LEICESTER CITY HEALTH AND WELLBEING BOARD

26th MARCH 2015

Subject:	**Update on the Progress of the Joint Health and Wellbeing Strategy**
Presented to the Health and Wellbeing Board by:	**Sue Lock**
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EXECUTIVE SUMMARY:

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

This is the fourth bi-annual progress report to the Health and Wellbeing Board. It serves two related purposes: providing assurance that actions identified in the strategy are being delivered and/or flagging up any potential risks to delivery; and, reporting on the performance indicators set out in Annex 2 of the strategy.

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

Progress can be seen in each priority area and there are positive performance trends for at least some of the measures tracking progress in every area. While improvements can be seen against specific measures, it is still early to judge where the desired impact on the health and wellbeing of the city's residents is being made overall.

RECOMMENDATIONS:
The Health and Wellbeing Board is requested to:

(i) Note progress on the delivery of the Joint Health and Wellbeing Strategy;
(ii) Note the areas of concern highlighted in the report and the response of the JICB to these (appendix 3).
(iii) Agree to replace the current 'dementia' indicator as recommended by the JCIB (page 7).

Update on the Progress of the Joint Health and Wellbeing Strategy

Report on behalf of the Leicester City Joint Integrated Commissioning Board

1. Introduction

This report presents information on progress in delivering the Joint Health and Wellbeing Strategy: 'Closing the Gap'.

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

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

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

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

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

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

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

Red	Action is at serious risk of not being delivered.	0
Amber	Some risk that actions may not be delivered but this risk will be managed.	5
Green	Good progress is being made and there are no significant problems.	14

This is a marked improvement on the judgements made in the last reporting period.

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

Reducing infant mortality: The commissioning of the Health Visiting service will be transferred from NHS England to local authorities in October 2015 and the contract is currently being negotiated with the provider in anticipation of handover.

Healthy lifestyles for children: Healthy and sustainable eating, which will lead to an increased uptake of school meals, an increase in healthy eating behaviours, increased cooking and growing skills in children and families and more knowledge about nutrition, food safety, shopping, growing food and where food comes from.

Physical activity and healthy weight: "Walking Away from Diabetes" groups are now running in the city using walking as a means of preventing type 2 diabetes. This scheme will be delivered through sports services from April 2015, with a focus on increasing the number of referrals into the programme particularly from GPs.

Older People: The Leicester Ageing Together Big Lottery bid continues to progress through the Lottery approval process. Success is virtually assured and this will bring nearly £5m into Leicester. Approval is expected in April and following this some 21 projects and 19 providers will begin to implement a number of initiatives to combat loneliness and isolation amongst older people

Dementia: Leicester City CCG has led a proposal to enhance the LRI based Primary Care Coordinators with dementia specialists as part of that team. This will greatly improve the identification of and support to patients with dementia upon arrival in hospital.

Carers: The Carers Rights day event at the Curve involved 33 partners organisations with Health, voluntary sector providers, the DWP and different council departments represented. The aim was to involve a range of partners who could not only advise on carer-specific matters but on a range of health issues such as strokes, drugs and alcohol and weight management.

Mental Health: The City Council in Partnership with the Leicester City CCG has commissioned Mental Health First Aid Training to be delivered to faith organisations across the city. It is an educational course which teaches people how to identify, understand and help a person who may be developing a mental health problem.

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

The 19 statements of progress, together with RAG ratings are set out at Appendix 1.

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

The majority of performance indicators in the strategy are outcome measures. They are designed to provide evidence that the actions identified in the strategy (and indeed the wider efforts of partners under the Board's "call to action") are having the desired impact, or not, as the case may be.

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

The baseline position for each indicator is given at Appendix 2, alongside an indication of the direction of travel of performance relative to this baseline. Where possible, a separate indication is given showing direction of travel since the previous update report. Overall the position remains broadly similar to that reported in October.

As highlighted above, many of these are outcome measures and will show improvement only after the successful completion of actions currently planned and/or being implemented. While improvements can be seen against some specific measures, it is still too early to judge whether the desired improvement "across the piece" is happening.

Measures showing particular improvement relative to the baseline in the Joint Health and Wellbeing Strategy include those monitoring:

Breast feeding at 6-8 weeks: Performance against this measure has shown continued improvement, with the latest data showing a rate of 61.8% compared to the baseline of 54.9%.

Smoking in Pregnancy: The latest data shows that the decline in performance experienced in 2013/14 has been reversed, with a current rate of 10.7% against the baseline rate of 12.7%.

Adults participating in recommended levels of physical activity: The latest performance data shows a rate of 33% compared to the baseline rate of 27.8%

Diabetes – management of blood sugar levels: Highlighted as a cause for concern in the previous report, 2013/14 outturn data shows a marked improvement, with a rate of 72.4% compared to the baseline rate of 62%. Leicester is now the highest performing area in its comparator family group.

Measures showing significant deterioration from the baseline in the Joint Health and Wellbeing Strategy or a marked decline since the previous report include those monitoring:

Number of people having NHS Checks: Although the out-turn for 2014/15 is likely to be well above the baseline in the strategy, the number of checks completed during the first half of the year are over 40% fewer than the corresponding period in 2013/14.

Smoking cessation - 4 week quit rates: The challenging conditions, largely attributed to changes in smoker's behaviour due to the further impact of e-cigarettes, continue and in q1 2014/15 the service reported that it was 36% below target for the quarter and, building on a recovery plan, at the end of q2 the gap had been narrowed to 23% of the cumulative target. Work will continue on the basis of the recovery plan.

Uptake of bowel cancer screening in men and women: Performance has dipped slightly below the baseline in the strategy due to a marked decrease (-9%) in uptake between 2012/13 and 2013/14.

Coverage of cervical screening in women: This was considered as an area of concern by the Board following our last progress report. Subsequent to this, data for 2013/14 has been published, showing a further decline in coverage.

Self-reported well-being - people with a high anxiety score: Performance has dropped below the baseline in the strategy due to a marked increase (+10%) in the percentage of people reporting high levels of anxiety between 2012/13 and 2013/14.

JICB responses to these areas of concern are set out in appendix 3 of this report.

In this report we have included benchmarking data, where it is available, to help us understand our performance and rate of improvement (or decline) in relation to other similar local authorities. We have used the most appropriate benchmarking group for each measure (e.g. National Foundation for Educational Research benchmarking group for children's and young people's measures).

Given the increased levels of data available for this fourth progress report, we have also been able to include improved trend analysis in graph form for most of our measures. This information is set out in appendix 2b.

When considering the last progress report in September 2014, the Board requested recovery plans for four measures that were giving cause for concern:

- *Readiness for school at age 5*
- *Coverage of cervical screening in women*
- *Diabetes: management of blood sugar levels*
- *Proportion of adults in contact with secondary mental health services living independently with or without support*

The recovery plans were presented to the Board in December 2014, but it is important to note that data contained in this report for the first three of these measures pre-dates the recovery plans. Work is currently underway to ensure that accurate data is reported for the fourth of these measures.

A summary of the current position on the 25 indicators in the strategy is shown below. The full report on the indicators is set out in appendix 2 of this report.

Direction of travel against baselines in the strategy

	Performance has improved from the baseline in the strategy	11
	Performance is similar to the baseline in the strategy	5
	Performance has worsened from the baseline in the strategy	5
	No data has been published since the baseline, or there are data quality issues (see below)	4

4. Data Issues

There are four measures that have either not been reported to date or have been subject to data quality issues.

Of these, we are confident that the data quality issues regarding the measure "*Proportion of adults in contact with secondary mental health services living independently with or without support*" have been identified and are currently being addressed.

Fieldwork on the survey to gather data on *smoking prevalence* is commencing shortly. As such we will be able to report a single dataset to report on progress on this measure before the end of the lifespan of the current strategy.

The changed definition for *"readiness for school at age 5"* means a comparison between latest data and the baseline published in the strategy is not valid.

However, there is one measure, "*Dementia - Effectiveness of post-diagnosis care in sustaining independence and improving quality of life*" which was included in the strategy as a 'placeholder' that we will not be able to report on. It was originally expected that data for this measure would be collected for the first time in 2014/15. This has now been deferred, meaning that we will not have any data on this measure over the lifetime of the strategy.

As such, it is recommended that a proxy measure relating to dementia is introduced over the remaining reporting period of the strategy.

The suggested measure is "*Dementia diagnosis rates: the percentage of patients diagnosed with dementia against the expected prevalence for the population*".

This indicator reflects the intention to *"… work to improve awareness of the needs of people with dementia and their families,* ***promote earlier diagnosis and intervention****, and provide a higher quality of care"* as set out in the strategy.

The measure was designed to support the national Dementia Strategy and Dementia Challenge. Diagnosis data comes from the Quality Outcome Framework (QOF) and is collected at practice level on a monthly basis. Diagnosis rates are then compared with expected prevalence, based on estimates produced by the Alzheimer's Society.

We have the following data for this measure:

	2010/11	2011/12	2012/13	2013/14	Nov-14	Dec-14	Jan-14
Leicester	55%	52%	57%	59.20%	70.20%	71%	71.30%
England	42.60%	46%	48.70%	60%	67%	67%	67%

Appendix 1

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

Progress: March 2015

Strategic Priority 1: Improve outcomes for children and young people

Section	1.1 Reduce Infant Mortality
Contact(s)	Jo Atkinson, Consultant in Public Health, Leicester City Council Bayad Abdalrahman: Registrar in Public Health, Leicester City Council

There is a wide range of work taking place in support of reducing infant mortality and increasing protective actions in the City. We are carrying out a detailed Children and Young People JSNA which follows a life-course approach including the pre-conception period. A multi-agency team is working to develop the 0-5 chapter of the needs assessment and discussions are also taking place to develop 0-5 Strategy alongside this piece of work.

A range of initiatives/services are in place and being further developed to tackle the risk factors for infant mortality:

- UHL and LPT achieved the UNICEF Baby Friendly Initiative stage 2 accreditation in November 2013 and are being assessed for Stage 3 in May 2015. This is linked to the Leicester's Infant Feeding strategy which is currently being refreshed with a health needs assessment recently completed.
- A healthy child programme lead commissioner was recruited to start in April 2015 who will provide further support to co-ordinating activity on tackling infant mortality in the city.
- A maternal obesity service for women was launched in 2013. Women receive a phone call from a dietician and advice and motivational support is provided. Women are offered a place on a 6 week programme involving advice and support from both a midwife and dietician along with a physical activity session.
- Smoking in pregnancy leads within maternity services and the smoking cessation team supporting pregnant women to stop smoking. All midwives attend mandatory training sessions about Smoking in Pregnancy and the "Step Right Out" campaign.
- A perinatal mortality group led by UHL meets regularly. An action plan has been developed tackling issues such as ensuring that all perinatal deaths are

fully reviewed in a timely manner and informing clinical service developments in relation to Intrauterine Growth Retardation and reduced foetal movements.

- Leicestershire Partnership Trust have recently developed a Policy on Safe Sleeping for infants.
- In Leicester, childhood immunisation now has more than 95% uptake rate of all vaccinations before the age of one, protecting against serious diseases such meningitis and whopping cough.
- A variety of community based multi-agency partnership projects have been taken across health, education, youth services and young people in Leicester to reduce teenage pregnancy.

The commissioning of the Health Visiting service will be transferred from NHS England to local authorities in October 2015 and the contract is currently being negotiated with the provider in anticipation of handover.

RATING Amber	Some risk that actions may not be delivered but this risk will be managed.

Section	**1.2 Reduce Teenage Pregnancy**
Contact(s)	Jasmine Murphy, Consultant in Public Health, Leicester City Council Liz Rodrigo, Public Health Principal, Leicester City Council David Thrussell, Head of Young Peoples Service, Leicester City Council

Teenage pregnancy is monitored on the rate of conceptions per 1,000 females aged 15 to 17. In Leicester, this had risen to 32.9 per 1,000 girls in 2012 from 30.0 per 1,000 girls in 2011. Annual data for 2013 was released on 24th February 2015 and shows a reduction to 29.7 per 1,000 girls. There has been a 54% decrease in teenage pregnancy locally from the 1998 baseline.

On 1st January 2014, the integrated sexual health service commenced. The service has reviewed its young people's provision and has extended delivery. Changes in youth provision have limited city centre accommodation for young people's sexual health service.

A service has started one day a week at the Connexions service at New Walk, this is limited due to lack of toilet facilities.

Community Based Public Health Services for Young People covering emergency hormonal contraception, chlamydia screening and long-acting reversible contraception is currently being re-procured and will commence on 1ST April 2015.

The integrated sexual health service is piloting a C-Card (Condom Card) scheme. This

scheme will make it easier for young people to get free condoms and sexual health advice. The scheme aims, to encourage longer-term sexual health awareness, change in behaviour and better use of other services. The scheme will be provided in pharmacies, GP surgeries and in community settings.

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

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

A revised RSE Strategy is required for Leicester in view of all the organisational changes. Public Health are commissioning some RSE provision via the Sexual Health and HIV prevention tenders. This includes the development of a core offer to schools. This will start on 1st April 2015. A review is currently being undertaken of RSE support for looked after children and their carers.

RATING Amber	Some risk that actions may not be delivered but this risk will be managed.

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

Action 1: Improving data systems to enable us to identify children at risk of achieving poor outcomes and who have delayed development at an early age, enabling us to target learning support to those who need it most.

Early Help Targeted services have continued to analysis attendance data using the IT information system e-start.to identify children who are vulnerable to poor outcomes. The service has now defined “engagement” as having been seen by the service three or more times in a 12 month period, and agreed a priority list of children which includes; children not seen in 12 months, children with siblings who fell into the bottom 20% at Early Years Foundation Stage profile and children living in the most disadvantage areas of the City. Thus targeting school readiness and poverty. The service continues to ensure contact where appropriate with families with a CAF, who are known to Social care, Think Family etc. Working with these priority groups the Children’s Centres (CC’s) liaise with health colleagues based in the CC’s to share information about whether children are known and to target for specific activity, for example making contact with the family to inform them about possible entitlement for two-year nursery education or invite to parenting programmes, “Talk Matters” groups or “Cook and Eat” type groups.

Children's Centres are also using DWP data to target those families identified as eligible for two year nursery education and inform and support attendance. They are also using this and data supplied by health to cross reference information and ensure the maximum number of children are registered with and known by the CC's. Children's Centre Teachers continue to access data net in order to pick up trends and identify children at risk of poorer outcomes at Foundation Stage, enabling them to target work with individual children and families and make contact through schools that have a greater proportion of children falling into the bottom 20%. Trends identified i.e. poor understanding of mathematical concepts at EYFSP is included in Stay and Play type sessions to promote this area of learning. Children's Centre staff continue to provide individual support to children and promote and enable parents to get involved in their child's learning

Children's Centre teachers' are working with the Foundation stage leads in local schools to identify and support transition to school.

Action 2: Improving our partnership working to improve the quality, quantity and take up of family orientated preventative health and wellbeing initiatives for children living in our most deprived areas.

The integrated model of services delivered through Children's Centres continues to support joint working with Health services. Most recently the Community Wellness teams have co-located into the CC's and there are plans for officers recently employed to improve oral health to work across the centres. CC's staff take part in regular liaison meetings with health and other professionals to share information and identify families that may benefit from specific interventions aimed at improving learning and health outcomes. This enables Children's Centres to include local information to data analysis to gain a more informed view of local needs and the services required to meet those needs. The two year old development check continues to be carried out jointly with CC staff and Health Visitors in some areas of the city, enabling issues to be identified early and actions planned to address emerging learning or health concerns. The majority of Children's Centre staff are trained in baby friendly breast feeding that enables them to promote the benefits of breast feeding and skin to skin contact. CC' staff will be involved in the recently commissioned service to promote breast feeding and work with volunteers once recruited. The CC's are also being assessed as part of the "Baby Friendly" initiative.

Some staff have been trained and others will be trained in healthy eating initiatives which enables them to provide informed information for parents' and some group activity to promote this in the CC's.

We are currently in the process of developing an ante natal programme that includes all elements contained in the DoH guidance for ante natal services. This builds on groups currently delivered in one area of the City, and when complete will be rolled out across the City and be jointly delivered with health and midwifery. The intended outcomes of the group will be to reach families early and share information about healthy lifestyles and early education. Including obesity, improving mental health and wellbeing, reducing

infant mortality, supporting breast feeding, reducing smoking in pregnancy, and promoting good oral hygiene.	
Rating Green	Good progress is being made and there are no significant problems.

Section	**1.4 Promote healthy weight and lifestyles in children and young people**
Contact(s)	Liz Mair, Interim Healthy Child Programme Manager, Leicester City Council

The latest National Child Measurement Programme (NCMP) data was released in December 2014 by the Health and Social Care Information Centre (HSCIC) and the key findings for Leicester for 2013/14 were:

- 1 in 10 children in reception year are classified as obese.
- More than 1 in 5 children are classified as obese by year 6.
- The results show that rates of childhood obesity in Leicester have not changed since 2012/13.
- The prevalence of childhood obesity in Leicester is still significantly higher than the England average in both reception and year 6.
- Leicester also has a significantly higher rate of underweight children in comparison to England in both reception year and year 6. Levels of underweight children are over double the national rate.
- Participation rates in the National Child Measurement Programme have decreased in reception year and increased in year 6 since 2012/13.
- There are a number of local services/initiatives currently in place aiming to tackle childhood obesity. The latest results confirm the ongoing need to review current activity and invest in evidence-based actions to tackle childhood obesity in Leicester.

Below is information about schemes that we are commissioning to promote healthy weight and prevent overweight and obesity. The projects aim to embedding lasting positive changes around healthy eating. These schemes build on the current 'Food Routes' scheme, which offer support and information to schools about healthy eating policies, and provides information about where food comes from and nutrition information and advice to children and young people.
New schemes for 2015 include:

- Healthy eating in early years settings: (to commence April 2015 for 2 years, with the option to extend for an additional year).
  The aim of the service is to ensure delivery of Healthy Eating Initiatives in early years settings in Leicester, to ensure that healthy and sustainable eating

behaviours in children and families increase. Settings include Children's centres, group care providers (e.g. nurseries) and child minders. The initiatives will ensure an increase in knowledge, skills and confidence related to promoting healthy eating in children, families and early years' practitioners. Settings will be supported to complete self-assessments and develop actions to promote compliance with the voluntary food and drink guidelines for early years' settings. Staff and volunteers will be trained to deliver practical cook and eat sessions, with links to community growing schemes supported. Good practice will be shared through the development of a learning network.
Provider: Leicestershire Partnership Trust's Nutrition and Dietetic Service (LPT)

- Healthy Eating in Schools:
  The programme will support schools to develop whole school approaches to healthy and sustainable eating, which will lead to an increased uptake of school meals, an increase in healthy eating behaviours, increased cooking and growing skills in children and families and more knowledge about nutrition, food safety, shopping, growing food and where food comes from.
  Provider: Food for Life Partnership (FfLP), an organisation working across the country and also working on an initiative with schools to increase uptake of school meals where it is low.

- Food growing training:
  We have also commissioned local organisations to provide training and resources to help individuals and groups to develop skills to grow fruit and vegetables

- 'Get Growing' scheme
  Along with the above, we have developed the 'Get Growing' grant scheme, where individuals and groups new to growing can apply for a grant to set up a growing scheme.

Rating Green	Good progress is being made and there are no significant problems.

Strategic Priority 2: Reduce premature mortality

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

The full year results for 2013/14 show that the smoking cessation service in Leicester achieved 98.6% of its expected 4 week quitters in a year that was marked by changes in smoker's behaviour due to the further impact of e-cigarettes. The challenging conditions continue and in q1 2014/15 the service reported that it was 36% below target for the quarter and, building on a recovery plan, at the end of q2 the gap had been narrowed to 23% of the cumulative target. Work will continue on the basis of the recovery plan,

which includes further promotional campaigns. Work has also continued to promote and support smoking cessation with communities, hospitals, primary care, maternity services and other settings. The CCG has funded some additional pilot work in strengthening smoking cessation efforts in UHL. The service continues to make smoking cessation available to younger smokers and works to reduce smoking in pregnancy.

The Step Right Out Campaign to reduce exposure to second hand smoke in homes and cars continues and is part of a number of promotional campaigns planned for the autumn and winter. The Tobacco Control Coordinating group is currently undertaking a CleaR assessment, reviewing its strengths and weaknesses so that improvements can be made – CleaR is an assessment tool developed by Public Health England and Action on Smoking and Health (ASH).

The service will be participating in a NIHR funded randomised controlled trial of e-cigarettes v standard NRT treatment in the spring of 2015.

Preparation is underway for the transfer of the STOP Smoking Cessation Service to the City Council from 1st April 2015.

The service continues to be among the best at attracting smokers to the service and helping them to quit. The number of people setting a quit date per 100,000 population aged 16+has declined over the past 5 years, this pattern is mirrored at national and regional level, however, the number of people setting a quit date in Leicester still remains above national and regional levels and Leicester has the 3rd highest number of people setting a quit date (per 100,000 population 16+) in comparison to its ONS comparators in 2013/14. Leicester is also performing well in terms of quitters - the percentage successfully quitting in 2013/14 (57%) is 4 percentage points higher compared to 2012/13 (53% and Leicester has the highest number of people successfully quitting smoking (per 100,000 population) in comparison to its ONS comparators in 2013/14. 72.4% of all quits were validated by CO monitoring (which measures the level of carbon monoxide in the bloodstream), significantly higher than the average for England (70.1%) and for the East Midlands (59.7%) and 4th among comparator authorities but significantly higher than the average for those authorities (65%).

RATING Amber	Some risk that actions may not be delivered but this risk will be managed.

Section	**2.2 Increase physical activity and healthy weight**
Contact(s)	Stephanie Dunkley, Public Health Principal, Leicester City Council

The new contract for the combined Lifestyle hub and health trainer service will commence on 1st April 2015.

Three newly awarded weight management contracts commence on April 2015. Weight

Watchers on referral from GP and a targeted and enhanced service delivered by Leicestershire Partnership Trust for specific communities with additional needs and for people with other health problems, such as heart disease. "Walking Away from Diabetes" groups are now running in the city using walking as a means of preventing type 2 diabetes. This scheme will be delivered through sports services from April 2015, with a focus on increasing the number of referrals into the programme particularly from GPs. The Active Lifestyle Scheme and physical activity pathway is still under review to support the inactive and people with increased risk of specific health problems to become more active. The healthy weight needs assessment has been completed, and the strategy is in development in parallel with the development of the physical activity pathway. A detailed action plan will also be developed.

RATING Amber	Some risk that actions may not be delivered but this risk will be managed.

Section	**2.3 Reduce Harmful Alcohol Consumption**
Contact(s)	Julie O'Boyle, Consultant in Public Health Chief Inspector Donna Tobin-Davies, Leicestershire Police Karly Thompson, Divisional Director East Midlands Ambulance Service Paul Hebborn, Leicestershire Fire and Rescue Service Justine Denton, Leicester City Council Trading Standards Mike Broster, Head of Licensing Leicester City Council Rachna Vyas, Head of Strategy and Planning, Leicester City CCG
Multi agency/partner alcohol awareness week held in November 2014 co-ordinated by LCC Alcohol summit held at beginning of December reviewed current strategy and highlighted priority areas for action. City Wide public spaces protection order agreed (started 5th January2015) to curb street drinking related anti-social behaviour. Street drinking strategy group established to agree joint enforcement/support approach to managing street drinking New specialist inpatient detox services commissioned	
RATING Green	Good progress is being made and there are no significant problems.

Section	**2.4 Improve the identification and clinical management of cardiovascular disease, respiratory disease and cancer** **3.1 People with long term conditions**
Contact(s)	Sarah Prema, Chief Strategy and Planning Officer, Leicester City CCG

One of the key clinical work streams for the CCG and integrated with the Better Care Together Programme is Long Term Conditions, including cardiovascular disease, respiratory disease and cancer. There are several elements within the LTC strategic programme which include clinical leadership, prevention, identification and management of the condition.

Clinical Leadership

In December 2014 the CCG confirmed that a GP has been recruited to support the CVD programme. The GP shall undertake 6 sessions per week to provide clinical leadership, mentor practices and co-develop the strategic direction for the identification and management of cardiovascular disease, respiratory disease.

The CCG invests in clinical leadership across the LTC strategic agenda. A total of 10 GP mentors deliver 584 sessions per annum to support the development, implementation and delivery of the LTC programmes.

Prevention

Lifestyle referral hub has been established, which gives health professionals a one stop-shop for patients who need lifestyle interventions such as exercise and diet advice.

Practices are involved in the local "Walking away from diabetes", whereby patient registers are reviewed to screen for patients at risk of developing Type 2 diabetes. Patients are invited into an interactive group education session to promote increased physical activity to reduce their risk of developing the disease.

Measure	2012/13 QoF	East Midlands	England	2014/15 QoF December 2014	CCG Change since 2012/13
CVD Primary Prevention % of patients with recorded risk assessment (CVD-PP01)	64.9%	70.6%	70.9%	77.1%	+ 12.2%

NHS Health Checks

As at December 2014, 11,127 NHS health checks have been completed. No actual target has been set for this year, with practices being asked to target all remaining eligible patients on their lists. Of the 11,127 patients, 1,042 have had conditions detected and a management plan put in place. As at December 2014 there are 31,379 who are eligible for an NHS Health Check. This compares with the performance for 2013/14, with 31,725 patients receiving health checks, and 3536 patients subsequently having a management plan put in place.

Cardiovascular Disease

A number of inter-dependent developments to improve the clinical outcomes for people with Cardiovascular Disease related conditions have been embedded within primary care since April 2103. These included pathways for atrial fibrillation, heart failure, warfarin management and diabetes.

a) Atrial Fibrillation and Heart Failure

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

The programme has demonstrated significant clinical outcomes for patients and reduced clinical variation in general practice, through improving knowledge and skills to detect and diagnose, improving care and outcomes for our patients and reducing avoidable hospital admissions and prevention of strokes.

- We are working on the prevention of strokes for our local population through identifying patients requiring anticoagulation therapy and initiating the treatment plans.
- We have embedded into primary care a programme for early detection and diagnosis of AF and HF which enables our primary care teams to implement treatment programmes and reduce emergency admissions.
- We have been clinically reviewing existing patients on the CVD registers and the management plans are being updated in line with NICE guidance.
- We have been undertaking opportunistic screening to detect and diagnose patients with AF, HF and diabetes.
- We have up skilled over 500 primary care clinicians in AF, HF, Anticoagulation and Diabetes to support our patients.
- We have been working as part of the 4-centre National Anticoagulation Initiative to develop a reporting tool and metrics to identify populations where strokes can be prevented
- We have reduced the risk of stroke for our patients by 50% through embedding the AF programme within primary care
- We have been working in partnership with an external clinical pharmacist provider to complete a clinical pharmacist-led AF optimised medicines review across all practices. This work is being integrated into the monthly clinically led support packages

ACHIEVEMENTS: Atrial Fibrillation, Anticoagulation and Stroke Prevention	**Year 1 of programme March 2013 to March 2014**	**Year 2: 2014/15 M08: ALL Practices**
Increase in AF diagnoses and recorded on the AF register	441 (13.3% increase)	125 (3.4% increase)
AF Recorded Prevalence	0.97% (12.5% increase)	1.0% (1.0% increase)

Number of AF patients reviewed (existing and opportunistic)	527	411 (78.0% increase)
Increase in number of patients on the AF register prescribed anticoagulation therapy	305 (16.5% increase)	319 (13.8% increase)
Prevention of additional strokes per annum from increasing patients prescribed anticoagulation therapy	8 prevented admissions	8.62 prevented admissions
Increase in Heart Failure diagnoses and recorded on the HF register	22 (1.3% increase)	34 (1.3% increase) *Nb: 1 practice closed*
Heart Failure Recorded Prevalence	0.69% (1.3% increase)	0.7% (1.4% increase)
Increase in number of patients on the HF register prescribed ARB, ACEi or beta blockers	Not recorded	257 (11.5% increase)
Reduction in the number of patients not prescribed HF therapy ARB, ACEi or beta blockers	Not recorded	223 (61.6% reduction)

Measure	**2012/13 QoF**	**East Midlands**	**England**	**2014/15 QoF** December **2014**	**CCG Change since 2012/13**
Atrial Fibrillation % of patients currently treated with anticoagulant therapy (AF7)	66.8%	64.3%	65.1%	82.8%	+ 15.8%
CHD Management % patients currently treated with ACEi, ARB, BB (CHD006)	73.6%	67.0%	68.0%	85.7%	+ 12.1%
HF Management % of LVD patients currently treated with ACE/ARB (HF003)	83.1%	82.5%	82.4%	94.5%	+ 11.4%
HF Management % LVD patients currently treated with ACE/ARD and beta blocker (HF004)	67.3%	63.1%	63.7%	90.7%	+ 23.4%
Stroke and TIA Management % patients treated with anticoagulation (STIA007)	88.6%	90.7%	90.5%	93.9%	+ 5.3%

In December 2014 a new model of care has been developed to deliver a passive digital monitoring service for patients who have been discharged from the acute setting following and emergency admission for Heart Failure to reduce readmission rates. The will service go-live in February 2015 and it will provide remote monitoring to each patient consented into the programme for 4 weeks post discharge by a specialist nurse. The

digital telehealth readings will enable to service to risk stratify those patients at high risk of readmission and proactively provide clinical interventions.

b) Diabetes

New Diabetes pathway has been introduced across the city which sees more complex patients to be managed in primary care, rather than in acute hospital settings. To support this new pathway, there has been investment in training for all practices for core diabetes skills and an accreditation training package for the primary care providers to be eligible for enhanced diabetes provider status.

- We are working in partnership with an external clinical pharmacist provider to complete a Diabetes Pen Needle review and assess compliance against the 9 core diabetes standards. This work shall be integrated into the monthly programme review and action plans for the practices
- We have implemented the Diabetes Carers Toolkit which has been designed to provide carers with guidance and support about relatives who may have diabetes or at risk of diabetes. It also provides information about carers' services and the support that's available locally and nationally.

ACHIEVEMENTS: Diabetes	**2013 / 2014 Increase from previous year**	**Year 2: 2014/15 M08: ALL Practices Increase from previous year**
Increase in Diabetes diagnoses and recorded on the Diabetes register	1,117 (4.5% increase)	871 (3.4% increase)
Diabetes Recorded Prevalence	6.8%	7.0%
Care Plans for patients	94	3722
Patients transferred from UHL outpatients into primary care enhanced diabetes service	0	719
Diabetes reviews completed on non-super-7 diabetes patients	0	1,613

In December 2014 a new model of care has been developed to deliver a passive monitoring service for diabetic patients through the application of wearable and ingestible sensor device to remotely measure a patient's diabetic control. The service will go-live in February 2015 and it will enable patients and doctors to be able to look at lifestyle changes that can prevent diabetes progression rather than opting for therapy escalation. Knowing whether a patient has true disease progression enables the clinician to make more accurate and ultimately safer treatment plans.

Respiratory Disease

A telehealth and health coaching service is supporting 70 patients with moderate to

severe COPD to support the management of their condition, improve self-management, reduce exacerbations and reduce emergency COPD admissions to hospital.

Evaluation of a COPD identification project which ran from November 2013 to April 2014 is being finalised to determine future commissioning intentions.

Smoking Cessation

A pilot service for potential smoking quitters is currently underway in the acute hospital and run by the local Smoking Cessation Service.

Risk Stratification

Practices are using risk stratification tools to identify those patients most at risk of hospitalisation and undertaking the appropriate interventions to support patients to better manage their condition and stay as independent as possible for as long as possible. This may include medicines review; care planning; and referral onto appropriate services.

ACHIEVEMENTS: Risk Stratification and Care Planning	**2014/15** **M08: ALL Practices**
Care Planning for 2% at most risk of hospitalisation	4,560
Care Planning for 2.1% to 10% at most risk of hospitalisation	4,569

RATING Green	Good progress is being made and there are no significant problems.

Strategic Priority 3: Support independence

Section	**3.1 People with long term conditions**
Contact(s)	Sarah Prema, Leicester City Clinical Commissioning Group
See 2.4 above	
RATING Green	Good progress is being made and there are no significant problems.

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

The Leicester Ageing Together Big Lottery bid continues to progress through the Lottery approval process. Success is virtually assured and this will bring nearly £5m into Leicester. Approval is expected in April and following this some 21 projects and 19 providers will begin to implement a number of initiatives to combat loneliness and isolation amongst older people

Locally, the Royal Voluntary Service has been successful in bidding to a national

investment fund through the Cabinet Office to support older people in hospital to return home safely at the earliest possible opportunity. The scheme offers a range of practical solutions such as home safety checks, provision of food, transport and can go onto to support the person with on-going good neighbour type relationships. Evaluation is ongoing to determine if the scheme should be picked up by local funders.

The Assistant City Mayor with responsibility for Adult Social Care, Cllr Rita Patel, has set up an Independent Adult Social Care Commission that will receive evidence from older people and key stakeholders about the services that they receive which impact positively or negatively upon their health and well-being. The Commission will report in 2016.

RATING Green	Good progress is being made and there are no significant problems.

Section	**3.3 People with Dementia**
Contacts	Bev White Leicester City Council Mike Murray West Leicestershire CCG Alison Brooks Leicester City CCG

Dementia has become a priority under the Better Care Together Frail Older People's work stream. A number of actions have been taken forward since October 2014 and continue to be taken forward. These are:

- A coordinated data gathering exercise capturing service provision for people with dementia on behalf of all statutory and voluntary organisations in LLR.
- The three CCGS are working towards sign off of a shared care protocol that will enable individuals with dementia who have been supported by the LPT specialist service and who are stable on medication to exit that service, return to primary care to be supported there with assistance from community based support services.
- ELCCG and WLCCG have developed Primary Care Diagnosis improvement plans to ensure continued improvement in this area; LCCCG's diagnosis rate is at 67%, well above the national average of 48% and on track to reach their year-end target of 72%.
- The three CCGs are working towards funding a hospital dementia support service at LRI that has been operated and funded by the Alzheimer's Society. This is a valued service that provides support to patients with dementia and their carers prior to and throughout a hospital stay. This improves their hospital experience, reduces excessive length of stay and supports after-care. Alzheimer's Society is providing a complimentary service at Glenfield Hospital to support patients and carers there.
- LCCCG has led a proposal to enhance the LRI based Primary Care Coordinators with dementia specialists as part of that team. This will greatly improve the identification of and support to patients with dementia upon arrival in hospital.
- LCC continue to contract with a number of voluntary sector organisations to commission services for people with dementia and their carers such as advocacy,

advice and information, carers training, peer support and activity groups.

- The Alzheimer's Society has secured national funding to operate a befriending service in the City.
- Governance arrangements and continue programme delivery – each agency retains their own governance arrangements in taking forward work in dementia but to support the LLR wide coordination and actions agreed as part of BCT Frail Older People work plan a work plan lead has been identified (Sue Wilson from Leicestershire County Council). A proposal for a LLR Dementia programme coordinator and a Clinical Champion is being considered by the BCT Board.

RATING Green	Good progress is being made and there are no significant problems.

Section	**3.4 Carers**
Contacts	Mercy Lett-Charnock, Lead Commissioner (Early Intervention and Prevention), Leicester City Council

The number of carers assessments carried out during the period is 392. There have been 325 Carers personal budget allocations during the quarter.

23 carers had training in regard to understanding Direct Payments and Personal Budgets. This was commissioned and delivered by LCIL.

A new training programme for carers will commence in February and includes carers assessments, the Mental capacity Act and Welfare Rights.

The Carers Rights day event at the Curve involved 33 partners organisations with Health, voluntary sector providers, the DWP and different council departments represented. The aim was to involve a range of partners who could not only advise on carer-specific matters but on a range of health issues such as strokes, drugs and alcohol and weight management.

The department has been working to ensure compliance for the Care Act, with a new Carers Assessment form developed for future use.

The National Carers Strategy second action plan has been published. Work has begun to look at appropriate actions for an updated local strategy action plan.

Voluntary sector providers awarded carer breaks funding have been delivering therapeutic and social activities to carers during the period to offer short periods of relaxation and respite from their caring role.

RATING Green	Good progress is being made and there are no significant problems.

Strategic Priority 4: Improve mental health and emotional resilience

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

The Public Health approach continues to focus on strengthening emotional wellbeing in schools and working with specialist services to ensure that there is mental health care provision for children and families in need. All services involved in the support of children are expected to promote mental wellbeing for children, pertinent to the level of care offered; from signposting through to specialist care.

With regard to local authority led services Children and Family Centres and Early Help services will support children and families in terms of managing behaviour, child development and building self-esteem. The Early Help and Stay Safe groups for Leicester have merged to follow a single agenda.

There is a need to ensure that universal and specialist services are more joined up, with better use of available resources including Health visitors, School Nurses, GPs, Educational Psychologists, schools, community paediatricians as well as specialist services. Leicester City Council is working with local CCGs to consider a universal approach for mental health promotion for children and young people.

The CCG is the commissioner of specialist Child and Adolescent Mental Health Services (CAMHS), such as the Children and Families Support Team, primary mental health services, the Leicester City Child Behaviour Intervention Initiative and is currently developing children's IAPT services.

CAMHS has a Tiered approach, so that children and young people should be able to gain timely access to the services that they require. There are additional specialist services for issues such as Attention Deficit-Hyperactivity Disorder, Eating Problems and Autism.

RATING Amber	Some risk that actions may not be delivered but this risk will be managed.

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

Progress towards improving mental health and emotional resilience in Leicester has been made in 3 areas:

- The Joint Specific Needs Assessment on Mental Health in Leicester was accepted and put onto the Leicester City Council JSNA Website in September 2014.

- The Leicester, Leicestershire and Rutland Better Care Together strategy prioritises mental health. The ***Better Care Together Mental Health Group*** advocates that people with mental disorders should gain timely access to effective treatment using a stepped care model. The ***Group*** believes that prevention and early intervention will reduce the frequency of crisis care and the requirement for secondary mental health care. People with urgent mental health care needs will also have access to specialist care services when required. Improving the management of mental illness in the community will contribute to meeting the objectives of ***No Health without Mental Health*** and ***Closing the Gap***, the local health and wellbeing strategy. A key component of the Better Care Together approach is to focus on the development of community mental health resources in order to promote early intervention to mental health services and resilience to mental illness.

- The Joint Commissioning Strategy on Mental Health in Leicester is being developed in the context of Closing the Gap, the Joint Specific Needs Assessment on Mental Health and Better Care Together. Leicester City Council (Adult Social Care and Public Health) and Leicester City CCG are working together to deliver the strategy. The strategy will cover topics such as housing, employment, education, personalisation, transition to adulthood as well as health. A stakeholder event to inform the Joint Commissioning Strategy was held in November 2014 and an online consultation was carried out through November and December.

The City Council in Partnership with the Leicester City Clinical Commissioning Group has commissioned ***Mental Health First Aid Training*** to be delivered to faith organisations across the city. It is an educational course which teaches people how to identify, understand and help a person who may be developing a mental health problem.

Other activities which have taken place in the latter half of 2014 include a World Suicide Prevention Event at Curve, Leicester at which 4 films aimed at Suicide Prevention and co-commissioned by Leicester City Council, Leicestershire County Council and Leicestershire Partnership Trust were launched.

RATING Green	Good progress is being made and there are no significant problems.

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

Adult mental health services are organised according to a stepped care model. More than 90% of people with mental health problems are managed entirely in primary care.

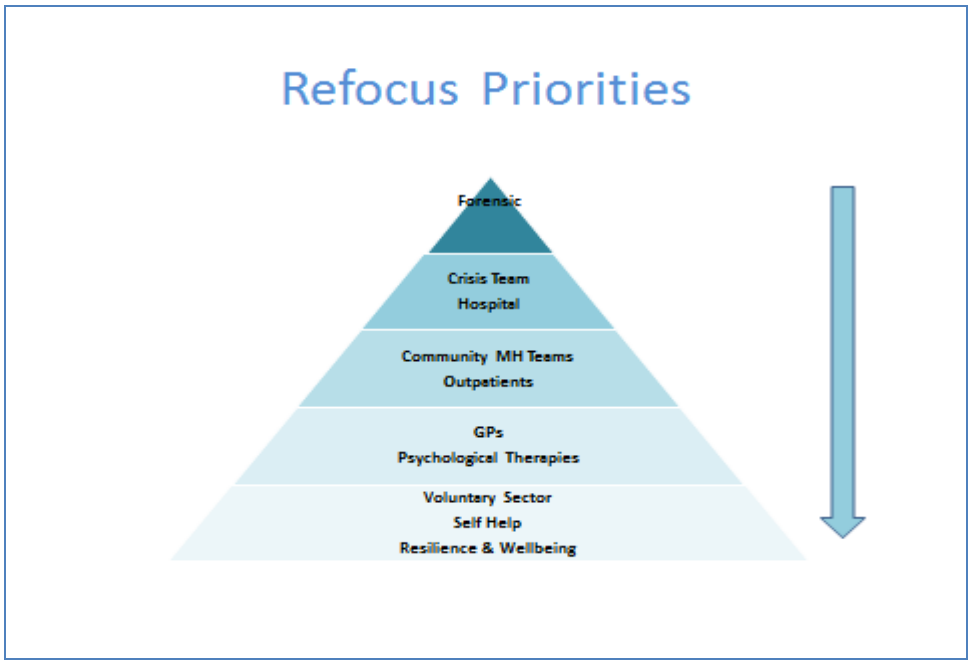
General Practice is also the main point of referral to other parts of the pathway, which includes the Improving Access to Psychological Therapies Service (IAPT), Mental Health Facilitators, and Community Mental Health Teams, Liaison Psychiatry and Access and Complex Care services.

To date services in Leicester have been characterised by the following:

- A large single mental health provider covering Leicester, Leicestershire and Rutland – NHS Leicestershire Partnership Trust.
- An inpatients service which has been under significant pressure in recent years.
- Lack of community based alternatives to support people in mental health crisis.
- Historic health funding for voluntary and community sector mental health provision which may not target those who need most support.
- Recently developed and NHS funded Improving Access to Physiological Therapies (IAPT) services.
- Services where access needs improving for example specialist counselling, early intervention in psychosis and better crisis care.
- The need to make services more responsive to needs of local communities, particularly black and minority ethnic and newly emerging communities.
- The need to meet the financial challenge on the NHS.

Locally the Better Care Together (BCT), based on partnership between NHS organisations and local authorities across Leicester, Leicestershire and Rutland (LLR), is the main vehicle to improve services for people with severe and enduring mental health needs.

The BCT Strategy 2014-19 prioritises Mental Health, with an overall aim to refocus priorities from traditional centralised services to primary and community based services, supported by a greater emphasis on building mental health resilience within the population.



Leicester City Clinical Commissioning Group is working BCT partners to implement this

strategy. The needs of the city, including minority communities, are reflected in future service planning and commissioning. Taken together the BCT and this joint strategy will:

Strengthen mental health resilience

We are working with Public Health and Council colleagues to strengthen MH promotion including:

- Programmes to educate people about mental health and the importance of early support.
- Wider MH promotion on understanding mental health to reduce stigma.
- Develop Mental Health First Aid training for professionals, employers, communities and faith groups.
- Develop social prescribing through GP Practices to address underlying causes; debt, employment, isolation, housing.

Improve crisis response services

- Work with partners in LLR to implement the local Mental Health Crisis Concordat action plan (ongoing).
- Work with West Leicestershire and East Leicestershire Rutland Clinical Commissioning Groups and NHS Leicestershire Partnership Trust to remodel and improve response times from crisis response and home treatment services (being implemented February 2015)
- Consider commissioning third sector support service for cohorts of patients who regularly present to crisis response services (being considered 2015/16)

Improve inpatient care services

- Work with West Leicestershire and East Leicestershire Rutland Clinical Commissioning Groups and NHS Leicestershire Partnership Trust to ensure ongoing and sustainable improvement in inpatient care services and limit the need for out of county placements and delayed transfers of care (ongoing)

Develop alternatives to hospital admission

- Work with partners to evaluate and review the LLR Crisis House pilot and inpatient step down service, within the context of the need of population of Leicester City (service goes live March 2015)
- Continue to explore alternatives to hospital, including potential Third sector provision (ongoing)

Strengthen primary and community based support services

- Improving access to psychological therapies (IAPT) services will include specific services for targeted groups, self-referral and extended provision of clinics in community venues (ongoing)
- Increase the number of primary care Mental Health Facilitators in order to provide support to vulnerable people in general practices (Business case being considered for 2015/16)
- Review existing funding to Third sector (including VCS) providers to ensure services are locally targeted and support the objectives of the BCT Mental Health

Strategy (in 2015/16) • Develop peer support and social networks to support and sustain recovery and resilience **Improving rehabilitation services** • Enable more timely recovery by refocusing LPT inpatient rehabilitation services (ongoing) • Accelerate recovery and return of people in rehabilitation placements away from home (ongoing)

RATING Green	Good progress is being made and there are no significant problems

Strategic Priority 5: Focus on the wider determinants of health

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

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

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

RATING Green	Good progress is being made and there are no significant problems.

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

The Deputy City Mayor is leading work on further plans to help improve community

engagement in implementing the strategy and assessing the equality impacts of decisions.

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

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

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

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

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

RATING Green	Good progress is being made and there are no significant problems.

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

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

The Board carries out engagement with local people and community groups in order to understand health and health inequality implications of decisions made or planned. Feedback from consultation on the draft Pharmaceutical Needs Assessment will influence the final Assessment. Initial engagement on the Joint Strategic Needs Assessment is currently underway and there will be further engagement in the summer.

RATING Green	Good progress is being made and there are no significant problems.

Section	**5.4 Encourage local professionals to explore with seldom heard and community groups how to improve two way communication, fostering better understanding and leading to improved perceived access to health and social care services.**
Contacts	Rod Moore, Acting Director of Public Health, Leicester City Council Sue Cavill, Public Health, Leicester City Council
The engagement and consultation described in connection with 5.1, 5.2 and 5.3 provides information about the perceived communication needs of the seldom heard and community groups which will help foster better relationships and perceived access. More work needs to be done working with all partners in the Health and Wellbeing Board to understand how these perceived communication needs can be met within current financial parameters.	
RATING Green	Good progress is being made and there are no significant problems.

Appendix 2(a)

'Closing the Gap': Leicester's Health and Wellbeing Strategy – 2013/16 Indicators

Improve outcomes for children and young people							
Indicator (For information on activity in support of each measure please see these sections of Appendix 1)	Reporting frequency	**Baseline as published in strategy**	**Latest data as at March 2015**	Direction of travel vs last report	**Direction of travel vs Baseline**	Rank within the appropriate family group	Next data Due
Readiness for school at age 5 (Section 1.3)	Annual	11/12 – 64% (old definition)	12/13 – 27.7% **13/14 – 41.0%**			11/11	October 2015
Breastfeeding at 6-8 weeks (Section 1.1)	Quarterly	11/12 – 54.9%	13/14 - 56.7% **Q2 14/15 - 61.8%**			(Not ranked – data quality issues)	26th March 2015

Smoking in pregnancy (Section 2.1)	Quarterly	11/12 – 12.7%	13/14 – 13.1% **Q2 14/15 - 10.7%**			5/10	17th March 2015
Conception rate in under 18 year old girls (per 1000) Section 1.2	Annual	2011 – 30.0	2012 - 32.9 **2013 – 29.7**			5/11	Feb / Mar 2016
Reduce obesity in children under 11 (bring down levels of overweight and obesity to 2000 levels, by 2020) (Section 1.4)	Annual	Reception: 10/11 – 10.6%	Reception: 12/13 – 10.4% **13/14 – 10.6%**			4/11	December 2015
	Annual	Year 6: 10/11 – 20.6%	Year 6: 12/13- 21.1% **13/14 – 21.1%**			3/11	December 2015

Reduce premature mortality							
Indicator (For information on activity in support of each measure please see these sections of Appendix 1)	Reporting frequency	**Baseline as published in strategy**	**Latest data as at March 2015**	Direction of travel vs last report	**Direction of travel vs Baseline**	Rank within the appropriate family group	Next data Due
Number of people having NHS Checks (Section 2.4)	Quarterly (cumulative)	11/12 – 8,238	13/14 -25,886 Q3 13/14 – 17,740 **Q3 14/15 – 11,127**			N/A (% measure used for benchmarking)	25th Feb 2015
Smoking cessation: 4 week quit rates (Section 2.1)	Quarterly (cumulative)	11/12 – 2,806 (1,153 per 100,000 adult pop.)	13/14 – 2,551 Q2 13/14 – 1,217 **Q2 14/15 – 1,012** **(385 per 100,000 adult pop)**			1/7	April 2015
Reduce smoking prevalence (Section 2.1)	No regular pattern (Next Survey 2014)	2010 – 26% (Lifestyle survey) 10/11 – 23.4% (Household survey)	-			N/A	Lifestyle survey to be done during Jan- Mar 2015, with headline results available in

							April.
Adults participating in recommended levels of physical activity (Section 2.2)	Annual	Oct 10/Oct 11 – 27.8%	Apr 13 / Apr 14 – 31.1% **Oct 13 / Oct 14 – 33.0%**			4/7	TBC
Alcohol-related harm Please see appendix 2c for technical note (Section 2.3)	Annual	11/12 – 6,283 (1,992 per 100,000 pop.) 11/12 (narrow definition) 719.1	2013/14 (narrow definition) 703.39 2013/14 Q2 358.41 **2014/15 Q2 360.43 (provisional)**			3/7	June 2015
Uptake of bowel cancer screening in men and women (Sections 2.4 & 3.1)	Annual	11/12 – 43%	12/13 – 46.6% **13/14 - 42.3%**			Not published nationally	TBC
Coverage of cervical screening in women	Annual	11/12 – 74.7%	12/13 - 73.9% **13/14 - 72.6%**			5/7	October 2015

(Sections 2.4 & 3.1)							
Diabetes: management of blood sugar levels (Sections 2.4 & 3.1)	Annual	11/12 – 62%	12/13 - 61.8% **13/14 - 72.4%**			1/10	October 2015
CHD: management of blood pressure (Section 2.4)	Annual	11/12 – 88.3%	12/13 - 89.1% **13/14 – 90.2%**			8/10	October 2015
COPD: Flu vaccination (Section 2.4)	Annual	11/12 – 92.3%	12/13 - 91.5% **13/14 – 95.6%**			5/10	October 2015

Support independence							
Indicator **(For information on activity in support of this measure please see these sections of Appendix 1)**	Reporting frequency	**Baseline**	**Latest data as at March 2015**	Direction of travel vs last report	**Direction of travel vs Baseline**	Rank within the group	Next data Due
People with Long Term Conditions in control of their condition Please see Appendix 2c for technical note (Section 3.1)	Quarterly data published every six months.	11/12 – 60.8% *Revised baseline*	13/14 – 62.0% **Q2 14/15 - 61.5**			8/10	July 2015
Carers receiving needs assessment or review and a specific carers service or advice and information (Section 3.4)	Quarterly (cumulative)	11/12 – 18.8%	12/13 – 26.5% 13/14 - 28.4%			13/16	TBC

Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement /rehabilitation services (Section 3.2)	Quarterly	11/12 – 77.2%	13/14 – 86.9% **14/15 Q3 – 91.2%**			8/16 **N/A**	April 2015
Older people, aged 65 and over, admitted on a permanent basis in the year to residential or nursing care per 100,000 population (Section 3.2)	Quarterly (cumulative)	11/12 – 763.20 (revised Feb 2014)	13/14 - 764.4 *13/14 Q3 – 514.7* **14/15 Q3 - 575.4**			10/16 **N/A**	April 2015
Dementia - Effectiveness of post-diagnosis care in sustaining independence and improving quality of life Please see Appendix 2c for technical note Section 3.3	N/A	N/A	No Data			N/A	No data expected until 2016/17

Carer-reported quality of life Section 3.4	Biennial (Next survey 14/15)	9/10 – 8.7	12/13 – 7.1 **14/15 – 7.2% (provisional)**			12/13 - 15/16 14/15 - N/A	July 2015 (First cut national data)
The proportion of carers who report that they have been included or consulted in discussion about the person they care for. Section 3.4	Biennial (Next survey 14/15)	9/10 – 70%	12/13 – 63.5% **14/15 – 68.5% (provisional)**			12/ 13 - 16/16 14/15 – N/A	July 2015 (First cut national data)

Improve mental health and emotional resilience							
Indicator **(For information on activity in support of this measure please see these sections of Appendix 1)**	Reporting frequency	**Baseline**	**Latest data as at March 2015**	Direction of travel vs last report	**Direction of travel vs Baseline**	Rank within the group	Next data Due
Self-reported well-being - people with a high anxiety score (Section 4.2)	Annual	11/12 – 41.99%	12/13 – 41.2% **13/14 – 45.4%**			6/7	September 2015
Proportion of adults in contact with secondary mental health services living independently with or without support Please see Appendix 2c for technical note (Section 4.3)	Quarterly	11/12 – 68.1%	13/14 - 34.1% **14/15 (monthly average April – October) – 33.8%**			12/16	TBC

Appendix 2(b)

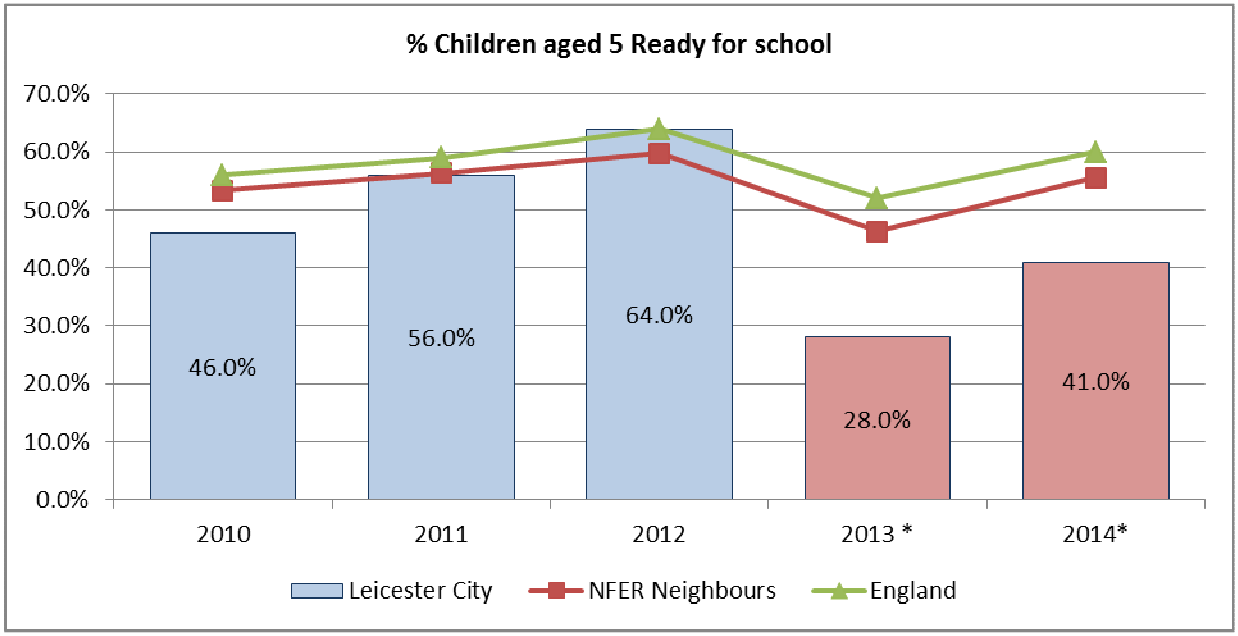
Performance Trends and Benchmarking

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

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

<u>Priority: 1 Improve outcomes for children and young people</u>

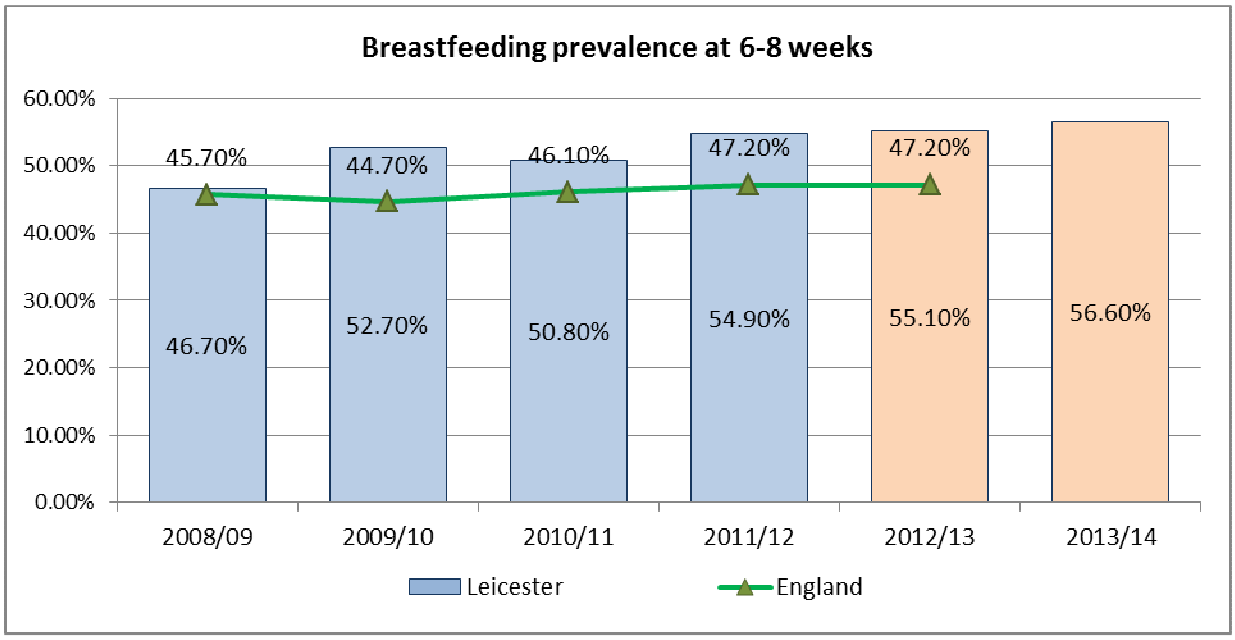
Readiness for school at age 5



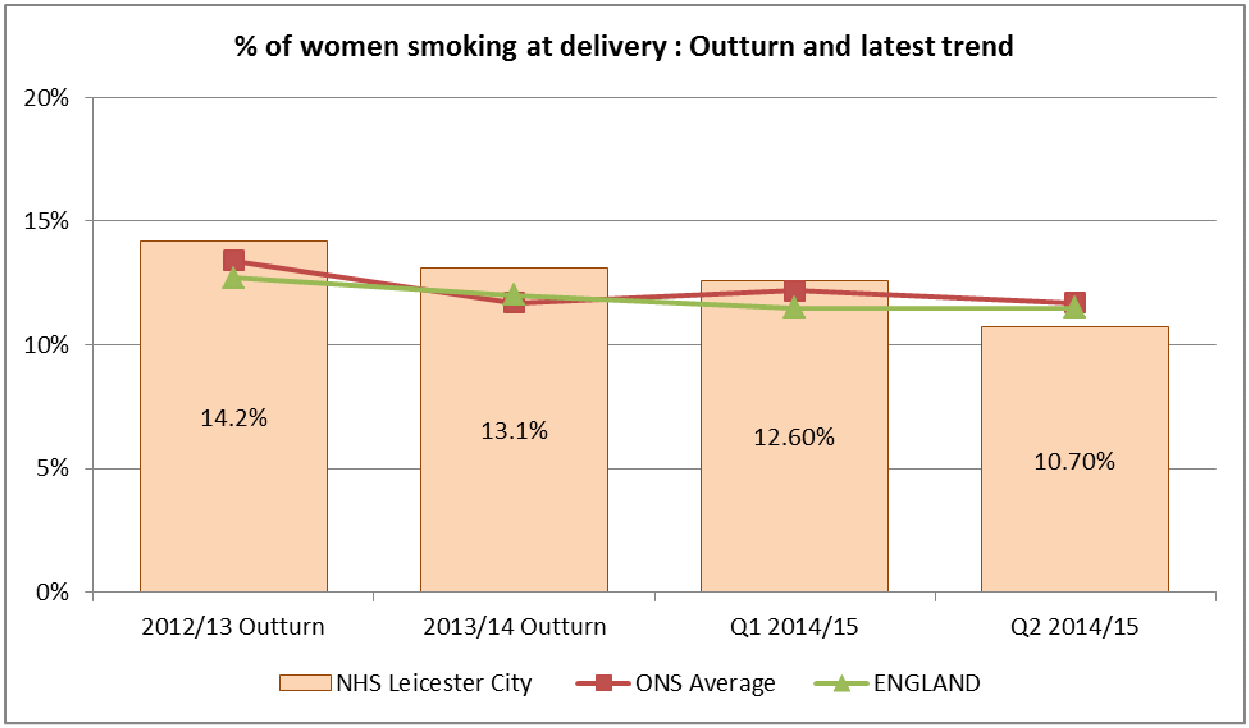
N.B. trend graph shows historical trend for the old measure of "Achieving a good level of development at Early Years Foundation Stage for 2009-2012. The first year of results for the new Foundation Stage Profile was 2013.

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

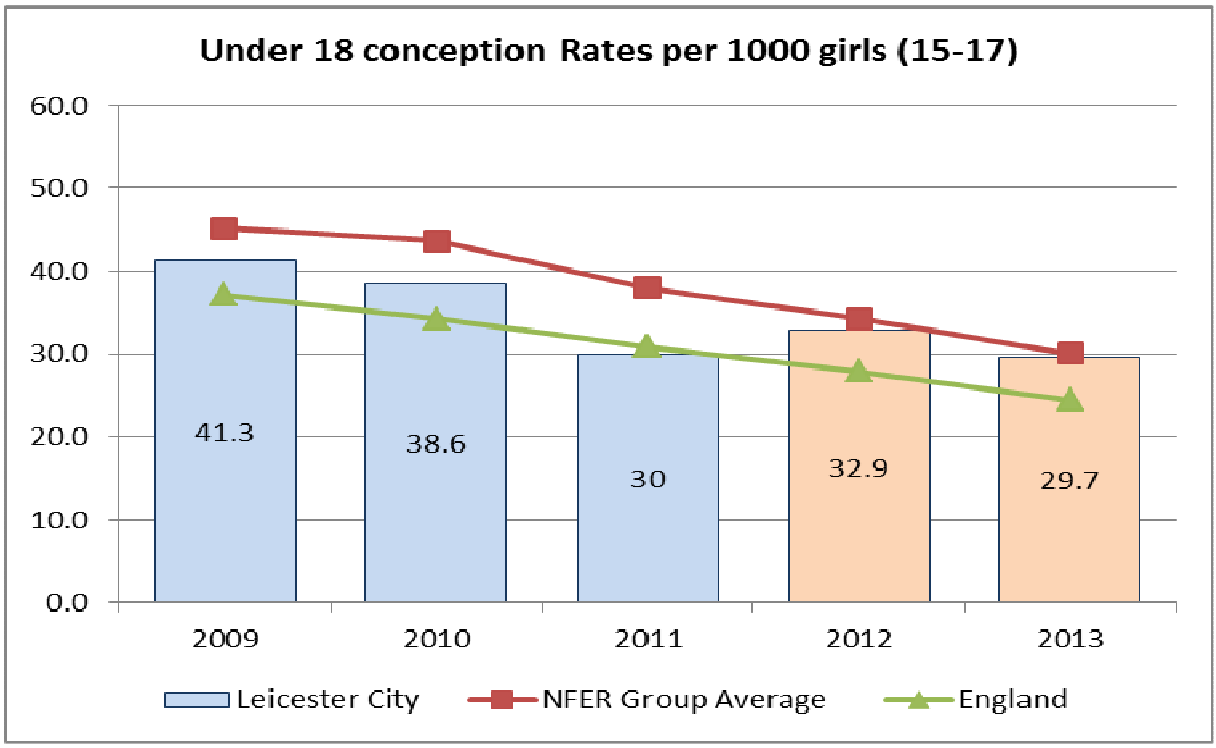
Breastfeeding at 6-8 weeks



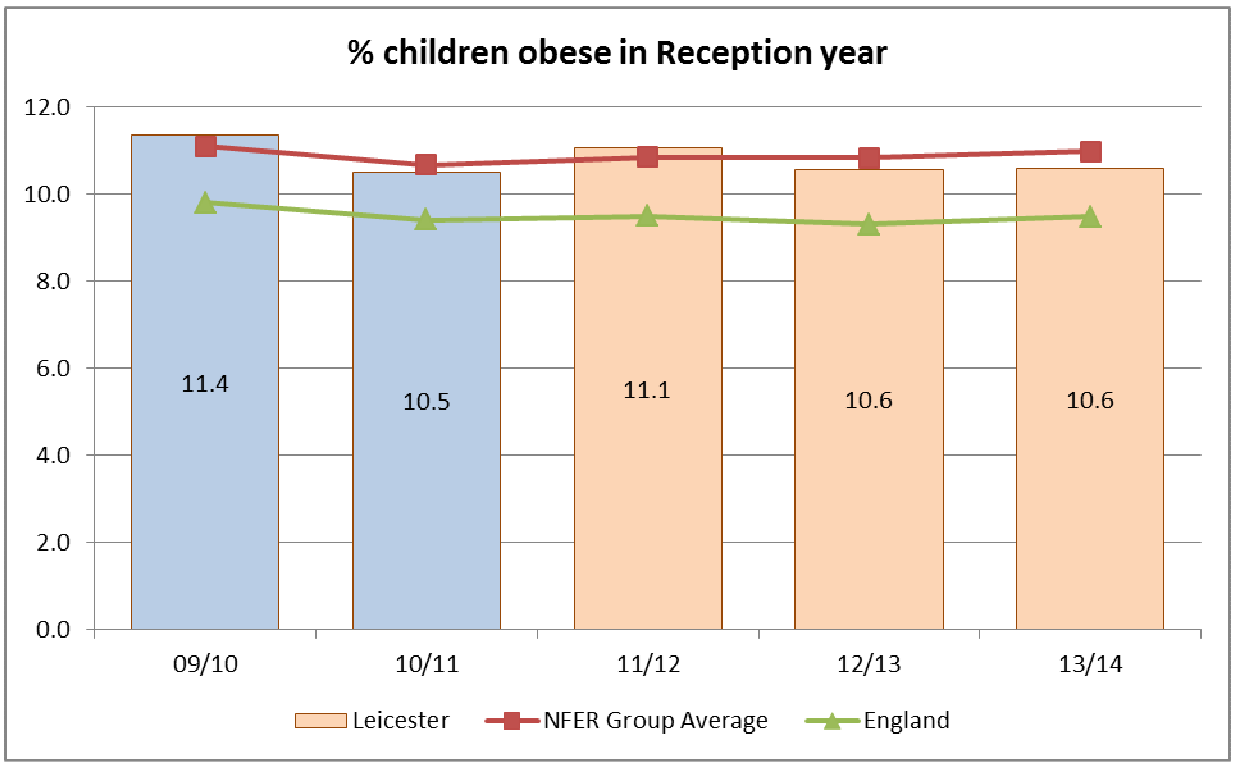
Smoking in pregnancy



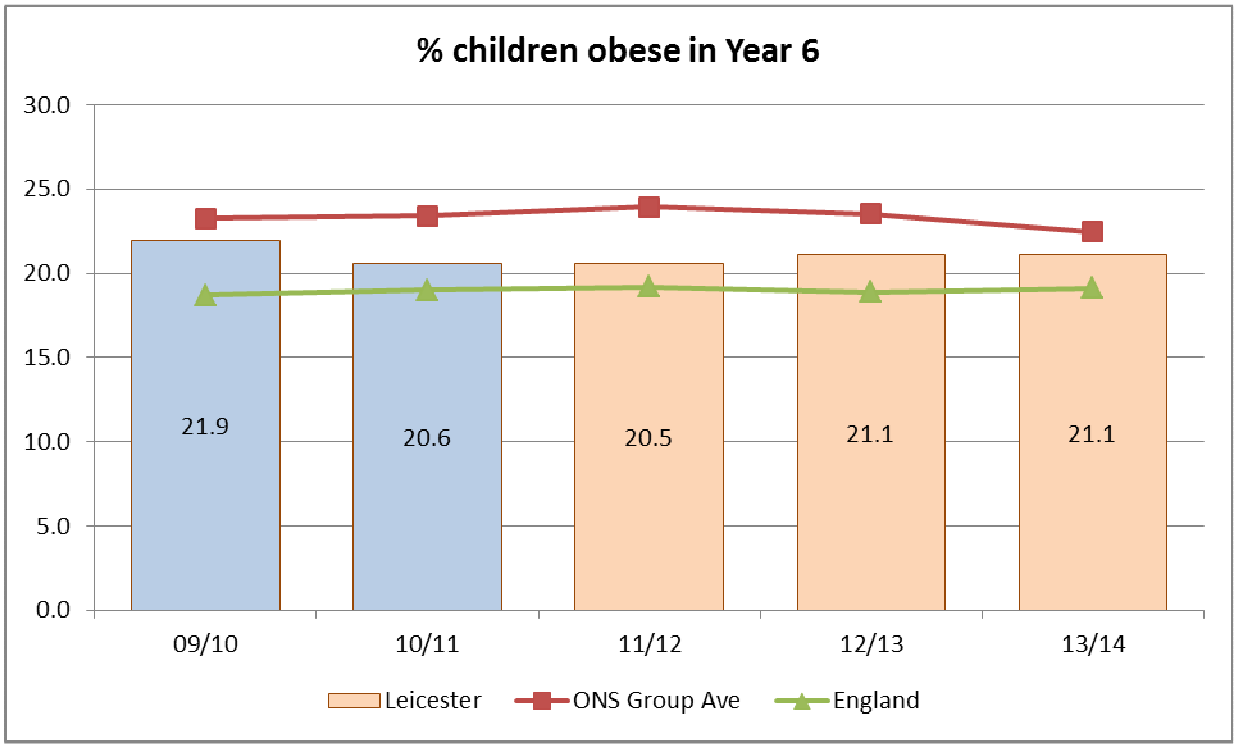
Under 18 conception Rates per 1000 girls (15-17)



% children obese in Reception year

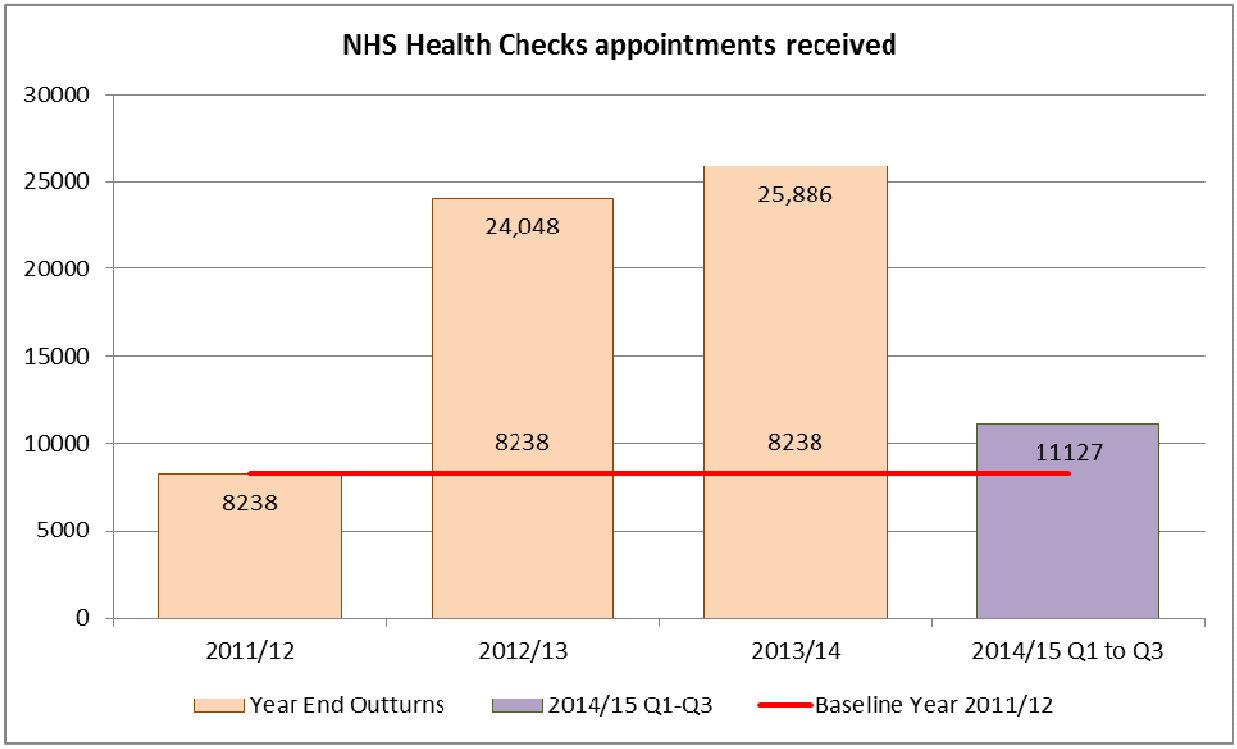


% children obese in Year 6

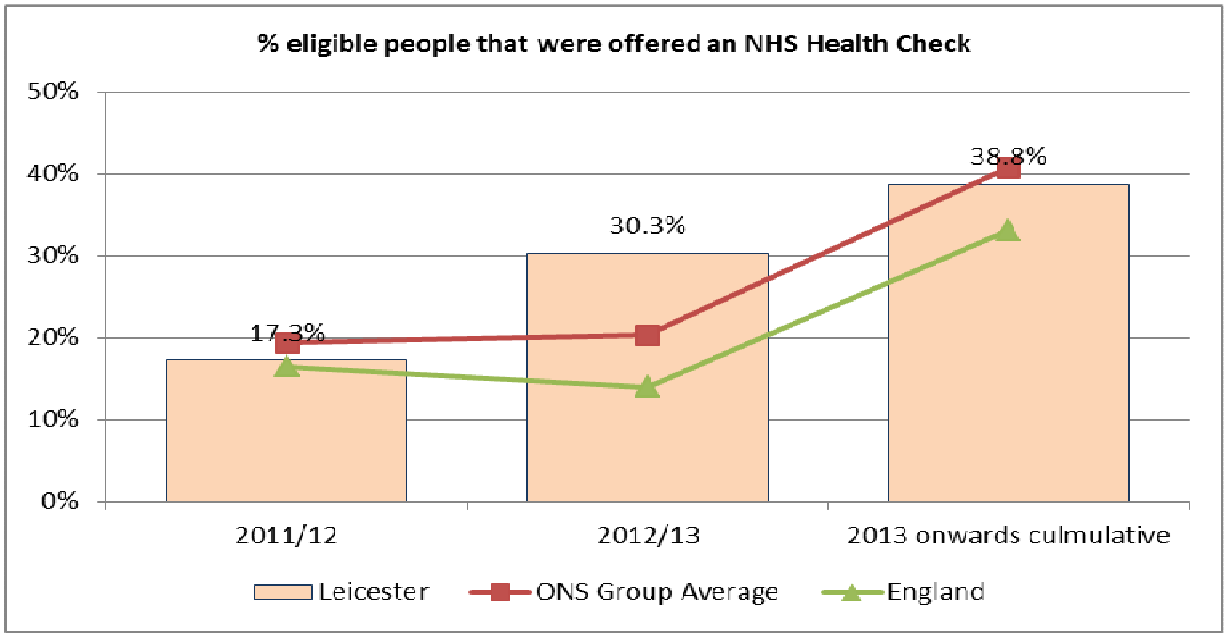


Priority 2: Reduce premature mortality

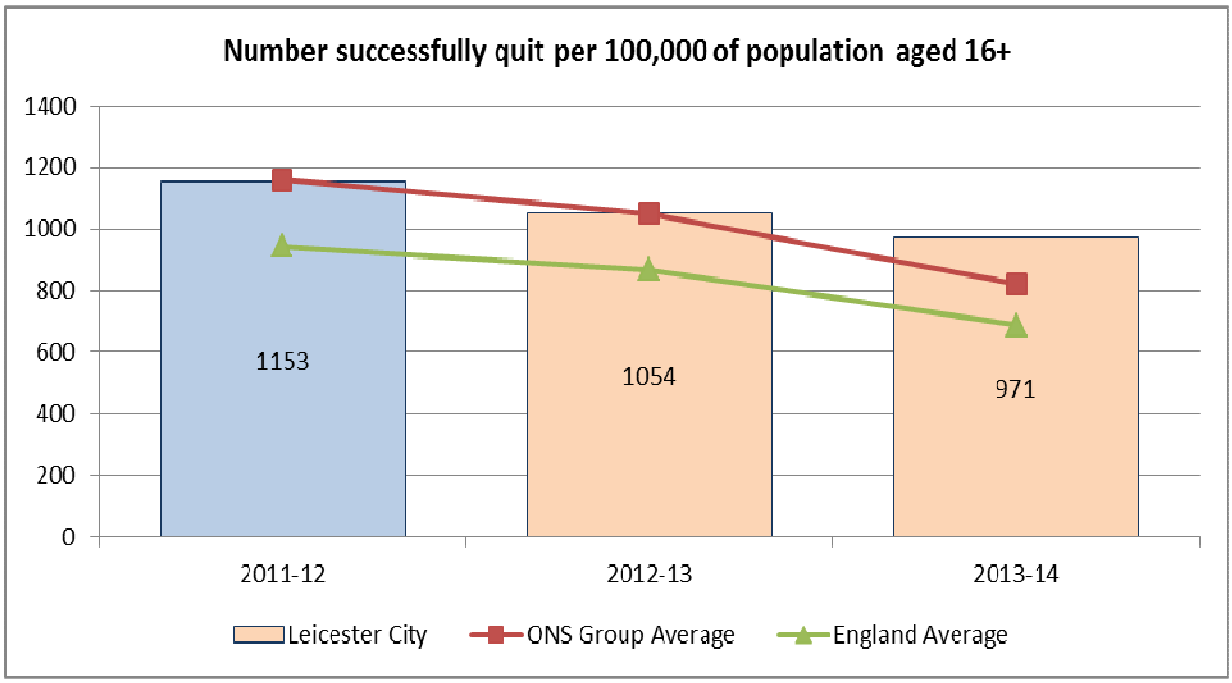
Number of people having NHS Checks



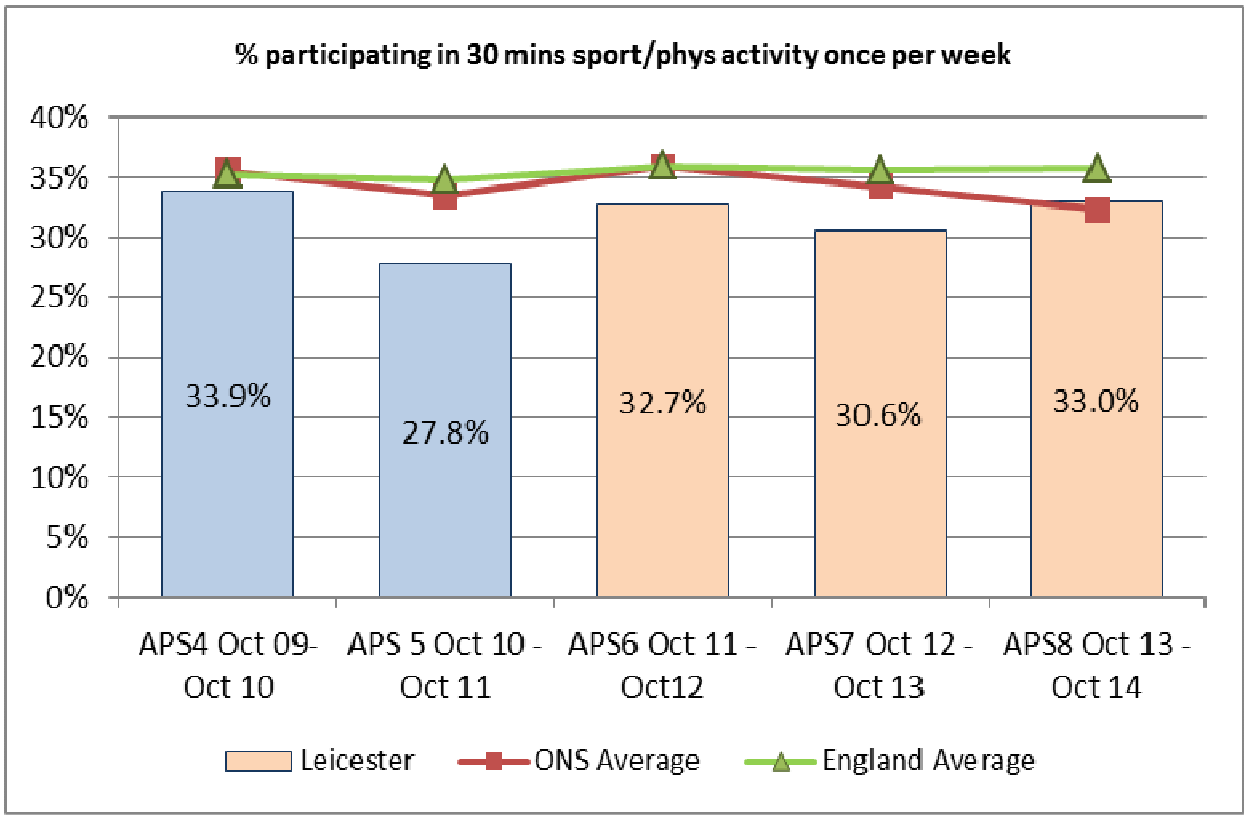
Proxy measure: **% eligible people that were offered a NHS Health Check (used because it enables meaningful comparisons between different sized areas)**



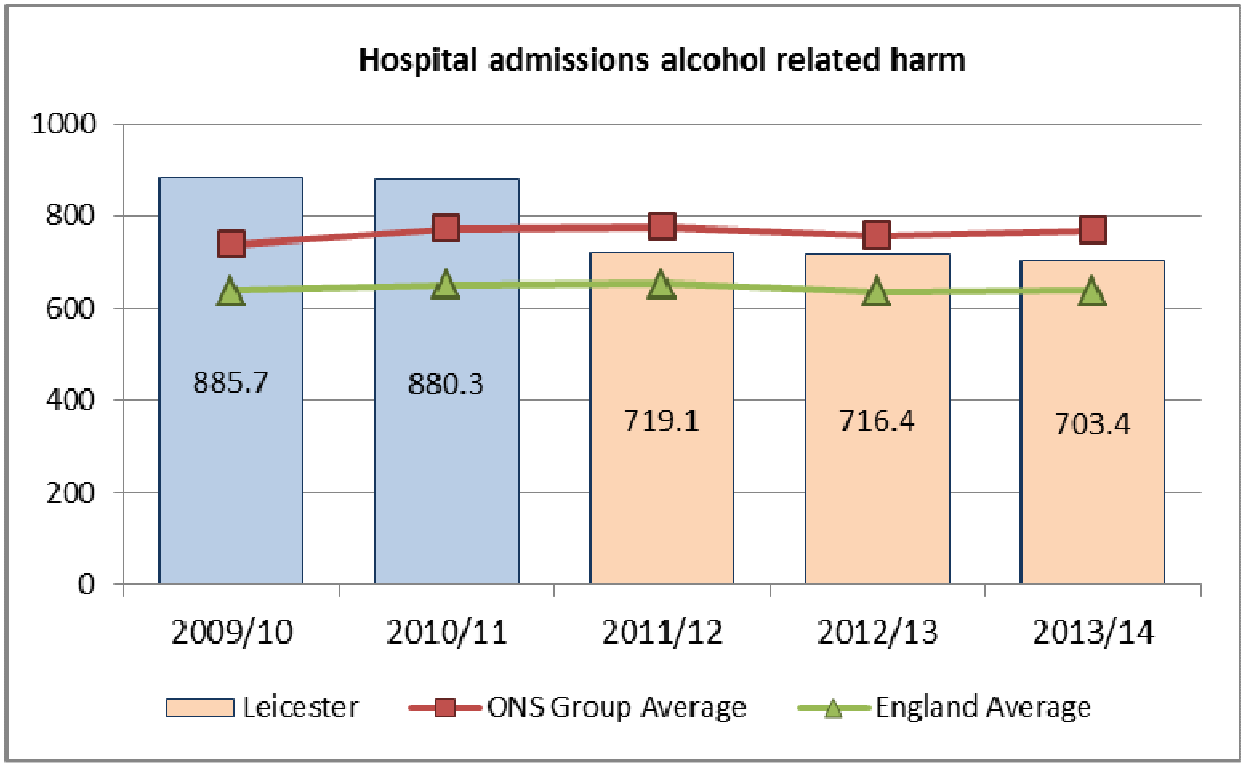
Number successfully quit (self-report) per 100,000 of population aged 16 and over



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



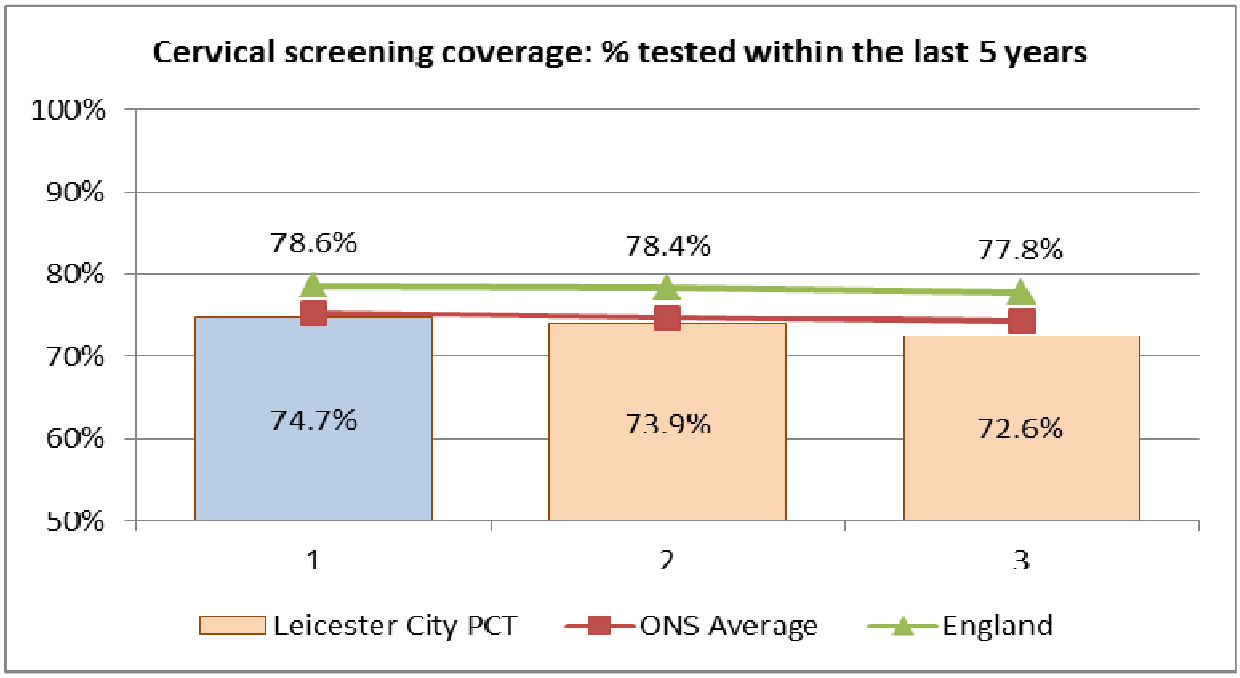
Hospital admissions for alcohol related harm, new narrow definition measure



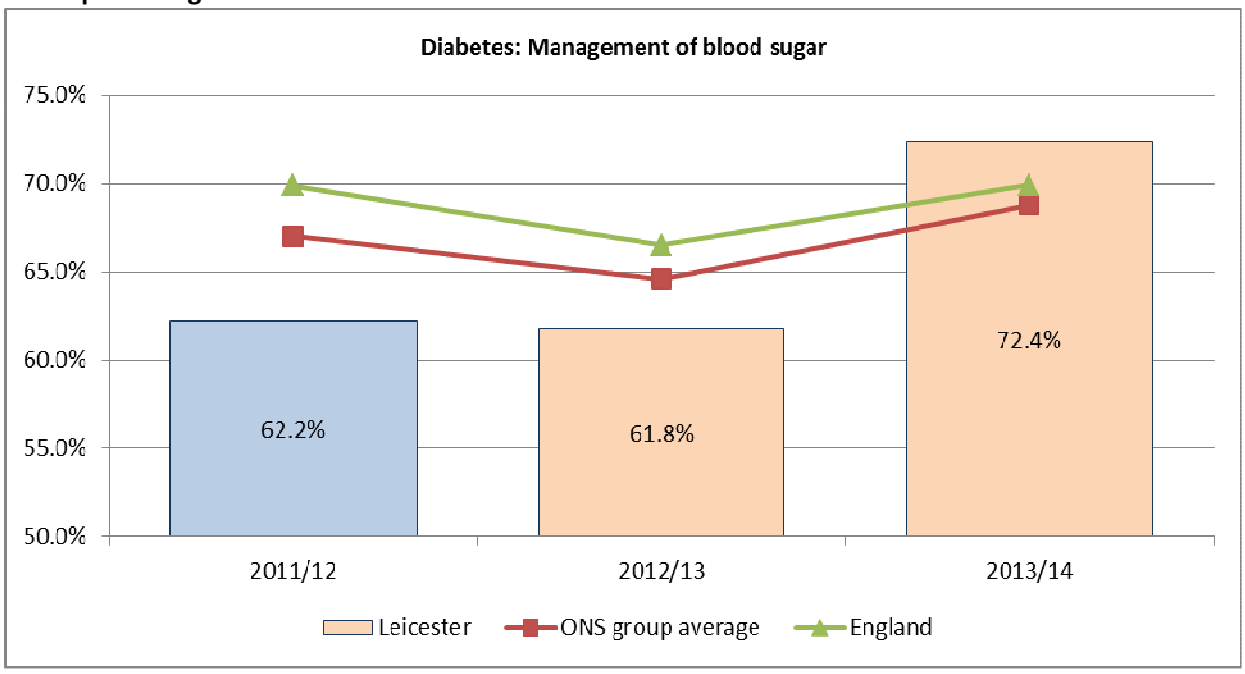
Reducing smoking prevalence:
Lifestyle survey be undertaken during January to March 2015

Uptake of bowel cancer screening
Data not published nationally

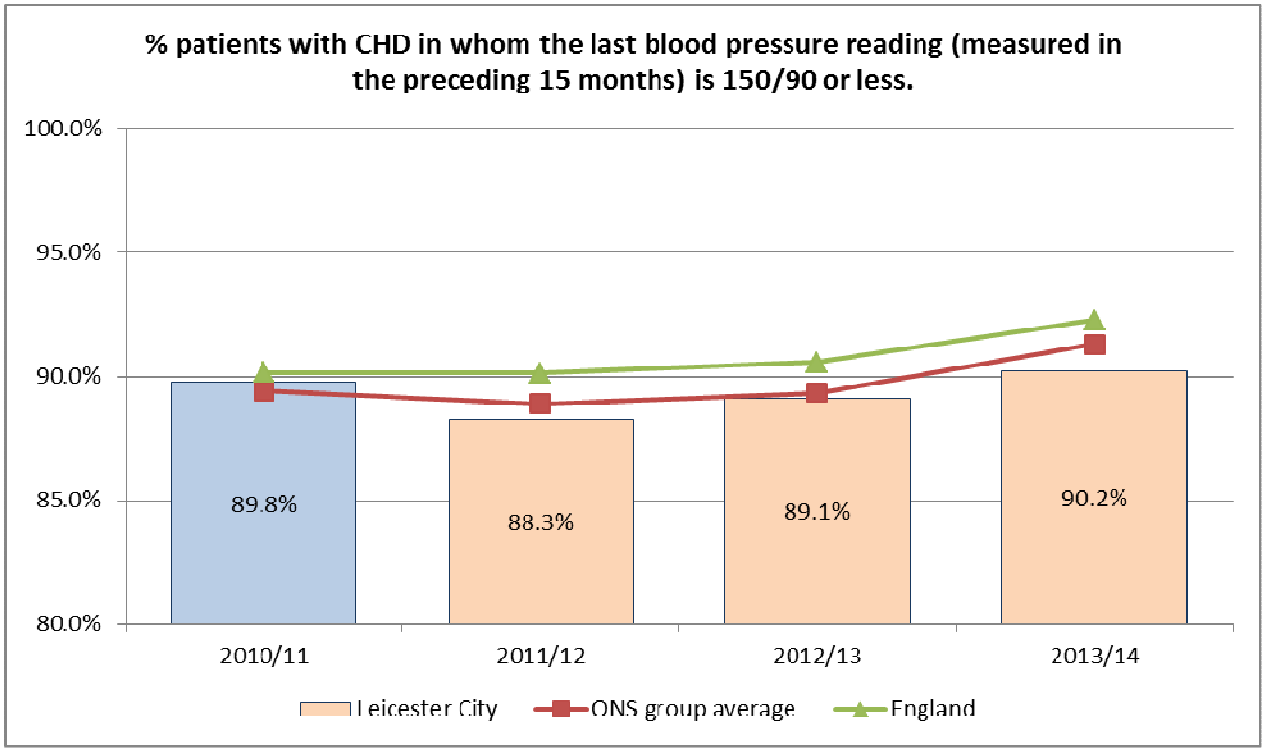
Cervical screening coverage



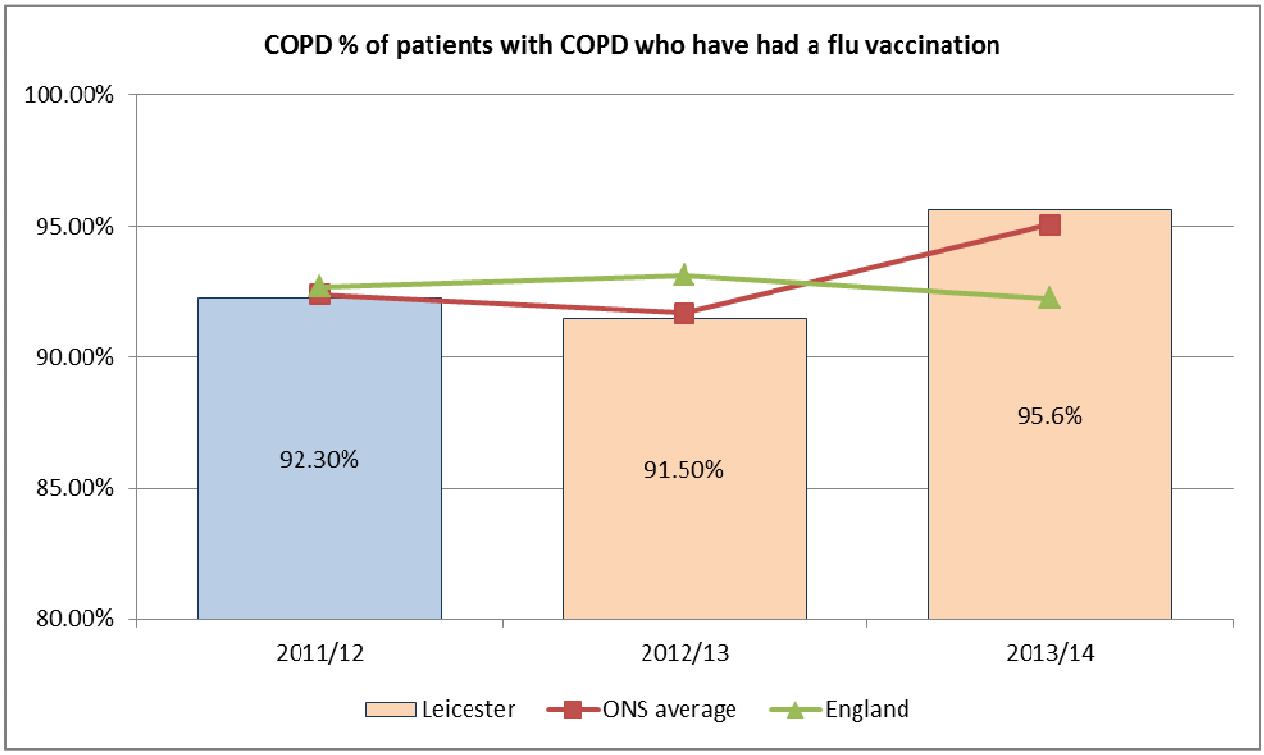
Diabetes: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol in the preceding 15 months.



Coronary Heart Disease: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less.

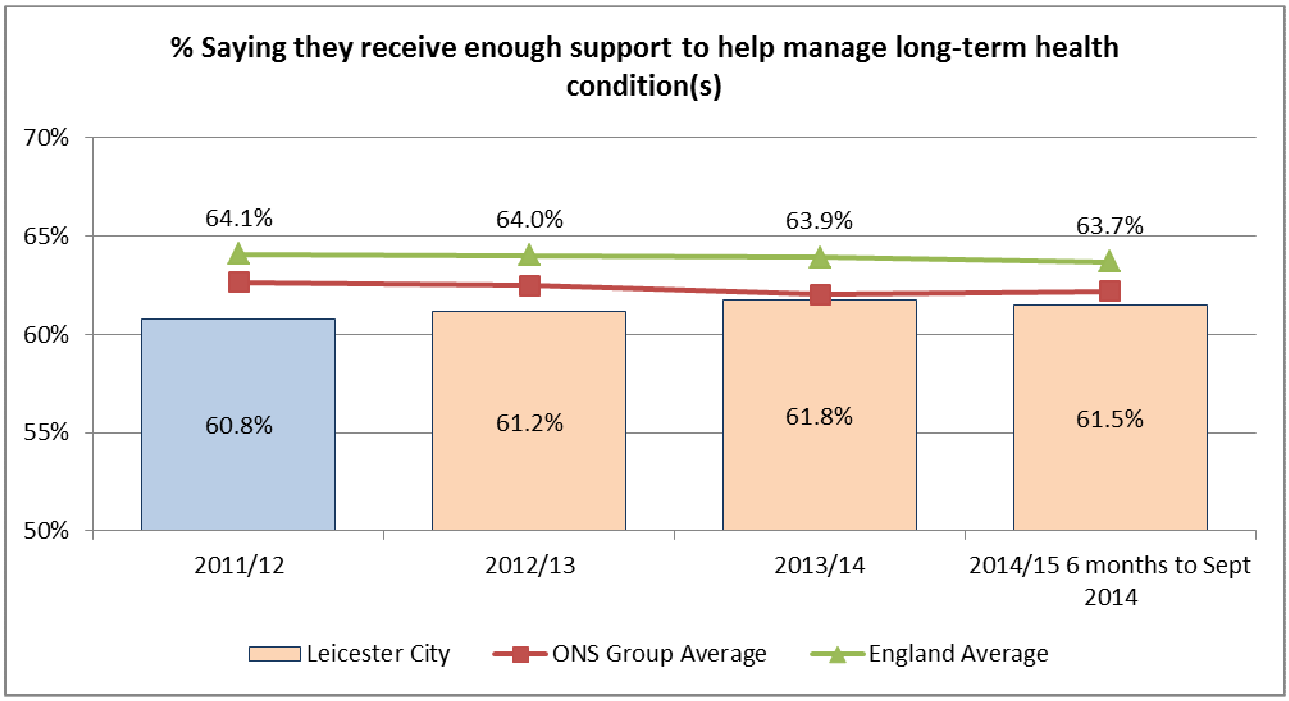


Chronic Obstructive Pulmonary Disease: percentage of patients with COPD who have had influenza immunisation

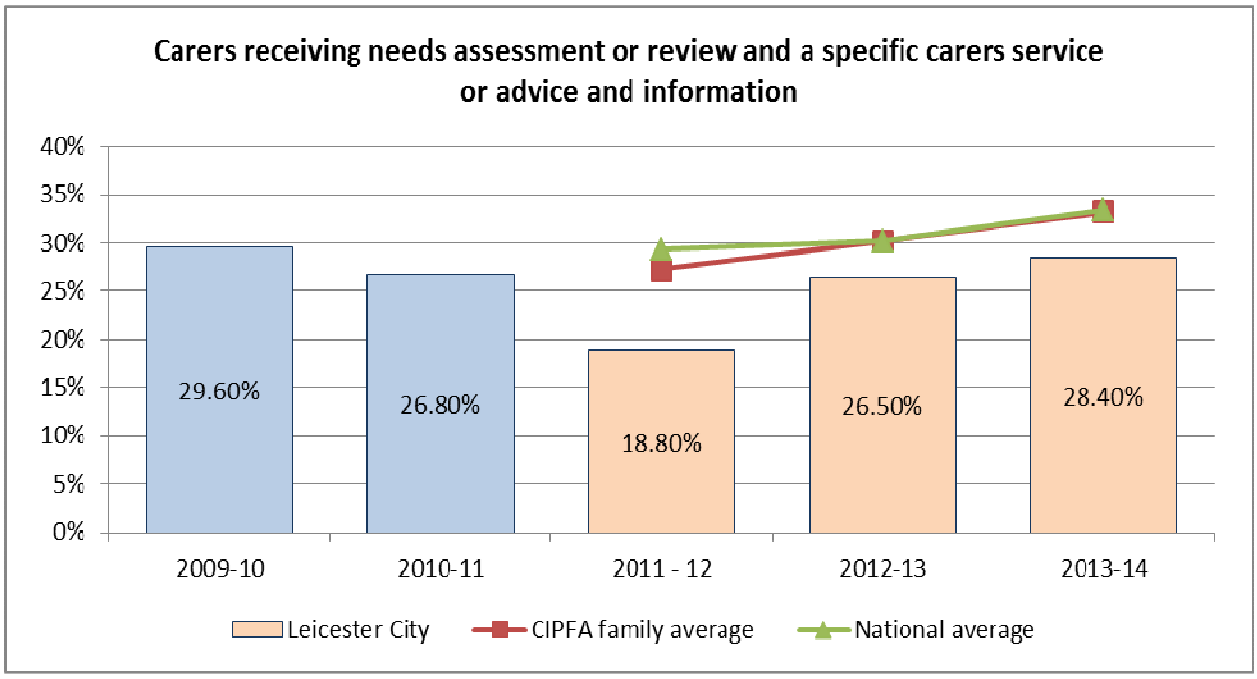


Priority 3: Promoting Independence

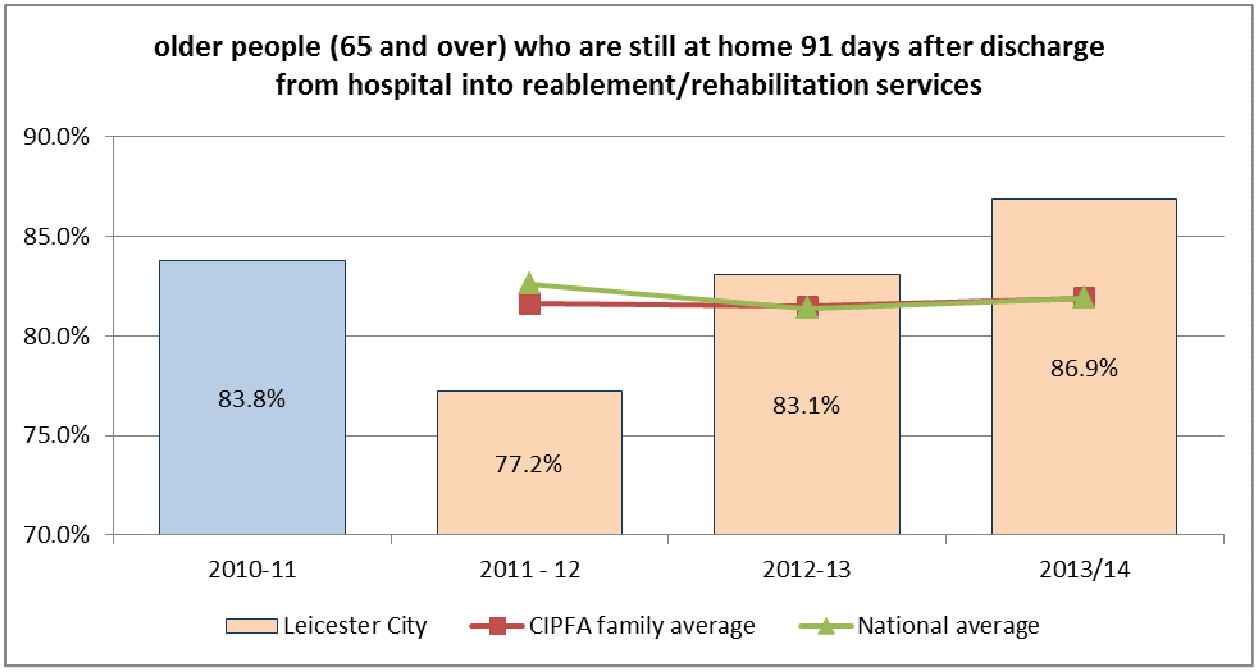
Long term conditions: People with Long Term Conditions in control of their condition



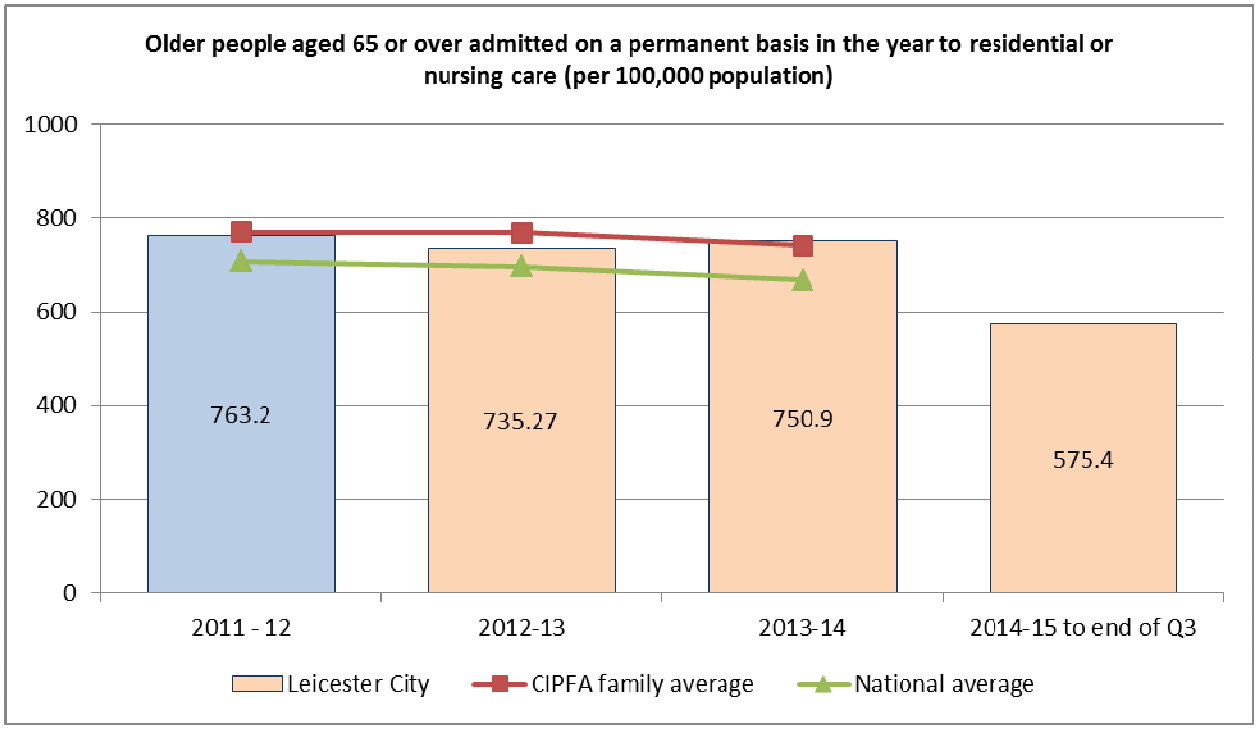
Carers receiving needs assessment or review and a specific carers service or advice and information (formerly NI135) *Please note there is no new data for this measure as the source reports are currently unavailable. This should be resolved later this month*



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

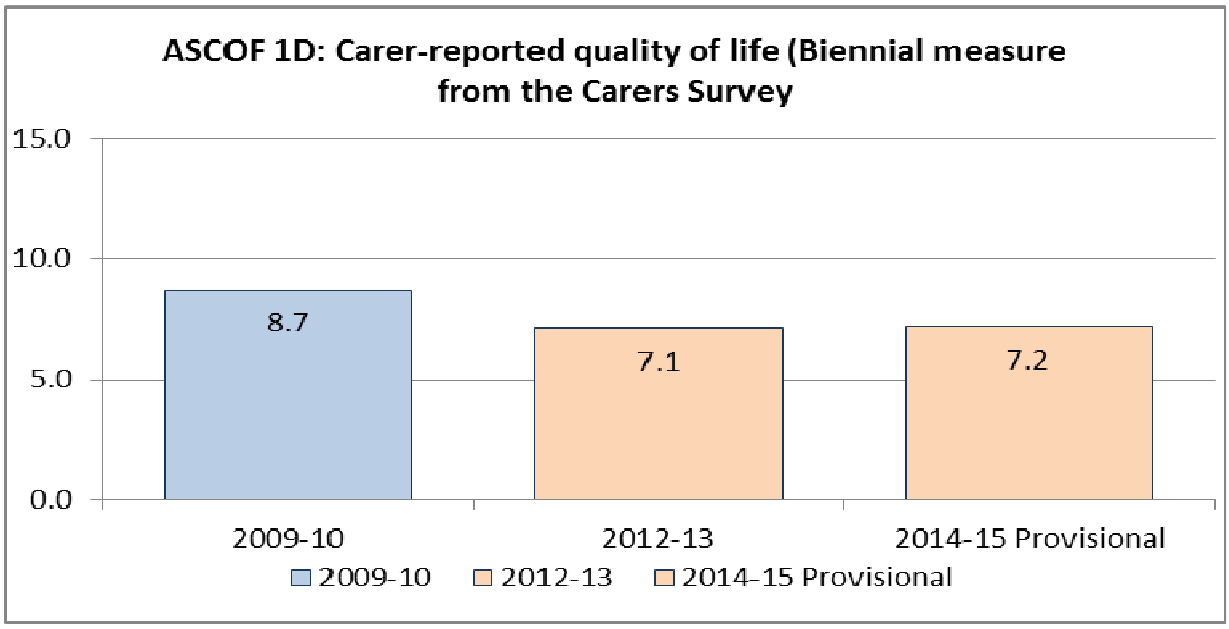


Older people aged 65 or over admitted on a permanent basis in the year to residential or nursing care (per 100,000 population) *Latest data to the end of Q3 2014/15*

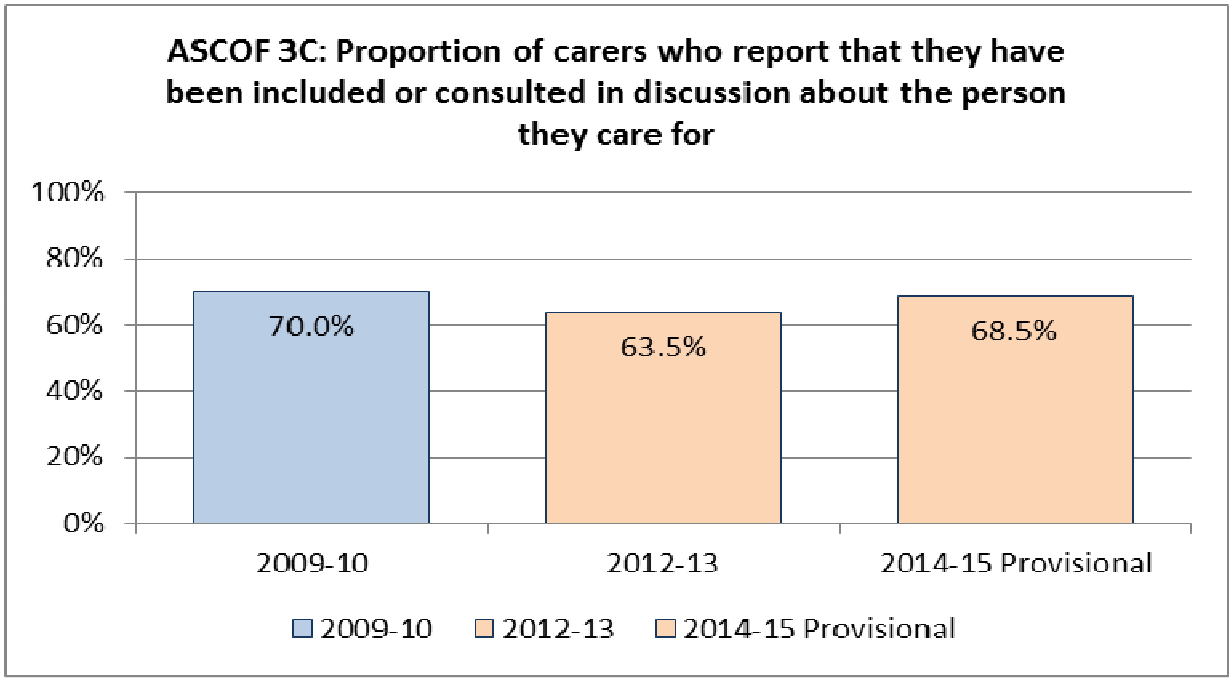


Dementia effectiveness – post dementia care:
No data will be available this measure during the life of the strategy.

Carer-reported quality of life (ASCOF 1D)

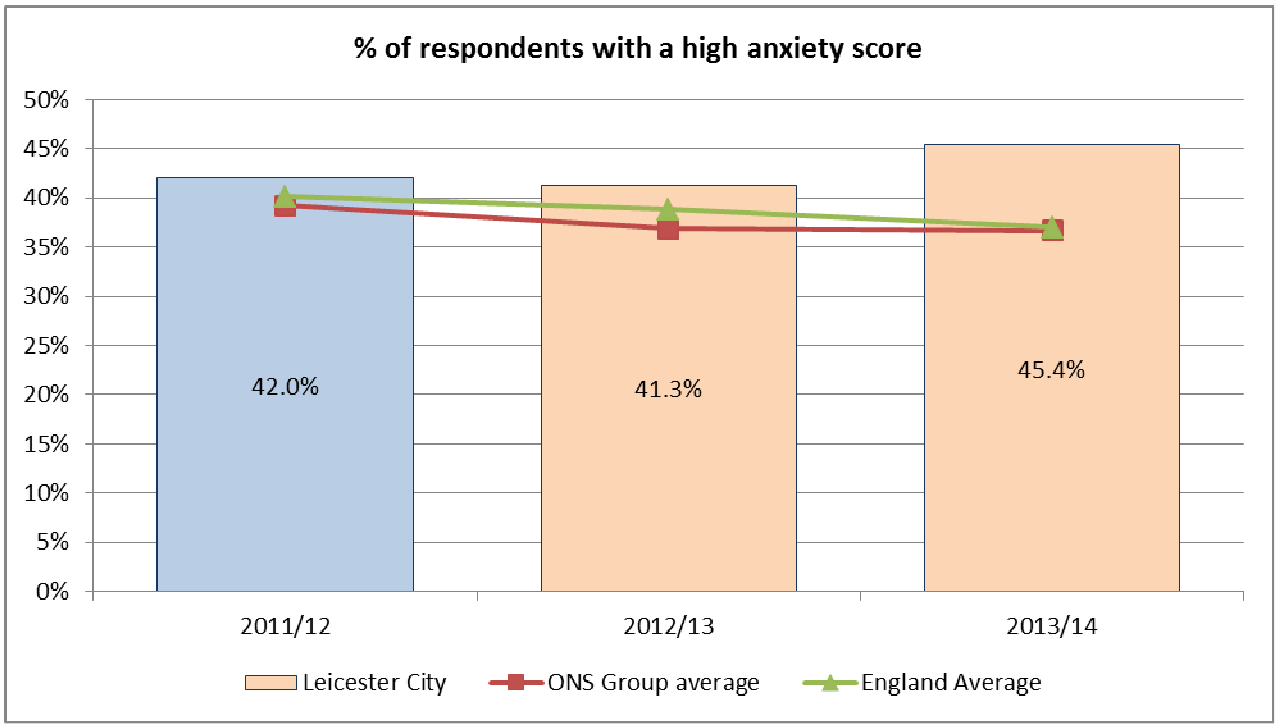


Proportion of carers who report that they have been included or consulted in discussion about the person they care for (ASCOF 3C)

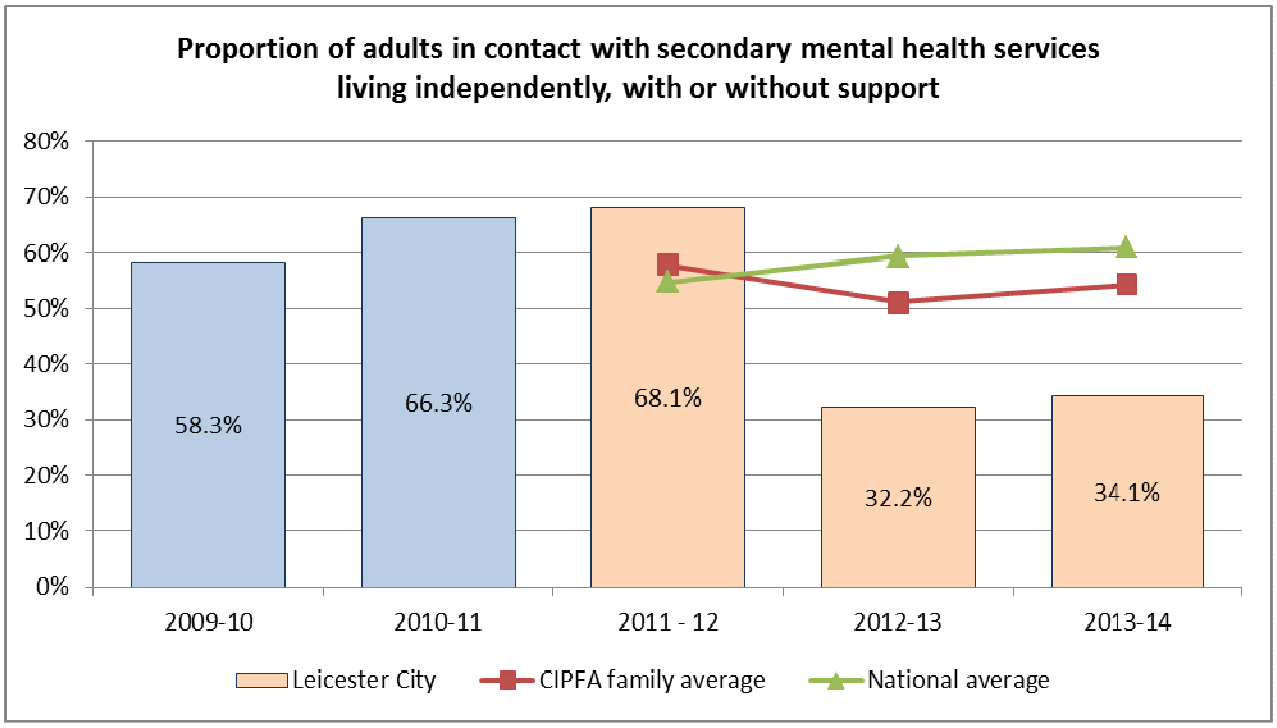


Priority 4: Improve mental health and emotional resilience

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



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



Appendix 2(c)

Technical Notes

Production of progress statements for Appendix 1:

To produce each statement, a contact person was identified for each of the areas. That person was asked to liaise with key colleagues to:

- refer to the text of the Joint Health and Wellbeing Strategy for their sub-section;
- report on progress with taking forward the actions in that section, as at December 2014, particularly referring to the bullet points listed under *What we plan to do*;
- make the progress statement short and succinct;
- focus particularly on any key achievements in the context of the strategy or any areas that are on significantly at risk of not being delivered (i.e. red rated); and
- provide a RAG rating for progress on work in that sub-section.

Reporting frequency for Appendix 2 indictors:

Of the 25 indicators, 2 are reported biennially, 13 annually, 8 quarterly, 1 has no fixed reporting pattern and 1 is a placeholder (not yet being collected).

Data quality issues and other technical notes on performance indicators

Indicator	Notes
Alcohol related harm	The definition of the alcohol-related hospital admissions measure has changed. The narrow definition indicator has been adopted for this report, roughly equating to alcohol specific admissions. This is not directly comparable with the previous NI39 data as there have been changes to the health conditions and fractions following new epidemiological evidence.
People with Long Term Conditions in control of their condition	Data is based on weighted survey results from GP Access Survey. Data quality issues have been resolved, the original baseline was incorrect and has subsequently been amended
Dementia - Effectiveness of post-diagnosis care in sustaining independence and improving quality of life	This measure was originally it was planned to be introduced from 14/15 onwards, however, it remains a placeholder in the 14/15 ASCOF framework. No data will now be produced for this measure during the lifetime of the strategy. An appropriate proxy measure is proposed
Proportion of adults in contact with secondary mental health services living independently with or without support	Data quality issues with this indicator are being resolved, the data is now being quality assured. Once this is done we should be able to make a judgement on direction of travel

Benchmarking:

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

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

Appendix 3.

JICB Response to Measures Showing Deteriorating Performance

NHS Health Check 2014/15 Update

Background

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk.

Local Performance

During initial implementation of the NHS Health Checks programme, each location was permitted to tailor the roll out of the programme to suit the local demographic and available budget. This resulted in varying approaches and levels of implementation success across the country.

Whilst there is no formal role for central performance management and targets in the development of the NHS health check, the legislation[1] does specify that:

"..the local authority shall act with a view to securing continuous improvement in the percentage of eligible persons in its area participating in the health checks."

Leicester initiated the NHS Health Check programme in 2010 and since that time has seen an annual increase in the number of those eligible having these checks (see table 1). By the end of 2013/14 approximately 62,000 out of the estimated eligible population 87,000 had received their NHS Health Check (71%).

The national modelling associated with the NHS Health Check programme suggests that from a 100% offer local commissioners should expect 70% of the population to attend for a check. Leicester is already well above this figure (currently 84%) with 2014/15 quarter 4 figures still to report.

Table1- NHS Health Checks completed annually

2010/11	2011/12	2012/13	2013/14	2014/15 (q1-q3)
7403	8238	24048	22396	11127

Current local performance still places Leicester among the top 3 performing local authorities for health checks completed in England.

Discussion

Performance to date in 2014/15 is significantly below those of 2013/14 however there are a number of factors that contribute to this:

[1] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/351/regulation/4/made last accessed 23/10/2013

- 2014/15 is the final year of the five year NHS Health Check cycle and many of those remaining in need of a health check may be those it has been most difficult to engage with over the previous 4 years
- Leicester's programme is primarily driven by opportunistic screening of eligible patients attending their GP surgery and this can make it difficult to complete screens amongst those who do not attend their surgery. The programme will be moving to call and recall as it moves to its second cycle and this will help to address this issue
- The accelerated programme between 2012/14 created an artificially high comparator. Routinely we would expect to carry out approximately 17,500/ year
- There has been a national decrease in the number of completed heath checks completed to date over 2014/15. The reason for this is unclear but there has been a suggestion, amongst local providers, that recent increasing workloads in general practice have 'squeezed' the delivery of the health check programme.
- As mentioned in the introduction the NHS Health Check programme is a 5 year recurring screening programme. In Leicester 2014/15 represents the 5th year of the programme and 2015/16 will see those who had received their check in the first year of the programme being recalled and consequently we would expect to see a sharp rise in performance as eligible patients return.

Action Plan

This local plan is based on the areas for action outlined in the Public Health England NHS Health Check implementation review and action plan.

Leicester NHS Health Check Implementation Review and action plan	
Issues	***Actions***
Leadership	We will ensure that the NHS health check subgroup reviews current performance and provides clear and timely advice to providers on local performance, emerging issues and developments proposed to improve programme performance. Presentations on these issues will be made to GP's, practice managers and nurses at Aprils Protected Learning Time (PLT) event
Improving uptake	We will work with will work PHE NHS Health Check teams to test the potential impact of behavioural insight and marketing interventions on uptake. This will include developing options for improving the awareness of the NHS Health Check programme locally. Working with the communications team we have developed and are implanting a communications plan, which includes a bus advertising programme. We are working with the communications team to establish the effectiveness of different approaches to recruitment and testing marketing campaigns to support uptake locally.
Providing the Health Check	The NHS health check programme has now been re-commissioned to run from 1st April 2015 for a period of up to 5 years. The new contract contains a

	range of provisions to support performance, these include training, audit and the ability to potentially remove contracts from poor performers.
Information governance	We will explore solutions to free up the system to enable the flow of data, including to and from GP practices, for the best possible delivery of the NHS Health Check programme. We shall continue to work with the CCG and GEM CSU on this area. We will explore the use of innovation and IT technologies to allow the flow of NHS Health Check data across the local health care system. This will create an environment that supports local teams to commission and evaluate programmes which aspire for excellence and improved outcomes
Supporting delivery	We will build upon and give continued support to established national, regional implementation support networks.
Programme governance	We will ensure clear programme governance arrangements are maintained or enhanced for the local programme,
Consistency	We will ensure that best practice guidance, describing all the elements and standards it would expect of a quality programme, are implemented by providers. A quality assurance template has been distributed to local providers as the first step in an ongoing local audit programme
Review	External audits have been commissioned from Leicester university and 360 Assurance to determine the delivery and outcomes of the programme and the appropriateness of provider claims. A full audit report, including equity audit, will be compiled on the local NHS Health Check programme June 2015

Ivan Browne
Consultant in Public Health
March 2015

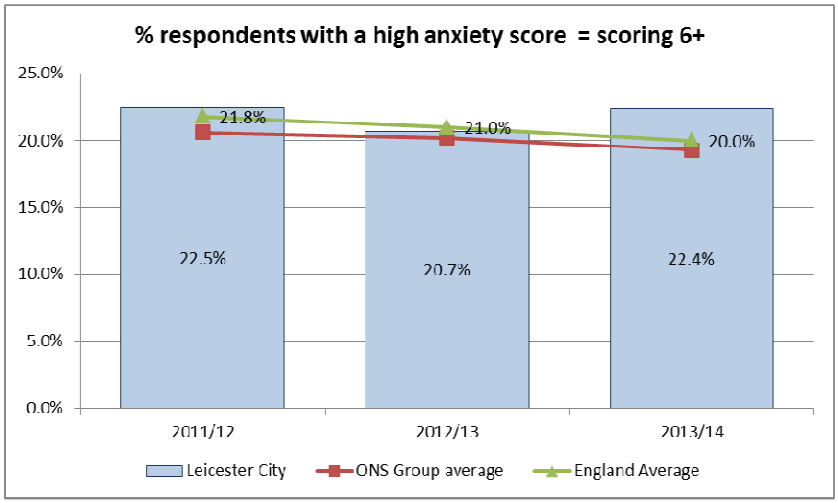
Self-reported well-being - people with a high anxiety score

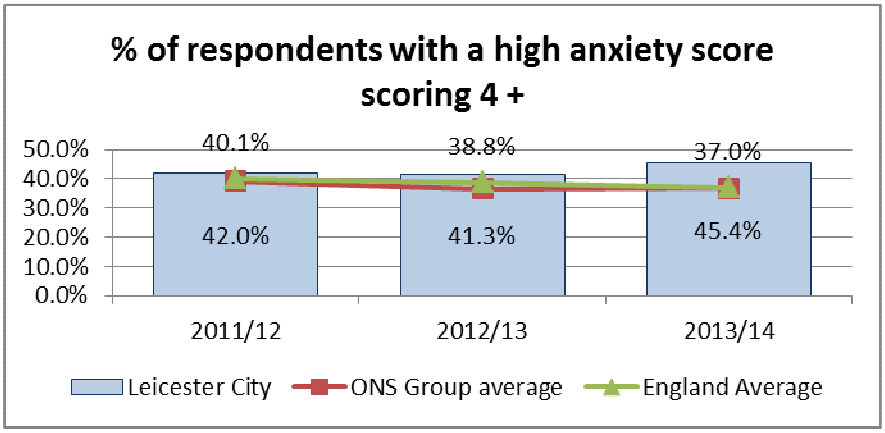
The metric used to measure this indicator is a self-reported question which asks people to rate on a scale of 0 -10 how anxious they felt yesterday.

A score of 0-1 is considered to be very low, 2-3 low, 4-5 moderate and 6-10 high.
In Leicester we have benchmarked this indicator at the proportion of people who score themselves at 4 or above to the question. The national benchmark is the proportion of people who score 6 or above to this question.

In Leicester the proportion of people scoring 4 or above has fluctuated since 2011 with an initial fall and then an increase in 2013/14. It is not possible at this point to determine whether this is a trend.

The proportion of people scoring 6 or above in Leicester is slightly higher than the national average but this is not a statistically significant difference. There is also less fluctuation year on year. This suggests that the rise in the indicator locally is a product of increasing numbers of people reporting that they feel moderately anxious (i.e. scoring 4-5).





Smoking Cessation 2014/15 update

Background

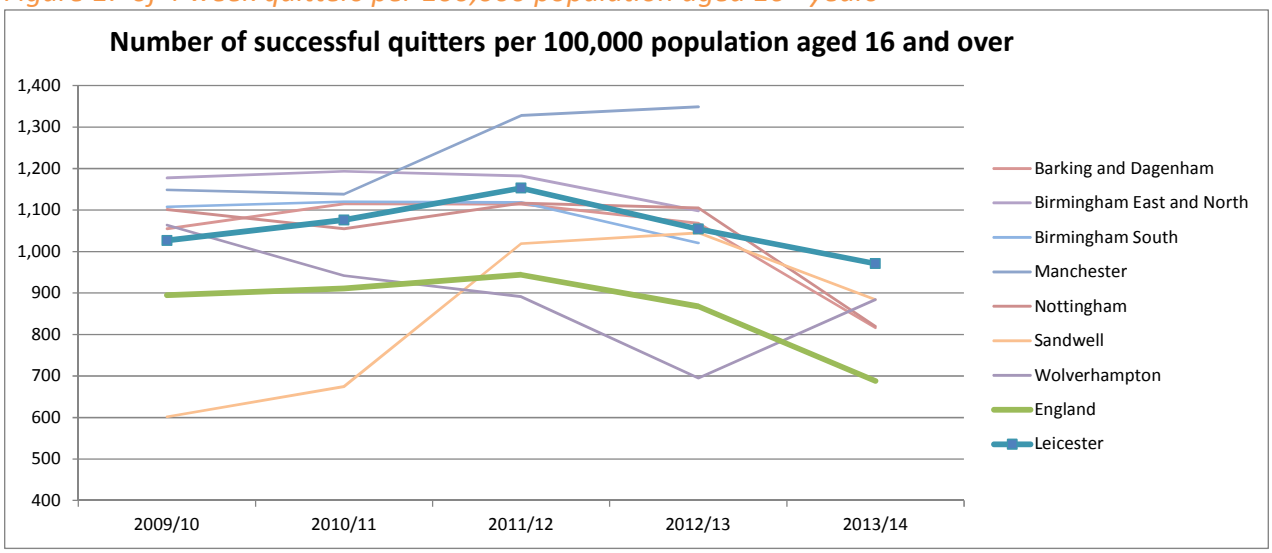
The full year results for 2013/14 show that the smoking cessation service in Leicester achieved 98.6% of its expected 4 week quitters in a year that was marked by changes in smoker's behaviour due to the further impact of e-cigarettes. The challenging conditions continued and in q1 2014/15 the service reported that it was 36% below target for the quarter and, building on a recovery plan, at the end of q2 the gap had been narrowed to 23% of the cumulative target. It is anticipated that the q3 results, due in a weeks time, will maintain a similar position regarding the cumulative target for the first three quarters of this year.

Work will continue on the basis of the recovery plan, which includes further promotional campaigns (including a major campaign jointly with the Leicester Mercury). Work has also continued to promote and support smoking cessation with communities, hospitals, primary care, maternity services and other settings. The CCG has funded some additional pilot work in strengthening smoking cessation efforts in UHL. The service continues to make smoking cessation available to younger smokers and works to reduce smoking in pregnancy.

Local Performance

The figure below shows the number of 4 week quitters per 100,000 population for Leicester, England and peer comparators.

Figure 1: of 4 week quitters per 100,000 population aged 16+ years



Data: HSCIC Stop Smoking Service data.

Note: Quit rates are provided for PCTs for 2009/10 to 2012/13 and for Local Authority areas in 2013/14. Data is not shown for 2013/14 where PCTs are not coterminous with Local Authority areas.

The service continues to be among the best at attracting smokers to the service and helping them to quit. Figure 1 shows that successful quitters per 100,000 population aged 16+has declined over the past 5 years with steep declines in the last three years. This pattern is mirrored at the national level (thick green line in Figure 1), however, the number of people

successfully quitting in Leicester still remains above national levels and Leicester has the highest rate of quitters among its ONS comparators in 2013/14. Leicester is also performing well in terms of its quit rate - the percentage successfully quitting in 2013/14 (57% of those who set a quit date) is 4 percentage points higher compared to 2012/13.It should be noted also that 72.4% of all quits were validated by CO monitoring (which measures the level of carbon monoxide in the bloodstream), significantly higher than the average for England (70.1%) and for the East Midlands (59.7%) and 4th among comparator authorities but significantly higher than the average for those authorities (65%).
Stop received full accreditation in August 2014 from the National Centre for Smoking Cessation and Training (NCSCT). The service will be participating in a NIHR funded randomised controlled trial of e-cigarettes v standard NRT treatment in 2015. Preparation is underway for the transfer of the STOP Smoking Cessation Service to the City Council from 1st April 2015.

Action Plan

Action	What is needed? Who will do this?	By when?	Outcome
Continue to recruit e-cigarette users into the service for behavioural support to improve the success of their quit attempt	Whole team	Throughout the year	Those using unlicensed products either in addition to or instead of licensed products showed >20% increase in success rates in Qs 1&2.
Joint campaign between Stop and the Leicester Mercury, managed by Soar Media. Concept created December 2014, planning meeting 5.1.15, campaign began 2.2.15, intended to end week of No Smoking Day 11.3.15	Content from the service and Leicester City Council, Trading Standards, Environmental Health, service users, GPs, UHL Consultant, sports ambassadors; etc.	Normal activity throughout the year. Special campaign Feb-March 2015	March 2015. Increase in calls directly to Stop Week 1 - 55 Week 2 - 36 Week 3 - 31 Week4 – 26 Week 5 – 27 Stop was previously getting between 1-3 direct calls per day. NB the vast majority of contacts to the service come through intermediaries.
Continue to work on sustainability of the Making Every Contact Count programme to frontline staff in all areas where high smoking prevalence is	Full implementation programme being developed for MECC Year3	Throughout the year	Increase in activity at LPT especially among those with poor mental health

an issue, using e-referrals (from Q3) as well as card referrals	This includes renewed emphasis on NHS staff quitting		
Contact all service users to invite them back into the service if they didn't quit on their most recent attempt, or if they have relapsed	Texts sent, by admin team	Throughout the year (standard practice)	This does bring a small number back in
Develop a scheme to enable GPs to refer smoking patients to the service electronically, auto-linked for QOF points	Developed in partnership with Health Informatics Service, system piloted in Q4 2013-14, now live and active	Training has been delivered at most practices	Awaiting revision of numbers for Q3
LPT/FYPC Neighbourhood Leads to ensure Stop information is circulated widely and embedded in contact with patients	Sara Tebbett, Neighbourhood Lead, is primary contact for Stop	On-going	This particularly benefits families in Leicester City
Smoking in pregnancy DVD/campaign launched by Leicester City Council Other new materials designed and produced (pregnancy calendar) for use by pregnant women who smoke	Alex Barker, Ann Cairns & pregnancy specialists Tina Adams	Launched October 2014 Distribution started February 2015	Further work continuing: roll-out, including schools, community pharmacists. First round of community pharmacists trained for Smoking in Pregnancy Dec 2014, in order to widen reach of service. Monitor and evaluate. (Slow to start, pharmacists finding it hard to find time for extra NCSCT smoking in pregnancy module)

To follow:

Uptake of bowel cancer screening in men and women

Coverage of cervical screening in women