Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 2 November 2016 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Ms. R. Palmer (0116 305 6098)**

Email: **rosemary.palmer@leics.gov.uk**

Membership

Dr. S. Hill CC (Chairman)

Mrs. R. Camamile CC	Dr. R. K. A. Feltham CC
Mr. J. G. Coxon CC	Mr. J. Kaufman CC
Mrs. J. A. Dickinson CC	Ms. Betty Newton CC
Dr. T. Eynon CC	Mr. T. J. Pendleton CC

Please note: this meeting will be filmed for live or subsequent broadcast via the Council's web site at http://www.leics.gov.uk/webcast – Notices will be on display at the meeting explaining the arrangements.

AGENDA

Item		Report by
1.	Minutes of the meeting held on 14 September 2016.	(Pages 5 - 12)
2.	Question Time.	
3.	Questions asked by members under Standing Order 7(3) and 7(5).	
4.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	
5.	Declarations of interest in respect of items on the agenda.	
6.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.	

7. Presentation of Petitions under Standing Order 36.

8. Development of Integrated Urgent Care and Winter Planning. (Pages 13 - 20)

9. Leicestershire's Approach to Falls. (Pages 21 - 28)

10. Annual Report of the Director of Public Health. (Pages 29 - 72)

11. Health Performance Update. (Pages 73 - 92)

12. Date of next meeting.

The next meeting of the Committee is scheduled to take place on 23 January 2017 at 2:00pm.

13. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

Members serving on Overview and Scrutiny have a key role in providing constructive yet robust challenge to proposals put forward by the Cabinet and Officers. One of the most important skills is the ability to extract information by means of questions so that it can help inform comments and recommendations from Overview and Scrutiny bodies.

Members clearly cannot be expected to be experts in every topic under scrutiny and nor is there an expectation that they so be. Asking questions of 'experts' can be difficult and intimidating but often posing questions from a lay perspective would allow members to obtain a better perspective and understanding of the issue at hand.

Set out below are some key questions members may consider asking when considering reports on particular issues. The list of questions is not intended as a comprehensive list but as a general guide. Depending on the issue under consideration there may be specific questions members may wish to ask.

Key Questions:

- Why are we doing this?
- Why do we have to offer this service?
- How does this fit in with the Council's priorities?
- Which of our key partners are involved? Do they share the objectives and is the service to be joined up?
- Who is providing this service and why have we chosen this approach? What other options were considered and why were these discarded?
- Who has been consulted and what has the response been? How, if at all, have their views been taken into account in this proposal?

If it is a new service:

- Who are the main beneficiaries of the service? (could be a particular group or an area)
- What difference will providing this service make to them – What will be different and how will we know if we have succeeded?
- How much will it cost and how is it to be funded?
- What are the risks to the successful delivery of the service?

If it is a reduction in an existing service:

- Which groups are affected? Is the impact greater on any particular group and, if so, which group and what plans do you have to help mitigate the impact?
- When are the proposals to be implemented and do you have any transitional arrangements for those who will no longer receive the service?
- What savings do you expect to generate and what was expected in the budget? Are there any redundancies?
- What are the risks of not delivering as intended? If this happens, what contingency measures have you in place?

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Agenda Item 1

Leicestershire County Council

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 14 September 2016.

PRESENT

Mrs. R. Camamile CC	Mr. J. Kaufman CC
Dr. T. Eynon CC	Ms. Betty Newton CC
Dr. R. K. A. Feltham CC	Mr. T. J. Pendleton CC
Mr. D. Jennings CC	Mrs. J. Richards CC

Apologies
Dr. S. Hill CC

In attendance
Mr. E. F. White CC, Cabinet Lead Member for Health.
Mike Sandys, Director of Public Health.
Rick Moore, Chair of Healthwatch Leicestershire.
Noelle Rolston, Senior Contracts and Provider Performance Manager, LLR CCGs, (minute 26 refers).
Jane Chapman, Chief Strategy and Planning Officer, East Leicestershire & Rutland CCG (minute 26 refers).
Gill Stead, Head of Prescribing, West Leicestershire CCG (minute 27 refers).
Phyllis Navti, Head of Prescribing, East Leicestershire CCC (minute 27 refers).
Vandna Gohil, Director, Healthwatch (minute 28 refers).

18. Appointment of Chairman for the meeting.

RESOLVED:

That Dr. T. Eynon CC be elected Chairman for this meeting of the Health Overview and Scrutiny Committee.

Dr. T. Eynon CC – In the Chair

19. Minutes of the previous meeting.

The minutes of the meeting held on 8 June 2016 were taken as read, confirmed and signed.

20. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 35.

21. Questions asked by members under Standing Order 7(3) and 7(5).

Mr R. Sharp CC asked the following questions:-

The Community Alarm Service known as Lifeline is intended to enable people in the Charnwood Borough to call for help in case of emergency 24 hours per day, 7 days a week. Lifeline is manned by on-call wardens who will call an ambulance on someone's behalf but are not trained or authorised to attend emergency incidents themselves. There seems to be a growing problem of long waiting times for ambulances to attend patients who have requested help using the Lifeline service.

Could the Chairman please clarify:-

1. Are ambulance response times for Lifeline residents recorded and reported?
2. Is there a cheaper and faster response option available other than an ambulance?
3. Could we train local Lifeline wardens to be first contact responders?

Dr. T. Eynon CC replied as follows:-

1. 999 calls from Lifelines are not recorded separately by EMAS. However, it is possible for EMAS to look into individual calls from Lifelines to investigate why there was a delay in response.

2. The Lifeline Service is provided by Charnwood Borough Council and any specific issues will need to be raised with that organisation. In general terms, if a frail elderly person falls, and an ambulance is called they will be assessed by a paramedic using the Falls Risk Assessment Tool to determine whether immediate hospital attendance is required. If being taken to hospital is not deemed necessary, but the person may need other support, referral can be made by the ambulance staff direct to Leicestershire Partnership Trust's Single Point of Access (SPA). The SPA will undertake a telephone assessment within two hours to determine the appropriate response which could include follow up in the home by the local community services team.

   There are no other emergency medical response services other than that provided by the East Midlands Ambulance Service. However, if the person's GP is contacted about the incident the GP might also assess if an urgent home visit from the GP practice should take place.

   All Leicestershire residents are also able to attend local urgent care centres such as the one at Loughborough Hospital which has x-ray facilities.

3. Lifeline responders are often family members. Where this is not the case, a response service is commissioned separately.

   The issue relating to providing Lifeline wardens with specialist first aid training needs to be taken up with Charnwood Borough Council who provides the service.

   It should also be noted that Lifeline is one of a number of similar services available, and different parts of the County may commission different products, this one is specific to Charnwood Borough Council.

Mr R. Sharp CC asked the following supplementary question:-

"Could the Committee, with support from EMAS, consider how falls are responded to in the County including ambulance response times."

Dr. T. Eynon CC replied to the effect that officers would be asked to add this issue to the work programme of the Committee.

22. Urgent Items.

There were no urgent items for consideration.

23. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Dr. T. Eynon CC declared a personal interest in all items on the agenda as a salaried GP and as she volunteered for Radio Carillon, a hospital radio station.

Mrs. M.E. Newton CC declared a personal interest in all items on the agenda as she had a relative employed by Leicestershire Partnership NHS Trust and another relative that worked for Leicester Royal Infirmary and was involved in the Vanguard programme.

Mr. D. Jennings CC declared a personal interest in all items on the agenda as he had a relative employed at Glenfield Hospital.

24. Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.

There were no declarations of the party whip.

25. Presentation of Petitions under Standing Order 36.

The Chief Executive reported that no petitions had been received under Standing Order 36.

26. Settings of Care Policy Update.

The Committee considered a report of Leicester, Leicestershire and Rutland Clinical Commissioning Groups which provided an update on the Leicester, Leicestershire and Rutland Clinical Commissioning Groups' Settings of Care Policy. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

It was noted that the public consultation on the Policy would include all individuals in receipt of continuing health care including hard to reach groups. The consultation would be advertised on the websites of all three Clinical Commissioning Groups, and there would be press releases and promotional events for members of the public to attend. The Committee asked that the Clinical Commissioning Groups consider how to ensure that elderly people are able to take part in the public consultation given that they may not be able to attend the events.

RESOLVED:

(a) That the plans to update the Leicester, Leicestershire and Rutland Clinical Commissioning Groups' Settings of Care Policy be noted.

(b) That officers be asked to ensure that the Health Overview and Scrutiny Committee is included in the public consultation on the Settings of Care Policy.

27. Update on the Review of Prescribing.

The Committee considered a report of Leicestershire and Rutland CCGs which provided an update on the outcomes of the survey undertaken by Healthwatch on paracetamol and other over the counter medicines and Gluten Free foods, and provided an overview on how the CCGs intended to act on this feedback. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

Arising from discussions the following points were made:

(i) Concerns were raised by Members that patients in receipt of free prescriptions would have to pay for paracetamol and some other over the counter medicines if they were no longer available on prescription. It was confirmed that the impact of the policy change on people on low incomes would be taken into account in determining the future policy direction.

(ii) Members of the Committee requested that further research be undertaken to determine the demographics of patients who benefitted from receiving gluten free food on prescription to ensure that those on a low income would not be unduly affected if it ceased to be available on prescription. The view was that it might be appropriate for the CCG to consider how it could support these patients to access gluten free bread at a low cost.

(iii) It was confirmed that GPs were no longer permitted to add a variety of drugs to one prescription. They were required to allocate one item per prescription charge.

(iv) Whilst it was proposed that paracetamol and other over the counter medicines would no longer be available on prescription from GP Practices this would not affect the prescribing of medication in hospitals. The Committee was pleased to note that liaison would take place with hospitals so that patients would not be discharged with a paracetamol prescription, as audits undertaken to identify wastage of prescribed medication had shown that paracetamol was often wasted.

(v) The Homely Remedies Guideline facilitated patients to be able to use their own paracetamol or care homes to buy and supply paracetamol for minor illnesses for a short period of time.

(vi) It was queried whether there was a County Council policy regarding medication being provided to children in schools by teachers or school nurses.

RESOLVED:

(a) That the update on the review of prescribing paracetamol and other over the counter medicines and gluten free foods be noted, and the proposals for how the Clinical Commissioning Groups will act on the results of the review be supported.

(b) That officers be requested to provide clarification on the guidance relating to staff at schools and nurseries being able to administer medication.

28. Healthwatch Leicestershire Annual Review 2015 - 16.

The Committee considered a report of Healthwatch Leicestershire (HWL), which provided an annual review of the work carried out by HWL in 2015-2016. The Committee also received a presentation from HWL which covered their work to date. A copy of the report marked 'Agenda Item 10', and the presentation slides, are filed with these minutes.

Arising from discussions the following points were made:

(i) The Committee commended HWL on the presentation of its annual report, and the work they had carried out during the 2015-16 year.

(ii) Members endorsed the 'Your Voice Counts' booklet produced by HWL which was designed to increase public awareness of the work of HWL and direct people to their nearest Urgent Care Centre. It was suggested that this booklet should be placed in pharmacies and clinics as well as GP Practices, however, it was noted that HWL may not have sufficient resources to fund the printing. Consequently HWL offered to email an electronic version of the booklet to CCGs and other health organisations so that it could be printed off and displayed.

(iii) It was noted that East Leicestershire and Rutland CCG was developing a mobile phone app to assist people in knowing where to go for medical treatment.

(iv) With regard to patients having problems accessing appointments at GP Practices it was suggested that HWL could carry out a piece of work involving making phone calls to GP Practices to check whether answer phone messages provided sufficient information to patients. HWL agreed to consider whether this was possible. It was noted that there was a system in place which enabled patients to book GP appointments online however each GP Practice needed to sign up to it and not all had done so.

(v) In response to concerns regarding the future of HWL it was noted that the contract with Voluntary Action Leicestershire (VAL), on the basis of which HWL had been procured, had been extended until spring 2017. A review had been undertaken to inform the future commissioning of HWL; the outcome of this would be reported to the Health and Wellbeing Board in November 2016. It was noted that HWL was low funded but was a high performing service in spite of this. The Committee commended HWL on the effectiveness of the work it had undertaken during the last year.

(vi) In answer to a question regarding the value HWL brought to scrutiny of Healthcare in Leicestershire it was noted that Healthwatch was unique in that it had powers to enter and view premises, derived from the Health and Social Care Act. It used these powers to undertake qualitative, patient centred reviews which complemented rather than duplicated other reviews and inspections of services. In addition Healthwatch reports had been highlighted as good practice.

RESOLVED:

That Healthwatch Leicestershire's Annual Review be welcomed.

29. Joint Health and Wellbeing Strategy.

The Committee considered a report of the Director of Public Health which presented the draft Health and Wellbeing Strategy 2017-2022 for comment. A copy of the report, marked 'Agenda Item 11', is filed with these minutes.

It was noted that the draft Health and Wellbeing Strategy would be considered at the meeting of the Health and Wellbeing Board on 15 September 2016 before going out for consultation. The final version of the Strategy would be updated to make reference to the NHS Sustainability and Transformation Plan before being presented to the Health and Wellbeing Board on 17 November 2016 for approval.

In response to concerns regarding the quality of housing in Leicestershire and in particular the effects of damp on people's health the Director of Public Health described some of the work which was already in place to deal with this problem which was as follows:

- Working with Planning departments at District and Borough Councils to ensure that health improving measures were included in new-build housing;
- A project with Hinckley and Bosworth District Council and the Local Government Association Design Council which worked with housing developers to make buildings health improving from first construction;
- A successful bid with the National Energy Authority which resulted in the receipt of £335,000 to support practical work to improve homes.

RESOLVED:

That the draft Health and Wellbeing Strategy 2017-2022 and the consultation plan be supported.

30. Social Prescribing and Local Area Co-ordination.

The Committee considered a report of the Director of Public Health which provided an update on work being undertaken to develop a consistent approach to social prescribing across Leicestershire, and an update on the pilot of Local Area Coordination. A copy of the report, marked 'Agenda Item 12', is filed with these minutes.

The Committee welcomed the social prescribing work particularly the use of the First Contact Service. It was noted that in future patients would be able to refer themselves to the First Contact Service so they did not have to visit their GP. Members asked the Director of Public Health to ensure that the scheme was well publicised so that people knew they could refer themselves, and the Director agreed to check the communications Plan.

The Committee praised the pilot Local Area Co-ordinators for the work they had done so far.

RESOLVED:

(a) That the work being undertaken to develop a consistent approach to social prescribing across Leicestershire be supported.

(b) That the update on the pilot of Local Area Coordination be noted and the scheme be supported.

31. Dates of future meetings.

RESOLVED:

It was noted that future meetings of the Committee would take place at County Hall at 2pm on the following dates:-

2 November 2016;
23 January 2017;
1 March 2017;
31 May 2017;
6 September 2017;
8 November 2017.

2.00 pm - 3.55 am CHAIRMAN
14 September 2016

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Agenda Item 8

NHS
West Leicestershire
Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 2 NOVEMBER 2016

REPORT OF WEST LEICESTERSHIRE CCG

URGENT CARE: DEVELOPMENT OF INTEGRATED URGENT CARE AND WINTER PLANNING

Purpose of report

1. The purpose of this report is to brief the Committee on the winter planning process for winter 2016/2017 and to provide an update on progress within the Leicester, Leicestershire and Rutland (LLR) Urgent Care Vanguard, particularly to inform the Committee about urgent care services being procured for 2017/2018.

Policy Framework and Previous Decisions

2. The Vanguard work takes forward the implementation of the Keogh Review of Urgent and Emergency Care.

Winter planning and preparedness 2016/2017

3. Winter planning is the responsibility of the Accident and Emergency Delivery Board (AEDB), which has replaced the System Resilience Group as the Executive oversight group for Urgent Care, in line with national guidance.

4. The LLR Winter Plan was submitted to NHS England on 3rd October 2016. The Winter Plan is a system-wide plan that outlines how the constituent organisations that make up the local urgent care system will individually and collectively respond to seasonal pressures and ensure that urgent care services run safely and effectively.

5. There has been no additional funding for winter made available in 2016/2017, therefore the LLR winter plan relies on what organisations can do within existing resources. The winter plan is in addition to the Surge and Escalation plan, which details how each organisation in the urgent care system will respond to differing escalation levels, or trigger points relating to demand pressures or unexpected events. The winter plan clearly describes how the health and care system will manage pressures in the system and use its collective resources to meet demand and cope with adverse events including harsh weather and outbreaks of seasonal illnesses including influenza and respiratory illnesses.

6. Key aspects of the winter plan are:
   - An additional 28 beds opened within University Hospitals Leicester (UHL) to cope with admissions;
   - UHL has continued to operate a Discharge Response Team funded from winter pressures in 2015.2016, despite this service not being funded;

- A clear protocol for opening escalation beds in Leicestershire Partnership NHS Trust (LPT). There are 14 additional beds in community hospitals that will be opened flexibly when there are patients waiting for transfer from UHL;
- A communications and engagement plan, including promotion of the flu jab and an online campaign showing how a group of real local families are keeping well and accessing services;
- Detailed planning for the Christmas and New Year period to ensure adequate capacity and responsiveness over peak periods and holiday periods.

7. Despite the lack of specific additional funding, there are a number of changes that have been made to urgent care services, or that are about to be implemented which will help to manage pressure on emergency services this winter. These include:

- A new social care support service called Help to Live at Home which will provide domiciliary care support for County patients being discharged from hospital, from 7th November;
- A Mental Health Triage Car operated by EMAS which has been successful so far in reducing the numbers of patients needing to be taken to Leicester Royal Infirmary Emergency Department (ED);
- Extended acute visiting services – longer hours in West Leicestershire and a pilot covering two localities in East Leicestershire. This service provides capacity for rapid home visits to patients at high risk of admission, including care homes;
- From the end of October, the introduction of clinical navigation linked to NHS111 providing greater levels of clinical triage, assessment and advice to patients, aiming to avoid ED attendances and ambulance dispatch

8. In LLR, East Leicestershire & Rutland do not offer a Pharmacy First service currently. West Leicestershire CCG has recently taken the decision to decommission the scheme. The decision was taken as uptake was very low (only being significantly used by three practices). Following evaluation of the impact of Pharmacy First, it was not possible to demonstrate savings either through reduced prescribing costs or reductions in GP appointments or urgent care/ A&E attendances. The CCG is reviewing its approach to using pharmacy to support urgent care pathways.

Learning from winter 2015/2016

9. Performance at UHL was very challenged over last winter, and performance dipped to 65.66% at its lowest point. Overall there was a 6% increase in activity and admissions were up 4.6%. UHL showed the predictable trend of big increases in the run up to Christmas then the activity levels dropped, with cessation of elective activity and a push on discharging patients, so that there were approximately 300 empty beds over the festive period. Emergency activity then picked up from boxing day through to the new year and into January. Attendances averaged 426 per day during January 2016.

10. The last winter was not a particularly harsh one, and there were no major flu outbreaks or spikes in seasonal illness. However, there were notable challenges relating to ambulance handover times and assessment times at Leicester Royal Infirmary ED. Ambulance handover delays peaked in November 2016 with 2204 hours lost at Leicester Royal Infirmary during the month. As a result of pressures at

UHL and delays in assessment, UHL were the subject of a Care Quality Commission warning notice. Actions taken to improve handover times by EMAS and UHL were effective in reducing these delays from January, and delays have dropped by about a third from the peak; these actions included a co-horting protocol in the ED and Standard Operating Procedures for assessing and streaming ambulance patients.

11. The winter plan for 2015/2016 included investment totalling £1.8m, plus £50k for Winter Communications which was overseen by the Urgent Care Board. Funding was used to support a range of schemes which provided additional capacity in health and social care services, including 7 day social work cover, additional discharge transport capacity, and funding for smartphone access to the directory of services for ambulance crews. Within the total, we also allocated some additional funding of £75K for delivering the communications and media plan.

12. The A and E Improvement Group and its predecessor group the Operational Resilience Group has undertaken a review of services funded within the 2015/2016 winter plan. Some services have been continued/picked up with internal resources, such as the Discharge Response Team in UHL, although the majority of services were stepped down at the end of March 2016.

13. The A and E Improvement Group is currently in the process of reviewing the learning from last year, and prioritising schemes which were shown to be effective in managing pressures. This is in order to have an agreed list of high priority schemes which would restart at short notice if funding does become available over the winter period. Additional social work capacity and inreach to hospital to support discharge are two areas which the Group would like to fund if there is any additional money in the system.

14. Communications Plan: despite a detailed communications plan in 2015/2016 including a number of media campaigns, there was no evidence that messages to the public about avoiding using Emergency Department services had any impact and, as mentioned above, there were sharp increases in activity over the last year. There is growing evidence both nationally and locally that media messages about Emergency services have the effect of increasing presentations at the ED rather than keeping people away. The learning from this has been reflected in this year's communications plan which places less emphasis on trying to tell people not to use ED services.

Developing Integrated Urgent Care in LLR

15. Work has been progressing within the LLR Vanguard to improve urgent care services, and significant progress has been made on developing a model of integrated urgent care, which the Vanguard Team is now in the process of implementing/contracting for.

    The Vanguard service model responds to the Keogh review and is based on the following principles:

    - Providing better support for people and their families to self-care or care for their dependants.
    - Helping people who need urgent care to get the right advice in the right place, first time.

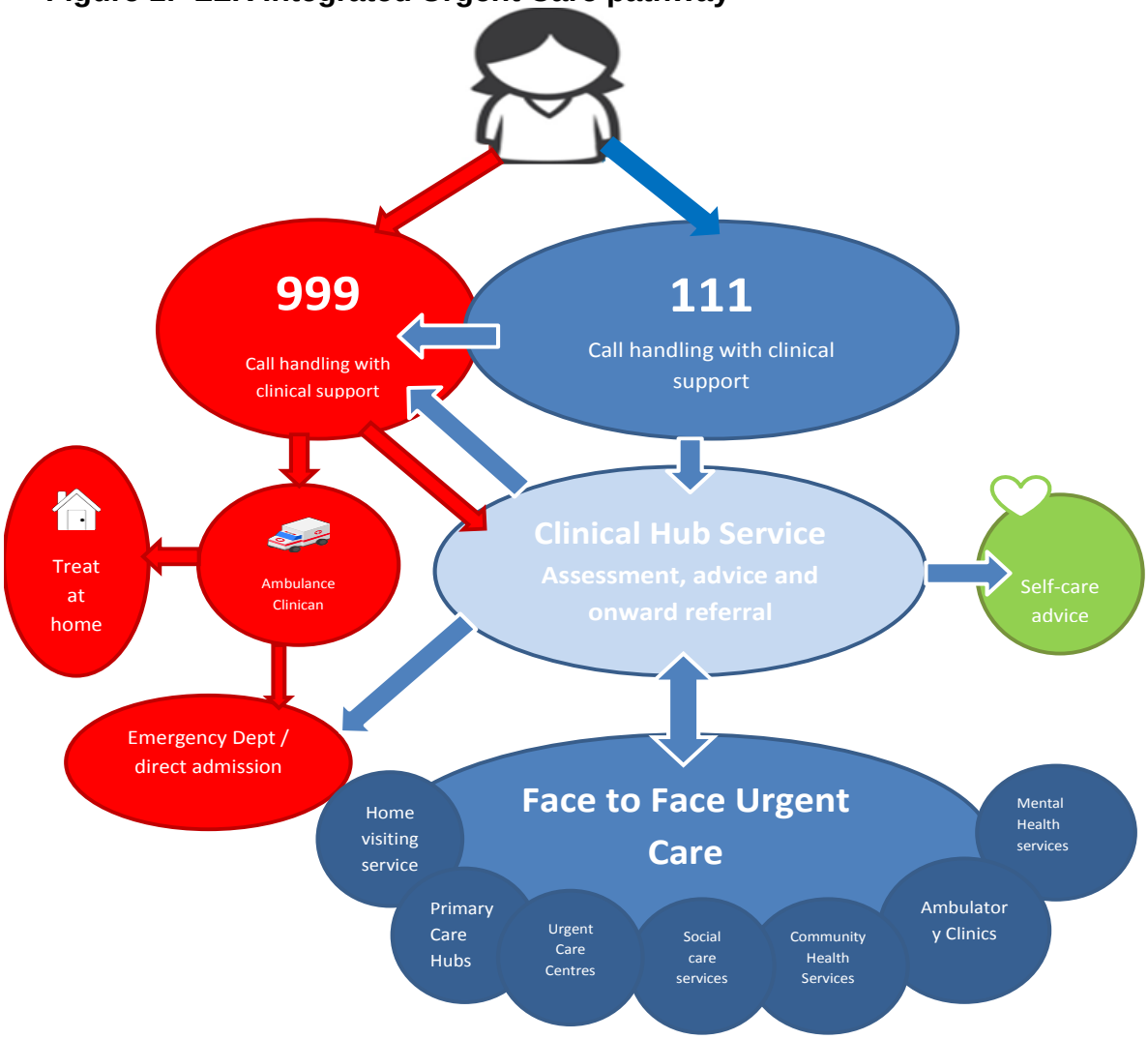
- Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.
- Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery.
- Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

16. The service model developed by the Vanguard has been developed in response to National guidance and the Five Year Forward View, as well as reflecting the needs of the LLR population and the diversity of population and geography. The principle of a core, consistent offer across LLR, with local flexibility has been followed.

17. The overall service model design for LLR is an integrated, coherent and intelligible urgent care system, with patients supported to access the right service via enhanced clinical navigation linked to NHS 111. Community urgent care services will be available 24/7, 7 days a week with reduced duplication as a result of functional integration, as part of an integrated network. There will be improved information sharing and signposting between providers.

18. The model of care at the LRI ED Front Door will be consistent with and reflect the integrated community urgent care model, with senior primary care clinicians at the Front Door streaming patients to an urgent care stream, ED majors or assessment units and base wards as appropriate to their clinical need. Where clinically appropriate, patients will receive rapid treatment and advice from the streaming service or be redirected to alternative primary and community based services.

Figure 1: LLR Integrated Urgent Care pathway



19. Achieving this vision will depend upon improved collaboration between providers, with a joint clinical governance framework supporting front line staff. In order to achieve this, LLR CCG Governing Bodies have agreed to develop an Alliance agreement, bringing together the providers of the individual service components along with commissioners to oversee the operation of the urgent care system, with shared outcomes and performance standards.

20. The new service model will comprise of four core service components.

Component 1: Integrated primary and community urgent care services

This is to be procured in 3 CCG sub-lots:

a. West Leicestershire CCG for 1st April 2017
b. Leicester City CCG for 1st April 2017
c. East Leicestershire and Rutland CCG for 1st April 2017.

Component 2: Leicester Royal Infirmary New Front Door & Urgent Care Service

This procurement is to be led by UHL with the close involvement of the CCGs and the Urgent and Emergency Care team) for 1st April 2017.

Component 3: LLR Urgent Care Home Visiting Service

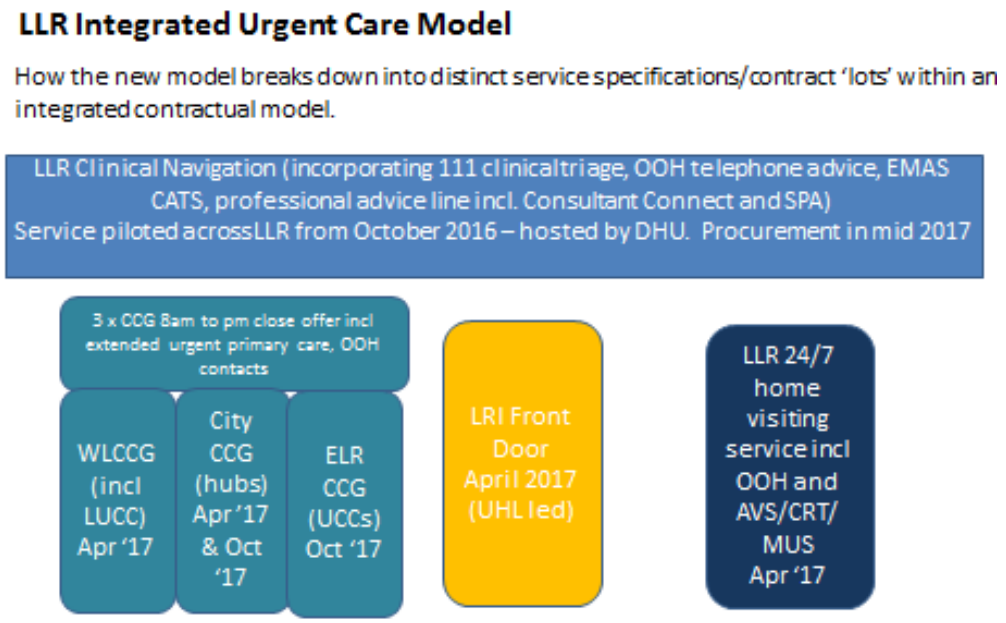
This incorporates Out of Hours (OOH) home visiting, Acute Visiting, Crisis Response Teams and Mobile Urgent Care Services for 1.04.17.

Component 4: Clinical Navigation Hub Service

This will not be procured at this point in time but will be initially piloted on a pan-LLR basis to assess the impact of the model, allowing commissioners to refine the service model and operating protocols before a formal procurement takes place. Derbyshire Health United (the current LLR provider of NHS111 and OOHs) will host this pilot, which enables the use of existing clinical staff, within clear and established information governance and clinical governance arrangements.

These service components form distinct lots for the purpose of procuring and contracting as described above and shown below.

Figure 2: The elements of the LLR Integrated Urgent Care system



Procuring the new service model

21. The three LLR CCGs have now commenced the process of procuring a number of new services as described above. Not all the new service contracts will come into place on 1st April due to the contract expiry dates for some existing services. This means that Urgent Care Centre services in ELR CCG will remain as they are until October 2017. However, changes to home visiting and clinical navigation/NHS 111 will cover all of LLR from the outset.

22. It is the CCGs' intention to construct an Urgent Care Alliance with the providers of the new service model. The Alliance will bring urgent care providers and the CCGs into a collaboration to deliver care with agreed, shared outcomes and incentives, with a shared clinical governance framework and risk/gain share.

Consultation

23. The service model has been developed in response to the feedback and views of local people, patients and carers. The CCGs have amassed a extremely rich library of the outputs of engagement exercises, analysed this output into key messages/themes and used this to inform the plans for improved services.

24. The Vanguard has carried out specific engagement activities with the three Healthwatch organisations for the region to seek people's views on integrated urgent care, and specifically to get feedback on the introduction of clinical navigation.

25. There are no major service changes in respect of sites or the level of service being provided and therefore it is the view of the CCGs that formal consultation on the changes is not required. However, using and responding to the views of local people has been at the heart of the Vanguard work.

26. Additional engagement on the planned changes to urgent care has taken place in forums such as CCG Annual General Meetings and with GPs and the Local Medical Committee.

27. Communications are planned with local people on the forthcoming changes and what they mean for them, using a 'You said, we did' approach. A stakeholder communication has been distributed and an animated video describing the changes is in production.

28. During the pilot for clinical navigation we will use the Experience Led Commissioning tool to gather people's feedback on the new pathway and use it to inform further developments to the service model.

Resource Implications

29. At the time of writing, the outcome of the procurement exercise is not known. However, the CCGs have undertaken extensive modelling and the new service model is expected to operate within the same financial resource as the current urgent care contracts. There is some scope for financial efficiencies relating to reducing duplication in both operational processes, staffing and assets. It is also expected that the service model will reduce activity in ED and ambulance services. No additional investment decisions have been made by the CCGs in order to deliver the new service model.

Officer to Contact

Tamsin Hooton, Director of Urgent and Emergency Care
Telephone: 01509 567 708
Email: Tamsin.hooton@westleicestershireccg.nhs.uk

Relevant Impact Assessments

Equality and Human Rights Implications

30. We have undertaken an EQIA for the new service model. Overall, there are considered to be positive benefits arising from the new service model relating to

equalities and groups of people with protected characteristics. The EQIA was shared with the CCG Governing Bodies to support their decision making in relation to the new service model.

Agenda Item 9

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 2ND NOVEMBER 2016

REPORT OF THE DIRECTOR OF HEALTH AND SOCIAL CARE INTEGRATION

LEICESTERSHIRE'S APPROACH TO FALLS

Purpose of report

1. The purpose of this report is to inform the Health Overview and Scrutiny Committee of the work being undertaken to develop a consistent approach to the prevention and treatment of falls in residents over the age of 65 across Leicestershire.

Policy Framework and Previous Decisions

2. At the meeting of the Health Overview and Scrutiny Committee on 14 September 2016, Mr Sharp CC asked a question regarding the response to falls, with particular emphasis on the East Midlands Ambulance Service. As a supplementary question, Mr Sharp asked the Committee, with support from EMAS, to consider how falls are responded to in the County including ambulance response times.

3. A consistent approach to the prevention and treatment of falls in the over 65 age group has been the local target for the Better Care Fund in Leicestershire since 2014. This programme is being developed between health and care partners across Leicester, Leicestershire and Rutland.

Background

Falls

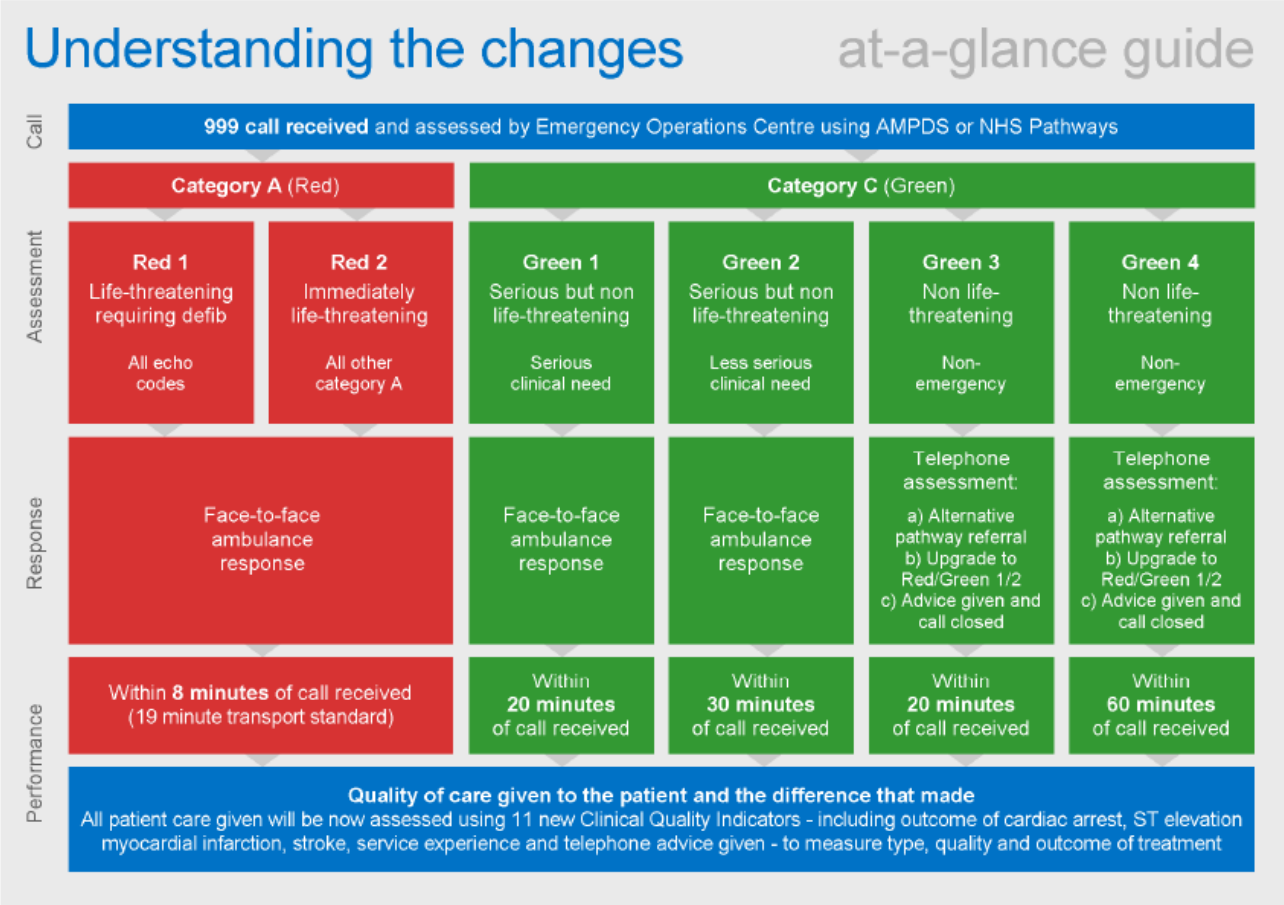
4. Falls in older people cause distress, loss of independence and increased pressure on the health and care system both locally and nationally. Falls in people aged over 65 represent one of the top three reasons for an EMAS call every year. In the initial four months of this financial year there have been 406 falls in the over 65 age group presenting to UHL A&E.

5. Evidence shows us that by the time a fall is significant enough to require the patient to be conveyed to hospital, the patient will have fallen an average of 4 or 5 times, many of which are never officially reported. These incidents result in reduced mobility through fear of falling, social isolation, loss of independence and reduced strength and balance increasing the risk of further falls as a result. The impact of each subsequent fall is therefore more severe, both physically and mentally.

6. Every year 35% of people aged over 65 will fall at least once every year, and this rises to over 45% when over the age of 80. Of those people that are over 65 and experience a major fall requiring treatment, less than 50% will currently return to their previous level of independence.

7. Calls to 999 are prioritised according to information given by the caller, and assessed by qualified paramedics as to level of priority which is illustrated in Figure 1 below:

Figure 1:



8. Nationally, ambulance services only have to report on the Category A target, and response times can vary according to demand and nature of calls. Calls can also be reprioritised according to subsequent calls received and the information provided at the time of the call.

9. A number of initiatives have already been put in place to reduce the impact of falls and associated delays within the system, these include:

- A paper based Falls Risk Assessment Tool (FRAT) to support paramedics in determining whether a patient is at further risk of falling when immediate conveyance to hospital is not required.
- A dedicated EMAS line into the Leicestershire Partnership Trust (LPT) Single Point of Access (SPA) to enable direct referral for community health service action where immediate conveyance is not required. Patients will have been seen, assessed and treated prior to this referral, with the paramedic ensuring that they are comfortable and will not need further medical treatment in the intervening period.

- A review of the treatment pathway to identify where delays in treatment currently occur, such as waiting for an outpatient clinic appointment before being able to access therapy programmes leading to further risk of falling and resultant serious injury.
- Receipt of appropriate services can also be delayed because of the lack of accessible prevention services resulting in no action being taken until a serious fall has occurred. Trialling postural stability training (to improve strength and balance) and improving the Information, Advice and Guidance (IAG) to assist residents in helping themselves to avoid falls. An initial evaluation of this trial is due December once the course has completed.

Draft Shared Vision

8. The draft pathway has been designed within the LLR Falls Steering Group which consists of partners from across the Health and Social Care organisations. Currently each stage of the pathway is being developed into an agreed level of service that will form part of the BCF LLR Falls Prevention and Treatment Strategy, which will go live in April 2017.

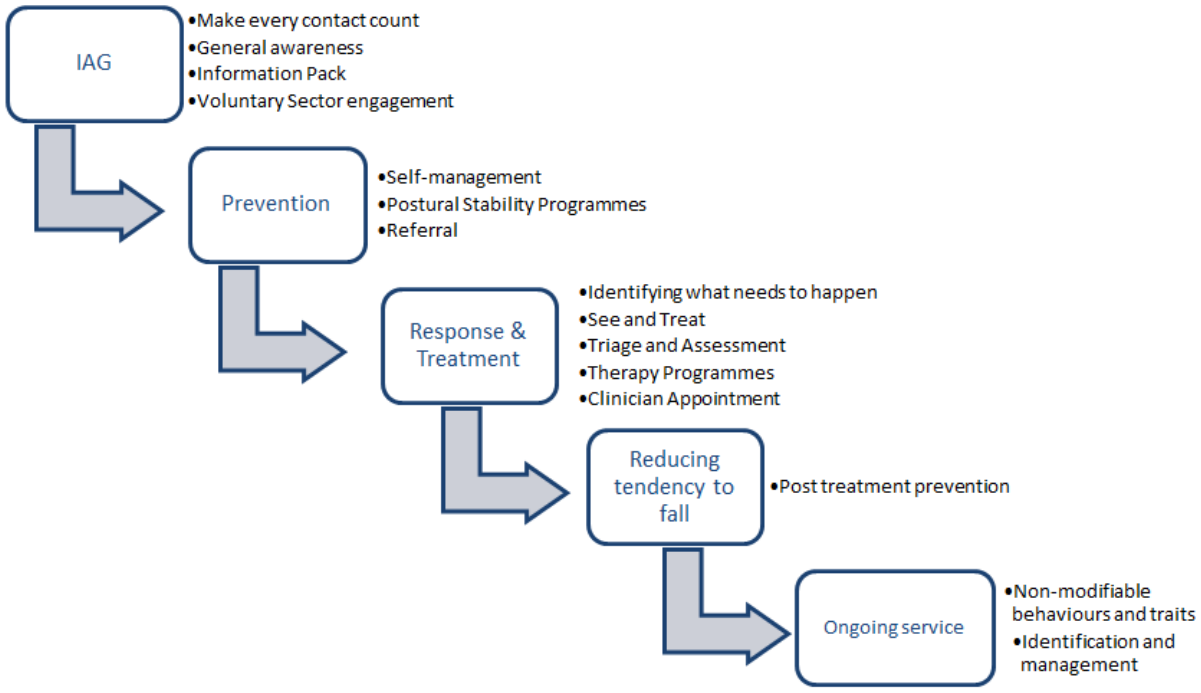
9. The LLR Falls Steering Group has developed a vision for the prevention and treatment of falls, and this is illustrated in Figure 2. This forms part of the overall Strategy and Business Case which is being developed for implementation in April 2017. This work is governed through the BCF Operations Group, Frail Older People Integrated Pathway Redesign Group and the Frail Older Persons and Dementia Programme Board.

10. The vision for falls is to offer a single falls prevention and treatment system across the Leicester, Leicestershire and Rutland region. By focussing on preventing falls, and increasing the information available, we will reduce the pressure on emergency and health services to respond to serious incidents.

11. The aim is to provide a level of service that all residents can expect, which is based on the latest NICE guidelines: Information and access to postural stability instruction that will help them maintain their independence; rapid response in the event of a fall; the most appropriate treatment following a fall as soon as possible; information to help them prevent further falls.

12. The new pathway has been designed to help prevent falls in older people, educate people in ways they can help themselves, provide resources to aid prevention, enable a swifter, more appropriate response and treatment in the event of a fall, and ensure that patients return as far as possible to the previous ability and level of independence they enjoyed prior to the fall. This is illustrated in Figure 1:

Figure 2



Progress to date

13. With regard to the urgent response needed once a patient has fallen, the following has been achieved so far:-

    a. The paper based FRAT, when 86% of Leicestershire Paramedics were trained, initially showed a reduction in conveyance rates to hospital by 35%, but due to a high level of staff turnover, this began to fall. Being paper based also meant that there was no audit trail of use and completion relied on a copy being available during a call.
    b. In partnership with the De Montfort University Hackathon team, an eFRAT (app-based FRAT for use on paramedic smartphones) was developed (See Appendix). This will be constantly available on every falls response, and supports a paramedic to assess the risk to a falls patient where immediate conveyance to hospital is not indicated. The app allows an in-app call direct to the dedicated EMAS call line in LPT SPA, where a patient referral for further medical treatment can be made. This allows:
        i. Paramedics to highlight the need for further non-acute medical treatment.
        ii. A quicker “see and treat” response time for paramedics, and avoiding delays and admission at hospital where acute emergency treatment is not necessary. Not only does this reduce pressure on the system, but allows patients to remain at home, where evidence shows they are more likely to return to previous level of independence.

iii. A telephone assessment will be carried out within two hours of this referral, with further action being one of the following:
    1. Immediate response by medical staff within four hours of initial referral.
    2. Response within eight hours for less urgent cases.
    3. Telephone follow up after twenty-four hours where medical treatment not deemed necessary.
iv. The second phase of the eFRAT is to record details of use of the app, including job reference number, falls risk score, and referral to SPA. This will enable reporting and clinical audit to take place.
v. The third phase will enable referrals to be made to other preventative services such as First Contact Plus, the Lightbulb Programme and Leicestershire Fire and Rescue Service where needs are identified. Access will also be rolled out to voluntary sector, care homes and possible the general public at this stage.

c. A rapid cycle test was undertaken in August 2016 for a new triage and assessment process. Under the current system, where a patient falls or is identified as at risk of falling, their GP will refer them to the Falls Service, and this requires a clinical outpatients appointment first. Currently waiting times for these appointments can be as long as five months, during which time further, more significant falls can occur. The aim of the testing was to review the referral and divert the patient directly to therapy where clinical input was not necessary.
    i. During the two week trial, 88 referrals were reviewed
    ii. Of these, 55% were assessed as not requiring clinical intervention, resulting in a reduction in waiting time of up to five months.
    iii. A further 8% were assessed as not being appropriate referrals, and these were signposted to other preventative activities and information.
    iv. Of the 55% requiring therapy only, home visits were undertaken where indicated, with assessment and low level therapeutic activity given to mobilise prior to therapy programme sessions.

14. Progress to date in preventing falls is as follows:-
    a. NICE Guidelines recommend postural stability instruction as one of the key aspects of a good falls prevention programme, with estimates of net system savings of just over £9,000 per person attending over the remainder of their lifetime. The region has been fortunate to benefit from external funding that has allowed two separate trials to run:
        i. A 26 week postural stability course, known as FaME (Falls Management through Exercise) has been piloted through matched public health/ Collaboration for Leadership in Applied Health Research and Care (CLARHC) funding.
        ii. The Royal Voluntary Service (RVS) secured Big Lottery Funding in Leicestershire to offer a chair based postural stability instruction pilot, this is being run at Armada Court in Hinckley.
    b. Key Falls prevention messages are regularly communicated through social media accounts covering:
        i. Look after your feet
        ii. Stay Well (eat regularly, take medications on time, stay hydrated, observe changing weather conditions)
        iii. Look after your eyes (sight checks are free for the over 65's)
        iv. Stay active, stay steady

v. Look after your home (worn floor coverings, trip hazards, poor lighting etc.)

c. First Contact Plus and Local Area Coordinators offer information and advice on falls prevention to residents making contact or referred to them. Comments from residents accessing information in this way have been very positive, and in some instances have led to more in depth group advisory work.

Conclusions

15. The falls prevention and treatment pathway has made good progress towards improving the urgent response to, and prevention of, falls. Plans for pilot activity targeted at each stage of the proposed new pathway are in place for the remainder of 2016/17, with the new service being offered from April 2017.

Resource Implications

16. An interim programme manager is currently funded through the Better Care Fund until the end of March 2017. The approach described in the draft strategy will be implemented by the integrated locality teams once they have been established, with an interim delivery plan being developed. It is anticipated that there may be some transitional costs during implementation while current backlogs are cleared.

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Relevant Impact Assessments

Equality and Human Rights Implications

21. Developments within the BCF Plan, such as falls, are subject to equality impact assessment and the evidence base supporting the BCF Plan has been tested with respect to Leicestershire Joint Strategic Needs Assessment. An EHRIA will be undertaken for the new strategy.

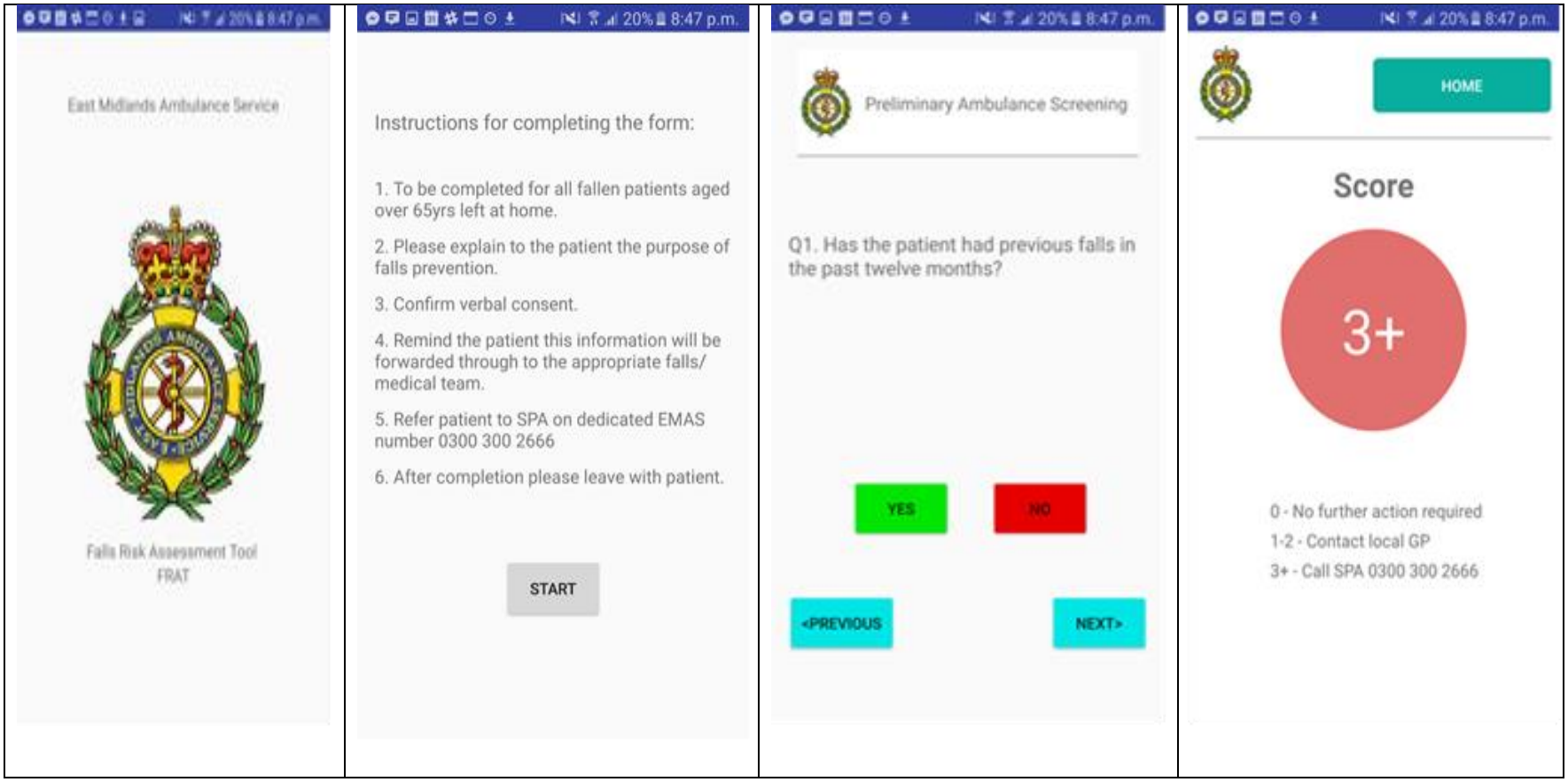
Partnership Working and associated issues

22. The delivery of the BCF Plan, including the emerging model for falls, is dependent on close collaborative working form Health and Wellbeing Board partners.

23. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the 5 year plan to transform health and care in Leicestershire, known as Better Care Together.

Appendix

The Falls Risk Assessment Tool (FRAT), developed as part of the Leicestershire Better Care Fund in conjunction with East Midlands Ambulance Service, has been converted into an app. The screen shots below (shortened process) illustrate how the app is used by paramedics to assess falls at home/in the community and avoid conveying people to hospital if this is not medically necessary. The App includes the option of contacting the Single Point of Access (SPA) for rapid further assistance from local community services. By using this tool we will be able to capture data on the effectiveness of this falls pathway.



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Agenda Item 10

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: NOVEMBER 2ND 2016

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016

OVERVIEW OF HEALTH IN LEICESTERSHIRE & THE ROLE OF WORKPLACE HEALTH IN IMPROVING HEALTH

Purpose of report

1. The Director of Public Health's (DPH) Annual Report is a statutory independent report on the health of the population of Leicestershire.

2. This year's report gives an overview of the health of the population and focusses on the role of workplace health in improving health.

3. The aim of this report is to raise awareness of the priorities for health improvement at district and county level over the next year, based on analysis of the health profile for 2016. It also highlights the role workplace health initiatives can play in improving the health of the population and the need for all partners concerned with the health and wellbeing of the population to work together to support and develop this role in the future.

Policy Framework and Previous Decisions

4. Last year's report focussed on the role of communities in improving health and this report includes an update on progress against the recommendations made in that report.

Background

5. Leicestershire is, comparatively speaking, a healthy county. However, people in Leicestershire are living ever longer lives, meaning that there are increasing numbers of older people living with long-term conditions and disabilities. It is therefore essential that we redouble our focus on preventing ill health, by focusing on those issues and areas where there are potential causes for concern.

6. The role that work plays in supporting health and wellbeing is important. Conversely, having a healthy population will aid the economic development of Leicestershire. The lead role public health has on 'the wider determinants of health' isn't just good for health, it is also good for the economy.

Consultation

7. The report is the independent report of the Director of Public Health.

Resource Implications

8. Full implementation of the recommendations of the report will need to be addressed through the commissioning cycle

Conclusions

9. The nationally produced Health Profiles are an important snapshot of the health of Leicestershire. Our comparative analysis of the Leicestershire health profiles and district health profiles show a number of topics public health will target, working with partners, in the next year. These include smoking prevalence, recorded diabetes, breastfeeding initiation and levels of obesity in adults.

10. Good health should improve an individual's chances of finding and staying in work and of enjoying the consequent financial and social advantages. Whilst 'good' work is recognised to be good for health, staff health and wellbeing also plays an important role in the overall health and productivity of an organisation. Better health, though, does not have to wait for an improved economy. Measures to reduce the burden of disease, to give children healthy childhoods, to increase life expectancy, themselves contribute to creating richer economies. Across our partners, public health will work to advocate the use of the Workplace Wellbeing Charter in improving staff health and continue our work on the wider determinants of health to maximise the health benefits of economic development.

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List of Appendices

Annual Report of the Director of Public Health 2016. Overview of health in Leicestershire & the role of workplace health in improving health.

Relevant Impact Assessments

Equality and Human Rights Implications

11. Implementation of the report's recommendations would have a positive impact on health inequalities

Partnership Working and associated issues

12. The recommendations within this report focus on actions across local government that will improve the population's health. The recommendations focus not just on the actions that Public Health will need to take as a lead agency, but on the actions that they can support as a partner as well as the actions that they can influence as an advocate. The basis of the report is improving population health in partnership with other key agencies.

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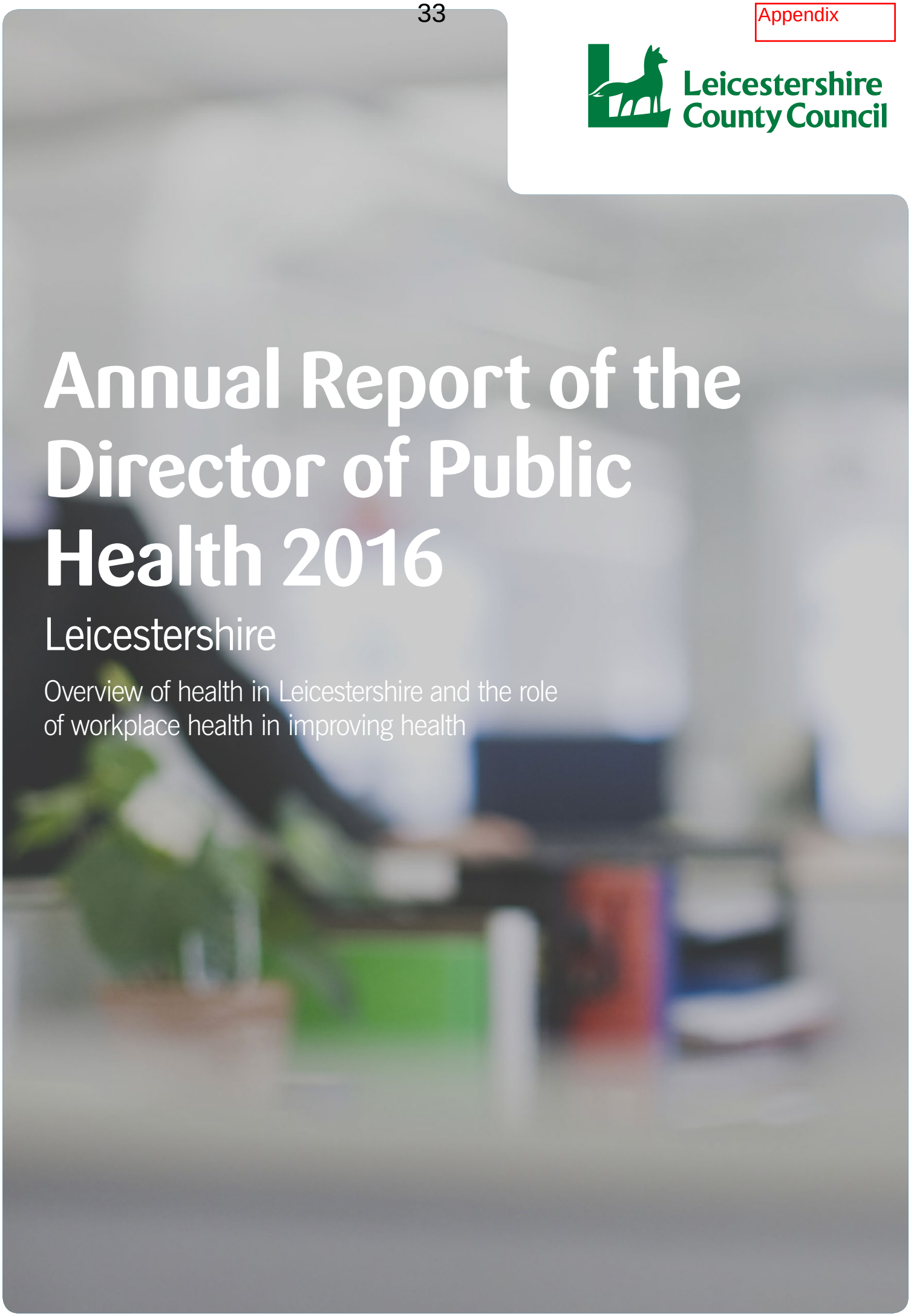
Appendix

Leicestershire County Council



Annual Report of the Director of Public Health 2016

Leicestershire

Overview of health in Leicestershire and the role of workplace health in improving health

Foreword

Welcome to my annual report for 2016. In my last annual report I set out the case for the role of communities in improving health and well being in Leicestershire. As can be seen in 'update on recommendations', the report has led to a renewed focus on community level work through the Prevention Review within the Council, the work of the Communities Strategy, and the work of the Unified Prevention Board within the Better Care Fund.

Mike Sandys
Director of Public Health

Last year I also highlighted the findings of the Joint Strategic Needs Assessment 2015. Presenting the findings using the 'lifecourse snake' went down well with people and partners and reminded me that the annual report can be a useful way of sharing information on the health of Leicestershire.

I have split the report between an information update and a focus on a topic important to health. In the first part of the report I have reviewed the Health Profiles for Leicestershire. These are the nationally produced snapshots of health across the country and set what I believe to be the priorities for action at County and district level in Leicestershire for the forthcoming year.

For this year's topic I have looked at the importance of work and health, covering the health of the working age population and the importance of workplace health. I have also revisited the progress being made on 'the wider determinants of health' from my report of 2014, highlighting how this work will underpin economic development and improved population health.

As always, I hope you find this interesting, informative and a spur to further progress in improving the health of Leicestershire. I would like to thank Gabi Price, Michele Monamy, Liz Orton and Rob Howard for their contributions to this report and the public health department for their continued hard work.

Mike Sandys
Director of Public Health

Contents

Introduction

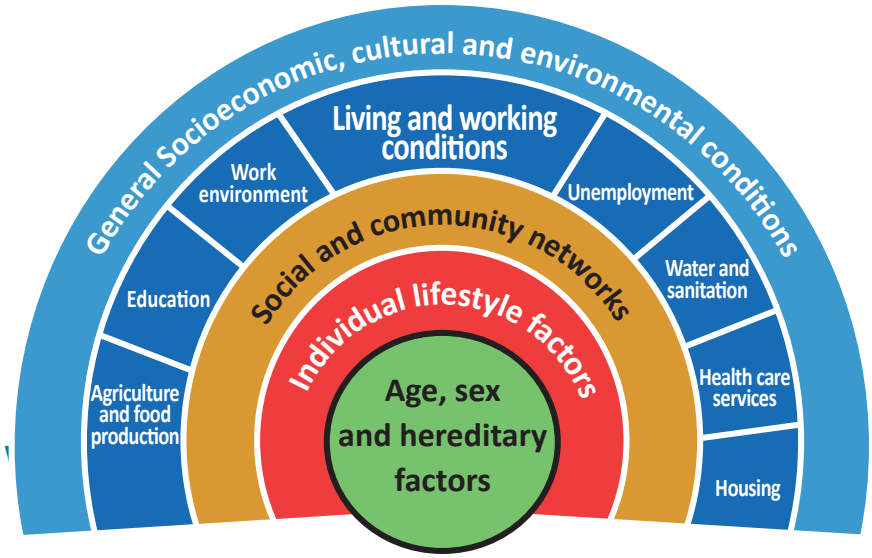
Each year the Director of Public Health publishes an independent report on the health and wellbeing of the local population. This report is a statutory duty and intended to inform local strategies, policy and practice across a range of organisations and interests. The purpose of the report is to highlight opportunities to improve the health and well being of people in Leicestershire.

Evidence suggests that good health should improve an individual's chances of finding and staying in work and of enjoying the consequent financial and social advantages. Furthermore work has an inherently beneficial impact on an individual's state of health (1). The review 'Is work good for your health and well-being?' concluded that work was generally good for both physical and mental health and well-being. It showed that work should be 'good work' which is healthy, safe and offer the individual some influence over how work is done and a sense of self-worth. Overall, the beneficial effects of work were shown to outweigh the risks and to be much greater than the harmful effects of long-term worklessness or prolonged sickness absence (2).

Personal characteristics, such as age, sex and ethnicity, are highly significant for health but cannot be influenced by public health. Consequently they sit at the core of the 1991 Dahlgren and Whitehead, wider determinants of health model (Figure 1). The basis of the model is the concept that some of the factors that influence health are fixed and others can be influenced. Individual lifestyle factors are behaviours such as smoking, alcohol and other drug misuse, poor diet or lack of physical activity. Lifestyle factors have a significant impact on an individual's health. Social and community networks are our family, friends and the wider social circles around us. Social and community networks are a protective factor in terms of health. Evidence tells us that important factors for life satisfaction are being happy at work and participating in social relationships (3). Living and working conditions include access to education, training and employment, health, welfare services, housing, public transport and amenities. It also includes facilities like running water and sanitation, and

having access to essential goods like food, clothing and fuel. General socio-economic, cultural and environmental conditions include social, cultural, economic and environmental factors that impact on health and wellbeing such as wages, disposable income and availability of work.

Figure 1: The Determinants of Health



Source: Dahlgren and Whitehead 1992

"Evidence suggests that good health should improve an individual's chances of finding and staying in work and of enjoying the consequent financial and social advantages."

Recommendations

Building on last year's report, the recommendations have been developed along the three key roles for public health as defined by the World Health Organisation, which include public health as a leader; public health as a partner; and public health as an advocate. The recommendations are set out below:

A Leader – We will refresh our strategic work on tobacco control, in the light of the new Health and Well Being Strategy and the findings of the health profiles 2016.

A Leader - We will continue to lead County Council progress on developing our approach to social value, recognising the impact this can have on economic development, and in turn health outcomes.

A Leader - Alongside Corporate Resources lead the implementation of the workplace wellbeing strategy within Leicestershire County Council.

A Partner - District and borough councils in Leicestershire have a key role to play in our work on the wider determinants of health. We will continue to provide specialist expertise on approaches to health impact assessment and health in all policies, working in partnership with district and borough councils.

A Partner - As a partner to the NHS, we will work with University of Hospitals of Leicester Trust and Leicestershire Partnership Trust on joint approaches to workforce health as part of the LLR response to the NHS 5 Year Forward View.

An Advocate – The Public Health Department will work with the public and private sector organisations to advocate the use of the Well Being Charter by employers, as part of approach to workplace health.

Overview of the health profile 2016

Public Health England publish health profiles for all local authorities in England on an annual basis.

Health Profiles provide useful, accessible summaries of the health of local populations, and help identify inequalities because they allow local authority populations to be compared with the average for England, and also allow comparisons between and within regions. The profiles assist in the planning and prioritisation of services. The indicators included in Health Profiles were chosen because they measure an important aspect of the health of the population and can be communicated easily to a wide audience.

Leicestershire County - Health in summary

The health of people in Leicestershire is generally better than the England average. Leicestershire is one of the 20% least deprived counties/unitary authorities in England, however about 11% (12,800) of children live in low income families.

Health inequalities

Life expectancy for both men and women is higher than the England average but there remains significant differences in life expectancy within Leicestershire. Life expectancy is 6.2 years lower for men and 5.0 years lower for women in the most deprived areas of Leicestershire than in the least deprived areas.

Child health

In Year 6, 16.4% (1,069) of children are classified as obese, better than the average for England. The rate of alcohol specific hospital stays among those aged under 18 is better than the average for England. Levels of teenage pregnancy and smoking at time of delivery are better than the England average.

Life expectancy in Leicestershire is

6.2 years lower for males

5.0 years lower for females in the least deprived areas

Adult health

The rate of alcohol-related harm hospital stays is 596 per 100,000 population, better than the average for England. This represents 3,964 stays per year. The rate of self-harm hospital stays is 126.4 per 100,000 population. This, again, is better than the average for England. This represents 845 stays per year. 908 people died of smoking related deaths in Leicestershire in the last year. Estimated levels of adult physical activity, rates of hip fractures, sexually transmitted infections, people killed and seriously injured on roads and Tuberculosis are better than average.

Likewise rates of violent crime, long term unemployment, deaths from drug misuse, early deaths from cardiovascular diseases and early deaths from cancer are better than average.

The table on page 10 shows how people's health in each district across Leicestershire and Leicestershire itself compares to the rest of England.

"rates of violent crime, long term unemployment, deaths from drug misuse, early deaths from cardiovascular diseases and early deaths from cancer are better than average."

Table 1: Health profiles 2016, comparison of performance across districts and Leicestershire

		Blaby	Charnwood	Harborough	Hinckley and Bosworth	Melton	North West Leicestershire	Oadby and Wigston	Leicestershire CC
Our Communities	1 Deprivation score (IMD 2015)								
	2 Children in low income families (under 16s)								
	3 Statutory homelessness								
	4 GCSEs achieved								
	5 Violent crime (violent offences)								
	6 Long term unemployment								
Childrens and young peoples health	7 Smoking status at time of delivery			↓		↓		↓	
	8 Breast feeding initiation	↑	↑			↑			↑
	9 Obese children (year 6)							↓	
	10 Alcohol-specific hospital stays (under 18)								
	11 Under 18 conceptions		↑						
Adults health and lifestyle	12 Smoking prevalence in adults								
	13 Percentage of physically active adults	↓							
	14 Excess weight in adults								
Disease and poor health	15 Cancer diagnosed at early stage								
	16 Hospital stays for self harm				↓				
	17 Hospital stays for alcohol related harm			↓					
	18 Recorded diabetes		↑						
	19 Incidence of TB								
	20 New sexually transmitted infections (STI)								
	21 Hip fractures in people aged 65 and over	↓		↓	↓	↑		↑	
Life expectancy and causes of death	22 Life expectancy at birth (male)					↑			
	23 Life expectancy at birth (female)								
	24 Infant mortality								
	25 Killed and seriously injured on roads				↓		↓		
	26 Suicide rate								
	27 Deaths from drug misuse								
	28 Smoking related deaths								
	29 Under 75 mortality rate: cardiovascular		↑			↑			
	20 Under 75 mortality rate: cancer								
	31 Excess winter deaths					↓			

Significantly better than England average
Not significantly different from England average
Significantly worse than England average
No significance can be calculated or data not available

No comparison available from 2015 (either new indicator, change in definition, or comparison not possible for technical reasons)

↓ Rag rating has moved from green to amber or amber to red ie performance is not as good as 2015
↑ Rag rating has moved from red to amber or amber to green ie performance has improved from 2015

It is clear that Leicestershire performs well in many indicators, Leicestershire has 19 indicators that perform significantly better than the England average.

There is 1 indicator where Leicestershire County has poor performance where figures are significantly worse than the national average: recorded diabetes. However, it may be that higher recorded rates are actually a sign that GPs are recording diabetes more comprehensively than elsewhere.

Other indicators where the Leicestershire figure is worse than average, but not significantly so, are:

- Breastfeeding initiation
- Smoking Prevalence
- Excess weight in adults
- Infant Mortality

At county level, compared with all other county and unitary local authorities, Leicestershire is ranked in the best 10 (ranked) for violent crime (5th) and deaths from drug misuse (1st).

"Leicestershire is ranked in the best 10 (ranked) for violent crime (5th) and deaths from drug misuse (1st)."

District Council health

In 2014, 2015 and 2016 the districts in Leicestershire County appeared in the best 10 (ranked) performing districts in the country for the following indicators:

Table 2 - District Council performance in top 10 in country

Indicator	2014[1]	2015[1]	2016
Children in poverty / low income families	Harborough (4)	Harborough (5)	Harborough (3)
Statutory Homelessness	Blaby (1)	Blaby (3)	
Alcohol specific hospital stays (under18)		Charnwood (1) Blaby (7)	Blaby (4) Harborough (7)

[1] Rankings are based on data published for the relevant 2014/2015 profiles at http://www.apho.org.uk/resource/view.aspx?RID=142075

Indicator	2014[1]	2015[1]	2016
Excess weight in adults			Charnwood (7)
Hip fracture in over-65s	Charnwood (8)	Charnwood (1) Harborough (2) Blaby (5)	Melton (1)
Excess winter deaths		Melton (1)	Melton (7)
Killed & seriously injured on roads	Oadby & Wigston (2)	Oadby & Wigston (2)	Oadby & Wigston (2)
Violent crime (violent offences)		Harborough (10)	Harborough (2)
Hospital stays for self-harm		Blaby (6) Charnwood (9)	Melton (1) Blaby (6)
Infant mortality		Oadby & Wigston (1)	Oadby & Wigston (1)

In 2014, 2015 and 2016 the districts in Leicestershire County appeared in the worst 10 (ranked) performing LADs in the country for the following indicators:

Table 3 - District Council performance in worst 10 in country

Indicator	2014	2015	2016
Recorded diabetes	Oadby & Wigston (10)		
Smoking prevalence in adults			Hinckley & Bosworth (8)
Excess winter deaths	North West Leicestershire (6)		
Statutory homelessness			Melton (3)

Overall Leicestershire districts have above average health outcomes. Districts in Leicestershire are in the top 10 of national performance for 9 indicators in 2016. This is a decrease from 2015 where districts were in the top 10 for 10 indicators.

Amongst Leicestershire districts, there are 2 indicators in the worst 10 nationally in 2016; smoking prevalence in Hinckley and Bosworth, and statutory homelessness in Melton.

North West Leicestershire has 5 indicators where performance is worse than the national average; Hinckley & Bosworth has 3 indicators where performance is worse than the national average and the following districts each have 1 indicator where performance is worse than the national average: Blaby, Charnwood, Melton, Oadby & Wigston.

Issues of concern

In 2016, Leicestershire is significantly worse than England for recorded diabetes. Recorded diabetes levels analysed by individual districts show the indicator is significantly worse than the England average in three Leicestershire districts (Hinckley and Bosworth, North West Leicestershire and Oadby and Wigston) and in Leicestershire County.

The statutory homeless indicator for Melton is significantly worse than England and is ranked 3rd highest amongst all districts in England while in Hinckley and Bosworth, smoking prevalence in adults is significantly worse compared to the England average and is ranked 8th highest of all districts in England.

Blaby, Hinckley and Bosworth and North West Leicestershire have significantly worse levels of excess weight in adults compared to England. GSCE achievement is significantly worse than England for Charnwood and North West Leicestershire.

North West Leicestershire remains significantly worse than England for breastfeeding initiation. North West Leicestershire has also decreased its rating from 'not significantly different' than England to 'significantly worse' than the England average for people killed and seriously injured on roads.

Compared to 2015, Harborough, Melton and Oadby & Wigston have decreased their rating from 'performing significantly better' than the

"In 2016, Leicestershire is significantly worse than England for recorded diabetes."

England average to 'no significant difference' for smoking status at time of delivery (the percentage of women smoking at time of delivery of their child).

A similar pattern of change is seen for hip fractures in Blaby, Harborough and Hinckley and Bosworth, with a decrease in rating from performing significantly better than the England average to no significant difference from the England average.

It is important to remember that health profiles provide a snapshot of health over a particular reporting time period. Given statistical variation it is likely that the pattern could change next year. Further analysis of trends over time is necessary to establish what is real and enduring and what is artefact.

However, it is clear that some lifestyle behaviours present an enduring challenge to public health. The percentage of adults with excess weight (overweight and obese) adults mirrors the national trend. With around two thirds of adults being either overweight or obese being 'amber' compared to the national average is not a situation that allows complacency.

Smoking prevalence, whilst at an all-time low, remains amber in most districts and in Hinckley and Bosworth is 'red' rated compared to the national average. More work is needed to understand why, but for Leicestershire an 'amber' on such an important indicator is not the level of ambition or performance we should tolerate.

Similarly rates of smoking in pregnancy in Leicestershire are at a level where Leicestershire should be aiming higher.

Whilst further analysis and interrogation of the data is needed to form a fuller picture, we need to focus the efforts of all parts of health and local government, not just the public health department in making the most of the resources and powers available to improve performance in these areas.

"rates of smoking in pregnancy in Leicestershire are at a level where Leicestershire should be aiming higher."

Recommendations

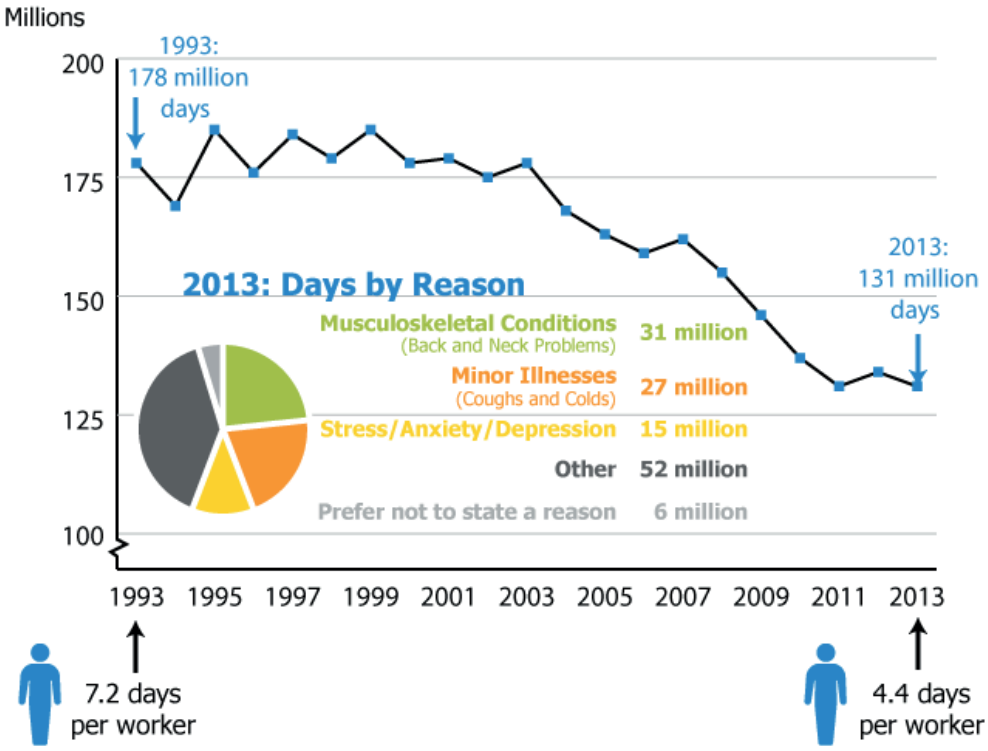
Leader and partner: That Public Health focus their work on district councils on smoking prevalence and smoking at time of delivery. In particular we will work with districts to ensure they make the most of their ability to improve the public's health using the resources at their disposal.

The role of workplace health in improving health

Health and well being of working age adults

Despite life expectancy and numbers in employment being high in the UK, around 131 million working days were lost to sickness in 2013. This is equivalent to over 4 days for each working person. Minor illnesses were the most common reason given for sickness absence (30%) but more days were lost to back, neck and muscle pain than any other cause at 30.6 million days lost (Figure 2). Mental health problems such as stress, depression and anxiety also contributed to a significant number of days of work lost in 2013 at 15.2 million days (5).

Figure 2: Number of working days lost due to sickness absence, 1993 to 2013, and the top reasons for sickness absences in 2013, UK (5).



Work and health

Employment levels provide a high-level indicator of the health of the working age population. Being in employment is a reflection of the health status of individuals, but also of the probability of being in work with a given health status (1). Between January and December 2015, in Leicestershire 332,000 (76.6%) people aged 16-64 were in employment; a rate that is higher than the regional (73.8%) and the national (77.85) average (6). A higher proportion of men (80.8%) than women (72.4%) were reported to have a job in 2015 (Figure 3).

Figure 3: Employment and unemployment (January to December 2015) – Leicestershire, East Midland and Great Britain (6)

Employment and unemployment (Jan 2015-Dec 2015)

	Leicestershire (Numbers)	Leicestershire (%)	East Midlands (%)	Great Britain (%)
All People				
Economically Active†	342,600	79.1	77.5	77.8
In Employment†	332,000	76.6	73.8	73.6
Employees†	287,200	66.9	64.4	63.1
Self Employed†	43,200	9.4	9.0	10.2
Unemployed§	10,500	3.1	4.7	5.2
Males				
Economically Active†	181,000	83.5	83.1	83.2
In Employment†	175,400	80.8	79.1	78.6
Employees†	145,600	68.0	66.5	64.4
Self Employed†	29,100	12.6	12.1	13.8
Unemployed§	5,600	3.1	4.7	5.3
Females				
Economically Active†	161,500	74.7	72.0	72.5
In Employment†	156,700	72.4	68.5	68.7
Employees†	141,600	65.7	62.3	61.7
Self Employed†	14,100	6.2	5.9	6.6
Unemployed§	4,900	3.0	4.7	5.1

Source: ONS annual population survey

† - numbers are for those aged 16 and over, % are for those aged 16-64

§ - numbers and % are for those aged 16 and over. % is a proportion of economically active

Although employment rates in Leicestershire are high, over 87,000 people aged 16-64 were economically inactive with nearly 64,000 (72.9%) stating that they do not want a job. Although the figures for people economically inactive account for students, individuals who are looking after family or home, or are retired, 13,000 people (14.9%) reported long-term sickness as the reason. This again is lower than regional and national average at 21% (6).

"87,000 people aged 16-64 were economically inactive with nearly 64,000 (72.9%) stating that they do not want a job."

Figure 4: Economic inactivity (January to December 2015) – Leicestershire, East Midland and Great Britain (6)

Economic inactivity (Jan 2015-Dec 2015)

	Leicestershire (Level)	Leicestershire (%)	East Midlands (%)	Great Britain (%)
All People				
Total	87,500	20.9	22.5	22.2
Student	26,600	30.4	25.7	26.2
Looking After Family/Home	18,800	21.5	25.2	25.1
Temporary Sick	#	#	1.6	2.3
Long-Term Sick	13,000	14.9	21.6	21.8
Discouraged	!	!	#	0.4
Retired	16,800	19.2	15.7	14.1
Other	11,200	12.8	10.0	10.1
Wants A Job	23,700	27.1	24.1	24.3
Does Not Want A Job	63,900	72.9	75.9	75.7

Source: ONS annual population survey
Sample size too small for reliable estimate
! Estimate is not available since sample size is disclosive
Notes: numbers are for those aged 16-64.
% is a proportion of those economically inactive, except total, which is a proportion of those aged 16-64

Supporting more people with a health condition into work will help to achieve the Government's aim of higher employment. Nationally the employment rate for disabled people has been gradually increasing (1).

The gap in the employment rate between those with a long-term health condition and the overall employment indicator measures the percentage

point gap between people who have a long-term condition who are classified as employed (aged 16-64) and the percentage of all people classed as employed (aged 16-64).

For Leicestershire in 2014/15 this gap was 7.4 percentage points and this is lower than the average for England at 8.6. Leicestershire ranked 11 out of 16 (with 1 having the smallest gap) in comparison with its nearest statistical comparators. At the same time, at 74.9 percentage points, the gap in the employment rate between those with a learning disability and the overall employment rate in Leicestershire was higher than the gap for England (66.9).

Leicestershire ranks 14 out of 16 nearest neighbours. However, the rate of the increase in the gap over the last four years has been slower locally (1.9 percentage point) than the national increase at 3.7 (Figure 5). The gap for employment rate for those in contact with secondary mental health services and the overall employment rate in Leicestershire for the period 2014/15 at 71.3 is higher than the gap recorded for England (61.4). Again it ranks 14 out of the 16 nearest neighbours. Further the rate of increase in the gap over the last four year in Leicestershire has been higher than the national increase.

"Leicestershire ranked 11 out of 16 (with 1 having the smallest gap) in comparison with its nearest statistical comparators."

Figure 5: Gap in the employment rate between those with a learning disability and the overall employment rate

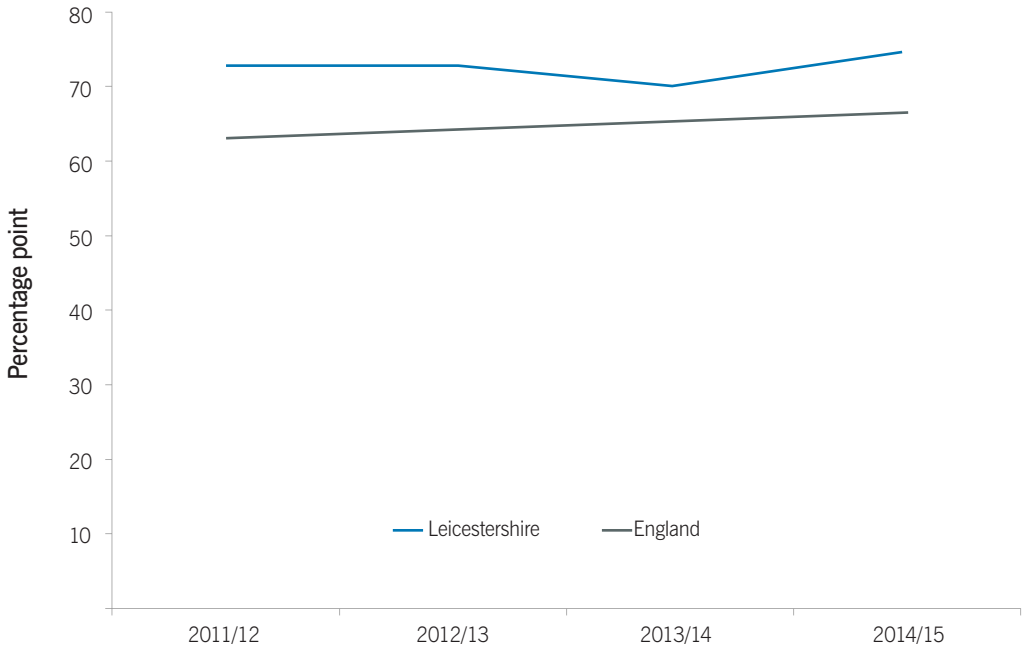
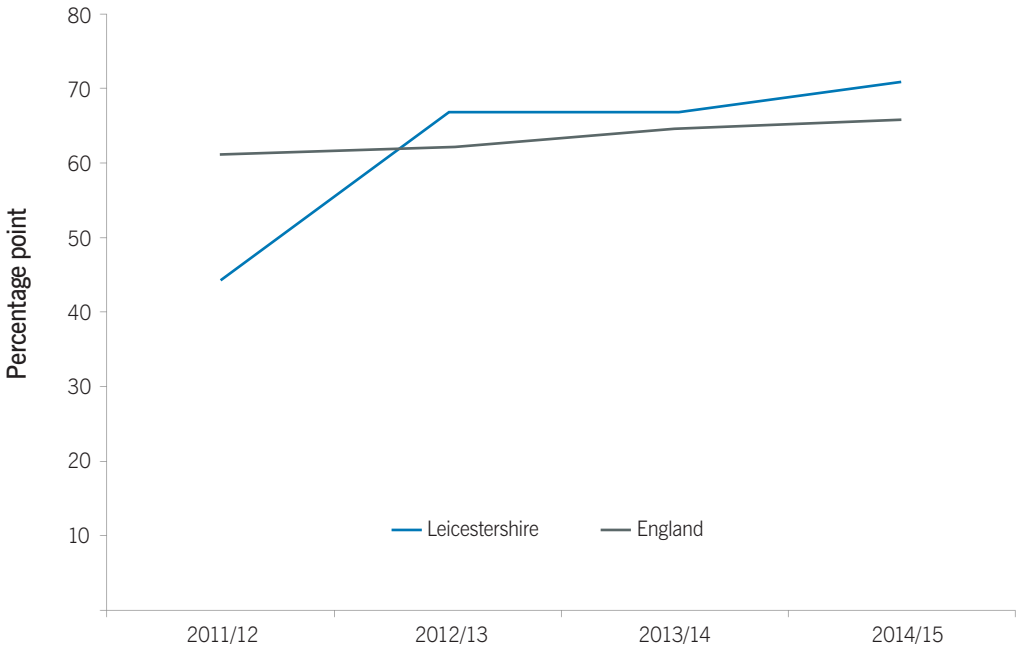


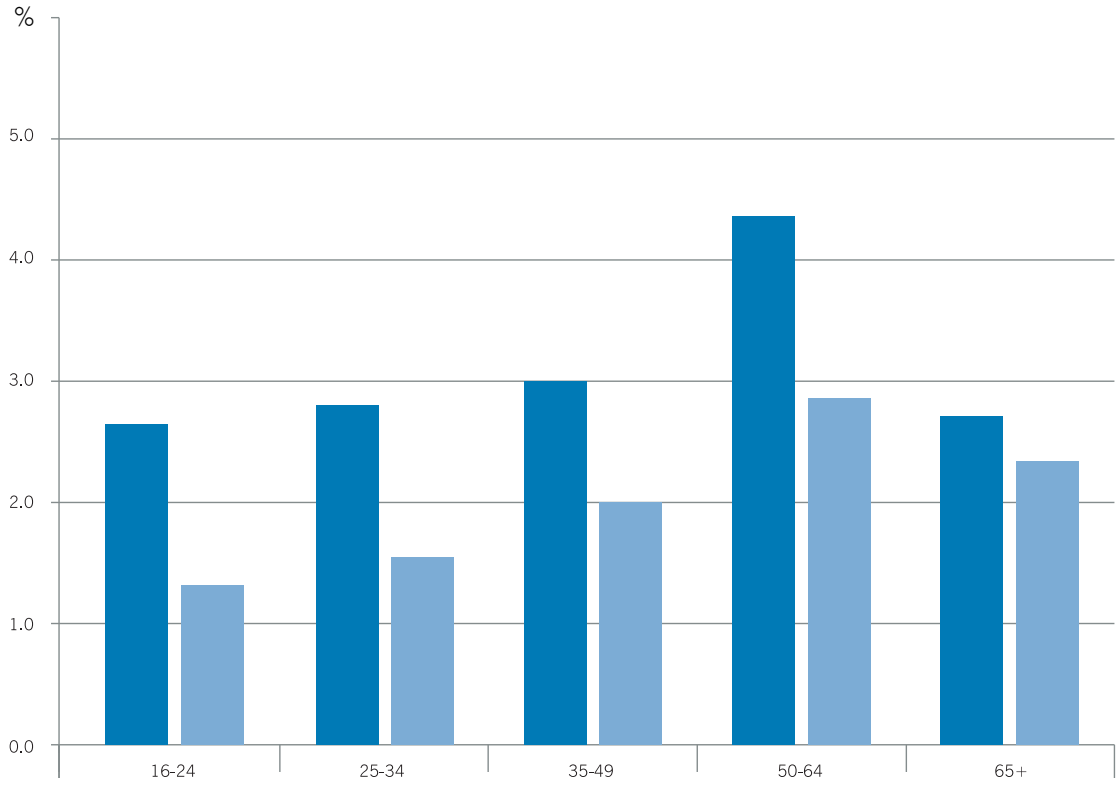
Figure 6: Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (7)



When employees develop a health condition, it does not always lead to absence from work, but can lead to reduced performance on the job. Lower productivity may also be linked to lower job satisfaction and wellbeing, which in turn may be due to workplaces that sap morale and energy. There is growing evidence that links employee morale and satisfaction with health outcomes as well as business performance measures (1). The proportion of population affected by long-term health problems and disability increases with age, whereas the proportion of people that report their health as good or very good decreases. Although nationally the percentage of working hours lost to sickness peaks at ages 50-64, this group had the greatest fall in sickness absence rates between 1993 and 2013. Older workers, aged 65 and over, had the smallest fall at 0.5 percentage points but the rate is lower than that recorded for ages 50 to 64 (Figure 7) (6)

"Lower productivity may also be linked to lower job satisfaction and wellbeing, which in turn may be due to workplaces that sap morale and energy."

Figure 7: Percentage of working hours lost to sickness by age group – 1993 (blue) and 2013 (light blue) (6)



Nationally sickness absence is generally lower than it was in the 1990s, however it is still substantial. The labour force survey provides self-reported information on the number of working days lost due to sickness absence during the previous week. According to the Labour Force survey in Leicestershire between 2011 and 2013, 2.4% of workers took a day off due to ill-health in the previous week. This is similar to the England average and it ranks 9 out of the 16 nearest neighbours (with 1 being the lowest value). For the same period, 1.5% of working days were lost due to ill-health. This is again similar to the England average of 1.5% and ranks 10 out of 16 nearest neighbours. Both percentages show an increasing trend that is faster than one observed nationally with the former increasing from 1.8% in 2009-11 and the later from 1.1% (7).

The percentage of hours lost has fallen for all age groups since 1993

But the smallest fall has been for those aged 65+

This may be related to an increase in the number of people working past state pension age

Incapacity benefits are paid to those who are unable to work because of ill-health or disability. The proportion of the working age population on incapacity benefits – or the equivalent benefits that preceded it – has been increasing from 1970s to mid-1990s, with a small decline in recent years (1). In November 2015 in Leicestershire, 16,820 (4%) aged 16-64 were in the receipt of the Employment and Support Allowance (ESA) or Incapacity Benefits. This was lower than the regional (5.9) and national (6.2%) average. More than 3,000 (0.7%) people were claiming benefits in Leicestershire because they were disabled which is again below regional and national average (Figure 8) (6)

"More than 3,000 (0.7%) people were claiming benefits in Leicestershire because they were disabled which is again below regional and national average"

Figure 8: Working-age client group – main benefit claimants (November 2015) (6)

Working-age client group - main benefit claimants (November 2015)

	Leicestershire (Numbers)	Leicestershire (%)	East Midlands (%)	Great Britain (%)
Total Claimants	31,980	7.6	11.3	11.8
By Statistical Group				
Job Seekers	2,770	0.7	1.3	1.5
ESA And Incapacity Benefits	16,820	4.0	5.9	6.2
Lone Parents	2,660	0.6	1.0	1.1
Carers	5,170	1.2	1.7	1.6
Others On Income Related Benefits	670	0.2	0.2	0.2
Disabled	3,090	0.7	0.9	1.0
Bereaved	790	0.2	0.2	0.2
Main Out-Of-Work Benefits†	22,920	5.5	8.5	9.0

Source: DWP benefit claimants - working age client group

† Main out-of-work benefits includes the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits. See the **Definitions and Explanations** below for details

Notes: % is a proportion of resident population of area aged 16-64
Figures in this table do not yet include claimants of Universal Credit

Employment rates in Leicestershire are high. Nevertheless over 87,000 people aged 16-64 were economically inactive with nearly 64,000 (72.9%) stating that they do not want a job and 13,000 people (14.9%) reported long-term sickness as the reason. There is also a gap in the employment rate between people with a long-term health condition or some of the vulnerable population groups and the overall employment.

For example, the gap for employment rate for those in contact with secondary mental health services and the overall employment rate in Leicestershire is higher than the gap recorded for England and it ranks 14 out of the 16 nearest neighbours (with 1 showing the smallest gap).

Long-term conditions can affect people's mental health and vice versa. They can also affect the ability to work, result in work absence and can reduce quality of life. In 2014/15 a higher proportion of people in Leicestershire than in England were registered with their GP as having hypertension, depression, diabetes, chronic kidney disease, cancer, atrial fibrillation, heart failure and epilepsy.

"Long-term conditions can affect people's mental health and vice versa. They can also affect the ability to work, result in work absence and can reduce quality of life."

Workplace health

Whilst 'good' work is recognised to be good for health, staff health and wellbeing also plays an important role in the overall health and productivity of an organisation.

As described in the previous chapter, people who work are generally healthier than the non-working population (8) but it is known that certain factors in work, such as poor leadership, can lead to stress, burnout or depression (9). Additionally there is evidence to suggest that people who go to work when they are sick are more costly to the business than absenteeism (10). It is therefore important that the working environment is a good one that promotes positive, healthy values.

The national Workplace Wellbeing Charter (11) provides employers with a way to assess and then improve their commitment to the health and well-being of their staff.

What is the Workplace Wellbeing Charter?

The Workplace Wellbeing Charter is an opportunity for employers to demonstrate their commitment to the health and wellbeing of their workforce. It is a set of independent standards against which employers can audit and benchmark, allowing them to identify what they already have in place and to identify gaps in health, safety and wellbeing for their employees. This provides employers with an easy and clear guide on how to develop their health and wellbeing strategies and plans and how to make workplaces a supportive and productive environment. It involves 94 indicators grouped into difference sections such as healthy eating or leadership. Employers complete the 94 questions and are able to identify areas that are good or need developing. The charter provides a framework for this development and organisations can be assessed against the national standard to achieve award status. Achievement of the Award enhances an organisations reputation as well as benefiting staff.

How does the standard work?

There are 3 key elements **(leadership, culture & communication)** and 8 standards in the charter:

- Leadership
- Absence management
- Health and safety
- Mental health
- Smoking and tobacco
- Physical activity
- Healthy eating
- Alcohol and substance misuse

The Standard has three levels:

1. **Commitment**

   The organisation has a set of health, safety and wellbeing policies in place and has addressed each area, providing employees with the tools to help themselves to improve their health and well-being.

2. **Achievement**

   Having put the building blocks in place, steps are being taken to actively encourage employees to improve their lifestyle and some basic interventions are in place to identify serious health issues.

3. **Excellence**

   Not only is information easily accessible and well publicised, but the leadership of the organisation is fully engaged in well-being and employees have a range of intervention programmes and support mechanisms to help them prevent ill-health, stay in work or return to work as soon as possible.

Employers can 'self-assess' themselves against the standards. To do this they need to register as a member on the Wellbeing Charter website: http://www.wellbeingcharter.org.uk/ This enables access to the self-assessment tool and a range of useful links and information.

Organisations can also be formally assessed against the Charter standards, giving further weight and recognition of their achievement. Once accredited, the organisation receives a certificate and the organisation is listed on the national register of award holders.

Box 1 illustrates how Leicestershire County Council has used the charter to progress its commitment to improving staff health and wellbeing.

"Organisations can also be formally assessed against the Charter standards, giving further weight and recognition of their achievement."

Box 1 – Using the National Workplace Wellbeing Charter

'Workplace health' refers to the combined efforts of the employer and the workers to encourage and support healthy lifestyle habits, making healthy choices the easy choices. Creating a health and wellbeing programme in workplaces can boost productivity and help staff to be happier and healthier at work and at home. Evidence suggests that early interventions to improve health in the workplace are effective.

Leicestershire County Council carried out a self-assessment process for its own workforce and then asked its six organisational departments and Unison to look at their self-assessment and say how well they agreed with the organisational self-assessment. The six departments and Unison carried out their own self-assessments and compared these to the organisation's assessment. The resulting comments and feedback were then used to develop a workplace wellbeing strategy for the organisation and newly formed task and finish groups to focus on action in the areas of 'Corporate policies, physical activity, food and nutrition, mental health and substance misuse.

The delivery of the workplace wellbeing strategy is anticipated to deliver:

- Improved attendance and reduced sickness absence;
- Reduced absenteeism;
- A more productive workforce;
- Improved staff engagement;
- Improved resilience to change;
- Greater retention and recruitment of staff

Implementation of the strategy is via action plans facilitated through a communications plan and an organisation-wide network of Workplace Wellbeing Champions that advocate wellbeing in their department. Sickness absence and staff satisfaction as measured through the Staff Survey will be used to monitor the impact of the programme and a process of re-self assessment will take place annually.

Working with partners to improve workplace wellbeing

The Leicester and Leicestershire Enterprise Partnership (LLEP) is a strategic body led by a Board made up of local government and business leaders as well as senior education and third sector representatives. As such, it provides an opportunity to address work and health as a place-based approach, given its remit to engage with business, local authorities, higher and further education establishments and the voluntary sector (see https://www.llep.org.uk/about-us).

The LLEP has produced a series of Sector Growth Plans for eight key sectors:

- Food and drink manufacturing
- Textiles manufacturing
- Logistics and distribution
- Tourism and hospitality
- Creative industries
- Low carbon
- Professional and financial services
- Engineering and advanced manufacturing

An opportunity exists to review each of the sector plans and to work with the LLEP to embed employee health and wellbeing within them, to increase the attractiveness of the Leicester and Leicestershire area for future employees and to increased economic productivity and prosperity.

As an example, on page 27 is an outline of the Food and Drink Manufacturing plan. Opportunities for considering employee health and wellbeing have been highlighted.

Sector plan	Summary overview	Headline targets of the plan	Opportunities for considering employee health and wellbeing
Food & drink manufacturing	Studies have shown the F&D sector in the LLEP area has weathered the recession well and expects significant growth in the next 3 years. The area is ideally placed geographically for growth and the F&D sector has a diverse range of traditional high quality products, allied with both mass production of staple foods and lower volume production of specialist products. Key localities include: Leicester Food Park and Melton Enterprise Zone. In terms of the economic contribution, the F&D sector in Leicester/shire is the second most important after non-food manufacturing and is estimated to be worth over £600 million to the area. Major players would be located in the centre; Walkers (PepsiCo), Samworth Brothers Ltd and Mars Group. Also Everards & United biscuits The percentage of employees engaged in the F&D sector across the LLEP area also are significantly higher than the average for England, only Hinckley & Bosworth and Harborough districts are below the average for England, the majority of the remaining districts are double the average or greater, with Melton Mowbray at 13.6% around 10 times the national average. The number of full time employees in the F&D sector rose from 10,245 in 2009 to 11,293 in 2013, an increase of 10.2%. The number of part time employees rose by only 2.2% in the same period however, from 1,116 to 1,140	People: There is a shortfall in skilled labour-attract, recruit, train & retain Business: There could be more information, better access to university resources, advice on grant applications, etc. These could be addressed by creating a 'Centre of Excellence', ideally a physical location for the F&D sector, but this could be extended to other sectors in order to be cost-effective. Focus innovation & export Places: There is a lack of premises suitable for food grade activities. transport and connectivity are also important issues affecting the growth potential of businesses in the sector imbalance in the promotion of the F&D sector product as well as business brands in the LLEP area and action should be taken to ensure that the wider range of businesses and their products are promoted, rather than focusing on a few	People: investment in workplace health could be significant draw for future workforce and then help to retain and get the best out of staff. Places: developing new premises that are within active travel distances to where people live (i.e. walking and cycling distance) and providing facilities to enable this (showers etc) could help to embed physical activity into daily lives. This is the most efficient way of getting people to be more active every day. There are opportunities to encourage more diverse and 'healthier food' manufacturing in the area, supporting a nutritional and sustainable food plan for the region that would make it nationally and internationally recognised as well as providing food security for the area.

Conclusions

There is overwhelming evidence of financial and operational benefits to having a healthy workforce with lower than average sickness absence levels, greater retention and recruitment of the best candidates. Organisations that tackle workplace health can identify areas for improvement to reduce sickness absence and improve satisfaction of their employees. The national Workplace Wellbeing Charter provides one mechanism of analysing and addressing workplace health in a strategic and systematic way, underpinned by evidence. Finally there is an opportunity to embed workplace health into policy and strategy within organisations and at the regional level in order to reduce health inequalities, invest in all staff, attract the highest quality employees to posts and in doing so, improve the economic prosperity in Leicestershire.

Recommendations

A Leader - Alongside the Corporate Resources Department, Public Health will lead the implementation of the workplace wellbeing strategy within Leicestershire County Council.

A Partner - As a partner to the NHS, we will work with University of Hospitals of Leicester Trust and Leicestershire Partnership Trust on joint approaches to workforce health as part of the LLR response to the NHS 5 Year Forward View.

An Advocate - The Public Health Department will advocate the use of the Workplace Well Being Charter in private sector employers as part of our workplace health programme.

"there is an opportunity to embed workplace health into policy and strategy within organisations"

Improving the economy and improving health by tackling the wider determinants of health

Background

We all know the old adage 'health is wealth'. The vast majority of researchers, though, instead present the reverse argument, that wealth is health. Recent literature, however, reflects changes in the perception of health and longevity such that they are no longer viewed as a by product of economic development but can drive economic development.

Better health does not have to wait for an improved economy. Measures to reduce the burden of disease, to give children healthy childhoods, to increase life expectancy, themselves contribute to creating richer economies.

This chapter outlines how we intend to maintain our focus on wider determinants and take advantage of the opportunity public health has now that it is back 'home' within local authorities.

Creating Healthy Places

Creating healthy places is an essential component of the County Council's focus on prevention. Healthy places can enable people to make healthy choices; promote physical activity and active travel; provide access to green spaces, healthy food and warm homes. In addition creating employment and high quality training opportunities are inextricably linked to physical and mental health and wellbeing.

Social relationships, norms and networks – or the absence of these – have an impact on the development of, and recovery from, health problems such as heart disease. They also affect:

(a) our ability to maintain independence

(b) our resilience

(c) whether we take up and maintain unhealthy behaviours such as smoking.

The Economy and Health

The Leicester and Leicestershire Enterprise Partnership (LLEP), which is made up of both public sector and business representatives, has a key role in economic development which has included the development of the Strategic Economic Plan (2014-20) which provides the framework for achieving the economic vision of the city and county. The plan forms the basis of a short and medium-term prioritisation of investment including Local Growth Fund, European Structural and Investment Funds and Growing Places Fund. The Strategic Economic Plan is being reviewed in 2016, ensuring that it reflects recent changes in the global, national and local economy.

In support of the LLEP's Strategic Economic Plan and the County Council's Strategic Plan 2014-18, the Council has produced a three year Enabling Growth Plan which sets out how it will contribute towards the overarching economic vision and priorities for Leicester and Leicestershire, setting out what the Council will do, and what it will invest in, to improve the economic prosperity of the county and the economic wellbeing of communities, residents and workers.

The Council is currently developing an Infrastructure Plan, which will establish a more strategic approach to infrastructure planning across its service departments by prioritising capital investment to support Leicestershire's economic growth priorities."

The Planning and Infrastructure Members Advisory Group oversees strategic land use planning work in Leicester and Leicestershire and acts as a vehicle for Local Planning Authorities to work collaboratively when preparing a development plan document such as a Local Plan. Its membership consists of representatives from all nine local authorities in Leicester and Leicestershire.

"The Council is currently developing an Infrastructure Plan, which will establish a more strategic approach to infrastructure planning across its service departments"

The proposed development of a Combined Authority for Leicester and Leicestershire will bring more formal governance arrangements to issues of economic development and regeneration, as well as transport by creating a clear and effective platform for accelerating economic prosperity in Leicester and Leicestershire through the creation of integrated, strategic frameworks to enable the delivery of investment plans for planning, transport and skills.

Housing and Health

The Housing Services Partnership's primary objective is for existing homes and housing related services to be improved to meet better the needs of the people of Leicestershire. Board members will be familiar with the progress made on maximising the health gain from housing, through initiatives such as Lightbulb. It also has a role in ensuring that impact on and from housing provision on other strategic outcomes is adequately considered.

Safer Communities

The Safer Communities Strategy Board is made up of the chairs of each of the six Community Safety Partnerships and their officers, the County Council and representatives from the CCG, Public Health, Police, National Probation Service, Community rehabilitation Company. A forward plan of meetings is in place for 2016/17 that sets out the reports going to each of the Boards quarterly meetings. There is a Safer Communities Performance dashboard in place that sets out the performance against each of the priority areas for the Board. The Safer Communities Strategy Board has strong links with the Strategic Partnership Board, chaired by the Police and Crime Commissioner. The Strategic Partnership Board's priorities for 2016/17 include Child Sexual Exploitation, Domestic Abuse and Sexual violence, supporting the most vulnerable and tackling hate.

It is proposed that the Health and Wellbeing Board receives regular, targeted updates from the above groups which will ensure board members gain and maintain a level of understanding about current work in progress across the range of these matters and, crucially their strategic alignment with, and contribution to, place based strategies including Leicestershire's Joint Health and Wellbeing strategy and the STP covering the LLR-wide footprint. The purpose of bringing these matters to the board is therefore to challenge Board Members to:

- leverage the strategic opportunities that arise from these developments across partners;
- take a cross cutting approach to achieving health and wellbeing outcomes;
- seek the added value (both to the Leicestershire citizen and the Leicestershire pound) by maximising the health and wellbeing benefits that can be realised;
- jointly promote prevention and demand management through our joint health and wellbeing strategy and other related strategies and policies.

Health in all Policies

To support the Board in focusing on its impact on the wider determinants of health and wellbeing and measuring this impact, the Health and Wellbeing Board will ake use of an existing tool and systematic approach called "health in all policies" (HIAP), which builds on the application of Health Impact Assessment (HIA). HIA is a systematic and objective way of assessing both the potential positive and negative impacts of a proposal on health and wellbeing and suggests ways in which opportunities for health gain can be maximised and risks to health and wellbeing assessed and minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework. HIA highlights the uneven way in which health impacts may be distributed across a population and seeks to address existing health inequalities and inequities as well as avoid the creation of new ones. HIA is a tool to implement a Health in all Polices (HIAP) approach.

HIAP describes a collaborative approach which emphasises the connections and interactions which work in both directions between

health and policies from other sectors. Central to HIAP is the concept of addressing the social determinants of health.

During 2015/16 the Public Health Department undertook a number of HIAs in order to pilot an approach to HIA/HIAP across Leicestershire focusing on healthy places. Examples of the pilot approach to HIAP are set out below:-

Lubbesthorpe

A desk based HIA of the for a proposed major development in Blaby District for over 10,000 people with a variety of homes, schools, shops, places to work, community facilities and parks and natural green spaces was undertaken with support from the New Lubbesthorpe Delivery Group and Blaby District Council. Key evidence based recommendations were made covering:

- road safety and active travel;
- street scene development;
- sustainability of residential units including community energy; and
- use of buildings and land for community develop projects.

The recommendations are being considered by the Lubbesthorpe Executive Board for inclusion into the final plans.

Melton Borough Council Local Plan

The emerging Options (draft plan) provided an opportunity to undertake a HIA. The Local Plan includes the development of at least 6,125 homes and 51 hectares of employment land between 2011-2036. The focus for the HIA was on two new large scale sustainable neighbourhoods – 'Melton North' and 'Melton South' urban extensions.

"The Local Plan includes the development of at least 6,125 homes and 51 hectares of employment land between 2011-2036."

The HIA included policy analysis, literature/evidence review, analysis of health needs and inequalities, and a stakeholder engagement event with members of the Local Plan reference group. Recommendations cover a number of policy areas including:

- minimising the disruption, anxiety and uncertainty – especially during construction phases;
- fostering and enabling community cohesion and social networks
- provision of sufficient and appropriate housing types,
- provision of allotments, community gardens and school gardens,
- accessibility and affordability of sports facilities;
- prioritising active transport and including 20mph zones.

The recommendations will now be considered alongside all other formal consultation responses in the development of the final plan.

North West Leicestershire Housing Strategy 2016 - 2021

This desk based/ rapid HIA also included community engagement as well as evidence appraisal, community profiles gaps analysis and recommendations. The latter covered:

- Supply – holistic delivery of housing; lifetime homes; Training skills and employment.
- Standards – affordable warmth; focus on private rented sector; build for life
- Support – energy advice; homelessness; community development and social networks.

As well as the opportunity to use HIA/HIAP for major strategies, plans and developments, this approach can also be used to enhance major procurements through applying these principles to social value policies. During 2016/17 Public Health will continue this approach in order to determine the most effective use of resources to maximise the impact of HIAP.

Recommendations

A Leader – We build HIAP into the LCC Social Value Policy and ensure a systematic approach to maximise health benefits and mitigate health harms in all major LCC procurements.

A Partner - We will work with Hinckley and Bosworth DC and the Design Council to maximise active transport and physical activity into the development of 800 new home development.

A Partner - We will bring a HIAP lens to the development of the 6 Cs Transport Strategy – 'Delivering Streets and Places 2016'.

An Advocate – We will ensure the Health and Wellbeing Strategy 2016 acknowledges and supports the role of HIAP to support improvement of the factors that affect people's health and wellbeing focussing on housing, education, employment and the wider environment.

An Advocate – We will support the prioritisation and inclusion of health improvement into the LCC Infrastructure Plan 2016.

Feedback from recommendations 2015

A Leader – The council should lead on programmes of work and support initiatives that increase place and asset-based community led interventions. The council should do this by providing opportunities for community capacity building through the allocation of grants, by including community-based approaches in service commissioning and by disseminating and sharing of good practice.

Tier 0 (Community Capacity Building approaches) is an integral part of the operating model for prevention as set out in the Early Help and Prevention Review and Strategy, considered and approved by Cabinet in June 2016.

The work of the Unified Prevention Board (a part of the Better Care Fund Plan for Leicestershire), co-chaired by the Director of Public Health and District Chief Executive lead for health, puts community-based approaches to service commissioning at its heart. This includes the provision of Local Area Coordinators in pilot parts of Leicestershire.

Our SHIRE Community Grants help to deliver the Communities Strategy through funding community projects. During 2015/16, 25 'large grants' of up to £10,000 were awarded, along with 83 'small grants' up to £2,500. The grants helped a range of voluntary organisations to deliver support for vulnerable and disadvantaged people, including vulnerable young people, adults with disabilities, and communities facing a range of challenges such as unemployment and mental health issues.

A Partner - District and borough councils in Leicestershire deliver a wide range services that can improve and protect residents health and wellbeing such as, leisure, housing, planning and environmental health. The Public Health Department should work in partnership with district and borough councils to use a community participatory approach to assess the health impact of their services and policies to enable them to promote the positive impacts and mitigate the negative impacts.

Public Health have supported districts in the application of Health Impact Assessment and Health in All Policies in North West Leicestershire, Melton and in connection with the Lubbesthorpe. In Melton in particular this has involved community involvement in assessing health impacts.

An Advocate – The Public Health Department should continue to advocate that health is integral to all of the council's policies. It should also develop robust community engagement that will feed into a Social Value Framework, which will subsequently apply to all higher value procurements across the authority. This will ensure all major procurements take into account community views and knowledge to improve and protect health and wellbeing.

Work continues on a draft social value framework for the County Council working closely with colleagues in the Commissioning Support Unit.

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 2 NOVEMBER 2016

REPORT OF THE CHIEF EXECUTIVE AND ARDEN/GEM COMMISSIONING SUPPORT PERFORMANCE SERVICE

PERFORMANCE UPDATE AT END OF QUARTER 2 2016/17

Purpose of Report

1. The purpose of the report is to provide the Committee with an update on health performance issues based on the available data at the end of quarter 2 of 2016/17.

Background

2. The Committee currently receives a joint report on performance from the County Council's Chief Executive's Department and the Arden/GEM Commissioning Support Performance Service. This particular report encompasses:

   a. Performance against key metrics and priorities set out in the Better Care Fund plan;
   b. An update on key Clinical Commissioning Group (CCG) and provider performance issues including mental health performance; and
   c. An update on wider public health metrics and performance.

Better Care Fund and Integration Projects – Appendix 1

3. The following section of the report summarises performance against the targets within the Better Care Fund (BCF) plan. Appendix 1 contains the BCF Plan indicators and targets applying from April 2016. These are all 2016/17 targets and were revised in July 2016 in light of new population projections released by the Office for National Statistics in May 2016.

   1. Metric 1 – Residential and nursing home admissions – 606.4 per 100k a year
   2. Metric 2 – Reablement – 84.2% for each rolling 3 month period
   3. Metric 3 – Delayed Transfers of Care (DTOC) quarterly targets - 236.66, 231.91, 214.66, 312.19 per 100k
   4. Metric 4 – Non-elective admissions – 724.37 per 100K per month
   5. Metric 5 – Patient experience – 63.5%
   6. Metric 6 – Falls – 139.76 per 100K per month

Metric 1 – Residential and Nursing Homes

4. In relation to residential and nursing home admissions - permanent admissions to care for those aged 65+ per 100k - the forecast is 605.4 (826 admissions) against a target of 606.4 (827 admissions). The indicator is therefore currently rated green. Performance in 2015/16 was 860 admissions (642.3)

Metric 2 - Reablement

5. In relation to reablement, the latest data on the percentage living at home 91 days after hospital discharge and reablement is 90.3% (364 out of 403). Performance continues to improve and meets the BCF target of 84.2%. Data published for 2015/16 puts Leicestershire above the national average. In relation to the percentage of people who had no need for ongoing services following reablement this is 79.7% (1275 out of 1600) against a target of 76%. 2015/16 data shows Leicestershire performance is above the average.

Metric 3 – Delayed Transfers of Care

6. In relation to delayed transfers of care (DToC) a meeting of the DToC task and finish group of the Discharge Steering Group met to discuss the reporting of this data across all partners. For July and August there have been 3,769 days delayed for Leicestershire residents. 2,342 (62%) were in the acute sector and 1,445 (38%) in the non-acute sector. Therefore the non-acute target is being achieved but the acute target is not.

7. 1,567 (41%) were at UHL, and 1,415 (37%) at LPT. The remainder are at out of county providers of which the biggest contributor is Burton Hospital with 188 days (5% of the total). In quarter 1 the biggest out of county contributor was Kettering General (11% of total).

8. While 'DII_nursing_home' is the most common reason for a delay, the number of delays due to 'B_public_funding' has been increasing since May, with more of these being reported in July and August. Most of the 'B_public_funding' delays are due to pressures in the NHS. It is likely that most of these are due to delays arranging Continuing Health Care. However this analysis should be regarded with caution. There are opportunities for providers to correct and update data they have submitted, so this analysis could change and members will be updated should that be the case.

Metric 4 - Non-Elective Admissions

9. Work undertaken since the last meeting has resulted in it becoming clear that the East Leicestershire and Rutland CCG's weekend AVS scheme is Better Care Fund funded. Avoided admissions from this scheme and a trajectory for it have not been included in previous reports. The target for avoided admissions in 2016/17 is 1,517. This has been aligned with CCG operating plans.

10. Work undertaken since the last meeting to understand the re-design of a number of schemes has led to a number of changes:

- East Leicestershire and Rutland CCG's GP-led 7 day services scheme has ended due to lower performance in the pilot period. The trajectory has been set to zero per month from August
- West Leicestershire CCG's weekday AVS scheme will be extending its opening hours to 8pm Mon-Fri.
- A draft increased trajectory for Loughborough Urgent Care Centre Extra Care Pathways has been included but ongoing re-procurement has limited capacity to engage with the data issues and provide assurance that the increased trajectory is realistic.
- A trajectory for the winter pilot of the Glenfield CDU ambulatory care scheme is not included because the commissioning intentions are not clear at the time of writing

BCF Schemes Action Plan Exception Report

Within the scheme updates, a number of issues have been highlighted as follows:-

Scheme	Commentary
West Leicestershire CCG 7 day services	The service achieved 83 avoided admissions in September against a trajectory of 115
Extra care pathways at Loughborough Urgent Care Centre	Activity continues to be low but this service will be redesigned as part of the Charnwood testbed project. A re-procurement for this service is ongoing.

Metric 5 – Patient Experience

11. In relation to patient experience and patients satisfied with long term support to manage long term health conditions the latest data shows a figure of 63.6% against a target of 62.2%

Metric 6 – Falls

12. In relation to emergency admissions for injuries due to falls in people aged 65+ the latest figure is 125.39 (171 falls) against a target of 139.76. The indicator is currently rated green.

CCG and Provider Dashboards - Appendix 2

13. In March 2016 NHS England published a new Improvement and Assessment Framework (IAF) for CCGs. From 2016/17 this replaced the existing CCG Assurance Framework. The Framework includes a set of 57 indicators across 29 areas. In the Government's Mandate to NHS England the new framework takes an enhanced and more central place in the overall arrangements for public accountability of the NHS. The IAF has been designed to supply indicators for adoption in Sustainability and Transformation Plans as markers of success.

14. This report looks to include relevant indicators from the new Framework, taking into account contents of the local Sustainability and Transformation Plan. The performance report is the vehicle to ensure that an appropriate governance and assurance process is in place for CCGs. The report focuses on a dashboard covering;

- Better Health - this looks at how the CCG is contributing towards improving the health and wellbeing of its population; and
- Better Care - this principally focuses on care redesign, performance of constitutional standards and outcomes, including important clinical areas.

15. Attached as Appendix 2 is the dashboard that summarises information on CCG and provider performance using the above Framework. The indicators within the dashboard are reported at CCG level. Data reported at provider level does differ and delivery actions indicate where this is a risk. The following provides narrative of those areas currently 'at risk' and actions in place to support improving performance.

Electronic Referrals

16. A joint improvement approach has been agreed with the CCGs and University Hospitals of Leicester (UHL) and a number of actions agreed. For CCGs the overarching actions were to promote the Electronic Referral System (ERS) to GPs and provide reassurance of system compatibility; improvements to the login process are being developed and that work is being carried out at UHL to reduce Appointment Slot Issues. UHL have provided a list of specialties on ERS and will identify which specialties currently on ERS are not being referred to. Making sure any triage/referral management clinics/hubs can refer on via ERS.

Antibiotic prescribing

17. The CCG Medicine Management Team monitors GP prescribing of antibiotics and there are a number of actions being undertaken locally by GP practices. These include self-assessment checklists, review of "Treating your Infection" leaflets and actions as a result, nomination of an antibiotic champion, participation in an awareness day, take up of the e-learning model and revision of antibiotic prescribing guidelines.

Cancer Waiting Times

18. 62 day waits – lower GI, lung and urology remain the most pressured tumour sites. Monthly performance meetings and ad-hoc weekly meetings are taking place to support tumour sites as appropriate with the Cancer Management Team. 2 week waits – both 2 week indicators were achieved in July and August. Additional activity continues to be arranged to support delivery within head and neck (ENT) and skin services. Patient choice is a key factor in underperformance for gynaecology. 31 day first treatment - urology has a known shortage of theatre capacity at UHL. Additional long term capacity is in the process of being identified with extra sessions and weekend working. Additional High Dependency Unit (HDU) capacity opened in July 2016 which enabled the services to treat patients who had previously had their appointments cancelled.

Cancer Experience

19. The National Cancer Patient Experience Survey 2015 is the fifth iteration of the survey first undertaken in 2010. The survey was overseen by a national Cancer Patient Experience Advisory Group and commissioned and managed by NHS

England. There are several areas where Leicestershire is below nationally expected scores and they are as follows:

- hospital staff gave the family or someone close to the patient all the information needed to help with care at home;
- the length of time for attending clinics and appointments was right;
- hospital staff gave information about the impact cancer could have on day to day activities;
- hospital staff gave information about support groups and the patient was able to discuss worries or fears with staff during the visit.

Improved Access to Psychological Therapies (IAPT)

20. No performance data is available due to national issues with extracting data however using local data performance shows no improvement in recent months. There is ongoing recruitment of Mental Health Facilitators and PWP workers. Low intensity workers returned to the service in June/July which increases the number of workers above establishment. Progress is being made on the development of Community Health Services to promote IAPT with their service users and aid in referrals. A request has been made to the service to profile monthly cohorts of patients and average time to completed treatments in order to predict future waiting times reporting

Specialist inpatient care for people with a learning disability and/or autism

21. There are a number of delays at the Agnes Unit which relate to; waiting for a step-up low secure placement since April, awaiting the outcome of Court of Protection, specific accommodation required upon discharge. Two patients were recently diagnosed with Asperger's at the Bradgate Unit, which have been added to the CCG list of patients. 18 patients are classed as specialist commissioning (NHS England commissioned). 4 new Child and Adolescent Mental Health Services (CAMHs) hospital placements were made since April.

Estimated diagnosis rate of people with dementia

22. With regard to East Leicestershire and Rutland CCG actions - the Clinical Dementia lead sends diagnosis rates and services/schemes to support practice diagnosis to practices on a monthly basis and through the GP Bulletin. Protected Learning sessions have focused on dementia and care planning. Nurses have also had awareness training. The GP SIP in 2016/17 has ensured that there is a named clinical lead for each practice responsible for improving dementia prevalence and prevalence figures are being audited on a monthly basis. The Better Care Together Dementia Delivery is chaired by CCG's GP Clinical Lead, including refresh of LLR dementia strategy; capacity in memory assessment clinics and movement of patients for treatment in primary care. Practice CQUINs are in place with incentive in place for completed dementia assessments; including investigations and referral; identification of carers, with review offered and signposting to dementia support services

23. With regard to West Leicestershire CCG actions - July's national position was used to revise the 67% target delivery trajectory to February 2017. This was

forwarded for September reporting. The action plan focusses upon use of data, locality and practice engagement, pathway improvements with providers and promotion, education and upskilling.

Maternity

24. Indicators are monitored through Leicester City CCG as the lead commissioner of maternity services. Women's experience of maternity services has been populated at CCG level and is rated red against the England average for East Leicestershire and Rutland only. Joint working on patient experience is being undertaken by Healthwatch, the CCGs and UHL with a survey which ended in September 2016.

University Hospitals of Leicester (UHL) Emergency Department (ED). Waiting Time < 4 Hours

25. Key UHL actions for October include continued work on improvements to the ambulatory pathways and use of the yellow zone; a focus on non-admitted/out of hours breaches; focus on streaming/treating and redirection of patients from the Emergency Department front door and roll out of SAFER placement and reopening of the discharge lounge.

Ambulance Response Times, Handovers between UHL ED and Ambulance Staff and Ambulance Crew Clear

26. With regard to Ambulance Response Times whilst performance across Leicestershire is still below national standards there has been an improvement, albeit a small one, across all categories in August. An EMAS Deep Dive Report was presented in September. A Joint Investigation will look at internal and external factors such as conveyance rates, acuity, handover delays and pathway changes and will determine whether the Contract Performance Notice (CPN) should be withdrawn or a Remedial Action Plan implemented. An agreed action plan will be shared no later than 3rd. October. EMAS are in financial turnaround and to obtain a better understanding of the root causes commissioners have commissioned a Strategic Demand, Capacity and Price Review which is due to report in January 2017.

27. Ambulance Handovers/Crew Clear - a new structure for the LLR Emergency Care Programme rolled out in September. The focus is to deliver five interventions this winter:- streaming at the front door to ambulatory and primary care; NHS 111 – increasing the number of calls transferred for clinical advice; Ambulances – decrease in conveyance and an increase in 'hear and treat' and 'see and treat' to divert patients away from the Emergency Department. Improved flow – must do's that each Trust should implement to enhance patient flow; and Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models.

Delayed Transfers of Care attributable to the NHS per 100,000 population

28. Delayed transfers of care performance has declined as at September 2016 against the outturn position for 2015/16 and is being closely monitored. Actions are being picked up through the accident and emergency recovery plan.

52 Week waiters at UHL

29. Orthodontics - the number of waits over 52 weeks has reduced significantly. With NHS Improvement and NHS England, UHL have identified treatment opportunities from across the regional health economy for the majority of the patients on the orthodontics waiting list. The service team are in the process of transferring patients to these providers.

30. Ear Nose and Throat (ENT) – delays can be attributed to administrative errors; however this has been exacerbated by the mismatch between capacity and demand in ENT. The Referral to Treatment Team delivered a bespoke education and training course for the ENT administrative team and continues to provide support. Extra capacity has been identified for both outpatients and inpatients via Medinet weekend clinics and theatre lists.

Cancelled Operations - non re-admitted in 28 days

31. The number of cancellations due to ward bed availability has deteriorated during August, a reflection of emergency pressures across the Trust. The ring fencing of ASU/Ward 7 for surgical patients continues. HDU bed cancellation is significantly down on last month. A dedicated member of staff is now in place to ensure data quality with regard to cancellations.

UHL QUALITY DASHBOARD

32. A dashboard relating to quality metrics at UHL has been included in Appendix 2. There have been 2 mixed sex accommodation breaches at UHL in August with a patient transferred from an inpatient ward for treatment in the Day Case Unit and another patient in Intensive Care Unit who stepped down from level 3/2.

33. There have been a significant number of Category 2 pressure ulcers at UHL in August (13). The main cause of avoidable pressure ulcers grade 2 is associated with device related harm. Particularly in hot weather, moisture caused by sweating can rapidly cause skin damage and more frequent observation is required. UHL will monitor areas in next month's validation to ensure that themes are not recurring and take action to put in target support from the Pressure Ulcer team if required. They will also raise awareness across nursing teams of the importance of checking skin more frequently in hot weather.

Mental Health Dashboard – Appendix 3

34. A new Mental Health dashboard has been developed which includes more detail on the mental health, learning disabilities and dementia CCG Improvement and Assessment Framework 2016/17 metrics. Actions to address those 'at risk' indicators have been included in the relevant sections above. A selection of Public Health Outcomes Framework indicators which identifies self-harm, suicide and anxiety levels across Leicestershire have also been reported. For each of these areas, levels of improvement have been seen from previous reports. These are all based on nationally published data.

Public Health Outcomes Performance – Appendix 4

35. Appendix 4 sets out current performance against targets set in the performance framework for public health. Public Health England have published an update to the public health outcomes framework (PHOF). In terms of high level outcomes 14 indicators are presented and Leicestershire is better than the England average for six of these. No indicators perform significantly worse than the England average.

36. A number of the PHOF indicators were updated in a data release in 2016 and Appendix 4 summarises the latest position. A number of issues flagged include take up of the NHS Health Check Programme, completions of drug treatment - non-opiate users and mental health – excess mortality and suicide rates

37. In September Public Health England published health profiles for all local authorities in England. The profiles summarise the health of the population using 31 indicators across a range of themes. In relation to Leicestershire 19 of the indicators are significantly better than the England average, 7 the same, with just one – recorded diabetes – significantly worse than the England average.

38. Further consideration will be given to actions to tackle these areas as part of the new Health and Wellbeing Strategy and public health service plan development process.

Recommendations

39. The Committee is asked to:

a) note the performance summary and issues identified this quarter and actions planned in response to improve performance; and

b) comment on any recommendations or other issues with regard to the report.

List of Appendices

Appendix 1– Better Care Fund Dashboard

Appendix 2 – CCG and Provider Performance Dashboards

Appendix 3 – Mental Health Dashboard

Appendix 4 – Public Heath Performance Dashboard.

Background papers

University Hospitals Leicester Trust Board meetings can be found at the following link:
http://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/

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APPENDIX 1	BETTER CARE FUND				November 2016/17
	Metric	**Target**	**Current Data**	**Trend**	**RAG**	**Commentary**
Better Care Fund Overarching Metrics	♦ METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population, per year	606.4	605.4		G	The current data shows the September forecast for 2016/17. The BCF target for 16/17 is a maximum of 827 admissions. The full year forecast is 826 admissions (or 605.4 per 100,000 population) which meets the BCF target.
	♦ METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	84.20%	90.30%		G	The target relates to hospital discharges between October and December 2016 followed by accommodation location between January and March 2017. The measure is monitored on a rolling period with the current performance relating to hospital discharges between April '16 and June '16 and accommodation location between July and September '16. The BCF target is met.
	♦ METRIC 3: Delayed transfers of care from hospital per 100,000 population, average monthly rate per quarter	231.91	349.53		R	BCF DToCs targets are quarterly and 231.91 covers the period Jul-Sep'16 (Q2). The Q2 performance is the average days delayed during Jul-Sep '16 and shown as a rate per 100,000 18+ population. Currently we have July and August's data but Q2 performance target is not on track to meet the Q2 target as there has been increases for both NHS and ASC delays.
	♦ METRIC 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, average monthly rate per quarter	724.37	713.31		A	For the period Apr-16 to Aug-16 there have been 25,199 non-elective admissions, against a target of 24,494 - a variance of 705. This is RAG-rated as amber. Furthermore, the forecast for the end of the 2016/17 financial year is that there could be 61,506 admissions, against a target of 58,896. This would be RAG-rated as amber.
	♦ METRIC 5: Patient / service user experience. Patients satisfied with support to manage long term health conditions	62.20%	63.60%		G	Current data shows July – September 2015 and January – March 2016 results published in July 2016. Target is for this period. The target was achieved.
	♦ METRIC 6: Emergency admissions for injuries due to falls in people aged 65 and over per 100,000 population, per month	139.76	125.39		G	There were 171 falls leading to admissions for injury for Leicestershire residents aged 65 and over in July 2016. This is a rate of 125.4 per 100,000, which currently meets the BCF target of 139.8. This would mean a final year out-turn, based on Apr – Jul data, of 1,333.0 which would be rated green against the target of 1,677.1.

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Appendix 2

West Leicestershire CCG and East Leicestershire & Rutland CCG Performance (CCG Improvement & Assessment Framework 16/17)							
BETTER HEALTH							
		Previous Data	Target	WL CCG	DoT	ELR CCG	DoT
Smoking	Maternal Smoking at Delivery	WL - 10.5% ELR - 8.6%	Below 15/16 baseline	8.9%	⇧	7.9%	⇧
Childhood Obesity	Percentage of children aged 10 - 11 classified as overweight or obese	WL - 29.9% ELR - 28.2%	Below 14/15 baseline				
Diabetes	% of people with diabetes meeting all 3 targets (HbA1c, blood pressure & cholesterol)	WL - 42.8% ELR - 41.9%	Above 14/15 baseline				
	People with diabetes diagnosed less than a year who attend a structure education course	WL - 0.4% ELR - 2.1%	Above 14/15 baseline				
Falls	Emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population	WL - 1729 ELR - 1828	Below 15/16 baseline	1582	⇧	1704	⇧
Personalisation and choice	Utilisation of the NHS e-referral service to enable choice at first routine appointment	WL - 58% ELR - 67%	WL - 78% ELR - 80%	54%	⇩	60%	⇩
	Personal health budgets						
	Percentage of deaths which take place in hospital	WL - 46.3% ELR - 44%	Below 14/15 baseline	46%	⇧	45%	⇩
	People with a long-term condition feeling supported to manage their condition	WL - 62.1% ELR - 64.8%	Above 14/15 baseline	63%	⇧	65%	⇧
Health Inequalities	Unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 popn (Local data)	WL - 767 ELR - 807	Below 15/16 baseline	12 mth rolling 719	⇧	12 mth rolling 754	⇧
	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s per 100,000 popn (Local data)	WL - 164 ELR - 168	Below 15/16 baseline	12 mth rolling 190	⇩	12 mth rolling 148	⇧
	Emergency admissions for acute conditions that should not usually require hospital admission per 100,000 popn (Local data)	WL - 1081 ELR - 1113	Below 15/16 baseline	12 mth rolling 1088	⇩	12 mth rolling 1099	⇧
	Emergency admissions from children with lower respiratory tract infections (LRTI) per 100,000 popn (Local data)	WL - 219 ELR - 254	Below 15/16 baseline	12 mth rolling 246	⇩	12 mth rolling 259	⇩
Anti-microbial resistance	Anti-microbial resistance: Appropriate prescribing of antibiotics in primary care	WL - 1.03 ELR - 1.04	1.161 or below	1.03	⇔	1.03	⇧
	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	WL - 11.7% ELR - 11.4%	WL - 10.2% or below ELR - 10% or below	11.0%	⇧	11.3%	⇧
Carers	Quality of life for carers	WL - 0.81 ELR - 0.83%	Above 14/15 baseline				

BETTER CARE							
		Previous Data	Target	WL CCG	DoT	ELR CCG	DoT
Cancer	Cancers diagnosed at early stage - % of cancers diagnosed at stage 1 & 2	WL - 46% ELR - 48.9%	Above 2013 CCG position	49%	⇧	52%	⇧
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	WL - 79% ELR - 78.3%	85%	77%	⇩	82%	⇧
	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent GP referral for suspected cancer	WL - 91% ELR - 91%	93%	92%	⇧	93%	⇧
	Cancer 31 Day Wait - % of patients receiving first definitive treatment within 31 days of a cancer diagnosis	WL - 96% ELR - 96%	96%	94%	⇩	96%	⇔
	One-year survival for all cancer	WL - 68.6% ELR - 69.3%	Above 2012 CCG position	69.5%	⇧	70.2%	⇧
	Cancer patient experience	National position 8.7	Above 2015 National Average (8.7)	8.6	⇩	8.6	⇩
Mental Health	IAPT Roll Out - Proportion of people that enter treatment against the level of need in the general population (CCG)	WL -14.6% ELR - 14%	15%	13.9%	⇩	13.4%	⇩
	IAPT Recovery Rate (CCG)	WL -51% ELR -55%	50%	55%	⇧	56%	⇧
	75% of people with relevant conditions to access talking therapies in 6 weeks	WL -45% ELR -52%	75%	65%	⇧	74%	⇧
	95% of people with relevant conditions to access talking therapies in 18 weeks	WL -95% ELR - 97%	95%	99%	⇧	99%	⇧
	50% of people experiencing first episode of psychosis to access treatment within two weeks	WL -50% ELR - 100%	50%	80%	⇧	88%	⇩
	Mental Health - Care Programme Approach (CPA) - % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	WL -96% ELR - 96%	95%	98%	⇧	100%	⇧
Learning Disability	Reliance on specialist inpatient care for people with a learning disability and/or autism (per 1m pop) **ALL LLR**		45.68 by Q1 16/17 LLR	52.7			
	Proportion of people with a learning disability on the GP register receiving an annual health check	WL -57% ELR - 54%	Above 14/15 CCG position				
Dementia	Estimated diagnosis rates for people with dementia	WL -66.4% ELR - 61.9%	66.7%	64%	⇩	62.6%	⇧
	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	WL -77.9% ELR - 73.7%	Above 14/15 CCG position				
Maternity	Neonatal mortality and still births per 1,000 population	WL -8.4% ELR - 4.4%	Below 2013 CCG position	8.2	⇧	6.7	⇩
	Women's experience of maternity services	England 79.7	Above 2015 England average	80	⇧	79.2	⇩
	Choices in maternity services	2015 only, no England position (CCGs in highest number of peers therefore green)		63.3		67.3	
Urgent and Emergency Care	Emergency admissions for urgent care sensitive conditions	WL - 1890 ELR - 2067	Below 15/16 baseline	12 mth rolling 1927	⇩	12 mth rolling 2077	⇩
	A&E Waiting Time - % of people who spend 4 hours or less in A&E (UHL)	87%	UHL 91.2% STF by March 17 / 95% national target	80%			⇩
	Emergency admissions to any provider following a previous discharge from any provider within 30 days (per 100,000 popn)	WL - 1508 ELR - 1631	Below 15/16 position	12 mth rolling 1564	⇩	12 mth rolling 1620	⇧
	Trolley Waits in A&E - Number of patients who have waited over 12 hours in A&E from decision to admit to admission (UHL)	2	UHL 0	0			⇧
	Ambulance Handover time - Number of handover delays of > 30 minutes (UHL)	21%	EMAS / UHL 0%	13%			⇧
	Ambulance Handover time - Number of handover delays of > 1 hour (UHL)	13%	EMAS / UHL 0%	6%			⇧
	Ambulance Clinical Quality - Category A (Red 1) 8 minute response time	69%	EMAS - 68% STF	69%			⇔
		67%		56%	⇩	52%	⇩
	Ambulance Clinical Quality - Category A (Red 2) 8 minute response time	61%	EMAS - 60% STF	58%			⇩
		57%		49%	⇩	39%	⇩
	Ambulance Clinical Quality - Category A 19 minute response time	87%	EMAS - 87% STF	85%			⇩
		85%		80%	⇩	74%	⇩
	Crew Clear delays of > 30 minutes (LRI)	4%	EMAS 0%	4.4%			⇩
	Crew Clear delays of > 1 hour (LRI)	0.9%	EMAS 0%	0.5%			⇧
	Delayed Transfers of care attributable to the NHS per 100,000 population	7.5	Below 15/16 Leics	10.2			⇩
	Population use of hospital beds following emergency admission		Below 15/16 CCG position				

BETTER CARE (continued)							
		Previous Data	Target	WL CCG	DoT	ELR CCG	DoT
Primary Medical Care	Management of long term conditions (Unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 popn)	WL - 767 ELR - 807	Below 15/16 CCG position	12 mth rolling 719	⇧	12 mth rolling 754	⇧
	Patient experience of GP services	WL - 85% ELR - 84%	Equal to or above Jan 16 CCG position	85% (July 16)	⇔	84% (July 16)	⇔
	Primary care access		New data collection - target yet unknown				
	Primary care workforce Number of GPs and Practice Nurses (full-time equivalent) per 1,000 weighted patients by CCG		No national target, but both CCGs in top 50% nationally	1.03		1.19	
Elective Access	Patients waiting 18 weeks or less from referral to hospital treatment - RTT - Incompletes (CCG)	WL - 95% ELR - 94%	92%	93%	⇩	93%	⇩
	No. of 52 Week Waiters	227	0	54 Orthodontics and 3 ENT patients at UHL all CCGs (Aug)			⇧
	Diagnostic Test Waiting Time < 6 weeks (CCG)	WL - 95.4% ELR - 94.5%	99%	99.4%	⇧	99.3%	⇧
	Cancelled Operations - % of patients re-admitted within 28 days of cancelled op (UHL)	96.2% 49 pts	100%	84.2% (All patients at UHL)			⇩
Dental	Patient experience of NHS dental services	WL - 86% ELR - 87%	Above Jan 16 position	89%	⇧	83%	⇩

UHL QUALITY DASHBOARD - All Patients					
Description	**Baseline Period**	**Baseline**	**Target 20116/17**	**Latest Period**	**YTD**
No patient has to tolerate an urgent operation being cancelled for the second time - UHL only	15/16	Zero Tolerance	Zero tolerance	YTD Aug 16	0
Mixed Sex Accommodation (MSA) Breaches	15/16	6	Zero Tolerance	YTD Aug 16	4 in June 1 in July 2 in Aug - patient transferred from an inpatient ward for treatment in the Day case Unit. Patient in Intensive Care Unit who steped down from level3/2
Serious Incidents - UHL all patients	15/16	UHL 49	less than or equal to 49 by end of 16/17	YTD Aug 16	17
Health acquired infection (HCAI) measure (MRSA)	15/16	1	Zero Tolerance	YTD Aug 16	1 in July 16
Health acquired infection (HCAI) measure (CDIFF)	15/16	60	61	YTD Aug 16	23 (FOT 55)
Number of category 2 pressure ulcers	15/16	89	<=7 per month	Aug-16	13
Number of category 3 pressure ulcers	15/16	33	<=4 per month	Aug-16	2
Number of category 4 pressure ulcers	15/16	1	0	Aug-16	0
Safety Thermometer - Harm Free	Mar-16	94.4%	Red = <92%	Aug-16	95.6%
Safety Thermometer - New Pressure Ulcers	Mar-16	22	RAG based on previous month	Aug-16	11
All falls reported per 1000 bed stays for patients >65years	15/16	5.4	<5.5	Aug-16	5.8
Safety Thermometer - Catheters & New UTIs	Mar-16	1	RAG based on previous month	Aug-16	1
New Venous Thromboembolism (VTE)	Mar-16	8	RAG based on previous month	Aug-16	6
Never Events	15/16	2	0	YTD Aug 16	1 in July - patient intravenously receives a strong potassium solution rather than an intended different medication

Appendix 3

LEICESTERSHIRE MENTAL HEALTH DASHBOARD
West Leicestershire CCG and East Leicestershire & Rutland CCG Performance

Mental Health

CCG Improvement & Assessment Framework 16/17 Indicator	Indicator Description	West Leicestershire CCG: Latest Baseline Position	Outturn/ Standard	Standard/ Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	YTD	East Leicestershire & Rutland CCG: Latest Baseline Position	Outturn/ Standard	Standard/ Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	YTD
Mental Health	IAPT Roll Out - Proportion of people that enter treatment against the level of need in the general population (CCG)	15/16	14.6%	15% (3.75% per quarter)	14.3%	13.5%	Lack of national data - data due Nov 16			13.9%	15/16	14%	15% (3.75% per quarter)	13.1%	13.1%	Lack of national data - data due Nov 16			13%
	IAPT Recovery Rate (CCG)	15/16	51%	50%	57%	52%				55%	15/16	55%	50%	57%	54%				56%
	75% of people with relevant conditions to access talking therapies in 6 weeks	15/16	45%	75%	65%	65%				65%	15/16	52%	75%	74%	75%				74%
	95% of people with relevant conditions to access talking therapies in 18 weeks	15/16	95%	95%	99%					99%	15/16	97%	95%	99%					99%
	50% of people experiencing first episode of psychosis to access treatment within two weeks	15/16	50% (3/6)	50%	No patients	67%	75%	100%		80%	15/16	100% (4/4) Feb 16	50%	100%	100%	0%	100%		88%
	Children & young people's mental health services transformation	Baseline data is available relating to 5 questions Progress being reported by MH contracting team to PPAG									Baseline data is available relating to 5 questions Progress being reported by MH contracting team to PPAG								
	Crisis care & liaison mental health services transformation																		
	Out of area placements for acute mental health inpatient care - transformation																		
	Mental Health - Care Programme Approach (CPA) - % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	15/16	96%	95%	96%	100%	97%	100%		98%	15/16	96.1%	95%	100%	100%	100%	100%		100%

Learning Disability

Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard/ Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	YTD
Reliance on specialist inpatient care for people with a learning disability and/or autism (per 1m pop) **LLR total**				45.68			43.34		
			2016/17	52.71			Q2 due Dec 16		
Proportion of people with a learning disability on the GP register receiving an annual health check	14/15	57%	Above 14/15 levels						

Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard/ Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	YTD
				45.68			43.34		
			2016/17	52.71			Q2 due Dec 16		
	14/15	57%	Above 14/15 levels						

Dementia

Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard/ Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	YTD
Estimated diagnosis rates for people with dementia	15/16	66.4%	66.7%	64.2%	63.7%	63.6%	63.6%	64.0%	
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	14/15	77.9%	Above 14/15 levels	15/16 due November 16					

Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard/ Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	YTD
	15/16	61.9%	66.7%	60.5%	60.3%	61.6%	61.9%	62.6%	
	14/15	73.7%	Above 14/15 levels	Data due November 2016					

Self Harm, Suicide & Anxiety

Public Health Outcomes Framework	Latest Baseline Position	Outturn/ Standard	Standard/ Target	
Emergency Hospital Admissions for Intentional Self-Harm, all ages per 100,000 popn	13/14	Leics 111.3 England 204	Below 13/14 levels	14/15 Leics 126.4 England 191.4
Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 pop	2011-13	Leics 9.8 England 9.8	Below 11-13 levels	2012-14 Leics 9.6 England 10
People with a high anxiety score from Annual Population Survey. % of respondents scoring 6-10 to the question "Overall, how anxious did you feel yesterday?" where 0 is "not at all satisfied/happy/anxious/worthwhile" and 10 is "completely	13/14	Leics 21.5 England 20	Below 13/14 levels	14/15 Leics 18.1 England 19.4
Estimates of Anxiety from the Annual Population Survey (APS) Personal Well-being dataset	April 2011 to March 2014	Very low 34%	Higher than baseline	April 2012 to March 2015: 39%
		Low 21%		21%
		Medium 22%	Lower than baseline	20%
		High 23%		20%

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Appendix 4

PUBLIC HEALTH AND PREVENTION INDICATORS: LEICESTERSHIRE

R - worse than target A - similar to G – better than L - lower than comparator S - similar to H - higher than

↑ - improving/increasing trend ↓ - deteriorating/decreasing trend → - no change in trend ◯ - n/a

* = Value for Leicestershire and Rutland combined. n/a = Value cannot be calculated as number of cases is too small

	Indicator	Period	Target	Value	DOT	RAG	Trend
Overarching indicators	0.1ii - Life expectancy at birth (Female)	2012 - 14	84.6	84	→	A	High
	0.1ii - Life expectancy at birth (Male)	2012 - 14	80.3	80.5	→	G	High
	0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female)	2012 - 14	4.8	5	→	L	None
	0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)	2012 - 14	6.5	6.2	→	H	None
Wider Health protection	1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2014 - Feb 2015	17.9	21.4	↑	G	High
	3.02 - Chlamydia detection rate (15-24 year olds) (Persons)	2015	1680	1888.9	→	G	High
	3.04 - HIV late diagnosis	2012 - 14	50	43.2	↑	G	Low
Healthcare and premature mortality	4.01 - Infant mortality	2012 - 14	4	4	→	A	Low
	4.02 - Proportion of five year old children free from dental decay	2014/15	92.8	71.6	◯	R	High
	4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2012 - 14	65.5	64	↑	G	Low
	4.05i - Under 75 mortality rate from cancer (Persons)	2012 - 14	133.1	128.4	↑	G	Low
	4.06i - Under 75 mortality rate from liver disease (Persons)	2012 - 14	17.8	13.5	↑	G	Low
	4.07i - Under 75 mortality rate from respiratory disease (Persons)	2012 - 14	23.6	23.3	↑	G	Low
	4.09i - Excess under 75 mortality rate in adults with serious mental illness	2013/14	351.8	437.1	↓	L	None
	4.10 - Suicide rate (Persons)	2012 - 14	8.9	9.6	→	R	Low

	Indicator	Period	Target	Value	DOT	RAG	Trend
Health improvement	2.02i - Breastfeeding - breastfeeding initiation	2014/15	74.3	74.4	→	G	High
	2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth	2014/15	43.8	47.2	↑	G	High
	2.03 - Smoking status at time of delivery	2014/15	10.8	10.3*	↑	G	Low
	2.04 - Under 18 conceptions	2014	24.2	18.5	↑	G	Low
	2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2014/15	19.9	20.3	→	A	Low
	2.06ii - Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2014/15	31.3	30	→	G	Low
	2.12 - Excess weight in Adults	2012 - 14	64.6	64.7	◯	A	Low
	2.13i - Percentage of physically active and inactive adults - active adults	2015	57	59.5	→	G	High
	2.13ii - Percentage of physically active and inactive adults - inactive adults	2015	28.7	26	→	G	Low
	2.14 - Smoking Prevalence in adults - current smokers (APS)	2015	16.3	17.4	→	R	Low
	2.15i - Successful completion of drug treatment - opiate users	2014	15	9.3*	→	R	High
	2.15ii - Successful completion of drug treatment - non-opiate users	2014	48	40.2*	↑	R	High
	2.18 - Admission episodes for alcohol-related conditions - narrow definition (Persons)	2014/15	548	595.9	→	R	Low
	2.20i - Cancer screening coverage - breast cancer	2015	75.4	83.5	→	G	High
	2.20ii - Cancer screening coverage - cervical cancer	2015	73.5	77.9	→	G	High
	2.22iv - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14 - 15/16	61	42.2	◯	R	High
	2.23ii - Self-reported wellbeing - people with a low worthwhile score	2014/15	3.8	n/a	→	R	

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