutes
- Utilise this wisely
- Focus on the 5 key questions & 6 population groups
- Consider what works well, what is the practice good at
- Consider what you are doing to improve in areas that you know you are not so good at
- Be honest, focus on what you are doing to improve
- Be positive
- Issues of concern not highlighted will be picked up under the well led key question

The CQC Report

NHS
Leicester City
Clinical Commissioning Group

- Presents a summary of findings, judgement and enforcement actions
- CQC conduct quality & consistency checks on all inspection reports
- Draft report sent to practice for factual checking
- Practice has an opportunity to challenge the accuracy and completeness of evidence used
- 10 working days for practice to undertake this
- Use the factual accuracy form to make and submit comments. If you do not use the form **do not** PDF your response.

Ratings

NHS
Leicester City
Clinical Commissioning Group

Level 1: Every key question for every population group

	Safe	Effective	Caring	Responsive	Well-led
Older people	Good	Outstanding	Good	Outstanding	Good
People with long term conditions	Good	Inadequate	Good	Inadequate	Good
Families, children and young people	Good	Good	Requires Improvement	Good	Requires Improvement
Working people (including those recently retired and students)	Good	Good	Outstanding	Good	Outstanding
People whose circumstances may make them vulnerable	Good	Outstanding	Good	Requires Improvement	Good
People with poor mental health (including people with dementia	Good	Good	Requires Improvement	Good	Requires Improvement

Level 2: Aggregated rating for every population group

Overall
Outstanding
Inadequate
Requires Improvement
Outstanding
Good
Requires Improvement

Level 3: Aggregated rating for every key question

	Safe	Effective	Caring	Responsive	Well-led
Location	Good	Good	Good	Good	Requires Improvement

Overall location
Good

Level 4: Overall rating for the practice

Enforcement notices

- CQC consider the extent and impact of the concerns found on people who use the services and the risk to quality and safety. Where a breach of regulation is identified an enforcement notice will be identified.

- Requirement notice: The key question will be rated as no higher than requires improvement
- Warning notice or imposing a condition of registration: key question will be rated as no higher than inadequate

- The only grounds for requesting a rating review after completion of the factual accuracy process and publication are that the CQC have failed to follow process

CareQuality Commission

The state of care in general practice 2014 to 2017

Findings from CQC's programme of comprehensive inspections of GP practices

STATE OF CARE

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

Contents

Foreword from the Chief Inspector

I am delighted to present CQC's report of the quality of care in general practice in England, which we are able to do after completing our programme of comprehensive inspections of every GP practice in England registered with CQC at October 2014. This was the first of its kind and, in total, we inspected and gave a first rating to 7,365 practices.

For the first time, we have an unprecedented detailed view of the quality of all GP practices, which enables us to look at the sector as a whole and see where it is good – which we celebrate – and where it needs to improve.

Everyone in our society deserves high-quality, accessible primary care. Of all the health and care sectors that CQC regulates and rates, GP practices have consistently received among the highest ratings and we should be immensely proud of the fact that as at 16 May 2017, nine in 10 practices that CQC has inspected were providing good or outstanding care to their patients. This is to be commended when considering the challenges that general practice currently faces, in terms of the widening gap between the demand from a growing population of people living longer with complex medical needs, and the capacity of general practice to meet these needs.

Through our inspections we are increasingly seeing evidence of GP practices delivering care in new and innovative ways to benefit patients and the wider community. We highlight innovative practice in our inspection reports to encourage others to learn from it, to be inspired by it and to adapt what is relevant to use in their own improvement journey. There are particular characteristics at the heart of high-quality general practice: practices proactively engage with patients to identify local needs; they use this understanding to create a strategy and provide services to respond effectively to meet these needs, sometimes in innovative ways; and they have strong leadership with a good mix of skills, and good external relationships and partnership working, to share learning with others in the wider health and care community.

But, at the same time, we recognise that there are pockets of persistent poor care in general practice, which is bad both for patients and healthcare professionals themselves, including doctors and practice staff. Although these professions are regulated, historically there was no regulation of general practice as a service before CQC's inspection programme, which meant little was known about the quality of care for patients. Our first inspections found practices where care had fallen short of the quality that people should be able to expect, and which had not been addressed before: on first inspection, 13% of practices were rated as requires improvement and a further 4% were rated as inadequate.

Our inspections have helped to highlight problems and ensure that these are addressed – not only for the benefit of patients, but to improve and support the profession. Where we found concerns, we have taken action to protect the public by re-inspecting to follow up the necessary improvements. In extreme cases, where we found very poor and unsafe practice that put patients at risk, we took more serious action more proportionate to our concerns, and in a small number of cases we used our urgent enforcement powers to cancel a provider's registration.

I know that the results of our inspections have helped to deliver improved care, which potentially affects more than 3.6 million patients. Practices that are open and willing to learn are able to respond quickly to the issues we identify in our reports and improve the quality of care. Many practices told us that their inspection provided valuable feedback on how their practice is run and that they valued our acknowledgement of what they are doing well, as well as the insight into where they could improve. The majority of practices are taking action on inspection findings and providing better care. We can see this from the percentage of practices originally rated as requires improvement or inadequate that have improved their ratings following re-inspection. From the patient's point of view, this means that at the end of the first inspection programme, more than 3.4 million more people had access to safer and better quality care from practices rated as good or outstanding, which shows the positive impact of regulation.

But there is no room for complacency; while some have improved, as at 16 May 2017, one in 10 GP practices still needed to improve the quality of their care. Although CQC's inspections are a catalyst for improvement, we believe that more must be done to support general practice to sustain this, as we are starting to see examples of practices that are unable to maintain improvement.

Consistent and sustainable support will enable general practice to deliver a high-quality service and play its important part in delivering care as part of the health and care system. Good and outstanding GP practices are the driving force leading to service changes and more integrated care in their local area. So we fully support the pledges made by NHS England in the General Practice Forward View to increase funding for general practice, improve leadership, increase the frontline workforce and skill mix, and invest in infrastructure. If properly targeted to meet local needs and used appropriately, investing in general practice will ensure that whole health economies remain sustainable and that outcomes for patients improve. We will continue to demonstrate the impact of these investments on the quality of care.

We will use the findings from our first programme of inspections as a baseline for the quality of general practice in England. As a regulator, we cannot afford to stand still. We must be vigilant and continue improving and adapting, enabling us to regulate in a more targeted, responsive and collaborative way.

We are using the learning from inspections to refine our approach to regulating general practice in England, which will be reflected in our Next Phase of regulation. On the ground, this will result in a greater focus on outcomes for patients and understanding of where quality of care is changing, while at the same time sharing what we know about what works well and what challenges remain.

To help ensure that the General Practice Forward View achieves its goals, we will work collaboratively with commissioners and other stakeholders to reduce duplication of what we ask of general practice and to share information effectively so we have a shared view of quality.

Going forward, CQC will continue to champion general practice, using our findings to highlight its strengths and promote innovative practice. We have seen some of the best care delivered to the most vulnerable in society, which all health and care services can learn from and aspire to achieve truly outstanding care.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

1. Introduction

Background and context

General practice is the 'front door' of the National Health Service and people's first point of contact for general healthcare. In England, there are more than 7,500 general practices registered with the Care Quality Commission (CQC). The core purpose of general practice, as set out in the national GP contract, is summarised as the services that GPs must provide to manage a registered list of patients. The majority of practices are run by GPs working as independent contractors under the terms of a national contract: the General Medical Services (GMS) contract and the Personal Medical Services (PMS) contract.

There is no official data collection, but one estimate indicated that there were 372 million general practice consultations in 2014-15[a], managing medical care from before birth to the end of life. This includes diagnosing, treating and preventing disease and illnesses, including a wide range of major health conditions, assessing risks, dealing with complex health conditions, coordinating long-term care and addressing patients' physical, social and psychological wellbeing, as well as acting as a gateway to specialists by referring patients for further care.

Challenges to the sector

General medical practice is a core part of primary care in the NHS, and therefore plays a fundamental role in the overall health of the population. A greater focus on prevention and early management of health problems in primary care should result in more appropriate and effective care leading to better health outcomes and greater equity in health. Therefore, it follows that properly investing in general practice should reduce the high costs associated with secondary care in hospitals.

However, general practice is currently facing unprecedented challenges. England has an ageing population: the number of people aged 65 and over is projected to increase in all regions of England by an average of 20% between mid-2014 and mid-2024.[b] The number of people with chronic conditions is increasing, including conditions such as diabetes, cancer and heart disease and dementia, which presents an enormous challenge. The majority of these are managed in general practice. GPs are also seeing patients with increasingly complex healthcare needs.

Concerns about capacity and demand are well-documented. We know that workload for general practice has increased substantially in recent years but this has not been matched by growth in either funding or in the workforce.

In its report on pressures in general practice, the King's Fund reported that the number of consultations grew by more than 15% between 2010/11 and 2014/15, and that many GPs are choosing to retire early or work part-time.[c] Without enough GPs to meet the growing demand, there is increasing pressure on general practice to manage patients' expectations about access to a consultation with a GP.

Workload also appears to be continuing to grow. In all regions across England, the number of patients registered at GP practices has been increasing year-on-year between 2013 and 2016, with an average increase of 7% and the largest rise in London at 10%. The South had the largest number of patients per practice in 2016, with an average of 8,661 patients per GP practice.[d] The rise in the number of patients per practice is not only related to a growing population but also a result of practices increasing in size through mergers and federations.

In June 2017, the number of full-time equivalent GPs and GP registrars in England was 34,242.[e] But there is a downward trend in the number of partner GPs in the UK, with a 400% increase in the number of salaried GPs from 2003 to 2012.[f] This could be a result of the increasing pressures associated with running a practice – either as an individual or as a partnership model – and a desire to control individual workload.

In April 2016, NHS England launched the General Practice Forward View in partnership with the Royal College of General Practitioners (RCGP) and Health Education England. This recognised that primary care has been under-funded compared with secondary care, and that general practice in particular has been under-funded over the past decade.[g]

As part of the GP Forward View, NHS England committed to invest an extra £2.4 billion a year by 2020/21 in a national sustainability and transformation package to support and grow general practice services to reverse the decline. The five-year programme pledges to address investment, workforce, workload, infrastructure and the redesign of care. It includes funding for 5,000 more GPs and 5,000 additional members of the practice team by 2020/21.

The workforce elements draw on a report for Health Education England, which recommended expanding the primary care workforce by using new clinical and support staff roles to address workload capacity issues.[h] It is vital that this investment is sustainable and used to make a meaningful impact and bring about positive change for the benefit of patients and the wider NHS.

The redesign of general practice has already started to evolve, with many smaller providers becoming part of a larger organisation or federation and closer, more integrated working with other primary healthcare teams and practices, which follows the recommendations of the RCGP's *Roadmap for General Practice*.[i] The benefits of the federated approach for patients are also echoed in RCGP's *Putting Patients First*, which stated "Federations would help ensure the continued viability of primary care – and the important personal link between the patient and the GP".[j]

A research study from the Nuffield Trust found that almost three quarters of surveyed GP practices are now in some form of collaboration with other practices, to deliver services at a larger scale, almost half of which formed during 2014/15.[k] In the British Medical Association's 2015 GP survey, in total over a third (37%) of GPs said their practice had joined with a network or federation, and the figure for England was 43%.[l] Many transformation approaches nationally also include new arrangements for general practice in primary care hubs or collaborative clusters, such as the Primary Care Home programme launched in October 2015, now serving eight million patients, across 14% of the population.[m]

At the time of writing, the GP Forward View is starting to make progress in terms of funding, although the impact on frontline general practice and patient care is yet to be seen in terms of benefits to patients.[n]

Regulation of general practice

All people in the UK are entitled to the services of an NHS GP, and they have the right to register with a GP practice that best suits their needs. However, for some patients, the choice of GP practice and access to high-quality care can be limited.

Regulation of general practice in England by CQC was introduced in April 2013. Before this, although there was regulation of GPs and nurses as professionals, there was no regulation of general practice that assured the quality of care on behalf of patients.

The focus of our approach to inspections – across all types of services we regulate – is on the quality and safety of services, based on the things that matter to people. This enables us to get to the heart of people's experiences. We developed the approach to regulating general practice by consulting with the public, people who use services, providers and organisations with an interest in our work, and tested it in the sector.

In October 2014, CQC started a comprehensive programme of inspections of GP practices. Our inspection teams are led by specialist CQC inspectors, always include a GP, and may also include other specialist input from a practice nurse or practice manager. They sometimes include an Expert by Experience (someone who uses a GP practice or has a particular experience of this type of care). We also speak with patients and staff to understand what the quality of care in a practice is truly like. Inspections look at the quality of care and treatment of the range of services offered in a practice – for example, from healthcare teams involving nurses, healthcare assistants, phlebotomists, pharmacists, physiotherapists and counsellors. This extends to how practice managers, receptionists and other staff contribute to patient care, and how a practice works with other healthcare professionals, such as health visitors, midwives, mental health services and social care services.

We completed our programme of comprehensive inspections in January 2017. This is the first comprehensive assessment of general practice of its kind. The evidence we have collected through our inspections has given us a detailed picture of general practice and an unparalleled resource of information. It has also provided us with a baseline against which we can continue to monitor and measure the quality of general practice in England.

This report

We are now able to set out the findings from our first inspection programme. In this report, we provide quantitative data on all the ratings we have given to practices, showing the ratings on first inspection compared with those as at 16 May 2017 when all practices had been inspected. Although we completed our initial programme of comprehensive inspections in January 2017, the data used in this report was extracted on 16 May 2017 to allow time for all inspection reports and ratings to be published. The data shows a picture for England across the overall ratings, and the ratings for each of our five key questions and population groups. We can also see where there are regional variations by looking at provision of GP practices within clinical commissioning group (CCG) and government regional office areas.

One of CQC's fundamental aims is to encourage improvement. In this report, we celebrate the fact that the vast majority of GP practices in England provide good or outstanding care. To find out what drives high-quality care, we carried out interviews with senior CQC inspection staff and national professional advisors across the country, including from a GP and nursing background, who have reviewed many inspection reports as part of our quality assurance process. We also analysed a sample of inspection reports where the GP practice was rated as outstanding overall.

This report is based on the knowledge and experience that CQC has amassed during the inspection programme.

We use this to present some of the common themes and characteristics that we found contributed to a GP practice providing high-quality care, and illustrate them by drawing from wider examples of inspection reports of high-performing providers, identified in the course of the inspection programme.

We also use our findings to look at how GP practices have improved the quality of care following an inspection – particularly those that were rated as inadequate and placed in special measures, or those subject to enforcement activity. As well as protecting the public from unsafe care, enforcement activity is designed to ensure that providers take action to improve the quality of their services. To give some insight into factors that either contributed to an improved rating, or that inhibited improvement, we analysed a selection of inspection reports of practices that had improved from a rating of inadequate to good, and carried out interviews with the CQC inspectors that re-inspected them. The interviews aimed to uncover the factors that had driven practices' improvement.

2. Ratings 2014 to 2017

Key points

- **Of all the health and care sectors that CQC regulates and rates, GP practices have consistently received among the highest ratings.**
- **On first inspection, 79% of GP practices were rated as good and 4% were rated as outstanding overall.**
- **At 16 May 2017, with re-inspections, this had improved to 86% rated as good and 4% outstanding overall.**
- **This meant that nearly three million people in England had access to care from practices rated as outstanding overall.**
- **But one in 10 practices needed to improve the quality of care, as 8% were rated as requires improvement and 2% rated as inadequate overall at 16 May 2017.**
- **Safety was the main concern as 27% were initially rated as requires improvement and 6% were rated as inadequate for the safe key question.**
- **Of the practices that were rated inadequate and re-inspected in the first programme, 80% improved their overall rating.**

2.1 Background

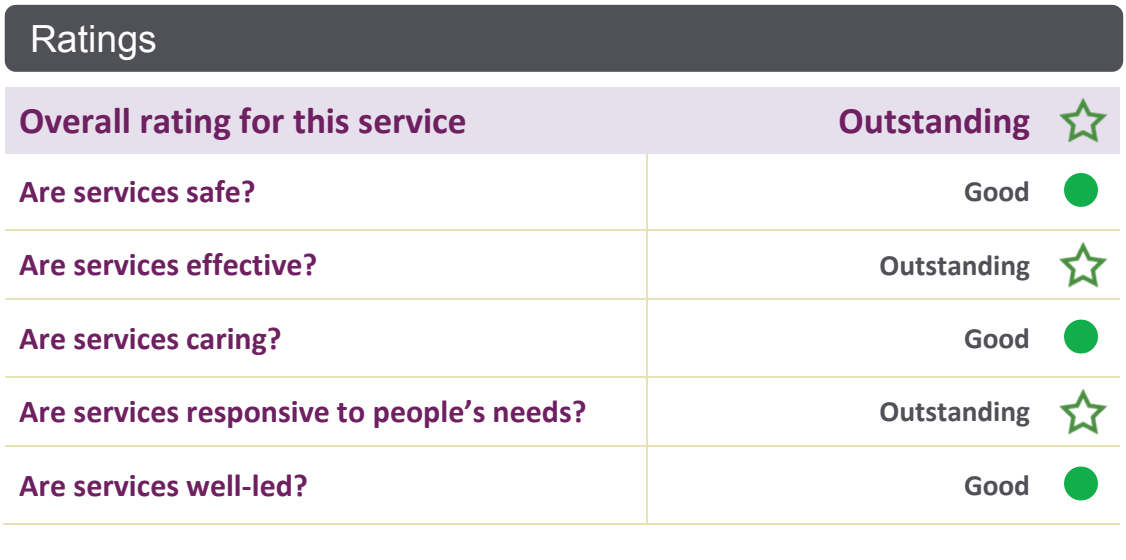
Our ratings of GP practices have been designed to give a clear indication to the public about the quality of their local services. They also act to encourage improvement, as they enable practices rated as requires improvement or inadequate to understand where they need to make improvements and aspire to achieve a higher overall rating.

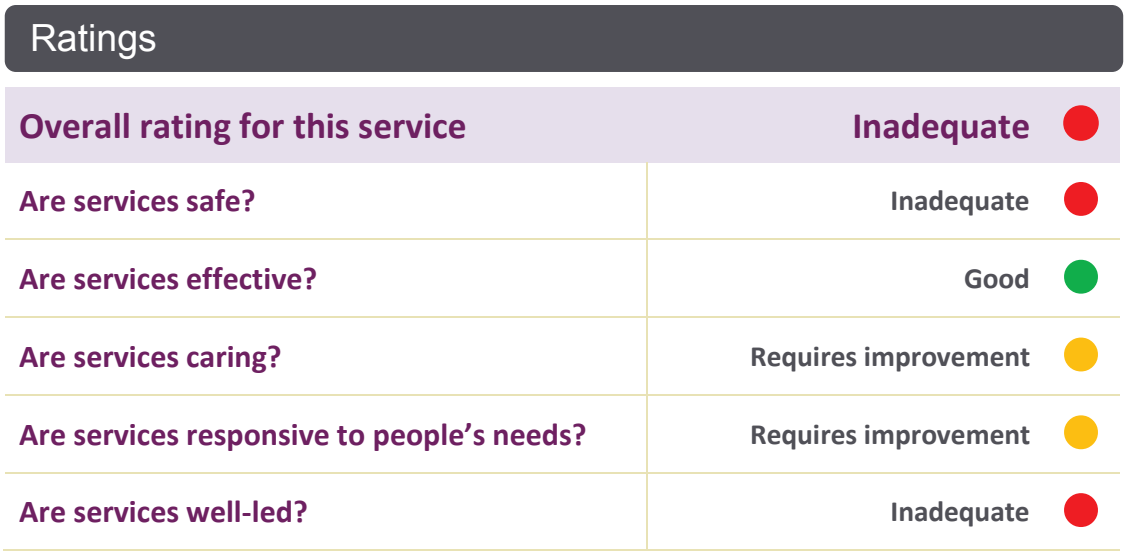
Ratings are based on a combination of what we find during an inspection, what the patients tell us, our monitoring data, and information from the practice itself. Inspectors use all the available evidence and their professional judgement and, following a thorough review process involving a number of checks to ensure quality and consistency, the inspection report is published on CQC's website.

As with all services that CQC rates, we ask five key questions: are they safe, effective, caring, responsive to people's needs and well-led? To decide on a rating, the inspection team asks: does the evidence demonstrate a potential rating of good? If yes, does it exceed the standard of good and could it be outstanding? If it suggests a rating below good, does it reflect the characteristics of requires improvement or inadequate?

We rate each of the five key questions and aggregate them to give an overall rating for a practice. Figure 1 shows examples of aggregated ratings for each key question and an overall rating.

Figure 1: Examples of overall ratings at practice level





For GP practices, we also look at the quality of care provided to six different population groups:

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people with dementia).

Each population group is rated separately and this feeds in to the overall aggregated ratings.

2.2 Overall ratings for GP practices

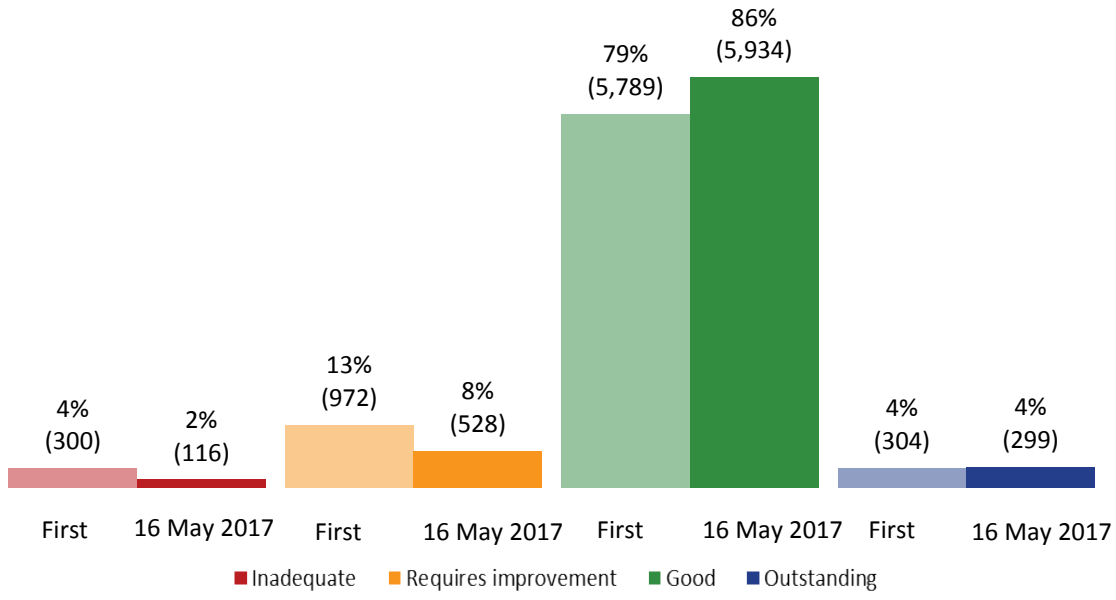
Of all the health and care sectors that CQC regulates and rates, GP practices have consistently received among the highest ratings.

It is important to compare the profile at the end of the first programme of inspections with the picture when practices received their first rating following an inspection, because the position has improved over time and the proportion of practices rated as good or outstanding has increased throughout the programme.

The quality of care in general practice overall is good. Of 7,365 first comprehensive inspections of GP practices, 79% were rated as good and 4% rated as outstanding. At the end of the first programme of inspections when a number of practices had been re-inspected (data from 16 May 2017), this increased to 86% rated as good and 4% rated as outstanding overall (figure 2).

We also found some poor care. When we carried out first inspections, a higher proportion of GP practices were initially rated as requires improvement or inadequate overall (13% rated as requires improvement, and 4% as inadequate). Again, these compare with figures from 16 May 2017, which show that 8% were rated as requires improvement and 2% rated as inadequate overall. This means that one in 10 practices still needed to improve the quality of care for patients.

Figure 2: Overall ratings of GP practices (at first inspection and at 16 May 2017)



Source: CQC ratings data (figures in brackets show the number of rated practices).

Where CQC rates a provider as inadequate, we will re-inspect it within six months. Of the practices that were re-inspected in the first programme, 80% improved their overall rating. We provide more details in the section on improvement in this report.

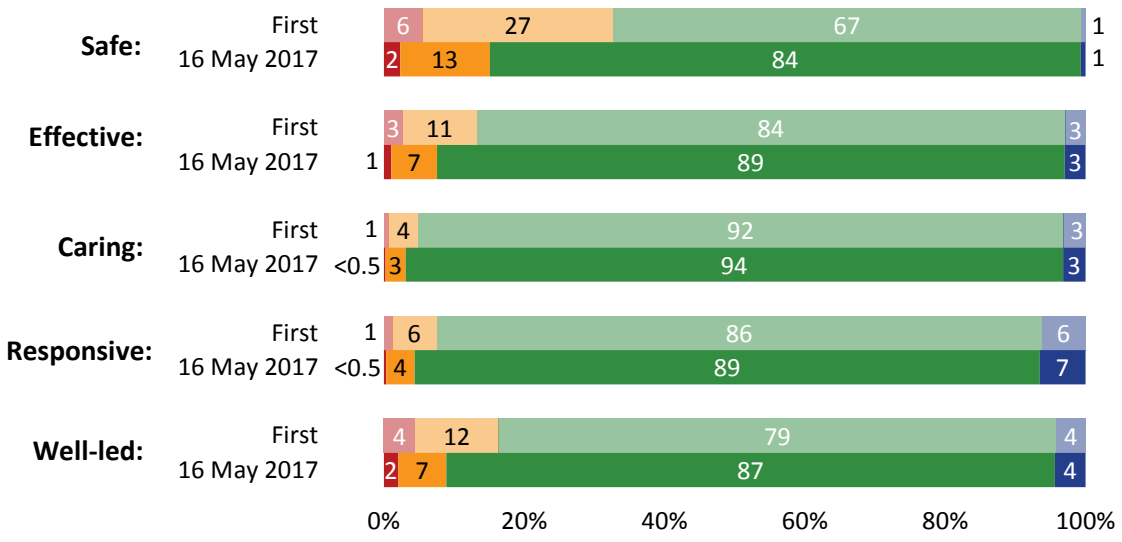
For most people, a GP is the first point of contact when they need healthcare and the place where they have an ongoing relationship with the NHS. At 16 May 2017, nearly three million people had access to care from practices rated as outstanding overall. But, while we are pleased with the high levels of good and outstanding care, there is still work to do as not everyone benefits from high-quality general practice. At the same time, more than 650,000 people in England were registered with practices rated as inadequate overall.

2.3 Ratings by key question

The vast majority of practices are caring, responsive and effective. Where we find problems, they are more frequently related to the practice's approach to safety and how well it is led and managed.

In the first inspections, 38% of practices were rated as requires improvement or inadequate in at least one of the five key questions. Although these ratings exposed a gap in quality, the sector has responded well and the picture at 16 May 2017 showed improvement (figure 3). We discuss this in more detail later in this report.

Figure 3: GP practice ratings by key question (at first inspection and at 16 May 2017)



Source: CQC ratings data (figures in bars are percentages).

Safe

Delivering safe care is essential. Patients can be protected from abuse and avoidable harm when a practice has robust systems and processes, creating a strong foundation to enable staff to be proactive about risk, assess and mitigate risk, and see problems before they happen. A safe track record, a willingness to report safety incidents and be actively involved in learning from them to drive improvement – both within and outside the practice – is a key indicator of its safety.

Overall performance for the safe key question continues to be the poorest of all the five key questions, as it shows the largest percentages of ratings of requires improvement and inadequate.

On first inspection, 27% of practices were rated as requires improvement and 6% were rated as inadequate for safety. This improved to 13% and 2% respectively, but still only 1% of practices were rated as outstanding for safety at 16 May 2017.

From our experience of the first inspection programme, the main issues we found included problems relating to poor systems and processes to manage risk so that incidents are less likely to happen again. These apply to many areas, such as safeguarding, effective administering of medicines and vaccines, managing serious incidents, and having appropriate equipment and medicines for emergency use. We found many practices had no arrangements for acting on patient safety alerts.

Having consistently safe care can be achieved partly by having the proper processes, formal training, and guidance for staff. Being able to easily access and follow up-to-date and relevant policies and guidance enables staff to be confident that they are acting in the right way for patients.

What may seem like simple day-to-day process issues can often be indicative of problems with overarching systems and governance. This is about having a culture that puts safety as a top priority and one that values ongoing learning from safety incidents. We have seen that a good safety culture within a practice is a result of leading by example, with partners and managers instilling this within the team. However, as well as lack of basic systems of management and out-of-date systems or processes, we have seen cases where a lack of governance around recruitment could have resulted in patients receiving unsafe care from a member of staff who was unqualified for their role. Where we found inadequate care that put patients at risk we took the appropriate enforcement action.

Although we have been concerned at the overall performance in safety, we have found significant improvement generally as individual practices have taken their inspection findings on board, and taken steps to improve. At 16 May 2017, although we had rated 15% of practices as inadequate or requires improvement for safety, this is an improvement from the overall figure of 33% found on first inspection.

Effective

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. An effective GP practice routinely reviews the effectiveness and appropriateness of its care as part of quality improvement. When care and support is effective, people have their needs assessed and their care and treatment delivered in line with current legislation, standards and evidence-based guidance. This is particularly important as patients are increasingly living longer with multiple, long-term and complex conditions.

On first inspection, 84% of practices were rated as good for the effective key question and 3% were rated as outstanding. This improved to 89% of practices rated as good and 3% as outstanding at 16 May 2017.

To support our judgements we look at existing data, including data from the Quality and Outcomes Framework (QOF), which is an annual reward and incentive programme detailing GP practice achievement results. We consider how QOF data compares with local clinical commissioning group (CCG) and national averages. Although QOF targets are a good indicator of meeting needs, reaching them all is not in itself an indicator of outstanding care.

Our qualitative analysis showed that the practices rated as outstanding for the effective key question went above and beyond QOF targets; they were proactive in identifying patients' needs and meeting them, and could demonstrate a positive effect as a result of their care. Importantly, we saw that those rated as outstanding could quantify the significant impact they were having on outcomes for patients. The interviewees point out that increasingly, these practices used non-traditional roles such as advanced nurse practitioners, care coordinators or healthcare assistants to support GPs and reduce referrals to secondary care or avoidable hospital admissions. This reflects the importance of having a multidisciplinary team and mix of skills in general practice. Outstanding practices also carried out more annual reviews for patients with long-term conditions by creating care plans or booklets that patients could use to better self-manage their conditions.

Where performance was poor for this question, our experience is that it was because practices had not carried out any clinical audits (in some cases for two years) or other quality improvement activity to demonstrate that they reviewed their own performance with national and local standards to ensure safe outcomes for patients. We have also seen practices with large backlogs of patient correspondence that had not been reviewed or filed onto the record system – for example, records of hospital, out-of-hours, walk-in centre and A&E discharge reports, and test results and prescription requests that had not been followed up for weeks. In the worst cases, referral letters for cancer opinions had not been followed up, which not only means that care may not be effective, but may also be unsafe. We acted in all cases of this nature to make sure that patients were protected and the practice made improvements.

Caring

Compassionate care has a lasting impact on people's experience of their GP practice. Our analysis of interviews and inspection reports found that practices with good and outstanding ratings got to know and understand their patients as individual people, and were sensitive to their preferences and requirements.

As well as observing how staff interact with patients, we base our judgements on patient feedback from comment cards, information from the patient participation group, data from the GP patient survey as well as the practice's own surveys, and to a lesser extent from Friends and Family Test results.

We found that, as with most other healthcare services, an overwhelming proportion of GP practices provide caring services to their patients, with caring being the best performing key question.

On first inspection 92% of practices were rated as good, 3% were rated as outstanding and 1% rated as inadequate. This improved further to 94% rated as good and fewer than 1% rated as inadequate at 16 May 2017.

This means that the vast majority of practices and the staff working in general practice treat their patients with compassion, kindness, dignity and respect. An example of this is by making sure they respect patients' privacy both in reception areas and in consulting rooms and explaining to patients what their care involves.

Other examples that our interviewees spoke of include providing 'extra special' end of life care and bereavement care, and practice staff responding to more vulnerable people from the moment they walk in – from receptionists to GPs. We found that another important aspect of caring is what practices do to identify and support patients who are carers. Where practices have identified a high percentage of carers on their patient list, we have seen some excellent outstanding practice, for example arranging special appointments for carers and having a coordinator within the practice to provide links with carers' organisations. Good and outstanding practices are also proactive in terms of carers' health, offering flu vaccinations and flexible carers' clinics.

However, where care could be improved, this related to a lack of continuity – where practices used multiple locums to address persistent staff shortages, with the result that their care was not person-centred, and also where patients had problems accessing an appointment.

Responsive

Good quality care is organised so that it responds to, and meets, the needs of the practice's local population. This includes access to appointments and services, choice and continuity of care, and meeting the needs of different people, including those in vulnerable circumstances. As well as face-to-face consultations, a responsive practice will carry out consultations by telephone or online by Skype, and offer tailored appointment lengths, home visits and extended opening hours.

On first inspections, we awarded the highest proportion of outstanding ratings for the responsive key question (6%) and rated 1% of practices as inadequate. These improved to 7% as outstanding and less than 1% as inadequate at 16 May 2017.

Our qualitative analysis showed that responsive practices go 'the extra mile' for vulnerable patients, for example, holding surgeries in other locations and providing free taxi services to help patients. We found that flexibility in providing care for patients is a central theme of outstanding services. The practices we rated as outstanding understood their patient population and their needs, and responded by adapting services and adopting different ways of working around these needs in a way that suited patients.

Practices that provide high-quality, responsive care also demonstrated that they have been proactive in engaging with their patients by 'including them in the conversation' and acting on feedback, complaints and concerns.

Being responsive is reflected in ratings for different population groups, for example, practices with a specific interest in care for homeless people. Practices that respond well to the needs of a particular demographic group have received the highest ratings for responsiveness for that population group.

However, throughout the inspection programme access to appointments remained an issue both in terms of what we found on inspection and what patients have told us. While this is a contractual requirement, poor access to appointments has a direct impact on quality and effectiveness of care. We have also found cases where practices had not responded to letters of complaint or discussed complaints within the practice so that trends were not identified and action could not be taken to improve.

Well-led

Good leadership, management and governance are essential in providing good quality care. They were the most common factors in practices that we rated as good or outstanding.

On first inspection, we rated 79% of practices as good and 4% as outstanding for being well-led. This improved to 87% and 4% at 16 May 2017.

Across the interviews with senior inspection staff in particular, participants shared the view that being rated outstanding for the well-led key question was an important driver for practices' performance across the other four key questions. We reflect on some of the underlying reasons that we have found for this in the next section.

In outstanding practices, we found that the leadership was clear about where they were going. They had a clear business plan, developed with the involvement of practice staff, which identified where they might be weak and had a strategic plan to address weaknesses.

Our qualitative analysis found that good leadership instilled a culture where staff work together so that everything they do is about the good of patients' health. These staff are thinking about the future and carrying out succession planning; for example, medical students that previously trained with the practice are now working there as GPs. Practices know what they will do if things go wrong. They plan for the future and may look to diversify.

From our inspections, we saw that where the quality of leadership was poor there were gaps in safe systems and processes and failures in communication between the leadership team and staff. Sometimes there were no regular practice meetings, which meant that there was no sharing or learning from significant events with staff.

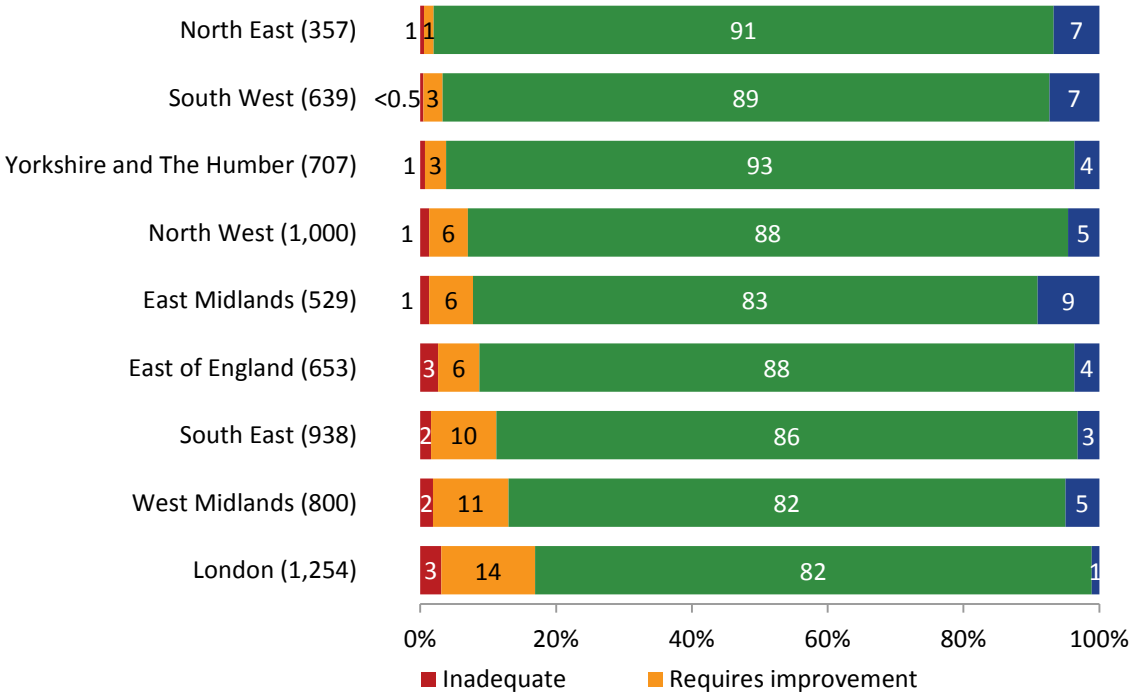
At 16 May 2017, overall ratings for the well-led question showed an improvement since first inspection. The proportion of practices rated as requires improvement reduced from 12% to 7% and ratings of inadequate reduced from 4% to 2%. However, 9% of practices still needed to improve the quality of their leadership. In these practices, GPs, partners and practice managers need to improve the way they lead the whole practice by continually improving, sharing their values and offering development opportunities to their clinical and non-clinical staff.

2.4 Ratings by geographical area

There is a clear regional variation in overall ratings for GP practices in England. Looking at the nine government regions, the North East had the largest percentage (98%) of practices rated as good (91%) and outstanding (7%), closely followed by Yorkshire and the Humber and the South West areas (figure 4).

In the London region, we inspected 1,254 practices and rated only 14 as outstanding. The London region had the largest number (17%) of practices rated as inadequate or requires improvement (14% rated as requires improvement and 3% as inadequate). We are also concerned about the numbers of practices in the West Midlands and South East that are rated as requires improvement or inadequate.

Figure 4: GP ratings by geographical area (at 16 May 2017)



Source: CQC ratings data (figures in bars are percentages).

There is a higher proportion of outstanding ratings in rural areas and a higher proportion of inadequate and requires improvement ratings in urban areas. We found examples of practices that have responded well to the challenges of having a low population density in a very rural area and have adapted their practices to meet people's needs. But similarly, in good and outstanding practices in urban areas, we have found the reasons for higher ratings may be down to how they address local challenges.

The variation in ratings may also be a result of clinical and professional isolation, depending on whether practice leaders are linked or isolated from their peers. There are many examples of outstanding practice in both rural and urban areas, as shown in the following excerpts from inspection reports.

Example of a caring small rural practice

"The surgery was embedded in and was an essential part of the local community. Staff regularly liaised with the local primary and secondary schools and were first on call for any health concerns. This helped to avoid unnecessary ambulance call outs and A&E attendances. Arrangements had been made to carry out joint home visits with district nurses and carers. This provided patients with a more co-ordinated care service. The practice offered a range of compassionate services to address social isolation among its patient population… Many people lived outside the village in very rural areas, for example on isolated farms. Some of the patients had been reluctant to engage with healthcare services in the past. The GPs had overcome this and spent time getting to know these patients. They carried out home visits and provided care and support where necessary."

Coniston Medical Practice, Coniston, Cumbria

Example of responding to homeless patients in a city

"The practice had a significant homeless and hostel dwelling population with drug and alcohol dependent needs. Access to services for these patients was good. The practice ran a combination of open, same day access clinics, along with booked appointments, as this flexible approach best suited the needs of people who often found it difficult to keep to rigid timetables and appointments. The practice had experienced clinicians including two dedicated homeless nurses, an alcohol nurse, shared drugs workers, two specialist GPs and close links with local homeless organisations. During the inspection we observed a flexible, sensitive, confidential and responsive approach when dealing with patients with complex health and mental health needs. We found the practice had good links with a local homeless hostel, and daily support was given by a support worker who acted as a waiting room mentor to support patients when they first and subsequently attended the homeless clinic."

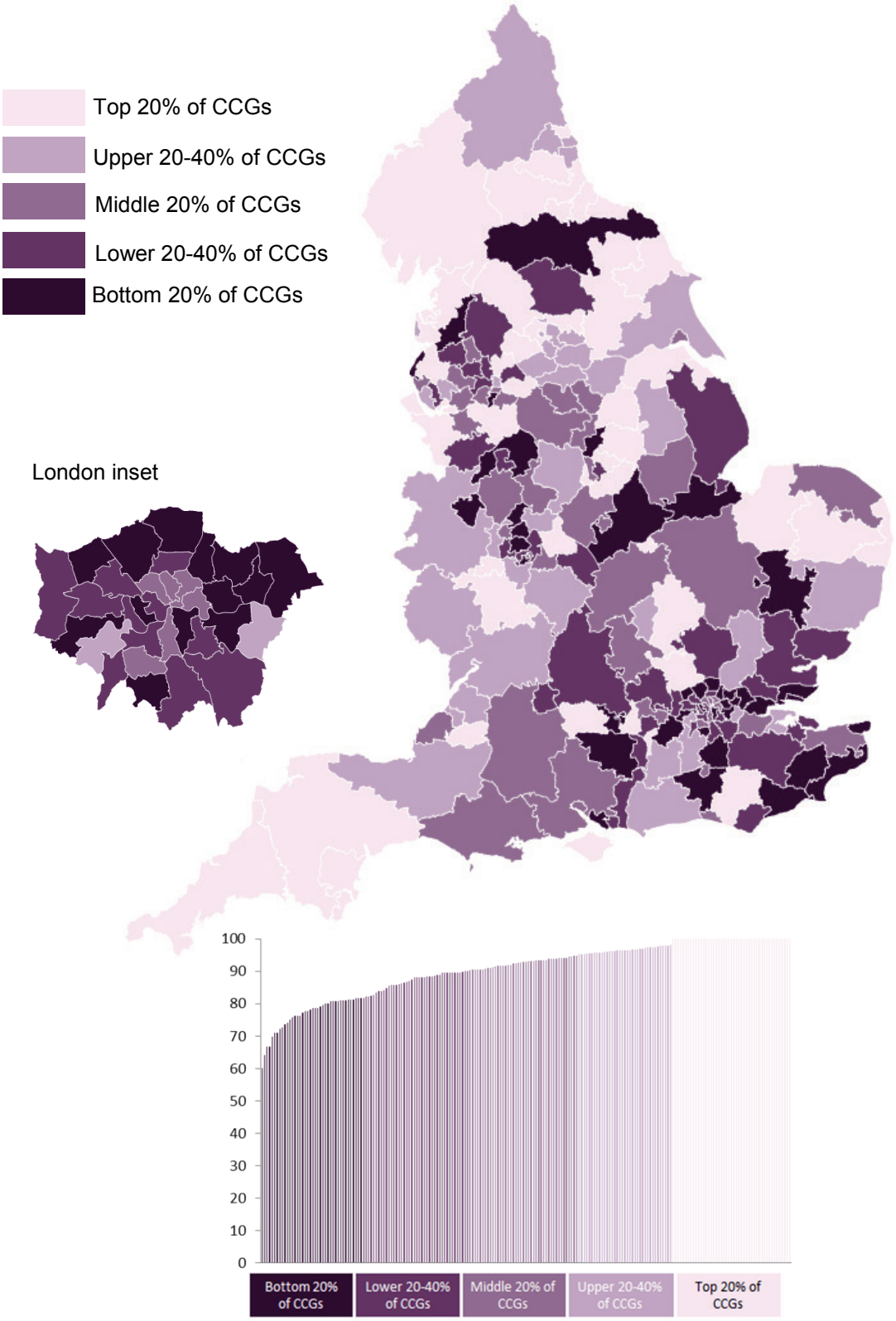
Brownlow Group Practice, Liverpool

Now that we have a more complete picture than ever before of the quality of general practice across the country, it is possible to map the variation. Although we have found the general standard to be high, we are continuing to explore the possible reasons for the geographical variation of ratings.

Figure 5 on the next page shows the percentage of practices with ratings of good and outstanding in each CCG area. The lighter areas on the map show where we found the highest rated practices.

It is important to note that CCGs in the lowest quintile still have between 60% and 82% of practices that are rated as good or outstanding.

Figure 5: Percentage of GP practices rated as good and outstanding by CCG (6,877 locations)



Note: Quintiles are based on the percentage of total number of GP practices rated as good and outstanding for each CCG. Source: CQC ratings data 16 May 2017.

2.5 Ratings by population group

As well as looking at practice-wide evidence that applies to everyone who uses the service, our inspectors look at specific evidence relating to six population groups. For example, we look at how a practice cares for older people, by offering proactive, personalised care from named GPs for patients who are aged over 75. And we look at the extra support for patients with mental health needs or dementia and whether the practice offers proactive screening and care plans. Our inspection reports highlight where we have found particularly innovative, high-quality or poor quality care for people in the different population groups.

We have learned that the most significant differences in quality between the population groups are highlighted in ratings for the effective and responsive key questions. This is because variation in practices' approach to safety and quality tends to affect all people using the GP practices and therefore impacts on all population group ratings in the same way.

Figure 6: Examples of variation in ratings for population groups within and between GP practices

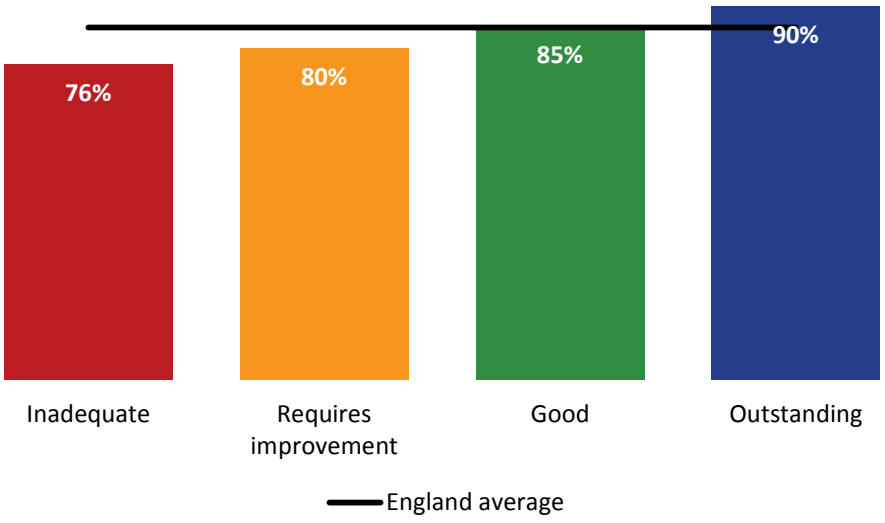
Because of the way our ratings are decided, there does not appear to be much difference between ratings for the population groups and the overall profile of ratings. Although we can see variation between practices (figure 6), it is difficult to see a national picture. We consulted on how we can improve and simplify the approach to rating population groups in our Next Phase of inspections, and will adapt our approach going forward.

2.6 Comparison with GP patient survey results

NHS England runs an independent annual national survey of patients registered with GP practices in England. This is sent to more than a million people and the results show how people feel about their GP practice. CQC's approach to inspection focuses on the importance of patients having a good experience of care and the overall quality of the service. It is therefore very useful to compare the results of the GP patient survey with our overall ratings.

Using results from the 2017 GP patient survey, figure 7 shows the total percentage of good experiences (responses as 'very good' and 'fairly good') for practices that we have rated. This shows that there is a link between people's experiences and CQC's ratings.

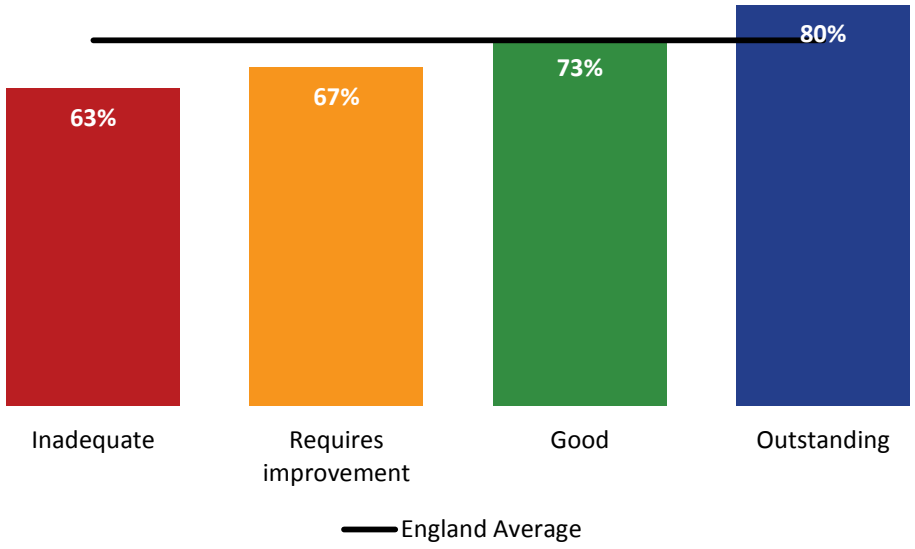
Figure 7: Overall good experience at the GP surgery (GP patient survey July 2017)



Source: GP patient survey July 2017 and CQC overall ratings 16 May 2017. Note: Based on all rated GP locations for which GP Patient Survey data is available. A small number of locations have no survey data.

The GP patient survey shows a similar link when looking at people's overall experience of making an appointment with their GP (figure 8). Again, where the survey shows a greater percentage of total 'good' responses, CQC's overall rating for a practice is better.

Figure 8: Overall good experience of making an appointment (GP patient survey July 2017)



Source: GP patient survey July 2017 and CQC overall ratings 16 May 2017. Note: Based on all rated GP locations for which GP Patient Survey data is available. A small number of locations have no survey data.

3. What drives great care?

The ratings from our programme of comprehensive inspections of GP practices show that the majority are providing good care. Furthermore, approximately 300 GP practices were rated as outstanding at 16 May 2017, delivering care to almost three million people.

This section of the report is based on interviews with senior CQC inspection staff and national professional advisors across the country, including from a GP and nursing background, who have reviewed many inspection reports as part of our quality assurance process. We draw on their reflections and experience of our first programme of inspections to understand the key factors and characteristics that drive truly excellent care. We also draw on an analysis of a sample of inspection reports where the GP practice was rated as outstanding overall. These themes are illustrated by drawing from wider examples in inspection reports of high-performing providers.

3.1 Proactively identifying and effectively responding to local needs

A GP practice can't deliver high-quality care that meets its patients' needs if it doesn't know what those needs are.

We found that GP practices providing high-quality care were proactive in identifying the needs of their patient population as well as people's health and care needs in the wider local community. Typically, they identified these needs by engaging effectively with patients, for example by working with their patient participation group (PPG) in a meaningful and constructive way and developing their own patient surveys. They worked in partnership with patients, which empowered and involved them meaningfully by designing services and developing the practice together. In these practices, our qualitative analysis found that patients and their feedback had often influenced care in the practice, including the strategy for the practice.

Once needs are identified, we found that practices providing high-quality care developed and implemented services in a way that responded to the identified needs. There were many examples of this for practices rated as outstanding, as in the following example of a practice that implemented initiatives not just to improve the health and wellbeing of patients, but also to reduce their reliance on primary healthcare or medication.

"The surgery was instrumental in setting up various social and community groups to suit the needs of the patient population as they had recognised that the high cost of joining social groups potentially made them unaffordable for patients. The groups included:

- BLISS (Believe Love Inspire Self-worth Support), for young isolated mothers, initiated by reception staff. A counsellor from the practice attended the group once a month.
- Mucky Monkeys, a group for young children and their parents, initiated by the Salvation Army and run by members of the reception staff.
- Inspire, a social group for older patients and the retired.

The practice employs in-house counsellors so they are easily accessible to patients. A focused care practitioner looked after a wide range of needs including family issues, alcoholism, sexual exploitation and sleep problems. The focused care practitioner saw patients on a regular basis when this was needed and put plans in place involving other organisations, such as the job centre or housing department, to ensure individual needs were met."

Hill Top Surgery (Hope Citadel CIC), Oldham

We often see excellent examples where GP practices are responsive to specific needs, for example, when there are more vulnerable people, such as homeless people or asylum seekers, or where there is a large student population. But being responsive to needs is also about being flexible and offering appointments for working people outside of normal working hours, longer appointments or using online appointments by Skype or telephone. The following practice was rated as outstanding for providing responsive care and rated as outstanding overall.

"There are innovative approaches to providing integrated patient-centred care. For example: The practice deals with the highest HIV rate in the county and worked closely with the local sexual health or genitourinary medicine clinic based in the same building as the practice, and an HIV service was provided at the adjacent pharmacy. The practice identified and provided additional support for children at risk of female genital mutilation, trafficking and radicalisation… The practice worked with a local women's refuge providing primary care and counselling support to women and their children."

Acorn Surgery, Huntingdon, Cambridge

Although there are recognised challenges to general practice from a local population and geographical context, this is not always a barrier to providing high-quality care and we have seen many examples of practices providing good and outstanding care in this context.

Our ratings showed that a larger proportion of services in cities were rated as inadequate, yet we have seen many examples of high-quality care in inner city areas, including some practices rated as outstanding. At the same time, we have seen outstanding care in rural practices in small villages.

In the interviews, our senior inspection staff spoke of outstanding practice in deprived areas with more social challenges, where practices have clear strategies to deal with these challenges and have committed practice teams that are values-driven and passionate about improving care for people. These staff wanted to 'make a difference' to people's lives and this, in turn, has had a positive impact on the culture of the practice and the quality of care. This included salaried GPs, GP partners, nurses, and receptionists. For example, we have seen high-quality care provided to homeless people and refugee populations.

Practices can face different challenges when delivering care whether they are an inner city practice or a rural practice. What matters is the way in which they identify and respond to local needs.

3.2 Innovative approaches that deliver real impact

Our analysis identified many examples of GP practices providing care in innovative ways that went beyond what they needed to do in terms of core services. This tended to be driven where they had tried to meet needs in a way that hadn't been tried before.

Many of the practices that we rated as outstanding have developed innovative working styles that have led to a direct improvement on patients' experiences and/or their outcomes of care, as well as indirect improvements, such as improving the working environment or developing new ways of working to use practice staff to their best potential.

However, innovation itself does not guarantee an outstanding rating. To be outstanding, our qualitative analysis found that innovation must be evidence-based and developed in response to a real need – either within the practice or within the local population, with evidence that it has had a positive, tangible impact on care. Some services are doing innovative work but they don't evaluate or measure it, therefore they cannot demonstrate its impact.

In the best practices, we saw clear evidence of the impact that the changes had made and the improvement over time. Inspectors noted that practices had made use of analytical tools and there was leadership capability to use available tools and techniques to drive continuous improvement and measure the impact.

Having evidence that an initiative has made a real impact on patient care is important and, in awarding our ratings, can elevate a rating to outstanding. Many practices have initiatives that are potentially outstanding because, for example, they have reduced rates of admission

to hospital, improved support for people with dementia by using dementia cafes, or organised fundraising events.

"The Bradford Bevan Pathway Team is a dedicated group of health and social care professionals that help patients who are homeless or vulnerably housed. The team attends regular meetings at the local hospital to review its patient group and any discharge plans. The Bevan team worked with the Bradford Respite and Intermediate Care Support Service (BRICSS), which is run by a social housing provider and provides accommodation, with Bevan Healthcare providing medical care for residents. It offers respite accommodation for homeless patients who need medical care after they are discharged from hospital. Bevan's Street Medicine Team also held mobile outreach clinics in city centre locations to enhance access for vulnerable patients and also offered advice and healthcare to people who were not registered with the practice.

These initiatives led to an increase in the number of homeless people registering with the practice, a reduction in the use of acute health care, A&E admissions and days spent in hospital.

A review conducted by an external agency of BRICCS, the Street Medicine Team and the Pathway Team found that for every £1 invested in these services the savings were from £1.50 to £8.00. The Bevan Pathway team was noted to have reduced acute health care costs by 62% by supporting homeless patients in primary care settings."

Bevan House, Bradford, West Yorkshire

In the following example, we saw evidence that the practice had been successful in reducing antibiotic prescriptions and that this effort was being maintained by using technology.

"Another audit looking at antibiotic prescribing showed that the practice had reduced its antibiotic prescribing by almost two-thirds despite an increasing list size. For example, the practice had prescribed the equivalent of 188 broad spectrum antibiotics (cephalosporins, quinolones and co-amoxiclav) per 12,000 patients in September 2014. This had reduced to the equivalent of 61 such prescriptions per 12,000 patients in June 2016. A computerised system was in place to alert a clinician if they were trying to prescribe an inappropriate antibiotic."

Cestria Health Centre, Chester Le Street, County Durham

But the interviews with CQC's senior inspection staff and professional advisors show that not all practices were able to demonstrate the impact that innovation has had on patient care, because they failed to measure the impact on wider system and health outcomes.

A holistic approach is also important in providing high-quality patient care, in particular achieving (and having evidence to prove) a positive impact on patients' all-round health

and wellbeing. The inspection programme has shown that good and outstanding practices proactively support people to live healthy lives, recognise social aspects such as employment, housing and finance, and then target support at people who are particularly vulnerable.

Our qualitative analysis found that as well as engaging with patients, meeting local needs is also achieved by engaging with external agencies and networks, including the voluntary sector.

3.3 Sharing learning internally and externally

The qualitative analysis found that a good practice constantly learns from positive and negative experiences, using the learning to improve services for patients. Some practices go further and share their learning with partners in the local health economy and with their patients. This particularly includes learning from safety incidents and serious events, so that they can prevent these from happening elsewhere. Where we had rated practices as outstanding for the safe key question, a key characteristic was evidence of a willingness to share learning externally with other GP practices and wider stakeholders. These practices got people involved by sharing learning across the health community through newsletters, and with the CCG. The inspection programme has shown that practices that had the foresight to pool and share resources were also able to respond more appropriately.

Conversely, the interviews with senior inspection staff and professional advisors found that practices rated as requires improvement or inadequate tend to be more inward looking and less responsive and keen to learn, and this can restrict their ability to learn, adapt and change.

If staff were able to share learning, it supported their own continued professional development, as well as the practice's contribution to the wider health economy. For example, a nurse who was designated 'nurse lead' may attend meetings and forums to share learning and reflect and maintain their clinical knowledge. They would then bring back ideas that could benefit patients by applying their learning to practice. When staff kept on top of latest evidence regarding treatment, this new evidence translated into practice, such as reviewing medication based on guidance.

The interviewees noted that GPs often have special or academic interests or are engaged outside of the practice in local or national roles with the CCG, NHS or Royal College of General Practitioners. They may bring the learning back into their own practice, but what makes it outstanding is whether there is evidence to demonstrate that this knowledge and experience is having an impact on the GP's practice and its patients. In practices that are rated as requires improvement or inadequate, we saw GPs with outside interests that took them away from the day-to-day business of the practice and had no direct impact on the care for their patients.

In the following example, the practice was participating in a research study and had been recognised for its contribution.

"The practice participated in local audits, national benchmarking, accreditation, peer review and research. At the time of our inspection the practice were involved in the East London Gene Study (aimed to improve health among people of Pakistani and Bangladeshi heritage by analysing the genes and health of local people) and had recruited over 600 candidates… and the HepFree Study aimed to identify patients with unknown chronic active hepatitis. The practice was awarded star GP practice of the month in May 2016 by the 'HepFree' team for high rates of testing and identification."

St Andrews Health Centre, Bromley-by-Bow, London

Some practices are also proactive in encouraging learning among their patients.

"Quorn Medical Centre took a lead role in organising a learning event for patients in the South Charnwood locality, conducted by pulmonary rehabilitation specialists for patients with asthma and chronic obstructive pulmonary disease. It was attended by 93 patients and feedback was 100% positive, indicating they had an increased knowledge in managing their condition and use of inhalers."

Quorn Medical Centre, Leicestershire

Throughout the first inspection programme, we have also found examples of high-performing practices that shared their learning with others in the local care system, as shown in the following example.

"The practice analysed its emergency admissions for patients and identified that many had been admitted from a care home with dehydration and worsening infections. The practice provided training to care home staff on recognising worsening illness and had developed protocols for situations such as what to do after falls, head injuries and weight loss pathways. Emergency admission rates for these conditions had reduced since 2014/15.

"The practice was an early adopter and innovator using computer tablets and mobile technologies to provide high quality care to patients in their own homes or in care home settings. The practice had committed to working with the CCG to share this knowledge and experience to help other practices implement new technologies."

Brinsley Avenue Practice, Stoke on Trent

3.4 Multidisciplinary working

The role of healthcare professionals other than GPs and practice nurses is becoming increasingly important in many GP practice teams. Most practices carry out some multidisciplinary working, but our inspections have found that a feature of high-quality general practice was where the work was driven by patient need to enhance care and overcome traditional organisational barriers, and was regularly planned and discussed.

Internally within practices, our qualitative analysis found that a larger team size, with a mix of skills encompassing staff from a range of professional backgrounds, contributed to high-quality care. In these practices, roles were clearly identified, and can include for example nurses, phlebotomists, counsellors, pharmacists, occupational therapists and physiotherapists. Having a broader skill mix in a practice could also be a solution to recruitment problems. Our findings echo those of the report by the Primary Care Workforce Commission for Health Education England, which recommended expanding the workforce in primary care by using new clinical and support staff roles and more multidisciplinary working to address workload issues within general practice.[o]

From our experience of general practice inspections, we found that those rated as good or outstanding tended to have invested in, and valued, their nursing teams. General practice nurses (GPNs) have a crucial and expanding role in delivering high-quality care, for example in the areas of long-term conditions, wound care and the success of the childhood immunisation programme. The role of GPN can sometimes be isolated, and we found that a larger nursing team presented several advantages. For example, in a larger team it is easier to develop expertise in specific areas and divide responsibilities that would often be the sole responsibility of a single GPN; this can cause practices to perform poorly in the safe key question, for example in the governance systems for monitoring medicines, equipment and infection control. Although we found a growth in the role of nurses providing care for patients with acute conditions, some providers could not always demonstrate sufficient clinical oversight and support for this advanced level of practice. We found the role of nurse manager was more common in large practices and is valuable in developing the nursing team with professional support and appraisal, including for Nursing and Midwifery Council revalidation and skill mix.

Providers have reported widespread problems in recruiting GPNs, and the General Practice Nursing Workforce Development Plan, which is part of the GP Forward View, aims to address this by improving training in GP practice settings and raising the profile of the role to help retain and expand the general practice nursing workforce.[p]

The findings from our interviews with senior inspection staff show that multidisciplinary working also contributed to high-quality care where teams worked out of the practice and with professionals from other services in the local community. We have seen evidence from practices rated as outstanding of multidisciplinary team meetings that were having a positive impact on care.

"Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Monthly meetings took place with other health care professionals including the GPs, healthcare assistant, the practice manager, the local hospice, district nurses, health visitor and members of the local health and social care team. Care plans were routinely reviewed and updated for patients with complex needs. Vulnerable patients were identified and their needs discussed.

"The practice was involved in setting a community hub operating centre (CHOC) within the town. This involved bringing together a team from different disciplines such as mental health, social care, community nursing, voluntary organisations and GPs to help make sure that the identified patients had a joined up care plan, which met their needs, and focused on keeping them well at home."

The Butchery Surgery, Sandwich, Kent

3.5 System-wide engagement

The interviews and inspection report analysis indicate that the majority of practices rated as outstanding are involved in their local area in a very active way, both in terms of planning services and in working with individuals to provide care with multidisciplinary teams as an externally focused activity. These practices welcome other services into the practice, engage with them, involve them in patient care, share learning and have a real sense of collaboration.

The interviewees noted that outstanding practices are not insular, but are proactive and outward-facing with excellent external relationships. This includes effective links with the wider health economy, including other GP practices, providers in other sectors such as care homes, community or acute trusts and hospital consultants, and the voluntary sector.

We saw many examples of this joint working and where this had had a positive impact on patient care. For example, they might be working with a local hospital trust with patients that repeatedly attend A&E, planning alternatives that involve district nursing, and they are aware of patients being discharged from hospital who may need more support. They adopt an individualised case management approach to reduce impact on the wider system for patients who have conditions that are better served elsewhere.

3.6 Thinking strategically and planning ahead

Having a clear strategy and vision is a key factor in providing quality general practice. Our inspection report analysis found that when practices have a strategy they plan for the future and recognise that how they deliver services, and the skills they need to deliver care, will change over time. In the following example, the practice successfully demonstrated that it was planning for the future and, furthermore, was involving patients through its patient participation group (PPG) in the process.

> "The practice acknowledged the challenges they faced with an increasing and ageing population with multiple health needs, coupled with limited finances. There was a documented five-year strategy to meet the challenges, which included succession planning. The practice was planning to extend their premises to accommodate more consulting rooms and office space. Patients and staff have been involved in the discussions and the PPG was actively involved in seeking planning permission."
>
> **Quorn Medical Centre, Leicestershire**

Planning for the future effectively includes considered succession planning with regard to staffing and recruitment and staff development, and aligning this to the strategy to ensure that patients have sustainable access to services. The analysis of inspection reports showed that this was sometimes achieved through regular meetings between GP partners and the management team, as in the following example.

> "The partners and management team met every two weeks to discuss key business issues and the long-term strategy of the practice. Succession planning had been implemented as two partners were to retire over the next 14 months and a salaried GP had already been recruited to maintain a good level of access for patients in the long term."
>
> **Dr Young and Partners, Spondon, Derbyshire**

From the sample of inspection reports of GP practices rated as outstanding, we saw that practices supported and encouraged their staff in all types of roles (including both clinical and administrative) to continue in their professional development and enhance their career. We also found that a non-hierarchical culture is important for ensuring that staff feel valued. In outstanding services, staff are actively engaged, feel able and supported to say what they feel, and are comfortable suggesting or leading improvements and saying when things went wrong. There is also high staff and patient satisfaction and staff are proud to work for the practice. This level of staff engagement is highlighted in the following outstanding example.

"The practice had a culture of encouraging staff to take ownership of tasks and we saw that staff were empowered. There were high staff satisfaction rates. Following staff suggestions, the practice had a communication board in the administrative area that highlighted areas for action. This highlighted where the staff needed to concentrate their efforts in order to improve the running of the practice and patient care. Staff told us they felt involved and engaged to improve how the practice was run."

Shinwell Medical Centre, Peterlee, County Durham

We saw that outstanding services had a shared and often values-based vision for the practice. This characteristic was also mentioned by our interviewees, who found that staff in these services worked together and everything they did was about the good of patients' health, particularly in a disadvantaged population.

However, we also have a contrasting experience of inspecting practices that were rated as inadequate, where we received negative feedback when talking to staff. Staff have told us that there was no engagement with GP partners to gather their views and they did not feel involved in discussions about how to run or develop the practice.

3.7 Size of practice

The size of a GP practice does not dictate whether it can provide good quality care (or is rated as good or outstanding), but there was a link. Findings from our interviews suggest that in a larger practice it is easier to have staff with defined roles, and there is a greater likelihood that there will be well-functioning nursing teams where nurses focus on particular areas, such as diabetes or chronic obstructive pulmonary disease (COPD), and junior nurses take on task-oriented roles.

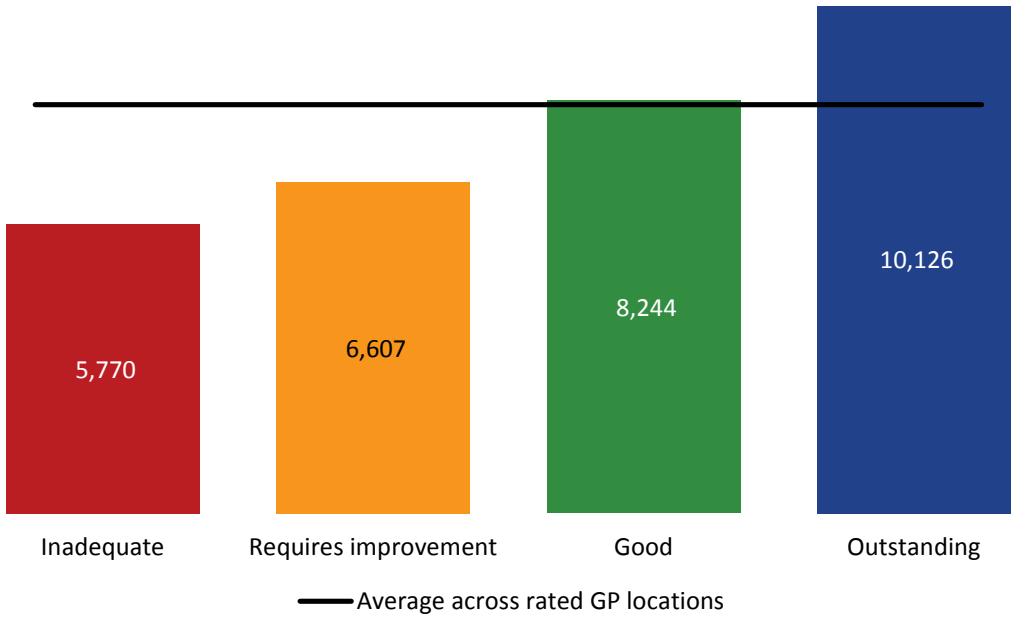
Our qualitative analysis indicated that the factors that inhibited a higher rating for a smaller practice could be related to financial pressures and professional or clinical isolation. Although patients value single-handed GPs, it can be harder to deliver high-quality, innovative services as a team of one. Where there are more people working in a practice, and a larger patient list, it is easier to deliver a wider range of high-quality services and be innovative.

We are seeing various routes to working at scale, such as the formation of super practices ranging from 10 GPs up to 60 or more GPs, and covering much larger geographical areas. But we are also seeing working at scale, where there has been no change to the provider status, through alliance agreements and collaborations. For example, the Primary Care Home programme run by the National Association of Primary Care is an innovative approach to strengthening and redesigning primary care by bringing together a range of health and social care professionals to work collaboratively to provide enhanced personalised and

preventative care for their local community.[q] Staff from GP practices, community, mental health and acute trusts, social care and the voluntary sector, focus on local population needs and provide care closer to patients' homes. There are now approximately 180 sites delivering this model across England covering eight million patients.

There is some relationship between the size of the practice and the rating. Figure 9 shows that where the practice is bigger – seen by having a bigger patient list – the rating is better.

Figure 9: Average number of registered patients per rated GP location by overall rating



Source: NHS Digital, 12 May 2017 and CQC overall ratings 16 May 2017. Note: 215 locations could not be Organisation Data Service code-mapped or did not provide list size data and so are not included.

However, CQC's inspection programme has shown that being outstanding is not necessarily about the size of the practice; rather it's about knowledge of the population and the provision of a service that meets their needs. We have seen some smaller practices that provide really caring and responsive services. For example, in some rural areas, a practice may be small out of necessity because it serves a small population spread out over a large area of countryside. Some single-handed practices also provide an excellent service because they are supported by good clinical networks. It is therefore important to support clinical networks for practice leaders to avoid clinical and professional isolation and enable practices to deliver high-quality care.

3.8 Influence of effective practice management

Investing in clinical and non-clinical staff is important. A highly motivated, experienced and knowledgeable practice manager has a picture of the business and clinical care, providing background support, and coordinating the whole running of the practice. Our inspections found that those practices rated as outstanding had proactive and committed practice managers who worked well with the GPs to ensure effective leadership across general as well as clinical management. Where the GP leaders handed over ownership and authority, the practice managers were able to flourish.

But we also found that they need to be valued as part of the team and have authority, which needs a good leadership culture and support from the partners, otherwise their efforts did not have any impact on patient care. Where we found poor performance around governance in the inspection programme, there was lack of clarity between the practice manager and GP partners.

For example, in one practice that was rated as inadequate, we received conflicting information on who had responsibility for managing and overseeing recruitment processes, which meant that the practice recruited inappropriate staff, potentially leading to unsafe care. But we have seen examples where the practice manager has become a partner in the organisation and this has sometimes been a key factor in driving a practice towards becoming outstanding. The following example shows how investing in training for a practice manager helped with motivation and continuity of staff.

"The GPs and leadership team had invested in their staff over a long period. This had led to a happy, loyal workforce with low staff turnover. Staff were supported both financially and with protected time to develop personally and professionally in addition to the required updates. For example, the practice manager had started at the practice as a sixth form school leaver. They started in the administration team and were sponsored to obtain a dispensary qualification, followed by a national vocational qualification (NVQ) in business and administration and Level 4 management NVQ. The practice then funded her foundation degree in Management and Leadership prior to promoting her to practice manager.

"There had been effective succession planning… the previous practice manager had spent six months coaching and supporting the new practice manager in their role to ensure competency and continuity of service during the transition of management."

Kingskerswell and Ipplepen Medical Practice, Newton Abbott, Devon

3.9 Leadership

Underpinning the delivery of high-quality care and the delivery of the approaches set out above relies on strong leadership. Our expert interviews found that, where there is strong leadership from GPs, nurses and practice management, there is a positive impact on the quality of care. The culture that leaders create within the practice is important: where we saw high-quality general practice there was a non-hierarchical structure and a culture that valued the input of staff, with a balanced team that respected and valued all professionals with mutual respect and connection.

The following example from the outstanding report analysis shows where a practice had strong leadership and governance embedded in its culture.

"The leadership, governance and culture were used to drive and improve the delivery of high-quality, person-centred care. The practice had undertaken training on personality testing, which they offered to all staff and used to plan team working. Teams within the practice were set up using the results, by ensuring that personality types were as important as skill mix in deciding who should work together. The practice believed that this method increased productivity and reduced workplace conflict. Staff told us that the personality tests had given them a better understanding of why people worked the way they did, and also about how they worked themselves, and felt that it had improved working relationships at the practice."

Distington Surgery, Workington, Cumbria

Because good leadership is a fundamental driver for practices' performance across all areas, when leadership is poor it has a detrimental effect on safety, effectiveness and responsiveness. We found examples in practices with a poor rating where, although practice staff knew who to go to with concerns, they were not confident that these would be addressed and they reported feeling demotivated, demoralised and disillusioned with the lack of management support.

The following example is from a practice rated as outstanding and shows that the leadership contributed to the overall safety of care.

"The practice had used the Manchester Patient Safety Framework as a basis for developing [its] error reporting protocol and facilitating "a team based self-reflection and educational exercise on improving patient safety culture". As a result, staff were fully committed to reporting incidents and near misses, as well as improving the safety culture within the practice. Every opportunity to learn from internal incidents and significant events was used by staff to improve patient care and outcomes. Improvement work had been undertaken in respect of medicines management and error reporting to ensure patients received safe care. The processes in place for monitoring safety and risk management were comprehensive and had been improved when needed. This included infection and control practices, use of equipment and arrangements to deal with emergencies and major incidents. Suitable recruitment procedures were in place to ensure fit and proper staff were employed. There were enough staff to keep patients safe."

Bakewell Medical Practice, Bakewell, Derbyshire

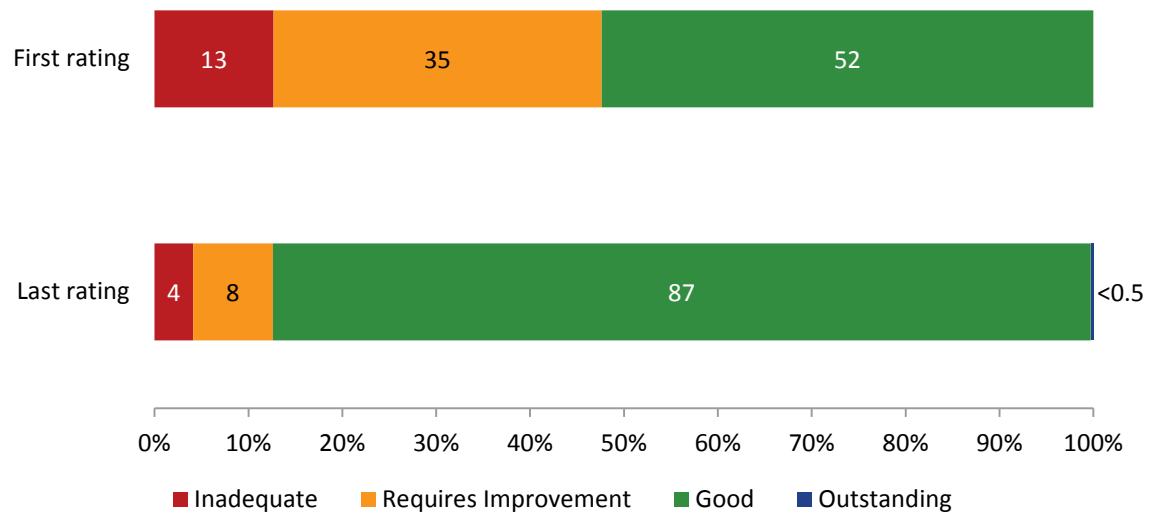
4. Improvement and deterioration

Key points

- **Of the practices rated as requires improvement or inadequate on first inspection and re-inspected, 82% had improved their rating by 16 May 2017.**
- **Over half (53%) of the practices that were rated as inadequate on first inspection and re-inspected were rated as good on the latest inspection.**
- **At the end of May 2017, 138 practices had come out of special measures because they improved (71% of practices re-inspected).**

Between the beginning of the inspection programme and 16 May 2017, we returned to re-inspect 1,333 practices (figure 10). Of these, 635 practices had been rated as requires improvement or inadequate for their first overall rating; following re-inspection, 520 (82%) had improved their performance and rating overall.

Figure 10: Overall ratings for GP practices before and after re-inspection

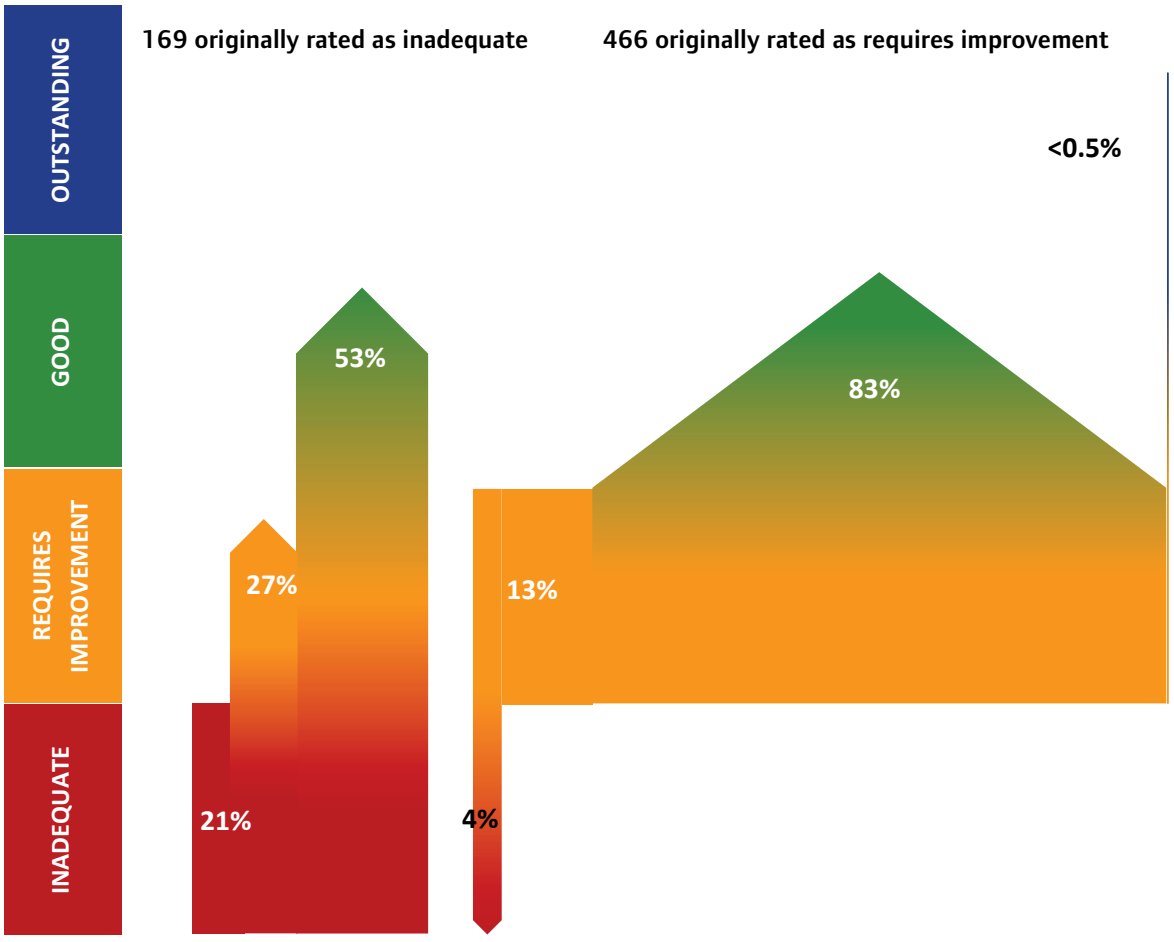


Source: CQC ratings data, based on 1,333 re-inspected locations, as at 16 May 2017 (figures in the bars are percentages).

Of all the practices that we re-inspected, 90% have improved in at least one key question and not deteriorated in any others. However, 4% have deteriorated in at least one key question and 6% have stayed the same.

Of those practices rated as inadequate on their first inspection and re-inspected, over half (53%) were rated as good on their latest inspection. However, 21% of those rated as inadequate remained inadequate. Of those rated as requires improvement on their first inspection, 83% improved to good on their latest inspection (figure 11).

Figure 11: Improvement in ratings on re-inspection (for practices rated as inadequate or requires improvement on their first inspection)



Source: CQC ratings data 16 May 2017. Note: The width of each cluster of arrows is relative to the number of re-inspections carried out.

4.1 Special measures

People who use GP services have the right to expect high-quality, safe, effective and compassionate care. Where care falls below this standard and we judge it to be inadequate following an inspection, we place the GP practice into special measures. This is because we want to ensure that practices found to be providing inadequate care do not carry on doing so and that they get the support they need to improve.

Under our current policy, a practice is automatically put into special measures if it is rated as inadequate overall, or if it is rated as inadequate in one or more key questions or population groups in two successive inspections. Such practices would normally be re-inspected after six months in special measures.

The purpose of special measures is to:

- ensure that providers found to be providing inadequate care significantly improve
- provide a framework within which we use our enforcement powers in response to inadequate care and work with, or make providers aware of, other organisations in the system, to ensure that the practice makes improvements
- provide a clear timeframe within which a practice must improve the quality of its care, or we will take further action, for example to cancel its registration
- open the way to a package of support from NHS England or the Royal College of General Practitioners to help the practice improve.

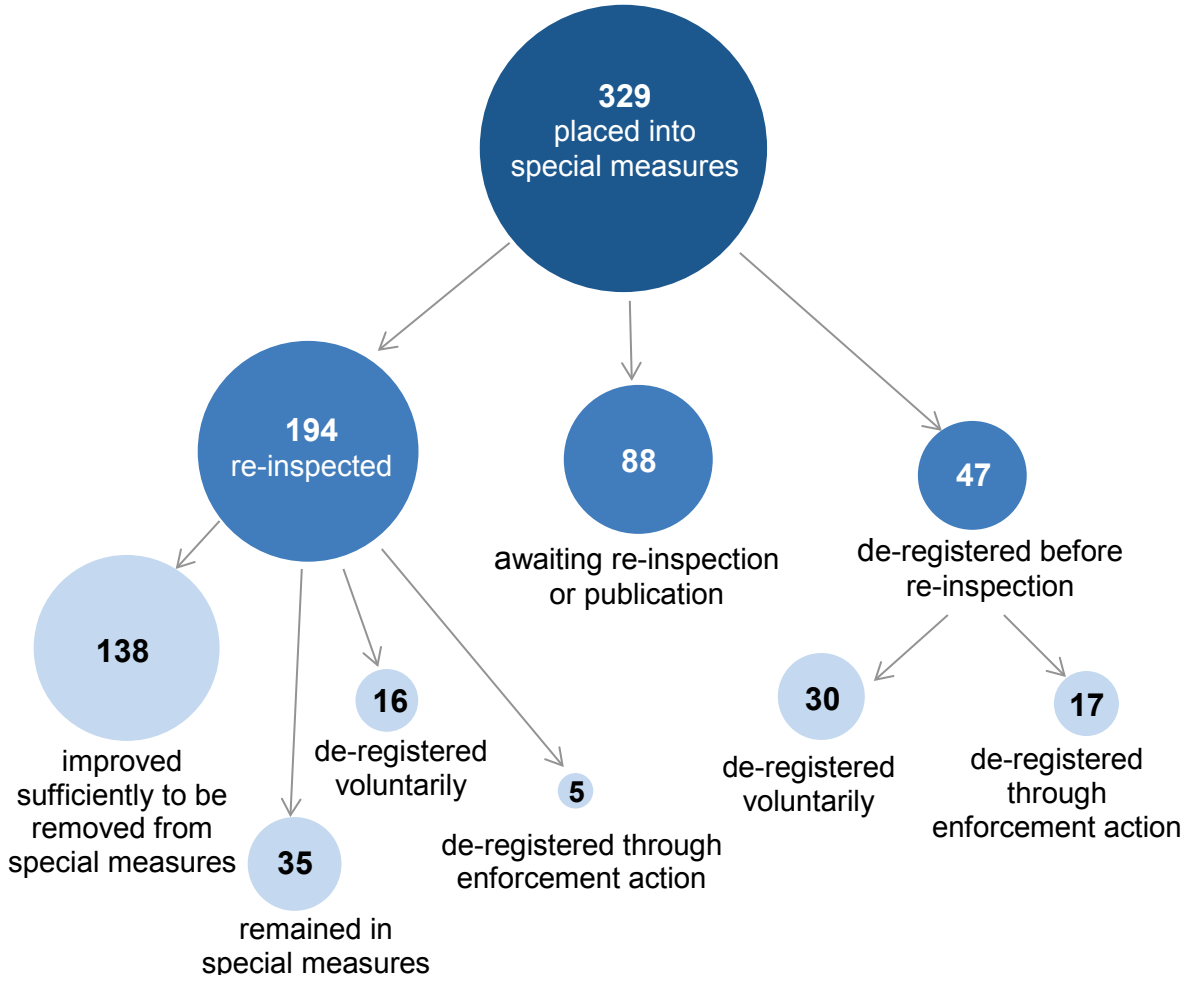
The strength of our regulatory action is always in proportion to the risk to the safety of patients. When we place a GP practice into special measures, we will re-inspect it within six months. At this inspection we expect to see improvements to the quality of care: if the practice continues to be rated as inadequate and has not made sufficient improvements by complying with the legal requirements in the warning notice, we will take action in line with our enforcement policy. In some cases, this can mean cancelling the practice's registration.

To come out of special measures, a GP practice needs to have an overall rating of requires improvement or better. In our re-inspections of practices that have been in special measures, the majority have made improvements and many are now providing good care.

From the start of the programme in January 2015 up to 31 May 2017, 329 practices entered special measures. Of the 194 practices that were re-inspected, 71% improved their rating and exited the regime.

At the time of writing, some practices had not received their second inspection, or had not shown enough improvement to exit special measures. A proportion of practices that had been put into special measures had their registration cancelled – either voluntarily or as a result of enforcement action by CQC (figure 12).

Figure 12: Journey of practices in special measures at



Source: CQC special measures data 31 May 2017.

4.2 What drives improvement?

In this section, we reflect on the factors that have enabled GP practices to improve from a rating of inadequate to a rating of good, drawing on findings from case studies. To develop the case studies, we analysed a selection of inspection reports and interviewed the inspectors that visited practices to carry out the re-inspection. The interviews aimed to uncover the factors that had driven practices' improvement.

Acknowledging the problems

A finding from the case studies was that acknowledgement of problems was important to improvement. Practices that improved had acknowledged that there were problems in the practice that needed attention and they were willing to learn from the findings of the inspection. They were motivated to change, keen to learn from what was wrong and were keen to access support to try to improve.

We saw that key members of senior staff, including GP partners and practice managers, needed to embrace the findings from the inspection as an opportunity to improve. These people were the driving forces behind the changes that were made. If there is a culture of owning problems and reflecting on the things that haven't gone well, then there is more likely to be improvement within the practice. They recognise that it is a whole staff effort, not just down to one person.

The case studies showed that an initial rating of inadequate can be a shock to the practice, but this can be channelled into making improvements. Some practices were eager to protect their reputation, and were motivated to improve to 'lose' the inadequate rating.

We found that a negative attitude towards the inspection meant that the findings from the inspection were dismissed and this was a key internal barrier to their improvement. In particular, practices that rejected the findings and rating, rather than focus on making changes, were less likely to improve as they had not recognised that they needed to change and lacked appreciation of the severity of the issues raised.

Governance

Our case study analysis found that a key driver of improvement was to address and resolve governance issues – the clinical and corporate systems and processes that underpin how practices assure their practice and the care they provide. Practices may improve by refreshing systems and processes through governance and appraisals. An example of this is a practice that had employed a reception manager to ensure a consistent set of policies across sites following concerns about the behaviour of receptionists; in turn, when the CQC inspector re-visited the practice, they saw that this had freed up time for the practice manager to focus on the governance concerns.

"The practice manager and partners had been able to develop new systems of governance by engaging with the staff and empowering them, by delegating responsibilities and action from governance meetings. The hiring of the reception manager freed up the time for the practice manager to do this."
(**CQC inspector**)

In other examples, practices had recruited operations managers to deliver a unified strategy and policies that aligned with it, and created new roles to share some of the responsibilities for governance with a GP partner. This helped to establish clearer roles and responsibilities. To be successful in driving improvement, the practice manager needed to have authority and be empowered to make the necessary changes.

Our case study analysis also identified that clinical partners were particularly important across the practices, as improvements were made when clinical partners engaged more with the business side of the practices and had a better understanding of the governance around safety, safeguarding and risk assessment.

Where practices failed to improve, we identified a lack of recognition of the importance of good governance. Many systems and processes such as patient record-keeping or clinical audits were absent or inadequate. When they were addressed, it was sometimes via a 'tick-box' approach, which was insufficiently embedded or monitored. It could be as a result of an 'old-fashioned' view of general practice and not keeping up-to-date with the vital role of clinical governance in quality services.

Leadership

In practices that had improved on re-inspection, leadership was particularly important. In some cases it was the leadership role performed by the practice manager that was a key driver of improvement. In the following example, the CQC inspector highlighted the dismissal of the practice manager as impetus for a positive shift in culture within the practice when they re-inspected.

"The management team 'got a grip on things'. The practice manager left after CQC's inspection team brought to light serious concerns. GP partners had previously left the running of things to the practice manager but, after the inspection, there was a shift in culture across leadership. They embraced the findings of the inspection and worked through the action plan set out for them. The departure of the practice manager and the change in culture allowed staff to learn new roles and become empowered. Going back in to the practice, it was like seeing a different group of people.''
(**CQC inspector**)

Poor leadership emerged as the strongest message from practices that had failed to improve.

The case study analysis identified that there were barriers around ownership of improvements. In one practice, the lead GP had outsourced the improvement process to an external consultant, who had come in to drive through changes in the practice. Elsewhere, the GP lead nominally gave the lead to the practice manager, but undermined decisions that would have led to improvement. In a third case, the GP lead left improvements to an over-stretched practice manager and a one-day-a-week locum GP. This undermined the sustainability of any changes made.

The lack of an effective practice manager was also a factor in practices' failure to improve. If practice managers were either absent, temporary, or overstretched across multiple services, they were not empowered to drive change, or did not have the time or the clinical background to fully address or monitor improvements. Therefore, effective clinical and management leadership are important if ratings are to improve.

Internal staffing issues and dysfunctional working relationships within the practice, which are often longstanding, stifled improvement. Difficulties in recruiting staff from all professional backgrounds – not just GPs but nurses – particularly following a rating of inadequate, limited practices from improving because of a perceived poor reputation. However, the interviews identified that some practices had overcome this challenge through having nurse-led services and creative recruitment strategies.

Support from external bodies

The case studies identified that practices that had improved from a rating of inadequate to good needed varying degrees of external support to deliver improvements. The Royal College of General Practitioners (RCGP) currently runs a peer support programme, commissioned and funded by NHS England. This is aimed at helping practices rated as inadequate and placed in special measures, and allows them to apply for funding. The scheme offers struggling practices up to six months of turnaround support including advice, mentoring and improvement plans. In some cases, we have seen strong support for practices from their clinical commissioning group (CCG) or local medical committee (LMC).

In some cases analysed in the sample, the input provided by the RCGP, CCGs and LMCs had an influence on practices' improvement from inadequate to good. In some examples, with refreshed leadership, practices were able to drive the improvements on their own, and in others, improvement came through working with another practice or forming a larger federation.

Where practices failed to improve on the second inspection, the case study analysis found that improvement was inhibited because practices were unwilling to accept that they needed support or to access the support that may be available to help them improve. This included support from other GP practices as well as the RCGP programme, which is optional.

Although access to external support can be a driver for improvement, we have seen that there is a lack of a system-wide coordinated programme of support for practices, rated as both requires improvement and inadequate.

We have not found any causal relationship between the funding that practices receive from the NHS and our ratings. This is a complex area that may benefit from further work.

4.3 Maintaining improvement

While most GP practices have improved since being rated as inadequate, there are a number that have failed to improve. Where a practice fails to improve and is rated as inadequate at the second inspection, we take further action in line with our enforcement policy and, in some instances, this is to begin the process of preventing the provider from operating the service.

Looking at practices that were rated as inadequate overall on their first inspection, which was more than six months before the ratings picture was extracted on 16 May 2017, we are able to track what has happened to them. There were 229 practices: 26 of these became inactive before we could re-inspect them. Being inactive means that the provider that was registered with us had either left the market entirely, or had at least changed a material aspect of its service and then re-registered with us. At 16 May 2017, 35 practices were either awaiting inspection or publication of their inspection report and rating.

This meant that we re-inspected 168 practices: of these, 133 improved their overall rating and 35 remained rated as inadequate. Of the 35 that remained as inadequate, 18 subsequently became inactive.

It is still too early for us to have a good overall picture of the sustainability of improvement. However, we have seen a small number of cases of practices whose rating had initially improved, but which then deteriorated. This shows the importance of a consistent and sustainable programme of support to help practices improve and to maintain that improvement. Implementing the pledges in the GP Forward View, and ensuring that practices are fully aware of available support, is therefore a key element of improvement.

Maintaining improvement in GP practices is particularly important for all health services in a local area, as we know that good and outstanding practices are a key driver for good integrated models of care for patients.

Conclusion

This report shows that the majority of people in England receive good quality care from general practice. It also shows that there are pockets of poor practice, which CQC has identified and highlighted so that care can improve for the benefit of patients, and the profession.

We want to support general practices in England so that everybody receives good quality care. To do this, we will continue to work with NHS England, NHS Clinical Commissioners, the professional regulators and other national bodies to develop a shared view of quality and reduce duplication of reporting and, as a result, the administrative impact on GPs more widely. Our inspections have found a number of internal and external factors that contribute to high-quality care, and factors that may inhibit it. We recognise the need for more multidisciplinary working to enable patients to see other healthcare professionals to reduce pressure on GPs. We also believe that sustainability in general practice can be achieved if practices work collaboratively.

The information we now have about the quality of care in general practice provides a valuable baseline. From this, we can share what we know about how practices are delivering high-quality care, at the same time as identifying those practices that need further support. In this respect, the funding from the GP Forward View must be targeted appropriately to ensure that struggling practices are able to sustain improvements. Delivery of the GP Forward View is critical to address the challenges that the sector faces and ensure that it gets the investment it needs to continue to play a key role in a sustainable local health economy and ensure that patients get access to the high-quality care they need.

We intend to look at how this investment has had an impact on the quality of care. We also intend to delve deeper into some of the factors identified in this report that enabled practices to improve, as well as the reasons for deterioration.

Going forward

As a learning organisation, CQC recognises what aspects of the first programme of inspections have worked, and those that we need to improve. We are now using the learning to refine our approach to how we regulate general practice in England. For example, where services are rated as good or outstanding our approach will be more proportionate, and we will work collaboratively with commissioners and other stakeholders to reduce duplication of what we ask of general practice and to share information effectively so we have a shared view of quality. But we will always continue to ensure that patient safety remains paramount through monitoring and taking action where we believe patients to be at risk.

We will use our monitoring information to follow up any potential changes in the quality of care and, in light of what we have found through our first programme, will always inspect the leadership, governance and culture of the practice.

As part of our monitoring of practices, we will still be looking for evidence of outstanding care, and where we think somewhere has improved beyond good we will inspect so that we can understand the reasons why and share the learning. We have consulted on our proposed changes and, after considering the feedback, will implement them in our Next Phase of regulation of general practice.

References

a. National Audit Office, *Stocktake of access to general practice in England*, November 2015.

b. Office for National Statistics, Subnational population projections for England: 2014-based projections

c. Kings Fund, *Understanding pressures in general practice*, May 2016.

d. NHS Digital 2016 supplementary information files, http://content.digital.nhs.uk/media/23016/Patients-per-practice-at-CCG-level-2013-2016/xls/Patients_Per_Practice_CCG_level_2013-2016.xlsx, and http://content.digital.nhs.uk/media/23017/GP-practices-by-CCG-2013-to-2016/xls/GP_practices_by_CCG_2013-2016.xlsx.

e. NHS Digital, General and Personal Medical Services, England June 2017, Provisional Experimental Statistics http://digital.nhs.uk/catalogue/PUB30052.

f. British Medical Association media briefing 2017.

g. NHS England, General Practice Forward View, April 2016.

h. The Primary Care Workforce Commission report for Health Education England, *The future of primary care, creating teams for tomorrow*, July 2015.

i. Lakhani, M, Baker, M, Field SJ, *The Future Direction of General Practice: A roadmap*, Royal College of General Practitioners, 2007.

j. Field S, Gerada C, Baker M, Pringle M, Aswani K, *Primary Care federations, Putting Patients First*, Royal College of General Practitioners, 2008.

k. Nuffield Trust, Is bigger better? Lessons for large-scale general practice 2015.

l. British Medical Association, National Survey of GPs: Future of General Practice, 2015.

m. www.napc.co.uk/primary-care-home

n. http://www.rcgp.org.uk/news/2017/july/gp-forward-view-falling-short-on-workforce-but-still-the-lifeline-general-practice-needs.aspx.

o. The Primary Care Workforce Commission report for Health Education England, *The future of primary care, creating teams for tomorrow*, July 2015.

p. Health Education England, *The General Practice Nursing Workforce Development Plan*, March 2017.

q. http://www.napc.co.uk/primary-care-home.

Published September 2017

Care Quality Commission

How to contact us

Call us on > 03000 616161

Email us at > enquiries@cqc.org.uk

Look at our website > www.cqc.org.uk

Write to us at >

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter > @CareQualityComm

Please contact us if you would like this report in another language or format.

CQC-381-092017

Appendix B

Health & Well-being Scrutiny Commission

Turning Point Care Quality Commission Report

Lead director: Ruth Tennant

Useful information

- Ward(s) affected: All
- Report author: Andy Humpherson; Group Manager
- Author contact details: 0116 454 2353 / Andy.Humpherson@leicester.gov.uk
- Report version number: 2

1. Summary

The purpose of this report is to provide the Health & Wellbeing Scrutiny Commission with an update on the Care Quality Commission's (CQC) inspection of Turning Point. The report also details the activity of the Contracts & Assurance Service (CaAS) to monitor the service.

2. Recommendations

The Commission is recommended to note the contents of this report and provide any comments necessary.

3.1 Background

3.1.1. Turning Point UK(TP) were awarded the Leicester and Leicestershire (LLR) integrated substance misuse contracts in February 2016, with the service beginning in July 2016 for a period of 4 years with the option to extend by a further one year. The service brought together 6 different service areas into one across Leicester and Leicestershire, with provision for Adults, Young People and those in Prison.

3.1.2. The 6 different services reviewed and brought together were:

3.1.2.1. Leicester Recovery Partnership (LRP) was a consortium led by Leicester Partnership NHS Trust with services sub contracted from Phoenix Futures and Reaching People, a local Community Voluntary Service (CVS) umbrella organisation. LRP were commissioned to provide a diverse range of interventions: outreach, Information Advice and Guidance, open access, needle exchange, clinical interventions, primary care services and structured day programme and recovery interventions.

3.1.2.2. Swanswell provided community substance misuse in Leicestershire and were commissioned to provide a range of interventions: outreach, Information Advice and Guidance, open access, needle exchange, clinical interventions, primary care services and structured day programme and recovery interventions.

3.1.2.3. Lifeline provided the Young People's Specialist Substance Misuse Service, with the aim of reducing the level of substance misuse and related-harm amongst young people (10-17 years). This was achieved

through the provision of age-appropriate information, advice and self-help guidance, provide structured substance misuse specific care planned treatment, and needle exchange services.

3.1.2.4. University Hospitals Leicester – Leicester, Leicestershire and Rutland hospital-based alcohol liaison service.

3.1.2.5. Derbyshire Leicestershire Northamptonshire & Rutland Community Rehabilitation Company (National Probation Service). Commissioned to meet needs of individuals with substance misuse related problems (including clinical interventions) and who had been in contact with any criminal justice agency across Leicester, Leicestershire & Rutland and those within HMP Leicester.

3.1.2.6. Inclusion Healthcare – Commissioned to meet needs of individuals with substance misuse related problems in HMP Leicester.

3.1.3. The services were procured following a review, which identified that an integrated approach across Leicester and Leicestershire should be commissioned. The review found that an Integrated approach:

- Provided the greatest opportunity to deliver efficiencies whilst delivering quality services through consolidation of various contracts and reducing duplication and back office management / overhead costs.
- Ensured equity in access to services regardless of whether users live in the city or the counties.
- Supported service user anonymity; users could access services not in their immediate area of residence, but equally would be able to access services close to home. This afforded service users more flexibility and choice in their treatment pathway, further reducing barriers to continued engagement.
- Provided seamless service provision that will support the movement of service users in their journey within the pathway, and lead to reduced attrition rates i.e. reduce the likelihood of service users dropping out of treatment as they navigate their way through the treatment journey.

3.1.4. This was the third recommissioning of substance misuse services since 2009-10. The Government's new 2017 Drug Strategy recognises the problems that can be caused by frequent re-tendering such as "unplanned consequences and instability with long-lasting effects e.g. high staff turnover, loss of trust and relationships."

3.1.5. Substance misuse services are commissioned jointly with Leicestershire County Council, the Office of Police & Crime Commissioner (OPCC) and NHS England (NHSE)(specifically those services in HMP Leicester), who make a funding contribution to the various services in the city.

3.1.6. An integrated substance misuse commissioning board (chaired jointly by the Directors of Public Health for the Councils) holds strategic oversight of individual services, as well as joint work around anti-social behaviour, and community safety.

3.1.7. The TP service is the City's main substance misuse service providing a range of direct access services including:

- Information, advice and harm reduction
- Structured treatment
- Access to mutual aid and recovery support

3.1.8 The service has a main base at 2 Eldon St but provides outreach at venues across the City. It has a separate base for its young person's service (at the 'Y' on Granby St).Services are accessible by phone, in person and through it's online 'well-being cloud'. Services are staffed Monday to Saturday including two evenings per week.

3.1.9. The Council commissions additional substance misuse services that support key areas of the treatment and recovery pathway:

- The Recovery Hub for street/dependent drinkers(Hill St)-through Inclusion HealthCare
- Substance misuse housing-related support for those in treatment who are at risk of homelessness-though Home Group.
- Inpatient detox services through Nottinghamshire Health care Trust

3.1.10. Substance misuse services are provided within a significant body of international evidence and national clinical guidance and where provided effectively are an important local intervention to reduce harm to individuals and communities.

3.1.11. Turning Point's mobilisation process was complex and included the TUPE of over 200 staff, the development of new sites, and the care planning for around 4,000 users in treatment(across L&L), around half of which had clinical interventions.

3.1.12. TP resourced the implementation/mobilisation at both a national and local level and brought a 'steady state' approach to transfer to ensure a seamless transfer and the clinical safety of users.

3.2 Care Quality Commission (CQC) Inspection

3.2.1 The service was inspected by a team from the Care Quality Commission (CQC) in June 2017. Whilst CQC do not currently rate substance misuse services, they have shared with the Councils that the overall assessment of the TP service was 'good'.

3.2.2 CQC particularly praised TP for showing "outstanding practice" in managing the transition. However, a number of minor issues were identified:

- Lack of a community detoxification service.
- Ligature audits and risk management plans were not always complete.
- Client's privacy and confidentiality was not always maintained while using the needle exchange service in Loughborough.
- Staff did not always update and document all risk assessments.

- Building repairs and maintenance at Granby Street were not always carried out in a timely manner.
- First aid boxes were not always regularly checked and maintained.

Two issues resulted in breaches of the Health & Social Care Act:

- Clinical waste was not managed in accordance with guidelines.
- Staff could not produce maintenance certificates for the stair lift at Granby Street.

3.2.4 All issues have been responded to and addressed by TP.

3.2.5 Leicester City Council met with the Care Quality Commissions lead inspector for this inspection to discuss the report.

3.2.6 CQC have stated that they will re-inspect Turning Point's provision in Leicester and Leicestershire within the next 12 months and the services will be given a rating.

3.2.7 Although CQC's assessment of the new service was positive, there have been a number of performance issues within the service as a result of the change in provider. These have included data quality issues and a reduction in the number of adults and young people in treatment. This has been partly as a result of the service focusing on the safety and treatment for highest risk clients, particularly opiate users. This is being closely performance monitored with Turning Point and an action plan has been developed to improve performance. Local data is being reviewed monthly and nationally-verified performance data is due to be released in early February. .

3.2.8 In addition to the CQC, the contracting and performance team are undertaking a more detailed quality visit of the service. This includes:

- An assessment of compliance against a number of outcomes and requirements of the specification.
- A postal / pick up survey of service users.
- Targeted surveys of complex groups e.g. street drinkers.
- Surveys of stakeholders and staff
- Announced visits to hubs and the main Eldon Street centre to observe practice, and any environmental risks.
- Audits of service user records and support.
- 1-2-1 interviews with service users, staff, and any stakeholders at hubs and the Eldon Street centre.
- Review of intelligence held within CaAS and with other key partner agencies.
- Review of data from the National Drug Treatment Management System.

3.2.9 The QAF will be completed in late January / early February; any non-compliance identified will be collated into an action plan with appropriate timescales for completion. A QAF report will be available in February.

4. Details of Scrutiny

No other scrutiny conducted

5. Financial, legal and other implications

5.1 Financial implications

No Financial Implications

5.2 Legal implications

No Legal Implications

5.3 Climate Change and Carbon Reduction implications

No Climate Change Implications.

5.4 Equalities Implications

No equalities implications

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

No other implications

6. Background information and other papers:

7. Summary of appendices:

Appendix 1 – Care Quality Commission Inspection Report

8. Is this a private report?

No.

9. Is this a "key decision"?

No

Turning Point Leicestershire and Leicester

Quality Report

2 Eldon Street
Leicester
LE1 3QL
Tel: 03303 036000
Website: www.turning-point.org.uk

Date of inspection visit: 19 June to 21 June 2017
Date of publication: 05/09/2017

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- Interview rooms were fitted with alarms. Staff had the option of carrying personal alarms. CCTV cameras were in all public areas of the building at Eldon Street.
- There was access to doctors and a team of 27 accredited voluntary peer mentors.
- The service was meeting their referral to assessment targets of three weeks. Treatment started immediately following assessment. There was no waiting list. The service was able to see urgent referrals within 24 hours.
- Managers and staff held weekly meetings to discuss new referrals, complex cases, and clients who had not attended for their appointments.
- There were robust systems and processes for reporting, investigating, tracking, and monitoring

Summary of findings

incidents, complaints, and safeguarding alerts. The service had a comprehensive audit programme. The provider had a comprehensive and ongoing programme of service improvements.

- Staff used encrypted laptops to work remotely away from base. This meant that staff could update care plans and colleagues could see the information in real time.
- Ninety percent of staff had completed mandatory training, 97% of staff had received an ongoing personal review (annual appraisal) and 100% of staff had to date supervision.
- Carers and family members had access to facilitated support groups. The service operated extended opening hours.
- Clients had designed the reception area and chosen the furnishings at Eldon Street with a proposal to have a coffee bar located in the reception area.
- Staff discussed alternative treatment options with clients including plans in the case of unexpected exit from treatment.
- The organisation had a clear vision, set of values and a definition of recovery that was understood by staff and clients.
- Senior managers, hub managers, and team leaders demonstrated the skills, knowledge, and capacity to lead effectively.
- The service recognised staff achievements through the Turning Point Inspired by Possibility Awards 2017 and Inspiring Leicestershire awards.

However, we also found the following issues that the service provider needs to improve:

- The ligature audit for Eldon was not complete.
- Staff had not labelled clinical waste bags in accordance with guidance and protocols.
- Staff had not checked first aid boxes. Staff could not produce maintenance certificates for the stair lift at Granby Street.
- The needle exchange service at Loughborough was located in the reception area of the building. Therefore, staff could not assure clients' privacy and confidentiality while using this service.
- Staff had not updated the original risk assessments in 14 out of 20 records we reviewed. However, they had updated the daily care notes with changes to a client's risk and the risk management plans. This meant that not all risk information was readily available. Managers were aware of this issue and were addressing it with the staff concerned.
- Some staff believed they could not carry out mental capacity assessments and were referring these cases to doctors and GP's.
- The provider was not offering a community detoxification service or comprehensive physical health care. Both of these activities are considered best practice for a recovery focussed substance misuse service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse/ detoxification		We do not currently rate standalone substance misuse services.

Summary of findings

Contents

Turning Point Leicestershire and Leicester

Services we looked at
Substance misuse/detoxification

Summary of this inspection

Background to Turning Point Leicestershire and Leicester

Turning Point is a national organisation with 750 healthcare and residential services nationally.

In July 2016 Turning Point, took over eight separate and pre-existing drug and alcohol services operating around Leicester, Leicestershire and Rutland to form the current independent substance misuse service registered as Turning Point Leicestershire and Leicester.

The service provides community based substance misuse interventions to 3,366 young people and adults across Leicester City, Leicestershire and Rutland. The service also holds the contract for Leicester prison drug and alcohol services.

The service operates through seven clinical teams working out of five hubs. The main hub in Leicester City Centre known as Eldon Street accommodates three teams, City North East with Market Harborough; City South West; and the Criminal Justice team. The Loughborough hub covers Loughborough, Melton and Rutland areas; the Coalville hub covers Coalville and Hinckley areas; and the Young People's team based at Granby Street hub in Leicester City Centre covers the Leicester City, County and Rutland areas. The prison in reach team who are based at Leicester prison, were not part of this inspection.

In addition to the clinical teams, there is a data performance and administration team, an engagement team, a partnership team, and a senior management team all based at Eldon Street Leicester.

During the inspection, we inspected all of the above clinical teams, with the exception of the prison in reach team, and held discussions with representatives from the non-clinical teams.

Leicester City Council, Leicestershire County Council, and the Office of the Police and Crime Commissioner commissioned the service. Turning Point Leicestershire and Leicester registered with CQC in July 2016. It is registered to provide treatment of disease, disorder or injury. The service has a registered manager, Lucy Kennedy.

Turning Point Leicestershire and Leicester has not previously been inspected by CQC.

Our inspection team

The team that inspected the service comprised CQC inspector Debra Greaves (inspection lead), two other CQC inspectors, an assistant inspector; a specialist advisor nurse, and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Summary of this inspection

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before the inspection visit, we reviewed information that we held about the location, asked other organisations for information.

During the inspection visit, the inspection team:

- visited four hubs for this location, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with 18 clients and four carers
- interviewed four senior managers, the registered manager and four team leaders
- spoke with two doctors and two independent nurse prescribers
- spoke with 13 other staff members employed by the service provider, including nurses, senior therapists, recovery workers and administrators
- spoke with three volunteer peer mentors, one on site police officer and a health champion
- received feedback about the service from two commissioners
- attended and observed two multidisciplinary meetings, three therapy intervention groups, a new starters clinic and the needle exchange service
- collected feedback using comment cards from 41 clients and carers
- looked at 20 care and treatment records, for clients
- reviewed ten staff files
- Looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

- We received 41 comment cards, and spoke with 18 clients and four carers.
- Positive comments included how the service had been easy to access and the staff treated clients with respect. Clients felt staff were knowledgeable about substance misuse had a caring attitude, and they could trust them to give good information.
- We received six negative comments from four separate clients and carers about the service. Two comments related to difficulties getting hold of key workers outside of appointment times. Two comments related to delayed prescriptions. One client told us they did not feel the health screening was very good, and another client told us communication between the service and their GP was not good.
- Clients stated staff were not judgemental, understood the problems there addictions caused and how these problems affected their family, work and social lives. Clients said staff were prepared to be flexible with appointments, offering times to fit in with work and family commitments.
- Clients we spoke with were all aware of their recovery plans, could recall when they last had a care review, and knew who their key worker was.
- Two carers told us they had been as involved as they had wanted to be with their family member while in treatment with the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- The ligature assessment for Eldon Street was not complete, some ligature points had been omitted.
- The Loughborough needle exchange clinic was located directly off the reception area, this meant that staff could not ensure clients' privacy and confidentiality would be maintained.
- Staff had not labelled clinical waste bags as per guidance.
- Staff had not updated the electronic risk assessment forms in 14 of the 20 risk assessment records we viewed. They had however updated changes to clients risk in the daily care notes. This meant that not all current risk information was readily available.
- Staff had not checked expiry dates, or replenished stock in first aid boxes. Staff could not produce maintenance certificates for the stair lift at Granby Street. This meant staff could not be sure if the chair lift was safe to use or not.

However, we also found the following areas of good practice:

- There were sufficient accessible rooms to carry out therapeutic interventions. With exception of the Loughborough hub, there were separate and discreet needle exchange clinics.
- Clients had access to nurses, recovery workers, counsellors, doctors and a team of 27 accredited voluntary peer mentors. Managers advised they had only used agency nursing on three occasions during the previous nine months to cover periods of leave
- Ninety percent of staff had completed mandatory training.
- There was no waiting list for the service at the time of inspection.
- Managers and staff held weekly meetings including flash meetings to discuss risks associated with new referrals, complex cases, and clients who had not attended for their appointments as part of the providers "Faltering engagement policy". In addition to this there were robust systems for reporting, investigating, tracking, feedback and monitoring incidents, complaints, and safeguarding alerts.

Summary of this inspection

- Staff we spoke with were aware of the early warning signs of deterioration in a client's mental state and told us how they would access advice and support from one of the doctors or nurses.
- Doctors and nurse prescribers issued electronic prescriptions to local pharmacists for fulfilment and collection by the clients. There were good lines of communication between the service and pharmacists including when clients' failed to collect their prescriptions
- The provider had policy and guidance relating to safeguarding of vulnerable adults and young people. Eighty one percent of staff had completed safeguarding level 2 training. The service had a dedicated safeguarding lead, who monitored the services compliance with safeguarding and offered staff advice about safeguarding.
- Managers and staff were aware of their duty of candour and the need to be open and honest with clients when things go wrong.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff ensured care plans were holistic and comprehensive. All care records contained plans if the client chose to exit treatment unexpectedly.
- Staff reviewed care plans with clients, and discussed them with their manager as part of the supervision process. Staff had updated 17 of the 20 care plans we reviewed in a timely manner.
- Staff used encrypted laptops allowing them to work remotely away from the team base. This meant that staff could update care plans and colleagues could see the information in real time.
- Client records showed staff worked with other agencies to implement social inclusion and supported clients to access work, training, and education.
- Policies and procedures followed National Institute for Health and Care Excellence guidance in prescribing, and guidelines on needle and syringe programmes.
- Staff were familiar with guidance in the Drug misuse and dependence – UK guidelines on clinical management, also known as the "orange book for substance misuse".
- Clients could access wellbeing nurses who provided general health screening, blood borne virus advice and support to make positive lifestyle choices.

Summary of this inspection

- The service had a mixture of skilled staff. Ninety seven percent of staff had received an on going personal review (annual appraisal) and 100% of staff were up to date with supervision.
- Eighty eight percent of staff had trained in Mental Capacity Act 2005.
- Staff working in the young people's part of the service were aware of the Children's Act 1983. They were aware that for children under the age of 16, Gillick competence governed the young person's ability to make decisions.
- The service supported people with protected characteristics, such as age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and maternity under the Equality Act 2010.

However, we also found the following issues that the service provider needs to improve:

- Staff informally assessed clients capacity to consent to treatment and recorded this in the clients daily care notes. Seven of the 15 staff we spoke with believed it was the responsibility of the doctors or GP to carry out mental capacity assessments. Not all staff were aware of the provider's guidelines known as CURB (communication, understanding, retention, and balance) for assessing clients' mental capacity themselves.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients told us staff were interested in their wellbeing, understood their needs and were approachable, polite, and compassionate. Clients said staff had given them information about their treatments and or care in a way they had understood.
- Staff demonstrated good understanding of how some of the treatments and interventions they offered could affect their clients' emotional and social wellbeing.
- Staff reported they felt able to raise concerns about disrespectful, discriminatory, or abusive behaviour and attitudes, and knew how to report these.
- The provider had clear confidentiality policies in place that staff and clients understood.
- Carers could access family and carers support groups offering information, advice and emotional support, during and after their family member was in treatment.

Summary of this inspection

- Clients confirmed they felt involved in their care planning, and their care plans reflected their thoughts about their treatment and goals. When staff had offered clients copies of their recovery plan, they recorded this in their notes.
- Clients had opportunity to give feedback to managers either through the web site, or via comment boxes. Managers reviewed comments and suggestions at their team meetings.
- Clients had designed the reception area and chosen the furnishings at Eldon Street with a proposal to have a coffee bar located in the reception area.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The provider had clear acceptance, referral and admission criteria agreed with relevant services and key stakeholders.
- The provider was meeting their target from referral through acceptance to initial assessment of three weeks. Staff saw the majority of clients within 7 – 10 working days.
- At the initial assessment, staff allocated clients to key workers and the treatment pathway was determined through joint discussion. Treatment pathways started immediately.
- Clients who did not meet the criteria for acceptance to the service, or who decided the service was not for them, were signposted to alternative care pathways and staff advised referrers of this decision.
- Staff discussed alternative treatment options with clients if they were not able to comply with specific treatment requirements, including plans in the case of unexpected exit from treatment.
- The service was able to see urgent referrals within 24 hours.
- Clients could access specialist services, additional support from staff and peer mentors and urgent care when required.
- Staff had identified potential discharge plans with measurable goals focussing on the client's strengths, beliefs, and values.
- All hubs had a range of rooms and equipment to support treatment and care. Interview and clinic rooms had adequate soundproofing and privacy.
- Recovery plans reflected the diverse and complex needs of the client, including clear care pathways to other supporting services e.g. maternity, social care, housing, or community mental health services.
- The service operated extended opening to accommodate those clients who worked or had other weekday commitments.

- There was a robust and clear complaints procedure and policy, including processes to feedback to staff and implement lessons learned.

However, we also found the following issues that the service provider needs to improve:

- Contact details for advocacy services were not readily available for clients. There was limited information available in other languages, unless requested.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The provider had a clear vision and values. Managers embedded the vision and values in policies, practice, team and individual objectives.
- Managers were developing the service in consultation with relevant stakeholders, including staff and client feedback. Services provided a high quality and sustainable service model, aligned to the wider mental health community including primary care, community mental health, and criminal diversion.
- The organisation had a clear definition of recovery. Staff, peer mentors and clients understood what the organisation meant by recovery.
- The service had key performance indicators, audits and other indicators to gauge the performance of the teams. There was a range of clear and robust quality assurance management and performance frameworks. Managers had integrated these across all organisational policies and procedures.
- Managers carried out internal case file audits and internal quality self-assessments to ensure compliance with the provider's policies and procedures.
- Senior managers, hub managers, and team leaders demonstrated the skills, knowledge, and capacity to lead effectively. The majority of staff held their managers in high regard, feeling they had managed the transition and service developments well.
- Managers and team leaders provided clinical leadership and supervision for their teams. Managers had monitored sickness and absence rates within the provider's policy.
- The organisation encouraged staff and managers to be creative and innovative ensuring that the service is using evidence based practice and new technology.
- All staff had supervision and appraisal objectives focused on improvement and learning.

Summary of this inspection

- Two managers had been nominated for, and successful in winning Turning Point Inspired by Possibility Awards 2017. Other recognitions included the inspiring Leicestershire awards; and the peer mentor accreditation training with 27 peer mentors graduated to date.
- The provider had a comprehensive and ongoing programme of service improvements.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Eighty eight percent of staff had trained in the Mental Capacity Act 2005.
- We reviewed 20 care records and found staff had recorded client's capacity in 18 of the records. However, staff recorded this in the consent to treatment section of the care record rather than on a designated form within the electronic record. However, we also saw evidence in daily care notes that staff were consistently seeking consent to treatment during one to one interventions.
- There was a Mental Capacity Act policy in place and managers told us staff were encouraged to use CURB (Communication, Understanding, Retention, and Balance) as a way of assessing and documenting capacity in clients.
- Staff we spoke with knew of the Mental Capacity Act policy, however only nine of the 15 staff and peer supporters confirmed they had completed training in the Mental Capacity Act. Seven of the 15 staff believed it was the responsibility of a doctor or the GP to determine a client's capacity to consent. Despite this lack of training staff we spoke with knew they should always assume the capacity of a person unless there was evidence to suggest otherwise.
- Staff explained that if someone attended the service lacking capacity due to intoxication, they would request that they came back later or if immediate assistance was required, the staff member could call on a member of the clinical team for help and second opinion.
- Staff working in the young people's part of the service were aware of the Children's Act 1983. They were aware that for children under the age of 16, Gillick competence governed the young person's decision-making ability. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.
- Staff we spoke with said they used the principles of Gillick to include the clients where possible in decision making regarding their care.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- Interview rooms were fitted with alarms. Staff also had the option of carrying personal alarms. A local police officer was based at the Eldon Street hub. This ensured staff and clients safety and promoted a positive image of law enforcement officers.
- The ligature assessment for Eldon Street was not complete. Ligature points are places clients could use to hang themselves. Managers had identified most ligature points and mitigated the risk through individual client risk assessment and by always escorting clients in areas above ground floor. However, we found some ligature points that managers had not identified. These included those on the walls at the top of the staircase, and the fixtures used to secure blinds on windows in the group and therapy rooms.
- There were CCTV cameras in all public areas of the building at Eldon Street, and staff in the main offices could monitor the cameras. There was signage to advise users of the building that CCTV cameras were in use.
- Staff had not checked first aid boxes. We found some first aid boxes, which were damaged or not been re-stocked.
- There was a chair lift at Granby Street but staff could not produce records to show that the chair lift had been checked or serviced. This meant staff could not use the chairlift, as it may be unsafe.
- With the exception of Granby Street and the Coalville hub, all other hubs were clean, well maintained and their cleaning records were up to date. At Granby Street and Coalville hubs, the décor was tired and dated and did not look clean.
- Granby Street was located over two floors of a shared rented building and space was limited. This meant rooms, were untidy with paperwork and other stored items. There was very little natural daylight on the lower floor, this being located in the basement of the rented building.
- Eldon Street had sufficient accessible rooms to carry out therapeutic interventions, while the Loughborough and Coalville hubs had limited space for carrying out therapeutic interventions. To overcome this problem staff used rooms in other community buildings.
- Clinics were clean and had basic equipment to carry out necessary physical examinations. We saw receipts indicating that staff had purchased the equipment used in the clinic rooms within the previous year and did not require calibration certificates at this time.
- At all hubs, staff recorded the clinic room fridge temperature daily and were aware what to do if the fridge temperature went out of range. However, staff had not monitored the actual clinic room temperatures. This meant that medications requiring controlled temperatures could be compromised. Having raised this as a concern at Eldon Street staff removed the Naloxone medication to an air conditioned room.
- There were separate and discreet needle exchange clinics. However, the Loughborough needle exchange clinic was directly off the reception area and waiting clients could see other entering the needle exchange room. At all the hubs staff used the accessible toilets for urine testing, staff carried out this practice discreetly.

Substance misuse/detoxification

- Staff had access to emergency naloxone (used to reverse the effects of opioids) and adrenaline. Senior managers had made a decision to not have automated external defibrillators or oxygen stored on their community sites.
- Maintenance records for most of the buildings were in order. However, at Granby Street managers had not been able to get building repairs carried out in a timely manner. We saw correspondence showing they had escalated this issue to organisational level.
- All hubs had designated, health and safety representatives, fire wardens, and first aiders Portable appliance testing stickers were visible and in date where applicable.
- Staff adhered to infection control principles. The service displayed hand-washing posters at each sink within the service. Hand sanitizer was available in the clinic rooms and reception areas.
- Staff were not labelling clinical waste bags as per safe disposal of clinical waste guidance.

Safe staffing

- The service had two staff vacancies, one whole time equivalent nurse and one whole time equivalent receptionist. The service had recently appointed two whole time equivalent nurse managers to the prison drug and alcohol part of the service. This had enabled other nurses within the service to spend more clinical time within the hubs.
- Managers advised they had only used agency nursing on three occasions during the previous nine months to cover periods of leave. On all other occasions, they had been able to cover team absences with existing resources. However, managers did acknowledge that nurse staffing for the prison contract had to take priority over community services and on several occasions, this had resulted in only one nurse being available for the county areas.
- The medical team, based within the hubs were always available for advice and support.
- Managers covered sickness and annual leave absences within the existing team. The service reported a total staff sickness rate of 11% percent over the last 12 months and a turnover rate of 21%. Managers told us the sickness rate was due to some long-term sickness. They managed this in line with the provider policy. Staff turnover was due to some staff leaving the service shortly after the takeover and merger between July and December 2016.
- Caseloads were averaging 58 cases per worker. The national average for similar services is 50 – 60 per worker. Managers were aware of staff concerns about caseload numbers and how some staff had reported feeling stressed.
- Managers told us of plans they had in place to help staff manage their caseloads. Plans included:- discharge identification and safeguarding as part of supervision; brief and targeted recovery and skills based group work provided by the engagement team to reduce the demand on key workers; therapeutic group work; on line recovery modules to supplement one-on-one work; peer support work; and the new starter's clinic to enhance the initial assessment process.
- Eighty five percent of staff had completed mandatory training that included incident reporting, infection control, equality, and diversity, safeguarding adults and children level 2 and 3 depending on grade and role within the organisation, and positive behaviour support.

Assessing and managing risk to clients and staff

- The service had a lone worker policy. Staff used a buddy system, and mobile phone check in while lone working or working away from base. In an emergency staff operated use of a code word phrase when conducting outreach visits, although most clients' appointments took place either on site or in local GP practices.
- The service had effective policies, procedures, and training relating to medication and medicines management including prescribing and detoxification. Medications apart from emergency use naloxone and adrenaline were not stored on site.
- Doctors and nurse prescribers issued electronic prescriptions to local pharmacists for fulfilment and collection by the clients. There were good lines of communication between the service and pharmacists including when clients' failed to collect their prescriptions.
- We reviewed 20 electronic client care records, including risk assessments. Nineteen of the records we viewed

had full and comprehensive risk assessments recorded at the point of access into the service. One electronic record related to a new client, and staff were still updating the record at the time of the inspection.

- However, staff had not updated the original risk assessment forms correctly. In 14 of the 20 records we viewed, staff were recording and updating ongoing risk assessment outcomes and plans in the daily care notes. This meant that other staff might not always be aware their colleagues had updated the risk assessment and plans.
- Managers were aware of the problem with updating risk assessments and told us they were exploring ways of resolving the issue. This included the introduction of additional risk assessment and management plan training, requiring team managers to submit fortnightly compliance reports, and carrying out enhanced case file audits to assess the quality of risk assessments.
- Managers had introduced a risk rating system as part of the multidisciplinary allocations process. This ensured that where staff had identified specific risks at the point of referral, staff prioritised further assessment and treatment for that client.
- Staff we spoke with were aware of the early warning signs of deterioration in a client's mental state and told us how they would access advice and support from one of the doctors or nurses. Staff made clients aware of the risks of continued substance misuse. Harm minimisation and safety planning was an integral part of the clients recovery plan.
- Clients we spoke with were aware of where and how to access emergency support and advice if they felt they required this. We saw this information recorded in the client's crisis and risk management plans.
- We saw evidence in care records of inter-agency team working and communication in regards to sharing of safeguarding and client risk management. We saw safeguarding information displayed on the walls in the reception area for clients to refer to.
- The provider had a policy and guidance relating to vulnerable adults and young people safeguarding. The service had a dedicated safeguarding lead, who also monitored the services compliance with safeguarding and offered staff advice about safeguarding.
- During the period, 01 March 2017 to 16 June 2017 there had been eight safeguarding concerns or alerts reported to CQC. Data spreadsheets showed that managers had dealt with concerns and alerts in accordance with the providers, and CQC policy and guidance.
- Data provided at the time of inspection showed that in the 12 months prior to inspection there had been 30 notifications of unexpected death and one expected death, and four notifications of abuse. Managers had recorded, reported, investigated, and dealt with all the reports in accordance with policy and guidance. Managers had identified the lessons learned and fed back to staff through hub meetings and supervision sessions.
- Eighty one percent of staff were up to date with safeguarding training. Staff we spoke with were aware of what constituted a safeguarding alert and how to escalate and report any safeguarding concerns.

Track record on safety

- The service had an Incident Management policy and incident reporting was part of the provider's mandatory training. Managers made us aware of one additional serious incident, a death, during the inspection.
- Managers explained the governance processes in place for all serious incidents and how the senior management group reviewed them at organisational level. The learning from these reviews was then cascaded to all local service managers for feedback to their teams.
- We saw evidence that managers had investigated all the death reports and made changes to the service accordingly, for example, amending the "did not attend" processes.

Reporting incidents and learning from when things go wrong

- Staff knew what an incident was and how to report it. Staff understood their responsibilities for reporting incidents and accidents. The service used an electronic reporting system that staff could populate from their own secure laptop. This meant that staff could record incidents in real time and other colleagues could see them as they occurred.

Substance misuse/detoxification

- We saw minutes of meetings, policy and protocols, and data spreadsheets showing the processes of reporting, reviewing, investigating, and feeding back outcomes from reported incidents. We saw hub minutes and the minutes of flash meetings where managers had shared with staff feedback from incidents.
- Staff told us they usually received de-briefs after serious incidents. One staff member told us how they been helped to access counselling following a serious incident they had been involved in.

Duty of candour

- Managers and staff were aware of the duty of candour principles and the need to be open and honest with clients when things go wrong. Managers and staff told us that the service supported them to be candid with clients.
- We observed staff interaction with a client where the staff member was being open and honest about why a client's prescription was missing. The staff member handled the situation well and the staff member corrected the error immediately.

Are substance misuse/detoxification services effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- We looked at 20 case files and found all clients had an up to date recovery focused care plan. Recovery plans included details of the clients' key worker. Staff ensured care plans were holistic and comprehensive. There were summaries of the clients' current situation written by staff.
- Care records contained initial risk management plans including what steps staff and clients needed to take if the client chose to exit treatment unexpectedly. Three clients we spoke with told us they could recall being given information at their assessment about the consequences of exiting treatment early or nor complying with their medication regimes.
- Staff reviewed care plans with clients, and discussed them with their manager as part of the supervision process. Staff had updated 17 of the 20 care plans we reviewed in a timely manner. Staff had updated the remaining three records within two weeks of the client and key worker discussion and following an internal audit.
- Care records were stored on a secure electronic database. Staff maintained their own electronic care records. Staff had encrypted laptops that allowed them to work remotely away from the team base. This meant that staff could update care plans and colleagues could see the information in real time.

Best practice in treatment and care

- Care records, staff, and client feedback showed clients were receiving holistic packages of care with a choice of treatments guided by needs assessments. Managers carried out internal case file audits and internal quality self-assessments to ensure compliance with the provider's policies and procedures.
- Policies and procedures followed National Institute for Health and Care Excellence guidance in prescribing, and guidelines on needle and syringe programmes. Staff were familiar with guidance in the Drug misuse and dependence – UK guidelines on clinical management, also known as the "orange book for substance misuse".
- Clients could access wellbeing nurses who provided general health screening, blood borne virus advice and support to make positive lifestyle choices. An onsite health trainer helped client's access primary care services.
- Staff completed a basic clinical health assessment for each client who was engaging in treatment. The assessment included discussion around substance use, medication, family history, sexual health, and blood borne virus status where appropriate.
- Managers reported the service had not been able to provide community detoxification programmes, or more comprehensive physical health care, particularly in the county areas. Both of these activities are considered good practice in a recovery orientated, community substance misuse service. This was due to the service previously carrying nurse vacancies.
- Managers had identified this issue on their risk register and put in place contingency plans to address this. Plans included prioritising health care assessments for clients on the medical treatment pathway, upskilling

some senior recovery workers to carry out basic health checks, and using their shared care agreements with GP's. The service also used the skills of their healthcare trainer to help clients identify their own healthcare needs and access primary care services.

- The service provided a range of psychosocial interventions, as directed by the National Institute for Health and Care Excellence guidelines, including role specific training such as cognitive behaviour therapy, relapse prevention, harm reduction, introduction to family therapy and motivational interviewing. In addition, staff had trained to use mindfulness, and the service offered peer led support groups.
- We saw evidence of managers collecting outcome measure data for analysis, to inform ongoing practice and development. Outcome measures included treatment outcome profiles, national drug treatment monitoring system data, and monitoring of successful treatment outcomes and discharges.
- The service had a comprehensive audit programme. Staff had participated in audits of patient files, health and safety, infection control and medicines management. Following the completion of audits, we saw evidence of learning and staff had formulated action plans to address any shortcomings.

Skilled staff to deliver care

- The service consisted of service managers, and team managers. Doctors, registered general nurses, mental health nurses, clinical psychologists, senior recovery workers, youth workers, young people's counsellors, and recovery workers. There were also teams of peer mentor support workers, administrators, and analysts. All staff had, or were receiving support to gain the necessary qualifications and experience to fulfil the requirements of their roles.
- Staff attended a corporate induction programme when they started employment with Turning Point. This included all staff who had transferred from the previous provider's drug and alcohol services.
- Data provided at the time of the inspection showed 97% of staff had received an ongoing personal review (annual appraisal) and 100% of staff were up to date with supervision. Staff interviews, supervision records, and focus groups confirmed that 1:1 supervision was taking place monthly.
- Staff said they were able to access specialist training to enable them to develop their skills for example solution focused brief therapy, motivational interviewing, hate crime and domestic abuse awareness.
- We saw evidence in the staff files of cases where managers had needed to use performance management in line with the provider's policies.

Multidisciplinary and inter-agency team work

- Minutes of team meetings showed that managers were holding regular multidisciplinary meetings with staff, and with the exception of the young people's team, this included twice-weekly flash meetings.
- Staff worked in conjunction with a range of services including probation, police, housing, pharmacy, general practitioners, commissioners, community mental health teams, accident and emergency department, and local authority safeguarding teams. We saw evidence of this joint working within client's recovery plans and the minutes of management and team minutes. We saw protocols for information sharing with other agencies.
- There was evidence in client records that staff worked with other agencies to implement social inclusion with clients. This supported client's access to work, training, and education.
- Staff knew how to refer clients to local crisis mental health teams and had done so for clients experiencing mental health problems. However staff also told us of examples where they had found it difficult to refer some clients with complex needs to statutory agencies. To help facilitate joint working the service had a partnership team, who linked with statutory and third sector agencies.
- A local police officer was based within the Eldon Street hub to support staff and clients safety and help forge positive links between clients and enforcement agencies.

Adherence to the MHA

Substance misuse/detoxification

- The Mental Health Act is not applicable to this service, as they do not accept clients detained under the Mental Health Act.

Good practice in applying the MCA

- Eighty eight percent of staff had completed Mental Capacity Act 2005 training including Deprivation of Liberty Safeguards.
- Despite this low training figure, staff we spoke with understood their responsibilities in relation to the Mental Capacity Act. Staff routinely and informally assessed client's capacity to consent to treatment, and recorded when they had done this in the clients daily care notes. Staff knew they should always assume the capacity of a client unless there was evidence to suggest otherwise.
- However, seven of the 15 staff we spoke with believed it was the responsibility of a doctor or the GP to determine a client's capacity to consent, and not all staff were aware of the providers capacity assessment tool known as CURB (Communication, Understanding, Retention, and Balance).
- We reviewed 20 care records and found 18 had recorded clients' capacity. Although staff had recorded capacity in the consent to treatment section of the care record rather than on a separate form within the electronic record. We saw evidence in daily care notes that staff were seeking consent to treatment as part of their interventions.
- Staff explained that if someone attended the service lacking capacity due to intoxication, they would request that they came back later. If immediate assistance was required, the staff member could call on a member of the clinical team.
- Staff working in the young people's part of the service were aware of the Children's Act 1983, and knew that the Mental Capacity Act did not apply to young people aged 16 or under. They were aware that for children under the age of 16, the young person's decision-making ability was governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.
- Staff we spoke with said they used the principles of Gillick to include the clients where possible in the decision making regarding their care.

Equality and human rights

- The service supported clients with protected characteristics, such as age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and maternity under the Equality Act 2010. Ninety three percent of staff had completed mandatory training in equality and diversity and there was a policy relating to equality and diversity.
- With the exception of the hubs at Granby Street, and Loughborough, the service was accessible for clients requiring disabled access; this included adapted toilets on site. Granby Street and Loughborough hubs had accessible toilets, however some floors of the buildings and therapy rooms were not accessible for clients with mobility difficulties.
- Staff explained the alternative arrangements they made for clients with mobility difficulties visiting Granby Street and Loughborough.

Management of transition arrangements, referral and discharge

- Managers described how the current service model streamlined access to and transition through the drug and alcohol pathway by sharing staff expertise and providing a wider range of treatment options. Staff told us this had improved their understanding of each other's roles and subsequently the clients' experience of transitioning from a young person's key worker to an adult key worker if required. All key workers, both those working with young people and those with adults held joint meetings and discussed complex cases that required gradual transfer.
- The service had a robust referral process. Clients had commented on how easy it had been for them to access the service. Staff accepted verbal and written referrals from general practitioners, criminal justice services, health professionals, and self-referral.
- Administration staff processed referrals into the service and passed them to the engagement team. This team of

experienced drug and alcohol workers screened all referrals and allocated them to the correct pathway or key worker based on any reported diagnosis, needs, history, and level of risk.

- Engagement team staff allocated new clients to a pathway or key worker within five working days. Referral logs showed that any inappropriate referrals were signposted to services that were more appropriate for the identified needs where possible.
- The multidisciplinary team discussed any complex or high-risk clients before allocating them to a pathway.
- Following allocation the first face to face meeting, whether individual or group, was within three weeks. Staff carried out further assessment of clients' needs including health screening, before formulating risk and care plans, and starting treatment.
- Care records showed staff had identified discharge plans with measurable goals that focused on the client's strengths, beliefs, and values. Eleven of the eighteen clients we spoke with said they were aware of their discharge plans. Four clients recalled having had conversations with their key workers about discharge, but were not aware of a written discharge plan. The remaining three clients were not sure what their discharge plans were.
- Managers had introduced a new case management audit as part of staff supervision. These supported managers and staff to identify those clients who were allocated to staff caseloads but in fact were not in receipt of any meaningful treatment. Managers and staff used this information to review caseloads and ensure timely discharge.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect, and support

- We observed staff speaking with clients and interacting with clients in a respectful and caring manner.
- Staff we spoke with demonstrated good understanding of how some of the treatments and interventions they offered could affect their clients' emotional and social wellbeing.
- Clients we spoke with told us that staff were interested in their wellbeing, understood their needs, and were approachable, polite, and compassionate. All the clients we spoke with said staff had given them information about their treatments and care in a way they had understood.
- The provider operated an accredited peer mentor scheme. Peer mentors are people who have used the service in the past, and as part of their own recovery plans have trained to become peer mentors. The service had 27 peer mentors across their sites. Peer mentors had dedicated office space within the hubs and welcome new clients to the service, supported existing clients, and helped with group work programs.
- Clients said they could involve their families' friends and carers if they wished and staff supported this. Carers commented they had been involved in their family members' care planning where appropriate and after staff had sought permission. The provider had set up city and county family and carers support groups. These groups offered information, advice, and emotional support, to carers and family both during and after their family member was in treatment.
- The provider had clear confidentiality policies in place that staff understood. We saw confidentiality recorded in case notes and ten of the clients we spoke to understood the principles around confidentiality and the need for staff to share safeguarding information.

The involvement of clients in the care they receive

- During our observations of group and individual interventions, we saw staff supporting and encouraging clients to engage in the care planning process. Clients also confirmed they felt involved in their care planning and their written care plans reflected their thoughts about their treatment goals. When staff had offered clients copies of their recovery plan, they recorded this in their notes.
- Clients had the opportunity to give feedback to managers of the service either through the web site, or via comment boxes. Managers reviewed comments and suggestions at their team meetings. We also saw "you said we did "posters in the reception areas.

Substance misuse/detoxification

- Clients had designed the reception area and chosen the furnishings at Eldon Street with a proposal to have a coffee bar located in the reception area.

Are substance misuse/detoxification services responsive to people's needs? (for example, to feedback?)

Access and discharge

- For the period 01 January 2017 to 31 March 2017 Turning Point Leicester and Leicestershire received 1780 referrals. Of these 1208 new referrals attended their initial appointments, and 572 did not. GP's, children and family services, psychiatric services social services and youth offending teams recorded the highest number of non-attenders. The diversion team, prison, hospital, and education, recorded the highest number of attenders. Sixty six percent of self-referrals attended their initial appointments.
- Managers and staff held weekly meetings including flash meetings to discuss new referrals, and clients with complex needs.
- The provider had a faltering engagement policy. For clients who did not attend planned treatment appointments we saw evidence of staff having attempted to telephone, text or write to the client. Staff also attempted to contact clients via their GP or other healthcare professionals who may be in contact with them. Staff we spoke with told us that one of these methods usually worked. However, unless the multidisciplinary team had identified the client as high risk they did not have the resources to do further outreach work.
- Staff from the engagement team saw new referrals within the provider's three-week timeframe, and usually within one to two weeks of referral. Data records and clients we spoke with confirmed this. There was no waiting list for the service.
- Clients who did not meet the criteria for acceptance to the service, or who decided the service was not for them, were signposted to alternative services and staff advised referrers of this decision. We saw evidence of staff having discussed alternative treatment options with clients if they were not able to comply with specific treatment requirements which also included plans in the case of unexpected exit from treatment.
- Staff demonstrated an understanding of the potential issues facing vulnerable groups. We saw evidence of partnership working to support vulnerable clients, such as those from the LGBT, and BME, communities, older people, people experiencing domestic abuse and sex workers.
- The provider had a clearly documented acceptance, referral and admission criteria agreed with relevant services and key stakeholders. Clients told us that access to the service had been easy.
- The service was able to see urgent referrals within 24 hours and often on the same day.
- Clients could access specialist services, additional support from staff and peer mentors and urgent care when required.
- Clients using services reported that staff very rarely cancelled or delayed appointments and on the occasions, this had happened staff explained the reasons and offered alternative appointments.

The facilities promote recovery, comfort, dignity and confidentiality

- All hubs had a range of rooms and equipment to support treatment and care.
- Interview and clinic rooms had adequate soundproofing and privacy. Although at Eldon Street we found some interview rooms had clear glass panels in the doors. This infringed client's privacy and confidentiality. Once pointed out staff immediately rectified this by obscuring the panels.
- Staff based treatment plans around clients using their own local community resources and activities as well as the resources offered through the hubs.

Meeting the needs of all clients

- There were no information leaflets about advocacy services, available in the reception areas, and two peer mentors we asked did not have the information to hand.

Eventually a staff member was able to locate the contact details on her mobile phone.This meant the services did not provide clients with accessible information about advocacy services.

- There was limited information available in other languages in the reception area at Eldon Street. However, we did not see similar leaflets or information at the Coalville or Loughborough hubs. Staff told us they could access interpreters including language and sign language interpreters, by arrangement. Staff told us that in the Eldon Street hub they had a number of staff who were multi-lingual and whenever possible they would try to match clients with someone who spoke the same language.
- Staff and peer mentors scheduled peer support groups in the evenings and at weekends to accommodate those clients who worked or had other weekday commitments. Staff worked flexible hours to accommodate evening and weekend appointments to match the services extended opening hours.
- Management had made adjustments to accommodate staff and clients with faith support, offered extended opening times and flexible appointments. At Loughborough hub, the upstairs group room was not accessible to clients with mobility difficulties; staff told us clients who could not access this area of the building were accommodated in one of the other hubs.

Listening to and learning from concerns and complaints

- For the period 31 July 2016 to 29 March 2017 Turning Point Leicester and Leicestershire had received 35 complaints. Complaints had related to clients not knowing who their new key workers were, not being able to speak to their key worker between appointments, and not been able to access the same groups and programmes they had with the previous providers. Complaints also included delays with prescriptions being passed to pharmacists, and not being able to see a doctor when they wanted to.
- Managers had upheld three of the complaints and had not been required to refer any of the complaints to the ombudsman. Managers had responded to the complaints, and had updated or changed systems such as those for prescribing. Managers explained that many of the complaints had been the result of the transitioning processes from the previous providers, and that since March 2017 they had only received two formal complaints.
- For the period 31 July 2016 to 29 March 2017 the service had received one compliment, and fifteen suggestions relating to the service via the suggestion box.
- There was a robust and clear complaints policy and procedure. We saw evidence of how managers had processed, discussed, and investigated complaints on spreadsheets and through minutes of team minutes. Managers had shared the identified lessons learned with staff, and made changes such as
- There were information leaflets in public areas telling clients how to make a complaint, and how to escalate their complaint to independent organisations.
- Clients and carers we spoke with reported they knew of the complaints system and how to access it.

Are substance misuse/detoxification services well-led?

Vision and values

- The service had a clear vision and set of values based on communication with authenticity; embracing change; delivering outcomes through new ways of thinking and working; believing that everyone has potential to grow and learn; and supporting people with respect no matter how challenging this may be. The services strap line was “inspired by possibility”. Staff understood the vision and values of the team and organisation and how their roles contributed towards achieving this.
- The organisation had a clear definition of recovery. Staff, peer mentors and clients understood what the organisation meant by recovery.
- Team meeting minutes, supervision, and annual appraisal records showed that both team objectives and individual objectives reflected the organisational values.
- Managers were developing the service in consultation with relevant stakeholders, including staff and clients. Managers had developed services to provide a high

quality and sustainable service model. This model was aligned to the wider mental health community including primary care, community mental health, and criminal diversion.

- Staff knew who their senior managers were, and confirmed that senior managers visited the hubs periodically.

Good governance

- The service had key performance indicators and other measures to gauge the performance of the teams. Managers carried out a range of audits to support the delivery of good quality care. These included extended case management audits, and prescribing audits. These audits formed the basis of their monitoring feedback to commissioners and other stakeholder organisations.
- We saw evidence of a range of clear and robust quality assurance management and performance frameworks in place. Managers had integrated these across all organisational policies and procedures. Managers regularly reviewed their policies, procedures and protocols, which included equality impact assessments.
- There were newly developed databases for recording and tracking notifications, safeguarding incidents and deaths. The data was processed, discussed, recorded, and submitted to external bodies and internal departments as required. Managers had embraced the need for enhanced databases.
- The organisation had a range of boards and committees and we reviewed minutes of these meetings. The minutes confirmed that issues such as quality, safety, safeguarding, deaths, the patient experience, and complaints were being discussed. That relevant senior managers attended these meetings to represent the service, and were taking the learning from the meetings back into the work place.
- All staff had supervision and appraisal objectives focused on improvement and learning. Remote working enabled staff to work from any location through a secure electronic platform, thereby ensuring they had access to the most up to date information.
- Managers were exploring new ways of helping to support staff with their caseloads. This included the development of targeted brief intervention groups, a new starter's clinic, and an engagement team focused on the client experience at the front end of service delivery.
- We reviewed ten staff files, and found them complete and well organise with job descriptions and evidence of in date disclosure and barring service checks. Data provided at the time of inspection showed that 153 of the 157 staff had in date disclosure and barring service check, and all volunteer peer mentors had a valid disclosure and barring service check. Those staff without a disclosure and barring service check were either on maternity leave or long- term sick. Managers stated they would ensure completion of these checks before the staff member returned to work.
- The provider submitted details of a comprehensive risk register. We saw the original version on the electronic database at the time of inspection. Staff knew what the risk register was and how to submit items for this register via their managers.
- We saw minutes of senior management meetings where managers had discussed and evaluated quality of the service, sustainability plans, and impact of changes including financial matters. Managers had identified those issues that presented significant risk and put them on the organisations risk register.
- Managers engaged staff, clients, families, and carers in the planning, development and delivery of the service. This was done through, team meetings and staff away days, comment boxes placed in public areas, carers groups and forums, "you said - we did" exercises, and an on line feedback form.
- We saw minutes of management meetings that evidenced service managers and senior staff actively engaged with commissioners, social care, the voluntary sector, and other relevant stakeholders. Managers had produced a series of data analysis for commissioners

Leadership, morale and staff engagement

- Senior managers, hub managers, and team leaders demonstrated the skills, knowledge, and capacity to lead effectively. Management prioritised leadership development with the focus on managing change.

Substance misuse/detoxification

- Managers had facilitated team building away days to enable staff to understand each other's roles and responsibilities. This promoted effective team working and communication between teams within the service.
- The provider had secured the services of an experienced change facilitator to mentor and guide the management team through the transition process. This ensured that managers were using the best possible methods to make the transition successful and sustainable.
- Managers and team leaders provided clinical leadership and supervision for their teams.
- We saw evidence in the staff records of how managers had monitored sickness and absence rates within the provider's policy.
- We heard about two reports of bullying and one of harassment. All three cases related to issues, around job satisfaction and high caseloads. However, the majority of other staff we spoke with denied there was any bullying, but did acknowledge there may be some staff who were not as happy as others. Staff felt this was about the introduction of new ways of working and changes to service delivery.
- Managers confirmed that promoting the new ways of working was an ongoing process. Some staff were more willing to take on board the changes than other staff, and this was an ongoing piece of work they were doing with all staff.
- Of the 23 team leaders, staff, and peer mentors we spoke with 17 said they felt positive about working for Turning Point Leicester and Leicestershire. They were positive about the management style and felt managers had supported them through the changes that had taken place by ensuring good lines of communication and honesty.
- Managers knew there were some dis-satisfied staff within the service, they had acknowledged and discussed this within their peer group and were addressing the issues. Managers acknowledged that it had been challenging bringing staff from eight separate services together into one new service, and accepted they still had further work to do in this area.
- The service had a whistle blowing policy in place, and staff knew how to use this.

Commitment to quality improvement and innovation

- Managers had identified that the dual diagnosis pathway was in the process of further development. The providers' plans for this pathway included strengthening shared care relationships with mental health colleagues.
- The organisation encouraged staff and managers to be creative and innovative. This ensured the service was using evidence based practice and new technology. Examples of this included the planned introduction of recovery based electronic modules that clients could register for and access from their home computers and laptops, and a new electronic prescribing process.
- We saw evidence of two staff members being recognised for their contributions to dedicated leadership, and inspiring staff. The two staff managers had been nominated for and successful in winning Turning Point Inspired by Possibility Awards 2017. Other recognitions included the inspiring Leicestershire awards; and fully trained peer mentors. Twenty seven clients and ex clients had trained and graduated to become peer mentors.
- The provider had an ongoing programme of service improvements. These improvements included more detailed outcome measurements, embedding treatment pathways to ensure the right intervention to the right clients at the right time. A new community detoxification model, increased wellbeing clinics, specialist steroid provision, and developing the dual diagnosis pathway. Managers hoped these new initiatives would reduce their reliance on primary care services, thereby freeing up more GP time.

Outstanding practice and areas for improvement

Outstanding practice

Turning Point Leicestershire and Leicester showed outstanding practice in managing the transition from eight separate independent drug and alcohol services around the city and county to one integrated service. The provider had secured the services of an experienced change facilitator to mentor and guide the management team through the transition process. This ensured that managers were using the best possible methods to make the transition successful and sustainable.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that clinical waste is managed in accordance with guidelines.
- The provider must ensure that the stair lift at Granby Street is properly maintained.

Action the provider SHOULD take to improve

- The provider should ensure all ligature audits are complete and risk management plans are in place.
- The provider should ensure that client's privacy and confidentiality is maintained while using the needle exchange service in Loughborough.
- The provider should ensure that staff update and document all risk assessments.
- The provider should ensure that all building repairs and maintenance at Granby Street is carried out in a timely manner.
- The provider should ensure that staff regularly check and maintain first aid boxes.
- The provider should ensure they have the required staff to develop a community detoxification service and enhance their physical health care activities in line with best practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Staff had not labelled clinical waste bags in accordance with guidance and protocols. This is a breach of regulation 12.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Staff could not produce maintenance certificates for the stair lift at Granby Street. This meant no one knew if the stair lift was safe to use or not. This is a breach of regulation 15

Appendix C

Health and Wellbeing Scrutiny Commission

Public Health Performance Report

2017/18 - Quarter 2

Date: January 2018

Lead Director: Ruth Tennant

Leicester City Council

Useful information

- Ward(s) affected: All
- Report author: Helen Reeve Julie O'Boyle
- Author contact details: 454 2034 helen.reeve@leicester.gov.uk
- Report version: 1

1. Summary

- This report brings together information on key dimensions of Public Health performance in the second quarter of 2017/18.

- This is the third performance report in the current format which was introduced in March 2017. Changes have been made to the format in light of previous feedback. The ultimate aim is to provide a holistic view of the Divisions performance and it is anticipated that the format will continue to be refined as we further develop appropriate outcome measures.

- The report demonstrates that performance management processes are in place and working within the division, that services are generally performing well and where concerns have been identified these are being managed.

The scrutiny commission is requested to note the areas of positive achievement and areas for improvement

2. Background

In 2013 Leicester City Council assumed new responsibilities to improve the health of the local population. The aim of this performance report is to reflect the overall performance of the division of Public Health and provide evidence that the statutory duties of the Director of Public Health are being fulfilled.

In assessing how well the division is performing there are a number of parameters that may be considered

- Performance of commissioned and directly provided services including safety, quality and effectiveness
- Performance of the local public health system as measured against the Public Health Outcomes Framework including surveillance of changes and trends
- Performance in delivering the Public Health Strategic Priorities for 2017/18 as set out in the Divisional Business Plan

This paper considers the first two of these parameters and sets out future plans for reporting on the third.

3. The performance management process

The majority of public health services are commissioned from external providers. A significant proportion of these services are mandated and are clinical services delivered by NHS providers. The services are commissioned by Public Health leads. Adult Social Care contract and Performance team (CaAS) are commissioned by public health to provide first line performance management of commissioned services including, collection of service data, holding review meetings and provision of initial comments on performance.
The performance reports are considered on a quarterly basis by the Public Health Performance Review Group and follow up actions with providers to ensure improvement are agreed.

4. Public Health Services
The role of public health is to improve the health and wellbeing of the population. This includes promoting healthy lifestyles e.g. increasing physical activity and supporting people to stop smoking, protecting the population's health e.g. preventing infectious diseases through immunisations, working with internal and external partners to address the wider determinants of health such as education, housing, and deprivation and by providing expert advice on the effectiveness and cost effectiveness of health programmes and services.

We do this by commissioning specific services and through influencing partners.

The Performance review process looks specifically at the services we either commission from external providers or we provide directly.

We currently have 25 such services and each of these are monitored against an agreed set of indicators. Services performing at or above expectations are rated Green we currently have 13 services rated green,

12 are Amber (where there are some concerns/issues to be addressed) and one service is rag rated as Red (serious issues to be addressed, immediate action required).

A summary is provided below and the full report is available at appendix 1.

Services progressing satisfactorily

Table 1 services rated Green

Contract	Provider	What the service does	Outputs
Healthy Child Programme	Leicestershire Partnership Trust	This service is offered to every family with children and young people under 19 in Leicester and includes antenatal support of pregnant women new baby development checks breast feeding support health visiting and school nursing	96% of babies received their new baby review at 10-14 days this is above target and a consistently improving picture
healthy eating initiatives in early year's settings and in schools	Soil association	Support to help schools develop a whole school approach to food health and sustainability	71 schools across the city signed up to the initiative
Oral health promotion	LCC	To co-ordinate activity to improve oral health,	1/5 primary schools; ¾ of nurseries and ¼ special schools are participating in the supervised tooth brushing initiative
emergency hormonal contraception (EHC) consultations in pharmacies	Pharmacies across the city	Advice and support including where appropriate provision of the morning after pill over the counter	In quarter 2 521 prescriptions for EHC were filled
Health trainers probation	Inclusion Healthcare	Access to lifestyle support services for people on probation	In quarter 2, 72 people started on a personalised plan to improve their health 91% successfully completed the programme
active lifestyle hub	LCC Sports Services	Individuals with complex co-morbidities referred by their GP or other health care	In quarter 2 there were over 900 referrals to the service

		professional for support to develop healthy lifestyles	
Adult weight management programme	Leicestershire Partnership Trust (LPT)	Weight management programme targeted at individuals with complex co-morbidities and other groups who are under represented on commercial weight management programmes.	There has been some drop in the proportion of participants completing at least 60% of sessions and we are working with the provider to remedy this
Stop smoking service	LCC STOP Service	support for people in Leicester City to stop smoking	In quarter 2 344 people were helped to quit smoking (51% of those referred). This service is recognised nationally as high performing and innovative
NHS health checks	GP's	National programme to identify people at risk of developing cardiovascular problems and provide appropriate interventions to reduce that risk	Over the past 5 years (2013/14 - 2017/18), Leicester City has undertaken over 55K Health Checks, making it one of the highest performing areas in the Country.
Substance misuse accommodation based support	Home Group	Specialist service providing accommodation based support and treatment to reduce substance misuse	Q2 data not submitted this is being rectified with provider
Substance misuse anchor centre	Inclusion Health Care	Specialist services for entrenched drinkers including street drinkers	The proportion of active street drinkers engaged with the service who no longer drink in the street continues to improve
suicide awareness programme	Leicestershire Rural Communities Council	To raise awareness of suicide through specialist training programmes	Service remains on target
community infection prevention and control		*To provide the DPH with assurance that community infection*	The number of high risks reported in Q2

services		*prevention and control principles are being applied within the local community providers*	has increased by 50% compared to the same period last year. The proportion of risks responded to within 1 day remains at 100%

Services with some concerns

Eleven services are rated amber, where there are some concerns/issues to be addressed mainly due to some under-performance against expectations or targets or issues with data. These issues are taken up with providers at contract meetings to understand reasons for under-performance and reported in performance reports. Services currently rated amber are listed in Table 1 below. One service is rated red and this provider has been served 12 month notice to terminate contract.

Table 2: Services rag-rated Amber or Red

Contract	Provider	Purpose	Issues taken up with providers
Training staff in Secondary Schools and FE colleges to deliver relationship and sex education (RSE)	Staffordshire and Stoke on Trent Partnership Trust (SSOTP)	To co-ordinate a programme of RSE teaching and support	Training of teachers and other relevant staff is above target. The number of RSE sessions delivered is consistently just below target. The reasons for this are being explored by commissioners.
Integrated sexual health services	SSOTP	Providing open access services, including all forms of contraception and STI testing and treatment	For some elements of service offered the number of patients being seen is lower than expected. This is in part due to staff vacancies and the service are addressing this.
Provision in GP practices of long-active reversible contraception	Commissioned GP practices	Fitting of contraceptive devices (coils and Implants) in GP practices	The number of devices being fitted in GP practices fluctuates. We want to preserve this option for women and are working to understand the reasons for the variation through the year.
Community based HIV prevention services *HIV positive people*	Leicestershire AIDS Support Service (LASS)	To improve sexual health outcomes for people who are HIV positive.	There have been some issues with the data submitted during the first 2 quarters of the year and we are working with the service provider to rectify this.
Community based HIV prevention services for: *people of African heritage*	LASS	To improve sexual health outcomes for people of who are HIV positive within the context of the wider health issues for this group	There are ongoing issues with the data submitted by the provider. We are working with the provider to rectify this.
Community based HIV	TRADE	To improve sexual health outcomes for people of	Data submitted shows high numbers for contacts and

prevention services for: *men who have sex with men*		who are HIV positive within the context of the wider health issues for this group	referrals to other services which is being reviewed with the provider.
Community based HIV prevention *services for: sex workers*	SSOTP	To improve sexual health outcomes for people of who are HIV positive within the context of the wider health issues for this group	There are issues with data submission for this service. The service is doing well in contacting women in saunas and brothels, but has some issues visiting street based sex workers.
Community based Food growing support projects (2 Projects)	Saffron Acres Project and The Conservation Volunteers	To deliver training and support to stimulate and develop food growing to communities across Leicester	The programme is not meeting targets for the number of schools engaged and the number of people attending food growing sessions. In part this is due to some staff changes in the provider. Work ongoing to increase attendance and number of schools engaged in food growing skills programmes
Healthy Lifestyles Hub and Health Trainers	Parkwood	Service supports referred individuals to adopt healthier lifestyles by signposting them to appropriate services e.g. lose weight, increase activity etc. and by helping them to develop personal health plans	85% of referred individuals were signposted to appropriate services in quarter 2 this is lower than the same period last year. There appear to be some ongoing issues with GP's understanding of the referral software.
Substance Misuse Services	Turning Point	Treatment services for people with substance misuse problems	Data quality issues in migrating data from previous contractual arrangements. Successful completions of treatment have been significantly lower in year one of the contract but have improved within the year.
Substance Misuse Services	**Woodlands Detox Unit (Notts Healthcare Trust)**	**Detox treatment for people with substance misuse problems**	**Consistent underutilisation of LCC allotted bed days. Provider has indicated everyone in need of an In Patient Detox has been referred, suggesting a lower level of need than anticipated. Provider served notice in May 2017 and Strategic commissioning will go out to tender for a new contract starting June 2018.**

5. Public Health Outcomes Framework

The Division's internal performance management arrangement also considers the Public Health Outcomes Framework (PHOF). This a nationally collated set of data regarding health and wellbeing in England and, in our case, Leicester. The PHOF focuses on two high-level outcomes to be achieved across the public health system: 'Increased healthy life expectancy' and 'Reduced differences in life expectancy and healthy

life expectancy between communities'.

A supporting set of public health indicators in the PHOF are split over four domains:

Improving the wider determinants of health (35 indicators) This includes issues such as deprivation, school readiness, employment, homelessness, social isolation, domestic abuse, violent crime

Health improvement (71 indicators) this includes issues such as healthy weight in adults and children, smoking, low birth weight, breast feeding, drug treatment uptake of screening programmes physical activity self-reported wellbeing.

Health protection (27 indicators) this includes immunisation rates TB treatment HIV late diagnosis antibiotic prescribing in primary care

Healthcare public health and preventing premature mortality (15 indicators) this includes infant mortality tooth decay, mortality rates (CVD. Cancer, Respiratory disease, communicable disease suicide) excess winter deaths hip fractures preventable sight loss

The most recent PHOF outcomes report for Leicester is presented in Appendix 2.

It will be noted that the PHOF indicators cover areas that are not directly commissioned or provided by public health. LCC's public health specialists must therefore work with and across partner agencies in order to influence them to take appropriate action to address these wider determinants of heath
The PHOF has been used for example to identify the priorities in the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy. Whilst the PHOF is kept under surveillance the indicators typically change slowly and updates are provided at different times during the year. As a consequence of this it is more meaningful to review the PHOF on an annual basis rather than quarterly.

The PHOF report compares Leicester to the England average and to other authorities within the East Midlands. It can be seen that although life expectancy in Leicester has been improving we are significantly worse than the England average in terms of both life expectancy and healthy life expectancy.

We have significantly higher rates of children living in low income families compared to England. We have significantly lower rates of people killed and seriously injured on our roads and hospital admissions for violence are low. We have high rates of low birth weight babies and significantly higher rates of breast feeding. Excess weight is significantly lower than the national average for 4-5 year olds but is significantly higher for 10-11 year olds. We have poor uptake of cancer screening services but uptake of NHS health checks (CVD risk) is significantly above the national average.

Childhood immunisation rates are generally good but uptake of HPV vaccine and flu vaccine is poorer than the England average.

The proportion of five year olds free from dental decay is improving but remains low. Premature mortality from cardiovascular disease, liver disease and respiratory disease remains above the national average.

6. Delivering Public Health Strategic Priorities

Public Health have identified 12 strategic priorities. Progress on meeting the priorities for the year is currently reviewed on a quarterly basis by the Divisional Management Team and monthly by the individual teams within the division.

Our priorities for the year are;

PH1	Healthy Start: we will maximise health and well-being in the early years
PH2	Healthy Lives: we will keep people healthy and reduce preventable illness in adults
PH3	Healthy Minds: we will improve health and well-being across the life course
PH4	Healthy Places: we will maximise opportunities to build health through the build environment and across the city & respond to threats to public health

PH5	Health & Well-being Strategy: we will lead the delivery of the HWS and will provide support to the HWB
PH6	We will work with the NHS to drive prevention in their core business through the local STP and the Public Health 'core offer'
PH7	We will use intelligence and data effectively to monitor and evaluate the impact of what we do and to provide effective evidence of health need across the city
PH8	We will provide safe and effective services supported by robust performance and quality monitoring
PH9	We will develop innovative approaches to improving health, including wider use of technology & social media, linked to Smart Cities
PH10	We will have effective business planning processes to manage the work of the division and to support effective decision-making & communication
PH11	We will support the development of staff and trainees to effectively deliver their roles and to develop their skills and capability
PH12	We will provide an effective and timely response to internal and external complaints, concerns and enquiries

Currently we have a number of programmes of work underway to deliver on the strategic priorities. Work is ongoing to develop an appropriate suite of indicators which will enable us to more effectively monitor our internal performance in delivering the operational plan for the division.

7. Recommendations

The scrutiny commission is requested to note the areas of positive achievement and areas for improvement

8. Financial, legal and other implications

8.1 Financial implications

8.2 Legal implications

There are no direct legal implications arising from the contents of this report at this stage.

8.3 Climate Change and Carbon Reduction implications

There are no direct climate change implications associated with this report.

8.4 Equalities Implications

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

Is this a private report?

the report is not private but a section has been removed due to it being determined, following the meeting, that it was referring to Exempt Information 12A of the Local Government Act 1972 - Category 3 'Information relating to the financial or business affairs of any particular person (including the authority) holding that information'.

9. Background information and other papers: None

10. Summary of appendices:

Appendix 1: Public Health Services Performance Report

Appendix 2: Public Health Outcomes Framework Report Leicester.

Leicester City Council

Division of Public Health Performance Report 2017/18 Quarter 2

Contents and Summary RAG ratings

RAG ratings for overall performance of service

Green – no issue identified, no action required.

Amber – some concerns/issues to be addressed.

Red – Serious issues to be addressed, immediate action required.

Grey – there are problems with data or other technical aspects of the report which make it unreliable to arrive at judgements at this point.

Public Health Outcome Framework trend indicators

Arrows are used to show the direction of travel (DOT) from the previous reporting period, and the colour represents statistical significance compared with England


- DOT improving and Leicester value significantly better than England


- DOT improving and Leicester value not significantly different to England


- DOT improving and Leicester value significantly worse than England

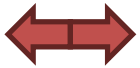

- DOT worsening and Leicester value significantly better than England


- DOT worsening and Leicester value not significantly different to England


- DOT worsening and Leicester value significantly worse than England


- DOT not available and Leicester value significantly better than England


- DOT not available and Leicester value not significantly different to England


- DOT not available and Leicester value significantly worse than England

Division of Public Health Performance Report: 2017/18 Quarter 2

Return to Contents

Healthy Together: Healthy Child Programme, 0-19 year olds

Provider: Leicestershire Partnership Trust

Purpose of service: The 0-19 Healthy Child Programme (know locally as Healthy Together) is an early intervention and prevention programme that is offered to every family with children and young people aged between 0-19 years living in Leicester city. It offers evidence-based developmental reviews, information and interventions to support the healthy development of children and young people.

Relevant PHOF indicators:

	Sig	DOT
0.1i - Healthy life expectancy at birth, Male	Red	↑
0.1i - Healthy life expectancy at birth, Female	Red	↑
4.01 - Infant mortality	Amber	↑
2.01 - Low birth weight of term babies	Red	↓
2.02i - Breastfeeding - Breastfeeding initiation	Green	↑
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth - historical method	Green	↑
2.03 - Smoking status at time of delivery	Amber	↑
2.04 - Under 18 conceptions	Red	↓
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	Green	↑
2.05ii - Proportion of children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review	Amber	→

Overall progress rating: Green

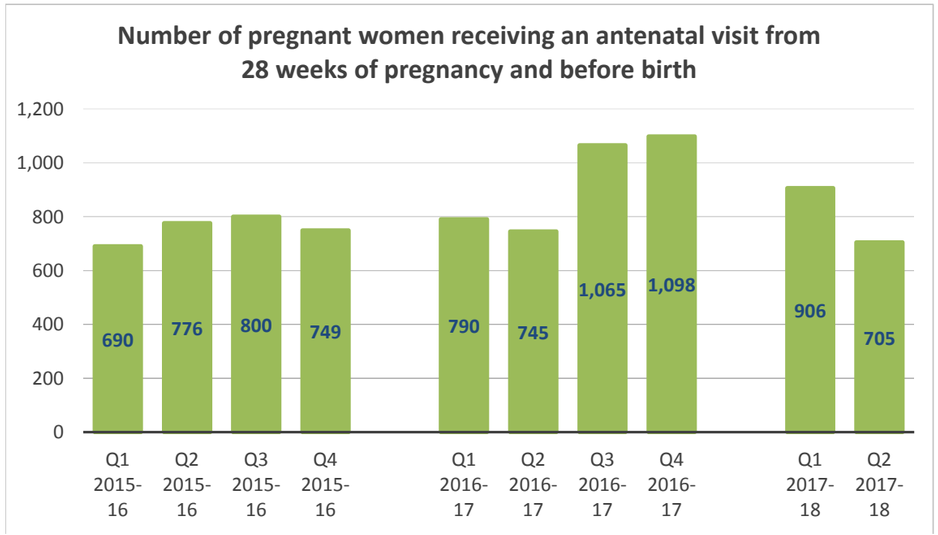
Key Performance Indicators	Activity	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Antenatal contact													
Number of pregnant women receiving an antenatal visit from 28 weeks of pregnancy and before birth	Target												
	Actual	690	776	800	749	790	745	1065	1098	906	705		
Percentage of pregnant women exposed to household smoke (Information only)													
	Actual										30%		
10-14 days New baby review													
Denom: Total number of infants who turned 30 days within the quarter													
	Actual	1251	1305	1371	1272	1298	1372	1241	1185	1175	1284		
Number of babies receiving a new baby review at 10-14 days													
	Actual	1131	1180	1249	1128	1177	1280	1138	1095	1081	1232		
% of babies turning 30 days within quarter receiving a new baby review at 10-14 days	Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
	Actual	90%	90%	91%	89%	91%	93%	92%	92%	92%	96%		
Number of babies recorded as totally/partially breastfed at 10-14 days													
	Actual												
% of babies babies recorded as totally/partially breastfed at 10-14 days (information only)													
	Actual										98%		
6-8 week review													
Denom: Total number of infants due a 6-8wk review by the end of the quarter													
	Actual	1273	1329	1316	1325	1223	1398	1306	1204	1323	1242		
Number of babies receiving a 6-8 week review													
	Actual	1139	1163	1211	1199	1103	1285	1196	1123	973	1124		
% of babies receiving a 6-8 week review	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	Actual	89%	88%	92%	90%	90%	92%	92%	93%	74%	90%		
Number of babies with breastfeeding status recorded at 6-8 weeks													
	Actual	1180	1148	1088	1262	1174	1342	1306	1119	1317	1533		
% of babies with breastfeeding status recorded at 6-8 weeks	Target												
	Actual	93%	86%	83%	95%	96%	96%	100%	93%	100%	123%		
Number of babies recorded as totally/partially breastfed at 6-8 weeks													
	Actual	760	732	643	776	698	800	764	697	942	1121		
% of babies recorded as totally/partially breastfed at 6-8 weeks	Target												
	Actual	60%	55%	49%	59%	57%	57%	58%	58%	71%	90%		
4 month review													
Denom: Number of babies eligible for 4 month review (tbc)	Target												
	Actual												
Number of babies receiving a 4 month review	Target												
	Actual												
% of babies receiving a 4 month review	Target												
	Actual										48%		
1 year development review													
Denom: Number of babies eligible for 1 year development	Target	0	0	0	0	0	0	0	0				

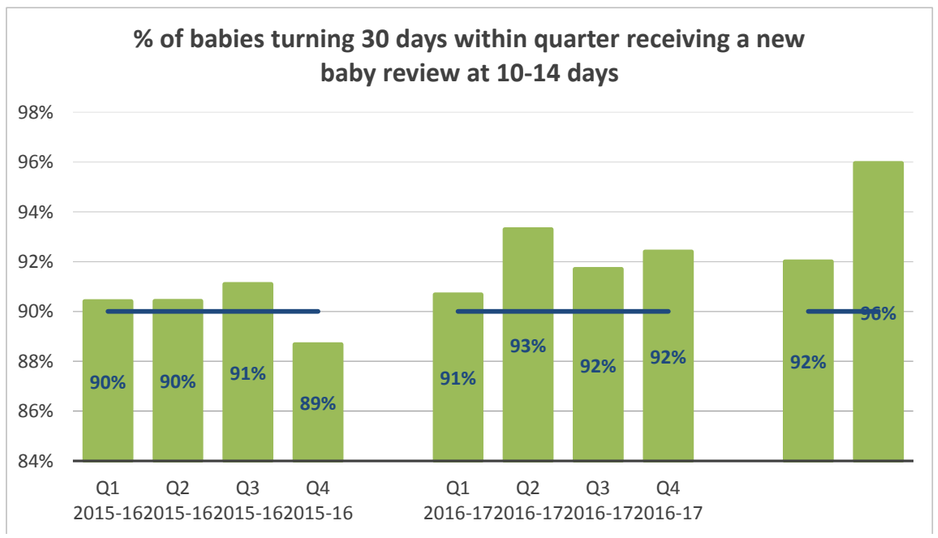
review (tbc)	Actual	1339	1361	1361	1272	1215	1338	1293	1178	1304	1304				
Number of babies receiving a 1 year development review	Target	0	0	0	0	0	0	0	0						
between 10 and 12 months	Actual	745	793	931	768	711	877	920	938	988	1000				
% of babies receiving a 1 year development review	Target														
	Actual	56%	58%	68%	60%	59%	66%	71%	80%	76%	77%				

Key Performance Indicators	Activity	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18		
2-2.5 year development review															
Denom: Number of babies eligible for 2-2.5 year development review (tbc)	Target	0	0	0	0	0	0	0	0						
	Actual	1336	1276	1246	1285	1251	1293	1293	1276	1311	1252				
Number of babies receiving a 2-2.5 year development review between 2 and 2.5 years	Target	0	0	0	0	0	0	0	0						
	Actual	980	961	1000	976	947	999	1040	1015	1020	1047				
% of babies receiving a 2-2.5 year development review	Target														
	Actual	73%	75%	80%	76%	76%	77%	80%	80%	78%	84%				
Intensive parenting support															
Number of families leaving the intensive support programme reporting improved levels of parenting confidence and capacity	Target														
	Actual														
Number of intensive support programme cases closed within the reporting period	Target														
	Actual														
Number of families participating in the Early Start programme	Target														
	Actual										48				
Breastfeeding peer support															
Number of women receiving a response from a breastfeeding peer supporter within 72 hours of request	Target	0	0	0	0	0	0	0	0						
	Actual	0	0	1	11	11	18	206	638	0	91				
Number of women requesting a contact from a breastfeeding peer supporter	Target	0	0	0	0	0	0	0	0						
	Actual														
% of women receiving a response from a breastfeeding peer supporter within 72 hours of request	Target														
	Actual	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%				
Number of breastfeeding peer supporters	Target	0	0	0	0	0	0	0	0						
	Actual	4	13	13	22	54	54	56	56	11					

Comments on performance	Lead:	Date:
This is the first time that we have collected information from LPT on the new Healthy Together offer. As such some indicators appear for the first time, and some will no longer appear. LCC have raised a number of questions about some of the data and we are working with LPT to smooth out issues in data	CM	Nov-17
Antenatal contact numbers are variable between quarters - need to work with LPT to ensure communication between midwifery and partners within reporting	CM	07/11/2017
% of 6-8 week reviews - variable numbers reported as due to mobilisation and staff training for new contract. Query raised with LPT re BF status recording of	CM	07/11/2017

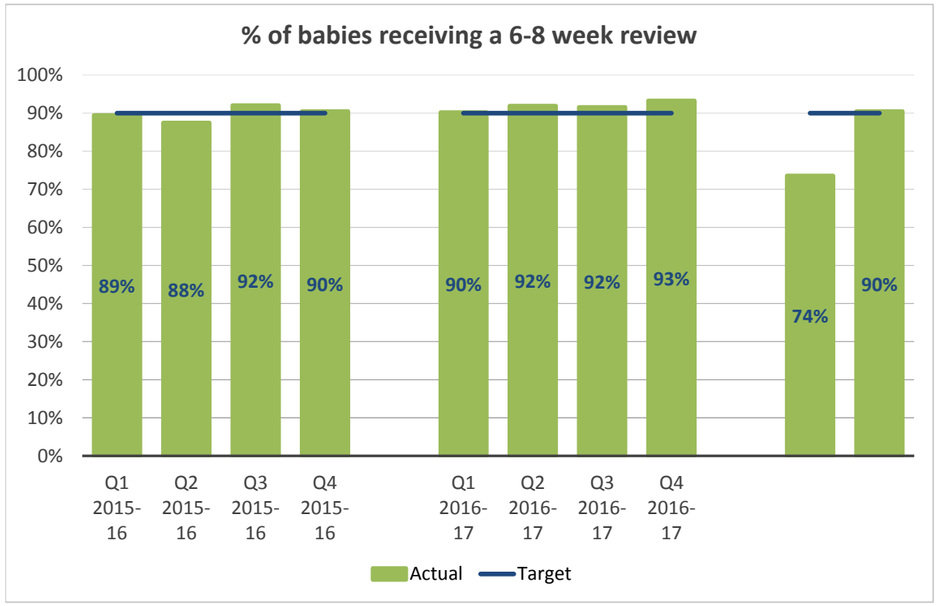
Key actions	Action by date:
Work with LPT to ensure data is correct and present	

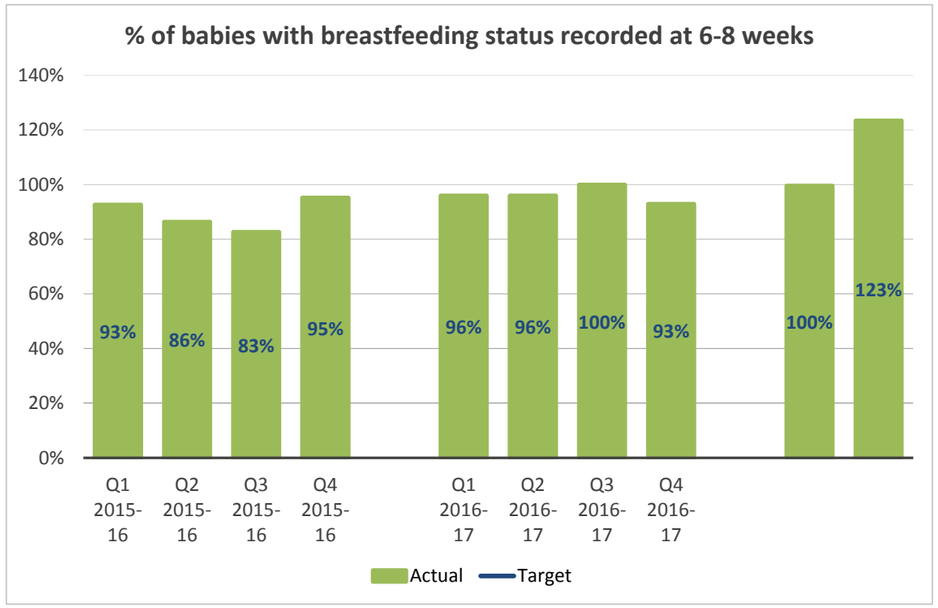


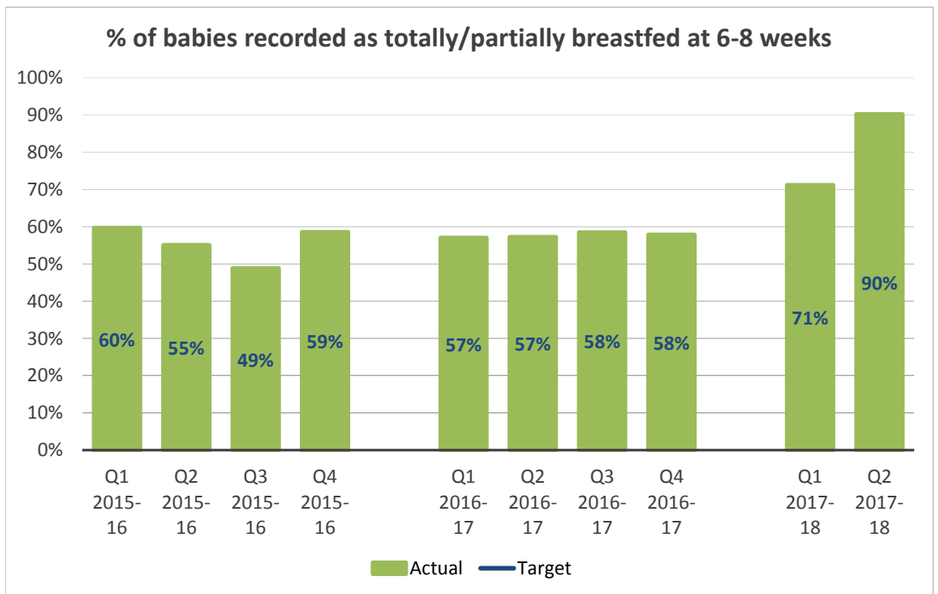


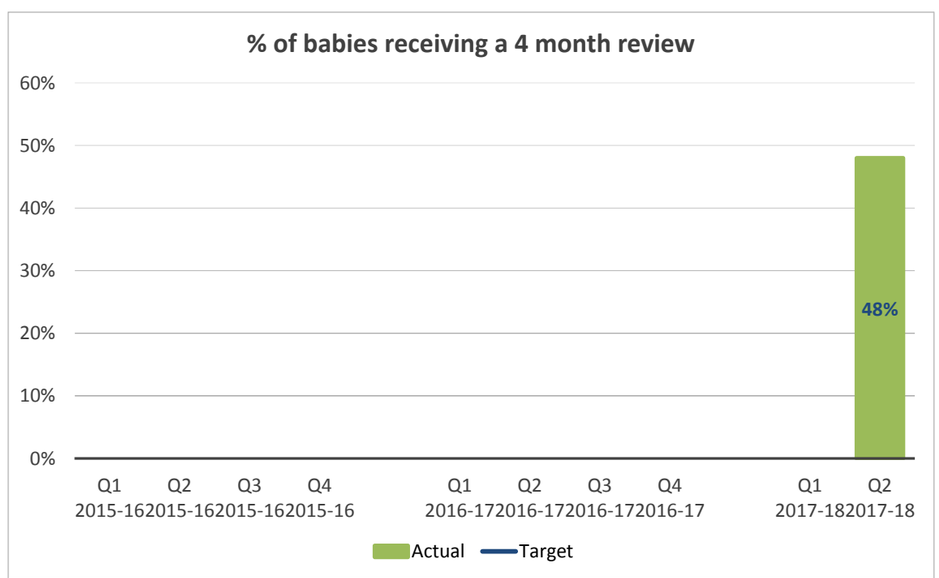

Actual

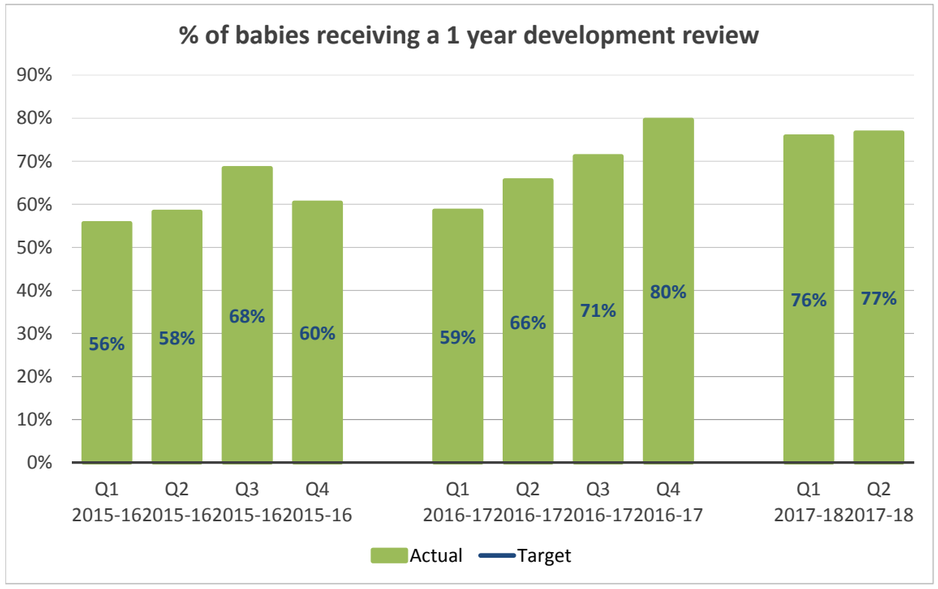

Actual
Target

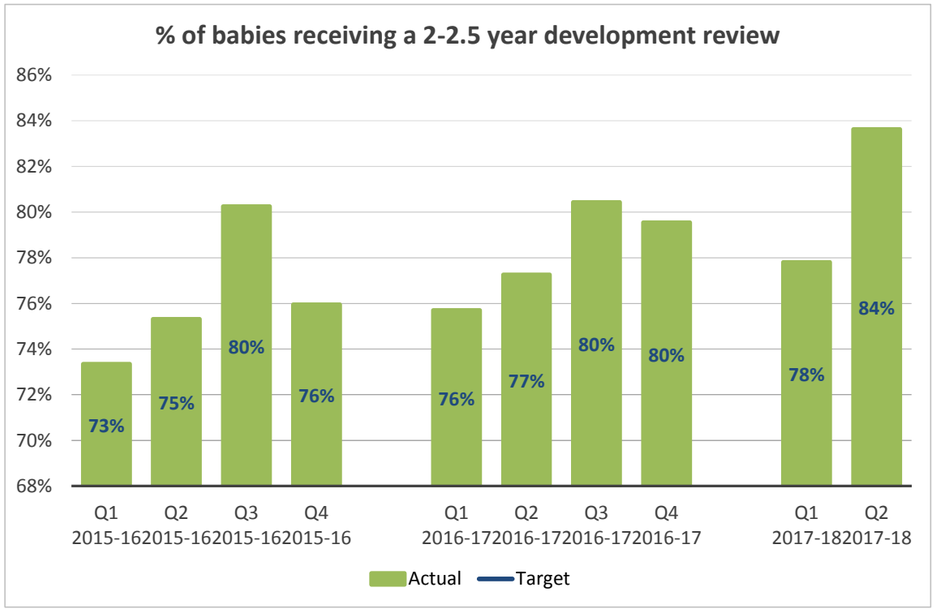

% of babies receiving a 6-8 week review
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
89%
88%
92%
90%
90%
92%
92%
93%
74%
90%
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Actual
Target


% of babies with breastfeeding status recorded at 6-8 weeks
140%
120%
100%
80%
60%
40%
20%
0%
93%
86%
83%
95%
96%
96%
100%
93%
100%
123%
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Actual
Target


% of babies recorded as totally/partially breastfed at 6-8 weeks
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
60%
55%
49%
59%
57%
57%
58%
58%
71%
90%
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Actual
Target


% of babies receiving a 4 month review
60%
50%
40%
30%
20%
10%
0%
48%
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Actual
Target


% of babies receiving a 1 year development review
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
56%
58%
68%
60%
59%
66%
71%
80%
76%
77%
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Actual
Target


% of babies receiving a 2-2.5 year development review
86%
84%
82%
80%
78%
76%
74%
72%
70%
68%
73%
75%
80%
76%
76%
77%
80%
80%
78%
84%
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Actual
Target

Division of Public Health Performance Report: 2017/18 Quarter 2

Healthy Together: Healthy Child Programme, 0-19 year olds

Provider: Leicestershire Partnership Trust

Purpose of service: The 0-19 Healthy Child Programme (know locally as Healthy Together) is an early intervention and prevention programme that is offered to every family with children and young people aged between 0-19 years living in Leicester city. It offers evidence-based developmental reviews, information and interventions to support the healthy development of children and young people).

Relevant PHOF indicators:

	Sig	DOT
1.02ia - School Readiness: the percentage of children achieving a good level of development at the end of reception	🔴	↑
1.02ib - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception	🟡	↑
2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds	🟢	↕
2.06ii - Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds	🔴	↓
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	🟢	↕
2.10ii - Emergency Hospital Admissions for Intentional Self-Harm	🟢	↓
4.02 - Proportion of five year old children free from dental decay	🔴	→

Overall progress rating: Amber

Key Performance Indicators			2017/18
Schools: health and wellbeing assessments	**Activity**		
% of children transitioning to secondary school (year 6/7) with a completed 'health and wellbeing assessment'	Target		
	Actual		
% of children transitioning to secondary school (year 9) with a completed 'health and wellbeing assessment'	Target		
	Actual		
% of children transitioning to secondary school (year 11) with a completed 'health and wellbeing assessment'	Target		
	Actual		
Number of web chats with children and young people focusing on emotional health and wellbeing issues	Target		
	Actual		

National Child Measurement Programme	Activity	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Number of children eligible for NCMP: reception year	Actual	4058	4242	4362	4438	4620	4862
Number of children measured in NCMP: reception year	Actual	3717	4034	4070	4164	4297	4390
% participation rate in NCMP: reception year	Target	93%	93%	93%	93%	93%	93%
	Actual	91.6%	95.1%	93.3%	93.8%	93.0%	90.3%
Number of children eligible for NCMP: year 6	Actual	3363	3566	3706	3893	4049	4283
Number of children measured in NCMP: year 6	Actual	3144	3381	3521	3700	3863	4068
% participation rate in NCMP: year 6	Target	95%	95%	95%	95%	95%	95%
	Actual	93.5%	94.8%	95.0%	95.0%	95.4%	95.0%

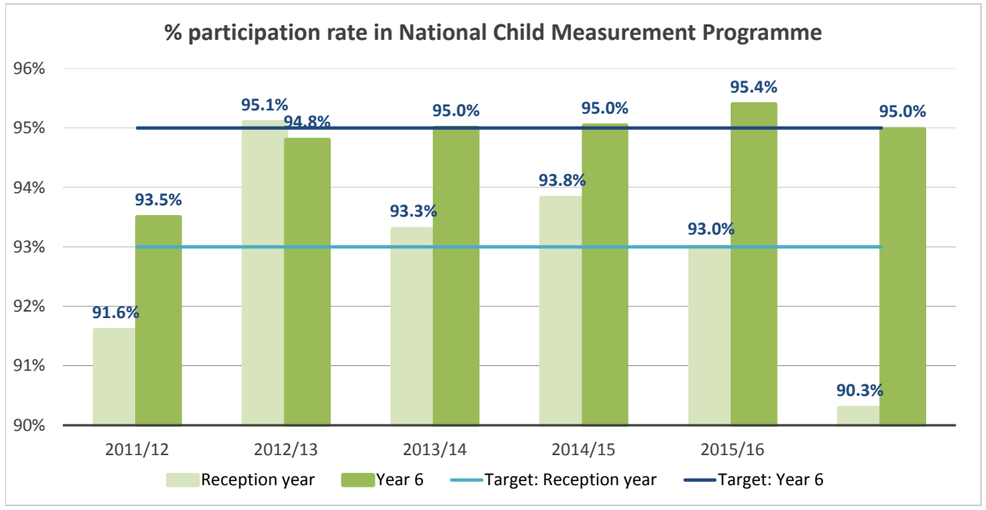
Child Weight Management Programme	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Numbers of participants completing the child weight management course	Target	75	75	18.75	37.5	56.25	75	18.75	37.5	56.25	75	18.75			
	Actual	88	82	24	21	24	19	22	15	27	18	25			
	Actual to date			24	45	69	88	22	37	64	82	25			
Total participants				30	29	30	21	26	19	37	24				
Child weight management course: % completing the course	Target	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%			
	Actual	81%	78%	81%	72%	80%	90%	85%	79%	73%	75%	76%			
Number of children completing the child weighrt management programme from deprivation quintiles 1 and 2	Actual starting												17		
	Actual completing												13		

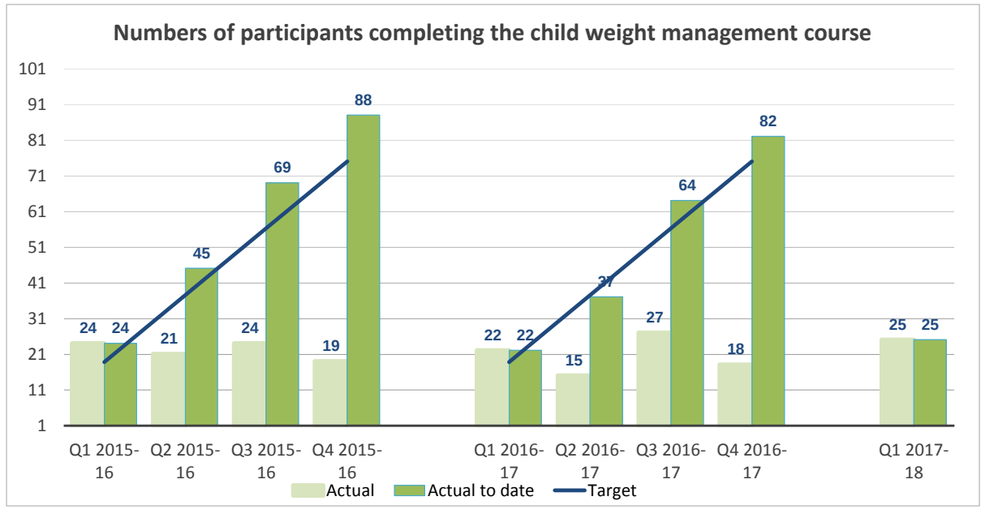
Healthy Settings Programme	Activity	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Number of Early Years Settings in Leicester City engaged with the Healthy Settings Programme	Target				
	Actual	10			
Percentage of Early Years Settings in Leicester City engaged with the Healthy Settings Programme	Target				
	Actual	Not yet available			

Looked after children	Activity	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Percentage of Review Health Assessments for 0-5 year olds completed within 6 months since the proceeding health assessment	Target				
	Actual	Not yet available			

Comments on performance	Lead:	Date:
This is the first time that we have collected information from LPT on the new Healthy Together offer. As such some indicators appear for the first time, and some will no longer appear. LCC have raised a number of questions about some of the data and we are working with LPT to smooth out issues in data reporting	CM	Nov-17
Baselines for school health and wellbeing assessments to be established during 2017/18	CM	Nov-17
Participation rate for reception year children in 2016/17 has fallen below target rate	HR	09/11/2017

Key actions	Action by date:
Work with LPT to ensure data is correct and present	





Division of Public Health Performance Report: 2017/18 Quarter 2

Healthy Eating Initiatives in Schools

Provider: Soil Association: Food for Life Partnership

Overall progress rating: Green

Purpose of service: To deliver an integrated food, health and sustainability support service to help schools implement a 'whole school' approach including curriculum activities, the running of the school and links into the surrounding community

Relevant PHOF indicators:
2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds
2.06ii - Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds

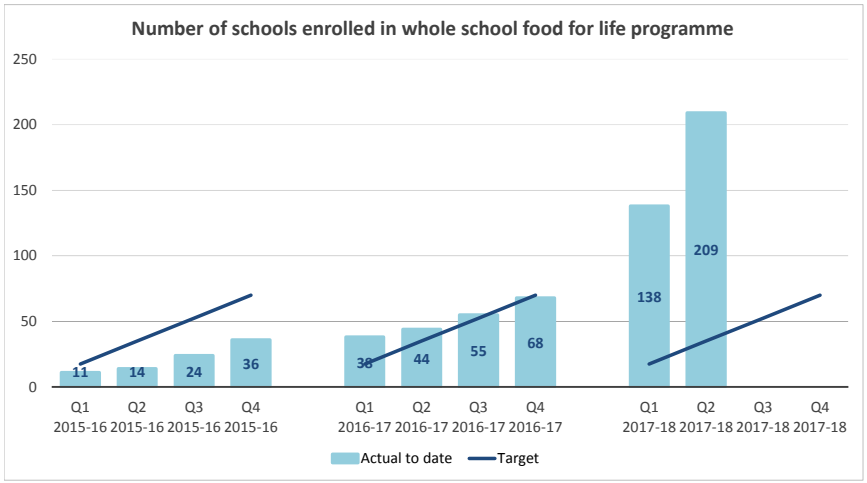
Return to summary page

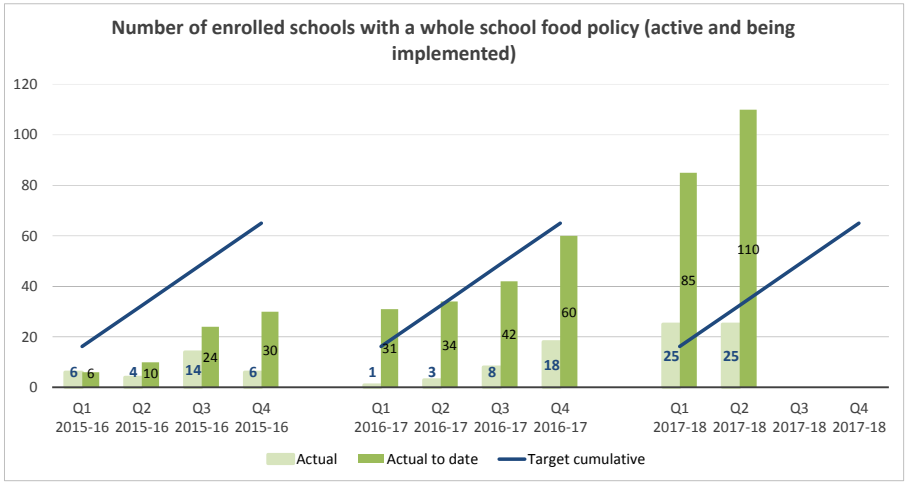
DOT Improving, Sig Better
DOT Worse, Sig Worse

Key Performance Indicators	Activity	2016/17	2017/18	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16		Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17		Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Number of schools enrolled in whole school food for life programme	Target	70	70	18	35	53	70		18	35	53	70		18	35	53	70
	Actual			11	3	10	12		2	6	11	13		70	71		
	Actual to date			11	14	24	36		38	44	55	68		138	209		
Number of enrolled schools with a whole school food policy (active and being implemented)	Target cumulat	65	65	16	33	49	65		16	33	49	65		16	33	49	65
	Actual			6	4	14	6		1	3	8	18		25	25		
	Actual to date			6	10	24	30		31	34	42	60		85	110		
Number of schools achieving FFL bronze award	Target																
	Actual											7					

Comments on performance	Lead:	Date:
1. Services have reported an improvement in the number of settings and schools that have enrolled and engaged with the healthy eating initiatives.	SH	
2. A lunch box audit has been carried out and reported separately		
3. The contract for healthy eating initiatives in schools delivered by the Soils Association is not included in the 0-19 procurements - commissioners are currently considering the future of this contract		
Seeking clarification with provider regarding which schools enrolled and implementing whole school food policy		
Number of schools enrolled in whole school food for life programme have achieved the Target for the first 2 years	CaAS	02/11/2017
Q2 target was easily met by over 34% from the set 35 target.	CaAS	02/11/2017

Key actions	Ation by date:
Need to embed overarching numbers enrolled and FFL bronze award indicators into the data monitoring process with providers. CaAS to follow up	Q4 2016-17
Bronze Medal is not recorded and it is not in the Service Specification which was revised 2017/18 (Q1)	


Number of schools enrolled in whole school food for life programme
250
200
150
100
50
0
11
14
24
36
38
44
55
68
138
209
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


Number of enrolled schools with a whole school food policy (active and being implemented)
120
100
80
60
40
20
0
6
6
4
10
14
24
6
30
1
31
3
34
8
42
18
60
25
85
25
110
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Actual to date
Target cumulative

Division of Public Health Performance Report: 2017/18 Quarter 2

Oral health promotion

Provider: Leicester City Council

Overall progress rating: Green

Service pupose: To support co-ordinated activity to improve oral health, reduce oral health inequalities and lay solid foundations for good oral health throughout life

Relevant PHOF indicators:

4.02 - Proportion of five year old children free from dental decay

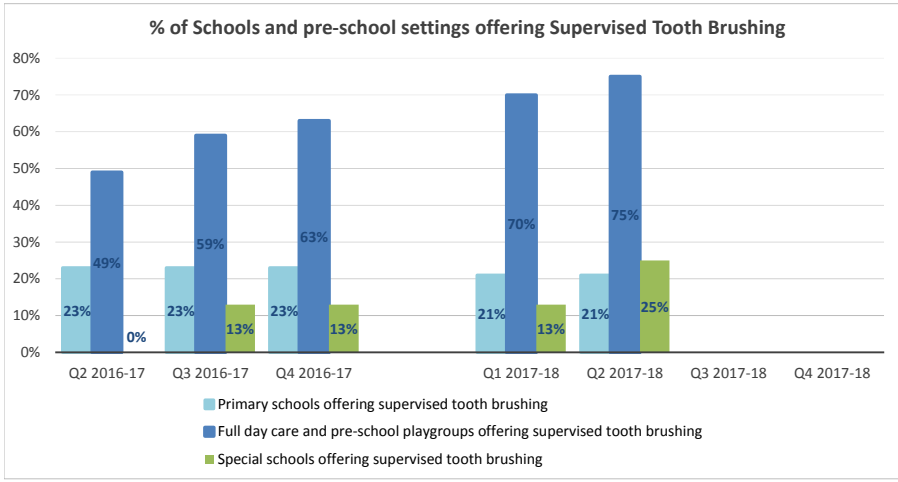
Return to summary page

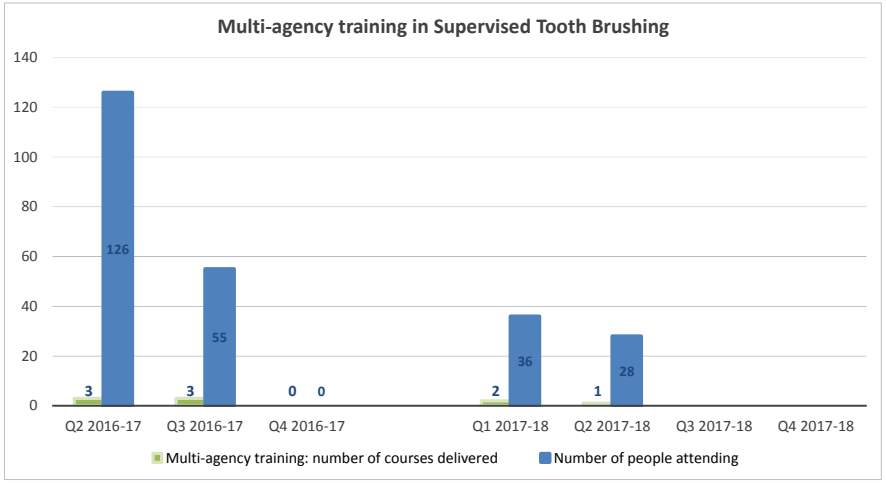
DOT N/A, Sig Worse

Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16		Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17		Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Primary schools offering supervised tooth brushing	Target																
	Actual num to date	17	18	-	12	16	17		17	17	17	18		16	19		
	Actual %	25%	23%	-	15%	25%	25%		23%	23%	23%	23%		21%	21%		
Full day care and pre-school playgroups offering supervised tooth brushing	Target																
	Actual num to date	58	84	-	37	49	58		60	67	77	84		94	90		
	Actual %	80%	63%	-					44%	49%	59%	63%		70%	75%		
Special schools offering supervised tooth brushing	Target																
	Actual num to date	0	1	-	0	0	0		0	0	1	1		1	2		
	Actual %	0%	13%	-	0%	0%	0%		0%	0%	13%	13%		13%	25%		
Multi-agency training: number of courses delivered	Actual	21	7	-	3	14	4		1	3	3	0		2	1		
Number of people attending	Actual	196	205	-	19	134	43		24	126	55	0		36	28		

Comments on performance	Lead:	Date:
STB programme in Special schools pilot in Ellesmere College is now complete and will be rolled out to other special schools. Previously special schools did not participate in supervised toothbrushing.	Michelle Hall	Jul-17
Few primary schools participate. We have 2 primary schools drop out of the scheme since last quarter. This was due to 'staffing issues.' The oral health promoters will be focusing on increasing the uptake in schools from Autumn 2017.		
In 2015/6 the proportions are incorrect due to the wrong denominator being used. As the number of nurseries in the city can vary from month to month, it is not possible to determine the true denominator for that financial period.		
There are no data for Q1 available due to the OHP service starting in that quarter.		
Service currently offers 2 types of formal training (1) STB, (2) Oral Health Training. To date 1372 people have been trained		Aug-17
Multi-agency training includes Health Visitors, School Nurses, LCC Staff, School Staff, Nursery Staff, Dieticians and others		
Decrease in number of nursery/pre-schools as some settings now closed		Nov-17

Key actions	Action by date:
During May and June, the remaining nursery settings will be targetted for STB sign up.	May/June 2017
Primary Schools will become the next target for Supervised Toothbrushing.	Autumn 2017


% of Schools and pre-school settings offering Supervised Tooth Brushing
80%
70%
60%
50%
40%
30%
20%
10%
0%
23%
49%
0%
23%
59%
13%
23%
63%
13%
21%
70%
13%
21%
75%
25%
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Primary schools offering supervised tooth brushing
Full day care and pre-school playgroups offering supervised tooth brushing
Special schools offering supervised tooth brushing


Multi-agency training in Supervised Tooth Brushing
140
120
100
80
60
40
20
0
3
126
3
55
0
0
2
36
1
28
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Multi-agency training: number of courses delivered
Number of people attending

Division of Public Health Performance Report: 2017/18 Quarter 2

Young People Relationships and Sex Education training

Provider: Staffordshire & Stoke on Trent Partnership Trust (SSOTP)

Overall progress rating: Amber

Purpose of service: Fulfils a role to co-ordinate a programme of training, RSE support and collation of local sexual health & HIV information to identify emerging trends on behalf of and in collaboration with the population group lot providers

Relevant PHOF indicators:

2.04 - Under 18 conceptions — DOT Worse, Sig Worse

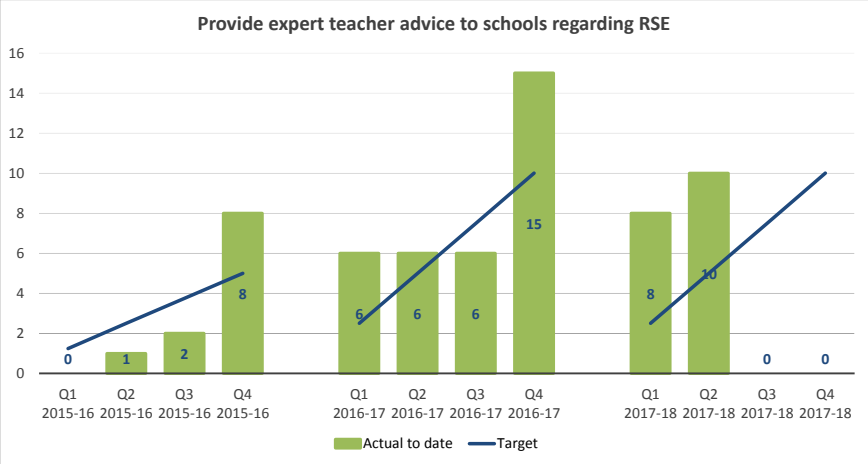
3.02 - Chlamydia detection rate (15-24 year olds) — DOT Worse, Sig Worse

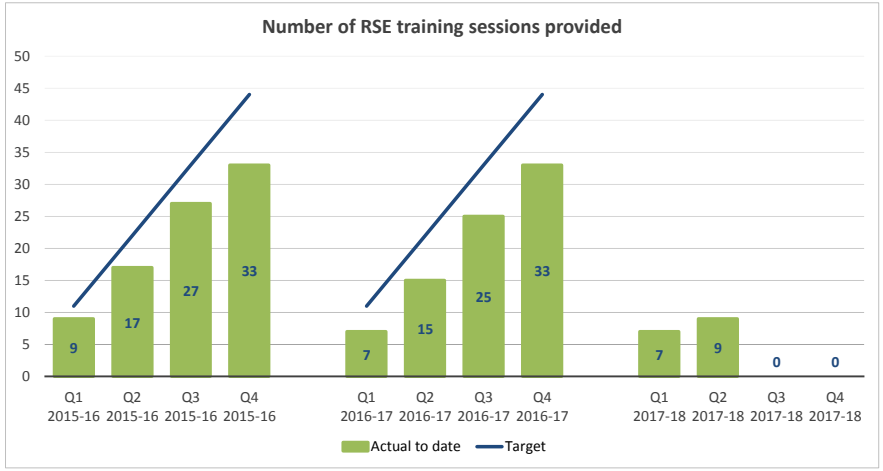
Return to summary page

Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Young People plus co-ordination of Traning, Relationships and Sex Education (RSE) Insight work															
Provide expert teacher advice to schools regarding RSE	Target	5	10	1	3	4	5	3	5	8	10	3	5	8	10
	Actual			0	1	1	6	6	0	0	9	8	2		
	Actual to date			0	1	2	8	6	6	6	15	8	10		
Number of RSE training sessions provided	Target	44	44	11	22	33	44	11	22	33	44	11			
	Actual			9	8	10	6	7	8	10	8	7	2		
	Actual to date			9	17	27	33	7	15	25	33	7	9		

Comments on performance	Lead:	Date:
Number of RSE training sessions consistently below target,the reason for this is not understood . May be some issues regarding access outside term time. Follow-up with provider. 2017/18 target not set	RS GSH	18/08/2017 01/11/2017

Key actions	Action by date:
Discussion with provider about reasons for no increase of RSE sessions and action plan about how this could be resolved Need to set target for Quarters	Aug-17 GSH 01/11/2017





Division of Public Health Performance Report: 2017/18 Quarter 2

Sexual Health Services: Integrated Sexual Health Services

Provider: Staffordshire & Stoke on Trent Partnership Trust (SSOTP)

Purpose of service: To provide an open access integrated sexual health service, including the provision of all forms of contraception and STI testing and treatment

Return to summary page

Relevant PHOF indicators:

2.04 - Under 18 conceptions — DOT Worse, Sig Worse

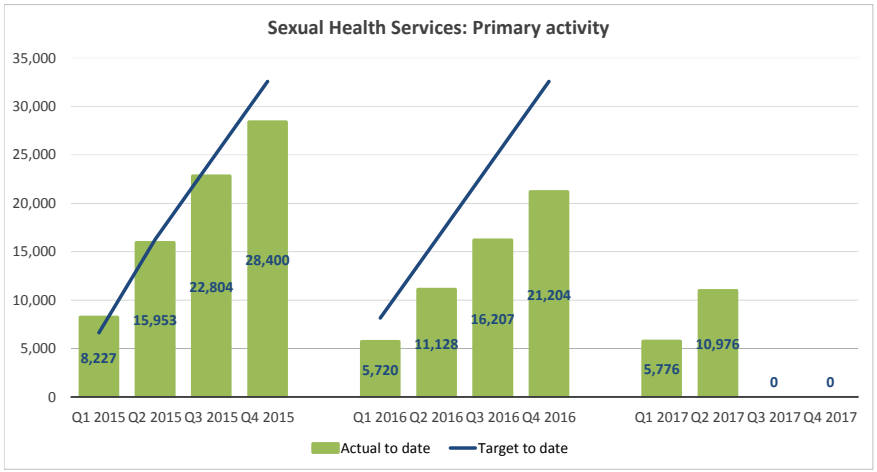
3.04 - HIV late diagnosis — DOT Worse, Sig Worse

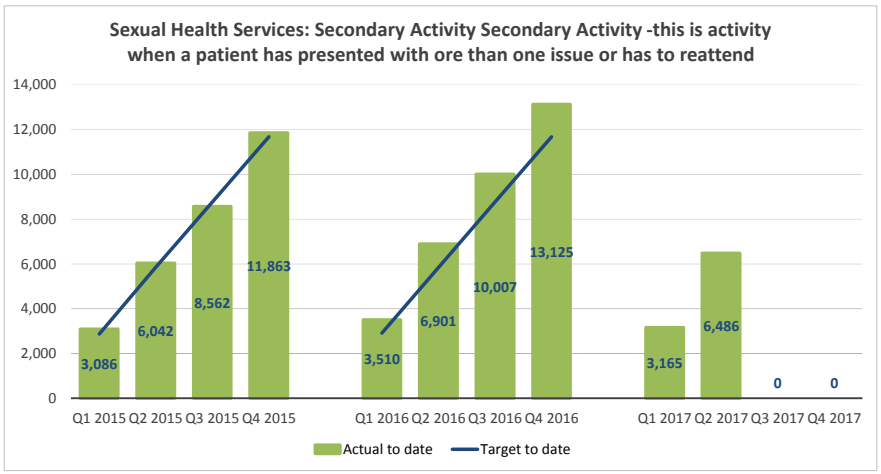
Overall progress rating: Amber

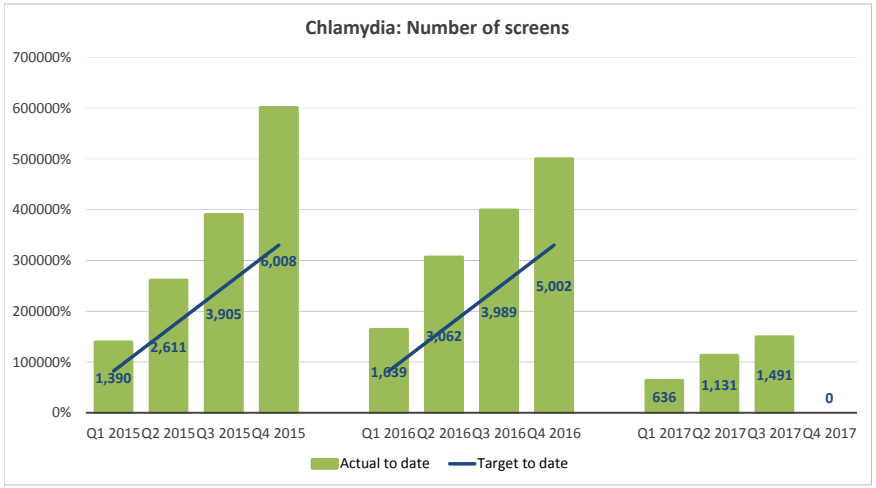
Key Performance Indicators	Activity	2015	2016	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Jan-Mar Q1 2017	Apr-Jun Q2 2017	Jul-Sep Q3 2017	Oct-Dec Q4 2017
Sexual Health Services: Primary activity	Target to date	26,578	32,573	6,645	16,287	24,430	32,573	8,143	16,287	24,430	32,573				
Primary activity - this is the most expensive issue that the patient presents with	Actual			8,227	7,726	6,851	5,596	5,720	5,408	5,079	4,997	5,776	5,200		
	Actual to date			8,227	15,953	22,804	28,400	5,720	11,128	16,207	21,204	5,776	10,976		
Sexual Health Services: Secondary Activity	Target to date	11,489	11,682	2,872	5,841	8,762	11,682	2,921	5,841	8,762	11,682				
Secondary Activity -this is activity when a patient has presented with ore than one issue or has to reattend	Actual			3,086	2,956	2,520	3,301	3,510	3,391	3,106	3,118	3,165	3,321		
	Actual to date			3,086	6,042	8,562	11,863	3,510	6,901	10,007	13,125	3,165	6,486		
Chlamydia: Number of screens	Target to date	3,300	3,300	825	1,650	2,475	3,300	825	1,650	2,475	3,300				
	Actual			1,390	1,221	1,294	2,103	1,639	1,423	927	1,013	636	495	360	
	Actual to date			1,390	2,611	3,905	6,008	1,639	3,062	3,989	5,002	636	1,131	1,491	
Chlamydia: Number of positives	Target to date	376	376	94	188	282	376	94	188	282	376				
	Actual			110	91	93	139	96	89	67	77	73	75	35	
	Actual to date			110	201	294	433	96	185	252	329	73	148	183	
Young peoples services activity	Target to date	1,100	1,100	275	550	825	1,100	275	550	825	1,100				
	Actual			319	189	86	284	240	167	145	252	357	234	116	
	Actual to date			319	508	594	878	240	407	552	804	357	591	707	

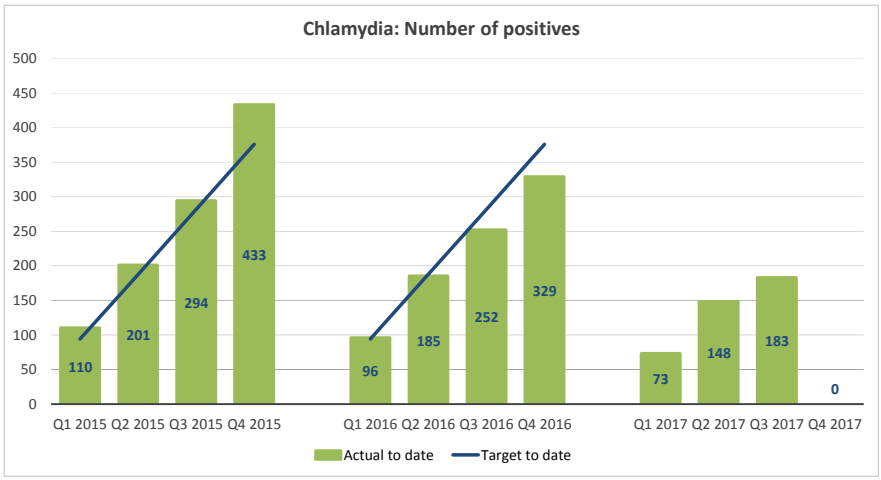
Comments on performance	Lead:	Date:
Low Primary activity in HIV testing, SRH Standard, T2 Chlamydia & Gonorrhoea Test, T3 Chlamydia, Gonorrhoea and Syphilis Test, TS Microscopy	LR	14/02/2017
Number of chlamydia screens - there has been achange in the contract in 2017 which requires less volume from the provider		
Young peoples service has gone up in the first quarter 2017/18	RS	02/08/2017

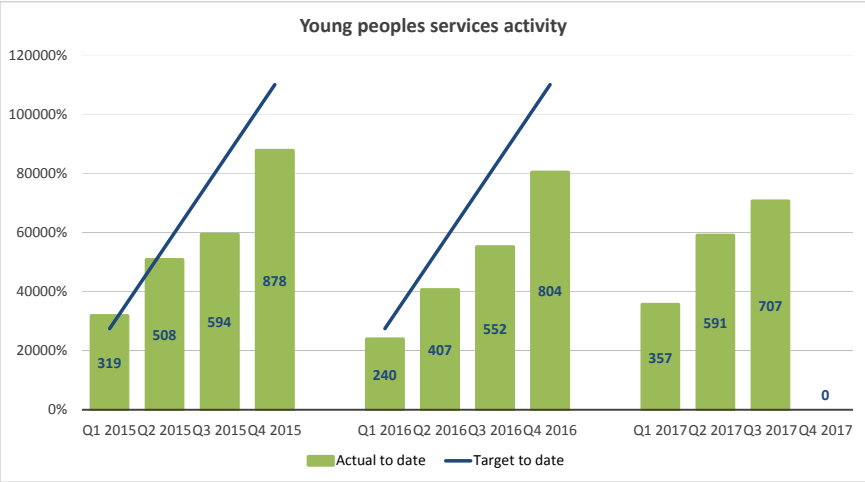
Key actions	Action by date:
Staff recruitment in service to increase capacity	Aug-17
New clinics for young peoples service being tried	May-17
Recruitment underway	Aug-17


Sexual Health Services: Primary activity
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
8,227
15,953
22,804
28,400
5,720
11,128
16,207
21,204
5,776
10,976
0
0
Q1 2015 Q2 2015 Q3 2015 Q4 2015
Q1 2016 Q2 2016 Q3 2016 Q4 2016
Q1 2017 Q2 2017 Q3 2017 Q4 2017
Actual to date
Target to date


Sexual Health Services: Secondary Activity Secondary Activity -this is activity when a patient has presented with ore than one issue or has to reattend
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
3,086
6,042
8,562
11,863
3,510
6,901
10,007
13,125
3,165
6,486
0
0
Q1 2015 Q2 2015 Q3 2015 Q4 2015
Q1 2016 Q2 2016 Q3 2016 Q4 2016
Q1 2017 Q2 2017 Q3 2017 Q4 2017
Actual to date
Target to date


Chlamydia: Number of screens
700000%
600000%
500000%
400000%
300000%
200000%
100000%
0%
1,390
2,611
3,905
6,008
1,039
3,062
3,989
5,002
636
1,131
1,491
0
Q1 2015 Q2 2015 Q3 2015 Q4 2015
Q1 2016 Q2 2016 Q3 2016 Q4 2016
Q1 2017 Q2 2017 Q3 2017 Q4 2017
Actual to date
Target to date


Chlamydia: Number of positives
500
450
400
350
300
250
200
150
100
50
0
110
201
294
433
96
185
252
329
73
148
183
0
Q1 2015 Q2 2015 Q3 2015 Q4 2015
Q1 2016 Q2 2016 Q3 2016 Q4 2016
Q1 2017 Q2 2017 Q3 2017 Q4 2017
Actual to date
Target to date


Young peoples services activity
120000%
100000%
80000%
60000%
40000%
20000%
0%
319
508
594
878
240
407
552
804
357
591
707
0
Q1 2015
Q2 2015
Q3 2015
Q4 2015
Q1 2016
Q2 2016
Q3 2016
Q4 2016
Q1 2017
Q2 2017
Q3 2017
Q4 2017
Actual to date
Target to date

Division of Public Health Performance Report: 2017/18 Quarter 2

GP Practice contracts: Long-Acting Reversible Contraception

Provider: Leicester GP Practices

Purpose of service: Provision of long-acting reversible contraception in GP Practices

Relevant PHOF indicators:
2.04 - Under 18 conceptions

Return to summary page

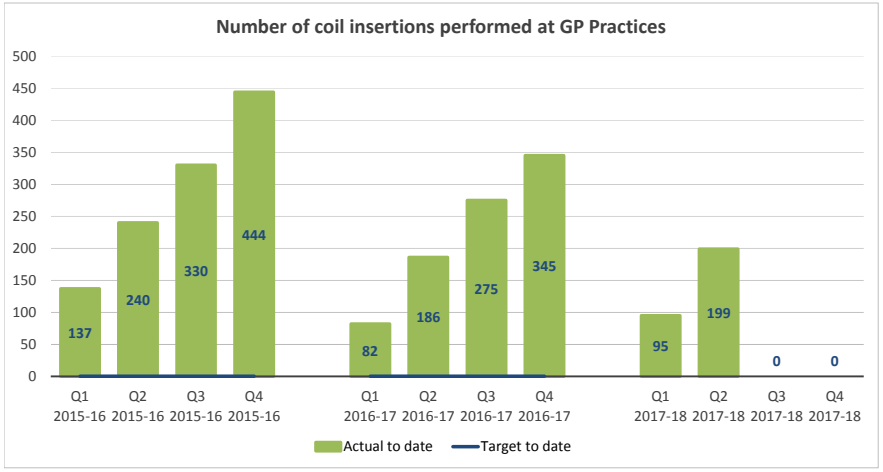
DOT Worse, Sig Worse

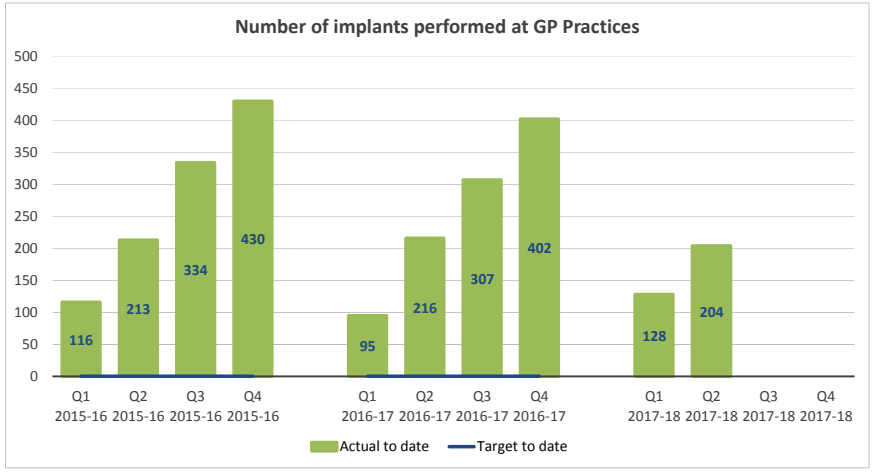
Overall progress rating: Amber

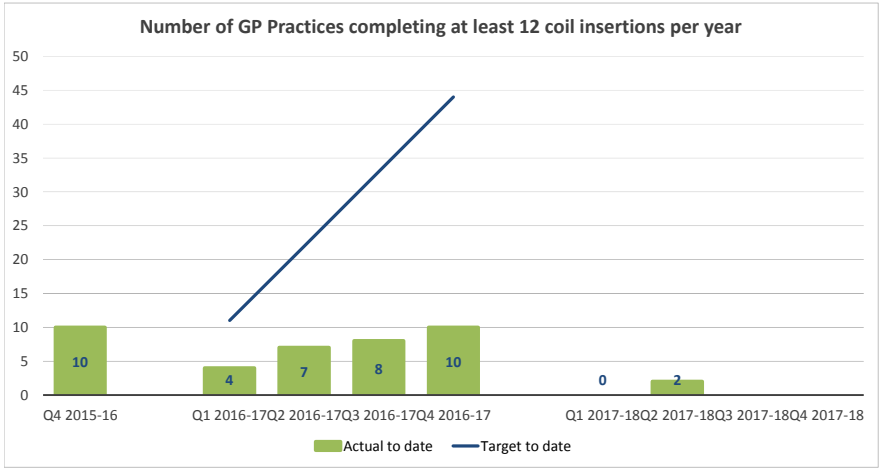
Key Performance Indicators	Activity	2015	2016	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Number of coil insertions performed at GP Practices	Target to date			0	0	0	0	0	0	0	0				
	Actual			137	103	90	114	82	104	89	70	95	104		
	Actual to date			137	240	330	444	82	186	275	345	95	199		
Number of implants performed at GP Practices	Target to date			0	0	0	0	0	0	0	0				
	Actual			116	97	121	96	95	121	91	95	128	76		
	Actual to date			116	213	334	430	95	216	307	402	128	204		
Number of GP Practices completing at least 12 coil insertions per year	Target to date	44	44	11	22	33	44	11	22	33	44				
	Actual	14		10				4	3	1	2	0	2		
	Actual to date						10	4	7	8	10	0	2		
Number of GP Practices completing at least 6 implants per year	Target to date	44	44	11	22	33	44	11	22	33	44				
	Actual	10		10				1	4	1	2	10	9		
	Actual to date						10	1	5	6	8	10	19		

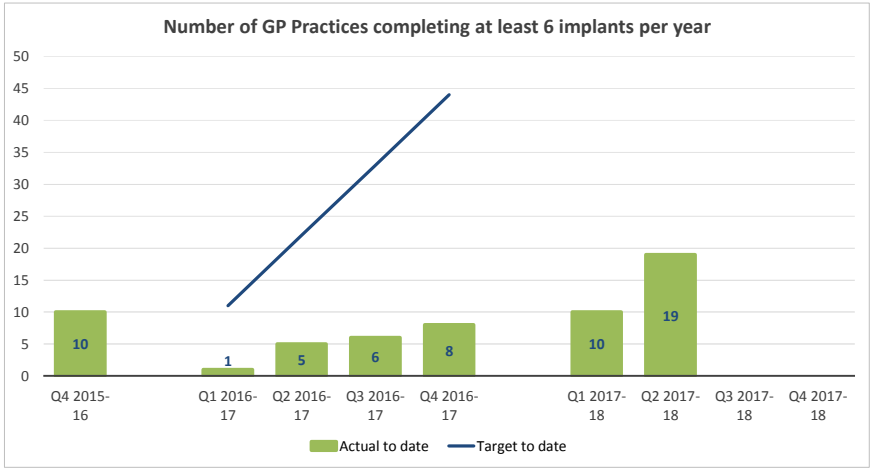
Comments on performance	Lead:	Date:
Increase numbers of Coils insertions of 9 in the last quarter	RS	03/11/2017
There is decrease in the Implants from the last quarter	RS	03/11/2017
Meetings held with GPs to understand reason which includes training requirements, renumeration and time constraints	RS	15/05/2017
Increase in number of GP completing at least 6 implants	RS	03/11/2017

Key actions	Action by date:
Discussion paper with GP Reference Group regarding low numbers and developing alternative model. Meetings held with each Health Need Neighbourhood, further meeting with GP reference group in June	Jun-17


Number of coil insertions performed at GP Practices
500
450
400
350
300
250
200
150
100
50
0
137
240
330
444
82
186
275
345
95
199
0
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target to date


Number of implants performed at GP Practices
500
450
400
350
300
250
200
150
100
50
0
116
213
334
430
95
216
307
402
128
204
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target to date


Number of GP Practices completing at least 12 coil insertions per year
50
45
40
35
30
25
20
15
10
5
0
10
4
7
8
10
0
2
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target to date


Number of GP Practices completing at least 6 implants per year
50
45
40
35
30
25
20
15
10
5
0
10
1
5
6
8
10
19
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target to date

Division of Public Health Performance Report: 2017/18 Quarter 2

Sexual Health Services: Emergency Hormonal Contraception through Pharmacies

Provider: Leicester Pharmacies

Purpose of service: Provision of free emergency hormonal contraception (EHC) to under 24s in pharmacies

Relevant PHOF indicators:

2.04 - Under 18 conceptions

Return to summary page

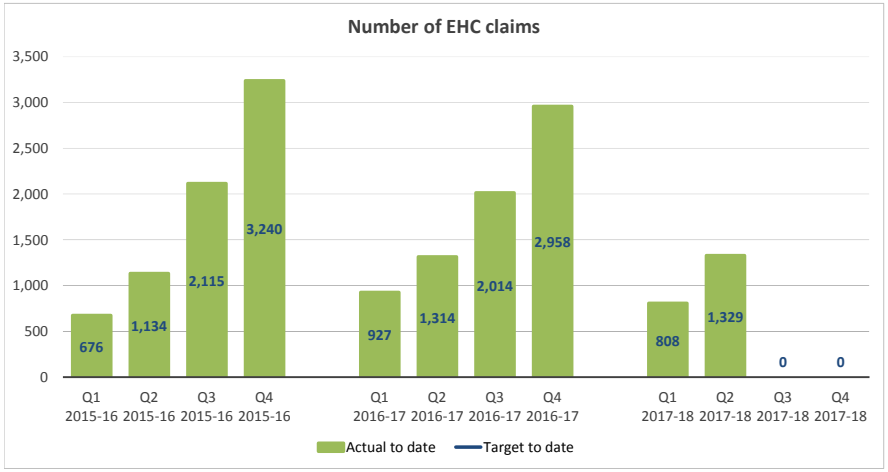
DOT Worse, Sig Worse

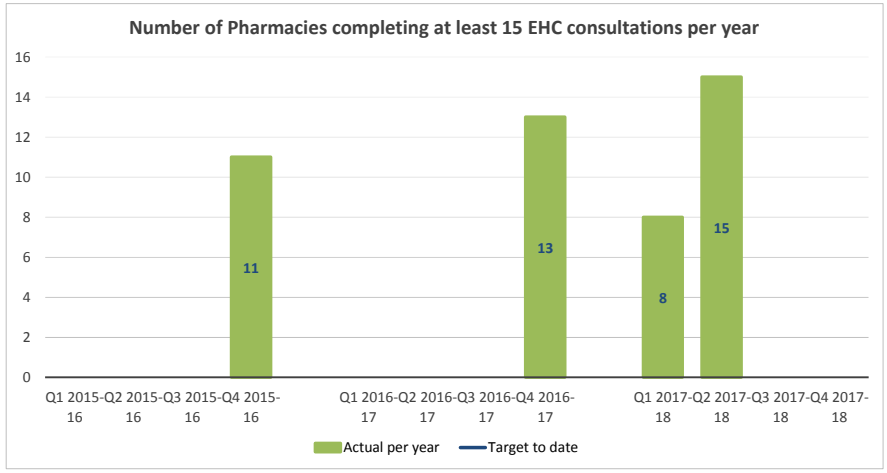
Overall progress rating: Green

Key Performance Indicators	Activity	2015	2016	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Number of EHC claims	Target to date														
	Actual			676	458	981	1,125	927	387	700	944	808	521		
	Actual to date			676	1,134	2,115	3,240	927	1,314	2,014	2,958	808	1,329		
Number of Pharmacies completing at least 15 EHC consultations per year	Target to date		71				15				15				15
	Actual			8	5	9	6	8	7	7	7	8	7		
	Actual per year						11				13	8	15		

Comments on performance	Lead:	Date:
Low numbers of pharmacies providing at least 15 EHC consultations per year	LR	15/05/2017
As July 2017 all Pharmacies which has provided less than 15 EHC consultation has been decomissioned.	RS	02/08/2017
There has been increase EHC Claims during Q2 is due to some Pharmacies had done their Q1 with Q2	RS	03/11/2017

Key actions	Action by date:
Pharmacies providing less than 15 EHC consultations per year de-commissioned	Completed





Division of Public Health Performance Report: 2017/18 Quarter 2

Community based HIV Prevention Services for HIV positive people

Provider: LASS

Purpose of service: To improve sexual health outcomes for people of who are HIV positive in Leicester and Leicestershire within the context of the wider health issues for this group

Relevant PHOF indicators:

3.04 - HIV late diagnosis

Return to summary page

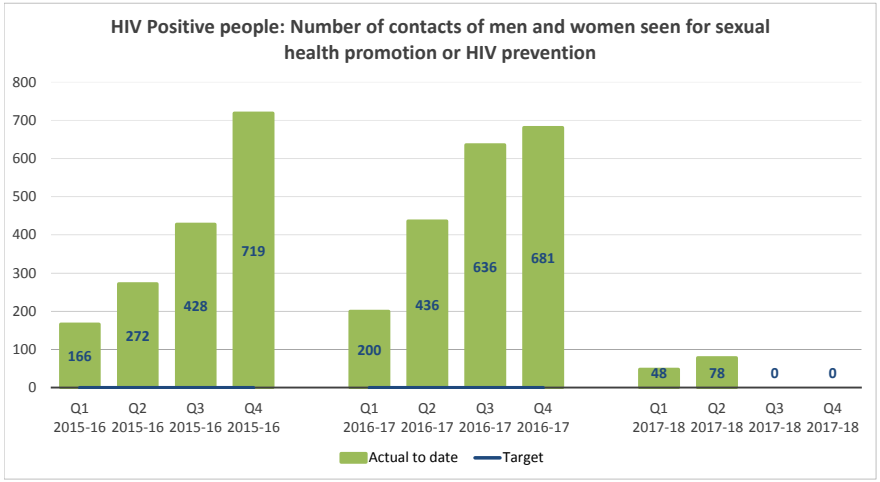
DOT Worse, Sig Worse

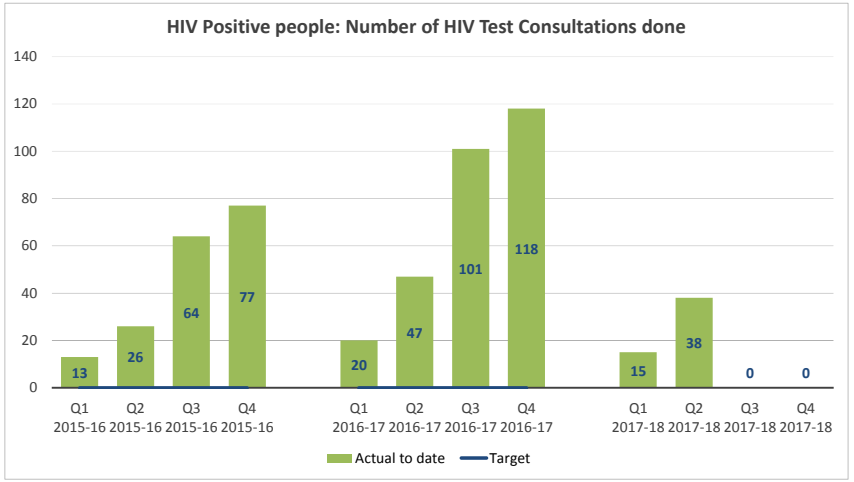
Overall progress rating: Amber

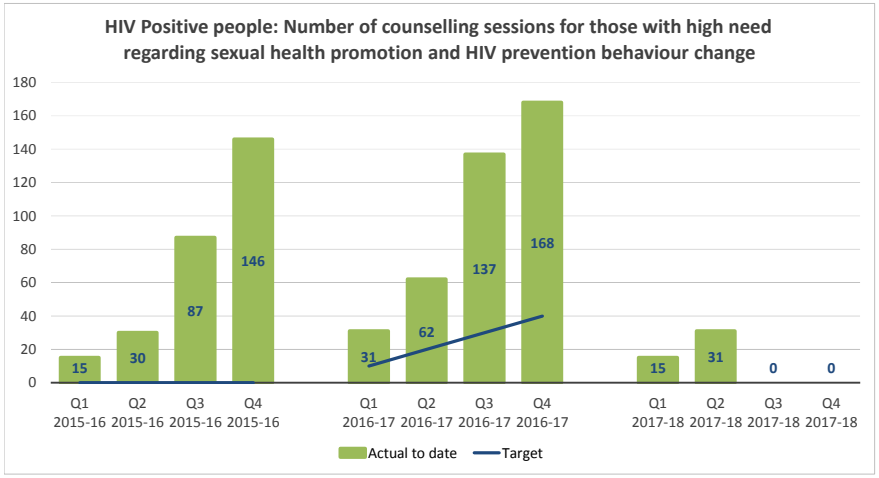
Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
HIV Positive people: Number of contacts of men and women seen for sexual health promotion or HIV prevention	Target			0	0	0	0	0	0	0	0				
	Actual			166	106	156	291	200	236	200	45	48	30		
	Actual to date			166	272	428	719	200	436	636	681	48	78		
HIV Positive people: Number of HIV Test Consultations done	Target			0	0	0	0	0	0	0	0				
	Actual			13	13	38	13	20	27	54	17	15	23		
	Actual to date			13	26	64	77	20	47	101	118	15	38		
HIV Positive people: Number of counselling sessions for those with high need regarding sexual health promotion and HIV	Target		40	0	0	0	0	10	20	30	40				
	Actual			15	15	57	59	31	31	75	31	15	16		
	Actual to date			15	30	87	146	31	62	137	168	15	31		

Comments on performance	Lead:	Date:
In 2016-17, there has been a significant increase in terms of contacts relating to sexual health promotion or HIV prevention. Q4 data low	CaAS	09/02/2017
The increases in activity are also represented in relation to HIV test consultations and the number of counselling sessions, this is very high .	CaAS	09/02/2017
Numbers of contacts for HIV have been revised in 2016/17. CaAS to advise		
Data appears to include people who have been given IAG . Need to ensure that reporting is about sexual health only	LR	
Number of people has fallen across all three KPI's - will raise this at the Contracts Meeting	RS	02/08/2017
In Q2 Down by 18 compared to Q1 that a percenrage drop of 24%	GSH	01/11/2017

Key actions	Action by date:
Discussion with provider about pathway and referrals from counselling sessions , Data is not satisfactory and it seems that the service is providing beyond commisioned activity. This needs some discussion	May 2017
Raise with the Provider as why the number of people has drop across all three KPIs	Aug 2017
Discussion with the providers to relook at Quarter 2 Data (some the Data did not add up in Quarter 2)	02/11/2017


HIV Positive people: Number of contacts of men and women seen for sexual health promotion or HIV prevention
800
700
600
500
400
300
200
100
0
166
272
428
719
200
436
636
681
48
78
0
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


HIV Positive people: Number of HIV Test Consultations done
140
120
100
80
60
40
20
0
13
26
64
77
20
47
101
118
15
38
0
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


HIV Positive people: Number of counselling sessions for those with high need regarding sexual health promotion and HIV prevention behaviour change
180
160
140
120
100
80
60
40
20
0
15
30
87
146
31
62
137
168
15
31
0
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target

Division of Public Health Performance Report: 2017/18 Quarter 2

Community based Sexual Health Promotion and HIV Prevention Services for people of African heritage

Provider: LASS

Purpose of service: To improve sexual health outcomes for people of African heritage in Leicester and Leicestershire within the context of the wider health issues for this group

Relevant PHOF indicators: 3.04 - HIV late diagnosis

Return to summary page

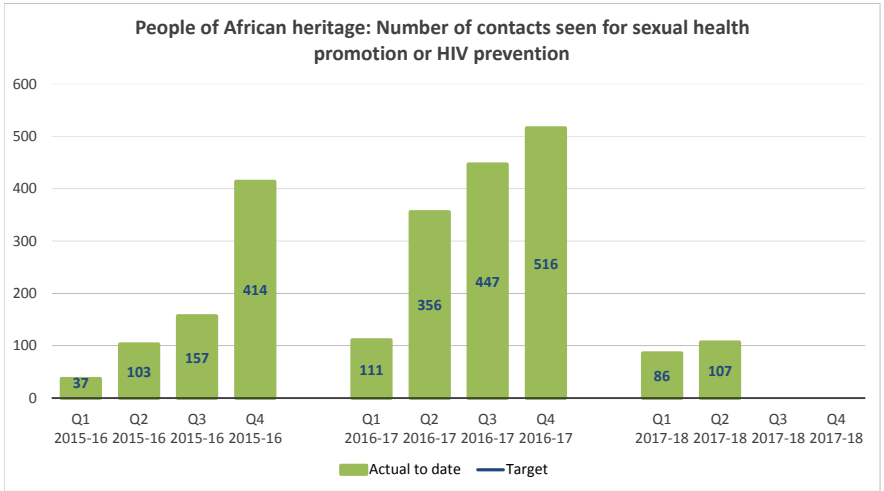
DOT Worse, Sig Worse

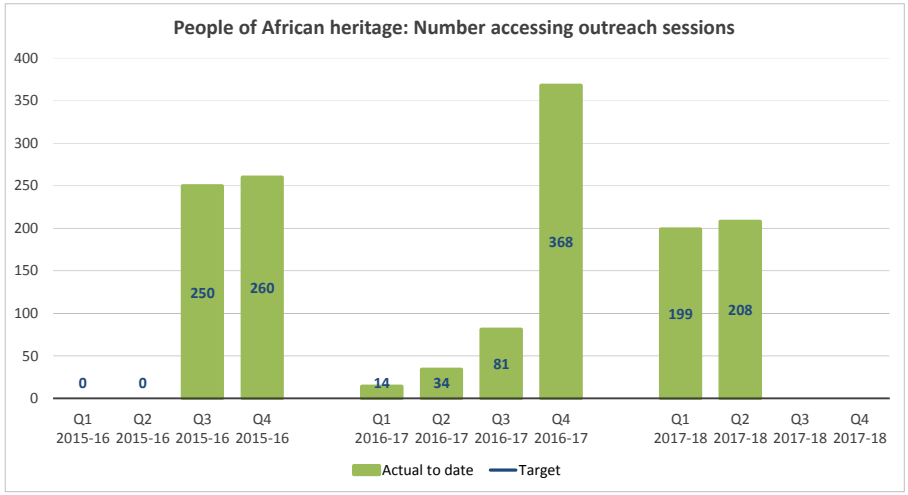
Overall progress rating: Amber

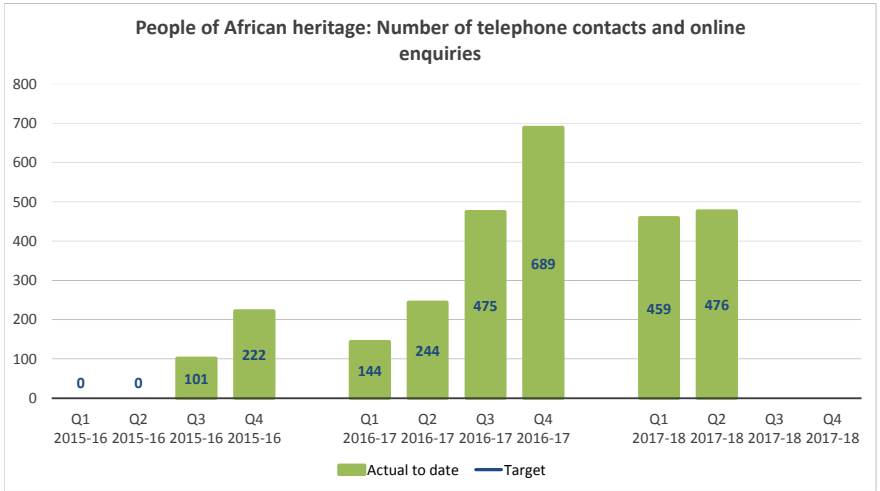
Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
People of African heritage: Number of contacts seen for sexual health promotion or HIV prevention	Target		Pending												
	Actual			37	66	54	257	111	245	91	69	86	21		
	Actual to date			37	103	157	414	111	356	447	516	86	107		
People of African heritage: Number accessing outreach sessions	Target														
	Actual					250	10	14	20	47	287	199	9		
	Actual to date					250	260	14	34	81	368	199	208		
People of African heritage: Number of telephone contacts and online enquiries	Target														
	Actual					101	121	144	100	231	214	459	17		
	Actual to date					101	222	144	244	475	689	459	476		
People of African heritage: Number referred to other services for sexual health promotion or HIV prevention	Target														
	Actual			43	141	90	13	24	24	107	26	27	11		
	Actual to date			43	184	274	287	24	48	155	181	27	38		
People of African heritage: Number of HIV tests done	Target														
	Actual					24	14	31	24	29	16	24	16		
	Actual to date					24	38	31	55	84	100	24	40		

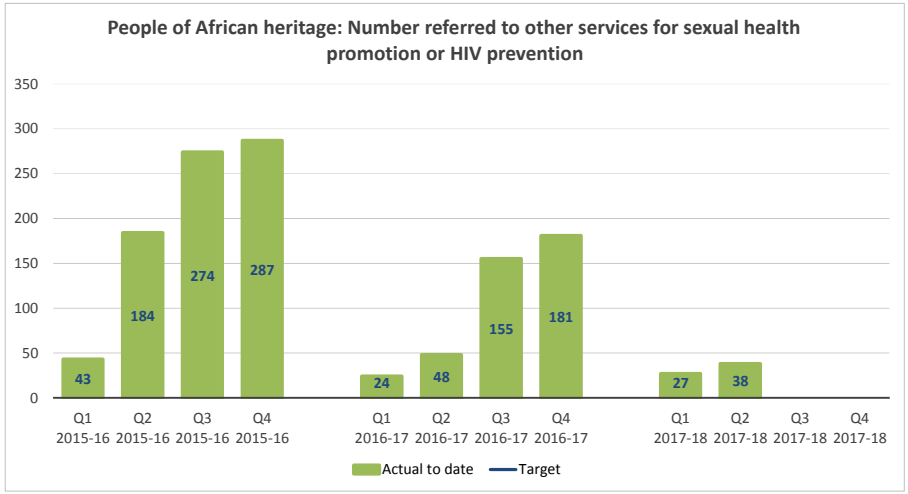
Comments on performance	Lead:	Date:
Data exceeds contracted activity . This could be erroneous and needs discussion with the provider	RS	02/08/2017
Low figures in 2017/18 Q2 due to rain during the African Caribbean carnival (low turnout)	CaAS	06/11/2017
Still no clarity about change in numbers eg reduction in telephone contacts from 459 in Q1 to 17 in Q2	LR	08/11/2017

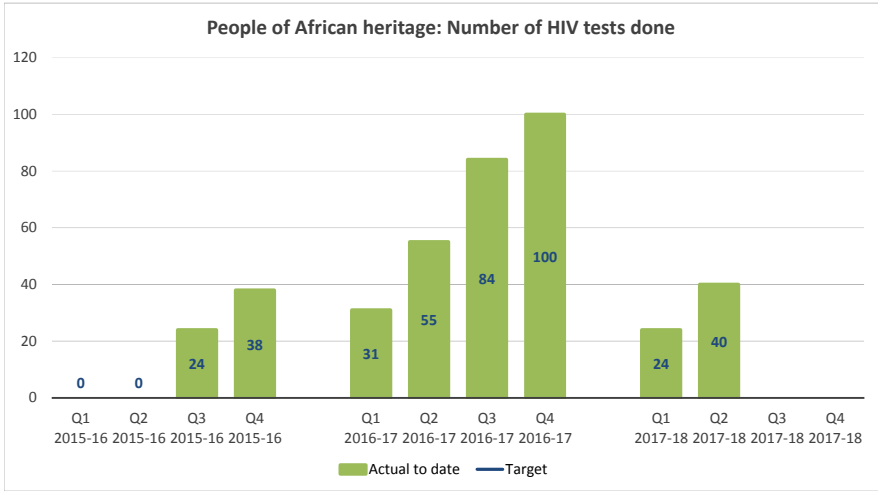
Key actions	Action by date:
Discuss reason for reductions and movement of activity	01/08/2017
Discussion with the providers to relook at Quarter 2 data (some the data did not add up in Quarter 2).	02/11/2017


People of African heritage: Number of contacts seen for sexual health promotion or HIV prevention
600
500
400
300
200
100
0
37
103
157
414
111
356
447
516
86
107
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


People of African heritage: Number accessing outreach sessions
400
350
300
250
200
150
100
50
0
0
0
250
260
14
34
81
368
199
208
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


People of African heritage: Number of telephone contacts and online enquiries
800
700
600
500
400
300
200
100
0
0
0
101
222
144
244
475
689
459
476
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


People of African heritage: Number referred to other services for sexual health promotion or HIV prevention
350
300
250
200
150
100
50
0
43
184
274
287
24
48
155
181
27
38
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


People of African heritage: Number of HIV tests done
120
100
80
60
40
20
0
0
0
24
38
31
55
84
100
24
40
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target

Division of Public Health Performance Report: 2017/18 Quarter 2

Community based HIV Prevention Services: Men who have sex with men (MSM)

Provider: TRADE

Overall progress rating: Amber

Purpose of service: To improve sexual health outcomes for Gay, Bisexual & other MSM in Leicester, Leicestershire & Rutland, within the context of the wider health issues for this group.

Relevant PHOF indicators:

3.04 - HIV late diagnosis

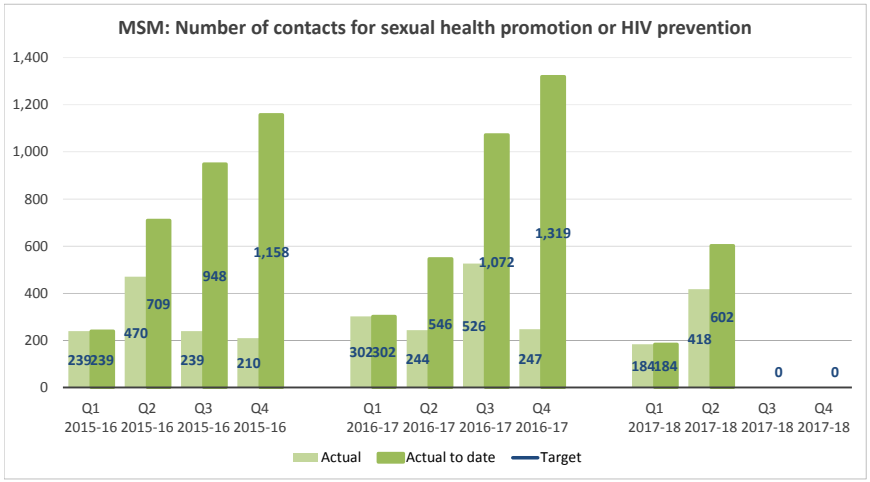
Return to summary page

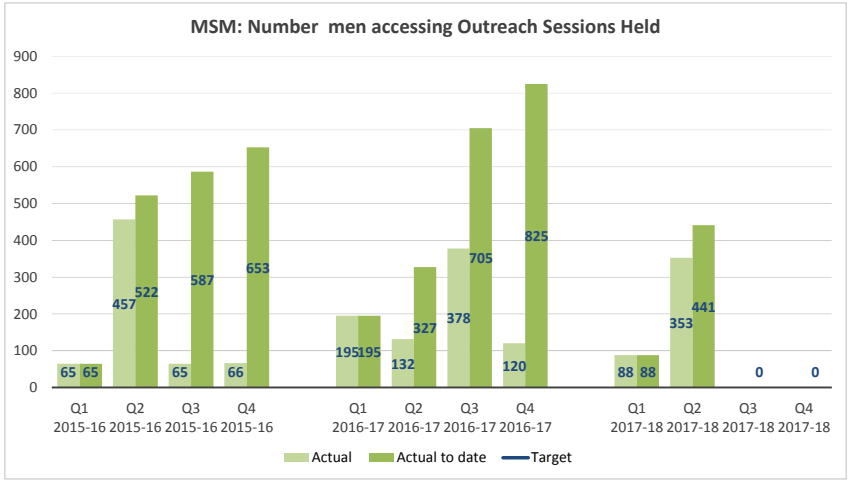
DOT Worse, Sig Worse

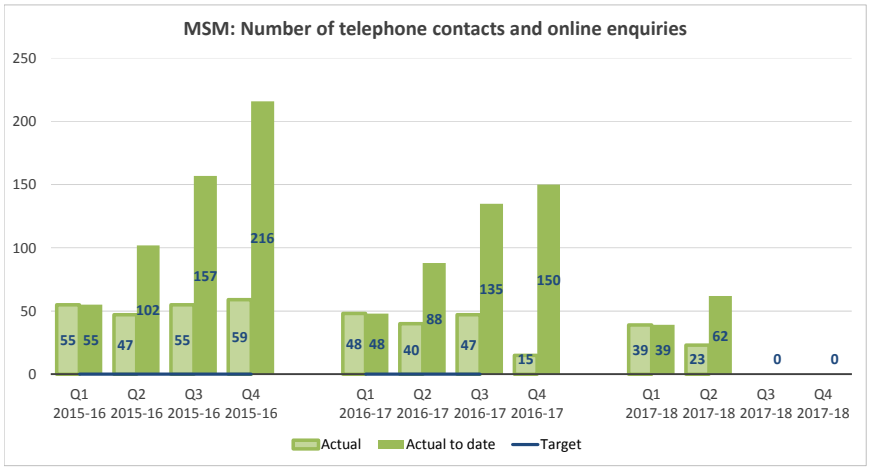
Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
MSM: Number of contacts for sexual health promotion or HIV prevention	Target														
	Actual			239	470	239	210	302	244	526	247	184	418		
	Actual to date			239	709	948	1158	302	546	1072	1319	184	602		
MSM: Number men accessing Outreach Sessions Held	Target														
	Actual			65	457	65	66	195	132	378	120	88	353		
	Actual to date			65	522	587	653	195	327	705	825	88	441		
MSM: Number of telephone contacts and online enquiries	Target			0	0	0	0	0	0	0					
	Actual			55	47	55	59	48	40	47	15	39	23		
	Actual to date			55	102	157	216	48	88	135	150	39	62		
MSM: Number of men referred to Other Services	Target							0	0	0					
	Actual			183	123	183	173	283	219	504	314	184	418		
	Actual to date			183	306	489	662	283	502	1006	1320	184	602		
MSM: Number of reactive test	Target			0	0	0	0	0	0	0	0	0	0		
	Actual			0	0	0	0	0	0	0	0	0	0		
	Actual to date			0	0	0	0	0	0	0	0	0	0		

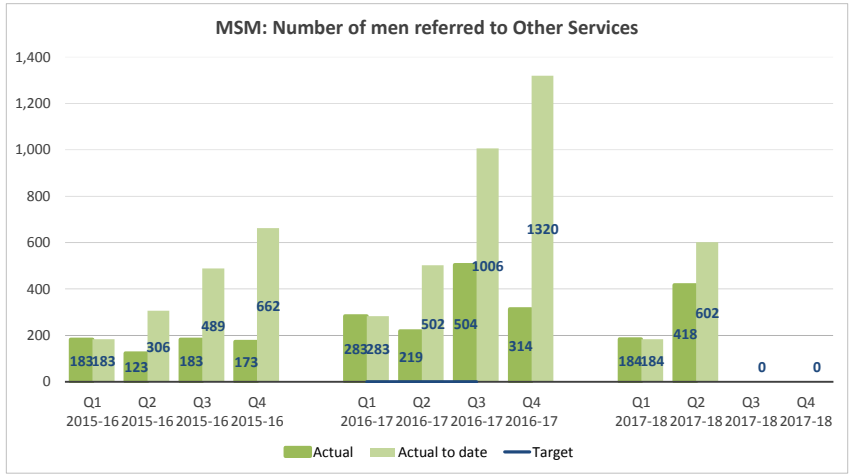
Comments on performance	Lead:	Date:
Increase in number of contacts due to the Pride Event.	CaAS	31/10/2017

Key actions	Action by date:
Discussion with provider about low activity, method of recording and agreement about how and what is counted in this data return	Nov-17


MSM: Number of contacts for sexual health promotion or HIV prevention
1,400
1,200
1,000
800
600
400
200
0
239 239
470 709
239 948
210 1,158
302 302
244 546
526 1,072
247 1,319
184 184
418 602
0 0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Actual to date
Target


MSM: Number men accessing Outreach Sessions Held
900
800
700
600
500
400
300
200
100
0
65 65
457 522
65 587
66 653
195 195
132 327
378 705
120 825
88 88
353 441
0 0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Actual to date
Target


MSM: Number of telephone contacts and online enquiries
250
200
150
100
50
0
55 55
47 102
55 157
59 216
48 48
40 88
47 135
15 150
39 39
23 62
0 0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Actual to date
Target


MSM: Number of men referred to Other Services
1,400
1,200
1,000
800
600
400
200
0
183 183
123 306
183 489
173 662
283 283
219 502
504 1006
314 1320
184 184
418 602
0 0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Actual to date
Target

Division of Public Health Performance Report: 2017/18 Quarter 2

Community based HIV Prevention Services: Sex workers

Provider: Staffordshire & Stoke on Trent Partnership Trust (SSOTP)

Overall progress rating: Amber

Purpose of service: aims to improve sexual health outcomes for sex workers in Leicester within the context of the wider health issues for this group

Relevant PHOF indicators:

3.04 - HIV late diagnosis

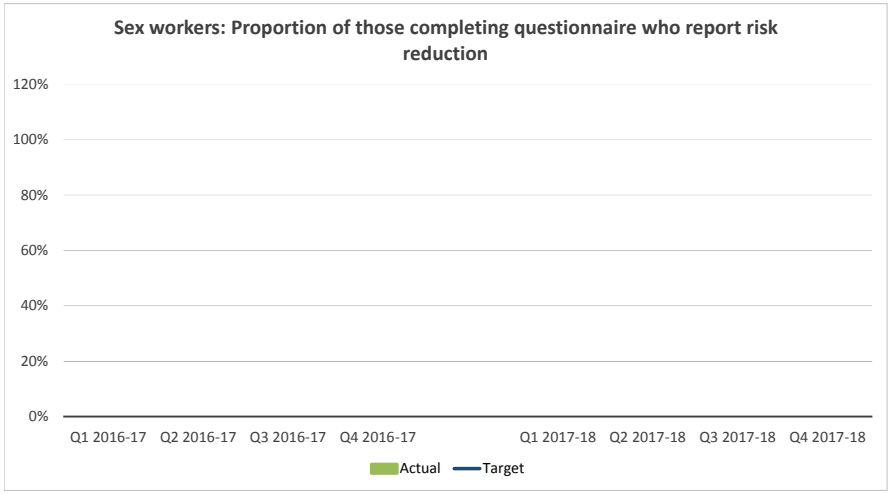
Return to summary page

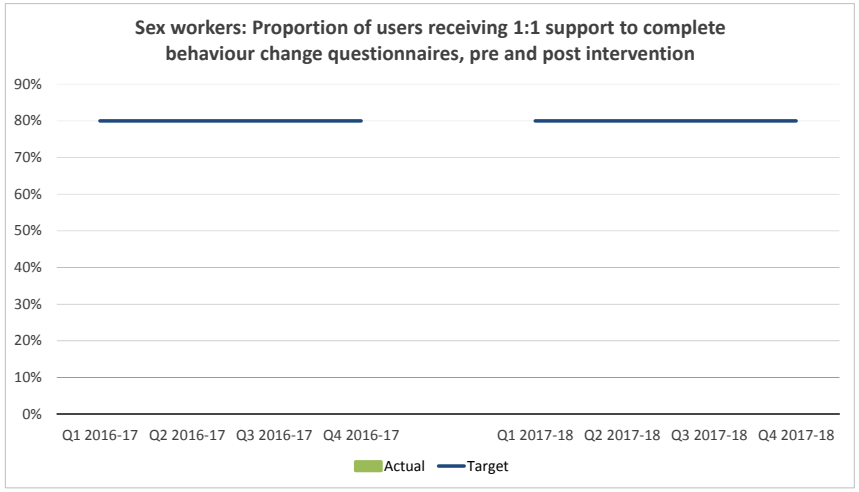
DOT Worse, Sig Worse

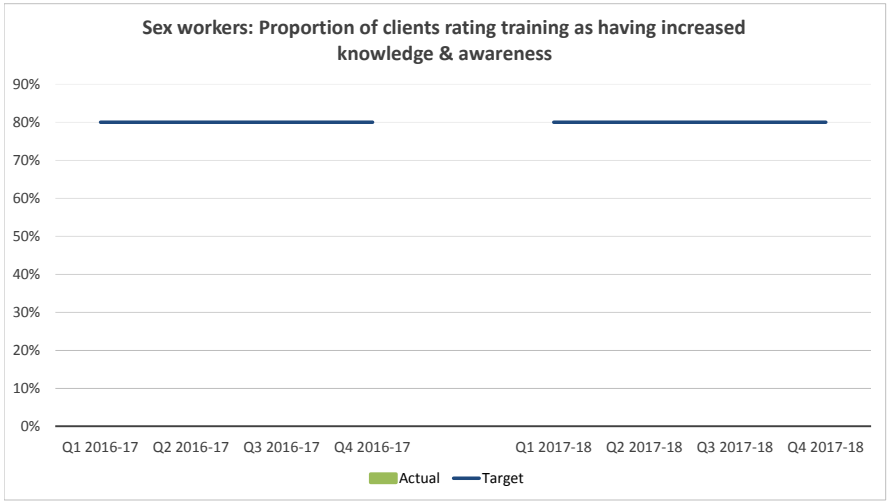
Key Performance Indicators	Activity	2015/16	2016/17	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Sexual health promotion and HIV prevention - people working											
Sex workers: Proportion of users receiving 1:1 support to complete behaviour change questionnaires, pre and post intervention	Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Actual										
Sex workers: Proportion of those completing questionnaire who report risk reduction	Target			0%	0%	0%	0%				
	Actual										
Sex workers: Proportion of clients rating training as having increased knowledge & awareness	Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Actual										
Sex workers: Numbers of sex workers provided with HIV testing	Target			0	0	0	0				
	Actual					3					
Numbers of saunas and brothels visited	Target										
	Actual					46		46	31		

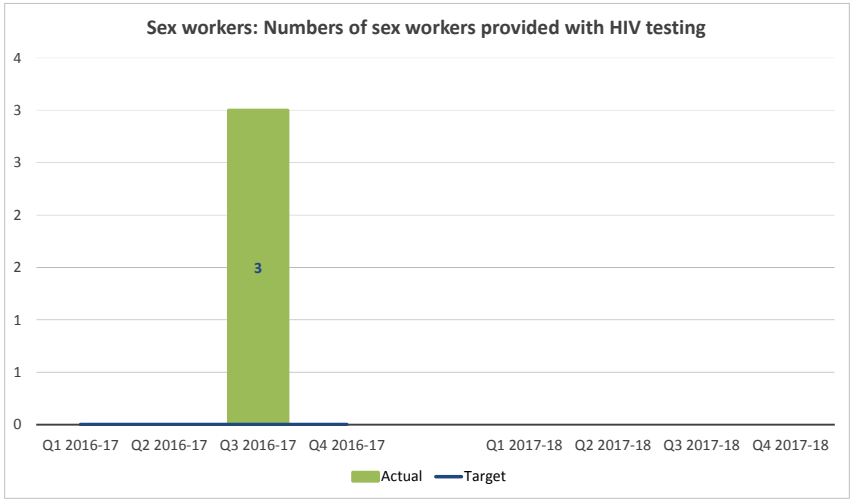
Comments on performance	Lead:	Date:
This service has been developing well and visiting saunas and brothels	LR	14/02/2017
Some issues with visiting street based sex workers	LR	14/02/2017
Monitoring template has just been developed and shared with provider. More data will be populated on future report.	CaAS	13/05/2017
2017/18 all the KPIs were not been answered during 2017/18 Q1 - returns	CaAs	01/08/2017

Key actions	Action by date:
Encourage provider to persist and discuss with police	May-17
Need to raise with provider as to why no KPIs were reported during this quarter	Aug-17


Sex workers: Proportion of those completing questionnaire who report risk reduction
120%
100%
80%
60%
40%
20%
0%
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Target


Sex workers: Proportion of users receiving 1:1 support to complete behaviour change questionnaires, pre and post intervention
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Target


Sex workers: Proportion of clients rating training as having increased knowledge & awareness
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Target


Sex workers: Numbers of sex workers provided with HIV testing
4
3
3
2
2
1
1
0
3
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Target

Division of Public Health Performance Report: 2017/18 Quarter 2

Community Food Growing Support Program

Provider: Saffron Acres Project

Purpose of service: To deliver training and support to stimulate and develop food growing to communities across the south of Leicester

Relevant PHOF indicators:

2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)

2.12 - Excess Weight in Adults

Return to summary page

DOT Improving, Sig Worse

DOT Worse, Sig NS

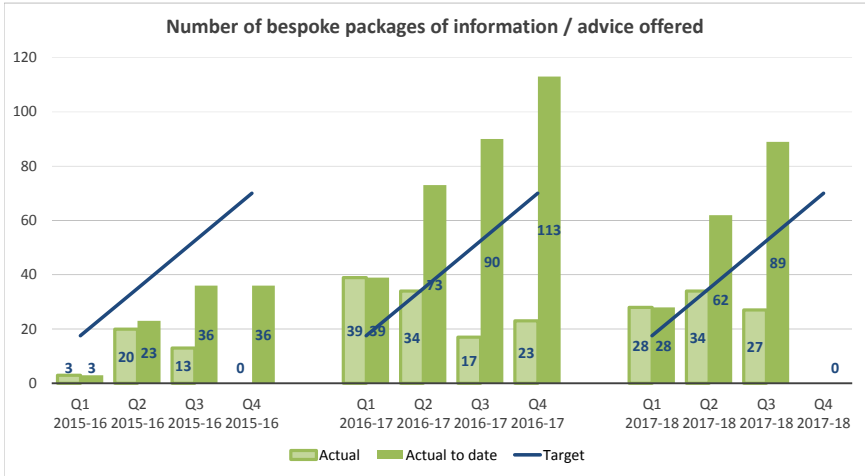
Overall progress rating: Amber

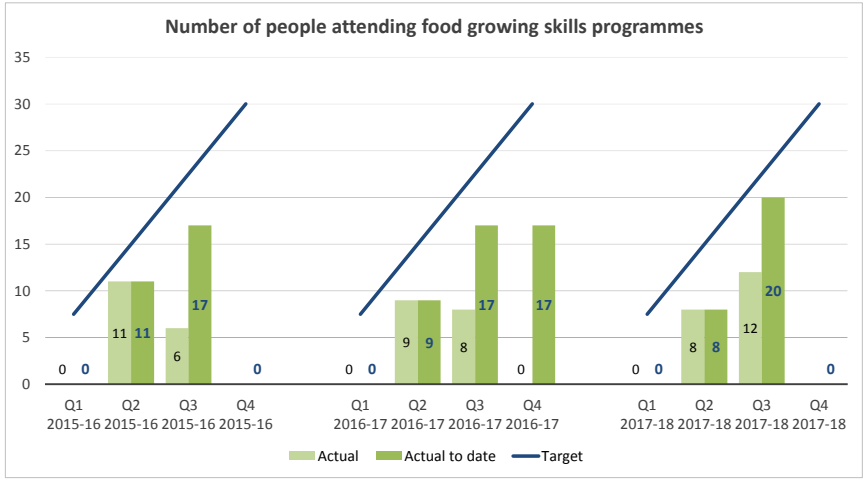
Contract runs from February

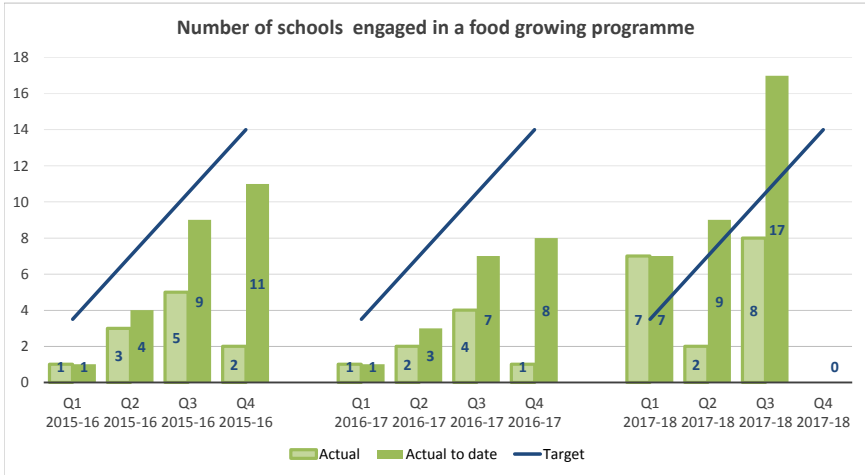
Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Number of bespoke packages of information / advice offered	Target	70	70	18	35	53	70	18	35	53	70	18	35	53	70
	Actual			3	20	13	Pending	39	34	17	23	28	34	27	
	Actual to date			3	23	36	36	39	73	90	113	28	62	89	
Number of people attending food growing skills programmes	Target	30	30	8	15	23	30	8	15	23	30	8	15	23	30
	Actual			0	11	6		0	9	8	0	0	8	12	
	Actual to date			0	11	17		0	9	17	17	0	8	20	
Number of schools engaged in a food growing programme	Target	14	14	4	7	11	14	4	7	11	14	4	7	11	14
	Actual			1	3	5	2	1	2	4	1	7	2	8	
	Actual to date			1	4	9	11	1	3	7	8	7	9	17	

Comments on performance	Lead:	Date:
Increase in number of schools engaged in the programme	CaAs	02/11/2017

Key actions	Action by date:
Speak to provider re shortfalls in attendances in food growing skills programmes - Provider information demonstrating improvement on	Sep-17


Number of bespoke packages of information / advice offered
120
100
80
60
40
20
0
3 3
20 23
13 36
0 36
39 39
34 73
17 90
23 113
28 28
34 62
27 89
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Actual to date
Target


Number of people attending food growing skills programmes
35
30
25
20
15
10
5
0
0 0
11 11
6 17
0 0
0 0
9 9
8 17
0 17
0 0
8 8
12 20
0 0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Actual to date
Target


Number of schools engaged in a food growing programme
18
16
14
12
10
8
6
4
2
0
1 1
3 4
5 9
2 11
1 1
2 3
4 7
1 8
7 7
2 9
8 17
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Actual to date
Target

Division of Public Health Performance Report: 2017/18 Quarter 2

Community Food Growing Support Programme

Provider: The Conservation Volunteers

Purpose of service: To deliver training and support to stimulate and develop food growing to communities across the north of Leicester

Relevant PHOF indicators:

2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)

2.12 - Excess Weight in Adults

Return to summary page

DOT Improving, Sig Worse

DOT Worse, Sig NS

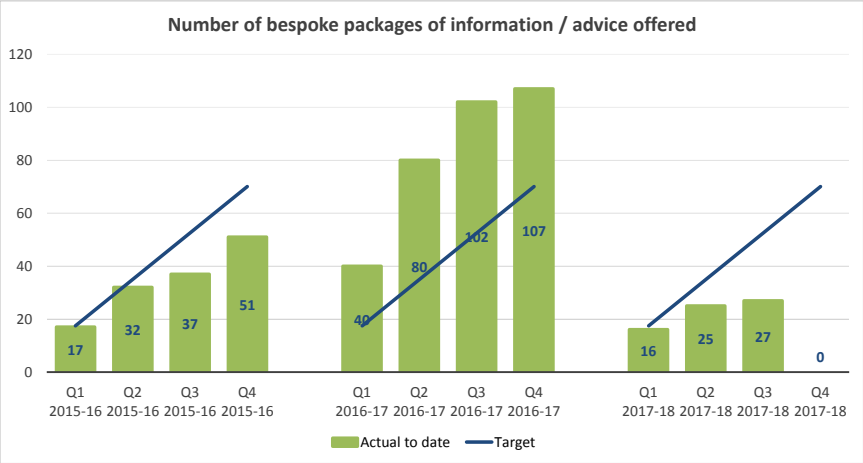
Overall progress rating: Amber

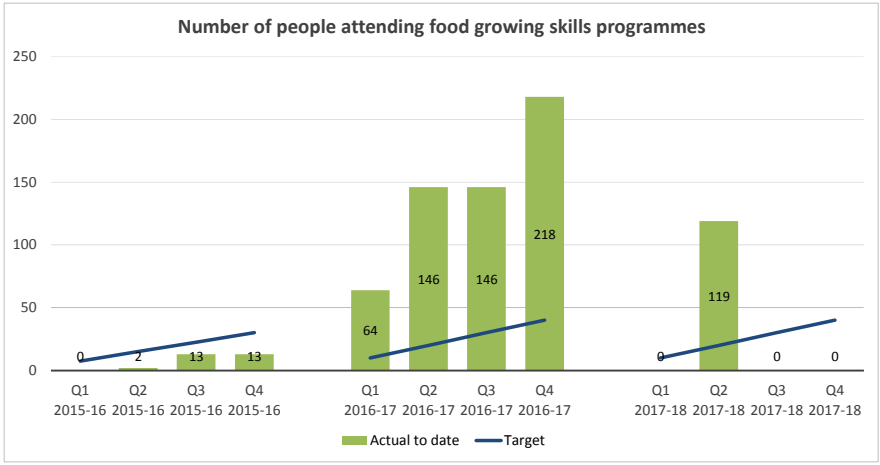
Contract runs from February

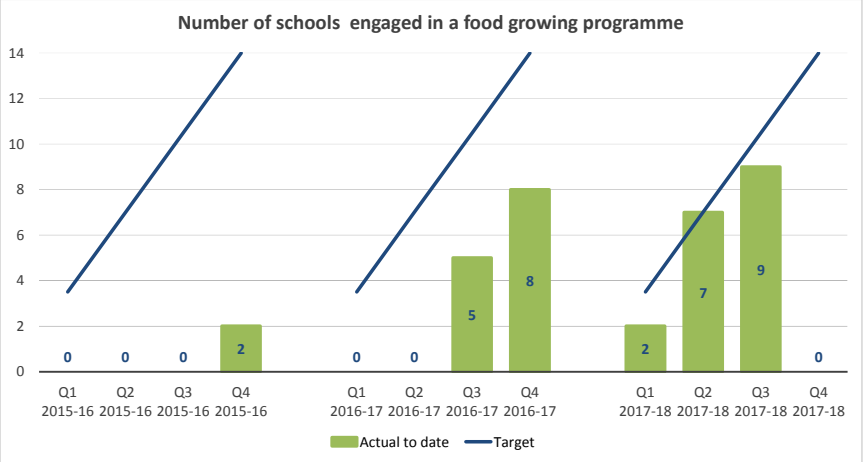
Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16		Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17		Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Number of bespoke packages of information / advice offered	Target	70	70	18	35	53	70		18	35	53	70		18	35	53	70
	Actual			17	15	5	14		40	40	22	5		16	9	2	
	Actual to date			17	32	37	51		40	80	102	107		16	25	27	
Number of people attending food growing skills programmes	Target	30	40	8	15	23	30		10	20	30	40		10	20	30	40
	Actual			0	2	11	0		64	82	0	72		0	119		
	Actual to date			0	2	13	13		64	146	146	218		0	119		
Number of schools engaged in a food growing programme	Target	14	14	4	7	11	14		4	7	11	14		4	7	11	14
	Actual						2		0	0	5	3		2	5	2	
	Actual to date			0	0	0	2		0	0	5	8		2	7	9	

Comments on performance	Lead:	Date:
There is sharp decrease in number of people attending food growing programmes compare to last quarter	CaAS	02/08/2017
Staff change in TCV has accounted for some of the drop in delivery. Further discusion is taking place to agree how to remedy the situation in September 2017	SH	

Key actions	Action by date:
Discussion have taken place to improve take up and outputs. A meeting mid december has been arranged to agree any further remedial action and also inform contract in the future.	Sep-17


Number of bespoke packages of information / advice offered
120
100
80
60
40
20
0
17
32
37
51
40
80
102
107
16
25
27
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


Number of people attending food growing skills programmes
250
200
150
100
50
0
0
2
13
13
64
146
146
218
0
119
0
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


Number of schools engaged in a food growing programme
14
12
10
8
6
4
2
0
0
0
0
2
0
0
5
8
2
7
9
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target

Division of Public Health Performance Report: 2017/18 Quarter 2

Healthy Lifestyles Hub and Health Trainer Programme

Provider: Parkwood Healthcare

Purpose of service: Behaviour change programme offering support to individuals to develop and implement successfully personal health plans (PHP)

Relevant PHOF indicators:
2.13ii - Percentage of physically inactive adults - historical method
2.12 - Excess Weight in Adults
2.14a - Smoking Prevalence in adults - current smokers (APS)

Return to summary page

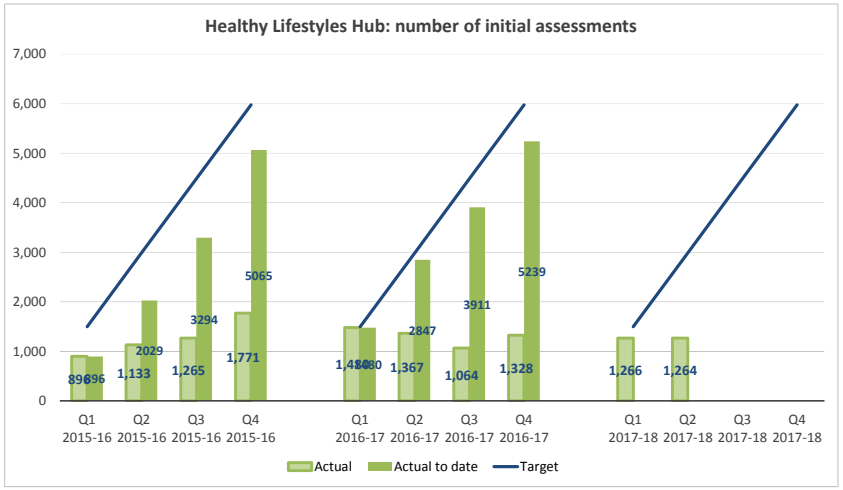
DOT Worse, Sig Worse
DOT Worse, Sig NS
DOT Improving, Sig NS

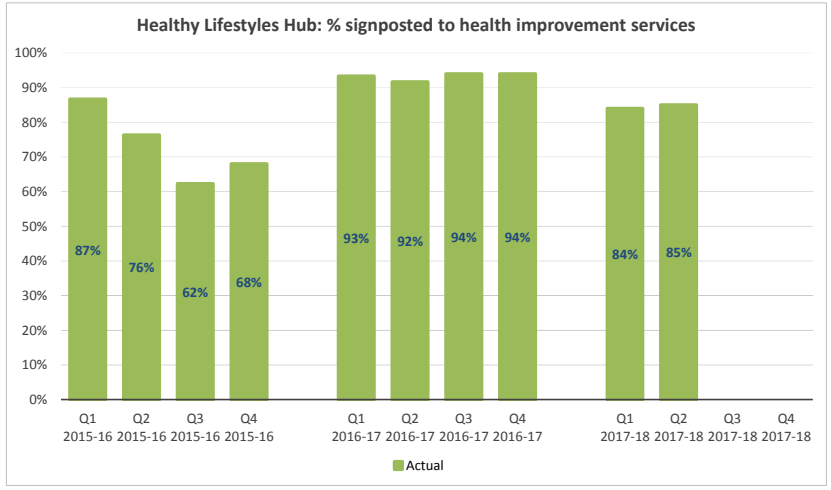
Overall progress rating: Amber

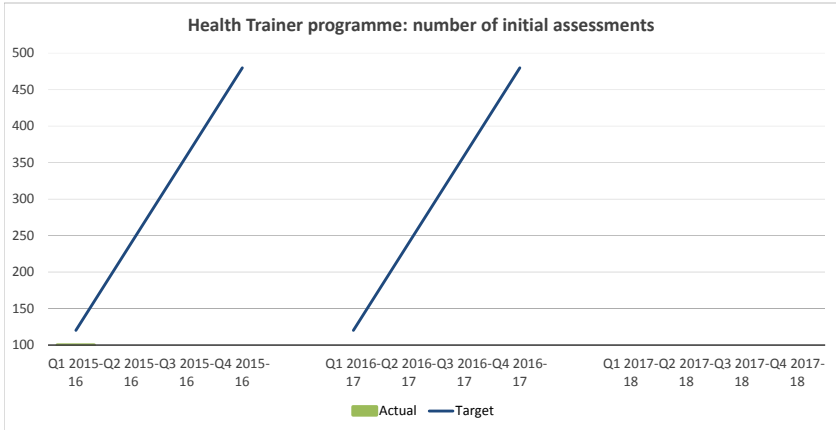
Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Healthy Lifestyles Hub: number of initial assessments	Target	5975	5975	1494	2988	4481	5975	1494	2988	4481	5975	1494	2988	4481	5975
	Actual			896	1133	1265	1771	1480	1367	1064	1328	1266	1264		
	Actual to date			896	2029	3294	5065	1480	2847	3911	5239	1266	2530		
Healthy Lifestyles Hub: number signposted to health improvement services				*777*	*865*	*789*	*1204*	*1381*	*1253*	*1000*	*1248*	*1063*	*1074*		
Healthy Lifestyles Hub: % signposted to health improvement services	Actual			86.7%	76.3%	62.3%	68.0%	93.3%	91.7%	94.0%	94.0%	84%	85%		
	Target	900	900	225	225	225	225	225	225	225	225	225	225		
Healthy Lifestyles Hub: number of clients initiating personal health plan	Actual			Pending. Definition to be agreed. See key actions											
Healthy Lifestyles Hub: % of clients initiating a personal health plan	Actual			Pending. Definition to be agreed. See key actions											
Health Trainer programme: number of initial assessments	Target	480	480	120	240	360	480	120	240	360	480	120			
	Actual			Pending. Definition to be agreed. See key actions											
	Actual to date														
Health trainer programme: number of clients initiating a personal health plan	Target	180	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%			
	Actual			45%	94%	100%	84%	94%	94%	92%	100%	93%			
Health trainer programme: % of clients completing personal health plan	Target			Pending. Definition to be agreed. See key actions											
	Actual														
Health Trainer Service															
Health Trainer programme: number of clients requiring tier 2 service	Target														
	Actual			712	372	98	113	235	260	251	273	219	265		
	Actual to date			712	1084	1182	1295	235	495	746	1019	219	484		
Health Trainers - Number of clients accessing tier 2 who are from deprivation quintiles 1 and 2	Target														
	Actual														
	Actual to date														
Health Trainers - Number of clients who initiate a personal health plan	Target														
	Actual														
	Actual to date														
Health Trainers - Number of clients who partially/fully succeed in a personal health plan	Target														
	Actual														

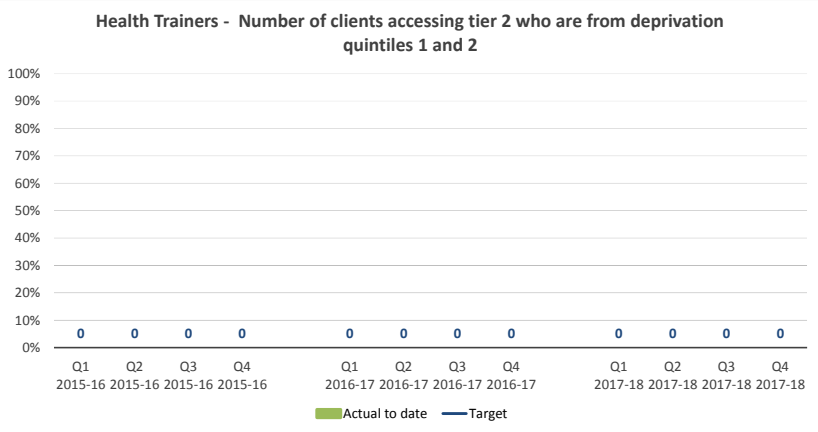
Comments on performance	Lead:	Date:
There are still issues with GP's unable to understand some of funtionality of the Prism so provider has not been receiving the referrals from the GPs in a timely manner.	CaAS	02/11/2017

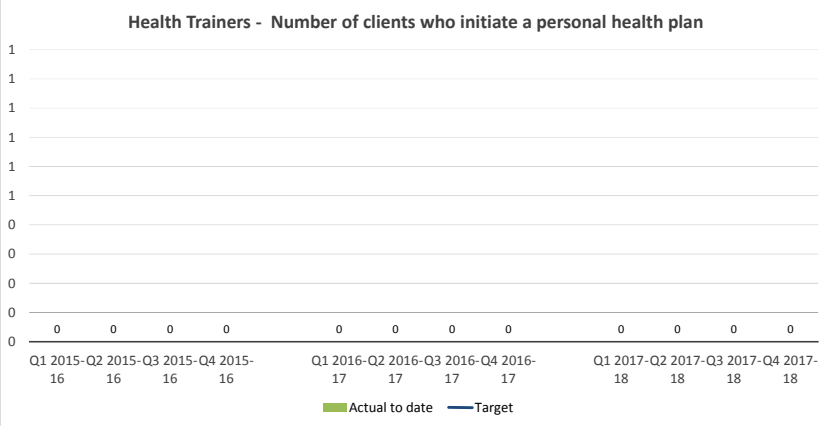
Key actions	Action by date:
Discussion required between CaAS and PH to agree what is considered a completion Health Trainer Programme). There are provider reporting requirements re 6 month and 12 month review, but it may be that an alternative indicator is preferred. This can be agreed, negotiated with the provider and embedded into this report	Aug-17
HLH service users initiating personal health plans is not currently a reported indicator. This can be negotiated with the provider and embedded into future reporting.	Aug-17

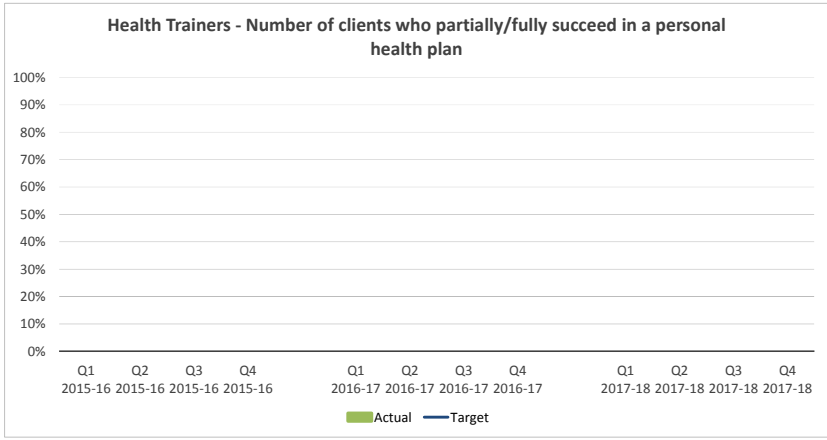





Health Trainer programme: number of initial assessments
500
450
400
350
300
250
200
150
100
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Target


Health Trainers - Number of clients accessing tier 2 who are from deprivation quintiles 1 and 2
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0 0 0 0 0 0 0 0 0 0 0 0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


Health Trainers - Number of clients who initiate a personal health plan
1
1
1
1
1
1
0
0
0
0
0 0 0 0 0 0 0 0 0 0 0 0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


Health Trainers - Number of clients who partially/fully succeed in a personal health plan
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual
Target

Division of Public Health Performance Report: 2017/18 Quarter 2

Health Trainers: Probation

Provider: Inclusion healthcare

Service purpose: a single point of assessment and access to a range of lifestyle support and behaviour change services for people on probation

Return to summary page

Relevant PHOF indicators:

2.13ii - Percentage of physically inactive adults - historical method — DOT Worse, Sig Worse

2.12 - Excess Weight in Adults — DOT Worse, Sig NS

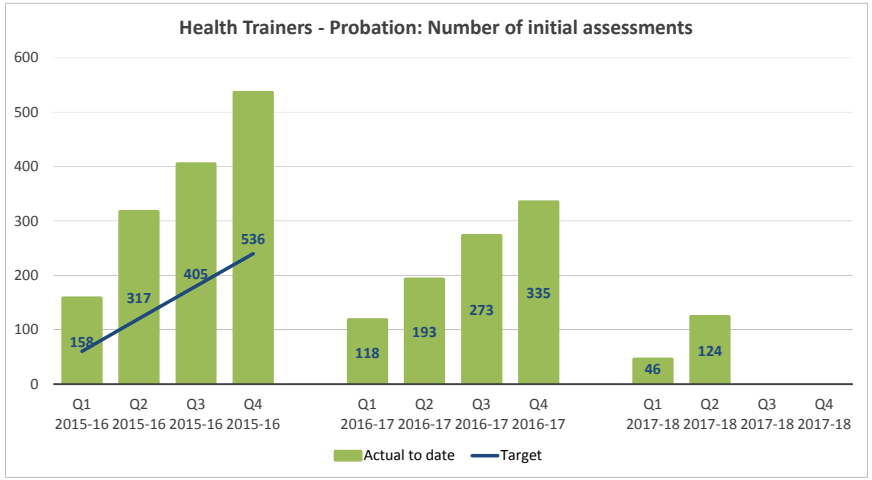
2.14a - Smoking Prevalence in adults - current smokers (APS) — DOT Improving, Sig NS

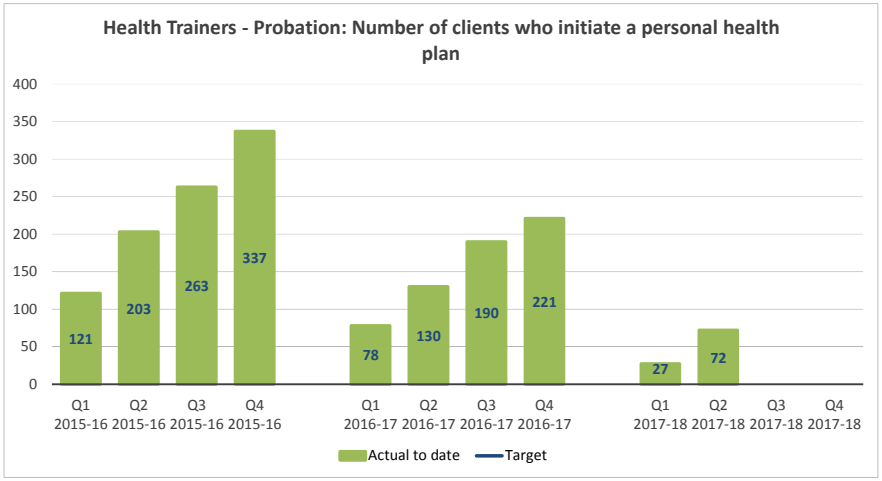
Overall progress rating: Green

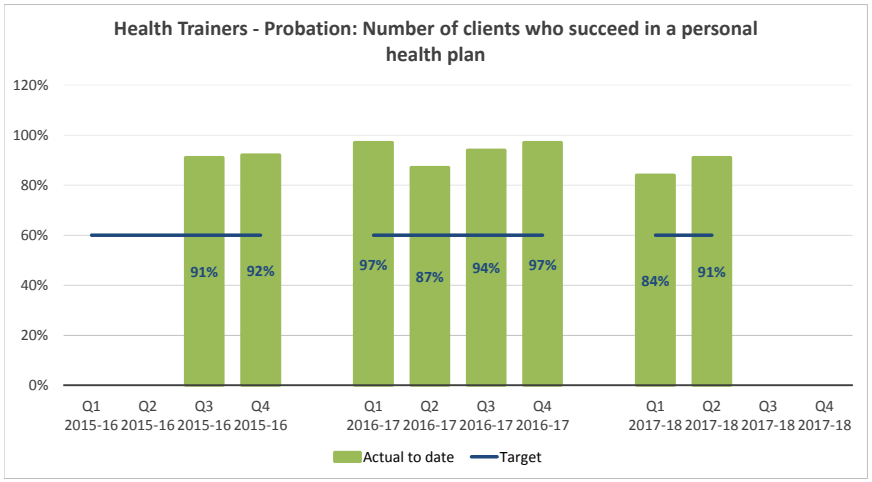
Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16		Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17		Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Health Trainers - Probation: Number of initial assessments	Target	240	240	60	120	180	240										
	Actual			158	159	88	131		118	75	80	62		46	78		
	Actual to date			158	317	405	536		118	193	273	335		46	124		
Health Trainers - Probation: Number of clients who initiate a personal health plan	Target	90	90%														
	Actual			121	82	60	74		78	52	60	31		27	45		
	Actual to date			121	203	263	337		78	130	190	221		27	72		
Health Trainers - Probation: Number of clients who succeed in a personal health plan	Target	60%		60%	60%	60%	60%		60%	60%	60%	60%		60%	60%		
	Actual																
Health Trainers - Probation: % of clients partially or completing succeeding int her personal health plan	Actual to date					91%	92%		97%	87%	94%	97%		84%	91%		

Comments on performance	Lead	Date
The proportion of Health Trainer users initiating assessments has been in excess of target throughout 2016-17 YTD. There were 32 extra assessments carried out in Q2 compared to Q1 making an overall percentage increase of 26%	CaAs	02/11/2017

Action plan	Action by date


Health Trainers - Probation: Number of initial assessments
600
500
400
300
200
100
0
158
317
405
536
118
193
273
335
46
124
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


Health Trainers - Probation: Number of clients who initiate a personal health plan
400
350
300
250
200
150
100
50
0
121
203
263
337
78
130
190
221
27
72
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


Health Trainers - Probation: Number of clients who succeed in a personal health plan
120%
100%
80%
60%
40%
20%
0%
91%
92%
97%
87%
94%
97%
84%
91%
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target

Division of Public Health Performance Report: 2017/18 Quarter 2

Active Lifestyle Scheme:

Provider: Leicester City Council Sports Services

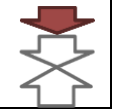
Service pupose: GP and Health Practioner referred service to increase physical activity levels and health outcomes for those with complex co-morbidities

Relevant PHOF indicators:

2.13ii - Percentage of physically inactive adults - historical method

2.12 - Excess Weight in Adults

2.14a - Smoking Prevalence in adults - current smokers (APS)



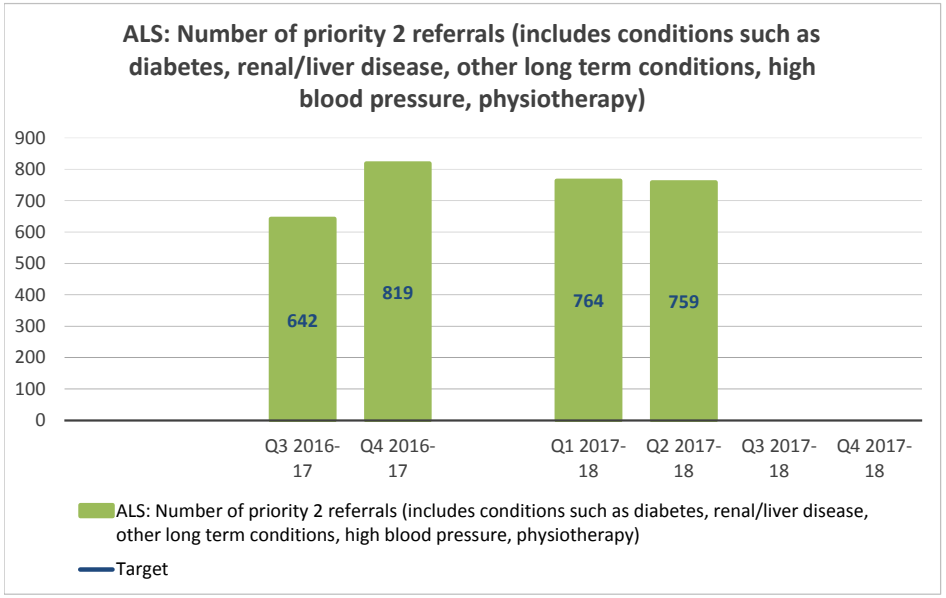
Overall progress rating: Green

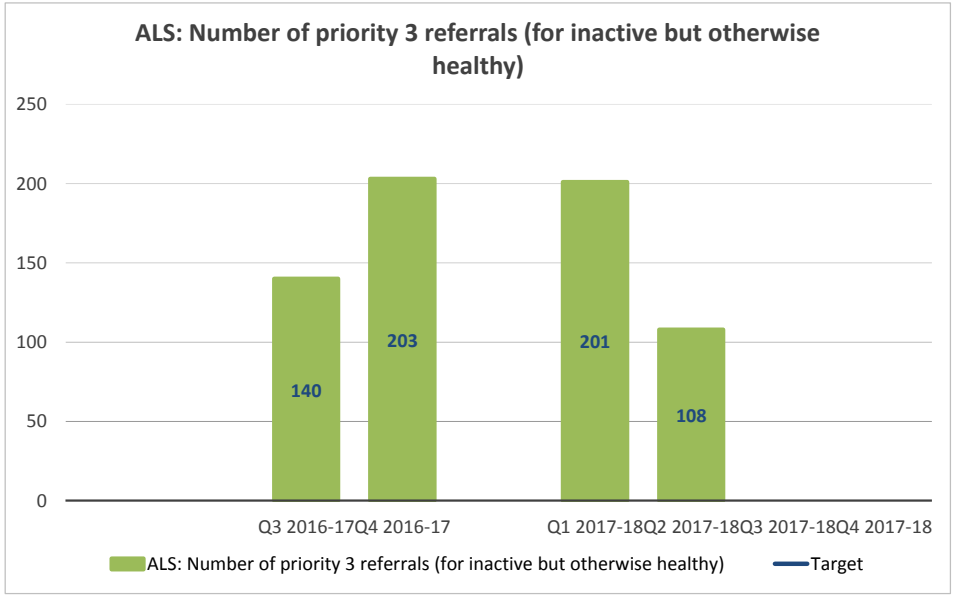
Performance Indicators	Activity	2015/16	2016/17			Q3 2016-17	Q4 2016-17		Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
ALS: Number of Priority 1 referrals (Cardiac/ COPD	Target											
	Actual					68	54		62	51		
ALS: Number of priority 2 referrals (includes conditions such as diabetes, renal/liver disease, other long term conditions, high blood pressure, physiotherapy)												
	Target											
	Actual					642	819		764	759		
ALS: Number of priority 3 referrals (for inactive but otherwise healthy)	Target											
	Actual					140	203		201	108		
ALS: Take-up rate of first appointment for priority 2	Target											
	Actual					70%	65%		62%	59%		
ALS: Retention of priority 2 referrals at 3 months	Target								Full quarter not available: Feb 46%, March 41%, April 52%			
	Actual											

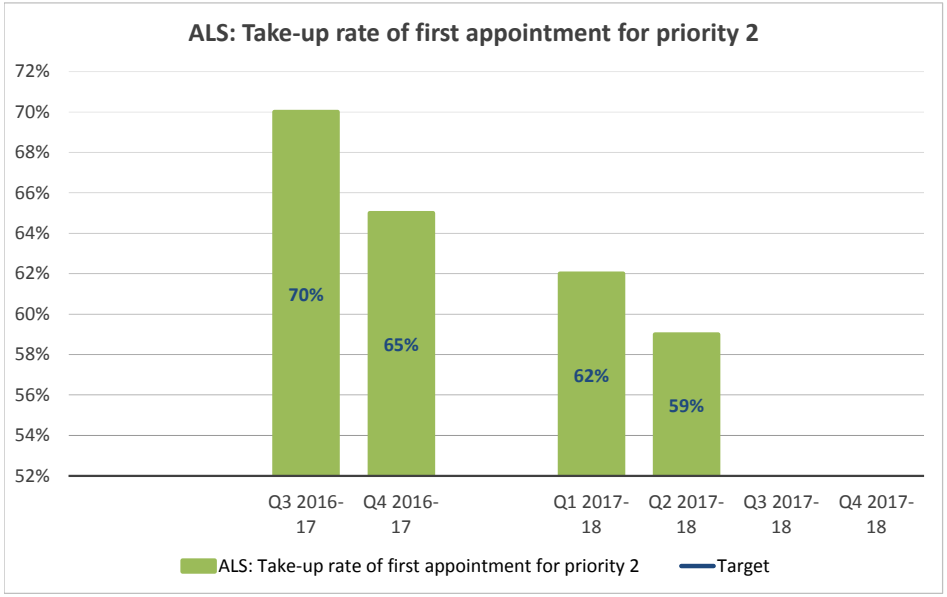
Comments on performance	Lead	Date
As of 30th October 4 centres are operating group sign up sessions these involve an overview of the service, essential paper work completed, tour of the building, baseline measurements taken and the opportunity to ask any questions concerning the scheme. These have been well attended so far with a maximum of 10 people per session. Uptake for signs up have been successful. This allows instructors the time to have with members in their one to one sessions to go through their goals and rediness to change. Circuit classess have been introduced in 4 centres and ALS members can access as many of these circit class delivered in the 4 centres. ALS admin are now calling P2 clients once their referral is received to book on to sign up session. This first contact is cruicial and allows the admin team to process to the correct pathway answer questions and book additional support if required. The Scottish Physical activity questionnaire (SPAQ) has been introduced in these sign ups making it easier to record activity levels, this will be repeated at the end of the 3 month period and then at 6 months. A committment agreement has been introduced to outline what is expeted from the client and what they can expect from the service. There is also an emphasis on	Jo Atkinson	

Action plan	Action by date
To have a full dedicated ALS team delivering the same in all leisure centres. To have group sign up sessions and circuit classes delivered from all leisure centres. Access community venues and green spaces across the city. To improve the recording and reporting system.	

client and what they can expect from the service. There is also an emphasis on completing a minimum of 9 weeks in order to qualify for a further 3 months. A code of conduct has also been introduced. The consultataion rooms have been revamped with new furniture and motivational quotes on the walls. The rooms are now user friendly and comfortable.					






ALS: Take-up rate of first appointment for priority 2
72%
70%
68%
66%
64%
62%
60%
58%
56%
54%
52%
70%
65%
62%
59%
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
ALS: Take-up rate of first appointment for priority 2
Target

Division of Public Health Performance Report: 2017/18 Quarter 2

Adult Weight Management

Provider: Leicestershire Partnership Trust

Purpose of service: A targeted weight management programme for groups traditionally under-represented in commercial weight management users and an enhanced weight management programme for those with complex co-morbidities

Relevant PHOF indicators:

2.12 - Excess Weight in Adults

DOT Worse, Sig NS

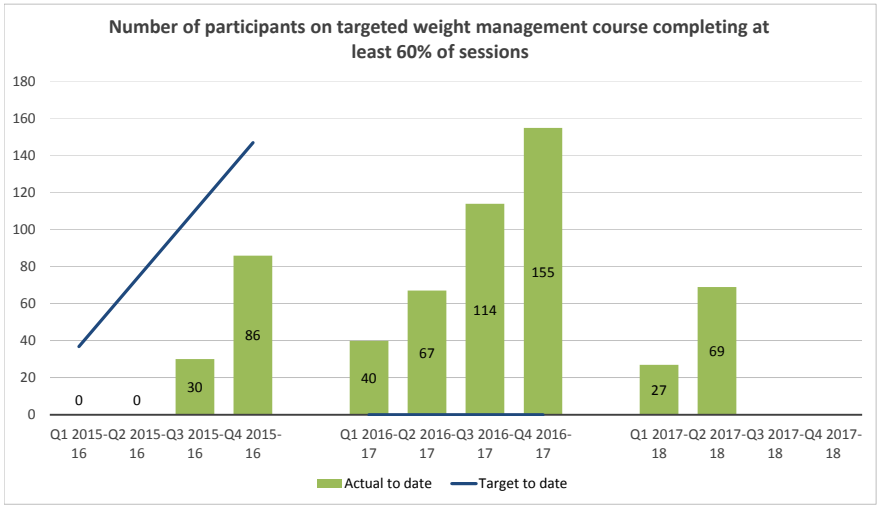
Return to summary page

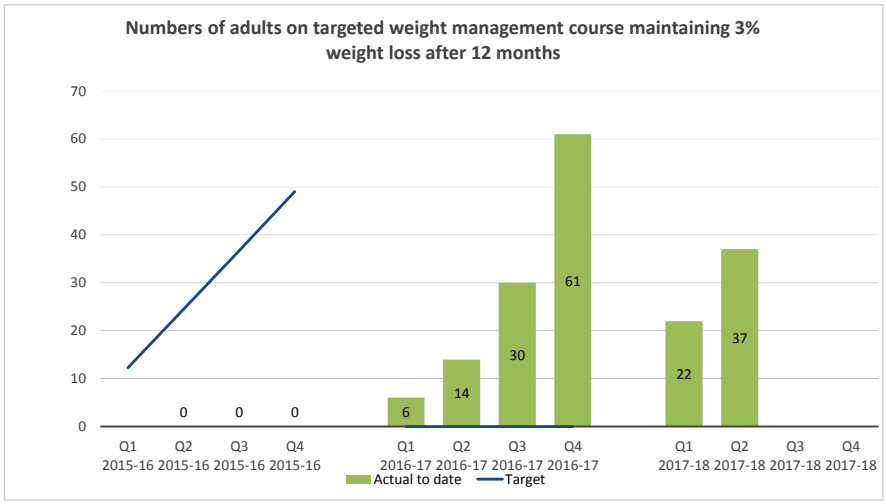
Overall progress rating: Amber

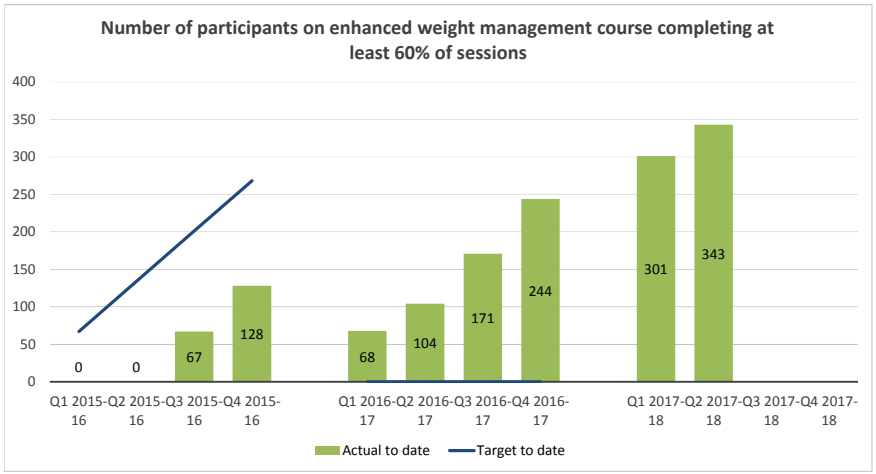
Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Targeted Adult Weight Management: for specific groups under-represented in commercial programmes															
Total number of participants	Actual			99	54	132	154	146	84	148	149	120	120		
	Actual to date			99	153	285	439	146	230	378	527	120	240		
Number of participants on targeted weight management course completing at least 60% of sessions	Target to date	147		37	74	110	147	0	0	0	0	0			
	Actual					30	56	40	27	47	41	27	42		
	Actual to date					30	86	40	67	114	155	27	69		
% of participants completing at least 60% of sessions of the adult weight management course	Target to date	60%													
	Actual					22.7%	36.4%	27.4%	32.1%	12.4%	7.8%	22.5%	17.5%		
	Actual to date					10.5%	19.6%	27.4%	29.1%	30.2%	29.4%	22.5%	28.8%		
Numbers of adults achieving **3% weight loss**	Target														
	Actual														
	Actual to date														
Numbers of adults on targeted weight management course maintaining **3% weight loss after 12 months**	Target	49		12	25	37	49	0	0	0	0				
	Actual			N/A	N/A	N/A	N/A	6	8	16	31	22	15		
	Actual to date				0	0	0	6	14	30	61	22	37		
Enhanced Adult Weight Management Service: for those with additional needs and complex co-morbidities															
Total number of participants	Actual					87	79	87	49	89	95	81	56		
	Actual to date					87	166	87	136	225	320	401	457		
Number of participants on enhanced weight management course completing at least 60% of sessions	Target to date	268		67	134	201	268	0	0	0	0				
	Actual					67	61	68	36	67	73	57	42		
	Actual to date					67	128	68	104	171	244	301	343		
% of participants completing at least 60% of sessions of the adult weight management course	Target to date	60%													
	Actual					77.0%	77.2%	78.2%	73.5%	29.8%	22.8%	14.2%	9.2%		
	Actual to date					77.0%	77.1%	78.2%	76.5%	76.0%	76.3%	75.1%	75.1%		
Numbers of adults achieving **3% weight loss**	Target														
	Actual														
	Actual to date														
Numbers of adults on enhanced weight management course maintaining **3% weight loss after 12 months**	Target	89		22	45	67	89	0	0	0	0				
	Actual							22	14	28	34	29	12		
	Actual to date							22	36	64	98	29	41		

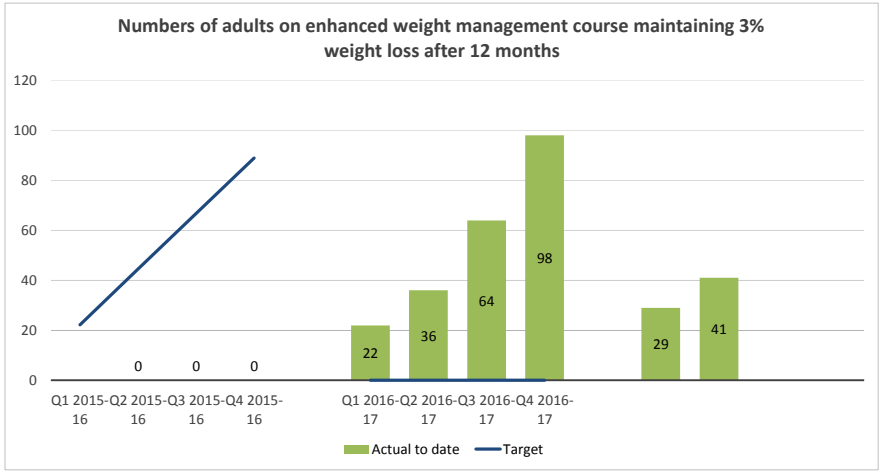
Comments on performance	Lead:	Date:
Total number of participants has remain static in Q2 2017/18 Number services accessing Targeted Service in Q2 is same as Quarter 2 compare 2016/17 Number of Service user achieving 3% weight loss after 12 within Targeted Service is above target	CaAS	02/11/2017

Key actions	Action by date:
Numbers of adults achieving 3% weight loss - not currently part of data collation. This will need to be negotiated with the provider and embedded into performance monitoring arrangements. CaAS to follow up.	
CaAS to liaise with Public health colleagues around definition of completed in this context. Hence, data omitted on this occasion. CaAS to action Currently no targets linked to numbers in service - discussion required between CaAS and PH to ascertain what expected levels of activity are	


Number of participants on targeted weight management course completing at least 60% of sessions
180
160
140
120
100
80
60
40
20
0
0
0
30
86
40
67
114
155
27
69
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target to date


Numbers of adults on targeted weight management course maintaining 3% weight loss after 12 months
70
60
50
40
30
20
10
0
0
0
0
6
14
30
61
22
37
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


Number of participants on enhanced weight management course completing at least 60% of sessions
400
350
300
250
200
150
100
50
0
0
0
67
128
68
104
171
244
301
343
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target to date


Numbers of adults on enhanced weight management course maintaining 3% weight loss after 12 months
120
100
80
60
40
20
0
0
0
0
22
36
64
98
29
41
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Actual to date
Target

Division of Public Health Performance Report: 2017/18 Quarter 2

Smoking Cessation:

Provider: Leicester City Stop Smoking Service

Purpose of service: To support people in Leicester City to stop smoking

Relevant PHOF indicators:
2.14a - Smoking Prevalence in adults - current smokers (APS)
2.03 - Smoking status at time of delivery

Return to summ

DOT Improvi
DOT Improvi

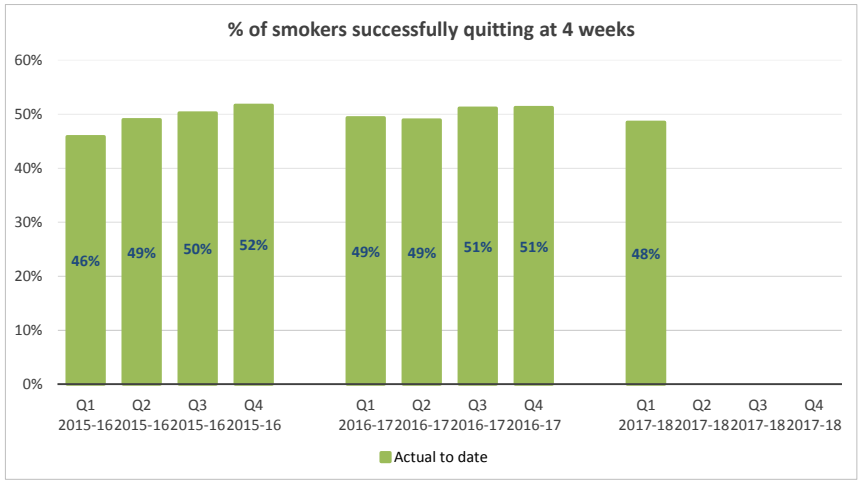
Overall progress rating: Green

Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Number of smokers setting a quit date	Target to date			0	0	0	0	0	0	0	0				
	Actual			942	944	815	1,017	902	760	650	872	687			
	Actual to date			942	1,886	2,701	3,718	902	1,662	2,312	3,184	687			
Number of smokers successfully quitting (4 weeks)	Target to date		1,615	0	0	0	0	404	808	1,211	1,615	363	725	1,088	1,450
	Actual			432	492	433	563	445	368	368	450	333			
	Actual to date			432	924	1,357	1,920	445	813	1,181	1,631	333			
% of smokers successfully quitting at 4 weeks	Target														
	Actual														
	Actual to date			46%	49%	50%	52%	49%	49%	51%	51%	48%			
Number of pregnant women setting a quit date	Target														
	Actual			58	48	59	55	56	39	44	55	49			
	Actual to date			58	106	165	220	56	95	139	194	49			
Number of pregnant smokers successfully quitting (4 weeks)	Target														
	Actual			22	26	25	23	20	17	14	32	23			
	Actual to date			22	48	73	96	20	37	51	83	23			
% of pregnant smokers successfully quitting at 4 weeks	Target														
	Actual							36%	44%	32%	58%	47%			
	Actual to date			38%	45%	44%	44%	36%	39%	37%	43%	47%			
Number of smokers from target SEC groups setting a quit date	% of total														
	Actual			691	715	613	780	681	590	527	698	560			
	Actual to date			691	1,406	2,019	2,799	681	1,271	1,798	2,496	560			
Number of smokers from target SEC groups successfully quitting (4 weeks)	Target														
	Actual			325	360	329	422	323	283	287	346	267			
	Actual to date			325	685	1,014	1,436	323	606	893	1,239	267			
% of smokers from target SEC groups successfully quitting at 4 weeks	% of total														
	Actual														
	Actual to date			47%	49%	50%	51%	47%	48%	50%	50%	48%			

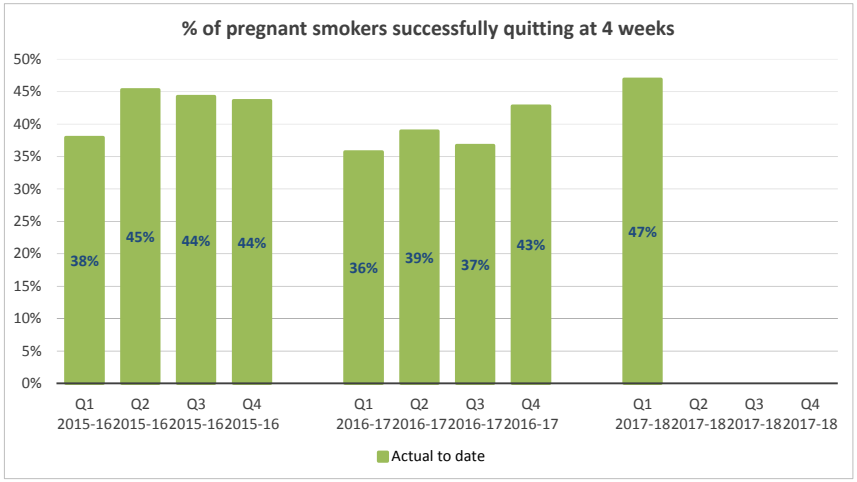
* target SEC groups include routine and manual groups, retired, carers, unemployed >1 year, sick/disabled

Comments on performance	Lead:	Date:
Services are expected to treat > 5% of local smoking populations annually. In 2016-17, Leicester City's access per 100k population was 6,853, (England average was 4,434, E Mids average was 4,318). Success rates must be maintained above 35%. In 2016-17, Leicester City's success per 100k population was 3,510, (England average was 2,248, E Mids average was 2,299). Smoking disproportionately affects people from health inequalities groups (including routine and manual workers). Reach among these groups is essential to reduce smoking prevalence and reduce poor health. Access to Stop smoking services from this group is 78% of total setting a quit date Pregnant women are primarily referred to the Stop Smoking Service by UHL midwives. The service attempts to contact all women referred, phoning 3 times and then sending a letter. Leicester City's Stop Smoking Service was name-checked in a House of Commons debate in October, for its pioneering approach to e-cigarettes		

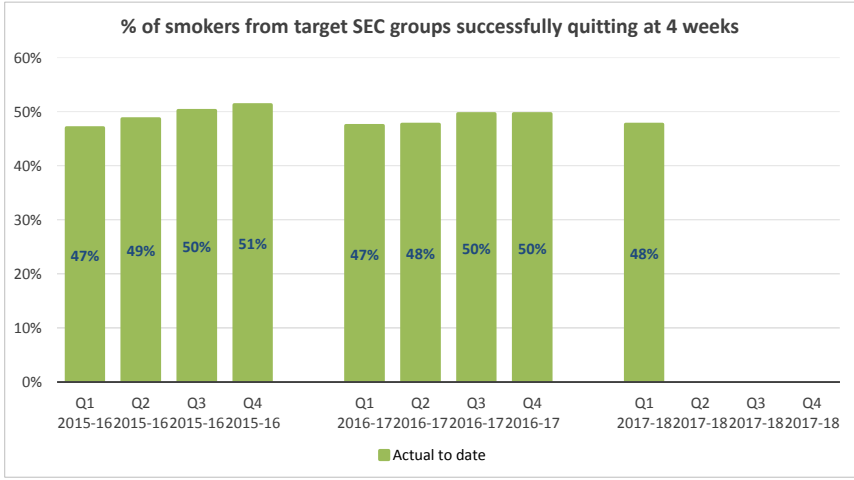
Key actions	Action by date:
Maintain progress on helping people to successfully quit smoking	




% of pregnant smokers successfully quitting at 4 weeks
250
200
150
100
50
0
58
22
106
48
165
73
220
96
56
20
95
37
139
51
194
83
49
23
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Number of pregnant women setting a quit date
Number of pregnant smokers successfully quitting (4 weeks)


% of pregnant smokers successfully quitting at 4 weeks
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
38%
45%
44%
44%
36%
39%
37%
43%
47%
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date


Number of smokers from target SEC groups successfully quitting (4 weeks)
3,000
2,500
2,000
1,500
1,000
500
0
691
325
1,406
685
2,019
1,014
2,799
1,436
681
323
1,271
606
1,798
893
2,496
1,239
560
267
0
0
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Number of smokers from target SEC groups setting a quit date
Number of smokers from target SEC groups successfully quitting (4 weeks)


% of smokers from target SEC groups successfully quitting at 4 weeks
60%
50%
40%
30%
20%
10%
0%
47%
49%
50%
51%
47%
48%
50%
50%
48%
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date

Division of Public Health Performance Report: 2017/18 Quarter 2

GP Practice contracts: NHS Health Checks

Provider: Leicester GP Practices

Overall progress rating: Green

Purpose of service: Provide an NHS Health check to eligible population aged 40-74

Relevant PHOF indicators:

2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check

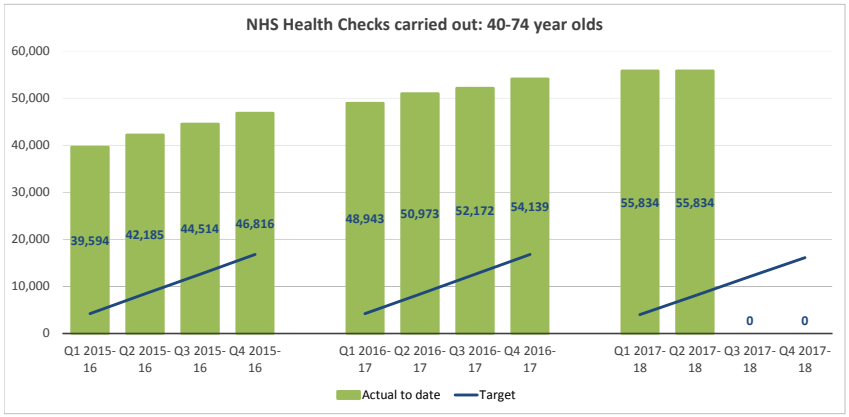
Return to summary page

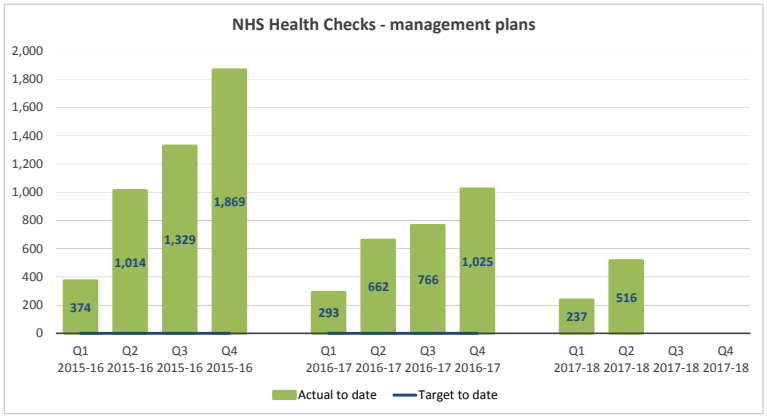
DOT Improving, Sig Better

Key Performance Indicators	Activity	2013/14	2014/15	2015/16	2016/17	2017/18	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
NHS Health Checks	Target (5 year)	76,947	86,452	83,992	83,826	80,449												
NHS Health Checks carried out: 40-74 year olds	Target	15,389	17,290	16,798	16,765		4,200	8,399	12,599	16,798	4,191	8,383	12,574	16,765	4,022	8,045	12,067	16,090
	Target to date	15,389	34,581	50,395	67,061		37,796	41,996	46,196	50,395	54,487	58,678	62,870	67,061	68,382	72,404	76,427	80,449
	Actual	22,369	13,867	10,580	7,323		3,358	2,591	2,329	2,302	2,127	2,030	1,199	1,967	1,695	1,806		
	Actual to date	22,369	36,236	46,816	54,139		39,594	42,185	44,514	46,816	48,943	50,973	52,172	54,139	55,834	55,834		
% of eligible population who have received a health check	% to date	29%	42%	56%	65%		47%	50%	53%	56%	58%	61%	62%	65%	67%	67%		
NHS Health Checks - management plans	Target to date						0	0	0	0	0	0	0	0				
	Actual						374	640	315	540	293	369	104	259	237	279		
	Actual to date						374	1,014	1,329	1,869	293	662	766	1,025	237	516		

Comments on performance	Lead:	Date:
Note: Programme runs for 5 years from 2013/14 to 2017/18. The target (eligible population 40-74 year olds) is revised each year and shows eligible population over the 5 year programme. 1. Over the past 5 years (2013/14 - 2017/18), Leicester City has undertaken over 55K Health Checks, making it one of the highest performing areas in the Country. 2. In April 2013, as part of the Health & social Care Act, Public Health departments became the responsibility of Local Authorities. At the same time, the 5 year cycle clock on NHS Health Checks was reset. Thus the first cycle is currently defined as 2013/14-2017/18. Leicester City had performed well in years prior to this, and as such it was known that: a) Performance would inevitably decline in the latter years of this, newly defined, cycle, as less people were available to have a check. b) That as those seen prior to 2013/14 would not be eligible until 5 years had elapsed, that the eligible population quoted was in fact substantially higher than the number eligible for a Health Checks as at 01/04/2013. It is key that the above points are noted and understood, and that this programme is viewed over a rolling 5 year, rather than an annual, cycle. 3. In 2017/18, those screened 5 years ago (2012/13), the final year prior to the clock being reset, was in fact Leicester City's highest performing year (with over 24K checked) and that these patient would become eligible once more. Consequently, an increase in number of checks undertake is forecast for the financial year 2017/18. 4. Since the programme became the responsibility of the Local Authority in 2013/14, over 55K checks have been conducted. Coupled with the proposed changes to the eligible population (see key actions) overall local performance is expected to remain high and well above national levels. 5. Alcohol screening included in Health Checks carried out in 2016/17 from January 2017.	IB	12/05/2017

Key actions	Action by date:
Leicester has refreshed its calculation of eligible population using actual exclusion data rather than the nationally modelled figure previously used. The actual eligible population for Leicester has been shown to be lower than the modelled figure, so following this action future reports will provide a more accurate reflection of on-going performance.	01.04.17
A comprehensive marketing campaign, involving billboards, local press & radio, cinema and social media, as well as collaborations with the main sports venues in Leicester was commissioned and ran from April 2017. It is anticipated that this action will support improved uptake and awareness of the NHS Health Checks programme.	On-going,
To assess how effective the campaign has been, an evaluation is to be undertaken, to be completed by the end of September 2017.	01.10.17
Leicester City Council is in the process of procuring an IT solution that, among other analytical benefits, will remove much of the administrative burden for the recording of an NHS Health Check. It is anticipated that this action could also help to improve uptake.	01.04.17
The marketing campaign evaluation had been delayed slightly but is now live and practices have been mailed 25 paper questionnaires each and prepaid envelopes, and posters advertising the evaluation. The evaluation is live until 27.11.17 and when this closes results will be collated and a report on findings prepared.	
There have been several issues to progressing the IT solution and so it has been decided to progress putting in place a contract directly with the provider of the clinical system used in Leicester City, SystmOne. Contact has been made with the provider, TPP (based in Leeds) and this continues to be progressed. It has been noted that in order to utilise the system in the Council, provision of smartcards and smartcard readers will be needed. In order to provide this an RA Manager must authorise. This is being progressed with Leicestershire Health Informatics service (LHIS).	03.11.2017


NHS Health Checks carried out: 40-74 year olds
60,000
50,000
40,000
30,000
20,000
10,000
0
39,594
42,185
44,514
46,816
48,943
50,973
52,172
54,139
55,834
55,834
0
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target


NHS Health Checks - management plans
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
374
1,014
1,329
1,869
293
662
766
1,025
237
516
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date
Target to date

Division of Public Health Performance Report: 2017/18 Quarter 2

Substance Misuse Treatment	
Provider Name:	Contract value:

Note: For continuity of reporting, this handbook page reports on financial years. However, it is worth noting that many of our Substance Misuse services actually run on contract years from July-June

Overall progress rating: Red

Purpose of service: Provide treatment and reduce impact of substance misuse

Return to summary page

Relevant PHOF indicators: Hospital admission rates from alcohol-related conditions

2.15i - Successful completion of drug treatment - opiate users	DOT Worse, Sig NS
2.15ii - Successful completion of drug treatment - non-opiate users	DOT Improving, Sig NS
2.15iii - Successful completion of alcohol treatment	DOT Improving, Sig NS
2.15iv - Deaths from drug misuse	DOT Improving, Sig NS
2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	DOT N/A, Sig Worse

Woodlands IPDU	Activity	2015-16	2016-17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Total number of service users admitted to IPDU *(sum of those admitted for stabilisation + admitted for withdrawal)*	Actual			28	25	28	25	24	25	16	19	19	11		
Total number of 'Occupied Bed Days'	Actual			247	207	296	193	214	226	147	137	213	124		
	LCC Allocated Bed Days			404	404	404	404	404	404	404	404	404	404		
	Percentage utilisation			61.1%	51.2%	73.3%	47.8%	53.0%	55.9%	36.4%	33.9%	52.7%	30.7%		

Comments on performance	Lead:	Date:
Woodlands IPDU From the IPDU data, we can see clearly that there has been a consistent underutilisation of LCC alloted bed days. This has continued and has been linked to a drop in referrals to the Woodlands. However, our community providers have indicated that everyone in need of an IPD has been referred as required; this would suggest a lower level of need than originally anticipated	CaAS	06/11/2017
In May 2017, the provider served 12 months notice on their contract, with the intention of reviewing the economic viability of the service. With this in mind, Strategic Commissioning are currently beginning to plan procurement for a new service in 2018	CaAS/Commissioning	06/11/2017

Key actions	Action by date:
Contract management ongoing. CaAS put forward a contractual change to reduce block purchase allocation	Jun-17
Action: provider served notice in May 2017 (12 months). Strategic Commissioning looking to go out to tender in November 2017, with a view to contract award in March 2018 and contract start on 01/06/2018	As per action

Division of Public Health Performance Report: 2017/18 Quarter 2

Substance Misuse Treatment	
Provider Name:	
Homegroup (HRS)	

Note: For continuity of reporting, this handbook page reports on financial years. However, it is worth noting that many of our Substance Misuse services actually run on contract years from July-June

Overall progress rating: Green

Purpose of service: Provide treatment and reduce impact of substance misuse

Return to summary page

Relevant PHOF indicators: Hospital admission rates from alcohol-related conditions

2.15i - Successful completion of drug treatment - opiate users	DOT Worse, Sig NS
2.15ii - Successful completion of drug treatment - non-opiate users	DOT Improving, Sig NS
2.15iii - Successful completion of alcohol treatment	DOT Improving, Sig NS
2.15iv - Deaths from drug misuse	DOT Improving, Sig NS
2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	DOT N/A, Sig Worse

HomeGroup (HRS)	Activity	2015-16	2016-17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Number of service users in receipt of Accommodation based support	Actual	44	51	9	11	12	12	11	13	13	14	16	Pending		
Number of service users to reduce substance use - Accommodation based support	Actual	33	44	6	9	8	10	9	11	12	12	14	Pending		
	Percentage	75.0%	86.3%	66.7%	81.8%	66.7%	83.3%	81.8%	84.6%	92.3%	85.7%	87.5%	Pending		
Number of service users in receipt of Floating support	Actual	72	180	4	10	22	36	44	46	41	49	53	Pending		
Number of service users to reduce substance use - Floating support	Actual	49	85	3	7	16	23	21	22	19	23	31	Pending		
	Percentage	68.1%	47.2%	75.0%	70.0%	72.7%	63.9%	47.7%	47.8%	46.3%	46.9%	58.5%	Pending		

Comments on performance	Lead:	Date:
HomeGroup HRS		
We have seen a significant increase in the numbers of service users in receipt of floating support in year two of the contract (2016-17). This is really positive to see, and follows work by the provider (working closely with CaAS) to understand the barriers to service usage and to improve referral routes into the service	CaAS	17/05/2017
However, the proportion of service users to have reduced substance use in 2016-17 has decreased. This however may be a trade off of greater activity, and is something will need to be monitored (2015-16 data was not really reliable due to low numbers accessing floating support)	CaAS	17/05/2017
In 2016-17, the proportion of service users in receipt of accommodation based support that have reduced their substance use has increased. This is a positive indication of performance	CaAS	17/05/2017
In Q1 2017-18, the contnued high rate of service users in accommodation based support that have reduced their substance misuse remains high, which is really positive. Also, the rate of floating support outcomes for service users reducing substance use has increased from 2016-17; this follows a downturn in 2016-17 compared to 2015-16		
Q2 2017-18 data currently pending. CaAS to chase up	CaAS	06/11/2017

Key actions	Action by date:
Continued monitoring	ongoing
CaAS will continue to monitor this, and continue to address any issues with the provider via the contract management meetings	ongoing
Continued monitoring	ongoing
Continued monitoring	ongoing
CaAS to chase up Q2 return and populate once available	Nov-17

Division of Public Health Performance Report: 2017/18 Quarter 2

Substance Misuse Treatment	
Provider Name:	
Anchor Centre	

Note: For continuity of reporting, this handbook page reports on financial years. However, it is worth noting that many of our Substance Misuse services actually run on contract years from July-June

Overall progress rating: Green

Purpose of service: Provide treatment and reduce impact of substance misuse

Return to summary page

Relevant PHOF indicators: Hospital admission rates from alcohol-related conditions

2.15i - Successful completion of drug treatment - opiate users	DOT Worse, Sig NS
2.15ii - Successful completion of drug treatment - non-opiate users	DOT Improving, Sig NS
2.15iii - Successful completion of alcohol treatment	DOT Improving, Sig NS
2.15iv - Deaths from drug misuse	DOT Improving, Sig NS
2.16 - Adults with substance misuse treatment need who successfully engage in community based structured treatment following release from prison	DOT N/A, Sig Worse

Anchor Centre	2015-16	2016-17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Total Number of Attendees within the period (total footfall)			N/A	N/A	N/A	N/A	N/A	1,018	1,221	1,436	983	1,321		
			N/A	N/A	N/A	N/A	N/A	1,018	2,239	3,675	983	2,304		
Number of Street Drinkers accessing service *(average number of unique individuals that present each month, that are known to be 'street drinkers')*	50.7	36.3	48.7	50.7	52.7	50.7	48.3	32.3	31.3	33.0	32.7	36.7		
Number of non-Street Drinkers accessing service *(average number of unique individuals that present each month, that are not known to be current 'street drinkers')*		24.2 (average from Q2-4)	Data not recorded	Data not recorded	Data not recorded	Data not recorded	N/A	9.3	30.0	33.3	29.7	36.3		
% of active street drinking clients no longer street drinking *(average across each month within relevant quarter taken)*	54.0%	41.1%	51.7%	48.9%	52.8%	62.7%	49.4%	33.5%	41.7%	35.9%	47%	51%		
% of active street drinking clients showing a major reduction in street drinking *(average across each month within relevant quarter taken)*	31.0%	26.2%	29.7%	34.5%	31.9%	27.9%	28.0%	27.3%	27.6%	21.2%	25%	24%		

Comments on performance	Lead:	Date:
Anchor Centre		
We have started to see an increase so far in 2017-18 in terms of both the overall footfall at the Anchor Centre, and also the breakdown of Street Drinkers/Non Street Drinkers accessing the service. This is encouraging given the identfied that has underpinned the review of this contract area	CaAS/Commissioning	06/11/2017
The overall rate of active street drinking clients no longer street drinking has increased again this quarter, following a decline in 2016-17. This is indicative of positive performance.	CaAS/Commissioning	06/11/2017
In relation to the active street drinking clients showing a major reduction in street drinking, we have seen performance plateau somewhat, which given the gains made with those no longer street drinking is still relatively positive. More work will be targetted with the Recovery Hub service to build upon these outcomes	CaAS/Commissioning	06/11/2017

Key actions	Action by date:
Continued monitoring	monthly
Continued monitoring. Work closely with new provider as part of mobilisation/service implementation	early 2018
Continued monitoring. Work closely with new provider as part of mobilisation/service implementation	early 2018

Division of Public Health Performance Report: 2017/18 Quarter 2

Suicide Awareness

Provider: Rural Communities Council Suicide Awareness Partnership Training

Service pupose: To advertise and deliver 12 validated suicide awareness training sessions to a total of 300 delegates annually

Relevant PHOF indicators:
4.10 - Suicide rate

Return to summary page

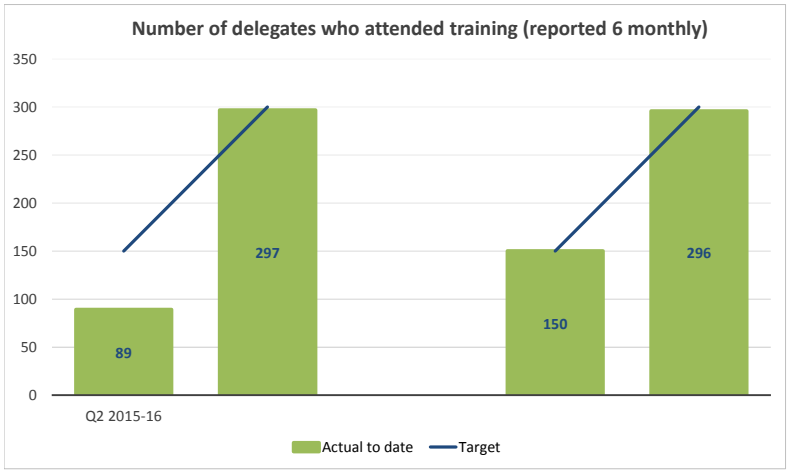
DOT Improving, Sig NS

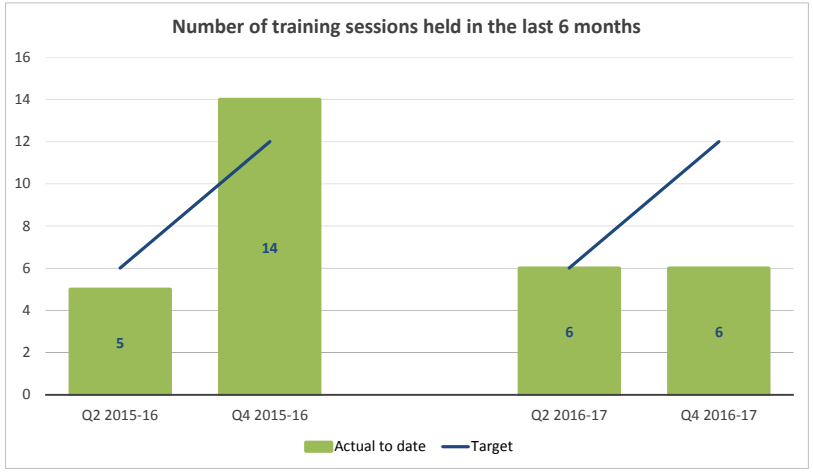
Overall progress rating: Green

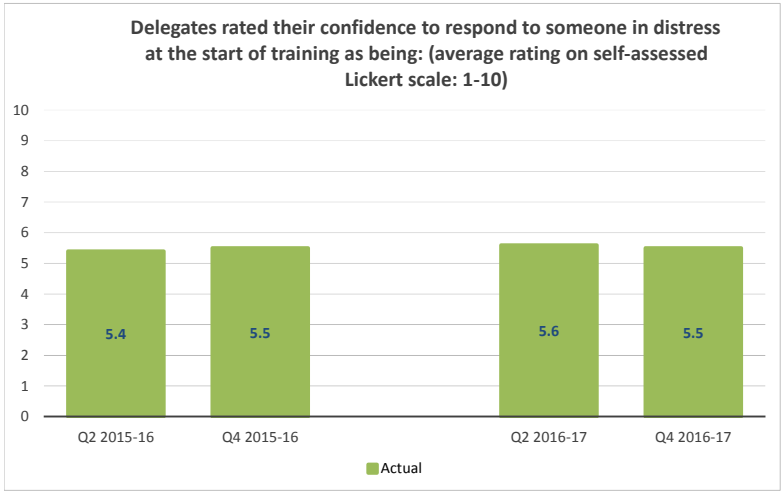
Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Number of delegates who attended training (reported 6 monthly)	Target	300	300		150		300		150		300		150		
	Actual	297	296		89		208		150		146		142		
	Actual to date	297			89		297		150		296				
Number of training sessions held in the last 6 months	Target	12	12		6		12		6		12		6		
	Actual	14	12		5		9		6		0		6		
	Actual to date				5		14		6		6				
Delegates rated their confidence to respond to someone in distress at the start of training as being: (average rating on self-assessed Lickert scale: 1-10)	Target														
	Actual				5.4		5.5		5.6		5.5		5		
Delegates rated their confidence to respond to someone in distress at the end of training as being: (average rating on self-assessed Lickert scale: 1-10)	Actual				8.2		8.3		8.1		8.1		8		

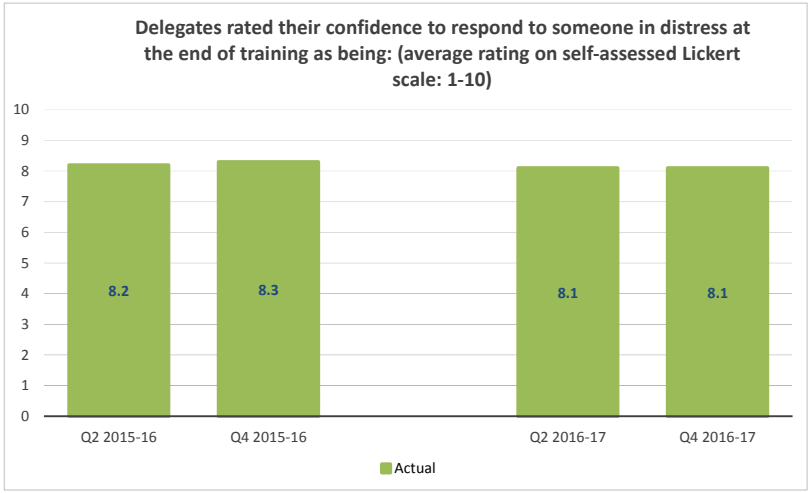
Comments on performance	Lead:	Date:
Service on track to meet key performance indicators - measured 6 monthly	RS	03/11/2017
Bi-monthly meeting with serivce provider to review training sessions and delegates in attendance	RS	03/11/2017
Steadily Trends across all quarters		

Key actions	Action by date:
It has been agreed that the Service will be extended until 31/03/2019	03/11/2017


Number of delegates who attended training (reported 6 monthly)
350
300
250
200
150
100
50
0
89
297
150
296
Q2 2015-16
Actual to date
Target


Number of training sessions held in the last 6 months
16
14
12
10
8
6
4
2
0
5
14
6
6
Q2 2015-16
Q4 2015-16
Q2 2016-17
Q4 2016-17
Actual to date
Target


Delegates rated their confidence to respond to someone in distress at the start of training as being: (average rating on self-assessed Lickert scale: 1-10)
10
9
8
7
6
5
4
3
2
1
0
5.4
5.5
5.6
5.5
Q2 2015-16
Q4 2015-16
Q2 2016-17
Q4 2016-17
Actual


Delegates rated their confidence to respond to someone in distress at the end of training as being: (average rating on self-assessed Lickert scale: 1-10)
10
9
8
7
6
5
4
3
2
1
0
8.2
8.3
8.1
8.1
Q2 2015-16
Q4 2015-16
Q2 2016-17
Q4 2016-17
Actual

Division of Public Health Performance Report: 2017/18 Quarter 2

Community Infection Prevention and Control Services (CIPC)

Provider: Leicestershire County Council

Overall progress rating: Green

Purpose of service: To provide the DPH with assurance that community infection prevention and control principles are being applied within the local community providers

Relevant PHOF indicators:

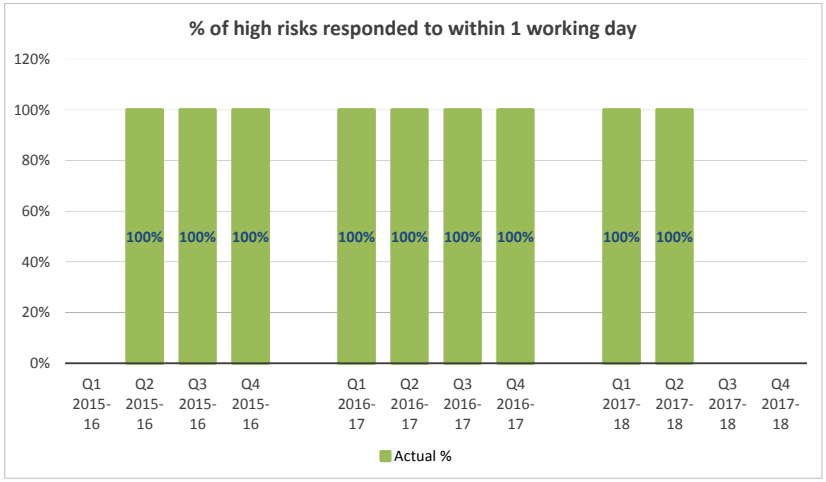
#N/A
#N/A

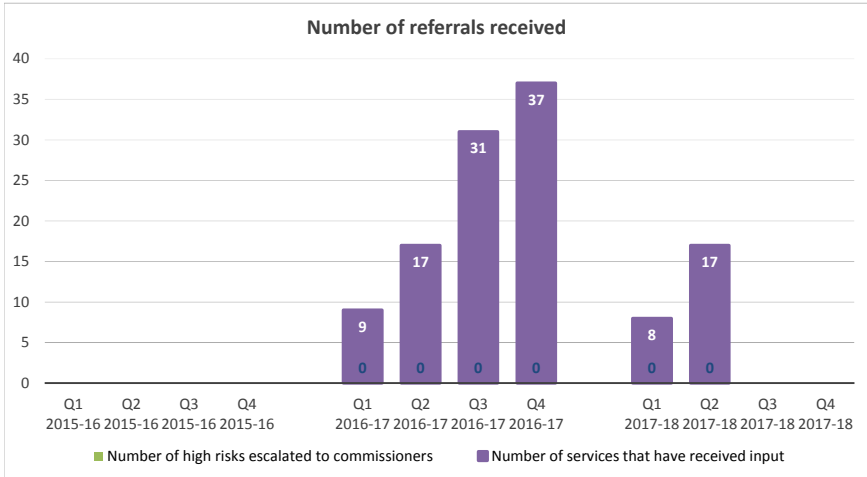
Return to Summary sheet

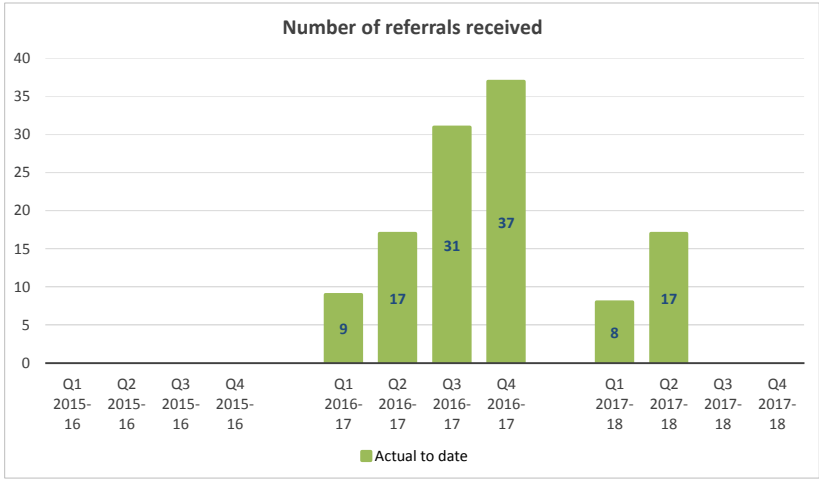
Key Performance Indicators	Activity	2015/16	2016/17	Q1 2015-16	Q2 2015-16	Q3 2015-16	Q4 2015-16	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
Number of risks reported	Actual			0	0	0	0	9	8	13	6	8	9		
	Actual to date							9	17	30	36	8	17		
Number of high risks reported	Actual				5	7	6	3	3	10	4	4	6		
	Actual to date				5	12	18	3	6	16	20	4	10		
% of high risks responded to within 1 working day	Target	100%	100%												
	Actual number				5	7	6	3	3	10	4	4	6		
	Actual %				100%	100%	100%	100%	100%	100%	100%	100%	100%		
Number of high risks escalated to commissioners	Target														
	Actual				4	1	2	0	0	0	0	0	0		
	Actual to date							0	0	0	0	0	0		
Number of services that have received input	Target														
	Actual				4	1	2	9	8	14	6	8	9		
	Actual to date							9	17	31	37	8	17		
Number of referrals received	Target														
	Actual							9	8	14	6	8	9		
	Actual to date							9	17	31	37	8	17		
Number of active referrals received	Actual							3	4	11	5	6	7		
	Actual to date							3	7	18	23	6	13		
Number of referrals responded to within 1 day (active)	% of total														
	Actual							3	4	11	5	6	7		
	Actual to date							3	7	18	23	6	13		
	%							100%	100%	100%	100%	100%	100%		
Number of referrals responded to within 5 days (routine)	Target														
	Actual							6	5	4	2	4	3		
	Actual to date							6	11	15	17	4	7		
Number of active referrals receiving recommendations within 24 hours	Target														
	Actual				5	7	6	3	4	11	5	6	7		
	Actual to date							3	7	18	23	6	13		
% of active referrals receiving recommendations within 24 hours	Target	100%													
	%							100%	100%	100%	100%	100%	100%		
Number and % of completed reports shared with LA commissioner and the CCG IPC team within 21 working days	Target														
	Actual							7	1	1	0	2	8		
	%							100%	100%	100%	100%	100%	100%		
Number of CCH &SCS IPC policies audited	Target														
	Actual							3	1	1	0	1	2		
	Actual to date							3	4	5	5	1	3		

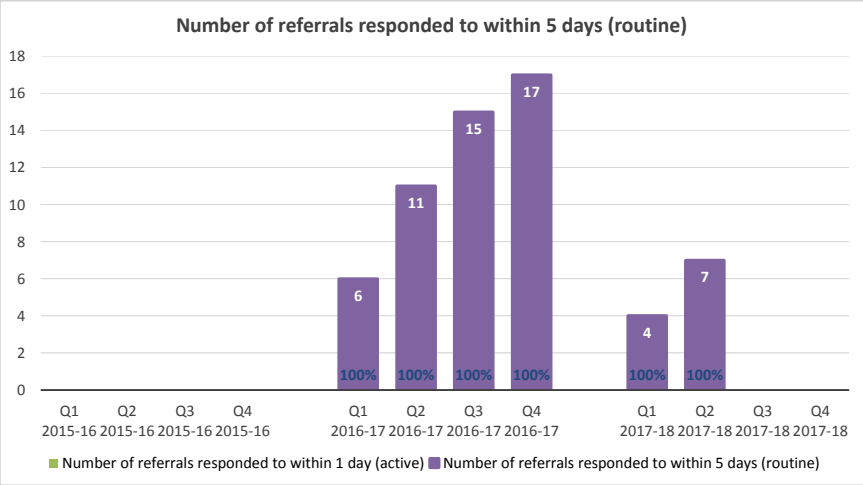
Comments on performance	Lead:	Date:
KPI is consistence to previous quarter and there is no sufficient change. Number of high risks reported has increased by 50% compared to Q2 2016/17	CaAS	02/11/2017

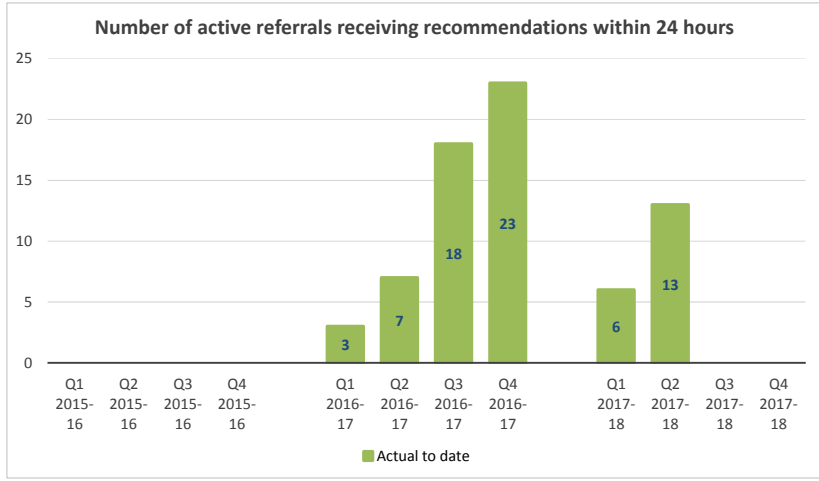
Key actions	Action by date:
Clarify data provision process Ensure new staff are integrated into the service and are able to address the backlog of proactive activity as soon as possible	




Number of referrals received
40
35
30
25
20
15
10
5
0
9
0
17
0
31
0
37
0
8
0
17
0
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Number of high risks escalated to commissioners
Number of services that have received input


Number of referrals received
40
35
30
25
20
15
10
5
0
9
17
31
37
8
17
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date


Number of referrals responded to within 5 days (routine)
18
16
14
12
10
8
6
4
2
0
6
100%
11
100%
15
100%
17
100%
4
100%
7
100%
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Number of referrals responded to within 1 day (active)
Number of referrals responded to within 5 days (routine)


Number of active referrals receiving recommendations within 24 hours
25
20
15
10
5
0
3
7
18
23
6
13
Q1 2015-16
Q2 2015-16
Q3 2015-16
Q4 2015-16
Q1 2016-17
Q2 2016-17
Q3 2016-17
Q4 2016-17
Q1 2017-18
Q2 2017-18
Q3 2017-18
Q4 2017-18
Actual to date

Red
Amber
Green
Not rated

Phof ratings
DOT worse, Sig worse
DOT worse, Sig NS
DOT worse, Sig better

PHOF Status	Score	
Sig worse, DOT worse	-11	
Sig worse, DOT same	-10	
Sig worse, DOT improving	-9	
Sig NS, DOT worse	-1	
Sig NS, DOT same	0	
Sig NS, DOT improving	1	
Sig better, DOT worse	9	
Sig better, DOT same	10	
Sig better, DOT improving	11	Sig Better, DOT Improving

Public Health England

Public Health Outcomes Framework

Leicester

Introduction

The Public Health Outcomes Framework Healthy lives, healthy people: Improving outcomes and supporting transparency sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. The framework concentrates on two high-level outcomes to be achieved across the public health system, and groups further indicators into four 'domains' that cover the full spectrum of public health. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life.

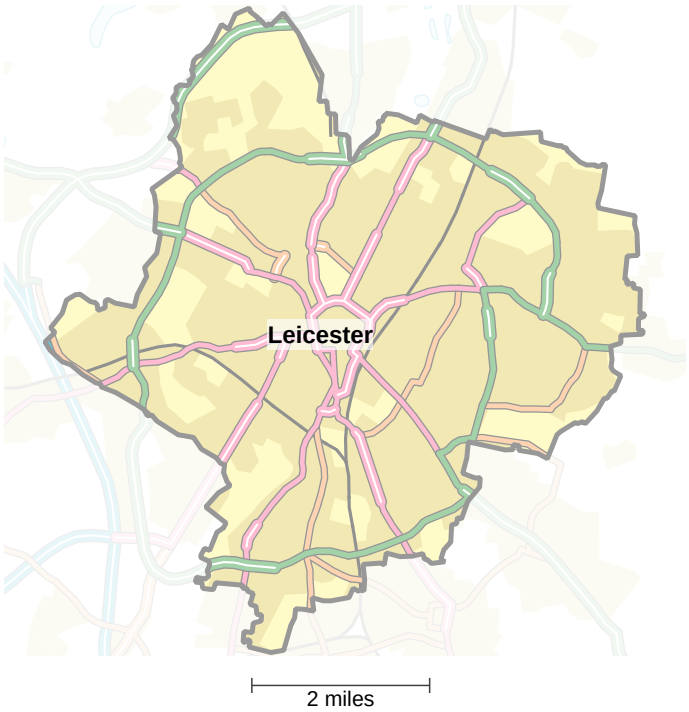
This profile currently presents data for the first set of indicators at England and upper tier local authority levels, collated by Public Health England.

The profile allows you to:

- Compare your local authority against other authorities in the region
- Benchmark your local authority against the England value

Public Health Outcomes Framework baseline data will be revised and corrected in accordance with the general DH statistical policy on revisions and corrections.

Contents



www.phoutcomes.info

Produced by Public Health England.

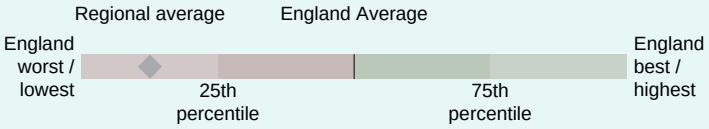
For enquiries please contact phof.enquiries@phe.gov.uk or call us on 020 7654 8307

Leicester

Spine Charts

Key
Significance compared to goal / England average:

- Significantly worse
- Not significantly different
- Significantly better
- Significantly lower
- Significantly higher
- Significance not tested



Overarching indicators

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
0.1i - Healthy life expectancy at birth (Male)	2013 - 15	59.1	63.4	54.0		71.1
0.1i - Healthy life expectancy at birth (Female)	2013 - 15	60.0	64.1	52.4		71.1
0.1ii - Life expectancy at birth (Male)	2013 - 15	77.1	79.5	74.3		83.4
0.1ii - Life expectancy at birth (Female)	2013 - 15	81.6	83.1	79.4		86.4
0.1ii - Life expectancy at 65 (Male)	2013 - 15	16.9	18.7	15.8		21.4
0.1ii - Life expectancy at 65 (Female)	2013 - 15	20.0	21.1	18.8		23.9
0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Male)	2013 - 15		9.2			
0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Female)	2013 - 15		7.1			
0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Male)	2013 - 15		83			
0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Female)	2013 - 15		55			
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)	2013 - 15	8.2	-	15.1		2.9
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female)	2013 - 15	6.6	-	12.7		1.7
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Male)	2013 - 15	-2.3	0.0	-5.2		3.9
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Female)	2013 - 15	-1.5	0.0	-3.7		3.3
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Male)	2013 - 15		18.9			
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Female)	2013 - 15		19.6			
0.2vi - SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas (Male)	2009 - 13	11.3	-	24.6		3.8
0.2vi - SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas (Female)	2009 - 13	11.2	-	22.1		2.8
0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Male)	2013 - 15		-			
0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Female)	2013 - 15		-			

Wider determinants of health

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
1.01i - Children in low income families (all dependent children under 20)	2014	29.2	19.9	41.9		6.8
1.01ii - Children in low income families (under 16s)	2014	28.8	20.1	39.2		7.0
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception (Persons)	2015/16	60.7	69.3	59.7		78.7
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception (Male)	2015/16	53.9	62.1	51.2		73.1
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception (Female)	2015/16	67.7	76.8	67.5		85.0
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Persons)	2015/16	52.2	54.4	41.0		72.1
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Male)	2015/16	44.2	45.8	29.5		68.6
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Female)	2015/16	59.8	63.5	47.7		80.4
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Persons)	2015/16	76.7	80.5	74.5		89.1
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Male)	2015/16	73.4	76.9	70.5		88.1
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Female)	2015/16	80.0	84.3	78.7		92.6
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Persons)	2015/16	67.0	68.6	53.2		84.2
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Male)	2015/16	61.0	63.6	46.6		84.0
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Female)	2015/16	73.1	74.0	56.8		100
1.03 - Pupil absence	2015/16	4.93	4.57	5.50		3.23
1.04 - First time entrants to the youth justice system	2016	339.8	327.1	739.6		97.5
1.05 - 16-18 year olds not in education employment or training	2015	6.3	4.2	7.9		1.5
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Persons)	2015/16	71.8	75.4	41.9		94.4
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Male)	2015/16	70.2	74.9	40.6		94.2
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Female)	2015/16	74.0	75.6	43.6		96.1
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons)	2015/16	62.3	58.6	1.6		92.6
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Male)	2015/16	61.3	57.4	1.3		92.1
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Female)	2015/16	63.8	60.0	0.6		93.5
1.07 - People in prison who have a mental illness or a significant mental illness - current method	2016/17		9.24			
1.07 - People in prison who have a mental illness or a significant mental illness - historic method	2013/14		5.55			
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2015/16	20.8	29.6	41.0		12.7
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Persons)	2015/16	58.1	68.1	77.8		48.3

Leicester

Wider determinants of health continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Male)	2015/16	66.1	73.0	83.0		47.4
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Female)	2015/16	50.7	63.6	74.8		38.4
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Persons)	2015/16	60.4	67.2	78.4		53.6
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Male)	2015/16	69.7	73.7	84.2		62.2
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Female)	2015/16	51.2	60.8	73.1		43.8
1.08iv - Percentage of people aged 16-64 in employment (Persons)	2015/16	63.3	73.9	60.4		84.3
1.08iv - Percentage of people aged 16-64 in employment (Male)	2015/16	72.3	79.2	64.6		88.7
1.08iv - Percentage of people aged 16-64 in employment (Female)	2015/16	54.4	68.8	53.6		80.0
1.09i - Sickness absence - the percentage of employees who had at least one day off in the previous week	2013 - 15	2.4	2.2	3.9		0.7
1.09ii - Sickness absence - the percent of working days lost due to sickness absence	2013 - 15	1.4	1.3	2.6		0.5
1.10 - Killed and seriously injured (KSI) casualties on England's roads	2013 - 15	29.4	38.5	74.0		11.8
1.11 - Domestic abuse-related incidents and crimes - current method	2015/16	14.7	22.1	9.4		38.4
1.11 - Domestic abuse - historic method	2014/15	20.6	20.4	5.5		33.8
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2013/14 - 15/16	37.9	44.8	133.4		9.1
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	2015/16	19.0	17.2	6.7		36.7
1.12iii- Violent crime (including sexual violence) - rate of sexual offences per 1,000 population	2015/16	1.9	1.7	0.9		3.5
1.13i - Re-offending levels - percentage of offenders who re-offend	2014	26.2	25.4	20.0		35.0
1.13ii - Re-offending levels - average number of re-offences per offender	2014	0.88	0.82	0.56		1.38
1.13iii - First time offenders	2016	242.2	218.4	68.3		440.1
1.14i - The rate of complaints about noise	2014/15	7.1	7.1 ^	72.9		2.2
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2011	4.7	5.2	20.8		0.8
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2011	6.6	8.0	42.4		1.2
1.15i - Statutory homelessness - Eligible homeless people not in priority need	2015/16	0.9	0.9	8.9		0.1
1.15ii - Statutory homelessness - households in temporary accommodation	2015/16	1	3	35		0
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	12.0	17.9	5.1		36.9
1.17 - Fuel poverty	2014	13.5	10.6	15.1		5.8
1.18i - Social Isolation: percentage of adult social care users who have as much social contact as they would like	2015/16	37.2	45.4	35.8		55.1
1.18ii - Social Isolation: percentage of adult carers who have as much social contact as they would like	2014/15	31.9	38.5	18.2		52.6

Note: ^ - Value estimated

Health improvement

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
2.01 - Low birth weight of term babies	2015	4.8	2.8	4.8		1.3
2.02i - Breastfeeding - breastfeeding initiation	2014/15	76.9	74.3	47.2		92.9
2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - current method	2015/16	- x	43.2 ^	18.0		76.5
2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - historical method	2014/15	62.1	43.8	19.1		81.5
2.03 - Smoking status at time of delivery	2015/16	11.4	10.6 $	26.0		1.8
2.04 - Under 18 conceptions	2015	26.2	20.8	43.8		5.7
2.04 - Under 18 conceptions: conceptions in those aged under 16	2015	5.8 *	3.7	8.6		0.9
2.05ii - Proportion of children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review	2015/16	- x	81.3 ^			
2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2015/16	20.4	22.1	30.1		14.3
2.06ii - Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2015/16	37.3	34.2	43.4		22.9
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2015/16	61.4	104.2	207.4		53.5
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2015/16	78.4	129.6	254.2		56.0
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2015/16	95.4	134.1	280.2		72.0
2.08i - Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	2015/16	14.4	14.0	17.6		10.2
2.08ii - Percentage of children where there is a cause for concern	2015/16	42.5	37.8	55.6		20.5
2.09i - Smoking prevalence at age 15 - current smokers (WAY survey)	2014/15	4.8	8.2	14.9		3.4
2.09ii - Smoking prevalence at age 15 - regular smokers (WAY survey)	2014/15	3.5	5.5	11.1		1.3
2.09iii - Smoking prevalence at age 15 - occasional smokers (WAY survey)	2014/15	1.4	2.7	7.6		0.6
2.09iv - Smoking prevalence at age 15 years - regular smokers (SDD survey)	2014		8			
2.09v - Smoking prevalence at age 15 years - occasional smokers (SDD survey)	2014		5			
2.10ii - Emergency Hospital Admissions for Intentional Self-Harm	2015/16	150.7	196.5	635.3		55.7
2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	2015	44.3	52.3	36.5		62.8
2.11ii - Average number of portions of fruit consumed daily (adults)	2015	2.34	2.51	2.11		2.93
2.11iii - Average number of portions of vegetables consumed daily (adults)	2015	1.94	2.27	1.70		2.60
2.11iv - Proportion of the population meeting the recommended "5-a-day" at age 15	2014/15	53.1	52.4	39.9		67.6
2.11v - Average number of portions of fruit consumed daily at age 15 (WAY survey)	2014/15	2.53	2.39	2.01		3.26
2.11vi - Average number of portions of vegetables consumed daily at age 15 (WAY survey)	2014/15	2.51	2.40	1.86		2.92
2.12 - Excess weight in Adults	2013 - 15	62.7	64.8	76.2		46.5
2.13i - Percentage of physically active and inactive adults - active adults	2015	50.0	57.0	44.8		69.8
2.13ii - Percentage of physically active and inactive adults - inactive adults	2015	33.9	28.7	43.7		17.5
2.14 - Smoking Prevalence in adults - current smokers (APS)	2016	17.0	15.5	24.2		7.4
2.15i - Successful completion of drug treatment - opiate users	2015	7.1	6.7	2.5		17.8
2.15ii - Successful completion of drug treatment - non-opiate users	2015	34.6	37.3	19.0		61.8
2.15iii - Successful completion of alcohol treatment	2015	34.6	38.4	16.8		64.9

Note: * - Disclosure control applied, ^ - Value estimated, x - Value Missing, $ - Data quality note

Leicester

Health improvement continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
2.15iv - Deaths from drug misuse	2013 - 15	2.8	3.9			
2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	2015/16	56.0	30.3	8.7		71.6
2.17 - Recorded diabetes	2014/15	8.9	6.4	3.7		8.9
2.18 - Admission episodes for alcohol-related conditions - narrow definition (Persons)	2015/16	753	647	1,163		390
2.18 - Admission episodes for alcohol-related conditions - narrow definition (Male)	2015/16	1022	830	1,427		509
2.18 - Admission episodes for alcohol-related conditions - narrow definition (Female)	2015/16	510	483	918		274
2.19 - Cancer diagnosed at early stage (experimental statistics)	2015	49.8	52.4	41.6		60.4
2.20i - Cancer screening coverage - breast cancer	2016	74.0	75.5	57.2		84.0
2.20ii - Cancer screening coverage - cervical cancer	2016	66.4	72.7	55.5		81.4
2.20iii - Cancer screening coverage - bowel cancer	2016	45.3	57.9	40.9		66.4
2.20iv - Abdominal Aortic Aneurysm Screening - Coverage	2015/16	69.2	79.9	57.5		87.2
2.20v - Diabetic eye screening - uptake	2015/16		83.0			
2.20vii - Infectious Diseases in Pregnancy Screening - HIV Coverage	2015/16		99.1			
2.20viii - Infectious Diseases in Pregnancy Screening - Syphilis Coverage	2014		97.4			
2.20ix - Infectious Diseases in Pregnancy Screening - Hepatitis B Coverage	2014		97.4			
2.20x - Sickle Cell and Thalassaemia Screening - Coverage	2015/16		99.1			
2.20xi - Newborn Blood Spot Screening - Coverage	2015/16	89.7 ^	95.6 ~	70.2		99.8
2.20xii - Newborn Hearing Screening - Coverage	2015/16	99.3	98.7	95.1		99.9
2.20xiii - Newborn and Infant Physical Examination Screening - Coverage	2015/16		94.9			
2.22iii - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	2013/14 - 16/17	64.6	74.1	23.0		100
2.22iv - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14 - 16/17	100.0	48.9	20.5		100.0
2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	2013/14 - 16/17	64.6	36.2	15.1		89.0
2.23i - Self-reported wellbeing - people with a low satisfaction score	2015/16	4.7	4.6			
2.23ii - Self-reported wellbeing - people with a low worthwhile score	2015/16	4.2	3.6			
2.23iii - Self-reported wellbeing - people with a low happiness score	2015/16	9.2	8.8	13.9		4.9
2.23iv - Self-reported wellbeing - people with a high anxiety score	2015/16	23.0	19.4	30.6		11.9
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Persons)	2015/16	2156	2169	3,426		1,237
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Male)	2015/16	2034	1733	3,116		825
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Female)	2015/16	2231	2471	3,859		1,535
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Persons)	2015/16	1128	1012	1,726		586
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Male)	2015/16	1094	825	1,628		354
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Female)	2015/16	1162	1177	1,891		789
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Persons)	2015/16	5140	5526	8,353		3,126
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Male)	2015/16	4759	4367	7,719		2,124

Note: ^ - Value estimated, ~ - Aggregated from all known lower geography values

Health improvement continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Female)	2015/16	5329	6223	9,583		3,664

Health protection

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
3.01 - Fraction of mortality attributable to particulate air pollution	2015	5.4	4.7	6.7		3.2
3.02 - Chlamydia detection rate (15-24 year olds) < 1900 1900 to 2300 ≥ 2300	2016	1711	1882	813		4,938
3.02 - Chlamydia detection rate (15-24 year olds) (Male)	2016	1155	1269	521		3,901
3.02 - Chlamydia detection rate (15-24 year olds) (Female)	2016	2263	2479	1,116		5,558
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2015/16	71.4	- x	0.0		100
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2015/16	63.6	- x			
3.03ii - Population vaccination coverage - BCG - areas offering universal BCG only	2015/16	- x	- x			
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) < 90 90 to 95 ≥ 95	2015/16	95.8	93.6	70.4		98.9
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) < 90 90 to 95 ≥ 95	2015/16	97.1	95.2	73.0		99.2
3.03iv - Population vaccination coverage - MenC < 90 90 to 95 ≥ 95	2015/16	96.4	- x	75.1		98.9
3.03v - Population vaccination coverage - PCV < 90 90 to 95 ≥ 95	2015/16	95.4	93.5	75.5		99.1
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old) < 90 90 to 95 ≥ 95	2015/16	94.0	91.6	65.2		97.5
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old) < 90 90 to 95 ≥ 95	2015/16	91.6	92.6	68.2		97.7
3.03vii - Population vaccination coverage - PCV booster < 90 90 to 95 ≥ 95	2015/16	94.1	91.5	67.1		97.6
3.03viii - Population vaccination coverage - MMR for one dose (2 years old) < 90 90 to 95 ≥ 95	2015/16	94.5	91.9	69.3		97.7
3.03ix - Population vaccination coverage - MMR for one dose (5 years old) < 90 90 to 95 ≥ 95	2015/16	96.5	94.8	71.1		98.9
3.03x - Population vaccination coverage - MMR for two doses (5 years old) < 90 90 to 95 ≥ 95	2015/16	90.3	88.2	56.5		98.6
3.03xii - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old) < 80 80 to 90 ≥ 90	2015/16	72.5	87.0	68.4		97.3
3.03xiii - Population vaccination coverage - PPV < 65 65 to 75 ≥ 75	2015/16	68.3	70.1	50.2		81.1
3.03xiv - Population vaccination coverage - Flu (aged 65+) < 75 ≥ 75	2016/17	71.1	70.5	48.6		78.1
3.03xv - Population vaccination coverage - Flu (at risk individuals) < 55 ≥ 55	2016/17	50.5	48.6	36.2		61.2
3.03xvi - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old) < 80 80 to 90 ≥ 90	2015/16	75.9	85.1	43.7		99.1
3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old) < 50 50 to 60 ≥ 60	2015/16	43.9	54.9	25.6		68.8

Note: x - Value Missing

Leicester

Health protection continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
3.03xviii - Population vaccination coverage - Flu (2-4 years old) < 40 40 to 65 ≥ 65	2016/17	34.6	38.1	19.2		52.4
3.04 - HIV late diagnosis < 25 25 to 50 ≥ 50	2013 - 15	59.0	40.1	75.0		12.5
3.05i - Treatment completion for TB < 50th-percentile ≥50th to <90th ≥90th	2014	82.1	84.4			
3.05ii - Incidence of TB > 50th-percentile ≤50th to >10th ≤ 10th	2013 - 15	41.8	12.0	85.6		1.2
3.06 - NHS organisations with a board approved sustainable development management plan	2015/16	50.0	66.2	25.0		100
3.08 - Adjusted antibiotic prescribing in primary care by the NHS ≤ mean England prescribing (2013/14) > mean England prescribing (2013/14)	2016	1.03	1.08	1.44		0.67

Healthcare and premature mortality

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
4.01 - Infant mortality	2013 - 15	4.6	3.9	7.9		2.0
4.02 - Proportion of five year old children free from dental decay	2014/15	55.0	75.4	43.9		85.9
4.03 - Mortality rate from causes considered preventable (Persons)	2013 - 15	241.0	184.5	320.5		130.5
4.03 - Mortality rate from causes considered preventable (Male)	2013 - 15	318.2	232.5	409.4		153.5
4.03 - Mortality rate from causes considered preventable (Female)	2013 - 15	169.6	139.6	239.7		101.1
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2013 - 15	113.2	74.6	137.6		45.4
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)	2013 - 15	165.9	104.7	184.9		68.4
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)	2013 - 15	63.0	46.2	93.2		22.1
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2013 - 15	77.8	48.1	89.5		27.2
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2013 - 15	119.9	72.5	132.0		44.6
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2013 - 15	37.6	25.0	49.2		13.6
4.05i - Under 75 mortality rate from cancer (Persons)	2013 - 15	147.6	138.8	194.8		105.8
4.05i - Under 75 mortality rate from cancer (Male)	2013 - 15	164.0	154.8	218.7		99.5
4.05i - Under 75 mortality rate from cancer (Female)	2013 - 15	133.6	123.9	172.6		90.0
4.05ii - Under 75 mortality rate from cancer considered preventable (Persons)	2013 - 15	90.0	81.1	129.3		59.6
4.05ii - Under 75 mortality rate from cancer considered preventable (Male)	2013 - 15	95.4	88.4	143.3		63.6
4.05ii - Under 75 mortality rate from cancer considered preventable (Female)	2013 - 15	85.7	74.5	120.5		53.2
4.06i - Under 75 mortality rate from liver disease (Persons)	2013 - 15	26.5	18.0	44.4		10.0
4.06i - Under 75 mortality rate from liver disease (Male)	2013 - 15	38.3	23.7	59.1		12.8
4.06i - Under 75 mortality rate from liver disease (Female)	2013 - 15	14.8	12.5	29.7		6.6
4.06ii - Under 75 mortality rate from liver disease considered preventable (Persons)	2013 - 15	24.2	15.9	40.8		9.0
4.06ii - Under 75 mortality rate from liver disease considered preventable (Male)	2013 - 15	35.9	21.4	54.7		11.8
4.06ii - Under 75 mortality rate from liver disease considered preventable (Female)	2013 - 15	12.7	10.6			
4.07i - Under 75 mortality rate from respiratory disease (Persons)	2013 - 15	45.4	33.1	68.3		16.5

Healthcare and premature mortality continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
4.07i - Under 75 mortality rate from respiratory disease (Male)	2013 - 15	51.4	38.5	80.2		20.5
4.07i - Under 75 mortality rate from respiratory disease (Female)	2013 - 15	39.7	28.0	60.6		14.3
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Persons)	2013 - 15	22.0	18.1	45.9		7.5
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Male)	2013 - 15	25.9	20.3	51.0		8.0
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Female)	2013 - 15	18.4	16.1	41.7		7.9
4.08 - Mortality rate from a range of specified communicable diseases, including influenza (Persons)	2013 - 15	11.2	10.5	23.7		6.1
4.08 - Mortality rate from a range of specified communicable diseases, including influenza (Male)	2013 - 15	14.8	11.5			
4.08 - Mortality rate from a range of specified communicable diseases, including influenza (Female)	2013 - 15	8.4	9.6	24.2		5.2
4.09i - Excess under 75 mortality rate in adults with serious mental illness	2014/15	370.8	370.0	570.4		164.8
4.09ii - Proportion of adults in the population in contact with secondary mental health services	2014/15	5.9	5.4	14.5		2.7
4.10 - Suicide rate (Persons)	2013 - 15	9.6	10.1	17.4		5.6
4.10 - Suicide rate (Male)	2013 - 15	14.8	15.8	27.5		8.5
4.10 - Suicide rate (Female)	2013 - 15	- x	4.7			
4.11 - Emergency readmissions within 30 days of discharge from hospital (Persons)	2011/12	11.7	11.8	14.5		8.8
4.11 - Emergency readmissions within 30 days of discharge from hospital (Male)	2011/12	12.6	12.1	14.9		8.7
4.11 - Emergency readmissions within 30 days of discharge from hospital (Female)	2011/12	10.9	11.5	14.7		8.3
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2015/16	152.3	114.0	403.9		11.8
4.12ii - Preventable sight loss - glaucoma	2015/16	14.3	12.8	39.2		4.0
4.12iii - Preventable sight loss - diabetic eye disease	2015/16	5.6	2.9			
4.12iv - Preventable sight loss - sight loss certifications	2015/16	54.6	41.9	109.1		5.7
4.13 - Health related quality of life for older people	2015/16	0.696	0.733	0.642		0.799
4.14i - Hip fractures in people aged 65 and over (Persons)	2015/16	641	589	820		391
4.14i - Hip fractures in people aged 65 and over (Male)	2015/16	604	416	669		259
4.14i - Hip fractures in people aged 65 and over (Female)	2015/16	673	710	962		439
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Persons)	2015/16	300	244	375		164
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Male)	2015/16	284	168			
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Female)	2015/16	317	311	506		202
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (Persons)	2015/16	1630	1591	2,311		953
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (Male)	2015/16	1529	1136	1,881		706
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (Female)	2015/16	1705	1868	2,611		1,175
4.15i - Excess winter deaths index (single year, all ages) (Persons)	Aug 2014 - Jul 2015	26.3	27.7	50.7		10.0
4.15i - Excess winter deaths index (single year, all ages) (Male)	Aug 2014 - Jul 2015	27.0	23.6	51.0		-2.7
4.15i - Excess winter deaths index (single year, all ages) (Female)	Aug 2014 - Jul 2015	25.7	31.6	62.6		3.1
4.15ii - Excess winter deaths index (single year, age 85+) (Persons)	Aug 2014 - Jul 2015	33.8	40.1	72.6		11.5
4.15ii - Excess winter deaths index (single year, age 85+) (Male)	Aug 2014 - Jul 2015	40.3	36.3	98.1		-5.7

Note: x - Value Missing

Leicester

Healthcare and premature mortality continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
4.15ii - Excess winter deaths index (single year, age 85+) (Female)	Aug 2014 - Jul 2015	29.8	42.4	77.0		3.8
4.15iii - Excess winter deaths index (3 years, all ages) (Persons)	Aug 2012 - Jul 2015	21.7	19.6	33.0		10.2
4.15iii - Excess winter deaths index (3 years, all ages) (Male)	Aug 2012 - Jul 2015	19.2	16.6	33.2		0.6
4.15iii - Excess winter deaths index (3 years, all ages) (Female)	Aug 2012 - Jul 2015	24.4	22.4	39.3		8.0
4.15iv - Excess winter deaths index (3 years, age 85+) (Persons)	Aug 2012 - Jul 2015	27.2	28.2	49.0		11.2
4.15iv - Excess winter deaths index (3 years, age 85+) (Male)	Aug 2012 - Jul 2015	28.6	26.5	61.1		-7.1
4.15iv - Excess winter deaths index (3 years, age 85+) (Female)	Aug 2012 - Jul 2015	26.2	29.2	54.1		9.1
4.16 - Estimated dementia diagnosis rate (aged 65+) ≥ 66.7% (significantly) similar to 66.7% <66.7% (significantly)	2017	86.5	67.9	53.8		90.8

Supporting information

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Supporting Information - Deprivation score (IMD 2010)	2010	33.6	21.7	43.4		5.4
Supporting information - Deprivation score (IMD 2015)	2015	33.1	21.8	42.0		5.7
Supporting information - % population aged	2015	23.9	21.3	17.6		29.9
Supporting information - % population aged 65+	2015	11.7	17.7	6.0		28.0
Supporting information - % population from Black and Minority Ethnic (BME) groups	2011	49.5	14.6	1.5		71.0

Tartan Rugs

Overarching indicators

Indicator		Period	England	Derby	Derbyshire	**Leicester**	Leics	Lincs	Northants	Nottingham	Notts	Rutland
0.1i	Healthy life expectancy at birth (Male)	2013 - 15	63.4	60.9	63.5	**59.1**	63.6	62.9	65.5	56.7	61.1	71.1
0.1i	Healthy life expectancy at birth (Female)	2013 - 15	64.1	59.6	63.8	**60.0**	65.8	63.7	67.0	57.2	62.2	70.6
0.1ii	Life expectancy at birth (Male)	2013 - 15	79.5	78.0	79.2	**77.1**	80.5	79.6	79.4	76.8	79.4	81.8
0.1ii	Life expectancy at birth (Female)	2013 - 15	83.1	82.7	82.8	**81.6**	83.9	83.1	83.1	81.4	82.8	85.2
0.1ii	Life expectancy at 65 (Male)	2013 - 15	18.7	17.9	18.3	**16.9**	19.2	18.8	18.8	16.9	18.5	20.2
0.1ii	Life expectancy at 65 (Female)	2013 - 15	21.1	21.0	20.7	**20.0**	21.7	20.9	21.0	20.1	20.7	23.0
0.2i	Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Male)	2013 - 15	9.2									
0.2i	Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Female)	2013 - 15	7.1									
0.2ii	Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Male)	2013 - 15	83									
0.2ii	Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Female)	2013 - 15	55									
0.2iii	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)	2013 - 15	-	10.4	8.2	**8.2**	6.1	6.3	8.8	8.0	8.8	- x
0.2iii	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female)	2013 - 15	-	8.4	6.4	**6.6**	4.8	5.4	7.0	7.2	8.0	- x
0.2iv	Gap in life expectancy at birth between each local authority and England as a whole (Male)	2013 - 15	0.0	-1.4	-0.3	**-2.3**	1.1	0.2	-0.1	-2.7	-0.1	2.3
0.2iv	Gap in life expectancy at birth between each local authority and England as a whole (Female)	2013 - 15	0.0	-0.5	-0.3	**-1.5**	0.8	0.0	0.0	-1.7	-0.3	2.1
0.2v	Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Male)	2013 - 15	18.9									
0.2v	Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Female)	2013 - 15	19.6									
0.2vi	SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas (Male)	2009 - 13	-	18.7	13.7	**11.3**	9.0	11.9	13.7	11.9	14.9	- x
0.2vi	SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas (Female)	2009 - 13	-	19.2	13.5	**11.2**	9.6	10.9	12.7	12.8	14.4	- x
0.2vii	Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Male)	2013 - 15	-									
0.2vii	Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Female)	2013 - 15	-									

Comparison with respect to England value / goal: Lower | Similar | Higher | Better | Similar | Worse | Not compared

Note: x - Value Missing

Leicester

Wider determinants of health

Indicator		Period	England	Derby	Derbyshire	**Leicester**	Leics	Lincs	Northants	Nottingham	Notts	Rutland
1.01i	Children in low income families (all dependent children under 20)	2014	19.9	24.6	16.3	**29.2**	12.0	17.5	15.6	33.6	17.1	8.3
1.01ii	Children in low income families (under 16s)	2014	20.1	25.0	16.8	**28.8**	12.4	18.1	16.1	34.3	17.7	8.5
1.02i	School Readiness: the percentage of children achieving a good level of development at the end of reception (Persons)	2015/16	69.3	66.4	70.8	**60.7**	67.5	70.5	68.1	63.5	67.0	72.1
1.02i	School Readiness: the percentage of children achieving a good level of development at the end of reception (Male)	2015/16	62.1	59.0	63.9	**53.9**	59.5	63.9	61.4	56.3	59.4	64.0
1.02i	School Readiness: the percentage of children achieving a good level of development at the end of reception (Female)	2015/16	76.8	73.9	77.9	**67.7**	75.4	77.3	75.4	71.5	75.0	82.8
1.02i	School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Persons)	2015/16	54.4	54.5	52.6	**52.2**	43.5	54.1	52.0	54.7	47.5	41.2
1.02i	School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Male)	2015/16	45.8	48.3	42.9	**44.2**	35.3	47.0	44.0	46.6	36.1	- *
1.02i	School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Female)	2015/16	63.5	61.3	62.2	**59.8**	54.0	61.6	61.5	63.9	58.7	- *
1.02ii	School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Persons)	2015/16	80.5	78.2	79.3	**76.7**	80.3	82.9	80.9	74.9	77.2	85.6
1.02ii	School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Male)	2015/16	76.9	74.0	74.5	**73.4**	76.8	79.6	77.7	70.5	72.8	77.3
1.02ii	School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Female)	2015/16	84.3	82.5	84.2	**80.0**	84.0	86.6	84.3	79.5	81.7	92.6
1.02ii	School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Persons)	2015/16	68.6	67.7	66.6	**67.0**	59.6	71.5	68.4	68.3	59.0	80.0
1.02ii	School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Male)	2015/16	63.6	62.6	58.2	**61.0**	54.1	67.4	65.0	62.6	52.1	62.5
1.02ii	School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Female)	2015/16	74.0	73.3	74.3	**73.1**	65.6	75.5	72.1	74.6	67.1	100
1.03	Pupil absence	2015/16	4.57	4.93	4.26	**4.93**	4.28	4.57	4.60	4.78	4.43	3.23
1.04	First time entrants to the youth justice system	2016	327.1	447.1	169.2	**339.8**	163.4 *	430.5	258.5	609.3	320.9	- *
1.05	16-18 year olds not in education employment or training	2015	4.2	4.8	3.6	**6.3**	3.0	3.5	4.6	5.8	2.5	2.1 $
1.06i	Adults with a learning disability who live in stable and appropriate accommodation (Persons)	2015/16	75.4	81.1	84.3	**71.8**	77.5	74.7	66.0	83.3	75.9	71.0
1.06i	Adults with a learning disability who live in stable and appropriate accommodation (Male)	2015/16	74.9	83.3	84.4	**70.2**	78.2	75.1	64.9	83.4	75.1	72.4
1.06i	Adults with a learning disability who live in stable and appropriate accommodation (Female)	2015/16	75.6	77.8	84.1	**74.0**	76.4	74.2	67.5	83.2	76.9	68.6
1.06ii	Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons)	2015/16	58.6	81.3	82.1	**62.3**	66.2	52.4	11.4	63.6	39.7	64.8
1.06ii	Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Male)	2015/16	57.4	79.1	79.3	**61.3**	65.8	49.1	12.0	57.4	36.5	71.6

Comparison with respect to England value / goal: Lower | Similar | Higher | Better | Similar | Worse | Not compared

Note: * - Disclosure control applied, $ - Data quality note

Wider determinants of health continued

Indicator		Period	England	Derby	Derbyshire	Leicester	Leics	Lincs	Northants	Nottingham	Notts	Rutland
1.06ii	Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Female)	2015/16	60.0	84.0	85.0	**63.8**	66.7	56.8	10.6	76.0	44.7	57.7
1.07	People in prison who have a mental illness or a significant mental illness - current method	2016/17	9.24									
1.07	People in prison who have a mental illness or a significant mental illness - historic method	2013/14	5.55									
1.08i	Gap in the employment rate between those with a long-term health condition and the overall employment rate	2015/16	29.6	22.6	33.5	**20.8**	32.9	33.6	35.3	20.4	36.1	21.9
1.08ii	Gap in the employment rate between those with a learning disability and the overall employment rate (Persons)	2015/16	68.1	66.6	76.0	**58.1**	74.2	68.6	76.2	64.9	71.0	63.4
1.08ii	Gap in the employment rate between those with a learning disability and the overall employment rate (Male)	2015/16	73.0	72.2	79.9	**66.1**	78.7	74.7	81.3	69.5	74.9	70.3
1.08ii	Gap in the employment rate between those with a learning disability and the overall employment rate (Female)	2015/16	63.6	60.8	72.4	**50.7**	69.8	63.0	71.1	- *	67.2	55.9
1.08iii	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Persons)	2015/16	67.2	66.6	68.3	**60.4**	70.1	68.3	78.4	58.3	69.1	65.3
1.08iii	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Male)	2015/16	73.7	73.6	74.6	**69.7**	75.6	76.6	83.7	64.2	74.6	- *
1.08iii	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Female)	2015/16	60.8	59.3	62.0	**51.2**	64.4	60.1	73.1	50.8	62.8	- *
1.08iv	Percentage of people aged 16-64 in employment (Persons)	2015/16	73.9	73.5	77.7	**63.3**	77.8	73.1	79.2	65.2	73.4	76.3
1.08iv	Percentage of people aged 16-64 in employment (Male)	2015/16	79.2	79.1	81.9	**72.3**	82.7	80.4	84.5	69.9	77.3	82.4
1.08iv	Percentage of people aged 16-64 in employment (Female)	2015/16	68.8	67.7	73.6	**54.4**	72.9	66.1	73.9	60.2	69.6	70.2
1.09i	Sickness absence - the percentage of employees who had at least one day off in the previous week	2013 - 15	2.2	1.9	2.6	**2.4**	2.3	2.1	1.6	2.4	2.9	2.5
1.09ii	Sickness absence - the percent of working days lost due to sickness absence	2013 - 15	1.3	1.0	1.6	**1.4**	1.3	1.4	0.8	1.4	1.9	1.4
1.10	Killed and seriously injured (KSI) casualties on England's roads	2013 - 15	38.5	33.9	44.5	**29.4**	33.8	51.6	45.8	38.6	41.9	61.4
1.11	Domestic abuse-related incidents and crimes - current method	2015/16	22.1	22.8	22.8	**14.7**	14.7	16.9	24.7	15.6	15.6	14.7
1.11	Domestic abuse - historic method	2014/15	20.4	22.0	22.0	**20.6**	20.6	17.2	18.0	20.7	20.7	20.6
1.12i	Violent crime (including sexual violence) - hospital admissions for violence	2013/14 - 15/16	44.8	51.9	37.1	**37.9**	21.0	31.5	41.2	64.2	34.0	26.8
1.12ii	Violent crime (including sexual violence) - violence offences per 1,000 population	2015/16	17.2	18.8	9.9	**19.0**	8.6	9.7	19.4	23.2	13.1	6.7
1.12iii	- Violent crime (including sexual violence) - rate of sexual offences per 1,000 population	2015/16	1.7	2.2	1.2	**1.9**	1.0	1.5	2.1	2.6	1.4	1.1
1.13i	Re-offending levels - percentage of offenders who re-offend	2014	25.4	29.4	24.2	**26.2**	20.7	24.5	23.7	28.6	24.9	20.0
1.13ii	Re-offending levels - average number of re-offences per offender	2014	0.82	1.02	0.75	**0.88**	0.62	0.80	0.72	0.99	0.78	0.60

Comparison with respect to England value / goal: Lower | Similar | Higher; Better | Similar | Worse; Not compared

Note: * - Disclosure control applied

Leicester

Wider determinants of health continued

Indicator		Period	England	Derby	Derbyshire	Leicester	Leics	Lincs	Northants	Nottingham	Notts	Rutland
1.13iii	First time offenders	2016	218.4	283.2	174.1	**242.2**	127.9	249.2	250.1	285.4	187.3	68.3
1.14i	The rate of complaints about noise	2014/15	7.1 ^	3.4 ^	4.3 ^	**7.1**	2.9 ^	4.9 ^	6.5 ^	5.4 ^	3.5 ^	3.3
1.14ii	The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2011	5.2	4.6	3.5	**4.7**	2.5	2.3	3.2	6.3	2.6	0.8
1.14iii	The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2011	8.0	6.1	6.3	**6.6**	5.1	3.2	5.0	7.7	4.3	1.2
1.15i	Statutory homelessness - Eligible homeless people not in priority need	2015/16	0.9	1.8	0.6 ~	**0.9**	0.4 ~	0.2 ~	0.4 ~	0.1	0.3 ~	- *
1.15ii	Statutory homelessness - households in temporary accommodation	2015/16	3	0	- *	**1**	0 ~	0 ~	- *	1	0 ~	0
1.16	Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	17.9	20.7	18.5	**12.0**	20.8	19.0	21.1	15.6	16.7	- x
1.17	Fuel poverty	2014	10.6	10.7	9.8	**13.5**	8.8	10.6	9.5	12.6	9.4	10.6
1.18i	Social Isolation: percentage of adult social care users who have as much social contact as they would like	2015/16	45.4	42.2	47.2	**37.2**	40.7	46.8	47.3	46.9	38.1	48.2
1.18ii	Social Isolation: percentage of adult carers who have as much social contact as they would like	2014/15	38.5	33.5	36.9	**31.9**	32.5	36.5	33.0	40.7	32.3	46.0

Health improvement

2.01	Low birth weight of term babies	2015	2.8	3.0	2.3	**4.8**	2.3	2.3	2.1	3.3	2.3	1.3
2.02i	Breastfeeding - breastfeeding initiation	2014/15	74.3	70.2	73.4	**76.9**	74.4	- x	74.3	71.1	69.0	81.5
2.02ii	Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - current method	2015/16	43.2 ^	41.5	40.7	**- x**	- x	37.3	44.1	47.7	39.8	- x
2.02ii	Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - historical method	2014/15	43.8	- x	- x	**62.1**	47.2	38.0	43.2	48.6	39.8	52.8
2.03	Smoking status at time of delivery	2015/16	10.6 $	14.2	14.2	**11.4**	10.0 *	- x	13.9	18.7	14.5	- *
2.04	Under 18 conceptions	2015	20.8	26.9	15.4	**26.2**	16.3	18.7	21.7	31.2	20.3	5.7
2.04	Under 18 conceptions: conceptions in those aged under 16	2015	3.7	5.1	2.4	**5.8 ***	3.2	3.3	3.6	7.4	3.7	- *
2.05ii	Proportion of children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review	2015/16	81.3 ^	99.6	92.0	**- x**	- x	84.8	89.4	99.4	82.6	- x
	2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2015/16	22.1	21.7	22.2	**20.4**	21.3	21.5	22.0	25.5	21.5	22.9
2.06ii	Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2015/16	34.2	36.7	32.3	**37.3**	31.3	34.7	32.6	37.0	30.6	31.4
2.07i	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2015/16	104.2	63.3	91.0	**61.4**	78.2	106.7	102.5	88.4	80.6	69.7
2.07i	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2015/16	129.6	65.3	109.3	**78.4**	83.0	136.0	121.7	111.3	90.9	107.6
2.07ii	Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2015/16	134.1	122.6	140.0	**95.4**	97.5	123.1	180.0	97.9	132.6	146.6
2.08i	Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	2015/16	14.0	16.4	16.9	**14.4**	16.6	15.1	13.6	16.0	14.5	15.2

Comparison with respect to England value / goal: Lower | Similar | Higher | Better | Similar | Worse | Not compared

Note: * - Disclosure control applied, ^ - Value estimated, x - Value Missing, $ - Data quality note, ~ - Aggregated from all known lower geography values

Health improvement continued

Indicator		Period	England	Derby	Derbyshire	**Leicester**	Leics	Lincs	Northants	Nottingham	Notts	Rutland
2.08ii	Percentage of children where there is a cause for concern	2015/16	37.8	51.4	50.8	**42.5**	51.8	43.5	33.7	49.2	39.3	- *
2.09i	Smoking prevalence at age 15 - current smokers (WAY survey)	2014/15	8.2	7.7	8.0	**4.8**	6.9	7.9	8.7	8.2	7.4	9.5
2.09ii	Smoking prevalence at age 15 - regular smokers (WAY survey)	2014/15	5.5	5.1	5.4	**3.5**	4.5	5.6	6.2	6.7	5.3	4.5
2.09iii	Smoking prevalence at age 15 - occasional smokers (WAY survey)	2014/15	2.7	2.6	2.7	**1.4**	2.5	2.3	2.5	1.5	2.1	5.0
2.09iv	Smoking prevalence at age 15 years - regular smokers (SDD survey)	2014	8									
2.09v	Smoking prevalence at age 15 years - occasional smokers (SDD survey)	2014	5									
2.10ii	Emergency Hospital Admissions for Intentional Self-Harm	2015/16	196.5	260.1	242.6	**150.7**	129.9	181.7	255.0	252.8	205.3	126.8
2.11i	Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	2015	52.3	52.4	53.3	**44.3**	55.6	54.3	51.0	44.4	56.2	62.8
2.11ii	Average number of portions of fruit consumed daily (adults)	2015	2.51	2.47	2.46	**2.34**	2.58	2.49	2.47	2.24	2.55	2.80
2.11iii	Average number of portions of vegetables consumed daily (adults)	2015	2.27	2.28	2.36	**1.94**	2.36	2.37	2.18	2.10	2.41	2.48
	2.11iv - Proportion of the population meeting the recommended "5-a-day" at age 15	2014/15	52.4	53.3	50.9	**53.1**	54.4	53.0	49.9	50.8	51.6	63.3
	2.11v - Average number of portions of fruit consumed daily at age 15 (WAY survey)	2014/15	2.39	2.36	2.17	**2.53**	2.36	2.32	2.29	2.37	2.32	2.42
	2.11vi - Average number of portions of vegetables consumed daily at age 15 (WAY survey)	2014/15	2.40	2.49	2.34	**2.51**	2.52	2.40	2.35	2.51	2.38	2.67
2.12	Excess weight in Adults	2013 - 15	64.8	66.0	68.3	**62.7**	64.7	69.9	67.3	62.4	67.6	67.3
2.13i	Percentage of physically active and inactive adults - active adults	2015	57.0	58.3	55.6	**50.0**	59.5	55.7	56.8	55.0	59.5	65.3
2.13ii	Percentage of physically active and inactive adults - inactive adults	2015	28.7	27.8	29.5	**33.9**	26.0	30.2	27.6	33.3	26.1	25.3
2.14	Smoking Prevalence in adults - current smokers (APS)	2016	15.5	17.8	13.9	**17.0**	13.5	17.7	16.3	21.5	15.7	12.3
2.15i	Successful completion of drug treatment - opiate users	2015	6.7	7.8	5.4	**7.1**	6.8 *	7.6	8.3	6.3	5.4	- *
2.15ii	Successful completion of drug treatment - non-opiate users	2015	37.3	33.9	37.5	**34.6**	40.5 *	41.3	29.8	44.1	28.5	- *
2.15iii	Successful completion of alcohol treatment	2015	38.4	28.5	39.2	**34.6**	47.5 *	39.7	32.6	35.6	29.8	- *
2.15iv	Deaths from drug misuse	2013 - 15	3.9	5.9	3.7	**2.8**	1.4	2.8	3.3	3.3	2.8	- x
2.16	Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	2015/16	30.3	27.2	59.9	**56.0**	- *	22.6	31.1	31.3	17.9	- *
2.17	Recorded diabetes	2014/15	6.4	7.1	6.9	**8.9**	6.5	7.5	6.1	5.4	6.6	6.7
2.18	Admission episodes for alcohol-related conditions - narrow definition (Persons)	2015/16	647	844	713	**753**	592	582	682	1000	693	566
2.18	Admission episodes for alcohol-related conditions - narrow definition (Male)	2015/16	830	1110	894	**1022**	731	741	858	1342	864	688
2.18	Admission episodes for alcohol-related conditions - narrow definition (Female)	2015/16	483	606	555	**510**	473	439	523	677	542	458
2.19	Cancer diagnosed at early stage (experimental statistics)	2015	52.4	48.5	50.7	**49.8**	51.6	51.3	56.7	48.7	50.6	58.1

Comparison with respect to England value / goal: Lower | Similar | Higher | Better | Similar | Worse | Not compared

Note: * - Disclosure control applied, x - Value Missing

Health improvement continued

Indicator		Period	England	Derby	Derbyshire	Leicester	Leics	Lincs	Northants	Nottingham	Notts	Rutland
2.20i	Cancer screening coverage - breast cancer	2016	75.5	76.9	79.6	**74.0**	84.0	79.0	79.7	73.3	81.6	84.0
2.20ii	Cancer screening coverage - cervical cancer	2016	72.7	73.9	79.1	**66.4**	77.7	76.5	73.6	72.6	79.0	78.4
2.20iii	Cancer screening coverage - bowel cancer	2016	57.9	57.2	62.1	**45.3**	63.1	56.8	59.5	50.7	60.0	66.4
2.20iv	Abdominal Aortic Aneurysm Screening - Coverage	2015/16	79.9	82.2	86.3	**69.2**	81.1	84.9	82.6	72.9	83.8	82.9
2.20v	Diabetic eye screening - uptake	2015/16	83.0									
2.20vii	Infectious Diseases in Pregnancy Screening - HIV Coverage	2015/16	99.1									
2.20viii	Infectious Diseases in Pregnancy Screening - Syphilis Coverage	2014	97.4									
2.20ix	Infectious Diseases in Pregnancy Screening - Hepatitis B Coverage	2014	97.4									
2.20x	Sickle Cell and Thalassaemia Screening - Coverage	2015/16	99.1									
2.20xi	Newborn Blood Spot Screening - Coverage	2015/16	95.6 ~	93.7 ^	- x	**89.7 ^**	92.2 ^	97.4 ^	95.0 ^	89.4 ^	92.7 ^	- x
2.20xii	Newborn Hearing Screening - Coverage	2015/16	98.7	99.6	99.0	**99.3**	99.4	98.9	99.2	99.0	99.4	99.7
2.20xiii	Newborn and Infant Physical Examination Screening - Coverage	2015/16	94.9									
2.22iii	Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	2013/14 - 16/17	74.1	60.0	68.1	**64.6**	100 $	81.0	66.7	46.5	58.1	89.8
2.22iv	Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14 - 16/17	48.9	47.0	53.8	**100.0**	43.1	59.7	51.3	48.9	56.9	53.6
2.22v	Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	2013/14 - 16/17	36.2	28.2	36.6	**64.6**	43.2	48.4	34.2	22.7	33.1	48.1
2.23i	Self-reported wellbeing - people with a low satisfaction score	2015/16	4.6	5.6	3.4	**4.7**	- x	3.8	4.0	6.7	- x	- x
2.23ii	Self-reported wellbeing - people with a low worthwhile score	2015/16	3.6	5.6	4.4	**4.2**	- x	3.7	- x	5.0	- x	- x
2.23iii	Self-reported wellbeing - people with a low happiness score	2015/16	8.8	11.5	8.0	**9.2**	6.9	6.9	9.0	10.6	7.3	- x
2.23iv	Self-reported wellbeing - people with a high anxiety score	2015/16	19.4	21.1	19.8	**23.0**	16.8	16.6	17.1	18.5	17.9	12.7
2.24i	Emergency hospital admissions due to falls in people aged 65 and over (Persons)	2015/16	2169	2368	2267	**2156**	1883	1762	2300	2508	2172	1869
2.24i	Emergency hospital admissions due to falls in people aged 65 and over (Male)	2015/16	1733	2027	1752	**2034**	1559	1319	1819	2089	1651	1327
2.24i	Emergency hospital admissions due to falls in people aged 65 and over (Female)	2015/16	2471	2606	2635	**2231**	2123	2113	2655	2811	2545	2288
2.24ii	Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Persons)	2015/16	1012	1153	988	**1128**	801	796	1041	1282	924	994
2.24ii	Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Male)	2015/16	825	954	739	**1094**	628	555	843	1007	706	- x
2.24ii	Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Female)	2015/16	1177	1323	1215	**1162**	957	1023	1225	1525	1118	1410
2.24iii	Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Persons)	2015/16	5526	5888	5974	**5140**	5021	4562	5952	6063	5791	4407
2.24iii	Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Male)	2015/16	4367	5136	4692	**4759**	4261	3533	4647	5227	4393	3613

Comparison with respect to England value / goal: Lower | Similar | Higher | Better | Similar | Worse | Not compared

Note: ^ - Value estimated, x - Value Missing, $ - Data quality note, ~ - Aggregated from all known lower geography values

Health improvement continued

Indicator		Period	England	Derby	Derbyshire	**Leicester**	Leics	Lincs	Northants	Nottingham	Notts	Rutland
2.24iii	Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Female)	2015/16	6223	6324	6754	**5329**	5504	5274	6804	6540	6683	4833

Health protection

3.01	Fraction of mortality attributable to particulate air pollution	2015	4.7	5.1	4.7	**5.4**	5.4	5.2	5.2	5.3	5.0	4.9
3.02	Chlamydia detection rate (15-24 year olds) < 1900 1900 to 2300 ≥ 2300	2016	1882	1746	1607	**1711**	1942	1993	2004	2168	1423	1402
3.02	Chlamydia detection rate (15-24 year olds) (Male)	2016	1269	1126	1125	**1155**	1386	1314	1266	1202	845	1294
3.02	Chlamydia detection rate (15-24 year olds) (Female)	2016	2479	2384	2111	**2263**	2561	2684	2744	3124	2031	1538
3.03i	Population vaccination coverage - Hepatitis B (1 year old)	2015/16	- x	100	100	**71.4**	80.0	- x	100	100	- x	- x
3.03i	Population vaccination coverage - Hepatitis B (2 years old)	2015/16	- x	81.8	0.0 *	**63.6**	60.0 *	- x	93.1	95.0	100	- x
3.03ii	Population vaccination coverage - BCG - areas offering universal BCG only	2015/16	- x	- x	- x	**- x**	- x	- x	- x	- x	- x	- x
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (1 year old) < 90 90 to 95 ≥ 95	2015/16	93.6	93.9	96.1	**95.8**	97.2	94.5	97.6 ^	91.1	95.6	- x
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (2 years old) < 90 90 to 95 ≥ 95	2015/16	95.2	95.4	97.1	**97.1**	98.2	96.3	98.0 ^	94.6	97.4	- x
3.03iv	Population vaccination coverage - MenC < 90 90 to 95 ≥ 95	2015/16	- x	96.3	98.1	**96.4**	98.1 *	96.8	97.3 ^	94.1	- x	- *
3.03v	Population vaccination coverage - PCV < 90 90 to 95 ≥ 95	2015/16	93.5	94.4	96.6	**95.4**	97.1	94.8	97.0 ^	90.7	95.2	- x
3.03vi	Population vaccination coverage - Hib / MenC booster (2 years old) < 90 90 to 95 ≥ 95	2015/16	91.6	91.2	96.0	**94.0**	96.4	91.8	95.8 ^	89.3	94.0	- x
3.03vi	Population vaccination coverage - Hib / Men C booster (5 years old) < 90 90 to 95 ≥ 95	2015/16	92.6	93.6	94.3	**91.6**	95.8	90.0	94.8 ^	88.8	95.2	- x
3.03vii	Population vaccination coverage - PCV booster < 90 90 to 95 ≥ 95	2015/16	91.5	91.2	96.0	**94.1**	96.3	91.5	96.0	89.2	94.3	- x
3.03viii	Population vaccination coverage - MMR for one dose (2 years old) < 90 90 to 95 ≥ 95	2015/16	91.9	91.4	95.7	**94.5**	96.1 *	92.5	96.0 ^	89.7	93.9	- *
3.03ix	Population vaccination coverage - MMR for one dose (5 years old) < 90 90 to 95 ≥ 95	2015/16	94.8	97.3	96.7	**96.5**	97.9	95.0	96.7 ^	95.9	96.2	- x
3.03x	Population vaccination coverage - MMR for two doses (5 years old) < 90 90 to 95 ≥ 95	2015/16	88.2	87.8	91.0	**90.3**	93.5	86.9	95.2 ^	84.2	89.9	- x
3.03xii	Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old) < 80 80 to 90 ≥ 90	2015/16	87.0	86.7	80.4	**72.5**	95.7	85.7	90.0	87.7	91.8	86.6
3.03xiii	Population vaccination coverage - PPV < 65 65 to 75 ≥ 75	2015/16	70.1	74.3	72.7	**68.3**	72.7	70.9	68.7	71.2	73.7	70.8
3.03xiv	Population vaccination coverage - Flu (aged 65+) < 75 ≥ 75	2016/17	70.5	72.4	73.3	**71.1**	72.5 *	70.7	69.2	70.6	73.5	- *

Comparison with respect to England value / goal: Lower | Similar | Higher | Better | Similar | Worse | Not compared

Note: * - Disclosure control applied, ^ - Value estimated, x - Value Missing

Leicester

Health protection continued

Indicator	Period	England	Derby	Derbyshire	**Leicester**	Leics	Lincs	Northants	Nottingham	Notts	Rutland
3.03xv Population vaccination coverage - Flu (at risk individuals)	2016/17	48.6	47.6	46.0	**50.5**	48.3 *	49.2	45.9	46.4	49.6	- *
< 55 ≥ 55											
3.03xvi Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old)	2015/16	85.1	90.9	43.7	**75.9**	85.3	84.4	97.2	83.9	90.1	85.2
< 80 80 to 90 ≥ 90											
3.03xvii Population vaccination coverage - Shingles vaccination coverage (70 years old)	2015/16	54.9	57.0	58.1	**43.9**	62.9	56.5	50.5	57.9	59.2	64.4
< 50 50 to 60 ≥ 60											
3.03xviii Population vaccination coverage - Flu (2-4 years old)	2016/17	38.1	35.4	48.3	**34.6**	49.3 *	43.5	39.8	34.1	44.0	- *
< 40 40 to 65 ≥ 65											
3.04 - HIV late diagnosis	2013 - 15	40.1	38.0	50.8	**59.0**	43.1	39.1	49.3	40.8	37.5	- *
< 25 25 to 50 ≥ 50											
3.05i - Treatment completion for TB	2014	84.4	93.8	66.7	**82.1**	90.5	70.0	75.0	90.0	79.4	-
< 50th-percentile ≥50th to <90th ≥90th											
3.05ii - Incidence of TB	2013 - 15	12.0	13.8	2.8	**41.8**	4.0	4.4	6.6	17.1	3.6	4.4
> 50th-percentile ≤50th to >10th ≤ 10th											
3.06 NHS organisations with a board approved sustainable development management plan	2015/16	66.2	75.0	66.7	**50.0**	40.0	37.5	71.4	100	63.6	40.0
3.08 - Adjusted antibiotic prescribing in primary care by the NHS	2016	1.08	1.04	0.97	**1.03**	1.02	1.21	1.16	1.05	1.11	1.02
≤ mean England prescribing (2013/14) > mean England prescribing (2013/14)											

Healthcare and premature mortality

4.01	Infant mortality	2013 - 15	3.9	5.8	3.5	**4.6**	4.1	3.2	4.3	6.2	4.2	5.9
4.02	Proportion of five year old children free from dental decay	2014/15	75.4	72.4	77.8	**55.0**	71.6	76.5	72.9	64.4	79.0	71.2
4.03	Mortality rate from causes considered preventable (Persons)	2013 - 15	184.5	218.4	189.7	**241.0**	153.5	179.2	183.7	255.2	183.3	139.3
4.03	Mortality rate from causes considered preventable (Male)	2013 - 15	232.5	278.5	238.3	**318.2**	192.0	223.3	233.5	326.4	228.8	153.5
4.03	Mortality rate from causes considered preventable (Female)	2013 - 15	139.6	163.7	144.4	**169.6**	117.6	137.1	136.1	187.8	141.0	123.8
4.04i	Under 75 mortality rate from all cardiovascular diseases (Persons)	2013 - 15	74.6	88.0	73.7	**113.2**	62.0	80.2	74.6	109.9	68.1	52.9
4.04i	Under 75 mortality rate from all cardiovascular diseases (Male)	2013 - 15	104.7	125.3	101.6	**165.9**	85.6	112.4	105.0	146.4	95.6	74.1
4.04i	Under 75 mortality rate from all cardiovascular diseases (Female)	2013 - 15	46.2	52.8	46.6	**63.0**	39.1	49.4	45.3	74.6	41.8	- x
4.04ii	Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2013 - 15	48.1	57.1	49.5	**77.8**	40.3	54.8	48.6	70.7	44.2	34.4
4.04ii	Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2013 - 15	72.5	87.8	72.9	**119.9**	61.7	82.2	73.2	98.9	67.7	57.1
4.04ii	Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2013 - 15	25.0	28.5	26.9	**37.6**	19.5	28.7	24.8	43.3	21.7	- x
4.05i	Under 75 mortality rate from cancer (Persons)	2013 - 15	138.8	143.6	139.7	**147.6**	124.5	136.7	136.0	169.1	143.1	109.4
4.05i	Under 75 mortality rate from cancer (Male)	2013 - 15	154.8	157.8	156.2	**164.0**	134.6	146.4	153.2	203.4	157.1	99.5
4.05i	Under 75 mortality rate from cancer (Female)	2013 - 15	123.9	131.3	124.0	**133.6**	115.0	127.5	119.5	137.0	130.0	120.0

Comparison with respect to England value / goal: Lower | Similar | Higher | Better | Similar | Worse | Not compared

Note: * - Disclosure control applied, x - Value Missing

Healthcare and premature mortality continued

Indicator		Period	England	Derby	Derbyshire	**Leicester**	Leics	Lincs	Northants	Nottingham	Notts	Rutland
4.05ii	Under 75 mortality rate from cancer considered preventable (Persons)	2013 - 15	81.1	86.7	83.0	**90.0**	66.9	77.1	80.3	104.6	84.5	64.5
4.05ii	Under 75 mortality rate from cancer considered preventable (Male)	2013 - 15	88.4	92.2	91.0	**95.4**	69.3	80.9	88.7	120.0	90.2	- x
4.05ii	Under 75 mortality rate from cancer considered preventable (Female)	2013 - 15	74.5	82.1	75.4	**85.7**	64.7	73.5	72.3	90.7	79.2	85.3
4.06i	Under 75 mortality rate from liver disease (Persons)	2013 - 15	18.0	25.3	18.4	**26.5**	13.8	13.2	16.7	28.5	18.0	- x
4.06i	Under 75 mortality rate from liver disease (Male)	2013 - 15	23.7	32.9	22.7	**38.3**	16.9	16.3	21.2	35.7	23.8	- x
4.06i	Under 75 mortality rate from liver disease (Female)	2013 - 15	12.5	18.0	14.2	**14.8**	10.8	10.2	12.3	21.1	12.4	- x
4.06ii	Under 75 mortality rate from liver disease considered preventable (Persons)	2013 - 15	15.9	23.4	16.4	**24.2**	12.3	11.6	14.7	26.0	16.3	- x
4.06ii	Under 75 mortality rate from liver disease considered preventable (Male)	2013 - 15	21.4	30.0	21.1	**35.9**	15.6	14.5	19.5	33.0	21.5	- x
4.06ii	Under 75 mortality rate from liver disease considered preventable (Female)	2013 - 15	10.6	17.1	11.8	**12.7**	9.1	8.8	10.1	18.9	11.2	- x
4.07i	Under 75 mortality rate from respiratory disease (Persons)	2013 - 15	33.1	43.2	33.1	**45.4**	24.0	31.8	33.9	54.7	31.0	- x
4.07i	Under 75 mortality rate from respiratory disease (Male)	2013 - 15	38.5	53.9	38.4	**51.4**	28.3	36.4	41.2	68.7	35.5	- x
4.07i	Under 75 mortality rate from respiratory disease (Female)	2013 - 15	28.0	33.4	28.0	**39.7**	19.8	27.4	26.8	40.7	26.8	- x
4.07ii	Under 75 mortality rate from respiratory disease considered preventable (Persons)	2013 - 15	18.1	24.6	17.5	**22.0**	11.3	16.8	19.1	32.8	15.9	- x
4.07ii	Under 75 mortality rate from respiratory disease considered preventable (Male)	2013 - 15	20.3	28.4	18.8	**25.9**	13.1	18.6	22.7	39.1	17.0	- x
4.07ii	Under 75 mortality rate from respiratory disease considered preventable (Female)	2013 - 15	16.1	21.0	16.1	**18.4**	9.7	15.1	15.7	26.3	14.7	- x
4.08	Mortality rate from a range of specified communicable diseases, including influenza (Persons)	2013 - 15	10.5	7.6	10.2	**11.2**	6.6	12.0	10.5	12.8	8.7	- x
4.08	Mortality rate from a range of specified communicable diseases, including influenza (Male)	2013 - 15	11.5	9.1	11.8	**14.8**	6.8	12.3	12.4	11.2	8.0	- x
4.08	Mortality rate from a range of specified communicable diseases, including influenza (Female)	2013 - 15	9.6	- x	9.2	**8.4**	6.2	11.6	9.2	12.9	9.2	- x
4.09i	Excess under 75 mortality rate in adults with serious mental illness	2014/15	370.0	310.5	332.2	**370.8**	362.9	303.4	392.6	470.4	382.7	247.8
4.09ii	Proportion of adults in the population in contact with secondary mental health services	2014/15	5.4	5.1	5.9	**5.9**	4.3	8.5	3.8	6.6	5.0	3.6
4.10	Suicide rate (Persons)	2013 - 15	10.1	10.2	10.3	**9.6**	9.3	10.4	10.6	11.3	9.3	- x
4.10	Suicide rate (Male)	2013 - 15	15.8	17.5	17.2	**14.8**	14.9	16.2	16.0	17.9	14.6	- x
4.10	Suicide rate (Female)	2013 - 15	4.7	- x	3.7	**- x**	3.9	4.9	5.4	- x	4.4	- x
4.11	Emergency readmissions within 30 days of discharge from hospital (Persons)	2011/12	11.8	12.3	11.4	**11.7**	11.5	10.7	12.1	13.3	11.4	9.7
4.11	Emergency readmissions within 30 days of discharge from hospital (Male)	2011/12	12.1	12.9	11.7	**12.6**	11.6	11.2	12.6	14.0	11.7	8.7
4.11	Emergency readmissions within 30 days of discharge from hospital (Female)	2011/12	11.5	11.8	11.1	**10.9**	11.4	10.3	11.7	12.7	11.2	10.7
4.12i	Preventable sight loss - age related macular degeneration (AMD)	2015/16	114.0	41.7	145.0	**152.3**	128.9	78.7	71.1	69.9	86.1	65.9

Comparison with respect to England value / goal: Lower | Similar | Higher; Better | Similar | Worse; Not compared

Note: x - Value Missing

Healthcare and premature mortality continued

Indicator		Period	England	Derby	Derbyshire	**Leicester**	Leics	Lincs	Northants	Nottingham	Notts	Rutland
4.12ii	Preventable sight loss - glaucoma	2015/16	12.8	6.9	11.8	**14.3**	9.6	13.3	9.0	7.6	8.7	- *
4.12iii	Preventable sight loss - diabetic eye disease	2015/16	2.9	4.2	3.7	**5.6**	2.2	3.0	2.1	2.6	2.6	0.0
4.12iv	Preventable sight loss - sight loss certifications	2015/16	41.9	23.2	50.0	**54.6**	50.2	40.3	26.0	25.4	33.3	36.8
4.13	Health related quality of life for older people	2015/16	0.733	0.732	0.731	**0.696**	0.754	0.746	0.750	0.694	0.732	0.799
4.14i	Hip fractures in people aged 65 and over (Persons)	2015/16	589	538	611	**641**	537	546	618	629	568	532
4.14i	Hip fractures in people aged 65 and over (Male)	2015/16	416	414	415	**604**	415	359	437	532	402	- x
4.14i	Hip fractures in people aged 65 and over (Female)	2015/16	710	627	746	**673**	628	694	750	706	687	752
4.14ii	Hip fractures in people aged 65 and over - aged 65-79 (Persons)	2015/16	244	236	220	**300**	207	218	268	282	227	- x
4.14ii	Hip fractures in people aged 65 and over - aged 65-79 (Male)	2015/16	168	- *	134	**284**	146	124	191	215	161	- *
4.14ii	Hip fractures in people aged 65 and over - aged 65-79 (Female)	2015/16	311	- *	299	**317**	263	306	338	342	286	- *
4.14iii	Hip fractures in people aged 65 and over - aged 80+ (Persons)	2015/16	1591	1414	1744	**1630**	1493	1496	1635	1635	1556	1261
4.14iii	Hip fractures in people aged 65 and over - aged 80+ (Male)	2015/16	1136	- *	1230	**1529**	1193	1041	1150	1450	1101	- *
4.14iii	Hip fractures in people aged 65 and over - aged 80+ (Female)	2015/16	1868	- *	2040	**1705**	1687	1817	1943	1760	1851	- *
4.15i	Excess winter deaths index (single year, all ages) (Persons)	Aug 2014 - Jul 2015	27.7	19.4	31.6	**26.3**	23.8	30.4	29.9	34.2	32.2	30.2
4.15i	Excess winter deaths index (single year, all ages) (Male)	Aug 2014 - Jul 2015	23.6	18.1	26.6	**27.0**	18.9	29.1	28.6	21.4	26.9	14.5
4.15i	Excess winter deaths index (single year, all ages) (Female)	Aug 2014 - Jul 2015	31.6	20.7	36.2	**25.7**	28.3	31.7	31.2	48.4	37.1	45.8
4.15ii	Excess winter deaths index (single year, age 85+) (Persons)	Aug 2014 - Jul 2015	40.1	38.1	43.8	**33.8**	38.4	49.1	38.1	60.4	53.8	33.9
4.15ii	Excess winter deaths index (single year, age 85+) (Male)	Aug 2014 - Jul 2015	36.3	33.0	43.4	**40.3**	29.1	55.1	38.4	67.2	47.6	0.0
4.15ii	Excess winter deaths index (single year, age 85+) (Female)	Aug 2014 - Jul 2015	42.4	41.7	44.0	**29.8**	44.3	45.5	38.0	56.3	57.6	56.9
4.15iii	Excess winter deaths index (3 years, all ages) (Persons)	Aug 2012 - Jul 2015	19.6	18.6	23.2	**21.7**	17.8	19.1	20.8	26.3	21.1	10.2
4.15iii	Excess winter deaths index (3 years, all ages) (Male)	Aug 2012 - Jul 2015	16.6	15.9	21.0	**19.2**	17.7	16.0	16.9	23.7	16.8	0.6
4.15iii	Excess winter deaths index (3 years, all ages) (Female)	Aug 2012 - Jul 2015	22.4	21.4	25.2	**24.4**	18.0	22.2	24.6	29.0	25.2	20.6
4.15iv	Excess winter deaths index (3 years, age 85+) (Persons)	Aug 2012 - Jul 2015	28.2	31.1	31.6	**27.2**	28.6	28.9	27.5	40.3	31.1	16.8
4.15iv	Excess winter deaths index (3 years, age 85+) (Male)	Aug 2012 - Jul 2015	26.5	28.2	35.5	**28.6**	32.2	26.6	22.9	42.4	28.8	-7.1
4.15iv	Excess winter deaths index (3 years, age 85+) (Female)	Aug 2012 - Jul 2015	29.2	33.0	29.5	**26.2**	26.5	30.3	30.3	38.9	32.5	34.5
	4.16 - Estimated dementia diagnosis rate (aged 65+)	2017	67.9	77.2	73.1	**86.5**	68.6	63.4	68.7	83.1	75.2	61.9

≥ 66.7% (significantly) | similar to 66.7% | &lt 66.7% (significantly)

Comparison with respect to England value / goal: Lower | Similar | Higher | Better | Similar | Worse | Not compared

Note: * - Disclosure control applied, x - Value Missing

Supporting information

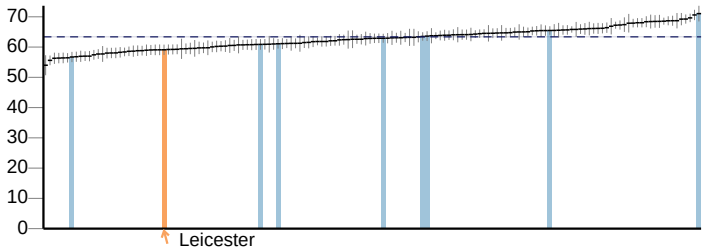
Indicator	Period	England	Derby	Derbyshire	**Leicester**	Leics	Lincs	Northants	Nottingham	Notts	Rutland
Supporting Information - Deprivation score (IMD 2010)	2010	21.7	24.6	18.5	**33.6**	11.7	18.9	17.4	34.4	19.5	8.6
Supporting information - Deprivation score (IMD 2015)	2015	21.8	27.8	18.5	**33.1**	12.5	20.6	18.9	36.9	18.9	9.6
Supporting information - % population aged	2015	21.3	23.1	19.6	**23.9**	20.1	19.3	22.5	20.7	20.3	20.3
Supporting information - % population aged 65+	2015	17.7	16.0	20.8	**11.7**	19.8	22.8	17.3	11.7	20.0	23.9
Supporting information - % population from Black and Minority Ethnic (BME) groups	2011	14.6	19.7	2.5	**49.5**	8.6	2.4	8.5	28.5	4.5	2.9

Comparison with respect to England value / goal | Lower | Similar | Higher | Better | Similar | Worse | Not compared

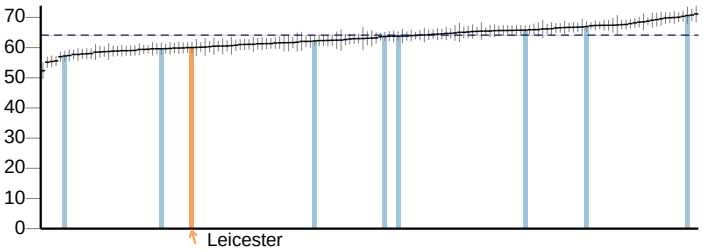
Summary Charts

Overarching indicators

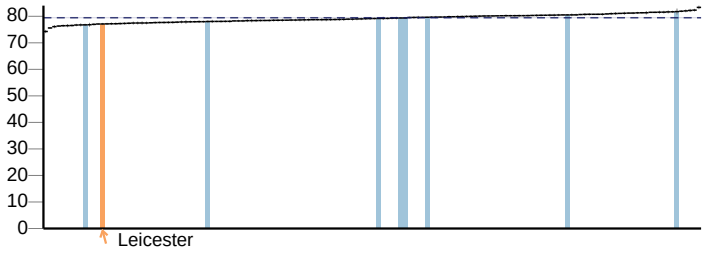
0.1i - Healthy life expectancy at birth (Male)



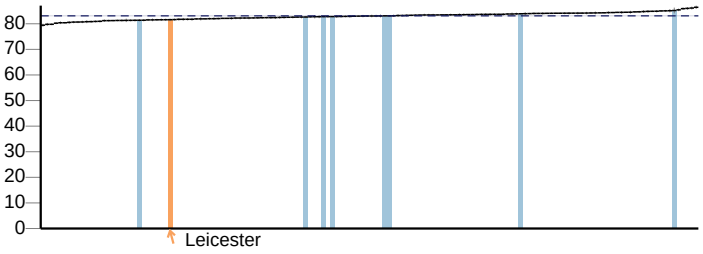
0.1i - Healthy life expectancy at birth (Female)



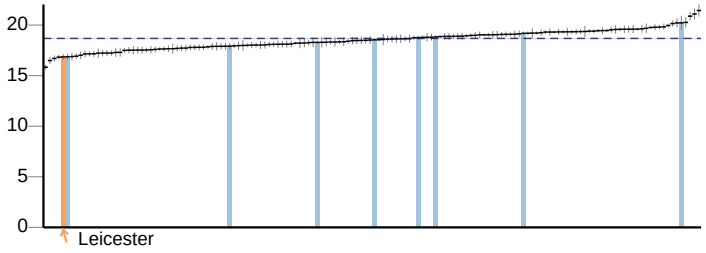
0.1ii - Life expectancy at birth (Male)



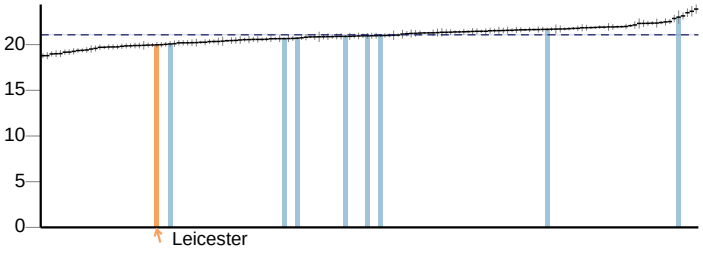
0.1ii - Life expectancy at birth (Female)



0.1ii - Life expectancy at 65 (Male)



0.1ii - Life expectancy at 65 (Female)



0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Male)

No data

0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Female)

No data

0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Male)

No data

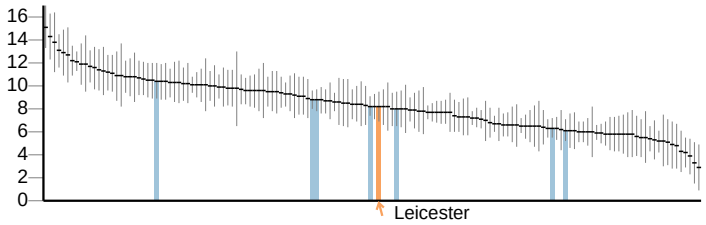
0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Female)

No data

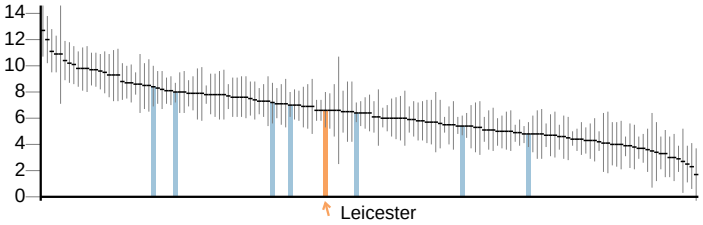
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Overarching indicators continued

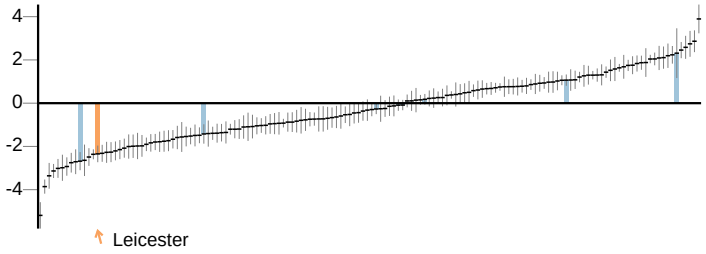
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)



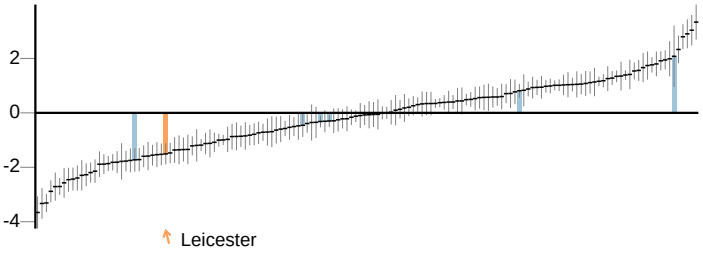
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female)



0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Male)



0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Female)



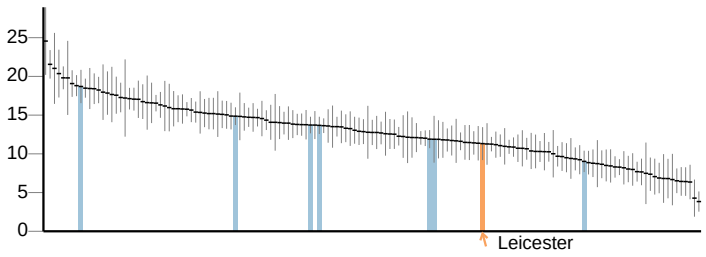
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Male)

No data

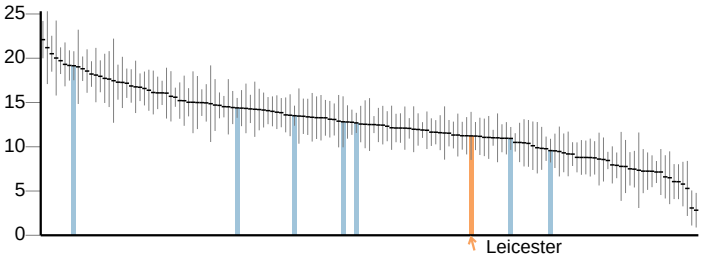
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Female)

No data

0.2vi - SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas (Male)



0.2vi - SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas (Female)



0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Male)

No data

0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Female)

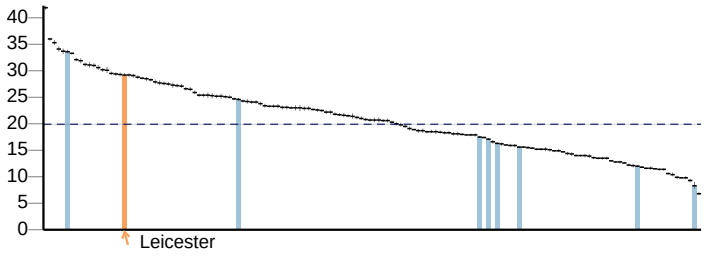
No data

Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

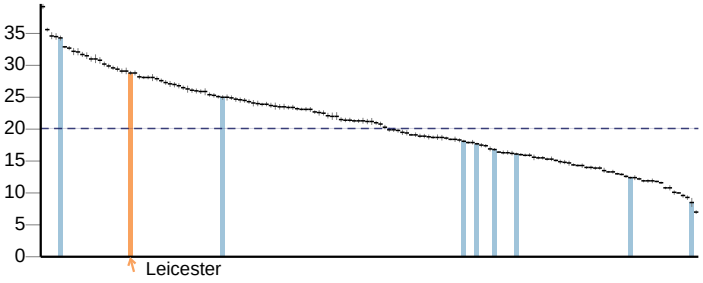
Leicester

Wider determinants of health

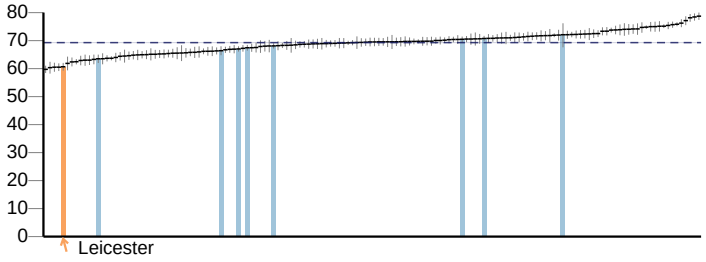
1.01i - Children in low income families (all dependent children under 20)



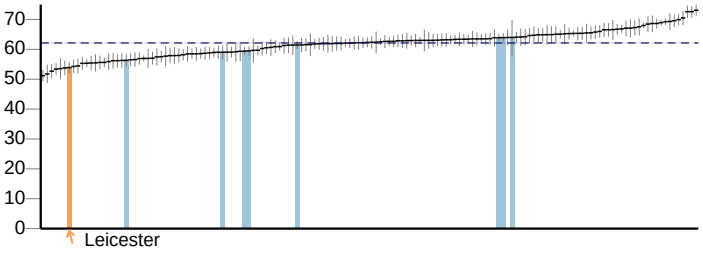
1.01ii - Children in low income families (under 16s)



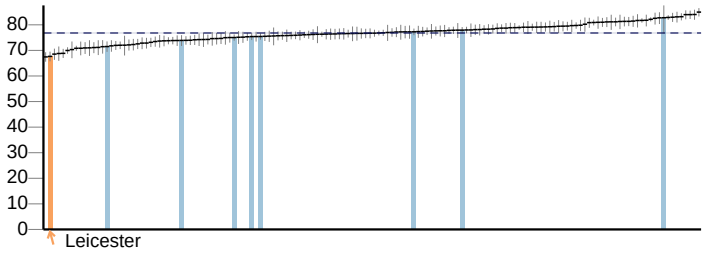
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception (Persons)



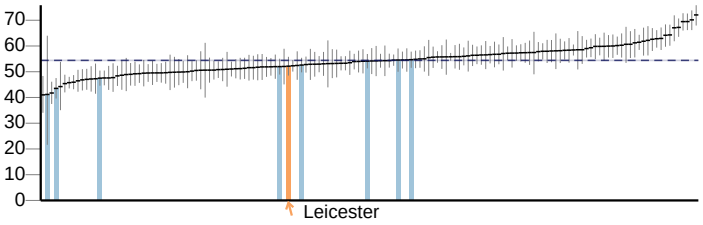
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception (Male)



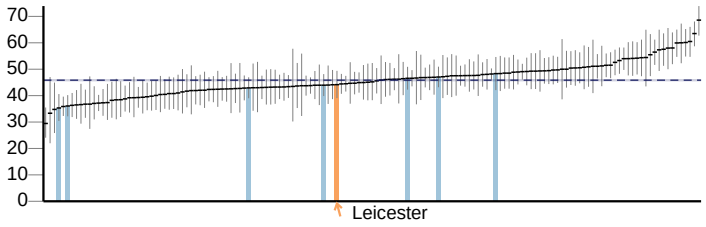
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception (Female)



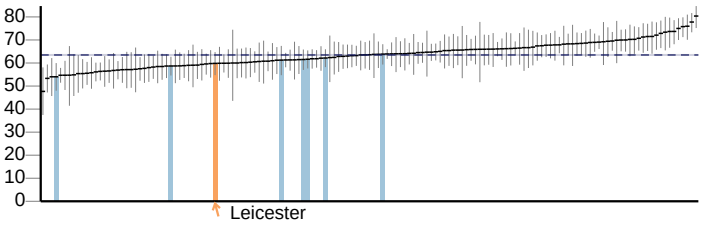
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Persons)



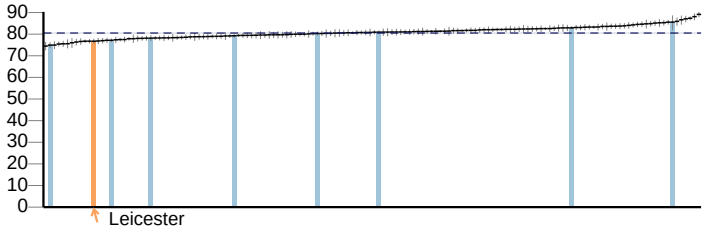
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Male)



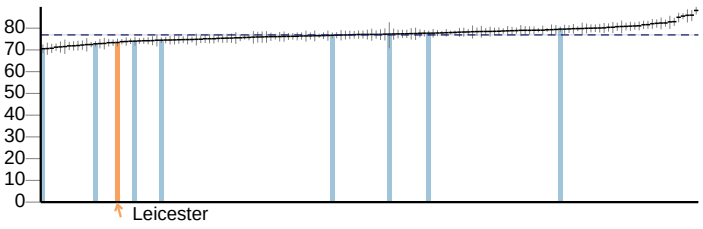
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception (Female)



1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Persons)



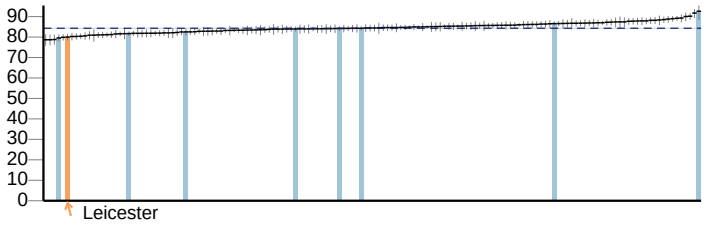
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Male)



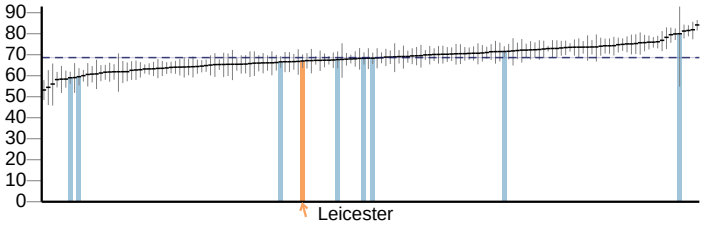
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Wider determinants of health continued

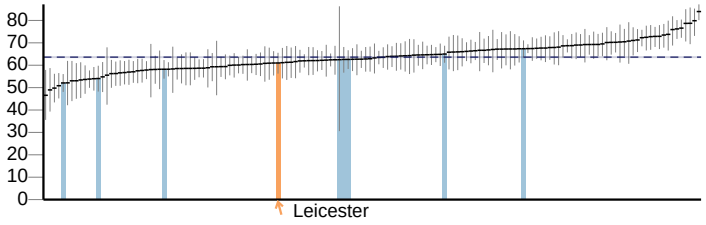
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check (Female)



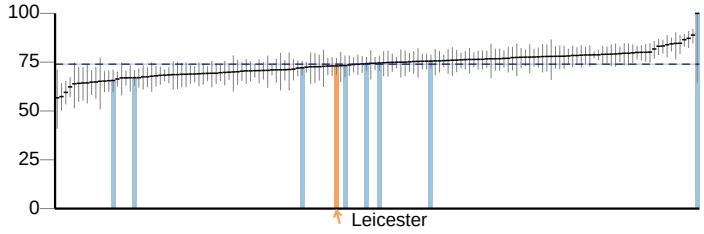
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Persons)



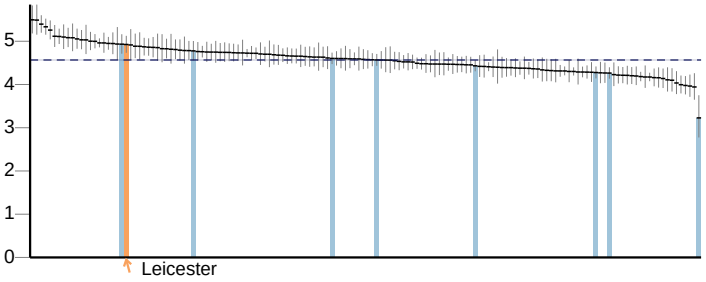
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Male)



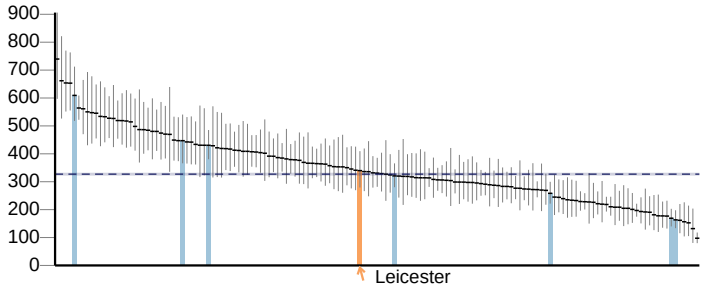
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Female)



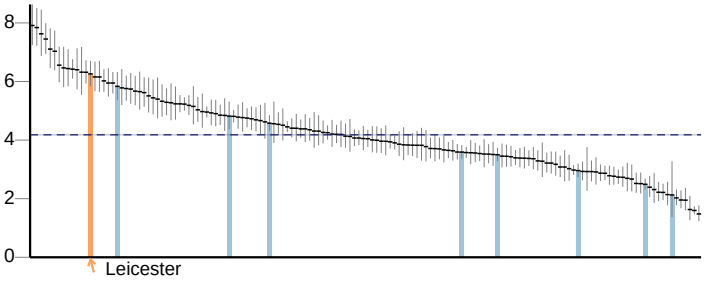
1.03 - Pupil absence



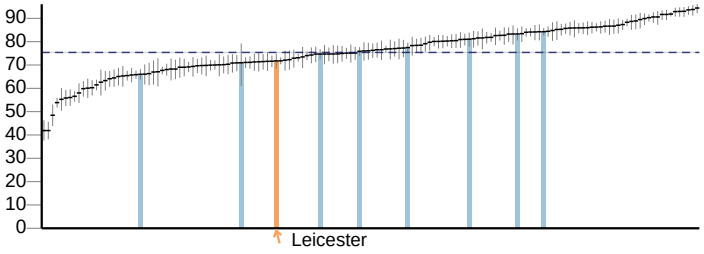
1.04 - First time entrants to the youth justice system



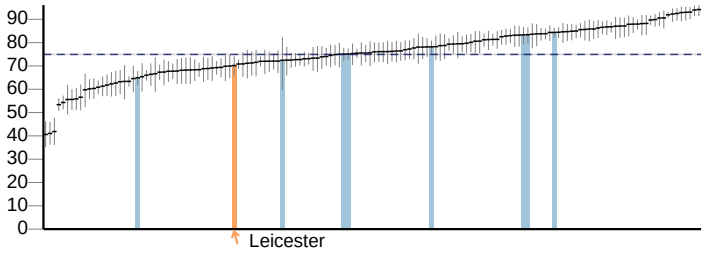
1.05 - 16-18 year olds not in education employment or training



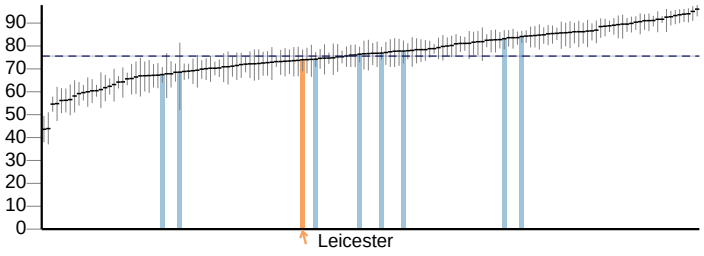
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Persons)



1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Male)



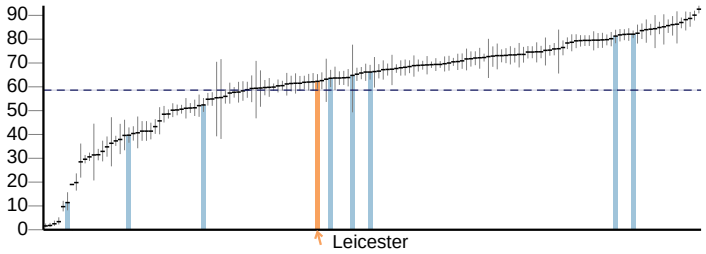
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Female)



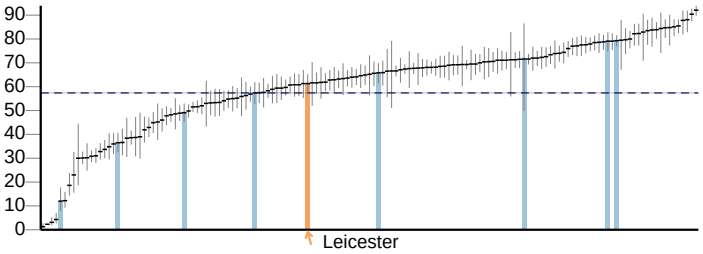
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Wider determinants of health continued

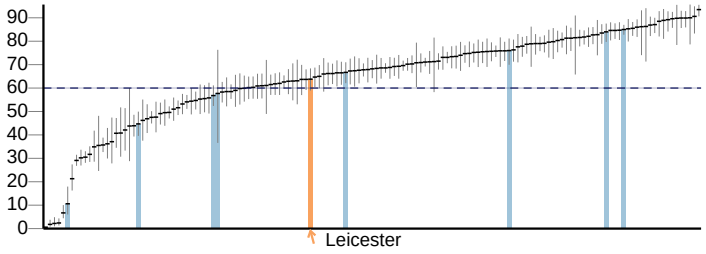
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons)



1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Male)



1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Female)



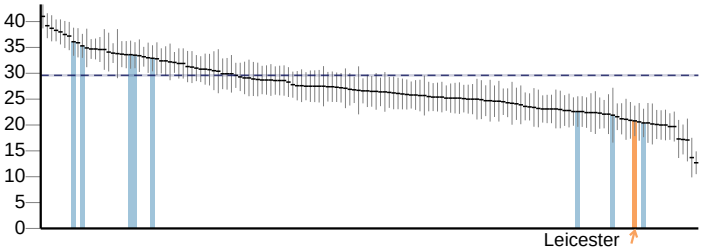
1.07 - People in prison who have a mental illness or a significant mental illness - current method

No data

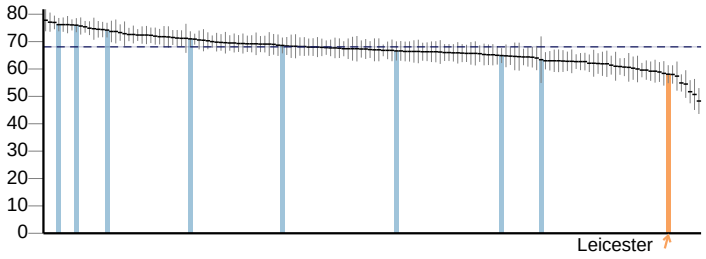
1.07 - People in prison who have a mental illness or a significant mental illness - historic method

No data

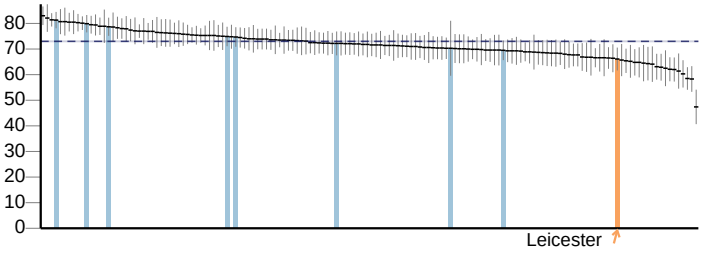
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate



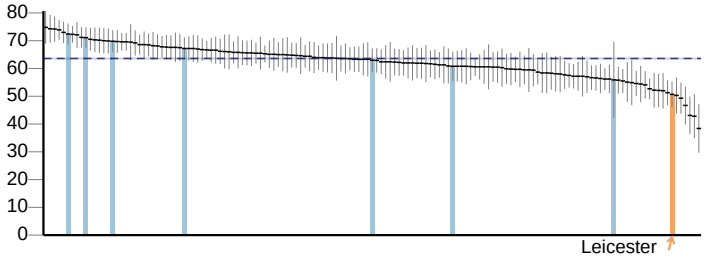
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Persons)



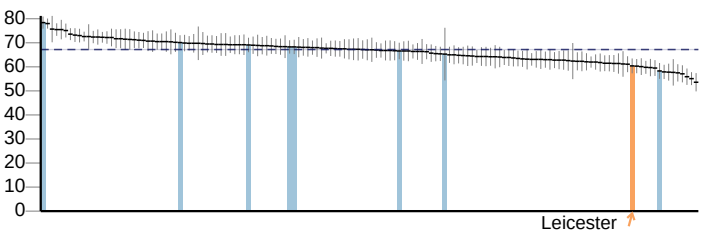
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Male)



1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (Female)



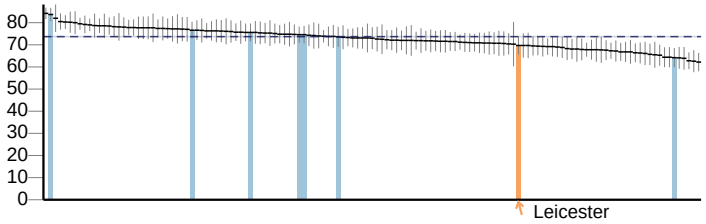
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Persons)



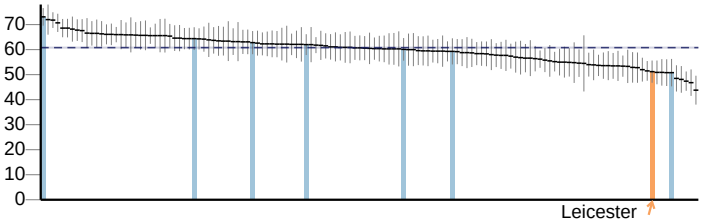
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Wider determinants of health continued

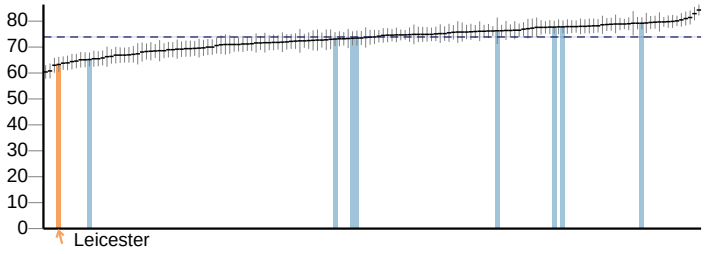
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Male)



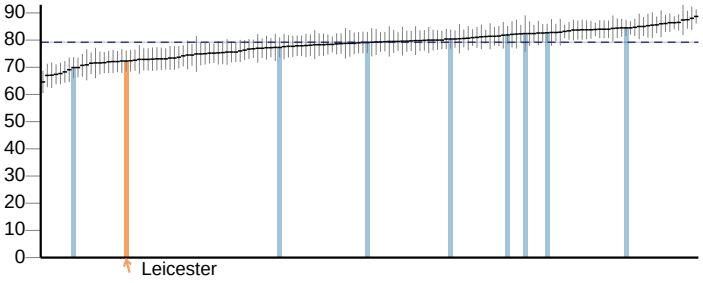
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Female)



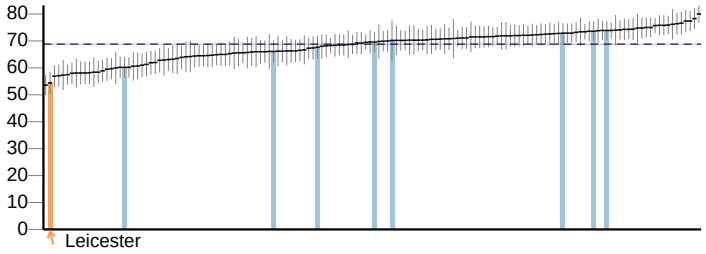
1.08iv - Percentage of people aged 16-64 in employment (Persons)



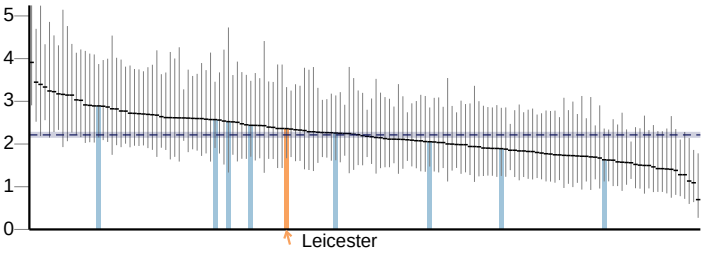
1.08iv - Percentage of people aged 16-64 in employment (Male)



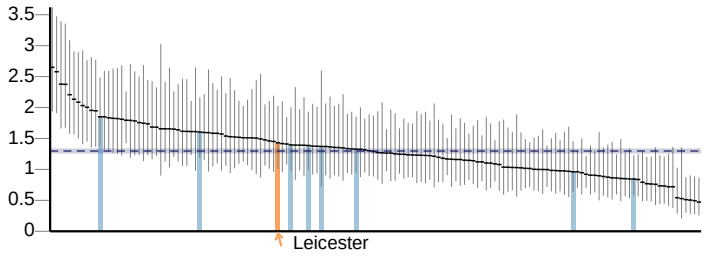
1.08iv - Percentage of people aged 16-64 in employment (Female)



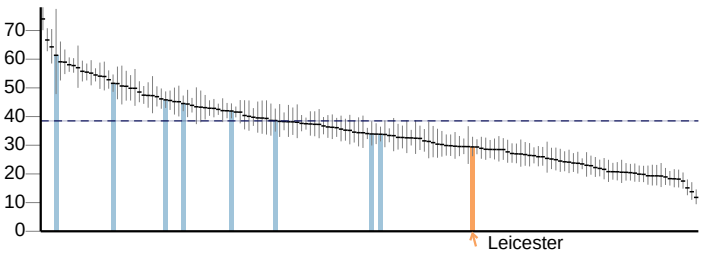
1.09i - Sickness absence - the percentage of employees who had at least one day off in the previous week



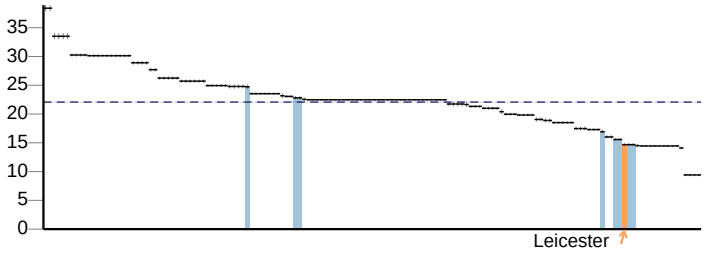
1.09ii - Sickness absence - the percent of working days lost due to sickness absence



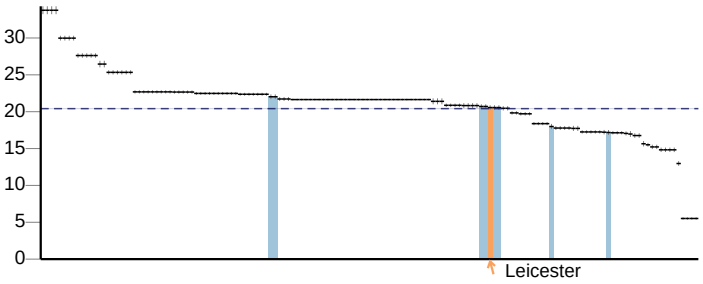
1.10 - Killed and seriously injured (KSI) casualties on England's roads



1.11 - Domestic abuse-related incidents and crimes - current method



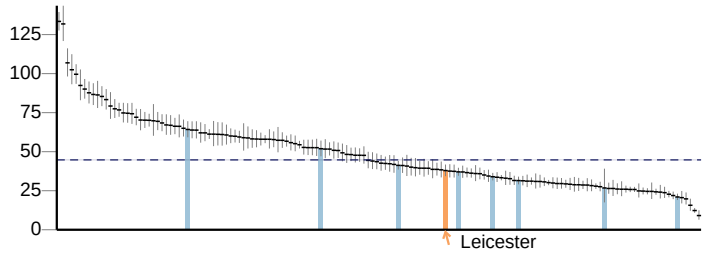
1.11 - Domestic abuse - historic method



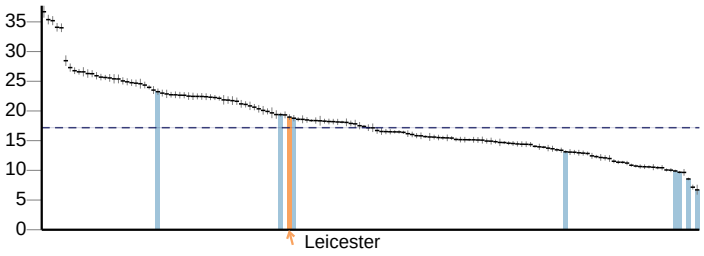
Key England value and confidence interval Leicester Other local authority in East Midlands

Wider determinants of health continued

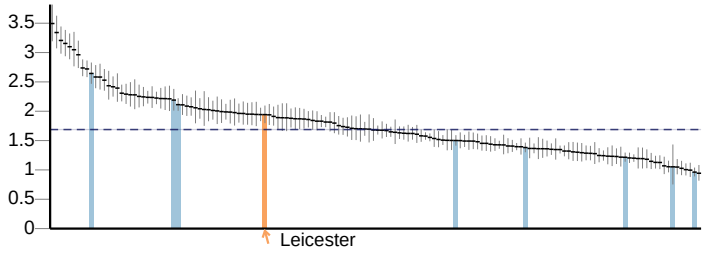
1.12i - Violent crime (including sexual violence) - hospital admissions for violence



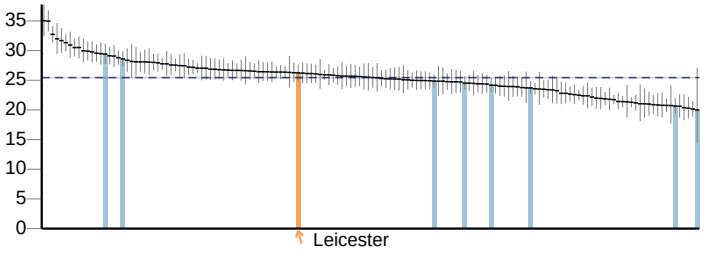
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population



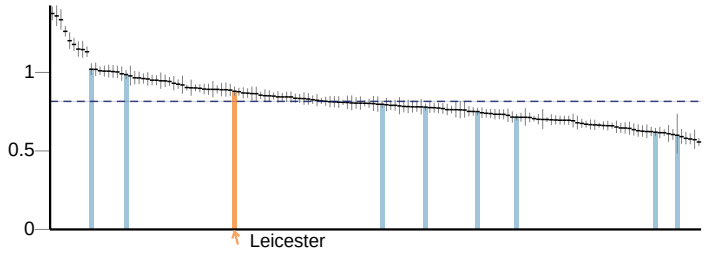
1.12iii- Violent crime (including sexual violence) - rate of sexual offences per 1,000 population



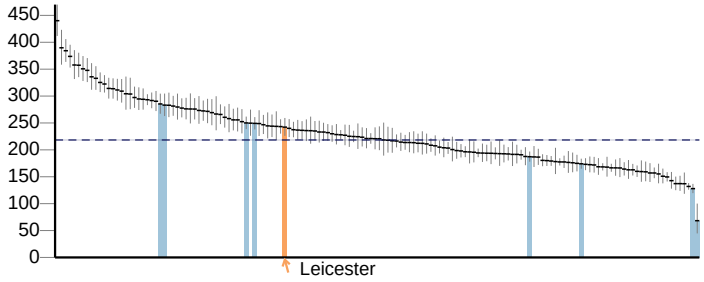
1.13i - Re-offending levels - percentage of offenders who re-offend



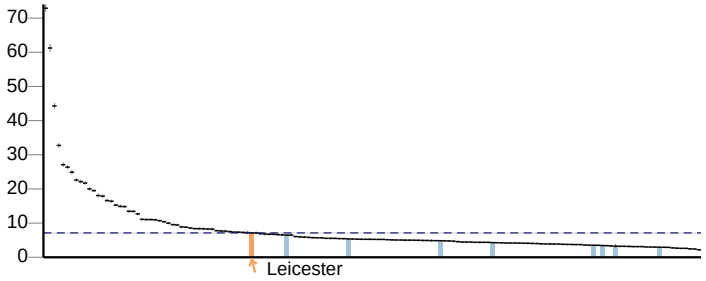
1.13ii - Re-offending levels - average number of re-offences per offender



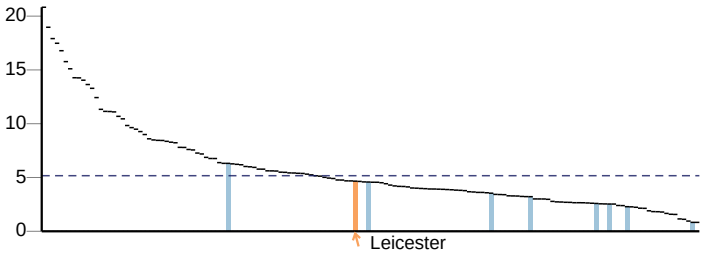
1.13iii - First time offenders



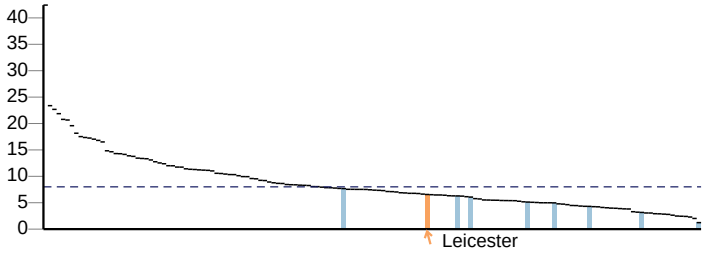
1.14i - The rate of complaints about noise



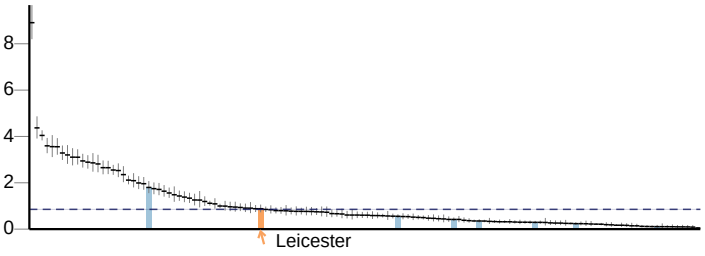
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime



1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time



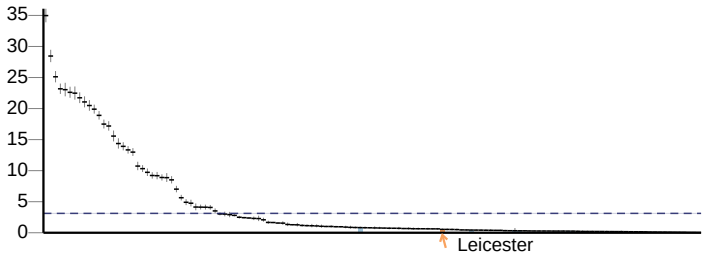
1.15i - Statutory homelessness - Eligible homeless people not in priority need



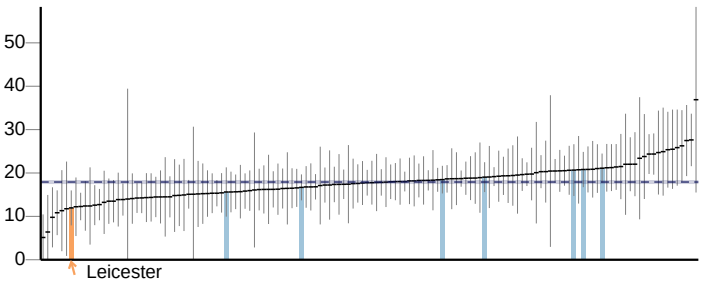
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Wider determinants of health continued

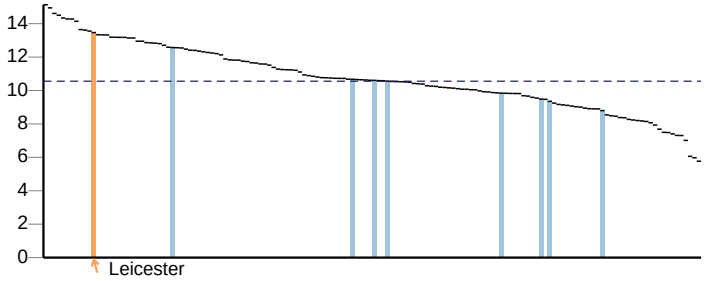
1.15ii - Statutory homelessness - households in temporary accommodation



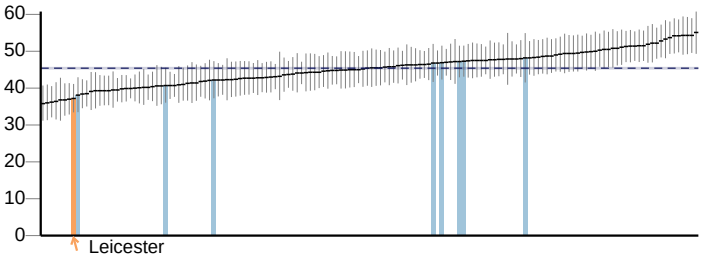
1.16 - Utilisation of outdoor space for exercise/health reasons



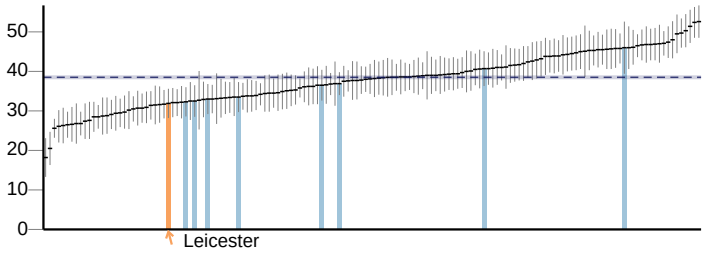
1.17 - Fuel poverty



1.18i - Social Isolation: percentage of adult social care users who have as much social contact as they would like



1.18ii - Social Isolation: percentage of adult carers who have as much social contact as they would like

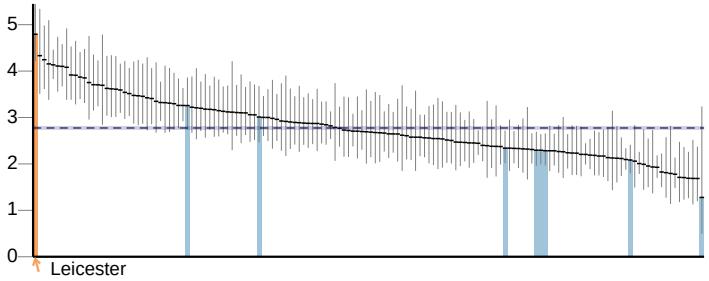


Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

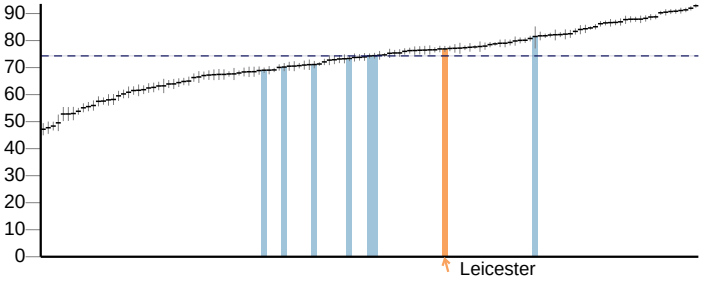
Leicester

Health improvement

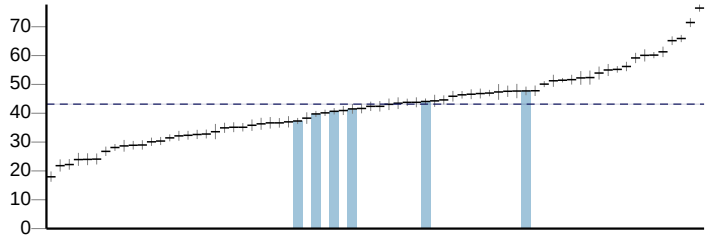
2.01 - Low birth weight of term babies



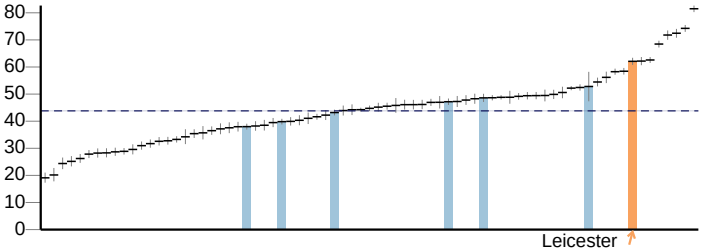
2.02i - Breastfeeding - breastfeeding initiation



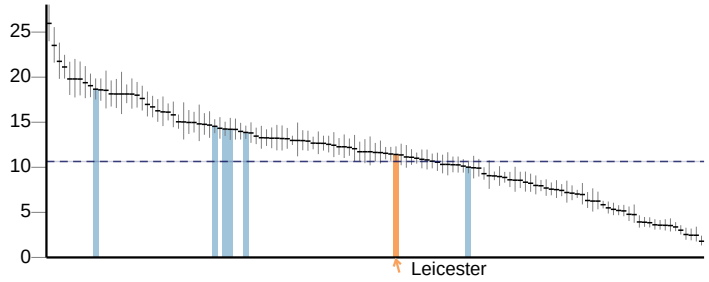
2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - current method



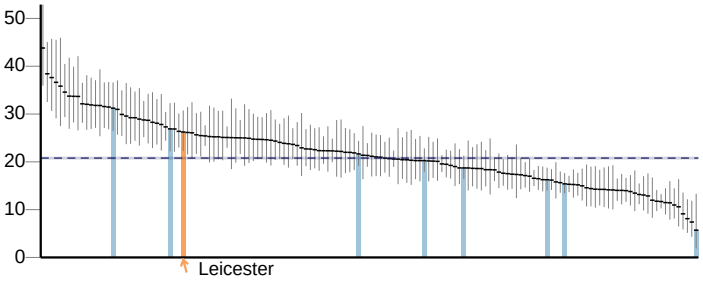
2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - historical method



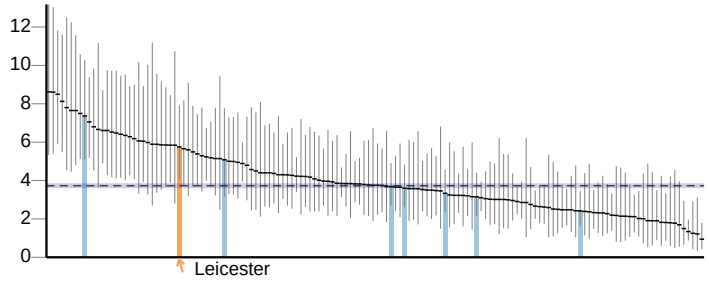
2.03 - Smoking status at time of delivery



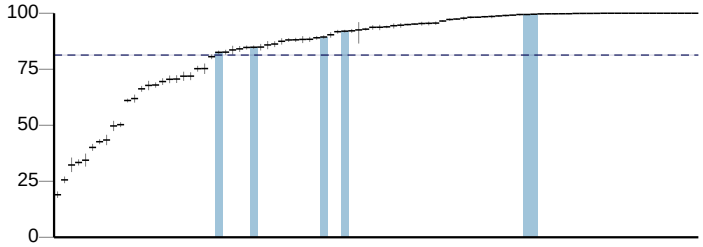
2.04 - Under 18 conceptions



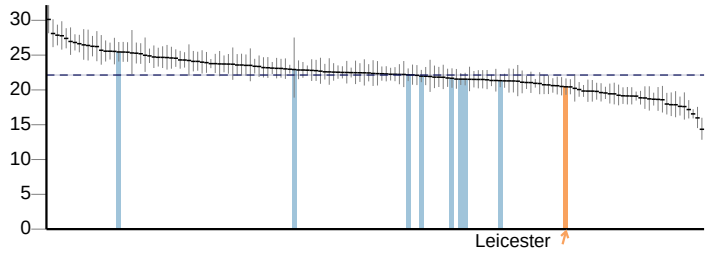
2.04 - Under 18 conceptions: conceptions in those aged under 16



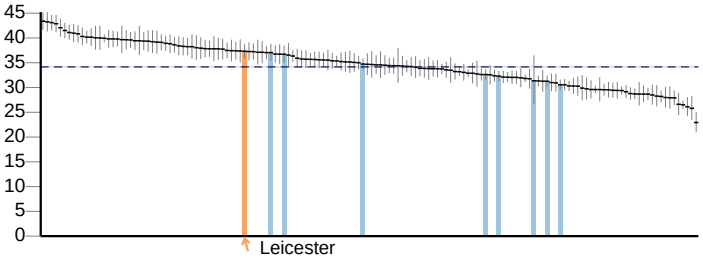
2.05ii - Proportion of children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review



2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds



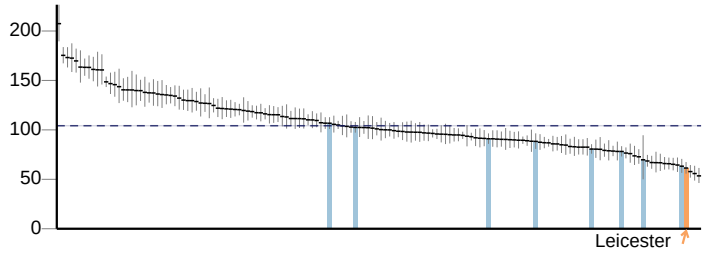
2.06ii - Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds



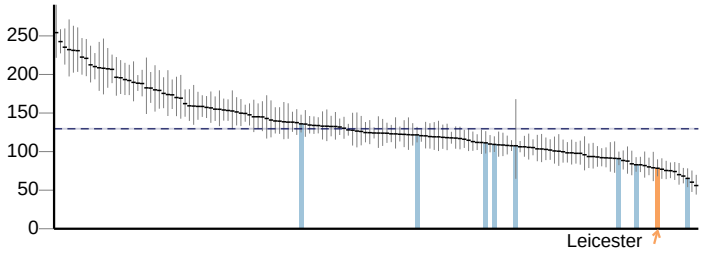
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Health improvement continued

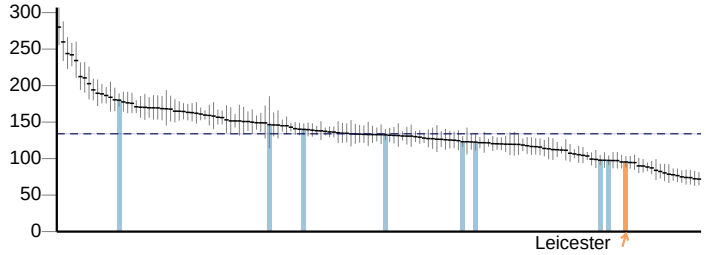
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)



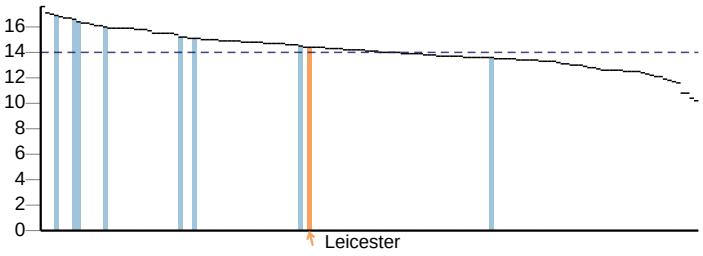
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)



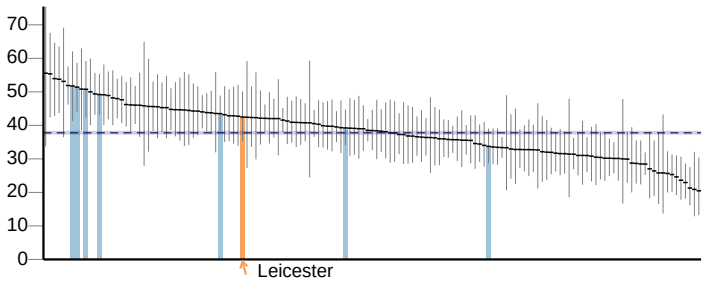
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)



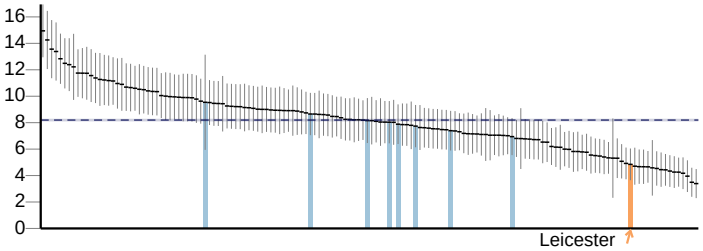
2.08i - Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March



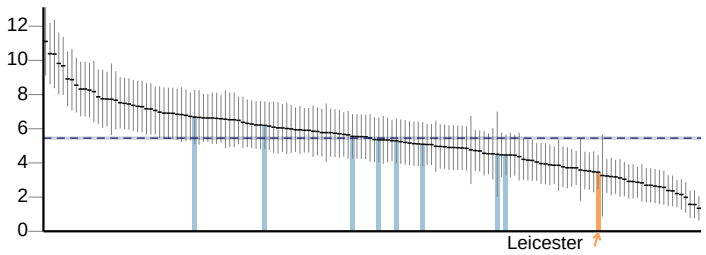
2.08ii - Percentage of children where there is a cause for concern



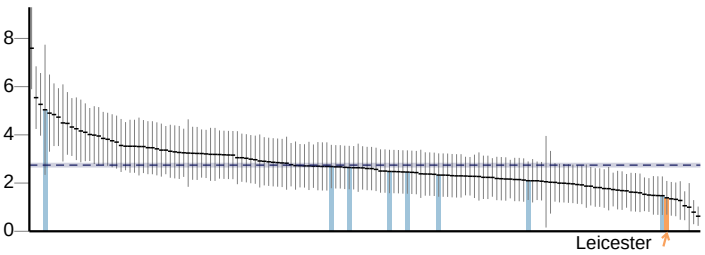
2.09i - Smoking prevalence at age 15 - current smokers (WAY survey)



2.09ii - Smoking prevalence at age 15 - regular smokers (WAY survey)



2.09iii - Smoking prevalence at age 15 - occasional smokers (WAY survey)



2.09iv - Smoking prevalence at age 15 years - regular smokers (SDD survey)

No data

2.09v - Smoking prevalence at age 15 years - occasional smokers (SDD survey)

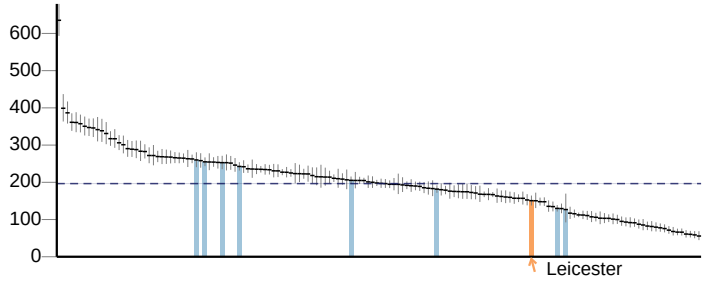
No data

Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

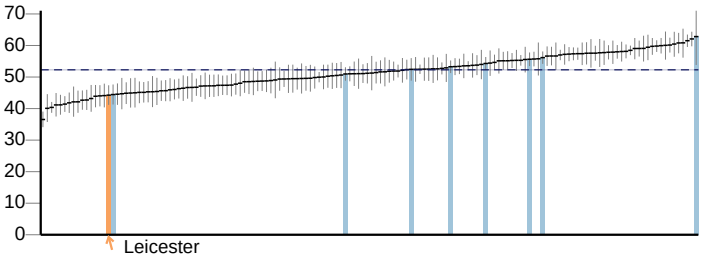
Leicester

Health improvement continued

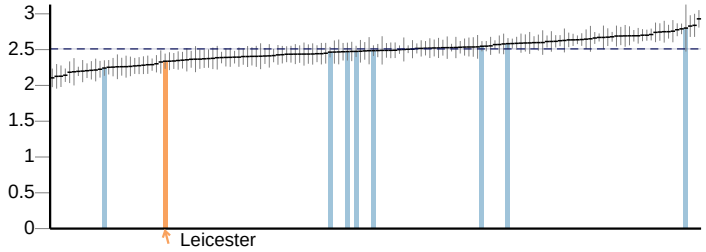
2.10ii - Emergency Hospital Admissions for Intentional Self-Harm



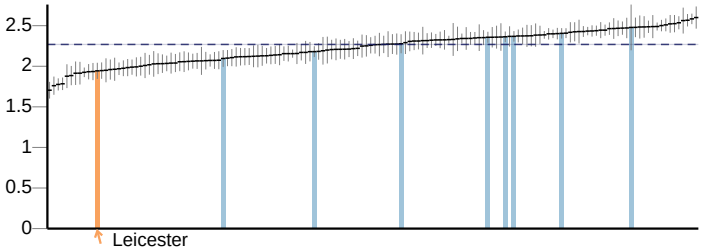
2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)



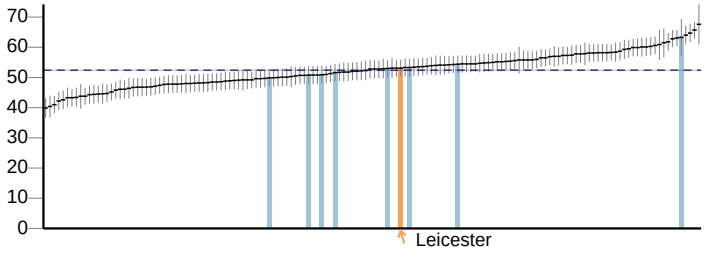
2.11ii - Average number of portions of fruit consumed daily (adults)



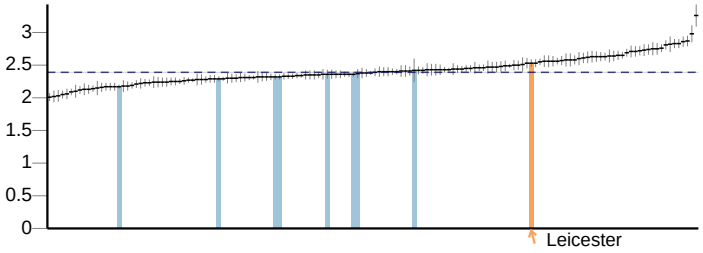
2.11iii - Average number of portions of vegetables consumed daily (adults)



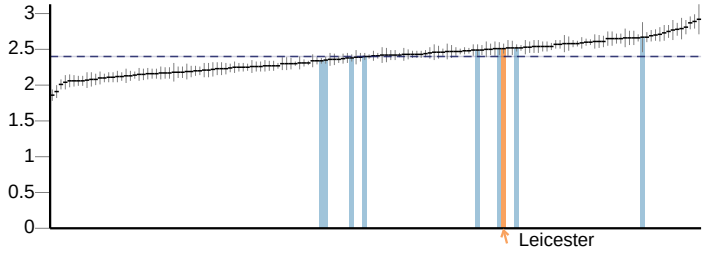
2.11iv - Proportion of the population meeting the recommended "5-a-day" at age 15



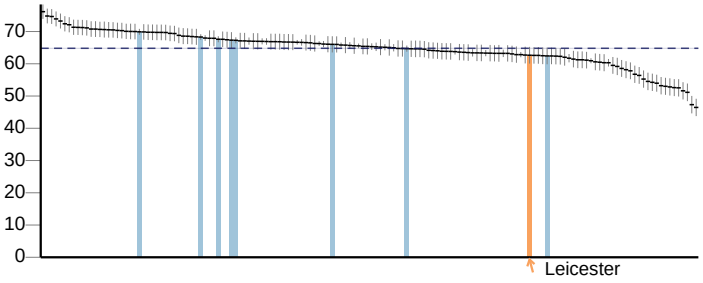
2.11v - Average number of portions of fruit consumed daily at age 15 (WAY survey)



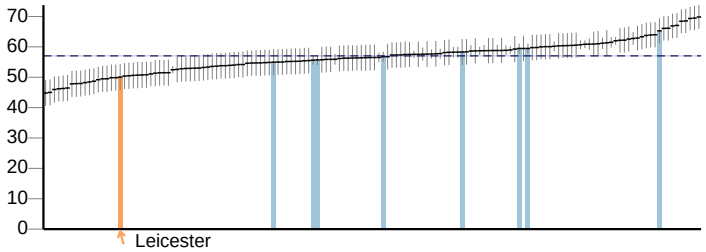
2.11vi - Average number of portions of vegetables consumed daily at age 15 (WAY survey)



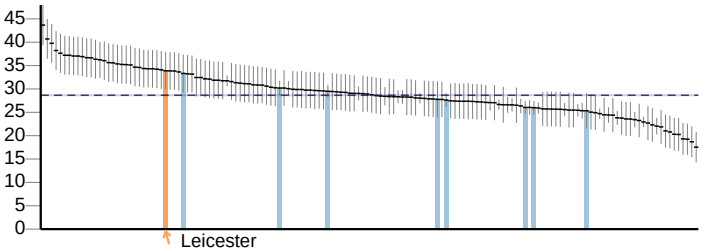
2.12 - Excess weight in Adults



2.13i - Percentage of physically active and inactive adults - active adults



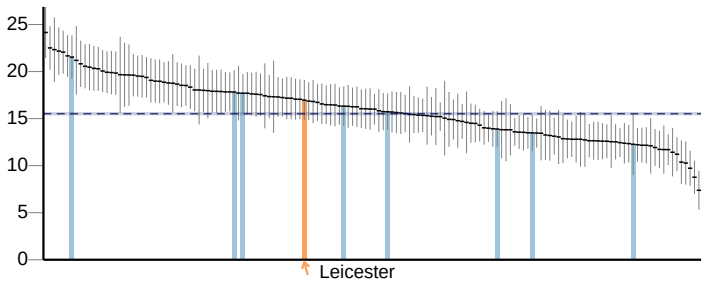
2.13ii - Percentage of physically active and inactive adults - inactive adults



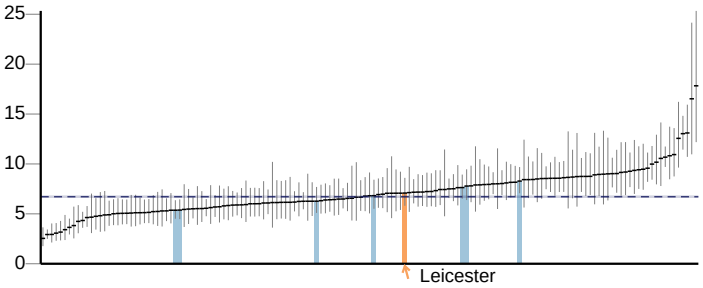
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Health improvement continued

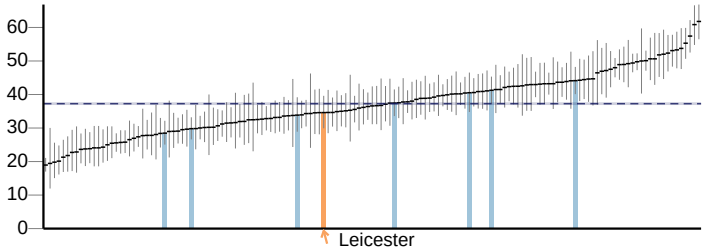
2.14 - Smoking Prevalence in adults - current smokers (APS)



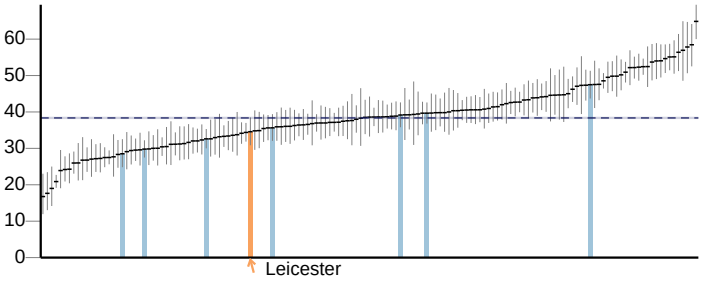
2.15i - Successful completion of drug treatment - opiate users



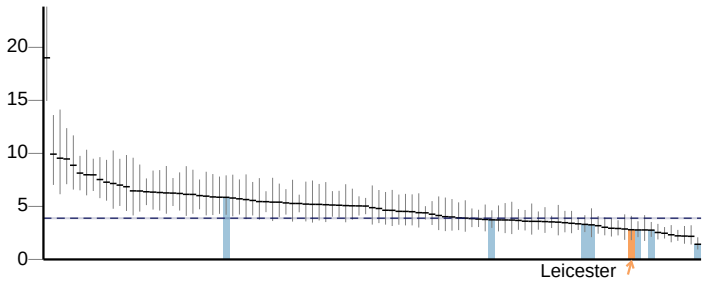
2.15ii - Successful completion of drug treatment - non-opiate users



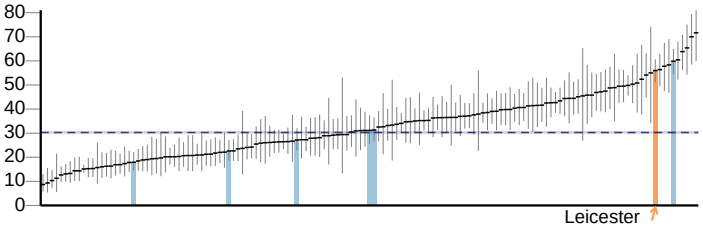
2.15iii - Successful completion of alcohol treatment



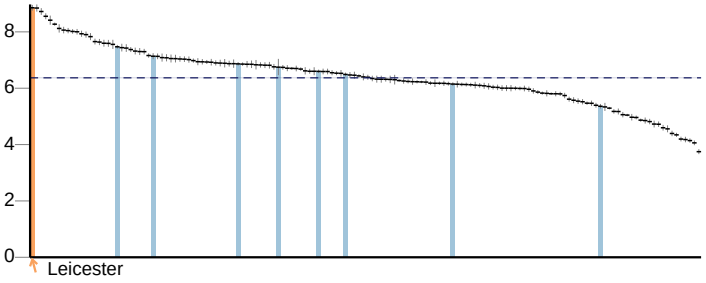
2.15iv - Deaths from drug misuse



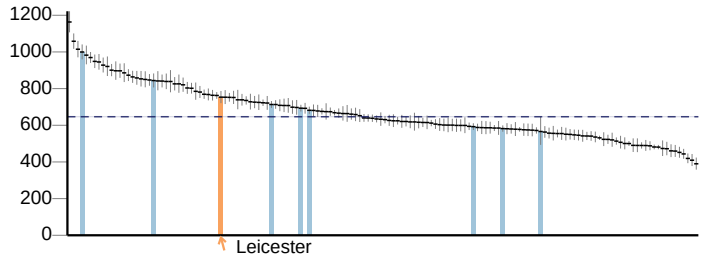
2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison



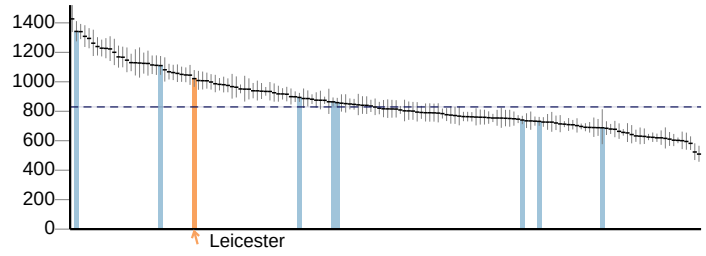
2.17 - Recorded diabetes



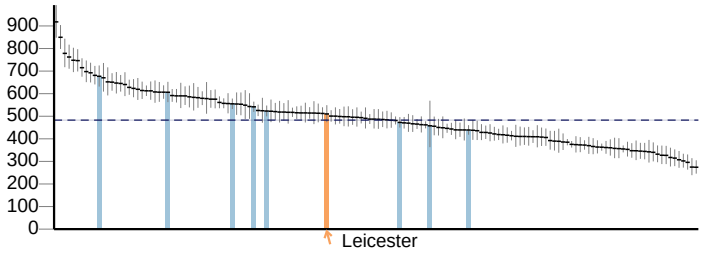
2.18 - Admission episodes for alcohol-related conditions - narrow definition (Persons)



2.18 - Admission episodes for alcohol-related conditions - narrow definition (Male)



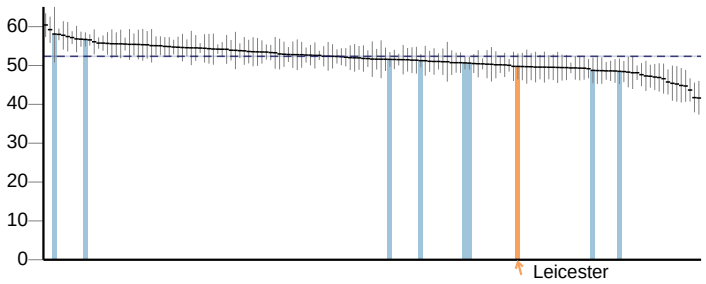
2.18 - Admission episodes for alcohol-related conditions - narrow definition (Female)



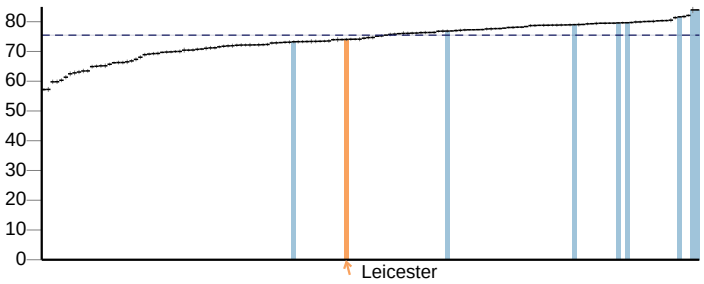
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Health improvement continued

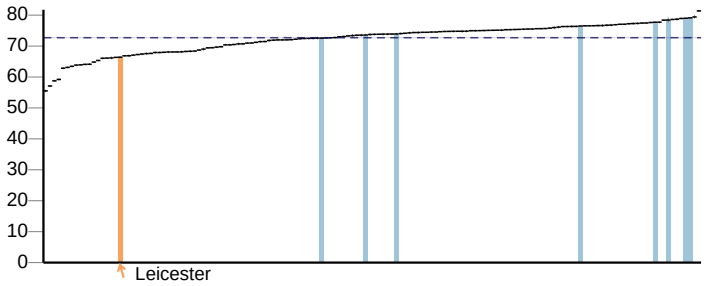
2.19 - Cancer diagnosed at early stage (experimental statistics)



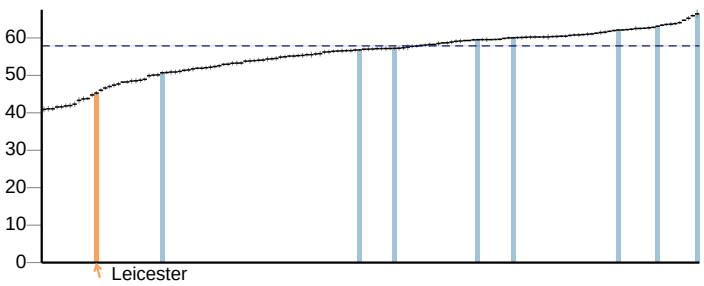
2.20i - Cancer screening coverage - breast cancer



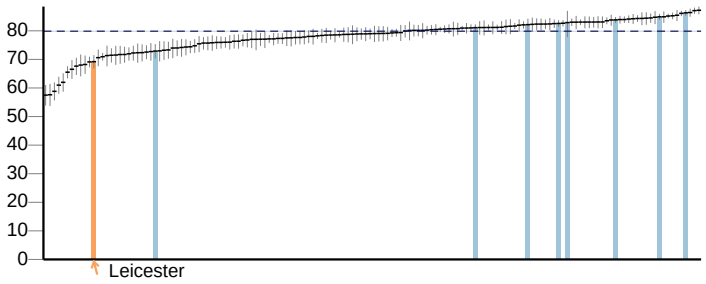
2.20ii - Cancer screening coverage - cervical cancer



2.20iii - Cancer screening coverage - bowel cancer



2.20iv - Abdominal Aortic Aneurysm Screening - Coverage



2.20v - Diabetic eye screening - uptake

No data

2.20vii - Infectious Diseases in Pregnancy Screening - HIV Coverage

No data

2.20viii - Infectious Diseases in Pregnancy Screening - Syphilis Coverage

No data

2.20ix - Infectious Diseases in Pregnancy Screening - Hepatitis B Coverage

No data

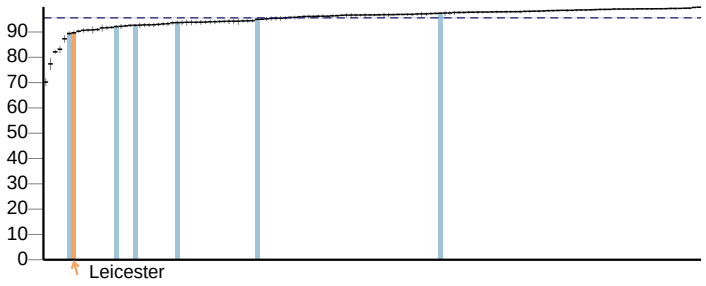
2.20x - Sickle Cell and Thalassaemia Screening - Coverage

No data

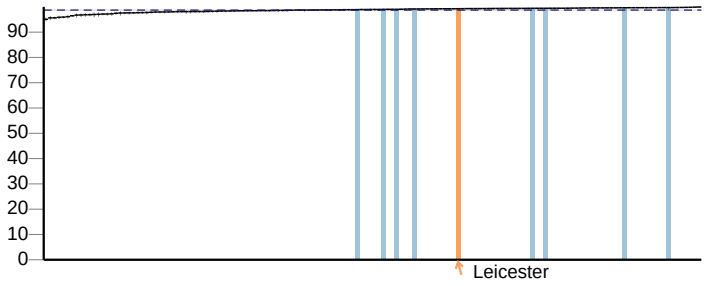
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Health improvement continued

2.20xi - Newborn Blood Spot Screening - Coverage



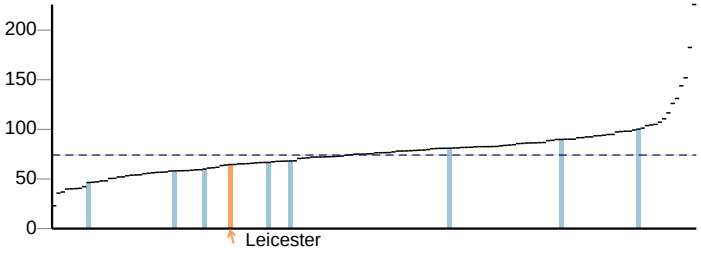
2.20xii - Newborn Hearing Screening - Coverage



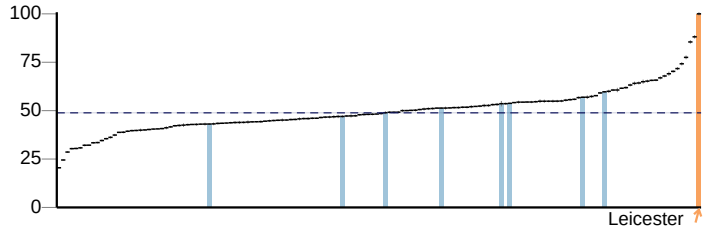
2.20xiii - Newborn and Infant Physical Examination Screening - Coverage

No data

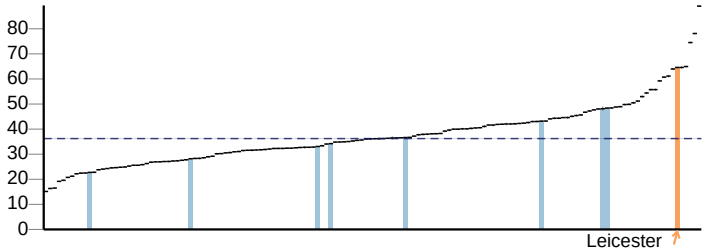
2.22iii - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check



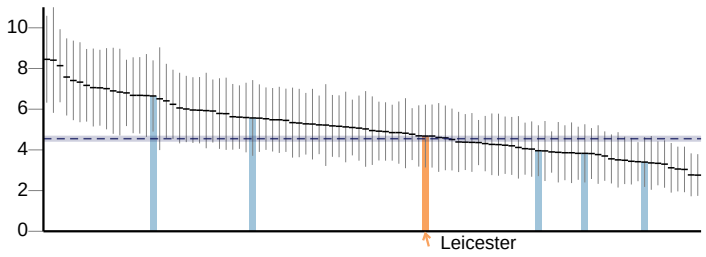
2.22iv - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check



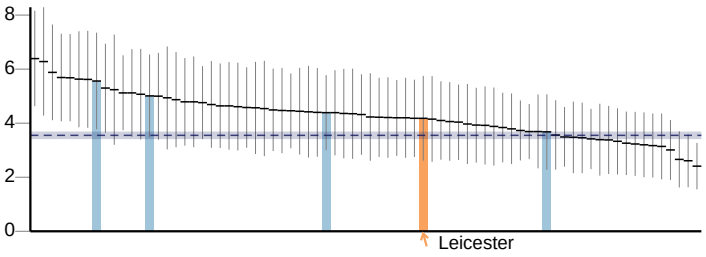
2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check



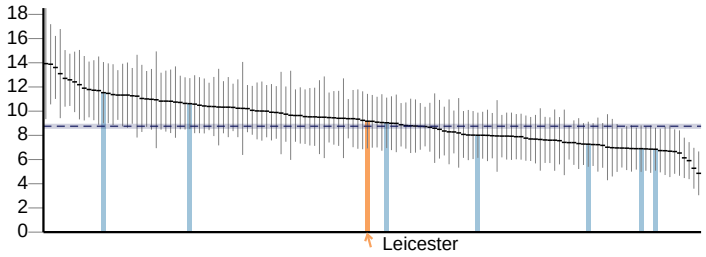
2.23i - Self-reported wellbeing - people with a low satisfaction score



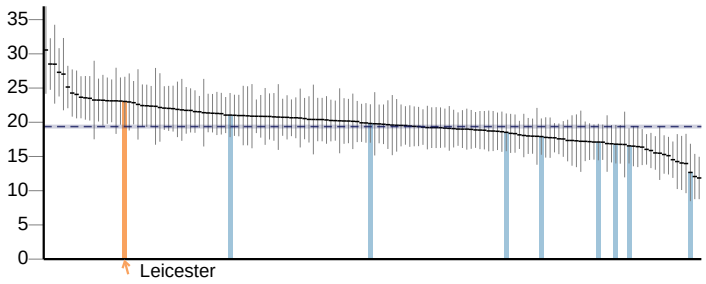
2.23ii - Self-reported wellbeing - people with a low worthwhile score



2.23iii - Self-reported wellbeing - people with a low happiness score



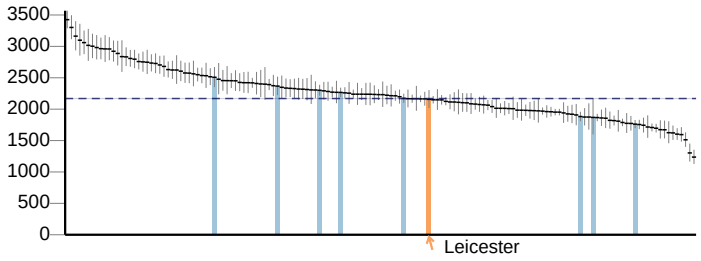
2.23iv - Self-reported wellbeing - people with a high anxiety score



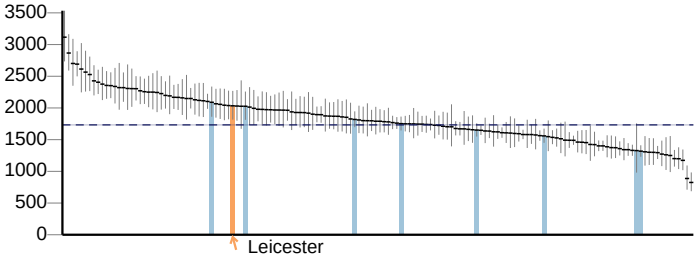
Key England value and confidence interval Leicester Other local authority in East Midlands

Health improvement continued

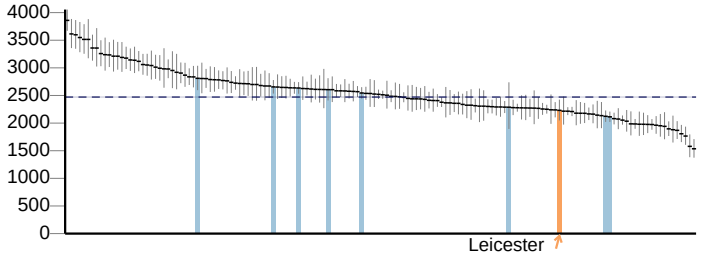
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Persons)



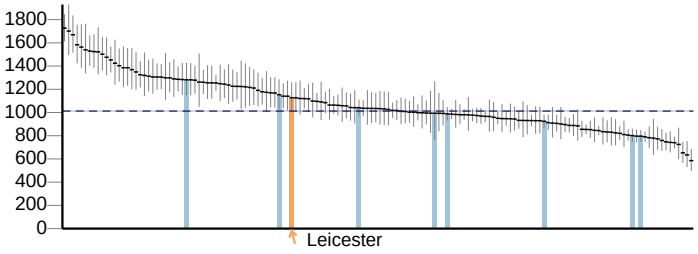
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Male)



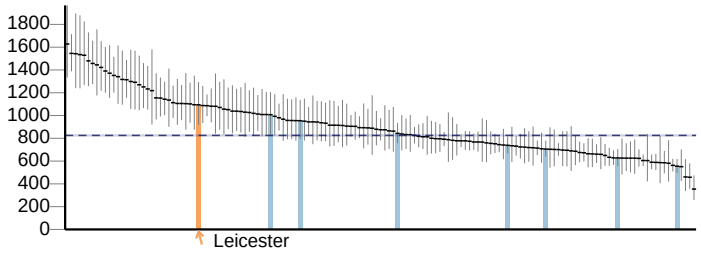
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Female)



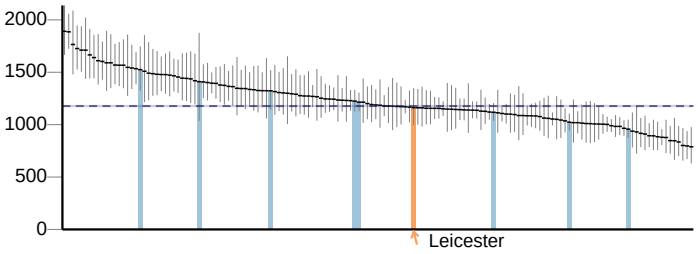
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Persons)



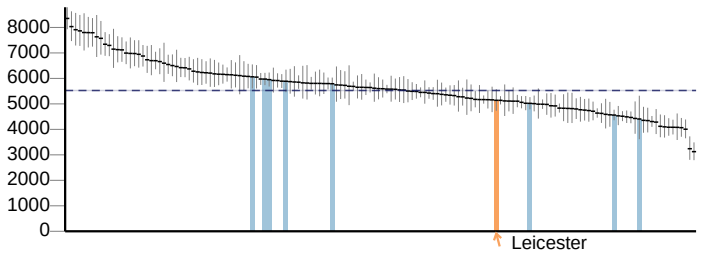
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Male)



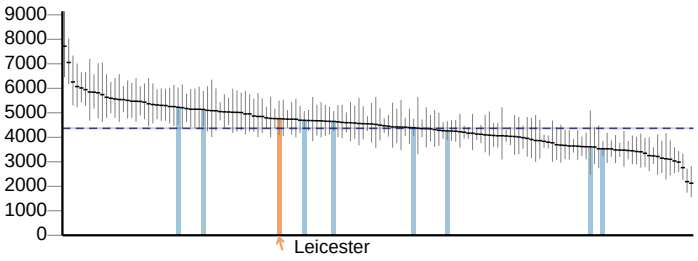
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Female)



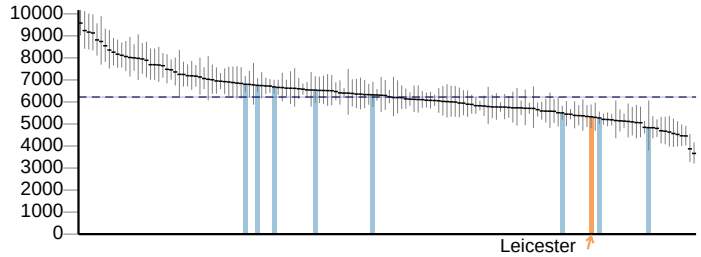
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Persons)



2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Male)



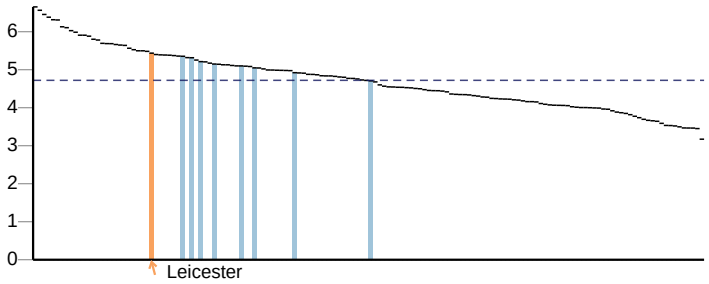
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Female)



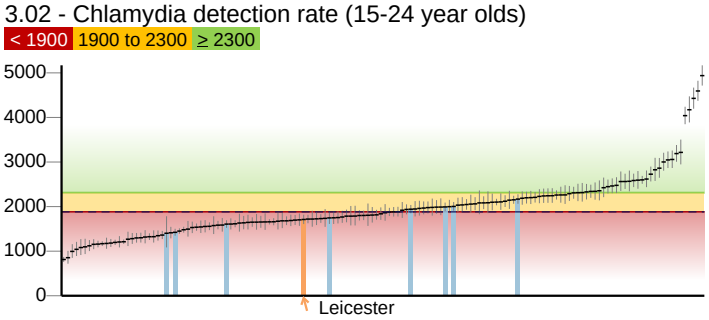
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Health protection

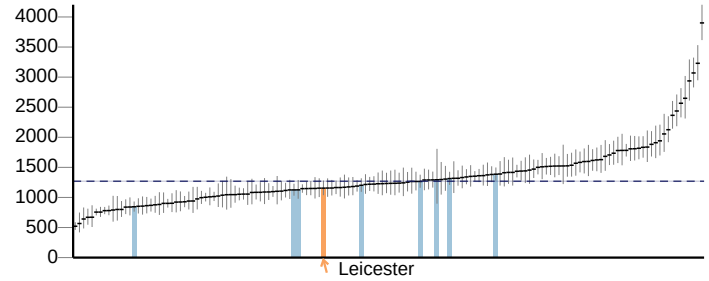
3.01 - Fraction of mortality attributable to particulate air pollution



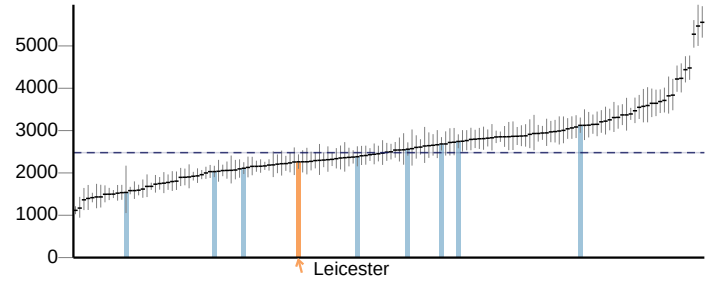
3.02 - Chlamydia detection rate (15-24 year olds)



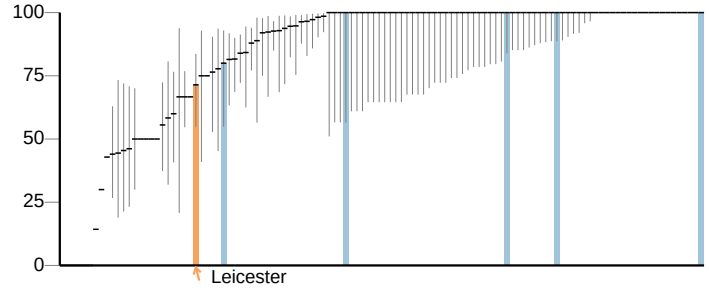
3.02 - Chlamydia detection rate (15-24 year olds) (Male)



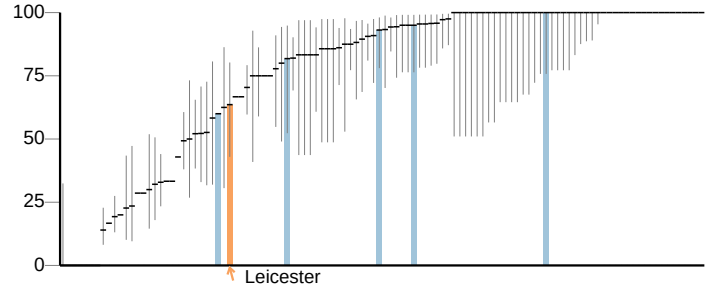
3.02 - Chlamydia detection rate (15-24 year olds) (Female)



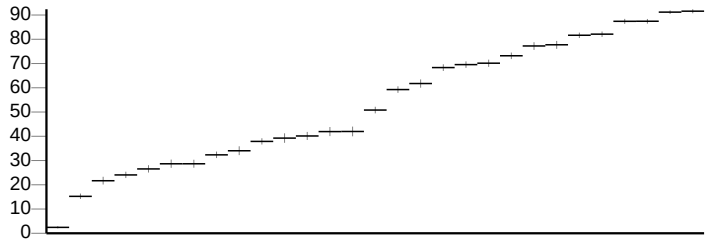
3.03i - Population vaccination coverage - Hepatitis B (1 year old)



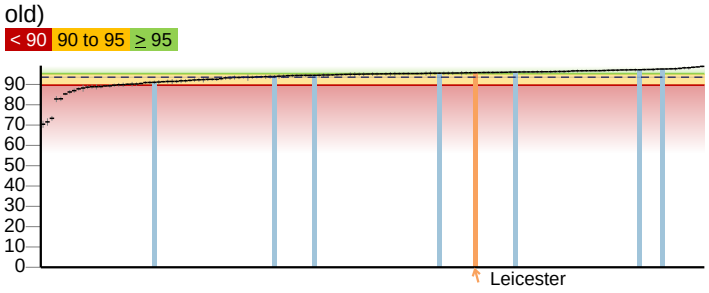
3.03i - Population vaccination coverage - Hepatitis B (2 years old)



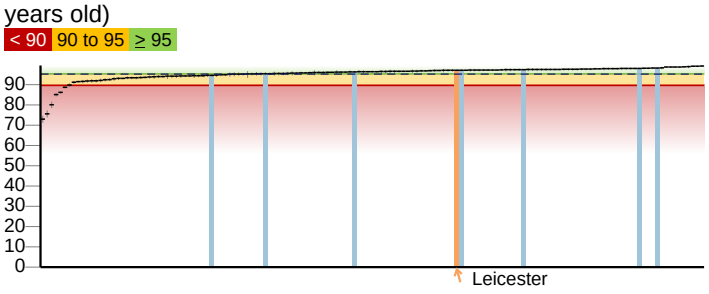
3.03ii - Population vaccination coverage - BCG - areas offering universal BCG only



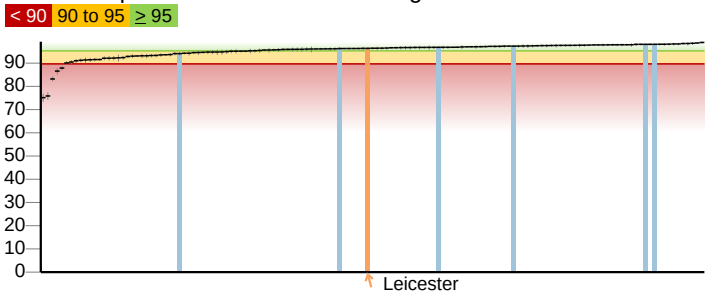
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)



3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)



3.03iv - Population vaccination coverage - MenC



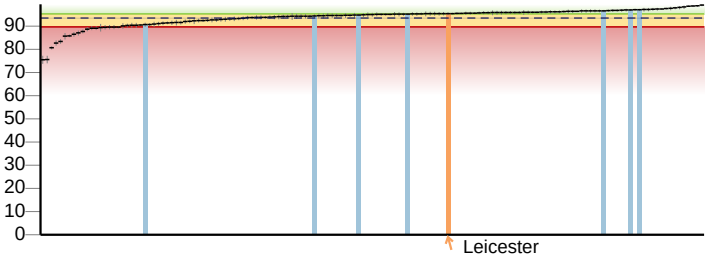
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Leicester

Health protection continued

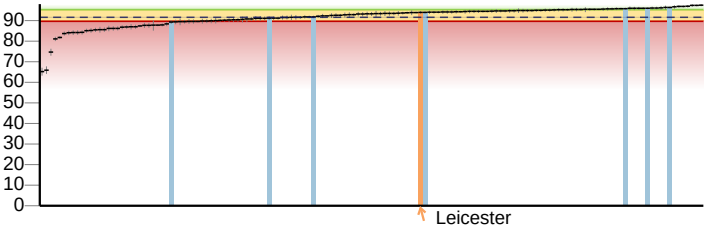
3.03v - Population vaccination coverage - PCV

< 90 | 90 to 95 | ≥ 95



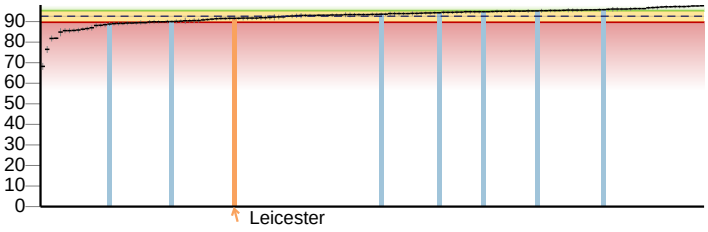
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)

< 90 | 90 to 95 | ≥ 95



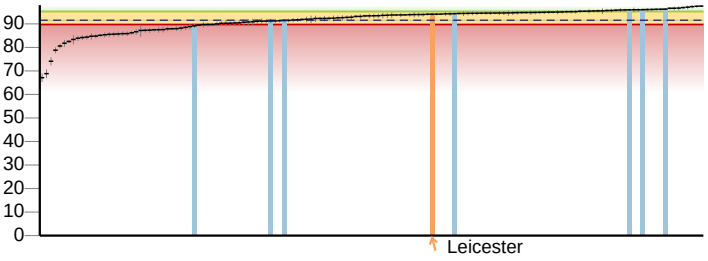
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)

< 90 | 90 to 95 | ≥ 95



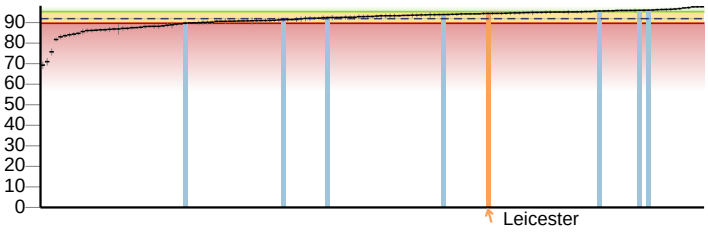
3.03vii - Population vaccination coverage - PCV booster

< 90 | 90 to 95 | ≥ 95



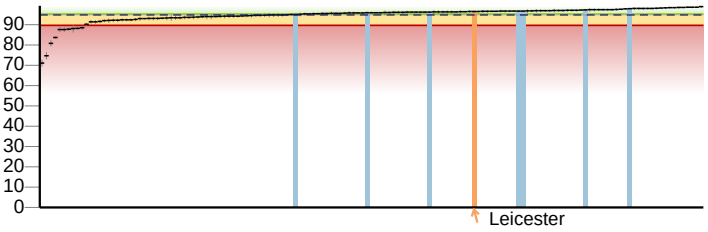
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)

< 90 | 90 to 95 | ≥ 95



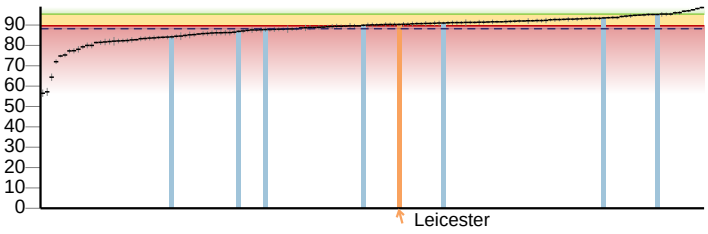
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)

< 90 | 90 to 95 | ≥ 95



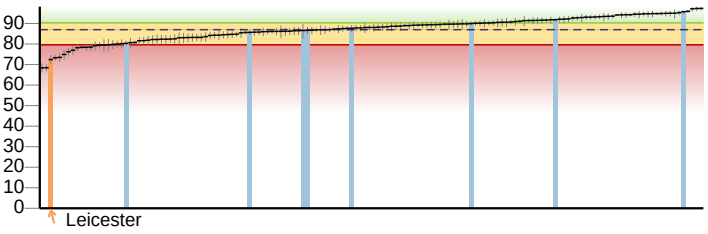
3.03x - Population vaccination coverage - MMR for two doses (5 years old)

< 90 | 90 to 95 | ≥ 95



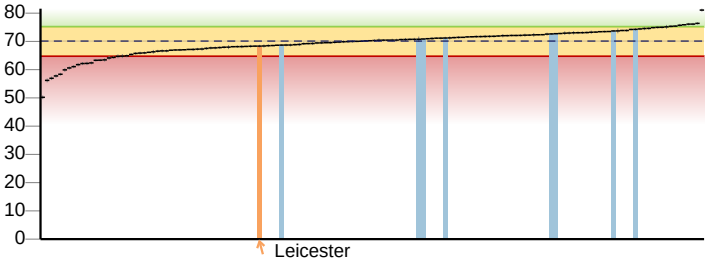
3.03xii - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old)

< 80 | 80 to 90 | ≥ 90



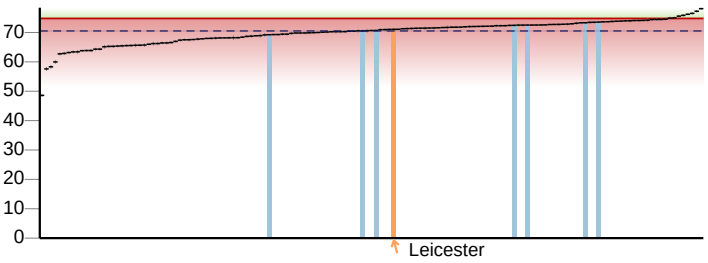
3.03xiii - Population vaccination coverage - PPV

< 65 | 65 to 75 | ≥ 75



3.03xiv - Population vaccination coverage - Flu (aged 65+)

< 75 | ≥ 75

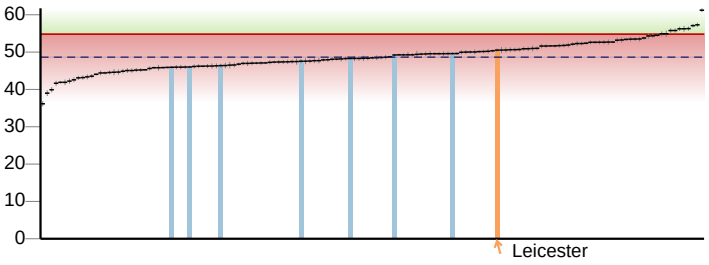


Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Health protection continued

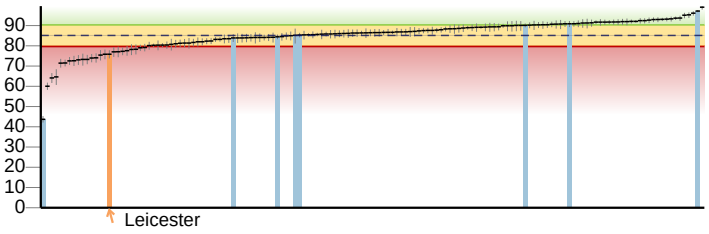
3.03xv - Population vaccination coverage - Flu (at risk individuals)

< 55 ≥ 55



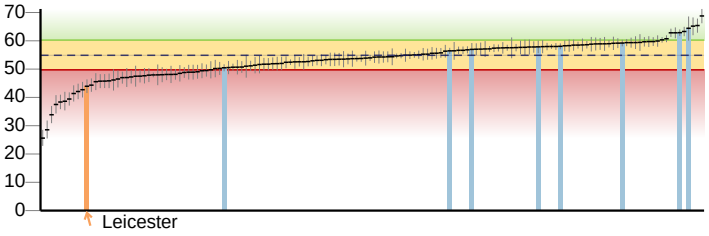
3.03xvi - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old)

< 80 80 to 90 ≥ 90



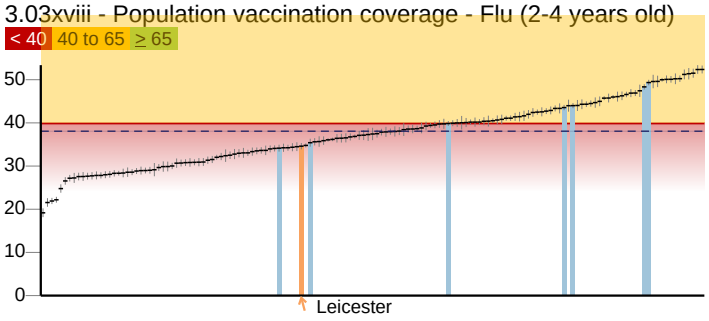
3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old)

< 50 50 to 60 ≥ 60



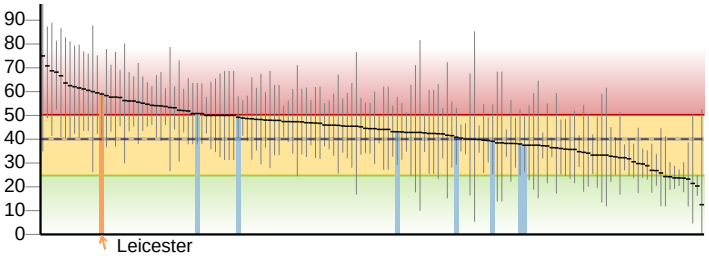
3.03xviii - Population vaccination coverage - Flu (2-4 years old)

< 40 40 to 65 ≥ 65



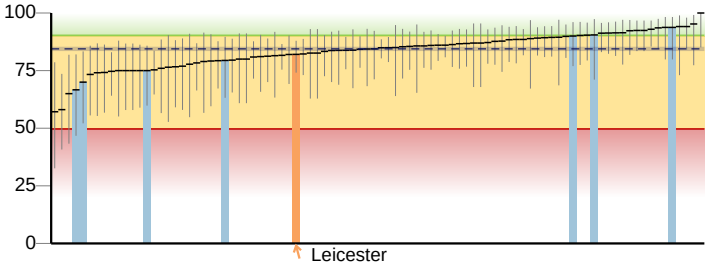
3.04 - HIV late diagnosis

< 25 25 to 50 ≥ 50



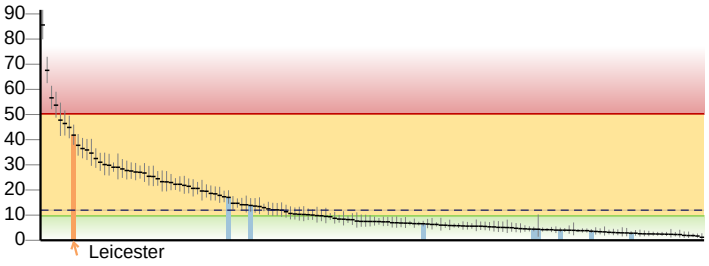
3.05i - Treatment completion for TB

< 50th-percentile ≥50th to <90th ≥90th

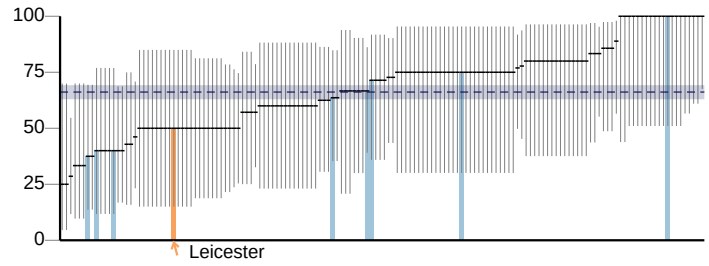


3.05ii - Incidence of TB

> 50th-percentile ≤50th to >10th ≤ 10th

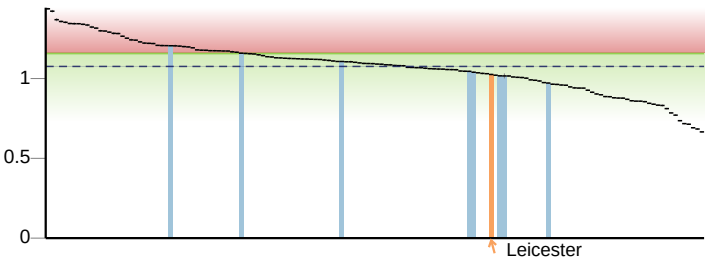


3.06 - NHS organisations with a board approved sustainable development management plan



3.08 - Adjusted antibiotic prescribing in primary care by the NHS

≤ mean England prescribing (2013/14) > mean England prescribing (2013/14)

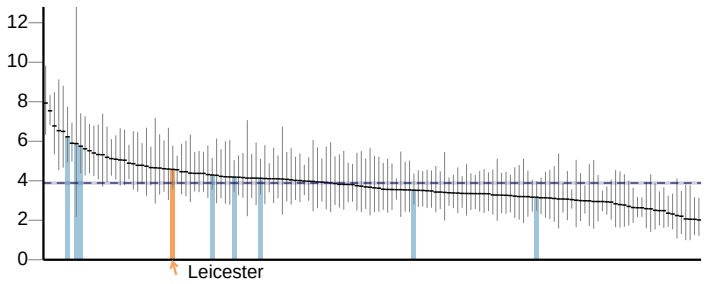


Key England value and confidence interval Leicester Other local authority in East Midlands

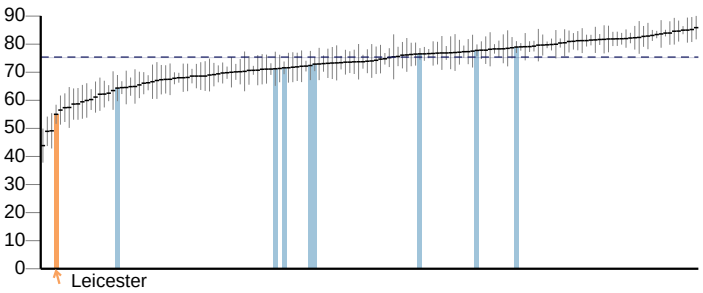
Leicester

Healthcare and premature mortality

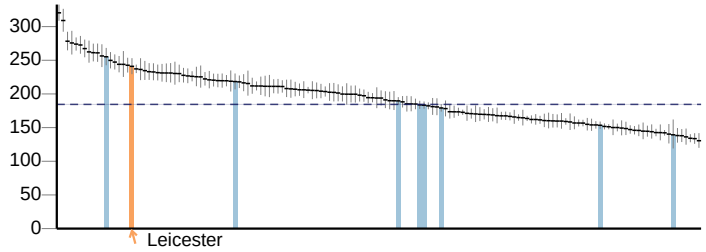
4.01 - Infant mortality



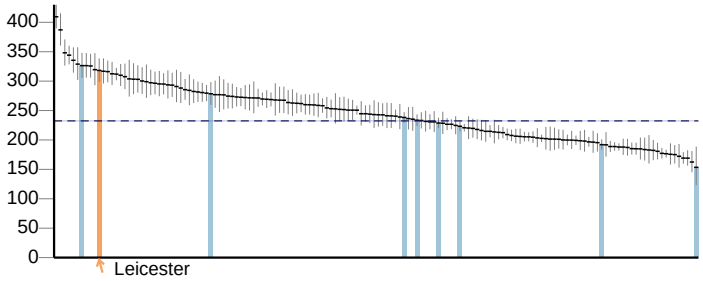
4.02 - Proportion of five year old children free from dental decay



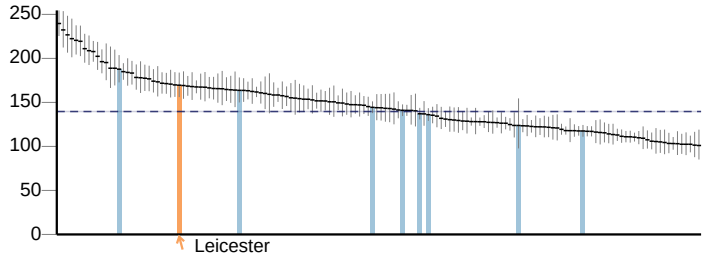
4.03 - Mortality rate from causes considered preventable (Persons)



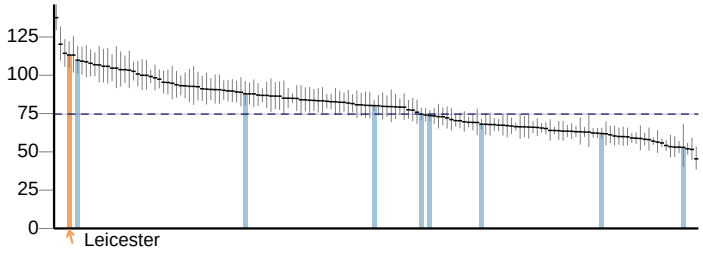
4.03 - Mortality rate from causes considered preventable (Male)



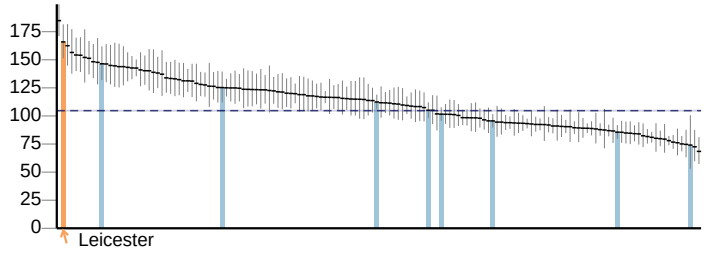
4.03 - Mortality rate from causes considered preventable (Female)



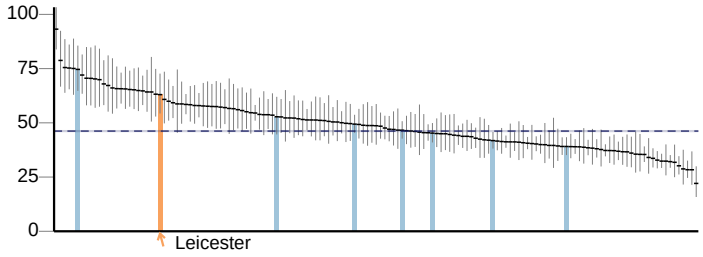
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)



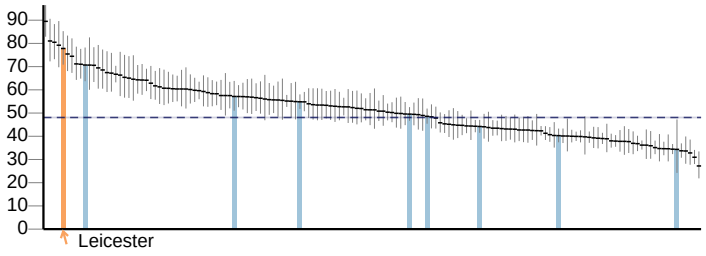
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)



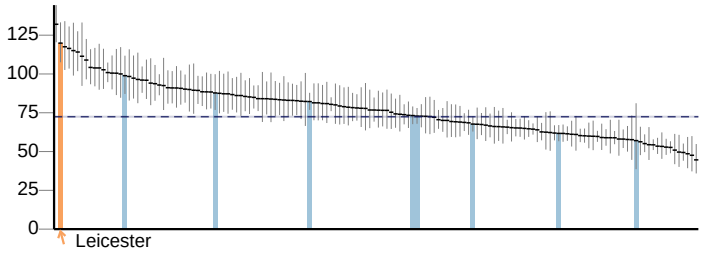
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)



4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)



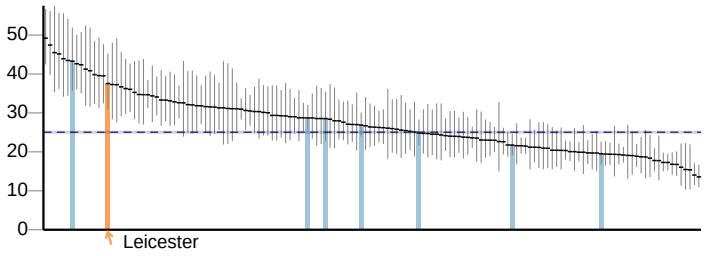
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)



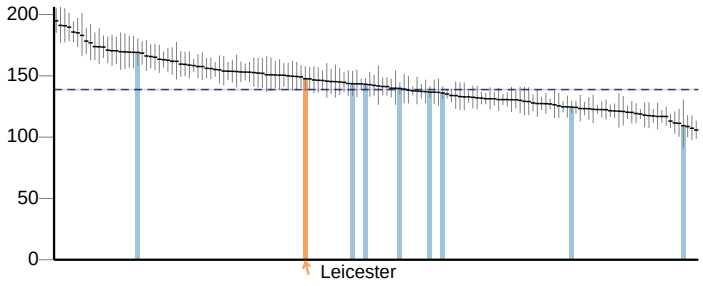
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Healthcare and premature mortality continued

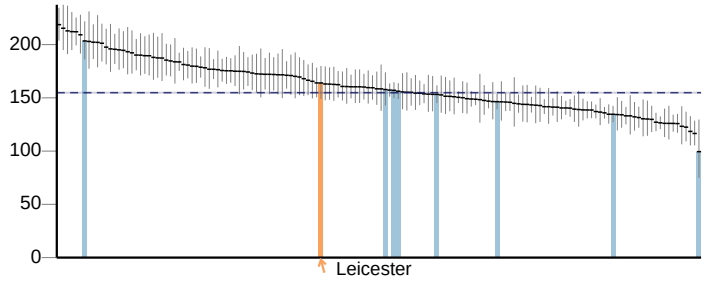
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)



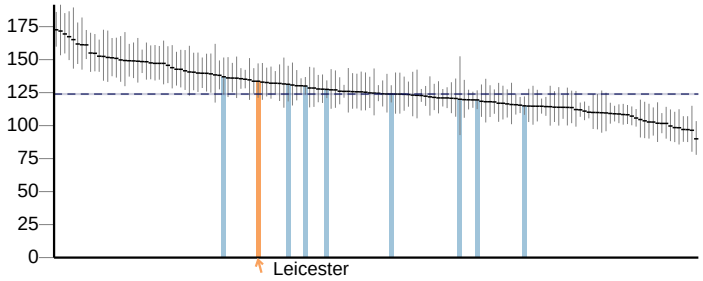
4.05i - Under 75 mortality rate from cancer (Persons)



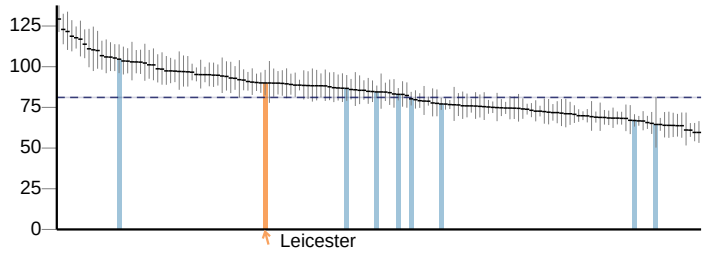
4.05i - Under 75 mortality rate from cancer (Male)



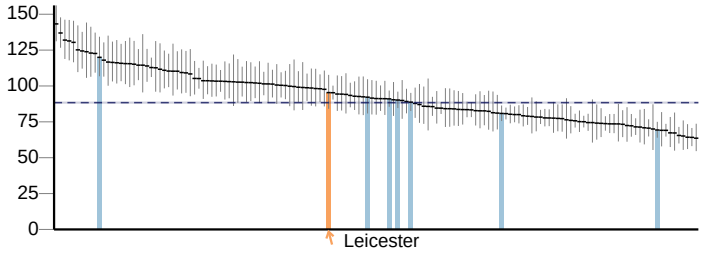
4.05i - Under 75 mortality rate from cancer (Female)



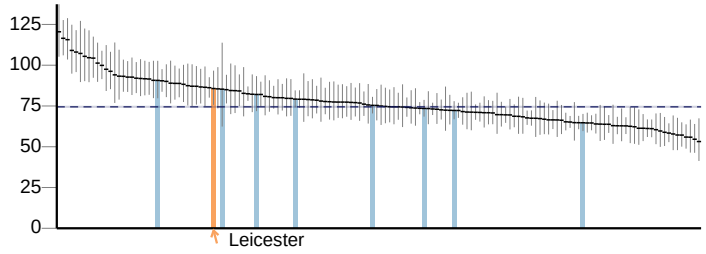
4.05ii - Under 75 mortality rate from cancer considered preventable (Persons)



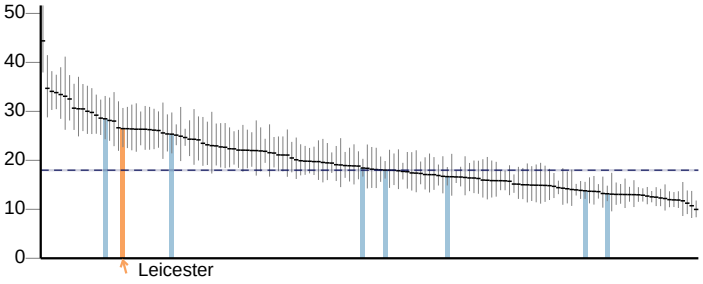
4.05ii - Under 75 mortality rate from cancer considered preventable (Male)



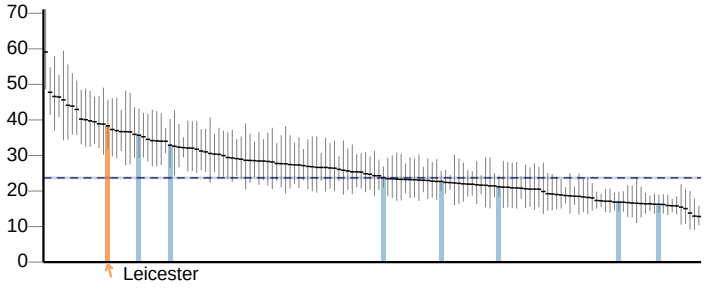
4.05ii - Under 75 mortality rate from cancer considered preventable (Female)



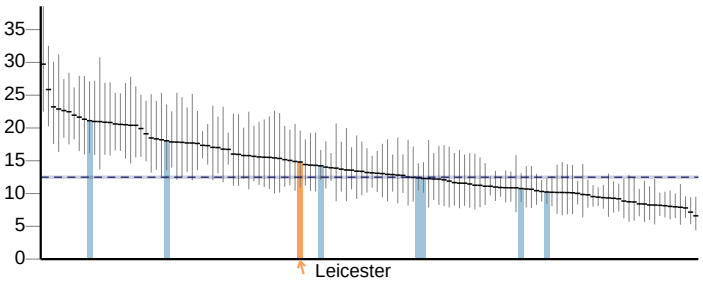
4.06i - Under 75 mortality rate from liver disease (Persons)



4.06i - Under 75 mortality rate from liver disease (Male)



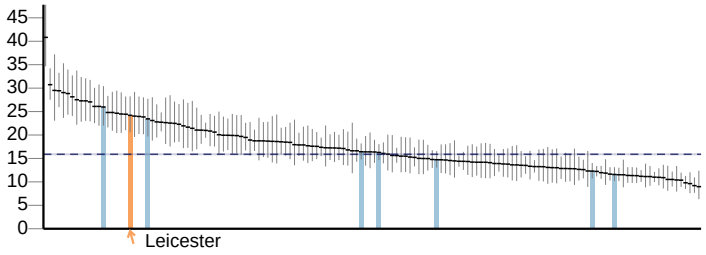
4.06i - Under 75 mortality rate from liver disease (Female)



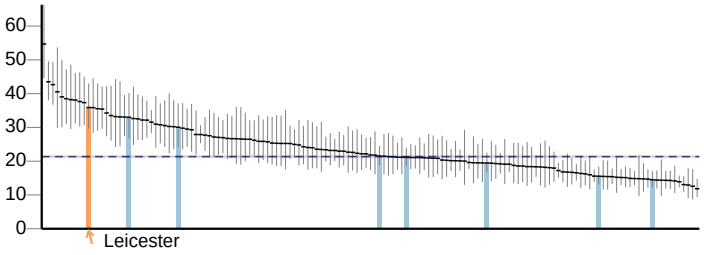
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Healthcare and premature mortality continued

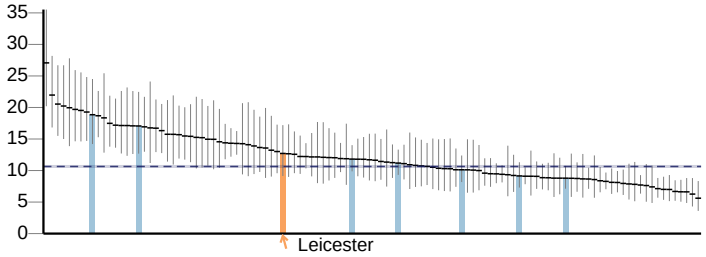
4.06ii - Under 75 mortality rate from liver disease considered preventable (Persons)



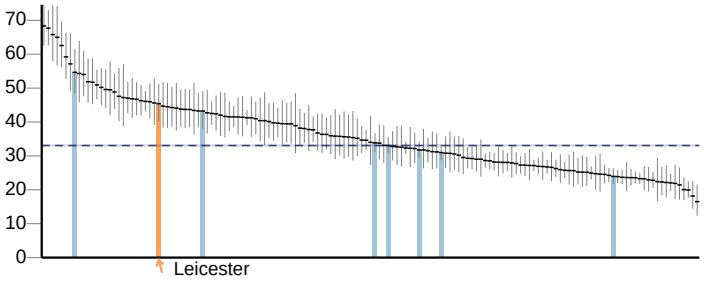
4.06ii - Under 75 mortality rate from liver disease considered preventable (Male)



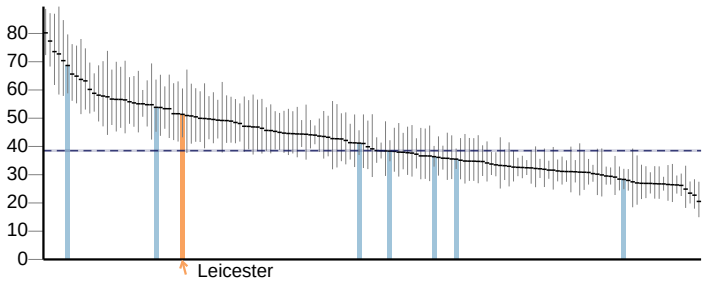
4.06ii - Under 75 mortality rate from liver disease considered preventable (Female)



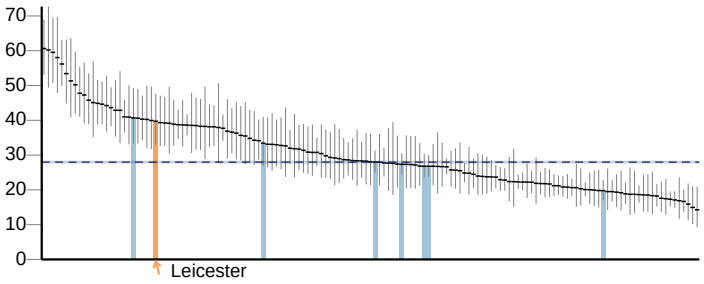
4.07i - Under 75 mortality rate from respiratory disease (Persons)



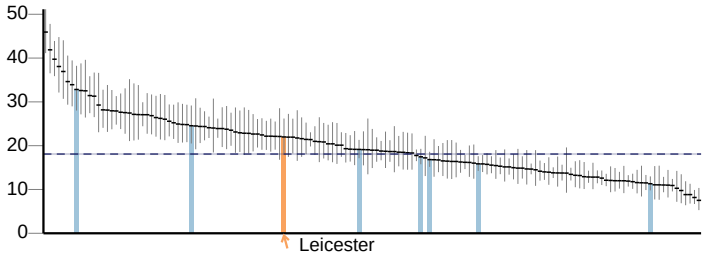
4.07i - Under 75 mortality rate from respiratory disease (Male)



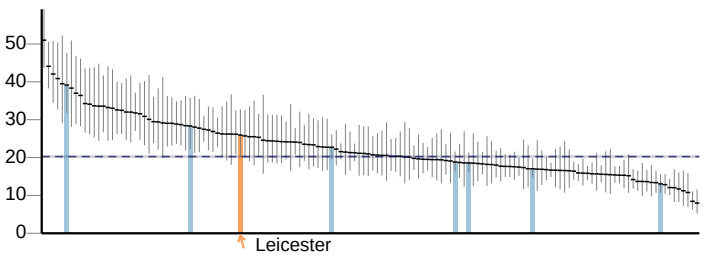
4.07i - Under 75 mortality rate from respiratory disease (Female)



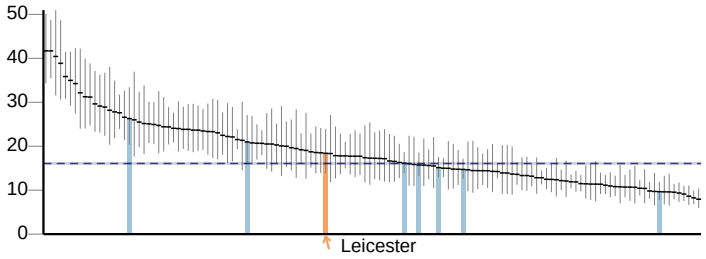
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Persons)



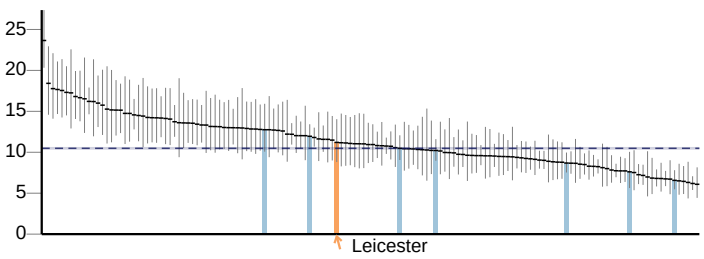
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Male)



4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Female)



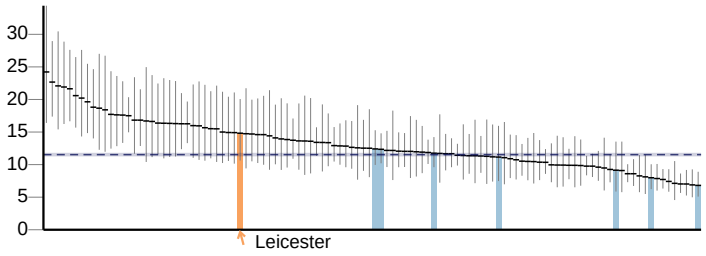
4.08 - Mortality rate from a range of specified communicable diseases, including influenza (Persons)



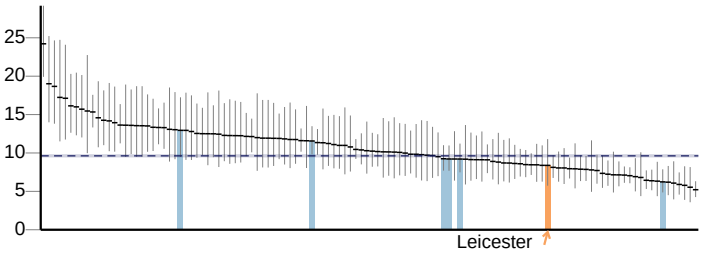
Key England value and confidence interval ↑ Leicester Other local authority in East Midlands

Healthcare and premature mortality continued

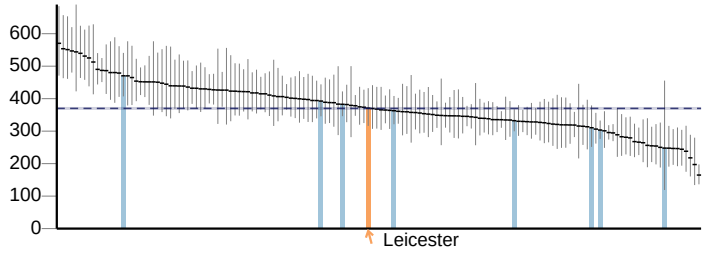
4.08 - Mortality rate from a range of specified communicable diseases, including influenza (Male)



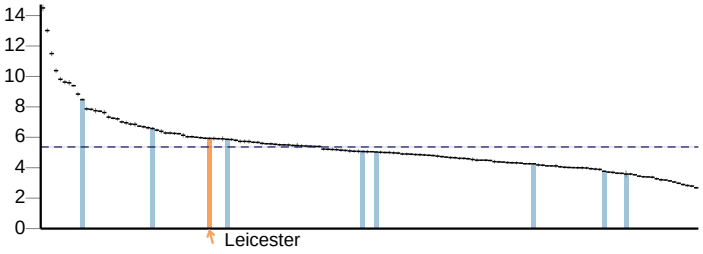
4.08 - Mortality rate from a range of specified communicable diseases, including influenza (Female)



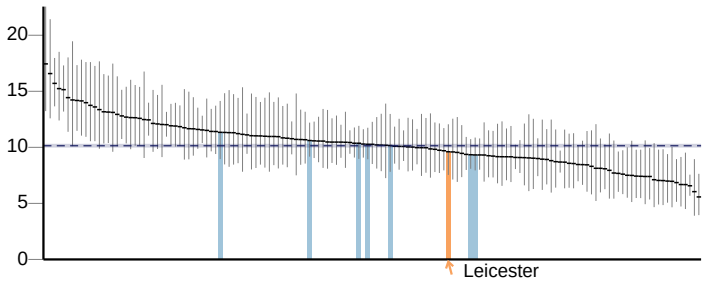
4.09i - Excess under 75 mortality rate in adults with serious mental illness



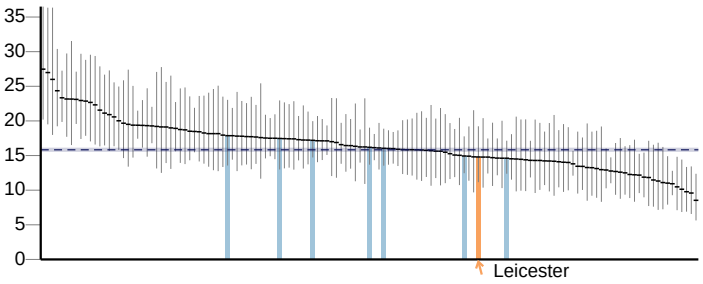
4.09ii - Proportion of adults in the population in contact with secondary mental health services



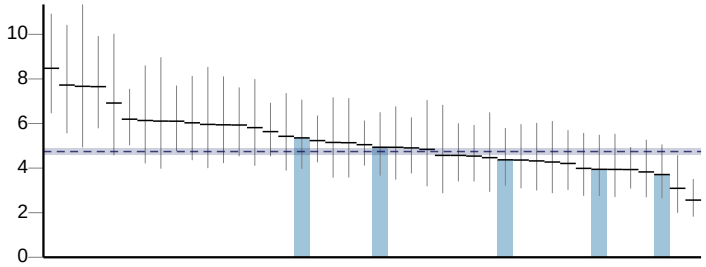
4.10 - Suicide rate (Persons)



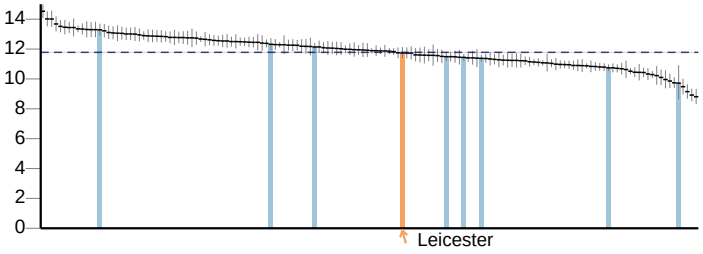
4.10 - Suicide rate (Male)



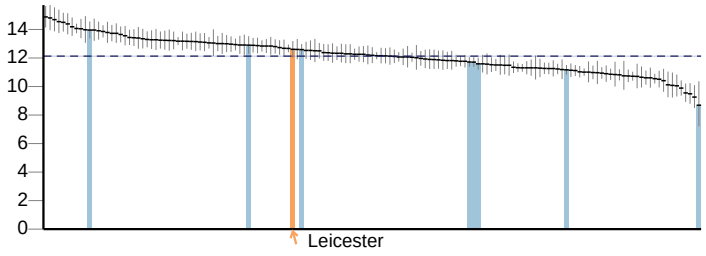
4.10 - Suicide rate (Female)



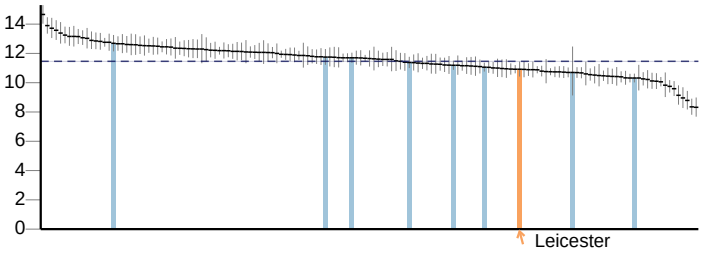
4.11 - Emergency readmissions within 30 days of discharge from hospital (Persons)



4.11 - Emergency readmissions within 30 days of discharge from hospital (Male)



4.11 - Emergency readmissions within 30 days of discharge from hospital (Female)

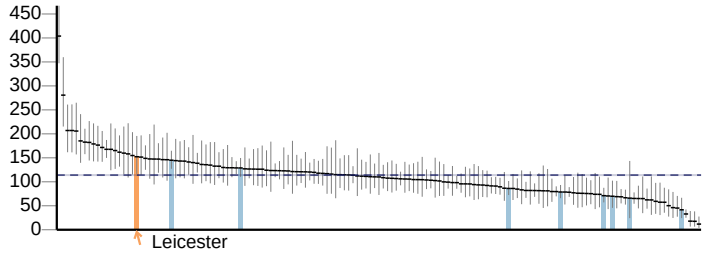


Key England value and confidence interval Leicester Other local authority in East Midlands

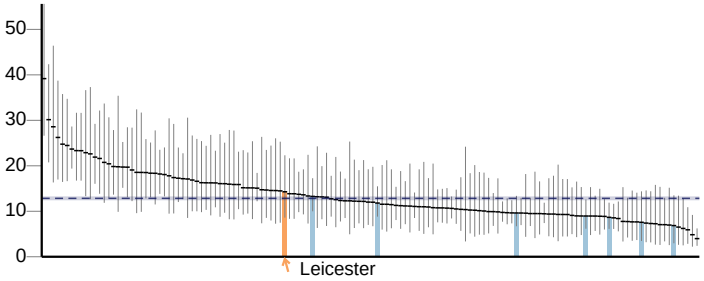
Leicester

Healthcare and premature mortality continued

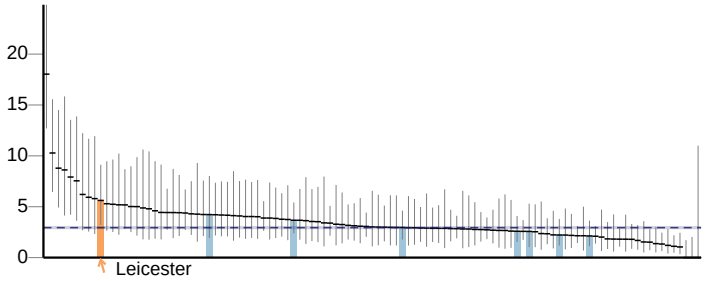
4.12i - Preventable sight loss - age related macular degeneration (AMD)



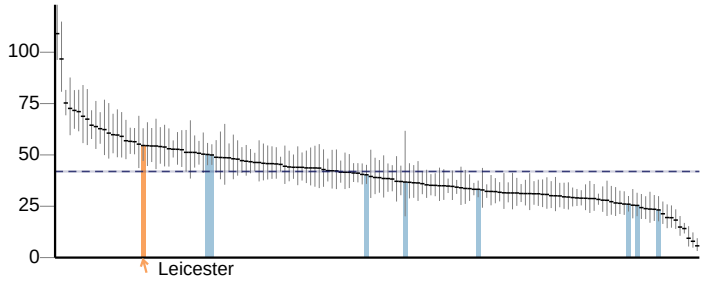
4.12ii - Preventable sight loss - glaucoma



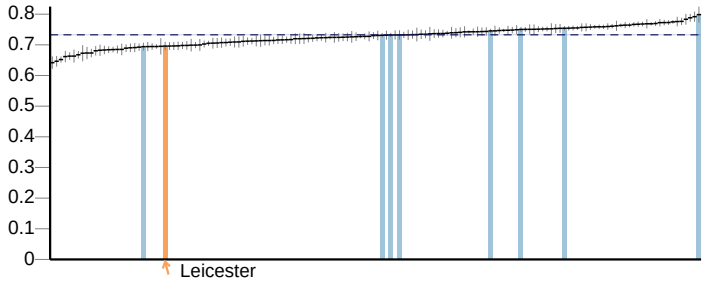
4.12iii - Preventable sight loss - diabetic eye disease



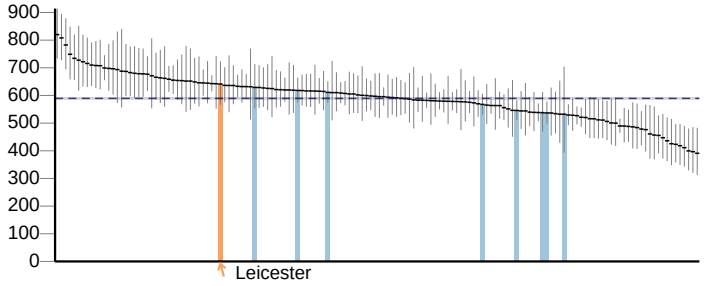
4.12iv - Preventable sight loss - sight loss certifications



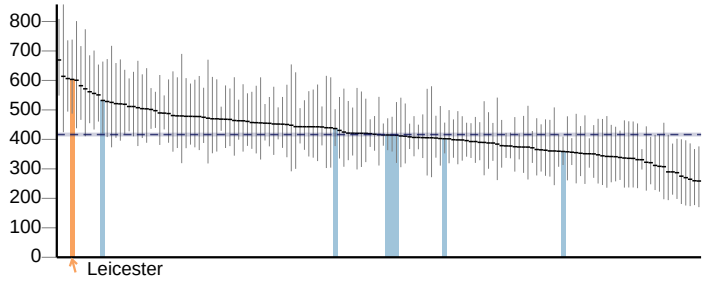
4.13 - Health related quality of life for older people



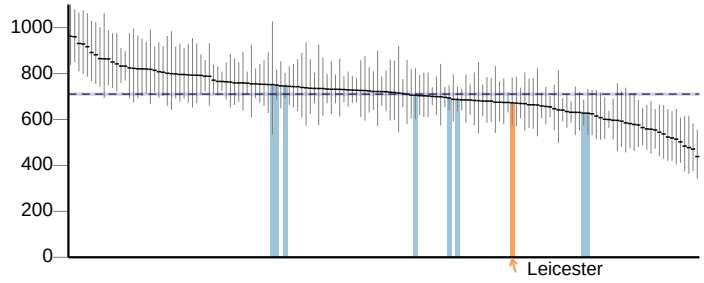
4.14i - Hip fractures in people aged 65 and over (Persons)



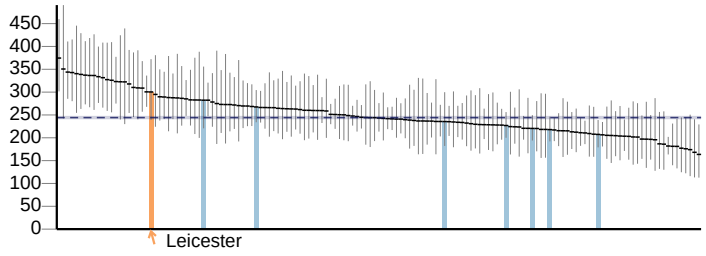
4.14i - Hip fractures in people aged 65 and over (Male)



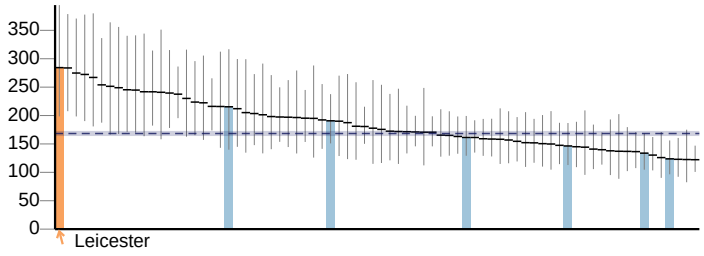
4.14i - Hip fractures in people aged 65 and over (Female)



4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Persons)



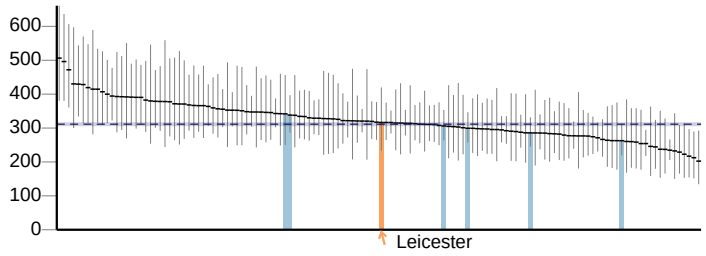
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Male)



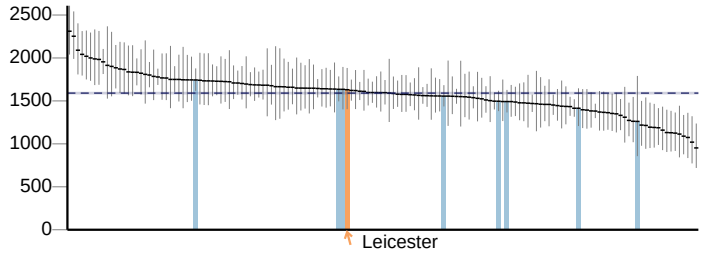
Key England value and confidence interval Leicester Other local authority in East Midlands

Healthcare and premature mortality continued

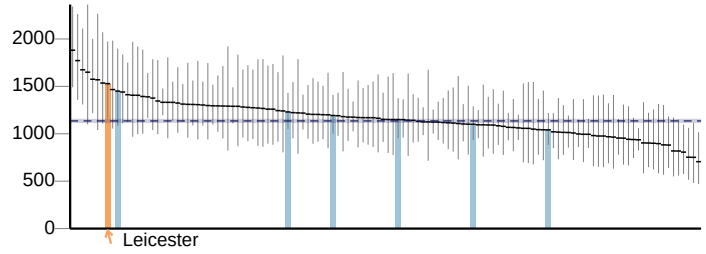
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (Female)



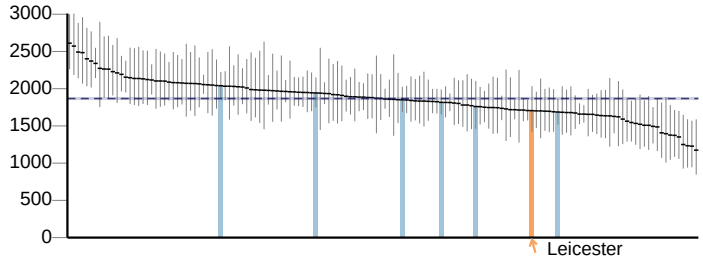
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (Persons)



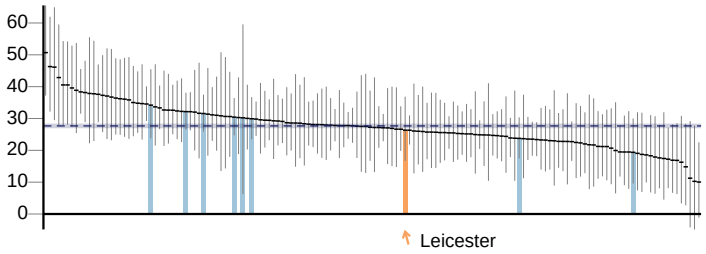
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (Male)



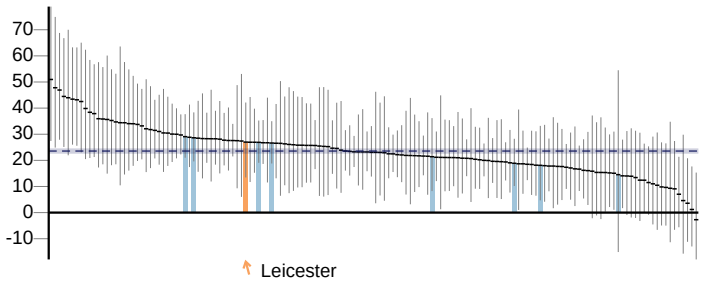
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (Female)



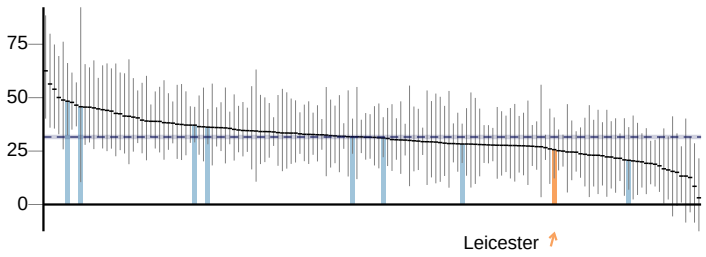
4.15i - Excess winter deaths index (single year, all ages) (Persons)



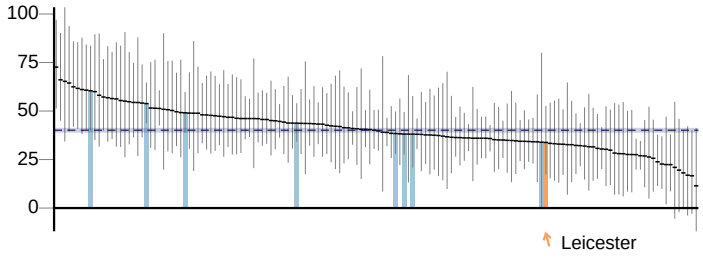
4.15i - Excess winter deaths index (single year, all ages) (Male)



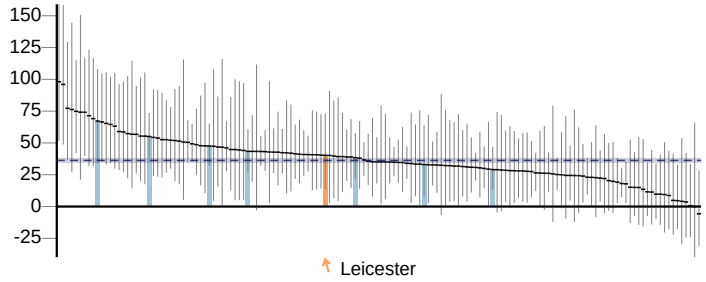
4.15i - Excess winter deaths index (single year, all ages) (Female)



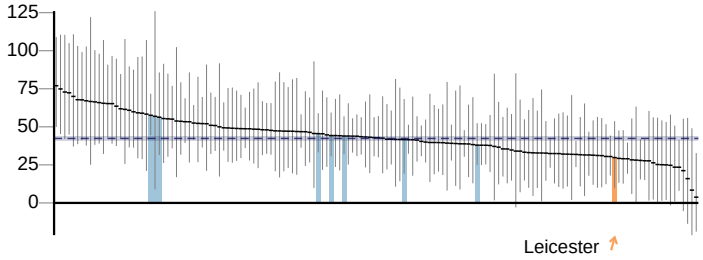
4.15ii - Excess winter deaths index (single year, age 85+) (Persons)



4.15ii - Excess winter deaths index (single year, age 85+) (Male)



4.15ii - Excess winter deaths index (single year, age 85+) (Female)

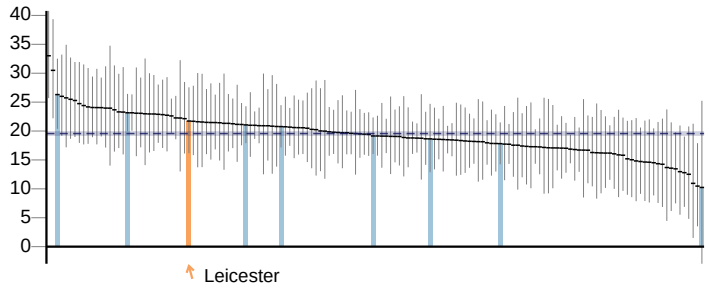


Key England value and confidence interval Leicester Other local authority in East Midlands

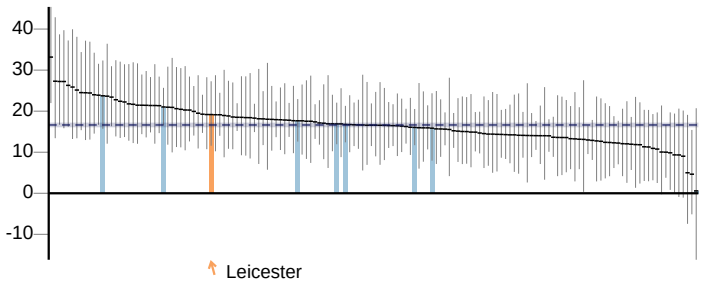
Leicester

Healthcare and premature mortality continued

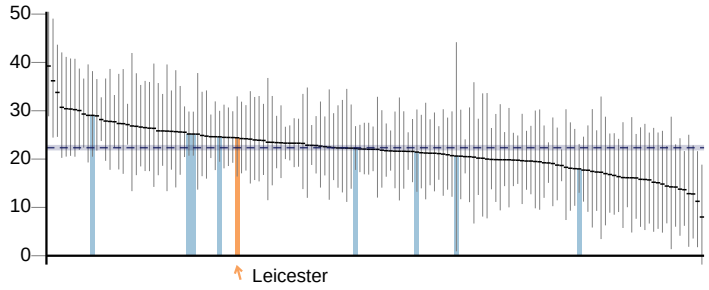
4.15iii - Excess winter deaths index (3 years, all ages) (Persons)



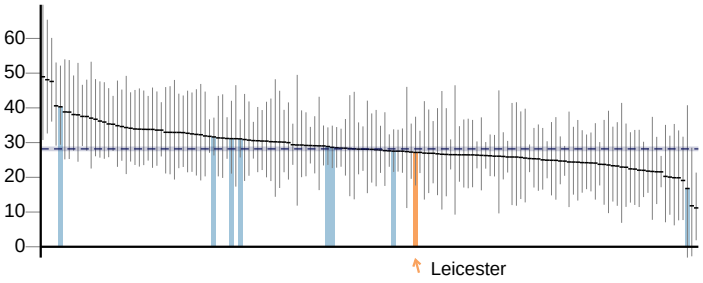
4.15iii - Excess winter deaths index (3 years, all ages) (Male)



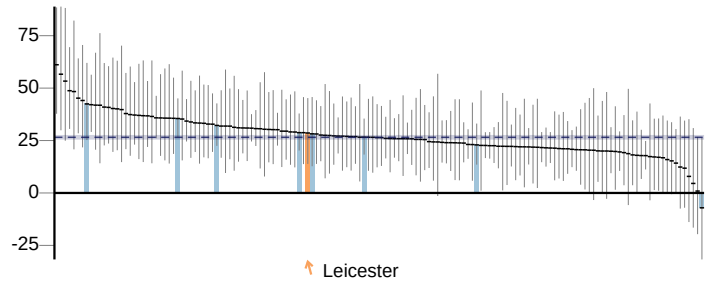
4.15iii - Excess winter deaths index (3 years, all ages) (Female)



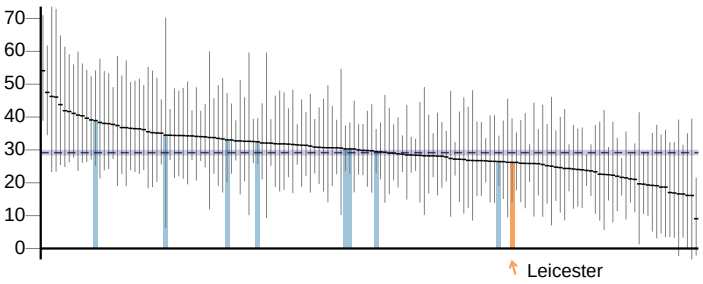
4.15iv - Excess winter deaths index (3 years, age 85+) (Persons)



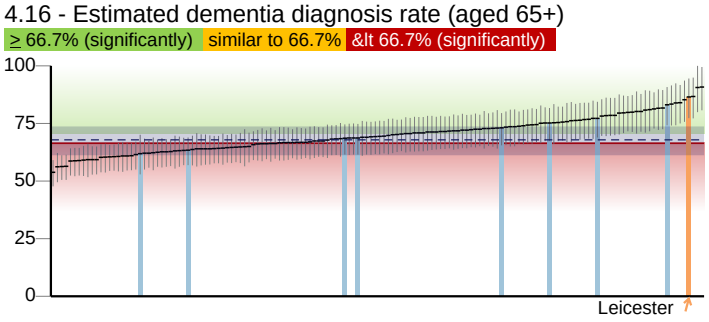
4.15iv - Excess winter deaths index (3 years, age 85+) (Male)



4.15iv - Excess winter deaths index (3 years, age 85+) (Female)



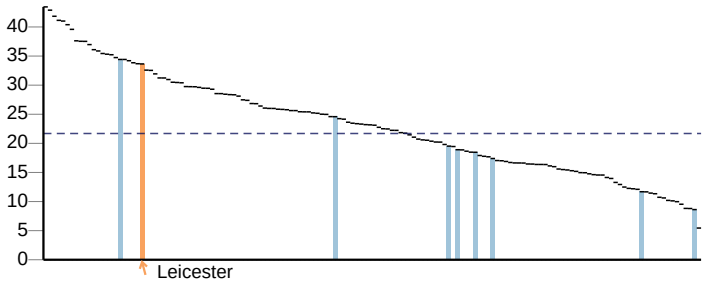
4.16 - Estimated dementia diagnosis rate (aged 65+)



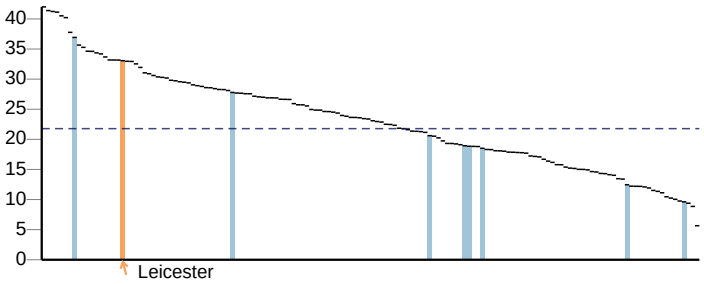
Key England value and confidence interval Leicester Other local authority in East Midlands

Supporting information

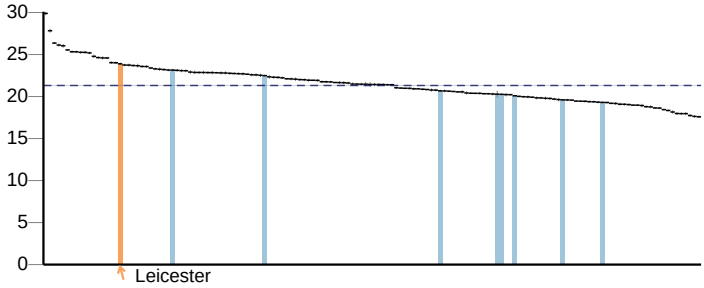
Supporting Information - Deprivation score (IMD 2010)



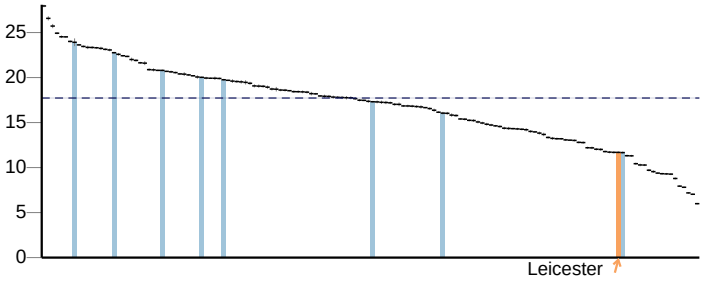
Supporting information - Deprivation score (IMD 2015)



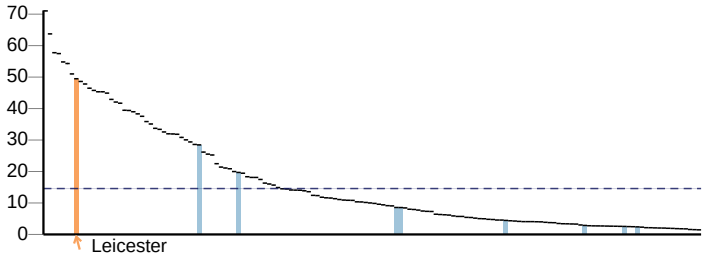
Supporting information - % population aged



Supporting information - % population aged 65+



Supporting information - % population from Black and Minority Ethnic (BME) groups



Key England value and confidence interval Leicester Other local authority in East Midlands

Definitions

Overarching indicators

0.1i Healthy life expectancy at birth: the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. 0.1ii Life expectancy at birth: the average number of years a person would expect to live based on contemporary mortality rates. 0.1ii Life expectancy at 65: the average number of years a person would expect to live based on contemporary mortality rates. 0.2i Slope index of inequality in life expectancy at birth based on national deprivation deciles within England: the range in years of life expectancy across the social gradient, from most to least deprived. 0.2ii Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in indicator 0.2iii) has decreased 0.2iii Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles: the range in years of life expectancy across the social gradient within each local authority, from most to least deprived. 0.2iv The gap in years between overall life expectancy at birth in each English local authority and life expectancy at birth for England as a whole. 0.2v Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England: the range in years of life expectancy across the social gradient, from most to least deprived. 0.2vi SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas 0.2vii Slope index of inequality in life expectancy at birth within English region, based on regional deprivation deciles: the range in years of life expectancy across the social gradient within each local authority, from most to least deprived.

Wider determinants of health

1.01i Percentage of all dependent children under 20 in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs) 1.01ii % of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is < 60% median income) for u-16s only 1.02i School Readiness: all children achieving a good level of development at the end of reception as a percentage of all eligible children. 1.02i School Readiness: all children achieving a good level of development at the end of reception as a percentage of all eligible children by free school meal status 1.02ii School Readiness: Year 1 pupils achieving the expected level in the phonics screening check as a percentage of all eligible pupils 1.02ii School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check 1.03 % of half days missed by pupils due to overall absence (incl. authorised and unauthorised absence) 1.04 Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population 1.05 % of 16-18 year olds not in education, employment or training (NEET) 1.06i % of adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family 1.06ii % of adults (age 18-69) who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support. 1.07 People in prison who have a mental illness or a significant mental illness - current method 1.07 People in prison who have a mental illness or a significant mental illness - historic method 1.08i % point gap in the employment rate between those with a long-term health condition and the overall employment rate 1.08ii % point gap in the employment rate between those with a learning disability and the overall employment rate 1.08iii The percentage point gap between the percentage of working age adults who are receiving secondary mental health services and who are on the Care Programme Approach recorded as being employed (aged 18 to 69) and the percentage of all respondents in the Labour Force Survey classed as employed (aged 16 to 64) 1.08iv % of all respondents in the Labour Force Survey classed as employed (aged 16-64) 1.09i % of employees who had at least one day off due to sickness absence in the previous working week 1.09ii % of working days lost due to sickness absence in the previous working week 1.10 Rate of people KSI on the roads, all ages, per 100,000 resident population 1.11 Rate of domestic abuse-related incidents and crimes recorded by the police 1.11 Rate of domestic abuse incidents recorded by the police per 1,000 population 1.12i Age-standardised rate of emergency hospital admissions for violence per 100,000 population 1.12ii Crude rate of violence against the person offences per 1,000 population 1.12iii Crude rate of sexual offences per 1,000 population 1.13i % of offenders who re-offend from a rolling 12 month cohort 1.13ii Average no. of re-offences committed per offender from a rolling 12 month cohort 1.13iii First time offenders - The number of first time entrants to the criminal justice system as a rate per 100,000 of the population 1.14i Rate of complaints per year per LA about noise per thousand population 1.14ii The percentage of the population exposed to road, rail and air transport noise of 65 dB(A) or more, LAeq,16h per local authority (16h is the period 0700 – 2300) according to the results of the strategic noise mapping carried out as required by the Environmental Noise (England) Regulations 2006, as amended. 1.14iii The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more, Lnight (LAeq,8h) per local authority (8h is the period 2300 – 0700) according to the results of the strategic noise mapping carried out as required by the Environmental Noise (England) Regulations 2006, as amended. 1.15i Statutory homelessness - Eligible Homeless People Not In Priority need per 1,000 households 1.15ii Households in temporary accommodation per 1,000 households 1.16 % of people using outdoor space for exercise/health reasons 1.17 The percentage of households that experience fuel poverty based on the "Low income, high cost" methodology 1.18i % of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey 1.18ii The percentage of adult carers who have as much social contact as they would like according to the Personal Social Services Carers survey

Health improvement

2.01 % of all live births at term with low birth weight 2.02i % of all mothers who breastfeed their babies in the first 48hrs after delivery 2.02ii % of all infants due a 6-8 week check that are totally or partially breastfed 2.03 % of women who smoke at time of delivery 2.04 Rate of conceptions per 1,000 females aged 15-17 2.04 Rate of conceptions per 1,000 females aged 13-15 2.05ii Proportion of children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review Prevalence of overweight (including obese) among children in Reception 2.06ii Prevalence of overweight (including obese) among children in Year 6 2.07i Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years per 10,000 resident population 2.07i Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years per 10,000 resident population 2.07ii Rate of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 per 10,000 resident population 2.08i Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March 2.08ii Percentage of children aged 5-16 who have been in care for at least 12 months on 31st March whose score in the SDQ indicates cause for concern 2.09i Smoking prevalence at age 15 - current smokers (WAY survey) 2.09ii Smoking prevalence at age 15 - regular smokers (WAY survey) 2.09iii Smoking prevalence at age 15 - occasional smokers (WAY survey) 2.09iv Smoking prevalence at age 15 years - regular smokers (SDD survey) 2.09v Smoking prevalence at age 15 years - occasional smokers (SDD survey) 2.10ii Emergency Hospital Admissions for Intentional Self-Harm 2.11i Proportion of the adult population meeting the recommended '5-a-day' on a 'usual day' (adults) 2.11ii Average number of portions of fruit consumed daily (adults) 2.11iii Average number of portions of vegetables consumed daily (adults) 2.11iv – Proportion of the population meeting the recommended “5-a-day” at age 15 2.11vAverage number of portions of fruit consumed daily at age 15 (WAY survey) 2.11viAverage number of portions of vegetables consumed daily at age 15 (WAY survey) 2.12 Percentage of adults classified as overweight or obese 2.13i Percentage of adults achieving at least 150 minutes of physical activity per week in accordance with UK Chief Medical Officer (CMO) recommended guidelines on physical activity. 2.13ii The percentage of adults classified as "inactive" 2.14 Smoking Prevalence in adults - current smokers (APS) 2.15i % of opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months 2.15ii % of non-opiate drug users that left treatment successfully who do not re-present to treatment within 6 months 2.15iii % of alcohol users that left alcohol treatment successfully who do not re-present to treatment within 6 months 2.15iv Deaths from drug misuse 2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison 2.17 % of QOF-recorded cases of diabetes registered with GP practices aged 17+ 2.18 Hospital admissions for alcohol-related conditions (narrow definition), all ages, directly age standardised rate per 100,000 population European standard population. 2.19 The proportion of invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin, diagnosed at stage 1 or 2 2.20i % of eligible women screened adequately within the previous 3 years on 31st March 2.20ii % of eligible women screened adequately within the previous 3.5 or 5.5 years (according to age) on 31st March 2.20iii % of people eligible for bowel screening who were screened 2.20iv Abdominal aortic aneurysm screening 2.20v Diabetic eye screening - uptake of routine digital screening event 2.20vii % of pregnant women eligible for infectious disease screening who are tested for HIV 2.20viii % of pregnant women eligible for infectious disease screening who are tested for syphilis 2.20ix % of pregnant women eligible for infectious disease screening who are tested for Hepatitis B 2.20x % of pregnant women eligible for antenatal sickle cell and thalassaemia screening who were screened 2.20xi % of babies eligible for newborn blood spot screening who were screened 2.20xii % of babies eligible for newborn hearing screening for whom screening process is complete within 4 weeks 2.20xiii % of babies eligible for newborn physical clinical examination screening who were tested within 72 hours of birth 2.22iii Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check in the five year period 2013/14 - 2017/18 2.22iv Cumulative percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check in the five year period 2013/14 - 2017/18

2.22v Cumulative percentage of eligible population aged 40-74 who received an NHS Health Check in the five year period 2013/14 - 2017/18 2.23i % of respondents scoring 0-4 to the question "Overall, how satisfied are you with your life nowadays?" 2.23ii % of respondents scoring 0-4 to the question "Overall, to what extent do you feel the things you do in your life are worthwhile?" 2.23iii % of respondents scoring 0-4 to the question "Overall, how happy did you feel yesterday?" 2.23iv % of respondents scoring 6-10 to the question "Overall, how anxious did you feel yesterday?" 2.24i Age standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population 2.24ii Age standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65-79 per 100,000 population 2.24iii Age standardised rate of emergency hospital admissions for injuries due to falls in persons aged 80+ per 100,000 population

Health protection

3.01 Fraction of all-cause adult mortality attributable to anthropogenic particulate air pollution (measured as fine particulate matter, $PM_{2.5}$) 3.02 Rate of chlamydia detection per 100,000 young people aged 15 to 24 3.03i % of eligible children who received 3 doses of Hepatitis B vaccine at any time by their 1st birthday 3.03i % of eligible children who received 4 doses of Hepatitis B vaccine at any time by their 2nd birthday 3.03ii Population vaccination coverage - Selective neonatal BCG vaccination coverage (aged under 1 year) - areas offering universal BCG only 3.03iii % of eligible children who received 3 doses of Dtap / IPV / Hib vaccine at any time by their 1st birthday 3.03iii % of eligible children who received 3 doses of Dtap / IPV / Hib vaccine at any time by their 2nd birthday 3.03iv % of eligible children who have received the completed course of Men C vaccine by their 1st birthday 3.03v % of eligible children who have received the complete course of PCV vaccine by their 1st birthday 3.03vi % of eligible children who have received one booster dose of Hib/Men C vaccine by their 2nd birthday 3.03vi % of eligible children who have received one booster dose of Hib/Men C vaccine by their 5th birthday 3.03vii % of eligible children who have received one booster dose of PCV vaccine by their 2nd birthday 3.03viii % of eligible children who have received one dose of MMR vaccine on or after their 1st birthday and anytime up to their 2nd birthday 3.03ix % of eligible children who have received one dose of MMR vaccine on or after their 1st birthday and at any time up to their 5th birthday 3.03x % of eligible children who have received two doses of MMR vaccine on or after their 1st birthday and at any time up to their 5th birthday 3.03xii Population vaccination coverage for one dose (females 12-13 years old) - HPV 3.03xiii % of eligible adults aged 65+ who have received the PPV vaccine 3.03xiv % of eligible adults aged 65+ who have received the flu vaccine 3.03xv Flu vaccination coverage (at risk individuals from age six months to under 65 years, excluding otherwise 'healthy' pregnant women and carers) 3.03xvi HPV vaccination coverage for two doses (females 13-14 years old) 3.03xvii 3.3xvii - Shingles vaccination coverage (70 years old) 3.03xviii 3.03xviii – Population vaccination coverage – Flu (2-4 years old) 3.04 3.04 - Percentage of adults (aged 15 or above) newly diagnosed with HIV with a CD4 count less than 350 cells per mm^3 3.05iProportion of drug sensitive TB cases who had completed a full course of treatment by 12 months 3.05iiIncidence of TB (three year average) 3.06 % of NHS organisations that have a Sustainable Development Management Plan that has been signed off at Board level 3.08 Adjusted antibiotic prescribing in primary care by the NHS

Healthcare and premature mortality

4.01 Infant mortality - Rate of deaths in infants aged under 1 year per 1,000 live births 4.02 Percentage of 5 year olds who are free from obvious dental decay 4.03 Age-standardised rate of mortality from causes considered preventable per 100,000 population 4.04i Age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age per 100,000 population 4.04ii Age-standardised rate of mortality considered preventable from all cardiovascular diseases (incl. heart disease and stroke) in those aged 4.05i Age-standardised rate of mortality from all cancers in persons less than 75 years of age per 100,000 population 4.05ii Age-standardised rate of mortality considered preventable from all cancers in those aged 4.06i Age-standardised rate of mortality from liver disease in persons less than 75 years of age per 100,000 population 4.06ii Age-standardised rate of mortality considered preventable from liver disease in those aged 4.07i Age-standardised rate of mortality from respiratory disease in persons less than 75 years per 100,000 population 4.07ii Age-standardised rate of mortality considered preventable from respiratory disease in those aged 4.08 Age-standardised rate of mortality from communicable diseases per 100,000 population 4.09i Excess under 75 mortality rate in adults with serious mental illness 4.09ii The percentage of the population in contact with Secondary Mental Health Services 4.10 Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population 4.11 Indirectly standardised % of emergency admissions to any hospital within 30 days of the previous discharge from hospital 4.12i Crude rate of sight loss due to age related macular degeneration (AMD) in those aged 65+ per 100,000 population 4.12ii Crude rate of sight loss due to glaucoma in those aged 40+ per 100,000 population 4.12iii Crude rate of sight loss due to diabetic eye disease in those aged 12+ per 100,000 population 4.12iv Crude rate of sight loss certifications per 100,000 population 4.13 Average health status score for adults aged 65 and over 4.14i Age standardised rate of emergency admissions for fractured neck of femur in those aged 65+ per 100,000 population 4.14ii Age standardised rate of emergency admissions for fractured neck of femur in those aged 65-79 per 100,000 population 4.14iii Age standardised rate of emergency admissions for fractured neck of femur in those aged 80+ per 100,000 population 4.15i Excess winter deaths index (single year, all ages) 4.15ii Excess winter deaths index (single year, age 85+) 4.15iii Excess winter deaths index (3 years, all ages) 4.15iv Excess winter deaths index (3 years, age 85+) 4.16Dementia: 65+ Estimated Diagnosis Rate

Supporting information

Supporting InformationIndex of multiple deprivation score (IMD 2010) Index of multiple deprivation score (IMD 2015) The percentage of the population aged The percentage of the population aged 65+ The percentage of the population classified as from Black and Minority Ethnic (BME) groups

Leicester City Council

Health and Wellbeing Scrutiny Commission **Date: 11 January 2018**
Council **Date: Draft for 21st February 2018**

General Fund Revenue Budget 2018/19 to 2020/21

Report of the Director of Finance

1. **Purpose**

1.1 The purpose of this report is to ask the Council to consider the City Mayor's proposed budget for 2018/19 to 2020/21.

1.2 The proposed budget is described in this report, subject to any amendments the City Mayor may wish to recommend when he makes a firm proposal to the Council.

1.3 This draft budget has been prepared in advance of the finance settlement for 2018/19, and the final report will be updated to reflect any new information received.

2. **Summary**

2.1 The Council is enduring the most severe period of spending cuts we have ever experienced.

2.2 On a like for like basis, government grant has fallen from £289.2m in 2010/11 to an estimated £167.0m by 2019/20, a cut of 51% in real terms.

2.3 As a consequence of these cuts, the Council's budget (on a like for like basis) has fallen from £355.7m in 2010/11 to an estimated £280.5m in 2019/20. Despite this, spending on social care is demand led, and numbers of older people requiring care and looked after children have increased over this period. As a consequence, spending on all other services will fall from £192m to an estimated £85m, a cut of 62% in real terms.

2.4 We know from reports of the Institute of Fiscal Studies and our own analysis that government cuts have disproportionately hit the most deprived authorities (such as Leicester).

2.5 Since 2014/15, the Council's approach to achieving these substantial budget reductions has been based on the following approach:-

(a) An in-depth review of discrete service areas (the "Spending Review Programme");

(b) Building up reserves, in order to "buy time" to avoid crisis cuts and to manage the Spending Review Programme effectively. We have termed this the "managed reserves strategy".

2.6 The Spending Review Programme is a continuous process. When individual reviews conclude, an Executive decision is taken and the budget is reduced in-year, without waiting for the next annual budget report. Executive decisions are informed by consultation with the public (where appropriate) and the scrutiny function.

2.7 This approach has served us well. Budgets for the period 2013/14 to 2015/16 contributed £42m to reserves, in order to buy time. In practice, the strategy has been sustained by the achievement of in-year savings which increased the amounts available. This has helped us to postpone the maximum impact of government cuts.

2.8 Since 2016/17, however, budgets have planned to take money from reserves rather than add to them. Reserves are consequently running out.

2.9 Because of the spending review approach, the Council has been able to balance the budget in 2018/19, making use of most of the remaining reserves. However, the outlook beyond 2018/19 is extremely difficult, as reserves will inevitably run out before 2020. There is no realistic hope of the strategy being extended this far.

2.10 Medium term budgets cannot be balanced without additional, deep, cuts. The forecast gap in 2019/20 is £27m, and the current estimate of reserves to bridge this is just £3.4m. Outstanding spending reviews will realise savings of £10m per year at the most.

2.11 In early December, local government employers made a pay offer amounting to 5.6% over 2 years. If additional funding is not received from the Government, an additional £4.5m saving will be required in 2019/20. In 2018/19, the budget contingency will need to be used.

2.12 As a consequence, the following approach has been adopted:-

(a) The budget for 2018/19 has been balanced using reserves, and can be adopted as the Council's budget for that year;

(b) A further round of spending reviews has commenced ("Spending Review 4"). This has allocated target savings of £20m across departments, and work to identify and achieve this level of saving is taking place;

(c) A more realistic assessment of the current outstanding reviews has been carried out, and a figure of £8.5m was rolled into the Spending Review 4

targets (rather than the formal outstanding amount of £12.8m). Of this £8.5m, £5.9m remains outstanding.

2.13 **What this means is that, in substance, the budget proposed is a one year budget with projections of the further cuts required beyond 2018/19.**

2.14 These cuts need to be planned over the next 12 months, and implementation commenced as quickly as possible. Any savings achieved before 2019/20 will increase the level of reserves available to support the budget in that year.

2.15 It cannot be stressed enough how difficult these cuts will be. We continue to face growth in social care costs, and it is not impossible that these services will consume an ever greater proportion of the budget (squeezing out the traditional services provided to the whole community). Government intentions for social care funding beyond 2019/20 are not known.

2.16 It should also be noted that there are some significant risks in the budget – more so than usual. These are described in paragraph 16, and to help mitigate these, a contingency of £2m has been included in the 2018/19 budget.

2.17 Additionally, a number of departments are facing difficulties living within their existing budget ceilings. These pressures, and mitigating actions, are further described in paragraph 7 below.

2.18 The budget provides for a council tax increase of 5%, which is the maximum available to us without a referendum. 3% of this 5% is for the "social care precept" – the Government has permitted social care authorities to increase tax by more than the 2% available to other authorities, in order to help meet social care pressures. In practice, increasing our tax by 5% for 2 years will only meet a small proportion of the extra costs we are incurring.

2.19 In the exercise of its functions, the City Council (or City Mayor) must have due regard to the Council's duty to eliminate discrimination, to advance equality of opportunity for protected groups and to foster good relations between protected groups and others. The budget is, in effect, a snap-shot of the Council's current commitments and decisions taken during the course of 2017/18. There are no proposals for decisions on specific courses of action that could have an impact on different groups of people. Therefore, there are no proposals to carry out an equality impact assessment on the budget itself, apart from the proposed council tax increase (this is further explained in paragraph 11 and the legal implications at paragraph 21). Where required, the City Mayor has considered the equalities implications of decisions when they have been taken and will continue to do so for future spending review decisions.

3. Recommendations

3.1 Subject to any amendments recommended by the Mayor, the Council will be asked to:-

(a) approve the budget strategy described in this report, and the formal budget resolution for 2018/19 which will be circulated separately;

(b) note comments received on the draft budget from scrutiny committees, trade unions and other partners (when received);

(c) approve the budget ceilings for each service, as shown at Appendix One to this report;

(d) approve the scheme of virement described in Appendix Two to this report;

(e) note my view that reserves will be adequate during 2018/19, and that estimates used to prepare the budget are robust;

(f) note the equality implications arising from the proposed tax increase, as described in paragraph 11 and Appendix Five;

(g) approve the prudential indicators described in paragraph 18 of this report and Appendix Three;

(h) approve the proposed policy on minimum revenue provision described in paragraph 19 of this report and Appendix Four;

(i) emphasise the need for outstanding spending reviews to be delivered on time, after appropriate scrutiny;

(j) agree that finance procedure rules applicable to trading organisations (4.9 to 4.14) shall be applicable only to City Catering, operational transport and highway maintenance.

4. Budget Overview

4.1 The table below summarises the proposed budget, and shows the forecast position for the following three years:-

	2018/19 £m	2019/20 £m	2020/21 £m
Service budget ceilings	252.8	254.9	258.9
Corporate Budgets			
Capital Financing	13.8	13.6	13.0
Miscellaneous Central Budgets	(3.3)	(3.2)	(2.9)
Corporate Contingency	2.0		
Education Funding Reform	3.8	3.8	3.8
Future Provisions			
Inflation		4.5	8.9
Planning provision		3.0	6.0
Managed reserves Strategy	(14.0)	(3.4)	
TOTAL SPENDING	**255.1**	**273.2**	**287.7**
Resources – Grant			
Revenue Support Grant	38.4	28.4	29.3
Business rates top-up grant	44.4	45.9	47.3
New Homes Bonus	6.0	5.1	3.6
Resources – Local Taxation			
Council Tax	106.8	109.6	112.6
Business Rates	58.4	60.2	61.8
Collection Fund Surplus	1.1		
TOTAL RESOURCES	**255.1**	**249.2**	**254.6**

Projected tax increase	5.0%	2.0%	2.0%
Gap in resources	NIL	24.0	33.2
Underlying gap in resources	14.0	27.4	33.2

4.2 The table above includes sufficient money for a 1% pay award for local government staff in each year. On 5th December, the employers' side of the NJC made a formal offer of a pay award averaging 2.8% p.a. nationally (2.5% locally). It is not yet clear if the government will be providing additional funding to local authorities to meet this cost pressure. If it is not fully funded, the corporate contingency is sufficient to meet the additional costs for 2018/19, but a significant additional cost pressure will arise in 2019/20 and 2020/21 (estimated at £4.5m per year).

4.3 Future forecasts are of course volatile and will change.

4.4 The forecast gap in 2019/20 and 2020/21 makes no allowance for most inflation (other than for pay awards). In real terms, the gap for 2020/21 is some £5m higher.

5. Council Tax

5.1 The City Council's proposed tax for 2018/19 is £1,492.77, an increase of just below 5% compared to 2017/18.

5.2 The tax levied by the City Council constitutes only part of the tax Leicester citizens have to pay (albeit the major part). Separate taxes are raised by the police authority and the fire authority. These are added to the Council's tax, to constitute the total tax charged.

5.3 The total tax bill in 2017/18 for a Band D property was as follows:-

	£
City Council	1,421.69
Police	187.23
Fire	62.84
Total tax	**1,671.76**

5.4 The actual amounts people are paying in 2017/18, however, depend upon the valuation band their property is in and their entitlement to any discounts, exemptions or benefit. Almost 80% of properties in the city are in band A or band B.

5.5 The formal resolution will set out the precepts issued for 2018/19 by the Police and Crime Commissioner and the fire authority, together with the total tax payable in the city.

6. Construction of the Budget

6.1 By law, the role of budget setting is for the Council to determine:-

(a) The level of council tax;

(b) The limits on the amount the City Mayor is entitled to spend on any service ("budget ceilings").

6.2 The proposed budget ceilings are shown at Appendix One to this report.

6.3 The ceilings for each service have been calculated as follows:-

(a) The starting point is last year's budget, subject to any changes made since then which are permitted by the constitution (e.g. virement);

(b) Decisions taken by the Executive in respect of spending reviews which are now being implemented have been deducted from the ceilings;

(c) Increases in pay costs. The pay award for local government staff from April 2018 is yet to be agreed; an offer averaging around 2.5% was made in December. Budget ceilings in Appendix One have been calculated on an assumed 1% pay award, plus the rise in the UK Living Wage. This will be revised in preparation of the final budget for Council approval.

6.4 Apart from the above, no inflation has been added to departments' budgets for running costs or income, except for an allowance for:-

(a) Independent sector adult care (2%);

(b) Foster care (2%);

(c) Costs arising from the waste PFI contract (3.8% - RPI).

6.5 The following spending review decisions have been formally taken since February 2017, and budgets reduced accordingly:-

	17/18 £000	18/19 £000	19/20 £000
Transforming Neighbourhood Services	12	41	69
Cleansing	365	508	700
Early Help Remodelling	1,200	3,500	3,500
Civic & Democratic Services	280	280	280
Investment Property	180	340	500
Corporate Administration	240	1,300	1,300
Using Buildings Better / Channel Shift	295	355	355
Regulatory Services	12	271	271
Sexual Health	245	245	245
Lifestyle Services	270	270	270
Youth Services	-	923	923
Community Capacity	62	125	125
Park & Ride	-	100	100
Supported Housing[1]	-	250	250
Tourism, Culture & Investment	381	620	1,008
	3,542	**9,128**	**9,896**

Savings realised in 2017/18 are being used to support the managed reserves strategy into 2019/20.

6.6 A full schedule of reviews included in the programme is provided at Appendix Eight. In addition, departments have been asked to prepare plans to save an

[1] This decision is subject to a "call in" at the time of writing

additional £20m by 2019/20, to address the remaining budget gap in that year. Work on these savings is ongoing, and has not yet been included in budget projections.

7. How Departments will live within their Budgets

7.1 The role of the Council is to determine the financial envelopes within which the City Mayor has authority to act. In some cases, changes to past spending patterns are required to enable departments to live within their budgets. Actions taken, or proposed by the City Mayor, to live within these budgets is described below.

Adult Social Care

7.2 In common with adult care services across the country, the department faces significant cost pressures. These principally arise from:-

(a) Demographic growth – an ageing population means the number of older people requiring care is increasing (which has been the pattern for many years);

(b) Increasing frailty and the impact of people having multiple health conditions that increase the level of care and support required (not just in older people, but also for adults of working age who are supported by the department);

(c) Increasing cost of packages after individuals have been assessed and care has started to be provided. In practice, this is proving to be an area of significant cost increase (projected at an average 5.7% on the original package cost);

(d) The National Living Wage – this was introduced by the Government in April 2016, and is due to increase in stages to around £9 per hour by 2020/21. These increases are creating substantial pressures for independent sector care providers, who are heavily dependent on a minimum wage workforce; and they will seek to pass on additional costs to local authorities.

7.3 The Government has partially recognised the difficulties facing adult social care, and has:-

(a) Permitted social care authorities to increase council tax by 5% in 2018/19 (as opposed to the usual referendum limit of 2%);

(b) Provided additional funds through the "Improved Better Care Fund" (iBCF). Monies available will rise to £15.5m by 19/20.

7.4 These measures are far from adequate, and we have no indication of what will be provided beyond 2019/20 (we have simply assumed BCF amounts in 19/20 will roll forward at the same level).

7.5 In 2016/17, the Council recognised the growing costs of care, and a significant injection of funds was provided.

7.6 The department has estimated the impact of increased packages of care on its current budget, and is able to fund these from a combination of growth in BCF monies and some one-off monies:-

	18/19 £m	19/20 £m
Forecast growth	7.2	11.5
Funding		
Better Care Fund	6.2	7.7
CCG Income	0.3	0.3
One-off Monies	0.7	3.5
Total funding	**7.2**	**11.5**

7.7 The use of one-off monies, and uncertainty about Government intentions, means that the position for 2020/21 and beyond is extremely vulnerable. Indeed, without additional funding, it is fair to say that social care provision (locally and nationally) will face crisis by 2020.

Education and Children's Services

7.8 The most substantial pressure facing the Education and Children's Services Department is increasing service demand. This manifests itself in growth in the numbers of looked after children (currently averaging 4% per annum). Like Adult Social Care, money was added to the budget in 2016/17, but this was predicated on an expectation that future growth could be curtailed. This has not proven to be the case.

7.9 The table below shows the cost pressures facing the department:-

	£m
Looked after children – placement costs	5.0
Home to school transport	1.2
Other pressures	1.1
Total pressures	**7.3**

7.10 In addition to looked after children, pressures have grown on home to school transport (the majority of which is itself caused by the increase in looked after children numbers). Other pressures arise for a number of reasons, principally due to increase in demand across all services and not realising some anticipated savings (although delivering some substantial transformation programmes).

7.11 A number of approaches are being adopted to mitigate these pressures, which include:-

(a) Reducing reliance on agency foster care, by recruiting 24 more internal foster carers. This is expected to save £0.9m by 2019/20;

(b) Reducing the number of external residential placements for looked after children (which are extremely expensive) by 10, by increasing semi-supported accommodation and returning young people to Leicester through planned moves. This is expected to save around £1.3m per annum by 2019/20;

(c) Expansion of the multi-systemic therapy treatment teams. These provide intensive support to children and families to address the reasons underlying the need for intervention: expanding the teams and piloting a new intervention method (Functional Family Therapy) is expected to save £1.2m per annum by 2019/20;

(d) Reviewing all cases of home to school transport to ensure the existing policy is being consistently applied, and where appropriate ceasing existing arrangements. This is anticipated to save £0.7m per annum by 2019/20;

(e) An end to end review of all elements of SEN transport provision is planned. This will examine eligibility, use of independent travel and personal transport budgets, use of fleet and the potential for multi-authority and regional solutions.

7.12 However, these measures by themselves are unlikely to be sufficient. Wider strategies will be adopted to address increased demand and rising placement costs, which are described below. The department may also need to make further savings during the course of the year.

7.13 In respect of the less complex non-residential placement growth, these strategies include:-

(a) Adopting the “no wrong door” principle;

(b) Integration of YOS case workers and advocates with “edge of care” social work;

(c) Implementation of a “Signs of Safety” programme, to improve quality of work and better assessment of risk by workers.

7.14 To address more complex residential placements, the following work is taking place:-

(a) Compilation of a placement and commissioning sufficiency strategy;

(b) Monthly reviews of all residential placements to check whether the placement can be stepped down to less expensive care;

(c) A provider event to see whether the market can be stimulated to provide more cost effective specialist homes in the city or specialist foster placements;

(d) Increased quality checks on the work of specialist residential homes;

(e) Earlier identification of complex cases with partners, to increase the number of joint funded placements as appropriate.

7.15 In addition to General Fund pressures, there are two other significant pressures affecting the department:-

(a) National changes in the education funding system have led to the loss of Education Services Grant (which was £4.5m in 2017/18). This will be replaced by a much smaller central services grant, and £2.8m of corporate funding has been made available to address the shortfall. However, the change with have a significant impact on the school improvement service, which will reduce in size by around £1m as a consequence;

(b) Significant pressure on the high needs block element of Dedicated Schools Grant is anticipated. This is not part of the overall General Fund: whilst £1m of corporate funding has been provided, reflecting reduced general fund overheads, the balance will need to be resolved within overall schools' funding.
Pressures have arisen because of rising numbers of SEN pupils, with some conditions (autism and mental health) increasing disproportionately. Changes to the national school funding formula will compound the problem, because the new formula will only provide £4,000 per special school pupil for growth. The expected impact is a significant reduction in support services for SEN provided by the authority, although in the short term the cost will be met from reserves of Dedicated Schools Grant.

<u>City Development and Neighbourhoods</u>

7.16 The department provides a wide range of statutory and non-statutory services which contribute to the wellbeing and civic life of the city. It brings together local services in neighbourhoods and communities, economic strategy, strategic and local transportation, tourism, regeneration, the environment, culture, heritage, libraries, housing and property management.

7.17 Historically, I have been able to report that the department has been able to live within its budget. This is now much more difficult. The department faces budget pressures of £1.5m in 2018/19 and beyond which can no longer be managed with service budgets. These arise from:-

	£m
Waste management	0.7
Bereavement income	0.4
Leicester market	0.4
Total	1.5

7.18 The pressures in **waste management** arise from a number of factors. These include the cumulative effect of increases in landfill tax rates since 2014/15; changes in Government regulations which mean that some waste from Wanlip has started to attract a higher rate of landfill tax; a shortfall of income at Gypsum household waste recycling centre, which can now be seen as permanent; and gradually increasing levels of waste going to landfill as the number of households rises.

7.19 **Bereavement income** has fallen on what appears to be an on-going basis due to competition from other facilities.

7.20 The income and expenditure budgets for **Leicester Market** need realigning in the light of current trends affecting markets nationally.

7.21 Additionally, the department faces a temporary pressure in 2018/19 as a consequence of the spending review programme. The department has been a substantial contributor to the success of this programme, and decisions have been taken to reduce budgets by some £19m to date. Completed reviews include:-

(a) Technical Services - £10.1m;
(b) Investment Properties - £0.6m;
(c) Neighbourhood Services - £1.5m;
(d) Parks and Open Spaces - £1.7m;
(e) Homelessness Services - £1.5m;
(f) Cleansing and Waste - £0.7m;
(g) Regulatory Services - £0.4m;
(h) Tourism, Culture and Investment - £1.1m.

7.22 All these savings are expected to be delivered, but the Technical Services Review is running late. Certain preparatory and ancillary works to minimise the impact of savings have taken longer than anticipated and resulted in some programme drift. As a consequence, around £1.5m of further pressures exist within the 2018/19 budget.

7.23 In practice, whilst some of the pressures can be mitigated (purchase of new equipment may reduce the additional landfill tax for instance), the department will need to make further savings during the course of the year.

Health and Wellbeing

7.24 The Health and Wellbeing Division consists of core public health services, together with Sports and Leisure provision. It is partly funded from Public Health Grant and partly from the General Fund.

7.25 Public Health Grant is falling, by an estimated £0.7m in each of 2018/19 and 2019/20. The department will manage these reductions through the spending review process. The following reviews are yet to finish and will ensure the necessary savings are achieved:-

(a) A review of sexual health services;
(b) A review of lifestyle services.

7.26 Both these reviews are on course to achieve the expected savings. The department is consequently able to live within its reduced level of budget (although it will also be expected to contribute to Spending Review 4 in due course).

7.27 Sport and Leisure Services are also subject to review, as part of the current spending review programme. A public consultation has recently been completed, and proposals will be made shortly.

Corporate Resources and Support

7.28 The key challenge facing the department is to be as cost effective as possible, in order to maximise the amount of money available to run public facing services. The department has achieved £14m of savings since 2011/12, and will inevitably need to save considerable further sums as part of the Spending Review 4 programme.

7.29 The department will manage within its budget ceilings for 2018/19, having absorbed new spending pressures. These pressures include:-

(a) Continuing reduction in housing benefit administration grant, received from the DWP. This is estimated to fall by £280,000 in 2018/19 and a further £190,000 in 2019/20. Grant received in 2019/20 will be less than half the £3.5m received in 2010/11;

(b) Pressures on the revenues and benefits service will increase with the "full service" roll out of Universal Credit in June 2018. This will be high risk in terms of delivery and customer impact;

(c) The department is working hard to retain levels of traded income, especially from the HR service to schools;

(d) The department has to facilitate a high level of change across the Council, with reduced staff. In particular, HR is affected by organisational change work, and a dramatic increase in employment case work volumes. Growth in the use of IT and the move to mobile working and greater use of on-line customer service channels continues to be a challenge for the IT division, and there are increasing needs to

respond to the threats of cyber security. Legal Services faces an increased number of child care proceedings and contested debt.

8. Sums to be Allocated to Services

8.1 Unusually this year, there are no sums which are required to be allocated to services during the course of the year.

8.2 It appears likely that the pay award for 2018/19 will exceed the 1% built into budget ceilings (see para. 4.2 above). If the Government does not fully fund this cost pressure to local authorities, further funding from the corporate contingency (see para. 9.3) may need to be allocated to make up the shortfall.

9. Corporately held Budgets

9.1 In addition to the service budget ceilings, some budgets are held corporately. These are described below (and shown in the table at paragraph 4).

9.2 The budget for **capital financing** represents the cost of interest and debt repayment on past years' capital spending. This budget is not controlled to a cash ceiling, and is managed by the Director of Finance. Costs which fall to be met by this budget are driven by the Council's approved treasury management strategy, which will be approved by the Council in January. This budget is declining over time, as the Government now provides grant in support of capital expenditure instead of its previous practice of providing revenue funding to service debt.

9.3 A one-off **corporate contingency** of £2m has been created in 2018/19 to manage significant pressures that arise during the year.

9.4 Paragraph 7.15 above describes the **education funding reforms** that will come into effect from 2018/19. Whilst the Education and Children's Services Department is making changes to mitigate these effects, a provision has been made for funding reductions which the department is unable to mitigate.

9.5 **Miscellaneous central budgets** include external audit fees, pensions costs of some former staff, levy payments to the Environment Agency, bank charges, the carbon reduction levy, monies set aside to assist council taxpayers suffering hardship and other sums it is not appropriate to include in service budgets. These budgets are offset by the effect of charges from the general fund to other statutory accounts of the Council (which exceed the miscellaneous costs).

10. Future Provisions

10.1 This section of the report describes the future provisions shown in the table at paragraph 4 above. These are all indicative figures – budgets for these years will be set in February prior to the year in question.

10.2 The provision for **inflation** includes money for:-

(a) Pay awards in 2019/20 and 2020/21. It is assumed that local funding will be required equivalent to 1% per annum. If Government funding is not forthcoming for the recent pay offer, the provision will be increased prior to the final report being considered by Council;

(b) A contingency for inflation on running costs for services unable to bear the costs themselves. These are: waste disposal, independent sector residential and domiciliary care, and foster payments.

10.3 A **planning provision** has been set aside to manage uncertainty. Our general policy is to set aside a cumulative £3m per year, each year for the duration of the strategy. This can then be removed in subsequent budget reports, to the extent that it has not been utilised elsewhere. In recent years, it has been used to deal with the impact of education funding reform.

11. Budget and Equalities (Hannah Watkins)

11.1 The Council is committed to promoting equality of opportunity for its local residents; both through its policies aimed at reducing inequality of outcomes, and through its practices aimed at ensuring fair treatment for all and the provision of appropriate and culturally sensitive services that meet local people's needs.

11.2 In accordance with section 149 of the Equality Act, the Council must "have due regard", when making decisions, to the need to meet the following aims of our Public Sector Equality Duty:-

(a) eliminate discrimination;

(b) advance equality of opportunity between protected groups and others;

(c) foster good relations between protected groups and others.

11.3 Protected groups under the public sector equality duty are characterised by age, disability, gender re-assignment, pregnancy/maternity, race, religion or belief, sex and sexual orientation.

11.4 When making decisions, the Council (or City Mayor) must be clear about any equalities implications of the course of action proposed. In doing so, it must consider the likely impact on those likely to be affected by the recommendation; their protected characteristics; and (where negative impacts are anticipated) mitigating actions that can be taken to reduce or remove that negative impact.

11.5 This report seeks the Council's approval to the proposed budget strategy. The report sets out financial ceilings for each service which act as maxima above which the City Mayor cannot spend (subject to his power of virement). However, decisions on services to be provided within the budget ceilings are taken by managers or the City Mayor separately from the decision regarding the budget strategy. Therefore, the report does not contain details of specific service proposals. However, the budget strategy does recommend a proposed

council tax increase for the city's residents. The City Council's proposed tax for 2018/19 is £1,492.77, an increase of just below 5% compared to 2017/18. As the recommended increase could have an impact on those required to pay it, an assessment has been carried out to inform decision makers of the potential equalities implications. This is provided at Appendix Five.

11.6 In a nutshell, the likely impact on a household depends on whether or not the household is reliant on social security benefits.

11.7 The assessment of the council tax increase for 2017/18 suggested a very limited impact on the household finances of council tax payers who are not dependent on social security benefits as it was argued that the increase would be readily mitigated by increased levels of household discretionary income which had been seen nationally. However, more recently, we have seen that disposable income has fallen in real terms. This has multiple causes: slow wage growth (only partly offset by rising employment rates), welfare changes and inflation.

11.8 The table below (taken from the ASDA income tracker) shows the changes in disposable income for different brackets of household earnings and shows that families with the lowest income have seen the biggest reduction, whereas those in the top bracket have seen spending power increase year on year.

Income Bracket	Weekly income	Weekly income growth	Weekly disposable income	Weekly disposable income growth
Highest income	£1,928	2.3%	£699	1.5%
2nd highest	£935	2.0%	£259	0.2%
Middle	£606	1.6%	£110	-3.5%
2nd lowest	£379	1.0%	£48	-10.0%
Lowest Income	£180	0.5%	£-26	-25.9%

The ASDA income tracker is an indicator of the economic prosperity of 'middle Britain', taking into account income, tax and all basic expenditure. ASDA's customer base matches the UK demographic more closely than that of other supermarkets.

11.9 60% of households saw their discretionary incomes decrease in the 12 months to August 2017. This reflects the continued pressure on household budgets. Inflation in a number of categories, from food prices to electricity and clothing, has increased the cost of essential spending substantially over the past months.

11.10 Having said this, in most cases, the change in council tax (maximum £1.06/week for a band B property) is a small proportion of disposable income, and a small contributor to the squeeze on household budgets.

11.11 Some households reliant on social security benefits are likely to be adversely affected by both an increase in inflation and further implementation of the Government's welfare reforms. Positively, many forecasters have predicted that inflation will have peaked in October 2017, before dropping back in 2018 as the impact of the pound's fall starts to fade.

11.12 The increase in tax alone would contribute only a small increase in weekly costs for many benefit dependent households but it must be considered that there is likely also likely to be an adverse impact on some benefit dependent households arising from the **rollout of Universal Credit in summer 2018** and, therefore, there is likely to be a cumulative impact on those households.

11.13 The Council has a number of mitigating actions in place to provide support in instances of short term financial crisis.

11.14 Locally, Council services provide (or fund) a holistic safety net including the provision of advice, personal budgeting support, and signposting provision of necessary household items. It is important to note that these mitigating actions are now the sole form of safety net support available to households in the city. A House of Commons Works and Pensions Committee report in January 2016 ('The local welfare safety net') described this devolution of discretionary support to those in short term financial crisis to local government. There is now no other source of Government support available.

11.15 Since April 2013, as a consequence of the Government's welfare reforms, all working age households in Leicester have been required to contribute towards their council tax bill. Our current council tax reduction scheme (CTRS) requires working age households to pay at least 20% of their council tax bill, and sets out to ensure that the most vulnerable householders are given some relief in response to financial hardship they may experience. In order to apply for a Council Tax Discretionary Relief, a charge payer must have a Council Tax liability and:

- be in receipt of Council Tax Reduction; and/or,
- be in receipt of Universal Credit (UC); and/or,
- require further financial assistance; and/or,
- suffer hardship through an extreme event or natural disaster where their main or sole residence has structural damage, which could not reasonably have been rectified within the normal period of exemption.

11.16 Leicester is ranked as the 21st most deprived local authority in the country. In addition to provision of a 'local welfare safety net', council services seek to address inequalities of opportunity that contribute to this deprivation. They do this by seeking to improve equality of outcomes for those residents that we can directly support. The role of Adult Social Care is crucial in this context, and the approval of the additional 3% of council tax to maintain this service provision for a growing number of elderly people (and to a lesser extent, those people who require support arising from a disability) will directly contribute to improved outcomes related to health; personal safety; and personal identity, independence and participation in community life. There are likely to be

significant equalities impacts should the council be in a position where they are unable to fund support for those who require it.

11.17 Our public sector equality duty is a continuing duty, even after decisions have been made and proposals have been implemented. Periodically we review the outcomes of earlier decisions to establish whether mitigating actions have been carried out and the impact they have had. The spending review programme enables us to assess our service provision from the perspective of the needs of individual residents. This "person centred" approach to our decision making ensures that the way we meet residents' needs with reducing resources can be kept under continuous review – in keeping with our Public Sector Equality Duty.

11.18 The Council has a legal duty to set a balanced budget. In the current financial climate, a lower council tax increase would require even greater cuts to services. While it is not possible to say where these cuts would fall (and therefore which specific groups would be affected), the users of Adult Social Care are mostly older people or, to a lesser extent, adults who have a disability and therefore there are likely to be negative equalities implications arising from a decision to implement a lower council tax increase.

12. Government Grant

12.1 At the time of writing this report, the finance settlement for 2018/19 had not been received. However, in 2016/17, the Government offered, and we accepted, a four year certainty deal which means the revenue support grant figures for 2018/19 and 2019/20 are fixed, "barring exceptional circumstances."

12.2 As can be seen from the table at paragraph 4, Government grant is a major, though reducing, component of the Council's budget. Under the current funding system, Government support for the general budget principally consists of:-

(a) **Revenue Support Grant** (RSG). This is the main grant which the Government has available to allocate at its own discretion. Consequently, cuts to local authority funding are substantially delivered through reductions in RSG (and the methodology for doing this has disproportionately disadvantaged deprived authorities). The impact on the city has been dramatic (RSG is reducing from £133m in 2013/14, to an estimated £28m in 2019/20).

(b) A **top-up to local business rates**. The local authority sector keeps 50% of business rates collected, with the balance paid to the Government. In recognition of the fact that different authorities' ability to raise rates does not correspond to needs, a top-up is paid to less affluent authorities (funded by authorities with greater numbers of higher-rated businesses). Our top-up was recalculated with effect from April 2017, to neutralise the effect of the business rates revaluation, and will increase each year with inflation;

(c) **New Homes Bonus (NHB)**. This is a grant which roughly matches the council tax payable on new homes, and homes which have ceased to be

empty on a long term basis. Since 2017/18, NHB is less generous than it was, and further cuts are expected in 2018/19. These changes have been made to secure more resources for social care: in two tier areas, this transfers money from districts to counties; in our case, we are simply moving money from one pocket to another.

12.3 No figures have been made available for RSG after 2019/20. The budget assumes no further cuts in RSG in 2020/21. In effect, we are assuming that the period of austerity will come to an end as far as local government budgets are concerned. This is a significant risk, which is discussed further at paragraph 16 below.

12.4 The Government also controls **specific grants** which are given for specific rather than general purposes. These grants are not shown in the table at paragraph 4.1, as they are treated as income to departments (departmental budgets are consequently lower than they would have been).

12.5 Some specific grants are subject to change:-

(a) The **Education Services Grant** has been cut as part of education funding reforms, as described at paragraphs 7 and 10 above;

(b) **Dedicated Schools Grant** (DSG), which funds schools' own spending and a range of education-related central services, is being reformed from 2018/19. This will lead to a reduction in the funding available for school improvement and SEN support services provided centrally.

(c) The **Better Care Fund** has increased nationally, and the city is expected to receive £15.5m by 2019/20. This is not entirely new money – some is being met from cuts to NHB, and from a reduction in the amount available for RSG. Unlike the original BCF, this new tranche is a direct grant to local government, although strings have been attached.

12.6 In 2016, the Institute for Fiscal Studies (IfS) calculated the disproportionate impact of funding cuts on deprived authorities[2]. Since 2009/10, the 10% of authorities most reliant on grant have seen budget cuts averaging 33% in real terms. The 10% of authorities least reliant on grant have seen cuts averaging 9%. This is a consequence of various changes in the funding regime which have had different impacts, and (to some extent) contravened the Government's stated intentions of protecting the most grant-dependent councils. The IfS states that "the overall impression is of rather confused, inconsistent and opaque policymaking."

[2] *A time of revolution? British local government finance in the 2010s*, IfS, October 2016, p.20

13. **Local Taxation Income**

13.1 Local tax income consists of three elements:-

(a) The retained proportion of business rates;

(b) Council tax;

(c) Surpluses or deficits arising from previous collection of council tax and business rates (collection fund surpluses/deficits).

Business Rates

13.2 Local government retains 50% of the rates collected locally, with the other 50% being paid to central government. In Leicester, 1% is paid to the fire authority, and 49% is retained by the Council. This is known as the "Business Rate Retention Scheme".

13.3 The rates collected from Leicester businesses changed from 2017/18, when a revaluation of all properties nationally came into effect. There is a transitional scheme which is phasing in increases and decreases over time.

13.4 Our estimates of rates income take into account the amount of income we believe we will lose as a consequence of successful appeals. The majority of appeals against the 2017 revaluation have not yet been decided, and appeals have been a source of volatility since business rates retention was introduced. However, the Government has recently taken steps to reduce this volatility – it remains to be seen whether "check, challenge, appeal" will succeed in this aim, but it has been criticised by some in the business community for making the process more difficult.

13.5 The Government's previous plans to introduce 100% business rates retention "by 2020" have now been postponed, as the parliamentary Bill required did not pass through Parliament before the 2017 General Election, and has not been reintroduced in the current session. The timescale for 100% rates retention is now unclear, although it remains an aim for the future. A re-assessment of need is still planned from 2020, however.

13.6 In 2017/18, the Council is part of a "business rates pool" with other authorities in Leicestershire. Pools are beneficial if district councils' rates grow, as the pool increases the amount of rates retained, and in 2016/17 the pool made a surplus of £5m. Surpluses are made available to the LEP to support economic regeneration in the sub-region.

13.7 A limited number of areas are piloting 100% rates retention in 2017/18, and the Government has asked for applications for further pilot areas for 2018/19. Leicester and Leicestershire has submitted a bid involving the City, County, districts and fire authority – if this is successful, it could lead to substantial (one off) financial benefits across the city and county. If the bid is unsuccessful we intend to retain the current rates pooling arrangements.

Council Tax

13.8 Council tax income is estimated at £106.8m in 2018/19, based on a tax increase of just below 5%. For planning purposes, a tax increase of 2% has been assumed in each of 2019/20 and 2020/21.

13.9 Normally, the Council would be unable to increase tax by more than 2% without a referendum. However, additional flexibility (the "social care levy") has been granted to social care authorities since 2016/17. This is designed to help social care authorities mitigate the growing costs of social care; the Government will expect us to demonstrate that the money is being used for this purpose.

13.10 Council tax income includes additional income raised from the Empty Homes Premium, which increases the charge by 50% for a property left empty for more than six months. The government has announced plans, as part of its housing strategy, to allow this premium to be doubled to 100% from April 2019. A decision on the level of premium to be charged will be required in due course; this report has been prepared on the basis that the premium remains at its current level.

Collection Fund Surpluses/Deficits

13.11 Collection fund surpluses arise when more tax is collected than assumed in previous budgets. Deficits arise when the converse is true. At this stage, figures in the draft budget are estimates which will be revised in due course.

13.12 The Council has an estimated **council tax collection fund surplus** of £1.1m, after allowing for shares paid to the police and fire authorities. This has arisen because of growth in the number of homes liable to pay tax (which has been greater than was assumed when the budget was set) and a reduction in the costs of the council tax reduction scheme (linked to improvements in the local economy).

13.13 The Council is currently forecasting a break-even position on **business rates** in the collection fund (i.e. there will be no significant surplus or deficit in the current year). This remains an area of risk, particularly around the impact of appeals, which is difficult to forecast.

14. General Reserves and the Managed Reserves Strategy

14.1 In the current climate, it is essential that the Council maintains reserves to deal with the unexpected. This might include continued spending pressures in demand led services, or further unexpected Government grant cuts.

14.2 The Council has agreed to maintain a minimum balance of £15m of reserves. The Council also has a number of earmarked reserves, which are further discussed in section 15 below.

14.3 In the 2013/14 budget strategy, the Council approved the adoption of a managed reserves strategy. This involved contributing money to reserves in 2013/14 to 2015/16, and drawing down reserves in later years. This policy has

bought time to more fully consider how to make the substantial cuts which are necessary. Since 2016/17, these reserves have been drawn down to balance the budget, although some remain to support 2018/19 and 2019/20.

14.4 The managed reserves strategy will be extended as far as we can: the rolling programme of spending reviews enables any in-year savings to extend the strategy. Additional money has been made available since the 2017/18 budget was set, and future reviews should enable further contributions to be made. However, the reserves available are forecast to be exhausted in 2019/20, and none will be available to cushion the 2020/21 budget.

14.5 The table below shows the forecast reserves available to support the managed reserves strategy:-

	2017/18 £m	**2018/19 £m**	**2019/20 £m**
Brought forward	27.1	17.4	3.4
Additional savings in year	8.0		
Planned use	(17.7)	(14.0)	(3.4)
Carried forward	**17.4**	**3.4**	**NIL**

15. Earmarked Reserves

15.1 In addition to the general reserves, the Council also holds earmarked reserves which are set aside for specific purposes. A schedule is provided at Appendix Six.

15.2 Earmarked reserves are kept under review, and amounts which are no longer needed for their original purpose will be used to extend the managed reserves strategy. The next such review will take place at the end of 2017/18.

16. Risk Assessment and Adequacy of Estimates

16.1 Best practice requires me to identify any risks associated with the budget, and section 25 of the Local Government Act 2003 requires me to report on the adequacy of reserves and the robustness of estimates.

16.2 In the current climate, it is inevitable that the budget carries significant risk.

16.3 In my view, although very difficult, the budget for 2018/19 is achievable subject to the risks and issues described below.

16.4 There are risks in the 2018/19 budget arising from:-

(a) Social care spending pressures - specifically the risks of further growth in the cost of care packages above budget assumptions, risks to our BCF income due to government expectations (particularly relating to delayed transfers of care) and inability to contain the costs of looked after children;

(b) Ensuring spending reviews which have already been approved, but not yet implemented, deliver the required savings;

(c) Managing the position of two departments (City Development & Neighbourhoods, and Children's Services) who need to do further work to live within their means in 2018/19;

(d) Achievability of estimated rates income (although technically any shortfall will appear as a collection fund deficit in the 2019/20 budget), and particularly the extent of successful appeals against the 2017 revaluations.

(e) Pay costs: the NJC pay offer made on 5th December significantly exceeds the 1% provided in the budget, for both 2018/19 and 2019/20. The government has not committed to providing any additional resources to local authorities in the financial settlement to meet this cost, which is therefore a significant risk.

16.5 In the longer term, the risks to the budget strategy arise from:-

(a) Non-achievement, or delayed achievement, of the remaining spending review savings, and the additional £20m of savings that departments have been asked to find by 2019/20;

(b) Loss of future resources. The funding landscape after 2019/20 is particularly unclear, with the delayed implementation of 100% business rates and the planned needs review (which could result in a gain or loss to the Council). The risk of further cuts to RSG in 2020/21 is significant - on current trajectories a further round of cuts would cut £10m in that year;

(c) Longer-term reforms to social care funding and expectations on local authorities, and the need to manage ongoing demographic pressures. Crucially, we need to know what additional funding the Government will make available after 2019/20;

(d) Continuing increases in pay costs, above the 1% per year allowed for in the budget. The LGA has made proposals for a revised pay spine from 2019/20, to make it compatible with the forecast increases to the National Living Wage and to retain pay differentials at the lower end of the pay scale. The proposals will see a significant cost increase in 2019/20 to authorities across the country (in addition to the 2018/19 pay award). Pay costs for 2020/21 also remain a risk, as upwards pressures on pay make it less likely that future pay increases will be limited to 1%.

16.6 Further risk is economic downturn, nationally or locally. This could result in new cuts to grant; falling business rate income; and increased cost of council tax reductions for taxpayers on low incomes. It could also lead to a growing need for council services and an increase in bad debts. The effect of Brexit remains to be seen.

16.7 The budget seeks to manage these risks as follows:-

(a) A minimum balance of £15m reserves will be maintained;

(b) A one-off corporate contingency of £2m is included in the budget for 2018/19 (this may be required to meet the costs of the pay award from April 2018);

(c) A planning contingency is included in the budget from 2019/20 onwards (£3m per annum accumulating);

(d) Savings from the Council's minimum revenue provision policy are being saved until they are required (see paragraph 19).

16.8 Subject to the above comments, I believe the Council's general and earmarked reserves to be adequate. I also believe estimates made in preparing the budget are robust. (Whilst no inflation is provided for the generality of running costs in 2018/19, some exceptions are made, and it is believed that services will be able to manage without an allocation).

17. Consultation on the Draft Budget

17.1 Comments on the draft budget will be sought from:-

(a) The Council's scrutiny function;
(b) Key partners and other representatives of communities of interest;
(c) Business community representatives (a statutory consultee);
(d) The Council's trade unions.

17.2 Comments will be incorporated into the final version of this report.

18. Borrowing

18.1 Local authority capital expenditure is self-regulated, based upon a code of practice (the "prudential code").

18.2 The Council complies with the code of practice, which requires us to demonstrate that any borrowing is affordable, sustainable and prudent. To comply with the code, the Council must approve a set of indicators at the same time as it agrees the budget. The substance of the code pre-dates the recent huge cutbacks in public spending, and the indicators are of limited value.

18.3 Since 2011/12, the Government has been supporting all new general fund capital schemes by grant. Consequently, any new borrowing has to be paid for ourselves and is therefore minimal.

18.4 Attached at Appendix Three are the prudential indicators which would result from the proposed budget. A limit on total borrowing, which the Council is required to set by law, is approved separately as part of the Council's treasury strategy.

18.5 The Council will continue to use borrowing for "spend to save" investment which generates savings to meet borrowing costs.

18.6 The Chartered Institute of Public Finance & Accountancy is currently consulting on changes to the code, which may require amendments to be made in the final version of this report.

19. Minimum Revenue Provision

19.1 By law, the Council is required to charge to its budget each year an amount for the repayment of debt. This is known as "minimum revenue provision" (MRP). The Council approved a new approach in November 2015: the proposed policy at Appendix Four is based on this new approach.

19.2 The proposed MRP policy results in revenue account savings when compared to the old approach, although these are paper rather than real savings – they result from a slower repayment of historic debt.

19.3 The proposed budget for 2018/19 would use the savings made in that year to set aside additional monies for debt repayment (voluntarily). This creates a "virtuous circle", i.e. it increases the savings in later years when we will need them more.

19.4 The approach to savings in 2019/20 and later years will be considered when the budgets for those years are prepared. At present, the capital financing estimates assume that the previous policy continues to apply.

19.5 Members are asked to note that the extent of savings available from the policy change will tail off in the years after they are fully brought into account.

19.6 The government is currently consulting on changes to national requirements around MRP. The draft policy shown at Appendix Four will be reviewed once the outcome of this consultation is known.

20. Financial Implications

20.1 This report is exclusively concerned with financial issues.

20.2 Section 106 of the Local Government Finance Act 1992 makes it a criminal offence for any member with arrears of council tax which have been outstanding for two months or more to attend any meeting at which a decision affecting the budget is to be made unless the member concerned declares the arrears at the outset of the meeting and that as a result s/he will not be voting. The member can, however, still speak. The rules are more circumscribed for the City Mayor and Executive. Any executive member who has arrears outstanding for 2 months or more cannot take part at all.

21. **Legal Implications (Kamal Adatia/Emma Horton)**

21.1 The budget preparations have been in accordance with the Council's Budget and Policy Framework Procedure Rules – Council's Constitution – Part 4C. The decision with regard to the setting of the Council's budget is a function under the constitution which is the responsibility of the full Council.

21.2 At the budget-setting stage, Council is estimating, not determining, what will happen as a means to the end of setting the budget and therefore the council tax. Setting a budget is not the same as deciding what expenditure will be incurred. The Local Government Finance Act, 1992, requires an authority, through the full Council, to calculate the aggregate of various estimated amounts, in order to find the shortfall to which its council tax base has to be applied. The Council can allocate more or less funds than are requested by the Mayor in his proposed budget.

21.3 As well as detailing the recommended council tax increase for 2018/19, the report also complies with the following statutory requirements:-

(a) Robustness of the estimates made for the purposes of the calculations;

(b) Adequacy of reserves;

(c) The requirement to set a balanced budget.

21.4 Section 65 of the Local Government Finance Act, 1992, places upon local authorities a duty to consult representatives of non-domestic ratepayers before setting a budget. There are no specific statutory requirements to consult residents, although in the preparation of this budget the Council is undertaking tailored consultation exercises with wider stakeholders.

21.5 As set out at paragraph 11, the discharge of the 'function' of setting a budget triggers the duty in s.149 of the Equality Act, 2010, for the Council to have "due regard" to its public sector equality duties. These are set out in paragraph 11. There are considered to be no specific proposals within this year's budget that could result in new changes of provision that could affect different groups of people sharing protected characteristics. As a consequence, there are no service-specific 'impact assessments' that accompany the budget. There is no requirement in law to undertake equality impact assessments as the only means to discharge the s.149 duty to have "due regard". The discharge of the duty is not achieved by pointing to one document looking at a snapshot in time, and the report evidences that the Council treats the duty as a live and enduring one. Indeed case law is clear that undertaking an EIA on an 'envelope-setting' budget is of limited value, and that it is at the point in time when policies are developed which reconfigure services to live within the budgetary constraint when impact is best assessed. However, an analysis of equality impacts has been prepared in respect of the proposed increase in council tax, and this is set out in Appendix Five.

21.6 Judicial review is the mechanism by which the lawfulness of Council budget-setting exercises are most likely to be challenged. There is no sensible way to provide an assurance that a process of budget setting has been undertaken in

a manner which is immune from challenge. Nevertheless the approach taken with regard to due process and equality impacts is regarded by the City Barrister to be robust in law.

22. **Other Implications**

Other Implications	Yes/ No	Paragraph References within the report
Equal Opportunities	Y	Paragraph 11
Policy	Y	The budget sets financial envelopes within which Council policy is delivered
Sustainable and Environmental	N	The budget is a set of financial envelopes within which service policy decisions are taken. The proposed 2018/19 budget reflects existing service policy.
Crime & Disorder	N	
Human Rights Act	N	
Elderly People/People on Low Income	N	

Background information relevant to this report is already in the public domain.

23. **Report Authors**

Catherine Taylor
Principal Accountant

catherine.taylor@leicester.gov.uk

Mark Noble
Head of Financial Strategy

mark.noble@leicester.gov.uk

7th December 2017

Appendix One

Budget Ceilings

	Current budget	Spending Review savings	Inflation	Technical & other changes	18/19 budget ceiling
	£'000s	£'000s	£'000s	£'000s	£'000s
1. City Development & Neighbourhoods					
1.1 Neighbourhood & Environmental Services					
Divisional Management	205.0		1.4		**206.4**
Regulatory Services	4,486.5	(259.0)	55.3		**4,282.8**
Waste Management	15,524.0		818.7		**16,342.7**
Parks & Open Spaces	3,411.9	(293.0)	102.1		**3,221.0**
Neighbourhood Services	6,031.6	(275.1)	41.6		**5,798.1**
Standards & Development	614.7	(79.0)	15.6		**551.3**
Divisional sub-total	**30,273.7**	**(906.1)**	**1,034.7**	**0.0**	**30,402.3**
1.2 Tourism, Culture & Inward Investment					
Arts & Museums	4,812.1	(60.0)	28.9		**4,781.0**
De Montfort Hall	946.5		21.9		**968.4**
City Centre	97.0		1.8		**98.8**
Place Marketing Organisation	390.3		2.0		**392.3**
Economic Development	471.9		12.5		**484.4**
Markets	(745.8)		6.6		**(739.2)**
Divisional Management	12.4	(238.9)	1.8		**(224.7)**
Divisional sub-total	**5,984.4**	**(298.9)**	**75.5**	**0.0**	**5,761.0**
1.3 Planning, Development & Transportation					
Transport Strategy	9,456.2	(120.0)	32.7		**9,368.9**
Highways	5,744.2	(121.0)	39.4		**5,662.6**
Planning	990.5		24.1		**1,014.6**
Divisional Management	196.3		2.0		**198.3**
Divisional sub-total	**16,387.2**	**(241.0)**	**98.2**	**0.0**	**16,244.4**
1.4 Estates & Building Services	**6,891.9**	**(1,550.0)**	**114.3**	**0.0**	**5,456.2**
1.5 Housing Services					
Housing Services	3,844.9	(250.0)	60.1		**3,655.0**
Fleet Management	5.1		8.7		**13.8**
Divisional sub-total	**3,850.0**	**(250.0)**	**68.8**	**0.0**	**3,668.8**
1.6 Departmental Overheads	**621.3**	**0.0**	**1.7**	**0.0**	**623.0**
DEPARTMENTAL TOTAL	**64,008.5**	**(3,246.0)**	**1,393.2**	**0.0**	**62,155.7**

Appendix One

Budget Ceilings

		Current budget	Spending Review savings	Inflation	Technical & other changes	18/19 budget ceiling
		£'000s	£'000s	£'000s	£'000s	£'000s
2.Adults						
2.1 Adult Social Care & Safeguarding						
	Other Management & support	1,524.5		24.0		**1,548.5**
	Safeguarding	417.3		5.6		**422.9**
	Preventative Services	7,491.4		54.0		**7,545.4**
	Independent Sector Care Package Cos	81,101.8		1,684.7	(459.0)	**82,327.5**
	Care Management (Localities)	7,367.4		71.5		**7,438.9**
	Divisional sub-total	**97,902.4**	**0.0**	**1,839.8**	**(459.0)**	**99,283.2**
2.2 Adult Social Care & Commissioning						
	Enablement &Day Care	4,433.3		48.7		**4,482.0**
	Care Management (LD & AMH)	5,235.9		49.9		**5,285.8**
	Preventative Services	3,749.2		3.9		**3,753.1**
	Contracts,Commissioning & Other Sup	2,716.4		33.1		**2,749.5**
	Substance Misuse	5,559.7				**5,559.7**
	Departmental	(16,116.4)	(200.0)	8.6		**(16,307.8)**
	Divisional sub-total	**5,578.1**	**(200.0)**	**144.2**	**0.0**	**5,522.3**
2.3 Health and Wellbeing						
	Sexual Health	4,145.6				**4,145.6**
	NHS Health Checks	371.0				**371.0**
	Children 0-19	9,517.5	(250.0)			**9,267.5**
	Smoking & Tobacco	922.0				**922.0**
	Physical Activity	1,158.0				**1,158.0**
	Health Protection	55.0				**55.0**
	Public Mental Health	234.0				**234.0**
	Public Health Advice & Intelligence	48.5				**48.5**
	Staffing & Infrastructure	1,525.4	(25.0)			**1,500.4**
	Sports Services	3,282.3	(120.0)	82.9		**3,245.2**
	Divisional sub-total	**21,259.3**	**(395.0)**	**82.9**	**0.0**	**20,947.2**
DEPARTMENTAL TOTAL		**124,739.8**	**(595.0)**	**2,066.9**	**(459.0)**	**125,752.7**

Appendix One

Budget Ceilings

	Current budget	Spending Review savings	Inflation	Technical & other changes	18/19 budget ceiling
	£'000s	£'000s	£'000s	£'000s	£'000s
3. Education & Children's Services					
3.1 Strategic Commissioning & Business Support					
Divisional Budgets	659.4		8.7		**668.1**
Operational Transport	(111.6)				**(111.6)**
Divisional sub-total	**547.8**	**0.0**	**8.7**	**0.0**	**556.5**
3.2 Learning Quality & Performance					
Raising Achievement	1,466.8		15.5		**1,482.3**
Adult Skills	(870.4)				**(870.4)**
School Organisation & Admissions	814.9		7.3		**822.2**
Special Education Needs and Disabiliti	6,941.9		29.5		**6,971.4**
Divisional sub-total	**8,353.2**	**0.0**	**52.3**	**0.0**	**8,405.5**
3.3 Children, Young People and Families					
Children In Need	9,520.5		65.6	(400.0)	**9,186.1**
Looked After Children	33,354.0		266.3	(1,950.0)	**31,670.3**
Safeguarding & QA	2,235.2		22.8		**2,258.0**
Early Help Targeted Services	7,666.4	(3,223.0)	83.4		**4,526.8**
Early Help Specialist Services	4,802.7		58.9	750.0	**5,611.6**
Divisional sub-total	**57,578.8**	**(3,223.0)**	**497.0**	**(1,600.0)**	**53,252.8**
3.4 Departmental Resources					
Departmental Resources	1,662.0	(370.0)	5.3		**1,297.3**
Education Services Grant	(4,468.1)				**(4,468.1)**
Divisional sub-total	**(2,806.1)**	**(370.0)**	**5.3**	**0.0**	**(3,170.8)**
DEPARTMENTAL TOTAL	**63,673.7**	**(3,593.0)**	**563.3**	**(1,600.0)**	**59,044.0**
4. Corporate Resources Department					
4.1 Delivery, Communications & Political G	**5,377.9**	**(63.0)**	**41.5**	**0.0**	**5,356.4**
4.2 Financial Services					
Financial Support	5,959.8		72.3		**6,032.1**
Revenues & Benefits	5,715.1	(60.0)	84.4		**5,739.5**
Divisional sub-total	**11,674.9**	**(60.0)**	**156.7**	**0.0**	**11,771.6**
4.3 Human Resources	**4,193.0**	**0.0**	**46.5**	**0.0**	**4,239.5**
4.4 Information Services	**9,120.2**	**0.0**	**52.1**	**0.0**	**9,172.3**
4.5 Legal Services	**2,045.2**	**0.0**	**38.8**	**0.0**	**2,084.0**
DEPARTMENTAL TOTAL	**32,411.2**	**(123.0)**	**335.6**	**0.0**	**32,623.8**
TOTAL -Service Budget Ceilings	**284,833.2**	**(7,557.0)**	**4,359.0**	**(2,059.0)**	**279,576.2**
less **public health grant**	(27,519.0)			715.0	**(26,804.0)**
NET TOTAL	**257,314.2**	**(7,557.0)**	**4,359.0**	**(1,344.0)**	**252,772.2**

Appendix Two

Scheme of Virement

1. This appendix explains the scheme of virement which will apply to the budget, if it is approved by the Council.

Budget Ceilings

2. Strategic directors are authorised to vire sums within budget ceilings without limit, providing such virement does not give rise to a change of Council policy.

3. Strategic directors are authorised to vire money between any two budget ceilings within their departmental budgets, provided such virement does not give rise to a change of Council policy. The maximum amount by which any budget ceiling can be increased or reduced during the course of a year is £500,000. This money can be vired on a one-off or permanent basis.

4. Strategic directors are responsible, in consultation with the appropriate Assistant Mayor if necessary, for determining whether a proposed virement would give rise to a change of Council policy.

5. Movement of money between budget ceilings is not virement to the extent that it reflects changes in management responsibility for the delivery of services.

6. The City Mayor is authorised to increase or reduce any budget ceiling. The maximum amount by which any budget ceiling can be increased during the course of a year is £5m. Increases or reductions can be carried out on a one-off or permanent basis.

7. The Director of Finance may vire money between budget ceilings where such movements represent changes in accounting policy, or other changes which do not affect the amounts available for service provision.

8. Nothing above requires the City Mayor or any director to spend up to the budget ceiling for any service.

Corporate Budgets

9. The following authorities are granted in respect of corporate budgets:

   (a) the Director of Finance may incur costs for which there is provision in miscellaneous corporate budgets, except that any policy decision requires the approval of the City Mayor;

   (b) the City Mayor may determine the use of the corporate contingency;

   (c) the City Mayor may determine the use of the provision for Education Funding reform.

Earmarked Reserves

10. Earmarked reserves may be created or dissolved by the City Mayor. In creating a reserve, the purpose of the reserve must be clear.

11. Strategic directors may add sums to an earmarked reserve, from:

    (a) a budget ceiling, if the purposes of the reserve are within the scope of the service budget;
    (b) a carry forward reserve, subject to the usual requirement for a business case.

12. Strategic directors may spend earmarked reserves on the purpose for which they have been created.

13. When an earmarked reserve is dissolved, the City Mayor shall determine the use of any remaining balance.

Appendix Three

Recommended Prudential Indicators

1. Introduction

1.1 This appendix details the recommended prudential indicators for general fund borrowing and HRA borrowing.

2. Proposed Indicators of Affordability

2.1 The ratio of financing costs to net revenue budget:

	2018/19 Estimate %	2019/20 Estimate %	2020/21 Estimate %
General Fund	5.4	5.5	5.1
HRA	12.1	12.5	12.4

2.2 The estimated incremental impact on council tax and average weekly rents of capital investment decisions proposed in the general fund budget and HRA budget reports over and above capital investment decisions that have previously been taken by the Council are:

	2018/19 Estimate £	2019/20 Estimate £
Band D council tax	0.0	0.0
HRA rent	0.0	0.0

3. Indicators of Prudence

3.1 The forecast level of capital expenditure to be incurred for the years 2017/18 and 2018/19 (based upon the Council capital programme, and the proposed budget and estimates for 2018/19) are:

Area of expenditure	2017/18 Estimate £000s	2018/19 Estimate £000s
Children's services	37,288	44,932
Young People	118	1,050
Resources ICT	2,905	500
Transport	33,994	33,678
Cultural & Neighbourhood Services	3,812	6,787
Environmental Services	711	355
Economic Regeneration	25,040	26,516
Adult Care	5,230	10,998
Public Health	328	1,723
Property	4,143	4,100
Vehicles	2,929	-
Housing Strategy & Options	2,650	3,450
Corporate Loans	-	-
Total General Fund	119,148	134,089
Housing Revenue Account	19,057	15,626
Total	138,205	149,715

3.2 The capital financing requirement, measuring the authority's underlying need to borrow for a capital purpose, is shown below. This includes PFI recognised on the balance sheet.

	2017/18 Estimate £m	2018/19 Estimate £m	2019/20 Estimate £m	2020/21 Estimate £m
General Fund	350	333	316	298
HRA	215	215	215	215

4. Treasury Limits for 2018/2019

4.1 The Treasury Strategy, which includes a number of prudential indicators required by CIPFA's prudential code for capital finance, will be presented to Council in January.

Appendix Four

Minimum Revenue Provision Policy

1. Introduction

1.1 This policy sets out how the Council will calculate the minimum revenue provision chargeable to the General Fund in respect of previous years' capital expenditure, where such expenditure has been financed by borrowing.

1.2 At the time of writing (November 2017), the national requirements for MRP are under review. This policy will need to be reviewed once the outcome of this consultation is available.

2. Basis of Charge

2.1 Where borrowing pays for an asset, the debt repayment calculation will be based on the life of the asset.

2.2 Where borrowing funds a grant or investment, the debt repayment will be based upon the length of the Council's interest in the asset financed (which may be the asset life, or may be lower if the grantee's interest is subject to time limited restrictions).

2.3 Where borrowing funds a loan to a third party, the basis of charge will normally be the period of the loan (and will never exceed this). The charge would normally be based on an equal instalment of principal, but could be set on an annuity basis where the Director of Finance deems appropriate.

3. Commencement of Charge

3.1 Debt repayment will normally commence in the year following the year in which the expenditure was incurred. However, in the case of expenditure relating to the construction of an asset, the charge will commence in the year in which the asset becomes operational. Where expenditure will be recouped from future income or capital receipt, and the receipt of that income can be forecast with reasonable certainty, the charge may commence when the income streams or receipt arise.

4. Asset Lives

4.1 The following maximum asset lives are proposed:-

- Land – 50 years;
- Buildings – 50 years;
- Infrastructure – 40 years;
- Plant and equipment – 20 years;
- Vehicles – 10 years;
- Loan premia – the higher of the residual period of loan repaid and the period of the replacement loan;

5. **Voluntary Set Aside**

5.1 Authority is given to the Director of Finance to set aside sums voluntarily for debt repayment, where she believes the standard depreciation charge to be insufficient, or in order to reduce the future debt burden to the authority. [This enables her to give effect to the budget strategy].

6. **Other**

6.1 In circumstances where the treasury strategy permits use of investment balances to support investment projects which achieve a return, the Director of Finance may adopt a different approach to reflect the financing costs of such schemes. A different approach may also be adopted for other projects which aim to achieve a return.

Appendix Five

Equality Impact Assessment

1. Purpose of the increase

1.1 The purpose of this appendix is to present the equalities impact of the proposed 4.99% council tax increase.

1.2 There are two elements to the proposed tax increase:

(a) A 3% increase to address Adult Social Care funding needs outlined in the budget strategy;

(b) A 1.99% increase in council tax to enable the council to maintain its budgeted policy commitments.

2. Who is affected by the proposal?

2.1 Since April 2013, as a consequence of the Government's welfare reforms, all working age households in Leicester have been required to contribute towards their council tax bill. Our current council tax reduction scheme (CTRS) requires working age households to pay at least 20% of their council tax bill, and sets out to ensure that the most vulnerable householders are given some relief in response to financial hardship they may experience.

2.2 NOMIS[3] figures for the city's working age population (June 2017) indicated that there are 161,000 economically active residents in the city, of whom 5.2% are unemployed. As of November 2016, there were 30,060 working age benefit claimants (12.9% of the city's working age population of 233,000) It should be noted that this does not include tax credit claimants (unless they are also in receipt of another benefit). The working age population is inclusive of all protected characteristics.

3. How are they affected?

3.1 The chart below sets out the financial impact of the proposed council tax increase on different properties, before any discounts or reliefs are applied. It shows the weekly increase in each band, and the minimum weekly increase for those in receipt of a reduction under the CTRS.

3.2 For band B properties (almost 80% of the city's properties are in bands A or B), the proposed annual increase in council tax is £55.28; the minimum annual increase for households eligible under the CTRS would be £11.06.

[3] NOMIS is an Office for National Statistics web based service that provides free UK labour market statistics from official sources.

Band	No. of Households	Weekly Increase	Maximum Relief (80%)	Minimum Weekly Increase
A	75,549	£0.91	£0.73	£0.18
B	24,830	£1.06	£0.85	£0.21
C	14,440	£1.21	£0.85	£0.36
D	6,051	£1.36	£0.85	£0.52
E	3,185	£1.67	£0.85	£0.82
F	1,464	£1.97	£0.85	£1.12
G	583	£2.27	£0.85	£1.42
H	58	£2.73	£0.85	£1.88
Total	**126,160**			

4. Risks over the coming year:

4.1 Recently, disposable income has fallen in real terms. This has multiple causes: slow wage growth (only partly offset by rising employment rates), welfare changes and inflation.

4.2 One of the main risks to household income in the previous year (2017/18) was increases in inflation. Inflation has increased, as predicted. The National Institute of Economic and Social Research (NIESR) have projected consumer price inflation to peak at 3.4 per cent in the final quarter of 2017, before gradually returning back towards the Bank of England's 2 per cent target. The Bank now expects inflation will hit 2.4% in 2018 and 2019. Therefore, the impact of rising inflation is less of a risk over the coming year. Having said this, it must be considered that until such a point that inflation returns towards the Bank of England's 2% target, households will continue to be squeezed and are likely to have less discretionary income than they would enjoy in the event that inflation were to fall.

4.3 Incomes of households reliant on social security benefits continue to be squeezed with the Government's continued implementation of the welfare reform programme. **Of particular relevance is the roll out of Universal Credit in Leicester (in summer 2018).** The chart below[4] gives an indication of anticipated decreases in household incomes by 2020/21, as a consequence of post 2015 welfare reforms:-

Couple – one dependent child	£900 p.a.
Couple – two or more dependent children	£1,450 p.a.
Lone parent – one dependent child	£1,400 p.a.
Lone parent – two or more dependent children	£1,750 p.a.
Single person working age household	£250 p.a.

[4] *Source: Centre for Regional Economic and Social Research/Sheffield Hallam University report: "The uneven impact of welfare reform – the financial losses to places and people" (March 2016).*

4.4 The Joseph Rowntree Foundation's annual "Minimum Income Standard" (MIS) for 2017, highlighted that millions of just managing families are on the tipping point of falling into poverty as prices rise in the shops (the price of a minimum "basket of goods" has risen 27-30% since 2008), with forecasts showing the cost of living could be 10 per cent higher by 2020. The Foundation is warning there is a fine margin where just managing can quickly tip into living in poverty, such is the precarious state of many household budgets.

4.5 Between 2008/9 – 2014/5, based on the latest available data from official statistics:

- The number of individuals below MIS **rose by four million**, from 15 million to 19 million (from 25 to 30 per cent of the population);
- There are **11 million people living far short of MIS**, up from 9.1 million, who have incomes below 75% of the standard and are at high risk of being in poverty;
- The remaining **eight million fall short of the minimum**, by a smaller amount, and despite having a more modest risk of poverty, are **just about managing at best**.

4.6 Almost three million working age households, six in 10 below MIS, have at least one person in work. Families with children continue to have the highest risk of having incomes that fall short of the standard, with working parents facing worsening prospects:

- For lone parents, even those working full time have a 42% risk of being below MIS, up from 28% in 2008/09. 151,000 out of 356,000 people in households headed by lone parents working full time are below the minimum.
- 56% of people in single-breadwinner couples with children live below – a substantial increase of more than a third over the six-year period. This affects 500,000 out of 880,000 people in such families.
- For couples with children where one adult works full time and the other is in part-time or self-employment, the risk of inadequate income has increased by a half, reaching 18%. This is 310,000 out of 1.7 million people in such families.

4.7 There are some offsetting current trends:

- There has been a continuing decrease in the percentage of the working age population unemployed in Leicester (NOMIS): June 2017, 5.2% (down from June 2016, 6.6%, June 2015, 7.7%; June 2014, 11.8%; and June 2013, 13.9%).
- The National Institute of Economic and Social Research (NIESR) have projected consumer price inflation to peak at 3.4 per cent in the final quarter of 2017, before gradually returning back towards the Bank of England's 2 per cent target. The Bank now expects inflation will hit 2.4% in 2018 and 2019.

5. Overall impact:

5.1 Any increased costs will be a problem for some households with limited incomes, as they will be squeezed by the next round of welfare reforms alongside inflationary increases of many basic household items such as food and fuel.

5.2 The weekly increase in council tax, however, is small for many of these households, as can be seen from the table above.

6. Mitigating actions:

6.1 For residents likely to experience short term financial crises as a result of the cumulative impacts of the above risks, the Council has a range of mitigating actions. These include: funding through Discretionary Housing Payments; the council's work with voluntary and community sector organisations to provide food to local people where it is required – through the council's or partners' food banks; and through schemes which support people getting into work (and include cost reducing initiatives that address high transport costs such as providing recycled bicycles).

6.2 Having said this, although it will continue to be in place as a mitigating action, there has been significant pressure on the Discretionary Housing Payment fund which has resulted in the need to review the policy for 2018.

6.3 Social welfare advice is currently in the process of being re-procured and will continue to be used as a mitigating action. Advice will continue to be provided in relation to welfare benefits, debt, housing, employment, community care, family issues and immigration. A full assessment of the impact of the proposals has been undertaken. The proposals are being considered by the NSCI Scrutiny Commission on 7/12/17 and a decision will be published shortly afterwards.

7. What protected characteristics are affected?

7.1 The table below describes how each protected characteristic is likely to be affected by the proposed council tax increase. The chart sets out known trends, anticipated impacts and risks; along with mitigating actions available to reduce negative impacts.

7.2 Some protected characteristics are not (as far as we can tell) disproportionately affected (as will be seen from the table) because there is no evidence to suggest they are affected differently from the population at large. They may, of course, be disadvantaged if they also have other protected characteristics that are likely to be affected, as indicated in the following analysis of impact based on protected characteristic.

7.3 Analysis of impact based on protected characteristic

Protected characteristic	Impact of proposal:	Risk of negative impact:	Mitigating actions:
Age	Older people are least affected by a potential increase in council tax. Older people (pension age & older) have been relatively protected from the impacts of the recession & welfare cuts, they receive protection from inflation in the uprating of state pensions. Low-income pensioners also have more generous (up to 100%) council tax relief. However, in the current financial climate, a lower council tax increase would require even greater cuts to services. While it is not possible to say where these cuts would fall exactly, there are potential negative impacts for this group as older people are the primary service users of Adult Social Care. Income inequality is likely to increase over the next few years. If real earnings grow as the Office for Budget Responsibility forecasts, high-income households will benefit more than lower-income ones. And if benefit cuts proceed as planned, they will act to significantly reduce the incomes of low-income working-age households. Working age people bear the impacts of welfare reform reductions – particularly those with children. Whilst an increasing proportion of working age residents are in work, national research indicates that those on low wages are failing to get the anticipated uplift of the National Living Wage. A recent report by the Institute for Fiscal Studies on Living Standards, Poverty and Inequality in the UK 2017, shows that trends in living standards for different age groups have been very different. By 2015–16, median income for those aged 60 and over was 10% higher than it was in 2007–08, but for adults aged 22–30 it was still 4% lower. These differences are primarily due to the negative labour market impacts of the recession, which were far more pronounced among younger people. The Joseph Rowntree Foundation's Minimum Income standard (MIS) shows that families with children continue to have the highest risk of having incomes that fall short of the standard, with working parents facing worsening prospects, as discussed at paragraph 4.6 above. The tax increase could have an impact on such household incomes.	Working age households and families with children – incomes squeezed through low wages and reducing levels of benefit income.	Access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on better managing household budgets.

Protected characteristic	Impact of proposal:	Risk of negative impact:	Mitigating actions:
Disability	Disability benefits have been reduced over time as thresholds for support have increased. The tax increase could have an impact on such household incomes.	Further erode quality of life being experienced by disabled people as their household incomes are squeezed further as a result of reduced benefits and impact of increased inflation.	Disability benefits are disregarded in the assessment of need for CTRS purposes. Access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on better managing budgets.
Gender Reassignment	No disproportionate impact is attributable specifically to this characteristic.		
Marriage & Civil Partnership	Couples receive benefits if in need, irrespective of their legal marriage or civil partnership status. No disproportionate impact is attributable specifically to this characteristic.		
Pregnancy and Maternity	Maternity benefits will not be frozen and therefore kept in line with inflation. However, other social security benefits will be frozen, but without disproportionate impact arising for this specific protected characteristic.		
Race	Those with white backgrounds are disproportionately on low incomes (indices of multiple deprivation) and in receipt of social security benefits. Some BME people are also low income and on benefits. The tax increase could have an impact on such household incomes. Nationally, one-earner couples have seen particular falls in real income and are disproportionately of Asian background – which suggests an increasing impact on this group.	Household income being further squeezed through low wages and reducing levels of benefit income, along with anticipated inflation.	Access to council discretionary funds for individual financial crises, access to council and partner support for food and advice on better managing household budgets.
Religion or Belief	No disproportionate impact is attributable specifically to this characteristic.		

Protected characteristic	Impact of proposal:	Risk of negative impact:	Mitigating actions:
Sex	Disproportionate impact on women who tend to manage household budgets and are responsible for childcare costs. Women are disproportionately lone parents. The Joseph Rowntree Foundation's Minimum Income standard (MIS) shows that Families with children continue to have the highest risk of having incomes that fall short of the standard, with working parents facing worsening prospects: For lone parents, even those working full time have a 42% risk of being below MIS, up from 28% in 2008/09. 151,000 out of 356,000 people in households headed by lone parents working full time are below the minimum.	Incomes squeezed through low wages and reducing levels of benefit income, along with anticipated inflation. Increased risk for women as they are more likely to be lone parents.	If in receipt of Universal Credit or tax credits, a significant proportion of childcare costs are met by these sources. Access to council discretionary funds for individual financial crises, access to council and partner support for food and advice on better managing household budgets.
Sexual Orientation	No disproportionate impact is attributable specifically to this characteristic.		

Appendix Six

Earmarked Reserves

1. Earmarked reserves as at September 2017 were as follows:

	Current balance £k
Departmental Reserves	
Adult Social Care	312
Voluntary Sector Prospective Work	1,500
Children's Services	956
City Development & Neighbourhoods	1,092
Housing (non HRA)	1,179
Public Health	662
Channel Shift	1,648
ICT Development	2,959
PC Replacement Fund	1,297
Surplus Property Disposal	912
Election Fund	1,020
Financial Services	3,347
Other Corporate Resources Department	3,814
Subtotal – departmental	**20,698**
Corporate Reserves	
Managed Reserves Strategy	27,496
BSF Financing	10,511
Capital Programme Reserve	37,498
Severance Fund	11,032
Insurance Fund	6,664
Service Transformation	7,302
Welfare Reform	4,004
Other corporate reserves	2,153
Subtotal – corporate	**106,660**
TOTAL UNRINGFENCED	**127,358**
Ringfenced Reserves	
NHS Joint Working Projects	1,769
Public Health Transformation	1,668
School Capital Fund	2,917
Schools Buyback	771
Dedicated Schools Grant not delegated to schools	14,205
School & PRU balances	14,683
TOTAL RINGFENCED	**36,013**
Total earmarked reserves	**163,371**

2. Earmarked reserves can be broadly divided into ring-fenced reserves, which are funds held by the Council but for which we have obligations to other partners or organisations; departmental reserves, which are held for specific services; and corporate reserves, which are held for purposes applicable to the organisation as a whole.

3. Ring-fenced reserves include:-

- **NHS joint working projects:** The Government has provided funding for joint working between adult social care and the NHS;
- **Public Health Transformation:** Ringfenced Public Health Grant money and will be used for future service changes;
- Amounts originating from **Dedicated Schools Grant** which are, by, law, ring-fenced to schools or relevant non-delegated functions. These balances will be used to fund growth in pupil numbers and cost pressures in the high needs block which will arise as a consequence of growth in numbers and national funding reform.

4. Departmental reserves include amounts held by service departments to fund specific projects or identified service pressures. Significant amounts include:-

- **Adult Social Care and Children's Services:** To meet budget pressures and prevent overspending;
- **City Development and Neighbourhoods:** It is anticipated that the reserve will be drawn upon to support 2017/18 cost and income pressures, as noted in budget monitoring reports. The remaining balance will provide resilience in 2018/19 should the department face in-year budget pressures as spending reviews take effect; to enable any new, one-off priority activities to be funded; and to meet known additional pressures such as a shortfall in bereavement income and reduced income at Leicester Market as the redevelopment continues.
- **Housing:** held to ensure that any short term increases in the demand for General Fund housing services can be managed without affecting the in-year budget; to secure increased availability of private rented sector accommodation where required; to support joined-up working with complex clients; and to fund planned service improvements.
- **Voluntary Sector Prospective Work:** To provide a grant pot which can be used by the voluntary sector for preventative non statutory support in the community of £250k per annum, initially for a three year period;
- **Channel Shift**: To fund work across the Council to both improve the customer experience and make savings through increasing the proportion of interactions with residents that use web-based and self-service systems, or streamlined customer services operations;
- **ICT Development:** The ongoing upgrade and modernisation of the Council's IT infrastructure (such as the Windows 10 rollout programme);
- **PC Replacement Fund:** To fund a rolling replacement programme for desktop PCs and portable devices as we continue to promote flexible and mobile working;
- **Election Fund:** To meet costs arising from future elections, smoothing out the cost between years;

- **Financial Services:** For expenditure on replacing the Council's main finance system, the Service Analysis Team and Welfare & Benefits as government housing benefit administration grants reduce and universal credit is rolled out.

5. Corporate reserves include:-

- **Managed Reserves Strategy** – a key element to delivering this budget strategy, as set out in para. 14 of this report;
- **BSF Financing:** to manage costs over the remaining life of the BSF scheme and lifecycle maintenance costs of the redeveloped schools;
- **Capital Fund:** to support approved spending on the Council's capital programme. This is fully committed to meet the costs of the capital programme;
- **Severance Fund:** to facilitate ongoing savings by meeting the redundancy and other costs arising from budget cuts;
- **Insurance Fund:** To meet the cost of claims which are self-insured;
- **Service Transformation Fund:** to fund projects which redesign services enabling them to function effectively at reduced cost
- **Welfare Reform:** set aside to support welfare claimants who face crisis, following the withdrawal of government funding for this purpose.

Appendix Seven

Comments from Partners

[To be added once consultation is complete]

Appendix Eight

Spending Review Programme

	Review	Summary	Savings Reported (£m)	Outstanding Savings (£m)	Outstanding Savings – sum reflected in Spending Review 4 (£m)
1.	Corporate Resources	Implementation complete.	3.9	Nil	
2.	Transforming Neighbourhood Services	Reviewing community use buildings on an area by area basis (libraries, community centres, adult skills, customer service centres). Review work mostly complete.	1.1	0.4	0.4
3.	Voluntary and Community Services	Implementation complete.	0.1	Nil	
4.	HRA Charging	Complete (decisions taken).	4.0	Nil	
5.	Sports and Leisure	Review of Council's direct sports provision and sports development. Public consultation recently concluded.		2.0	1.2
6.	Parks and Open Spaces	Review work complete.	1.5	Nil	
7.	Park and Ride	Service expected to become self-financing. Review work complete; fare rises implemented.	0.2	Nil	
8.	External Communications	Implementation complete.	0.1	Nil	
9.	Substance Misuse	Complete.	1.0	Nil	
10.	Welfare Advice	Decision taken.	0.2	Nil	
11.	Investment Property.	Review of property assets held for investment income.	0.5	0.1	Nil
12.	IT	Review work complete.	2.4	Nil	
13.	Homelessness Services	Review of services to prevent homelessness. Review work complete.	1.5	Nil	
14.	Technical Services	Covers facilities management, operational property services, traffic and transport, repairs and maintenance of all buildings (including housing), fleet management, stores, energy, environment team. In implementation.	10.1	Nil	
16.	Children's Services	All services provided by Education and Children's Services, other than schools and social care. Early Help and Youth Services review work complete.	4.4	0.6	0.6
17.	Regulatory Services	Protective services including neighbourhood protection, business regulation, pest control, licensing and community safety. Phase one complete; further savings unlikely.	0.4	0.6	Nil
18.	Cleansing and Waste	City and neighbourhood cleansing, litter disposal, waste collection and disposal (including PFI arrangements). Phase one review complete and to be evaluated in December.	0.7	1.8	1.0

	Review	Summary	Savings Reported (£m)	Outstanding Savings (£m)	Outstanding Savings – sum reflected in Spending Review 4 (£m)
19.	City Centre	Services provided by City Centre Division, including tourism. Complete.	0.1	Nil	
20.	Using Buildings Better	Extends scope of Transforming Neighbourhoods to review other neighbourhood buildings (depots and local non-customer facing offices). Revenue savings will arise from channel shift and staff accommodation.	0.4	1.6	0.8
21.	Tourism, Culture & Inward Investment	Covers arts organisations, museums, support to festivals and other divisional services. Phase one complete.	1.1	0.4	Nil
22.	Car Parking and Highways Maintenance	Complete.	0.8	Nil	
23.	Parks standards and development	Efficiency savings.	0.2	NIL	
24.	Community Capacity Building	Revisit current arrangements with Voluntary Action Leicester & other projects - complete apart from element dependent on Social Welfare Advice review	0.1	0.1	0.1
25.	Civic & Democratic Services	Democratic and civic functions. Implementation complete.	0.2	Nil	
26.	Departmental Administration	Review of departmental administrative services. Savings being delivered departmentally.	1.3	Nil	
27.	Adult Learning	Aim to increase the £0.8m currently contributed to Council support. Service realignment being considered, savings unlikely.		0.4	Nil
28.	Advice Services (Social Welfare)	Review of internal and external advice services provided by internal Welfare Rights, STAR service and external organisations; aims to eliminate duplicate provision. Being considered by NCSI Scrutiny Committee in Dec 17 (public consultation recently undertaken).		0.5	0.3
29.	Sexual Health Services	On demand sexual health and contraception services at St. Peter's Health Centre. Public consultation recently concluded.	0.2	0.6	0.6
30.	Lifestyle Services	Services which support improved diet and physical activity, and cessation of smoking. A single, integrated service is under development.	0.3	1.1	1.1
31.	CDN	Management savings	0.3	Nil	
	Subtotal		**37.0**	**10.2**	**5.9**
	Additional savings target ("SR4")				19.8
	Total savings sought by 2019/20				**25.7**

Health and Wellbeing Scrutiny Commission

Work Programme 2017 – 2018

Meeting Date	Topic	Actions arising	Progress
21 Jun 17	1. Lifestyle Services Review 2. Infant Mortality Rates	1. Information on workshops to be circulated to Members.	
23 Aug 17	1. Sexual Health Review 2. Settings of Care Policy – Verbal Update 3. STP – Primary Care	1. A letter highlighting concerns about the lack of engagement of schools to be sent to Strategic Director, Children's Services 2. Further update to come to a future meeting. 3. Questions/comments to be sent to the CCG.	
4 Oct 17	1. STP – Mental Health 2. EMAS – Handovers with LRI 3. Accident & Emergency Services at UHL – progress report on new facilities and phase 2 4. Services for Lower Back Pain	1. Questions/comments to be sent to the LPT and CCG with a further report in 6 months' time. 2. Update on the Quality Improvement Plan to come in 6 months' time. 3. Further update on Phase 2 to come in spring 2018.	
29 Nov 17	1. CQC Inspection of LPT – Update 2. Settings of Care Policy 3. Repeat Prescriptions and Pharmacies 4. Sexual Health Review 5. Oral Health Update	1. Further update to come to the Commission in spring to include information on agency staffing and estate investment. 2. Letter to be written to the CCG to request the threshold remains at 25%. Chris West to pass on this view to Commissioning Collaborative Board. 3. CCG to share copy of recommendations to NHS England following engagement exercise on community needs and pharmacy locations. 4. Cllr Clarke to invite commission members to a site visit once preferred site agreed.	

Meeting Date	Topic	Actions arising	Progress
11 Jan 18	1. CQC Inspections on GP practices 2. Drugs & Alcohol Services (Turning Point) – CQC Inspection 3. Anchor recovery hub – Update on how it is progressing following a move to the new site 4. Public Health Performance Report 5. Draft Revenue Budget 2018/19 Report		
7 Mar 18	1. STP – Update 2. CQC Inspection of LPT 3. Lifestyle Services Review – Update		

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee

Meeting Date	Topic	Actions arising
29 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.
14 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.
14 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.
27 Jun 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust	It was agreed for the committee response to be collated following information heard at the meeting and submitted to NHS England. It was also agreed to write to the Secretary of State to request he looks at the process and reconsiders the review and drop proposals to close the CHD centre at Glenfield Hospital.
11 Dec 17	1) NHS England's Decision for Congenital Heart Disease Services at UHL NHS Trust 2) Paediatric Critical Care and Specialised Surgery in Children Review	**To be rearranged in the New Year**

Joint Children Young People and Schools and Health and Wellbeing Scrutiny Commission

Meeting Date	Topic	Actions arising
7 Nov 17	1) Children's Mental Health - Future in Mind - CAMHS 2) CQC Review of Health Services for LAC and Safeguarding	1) The following is requested at a future joint meeting: • Further meeting to look at the specific services available and at what stage these interventions/services are provided; effectively mapping all services for children's mental health and what is offered and by whom. • What governance structures in place, who is accountable to whom for different elements, including LA, LPT, schools etc, as well as what services are available. • Examples of anonymised case studies which help understand a child's journey through services as part of this report. • Clarity about the role of schools and how they fit into the process and their role in identifying young people and how they are supported to help young people into the right pathway. • Commission Members to have sight of the Local Transformation Plan • Invite headteachers to the next meeting to get their viewpoint. • Further information on the CAMHS 'improvement journey' with particular information on how the improvements have impacted on outcomes. • More detail about what happens to those who are not 'accepted' by CAMHS

Forward Plan Items

Topic	Detail	Proposed Date
Air Quality Action Plan	To be considered jointly with EDTT Scrutiny	
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	
EMAS Quality Improvement Plan	Update	May/June 2018
LRI Phase 2	Update	May/June 2018
Cancer Treatment Performance	Update	March 2018
Oral Health	Update	June 2018
GP Workforce Plan	To be shared with the Commission.	
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?	