LEICESTER CITY HEALTH AND WELLBEING BOARD

10 October 2016

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

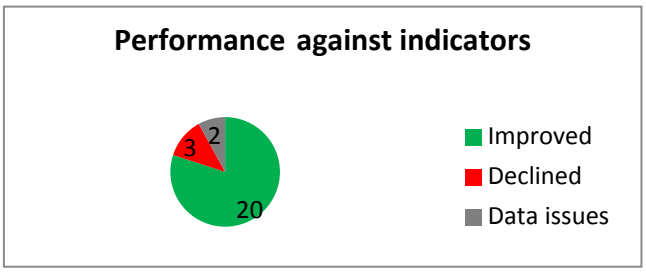
EXECUTIVE SUMMARY:

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

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

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

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



RECOMMENDATIONS:
The Health and Wellbeing Board is requested to:

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

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

Report on behalf of the Leicester City Joint Integrated Commissioning Board

1. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Measures showing deterioration from the baseline in the strategy are:

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

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

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

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

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

Direction of travel against baselines in the strategy:

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

Data Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1(a)

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

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

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

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

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

Appendix 1(b)

Performance Trends and Benchmarking

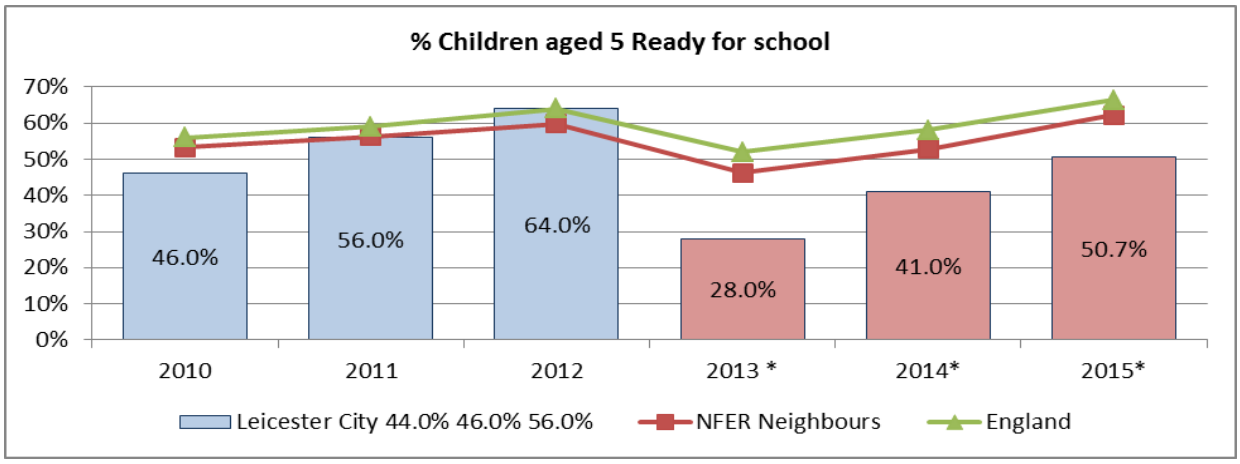
Key for Graphs
NFER Neighbours = National Foundation for Educational Research Statistical Neighbour Group
ONS = Office for National Statistics Neighbour Group
CIPFA = Chartered Institute for Public Finance and Accountancy Statistical Neighbour Group

(See appendix 1c for membership of comparator groups)

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

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

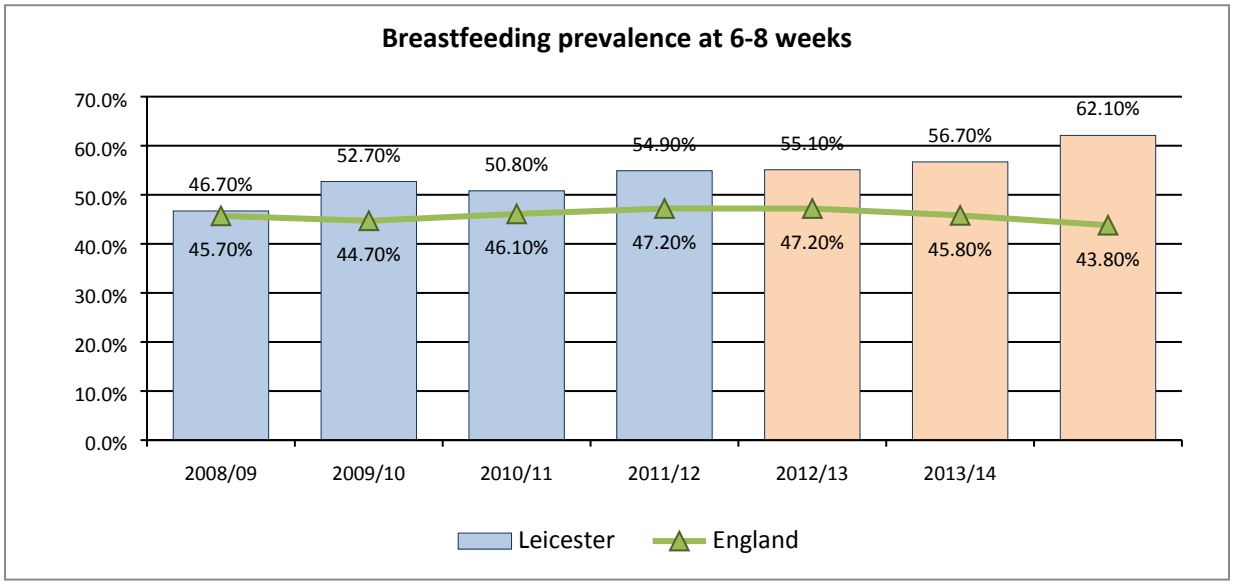
Readiness for school at age 5



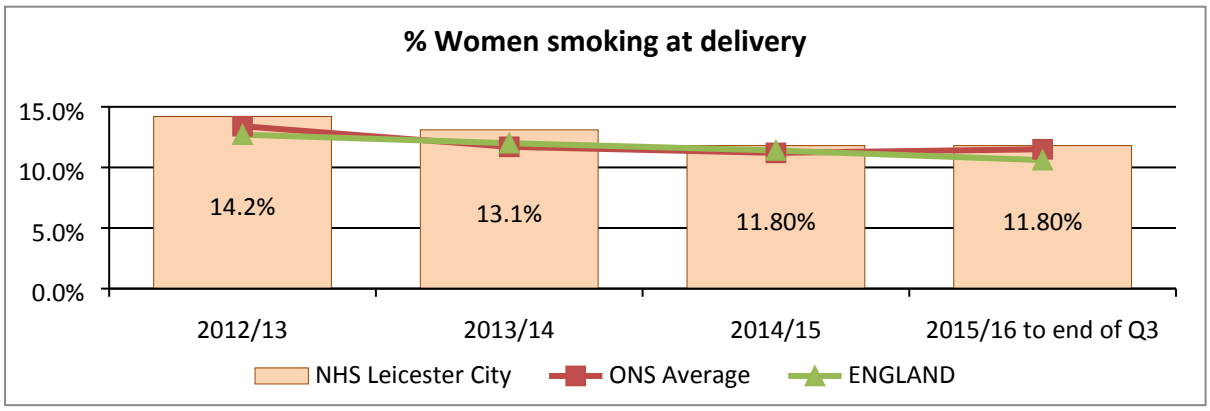
N.B. trend graph shows historical trend for the old measure of "Achieving a good level of development at Early Years Foundation Stage for 2009-2012. The first year of results for the new Foundation Stage Profile was 2013.

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

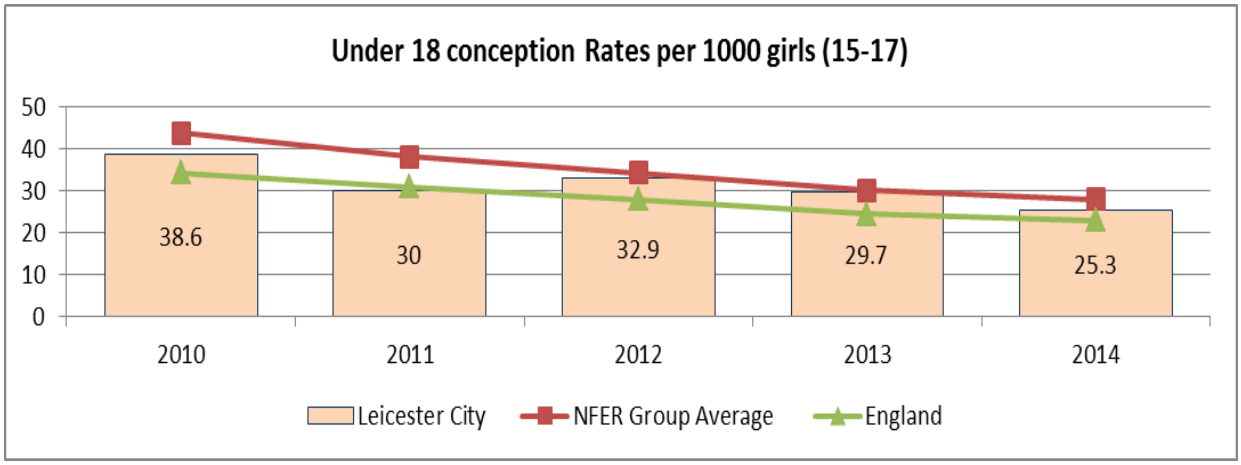
Breastfeeding at 6-8 weeks



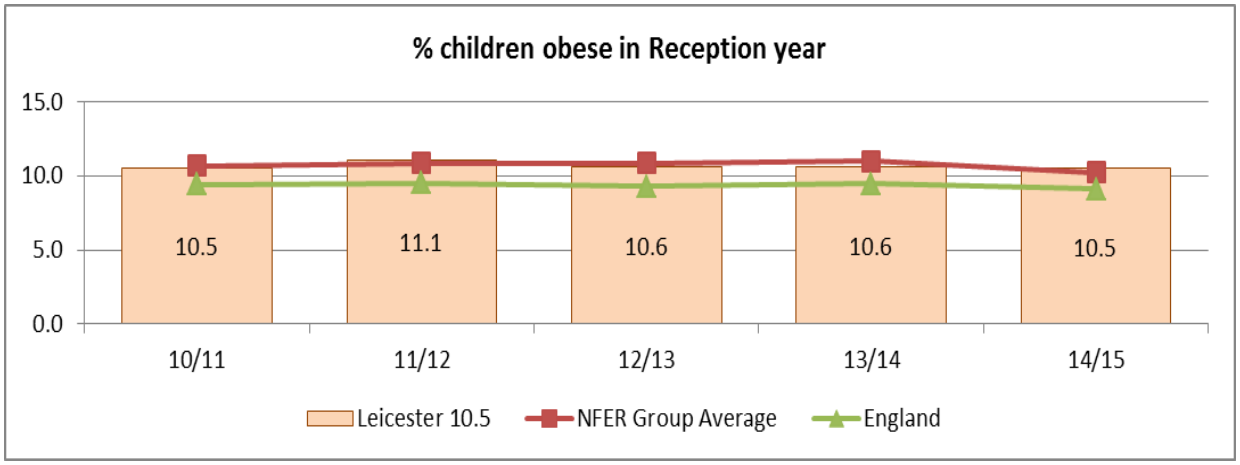
Smoking in pregnancy



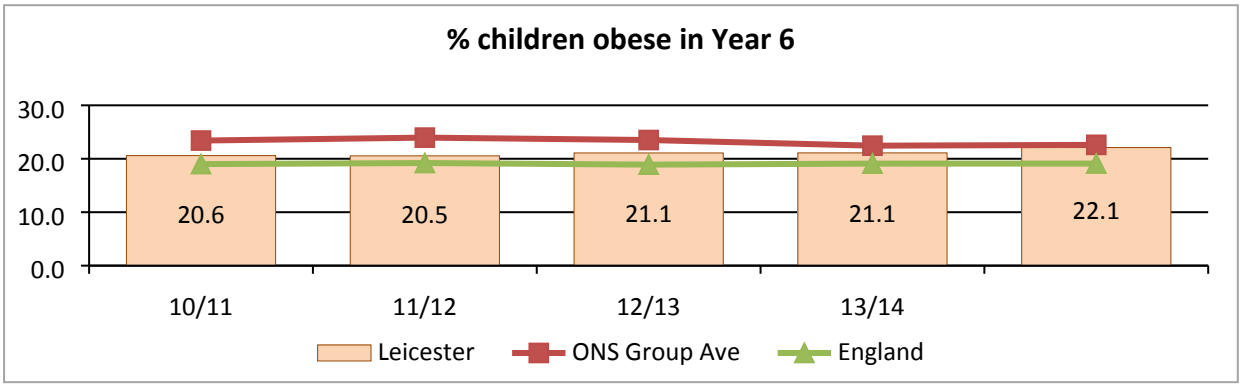
Under 18 conception Rates per 1,000 girls (15-17)



% children obese in Reception year

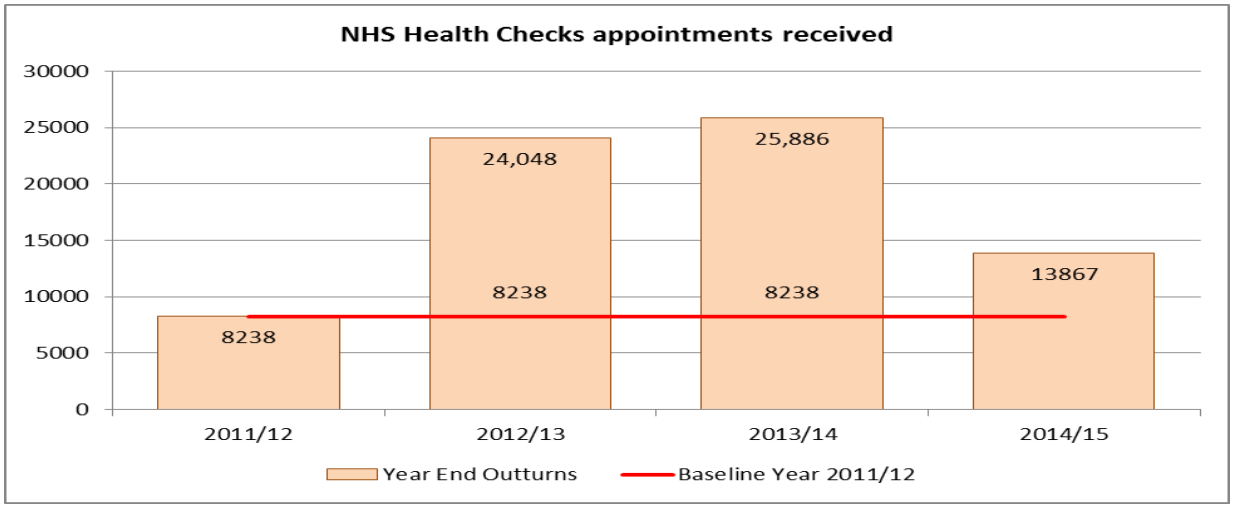


% children obese in Year 6

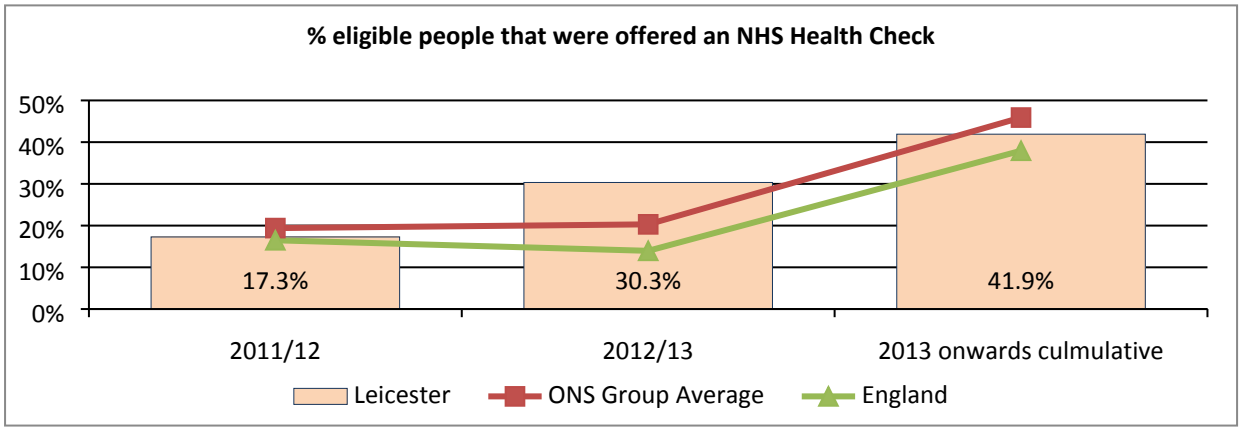


Priority 2: Reduce premature mortality

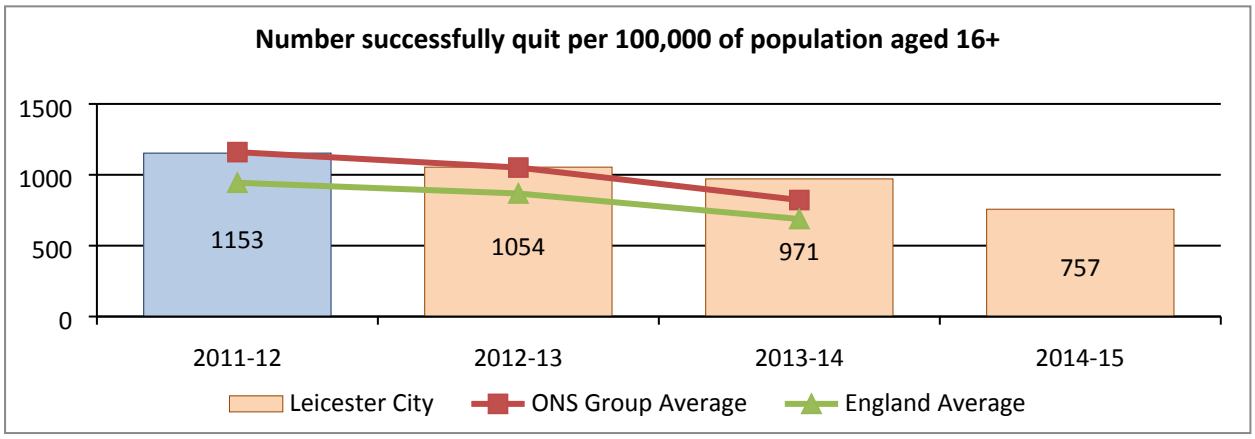
Number of people having NHS Checks



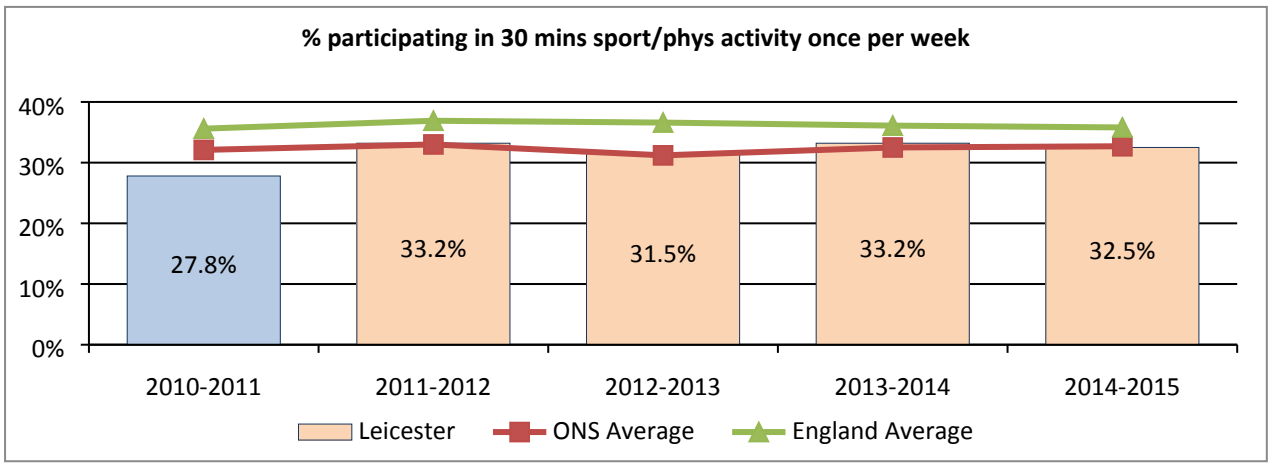
Proxy measure: % eligible people that were offered a NHS Health Check (used because it enables meaningful comparisons between different sized areas)



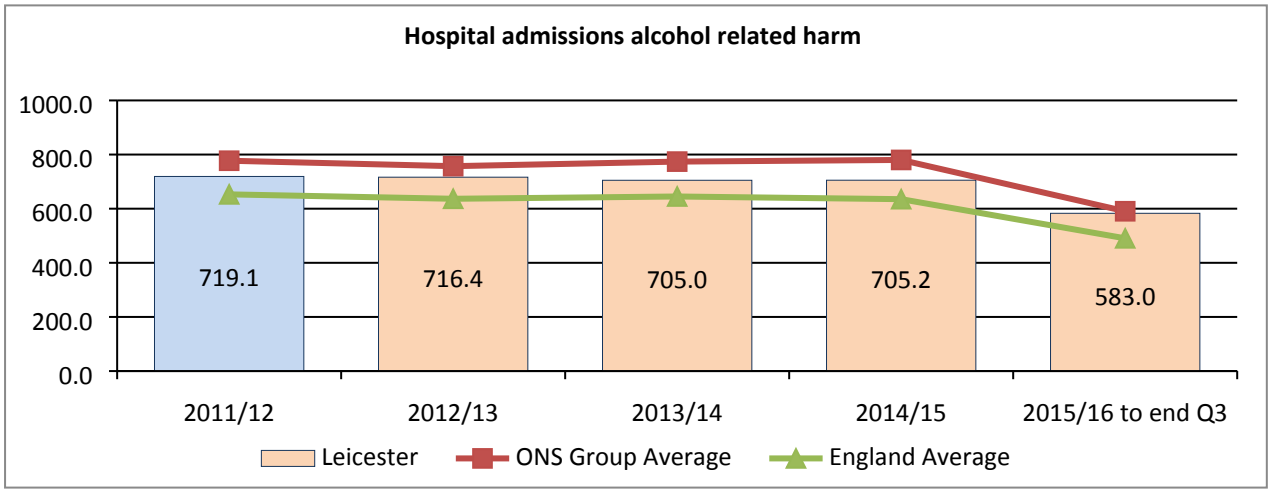
Number successfully quit (self-report) per 100,000 of population aged 16 and over



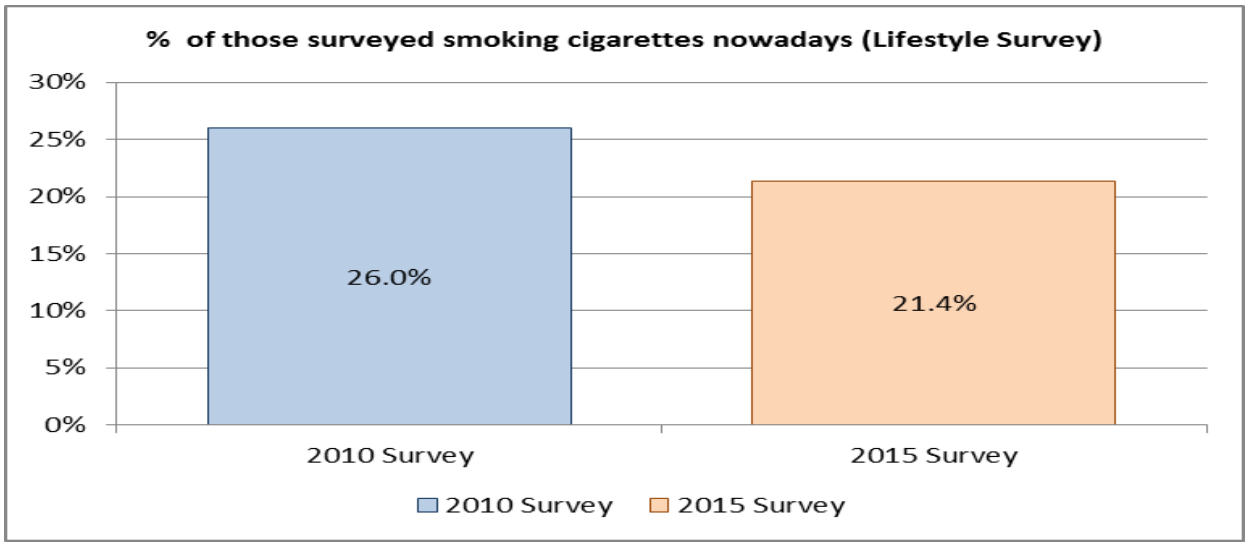
% participating in 30 minutes of sport/physical activity per week



Hospital admissions for alcohol related harm, new narrow definition measure

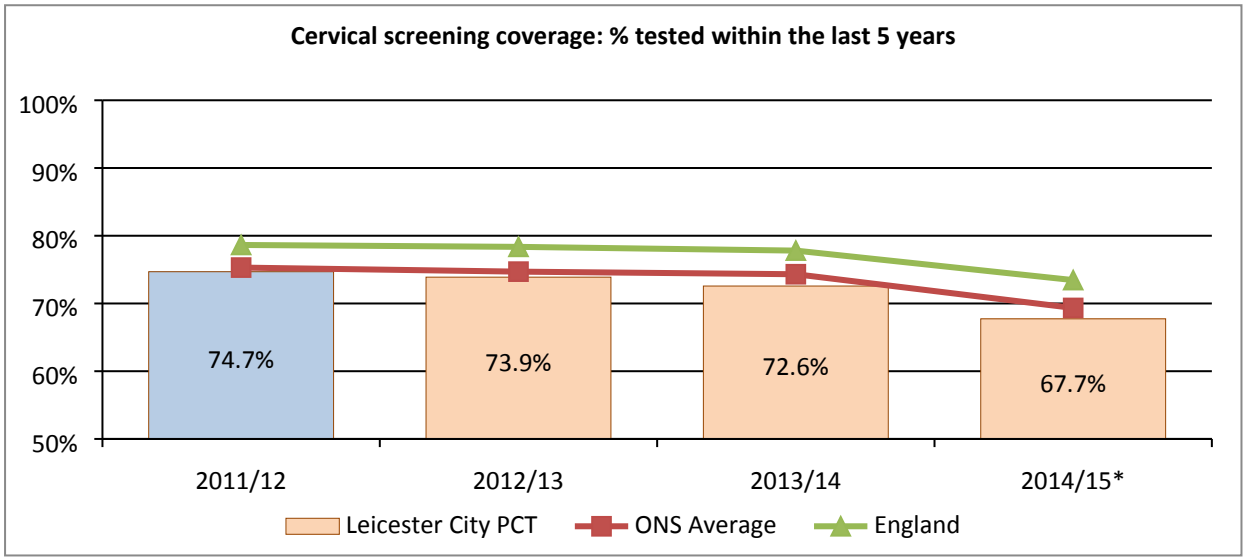


Reducing smoking prevalence:

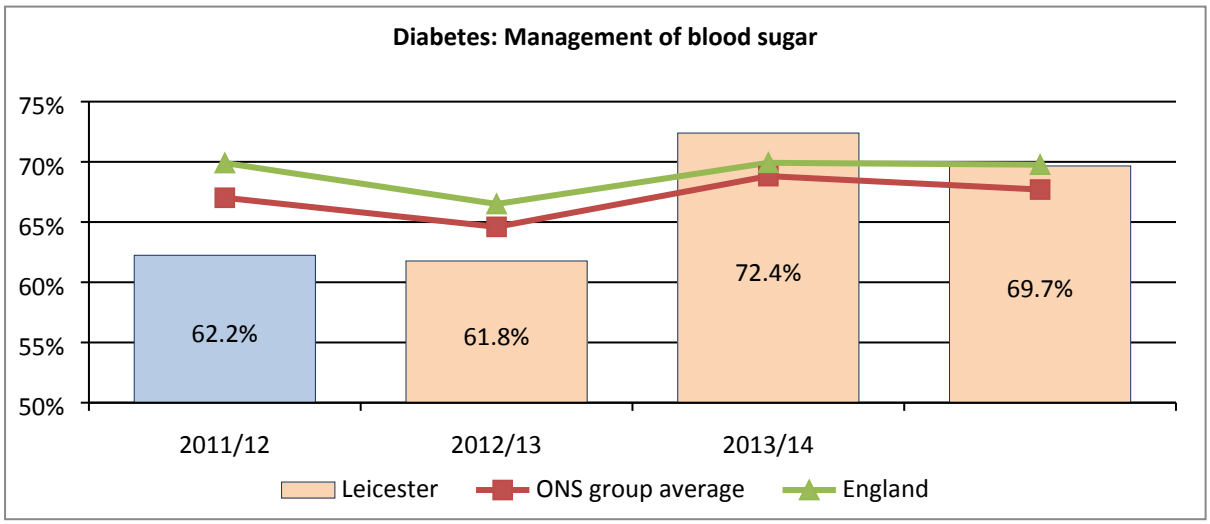


Uptake of bowel cancer screening
Data not published nationally

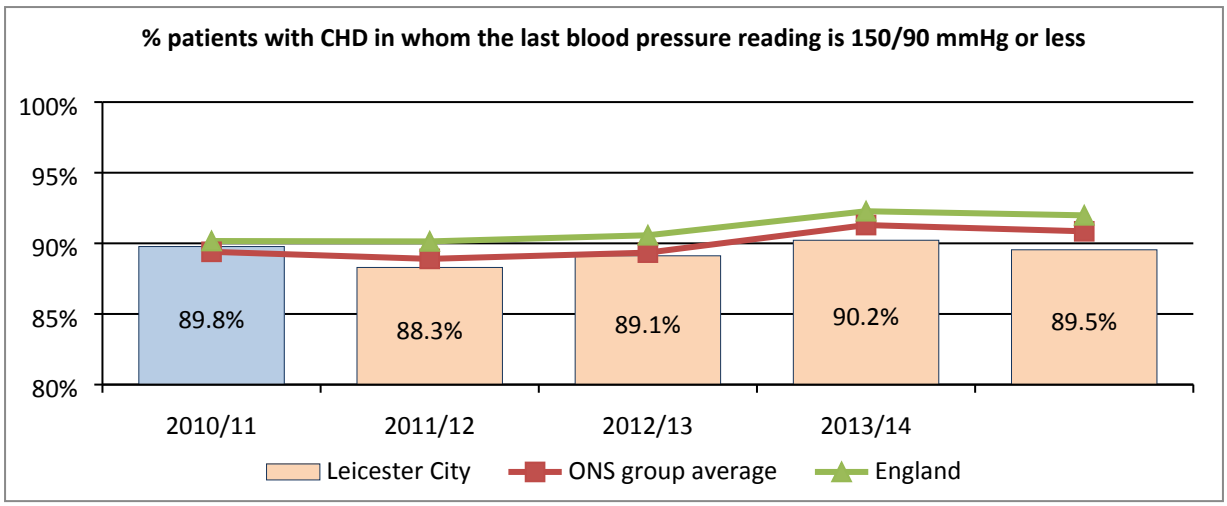
Cervical screening coverage



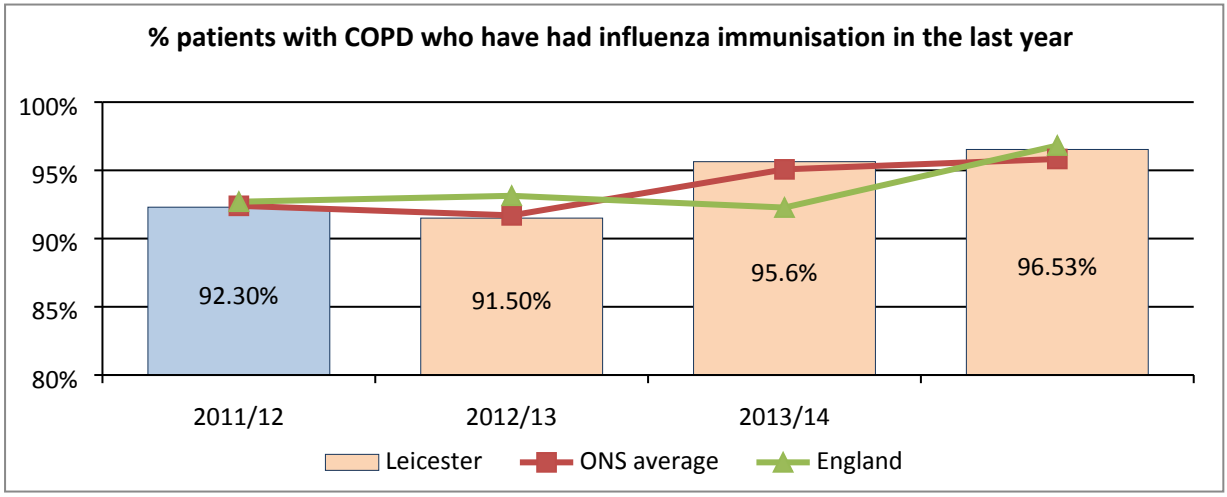
Diabetes: Percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol in the preceding 15 months.



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

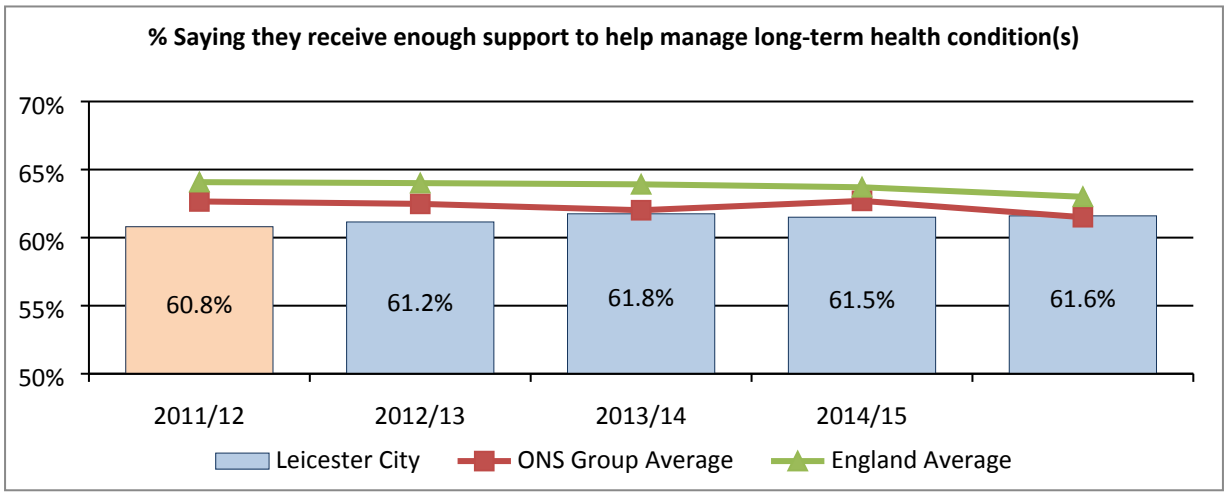


Chronic Obstructive Pulmonary Disease: Percentage of patients with COPD who have had influenza immunisation

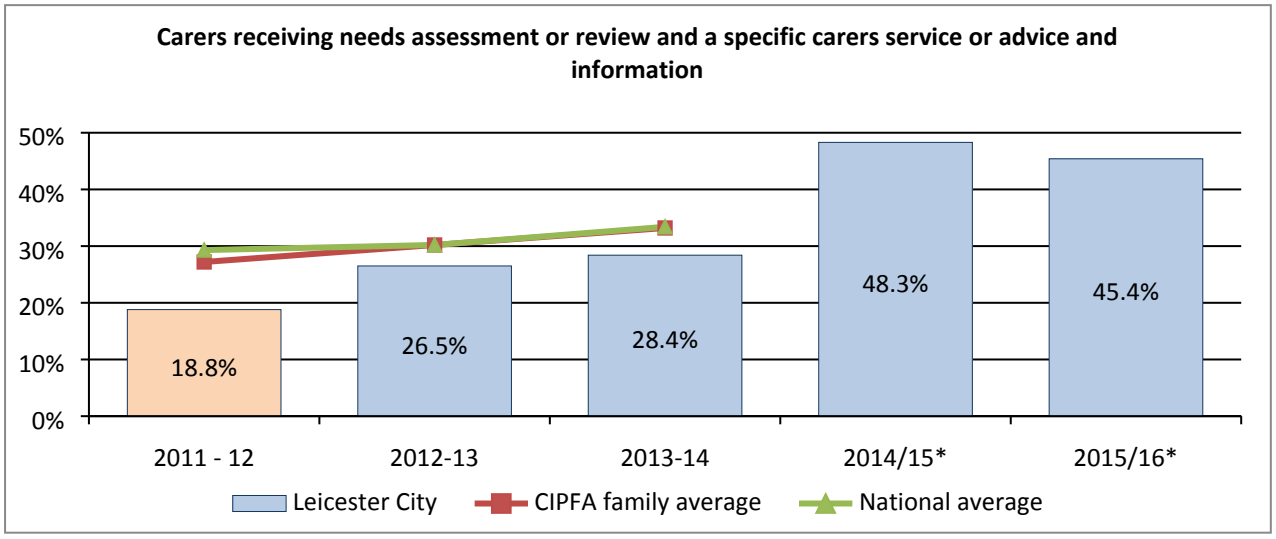


Priority 3: Promoting Independence

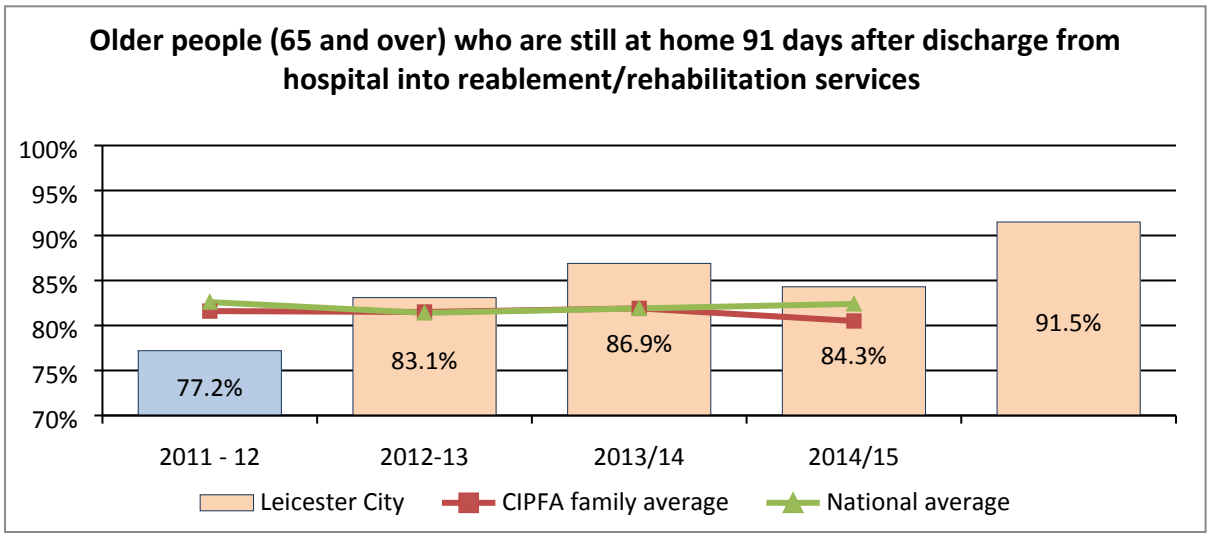
Long term conditions: People with Long Term Conditions in control of their condition



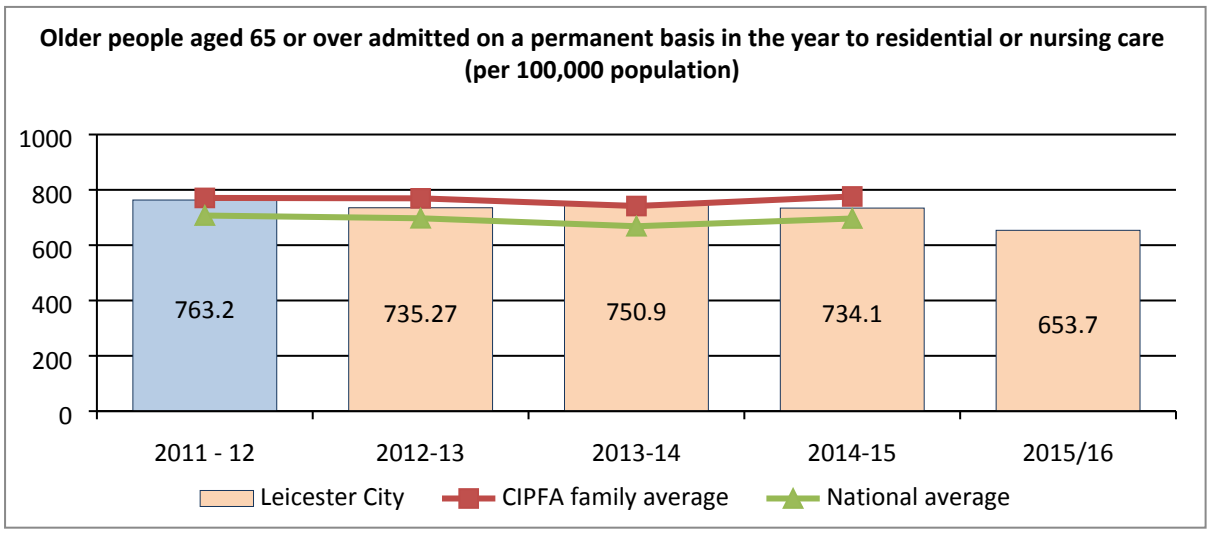
Carers receiving needs assessment or review and a specific carers service or advice and information (formerly NI135) **local measure only from 2014/15 onwards*



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

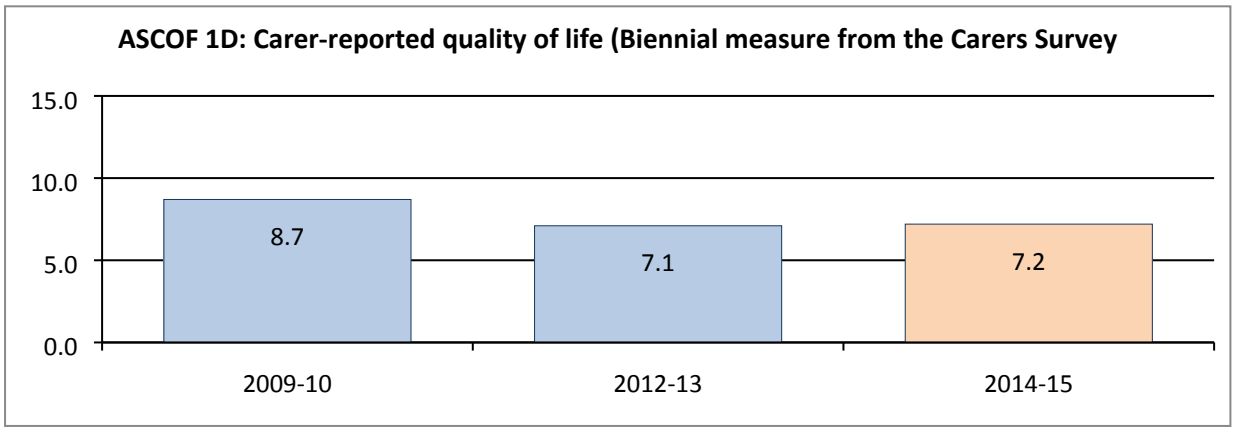


Older people aged 65 or over admitted on a permanent basis in the year to residential or nursing care (per 100,000 population)

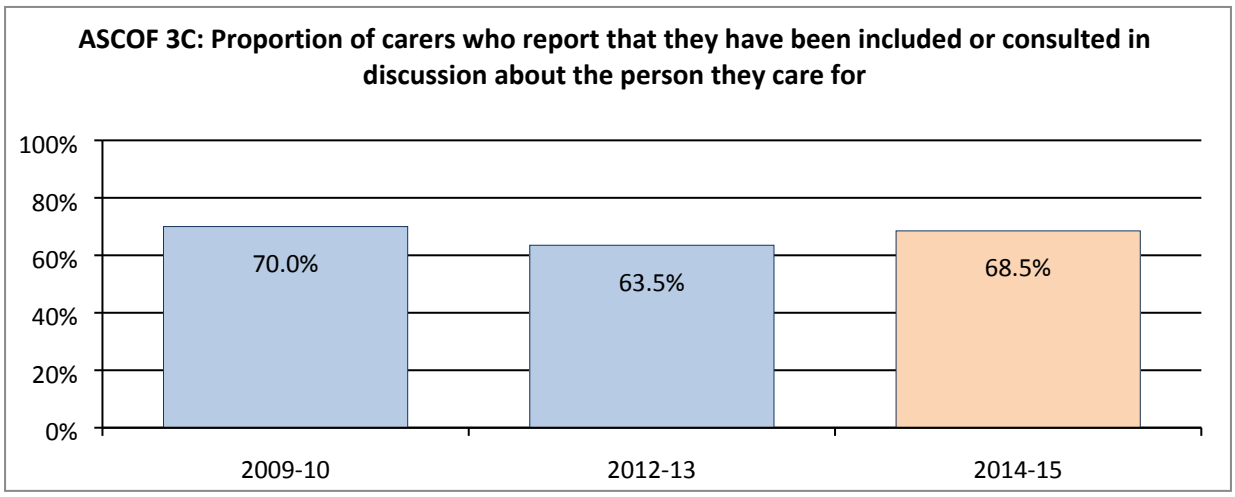


Dementia effectiveness – post dementia care:
No data will be available this measure during the life of the strategy.

Carer-reported quality of life (ASCOF 1D)

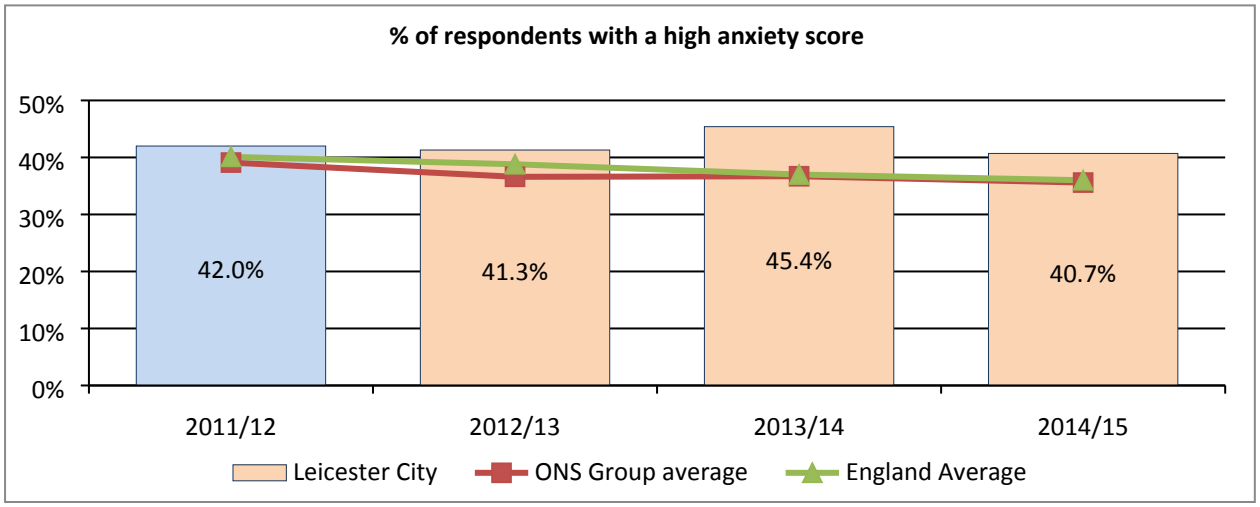


Proportion of carers who report that they have been included or consulted in discussion about the person they care for (ASCOF 3C)

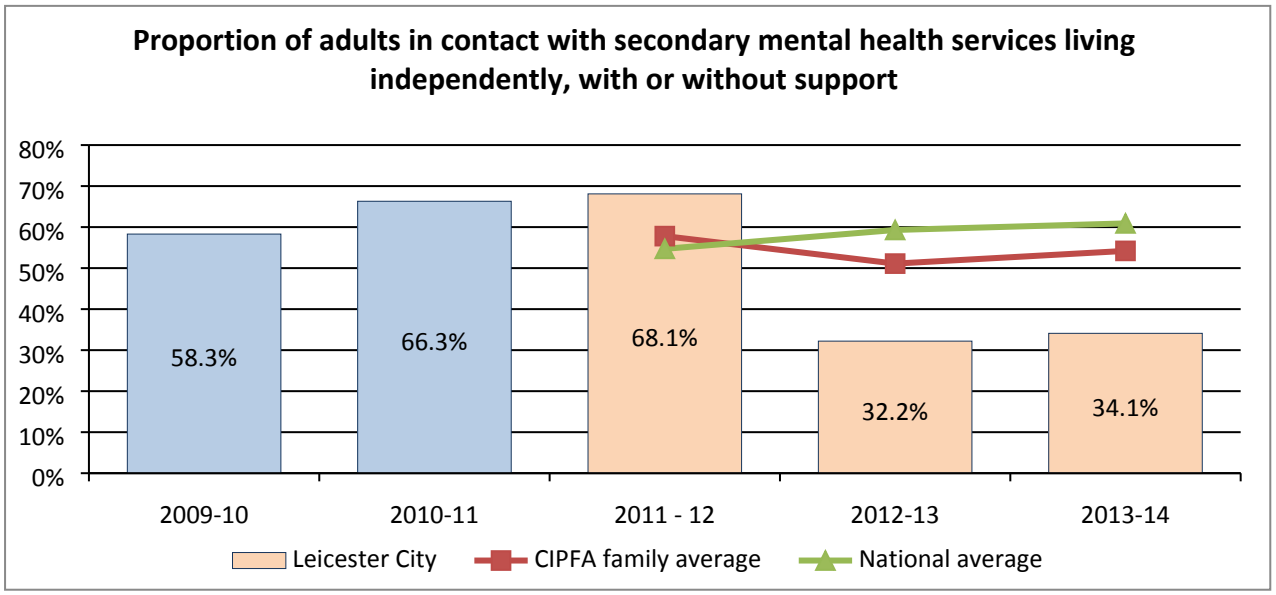


Priority 4: Improve mental health and emotional resilience

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



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



Appendix 1(c)

Technical Notes

Benchmarking:

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

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

Appendix 2

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

Implementation of actions

Final Statements: April 2016

Strategic Priority 1: Improve outcomes for children and young people

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Strategic Priority 2: Reduce premature mortality

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Context

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

Clinical Leadership

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

Cardiovascular Disease Management

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

Atrial Fibrillation and Heart Failure

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

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

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

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

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

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

Diabetes

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

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

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

Respiratory Disease Management

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

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

Strategic Priority 3: Support independence

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Strategic Priority 4: Improve mental health and emotional resilience

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	John Singh, Strategy and Implementation Officer, Leicester City CCG

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

Some progress has been made against these priorities including:

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

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

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

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

Strategic Priority 5: Focus on the wider determinants of health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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