Appendix 3

Melton Borough Community Health and Wellbeing Plan 2023 – 2028



V.15 Final August 2023

Contents

Foreword

Our Community Health and Wellbeing Plan for the Melton Borough brings together a wide range of partners with the common purpose of improving the health and wellbeing of the local population. Forming partnerships between health and care organisations on a local footprint is key to planning and delivering joined up services to improve the lives of people who live and work in the area.

By working together in collaboration, we have agreed a set of priorities that all partners across Melton Borough recognise and support. We remain committed to making a real change by focusing on these key priorities and tackling health inequalities which are present within our population. This plan recognises and acknowledges the importance of creating engaged and cohesive communities by building trust and gaining a deeper understanding of their needs to make a difference. Tackling the wider determinants of health to address the root causes of health and wellbeing is at the heart of everything we do.

We are united as partners, and we are proud to support our organisations in this journey as we move forward over the next 5 years.

Andy Williams

Chief Executive
Leicester, Leicestershire and
Rutland Integrated Care Board

Edd de Coverly

Chief Executive
Melton Borough Council

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We would like to express our thanks and appreciation to our Leicestershire County Council Public Health colleagues for their valuable input and support into the development of the Melton Borough Community Health and Wellbeing Plan.

Introduction

1.1 Executive Summary

In January 2021, the Department for Health and Social Care (DHSC) published proposals through the White Paper: 'Integration and Innovation: Working together to improve health and social care for all', to develop the NHS long term plan and bring forward measures for statutory Integrated Care Systems (ICS). The ICS for Leicester, Leicestershire and Rutland (LLR) was established in July 2022.

Partnership working has been established across the system (LLR collectively), place (Leicester, Leicestershire, and Rutland separately) and neighbourhood (at locality level). The NHS long term plan highlights the importance of joint working. The White Paper outlines a duty for the NHS and Local Authorities to collaborate with the introduction of Health and Care Partnerships to support integration to address health, public health and social care needs, with a key responsibility being to support place based joint work.

As part of the ICS's requirement for the development of a Place Based Plan, a Joint Health and Wellbeing Strategy has been created, which sets out the strategic vision and priorities for health and wellbeing across the County of Leicestershire over the next ten years. This strategy will help to shape our response across Leicestershire and ensures we are tackling many of the common factors across the County that contribute to poor health and wellbeing outcomes.

However, we also acknowledge that some needs are better identified and tackled at a neighbourhood level. Our district council, voluntary sector and primary care networks, along with many other local services, operate at more localised levels to improve health and wellbeing outcomes. Therefore, Community Health and Wellbeing Plans are also being developed, they identify local needs and actions that, alongside the County and system wide work, will help to improve people's overall health and wellbeing. The Community Health and Wellbeing Plans are a collaborative summary of the health and wellbeing needs experienced by the population living in our seven neighbourhoods across Leicestershire and the collective efforts we intend to make to ensure everyone gets the best chance at a healthy, independent life. Many people and agencies have contributed to these plans, and we are grateful to them all for their valuable input and collaboration.

This range of strategies and plans form our strategic response to our population's health and care needs across the Leicester, Leicestershire and Rutland area. This is a vital part of our joint planning and thereafter for delivery to achieve local integration, prevention and improvement.

Whilst our Plan spans the priorities for the next five years, we have looked at the housing growth projections for the neighbourhoods for a longer period to ensure we are considering the longer-term needs for future populations. We know that our GP practices will be challenged by the increasing numbers of people moving to many of the areas. This includes the increasing number of people dispersed across the UK through displacement and resettlement schemes. We must ensure that the Primary Care offer grows alongside housing

to support residents to access provisions when needed. At the same time, we need to reduce the reliance on Primary Care and the need for clinical intervention when not required. To achieve this, we will need to work closely in partnership around developments of Access to Primary Care services, the recovering of Primary Care and ensuring a sustainable Primary Care workforce is planned for now. In addition, we can do this by also supporting people to make healthy lifestyle choices and ensuring access to sports and leisure services, support and social groups, and an integrated approach to prevention and intervention.

1.2 Purpose of this Document

The purpose of the Community Health and Wellbeing Plan is:

- To understand the local needs concerning health and wellbeing and the variance to England, other areas of the County or across the footprint covered by the Plan.
- To ensure we have plans to drive improvement to the health and wellbeing of local populations and to manage any risks to this arising.
- To both inform the Joint Health and Wellbeing Strategy (through identification of local needs) and respond to Joint Health and Wellbeing Strategy priorities at a neighbourhood level.

To do this, we have gathered information to help us understand local need, inequity and outcomes, looked at local healthcare services to understand the patterns of access to community hospitals, outpatient, elective and day case treatment, and considered housing growth planned for the local area, ensuring there are plans in place to support.

Where possible, our priorities and actions will fit with our principles of:

- Understanding local need
- Embedding prevention in all that we do
- Enabling independence and self-care
- Bringing care closer to home
- Supporting Covid-19 pandemic recovery

Key enablers to help us achieve this are:

- Working together where we can add value or reduce duplication through a joint approach
- Clear and coordinated planning and delivery
- Effective communication and engagement
- Utilising local partnerships

The Plan is directly linked to longer term major NHS strategic priorities for Leicester, Leicestershire, and Rutland (LLR). It depends on other complex organisational and national programmes requiring closer working with local and national partners at all levels to ensure we successfully deliver this Plan for the people of Melton. To support this, we have developed

the Melton Helping People Partnership into a more Community Health and Wellbeing centred Partnership to oversee the delivery of action in the plan.

1.3 What are the drivers for making change?

National Context

The 2019 NHS Long Term[1] plan covers a ten-year period and was developed at the request of the Government. The Long-Term Plan includes seven priorities which look at different things the NHS wants to make better and is based on what the public and staff think the NHS needs. The vision is that local area partners work closely together to develop local improvement plans that help us to spend NHS money to help local people.

The seven national priorities of the Long-Term Plan that the local NHS and Council partners are working closely on are:

1. Ensuring the NHS works in the best way possible so that people can get help more efficiently and they can get care close to where they live when they need it
2. Getting better at helping people to stay well
3. Making care better
4. Supporting our staff better and looking at the things which make their jobs hard
5. Putting more money into new technology and online services and systems
6. Using extra money to make sure the NHS works well in the future
7. New ways that the NHS and Local Councils work more closely together through an approach called an **Integrated Care System (ICS).** The Leicester, Leicestershire, and Rutland Partnership is an ICS.

Primary Care Networks (PCNs) formed in July 2019, building on core primary care services to enable greater proactive, personalised, coordinated and more integrated health and social care for local communities. Significant national investment is planned into Primary Care Directed Enhanced Services (DES) between now and 2024. The DES includes funding for more health professionals. It will enable the development of more integrated community teams that provide tailored care for local patients. This new model of care will also allow GPs to focus more on people with complex health needs.

Health and Social Care integration: joining up care for people, places, and populations (2022)[2] is a policy white paper that sets out key measures that enable local areas to make Integrated Health and Social Care a reality for everyone regardless of the location they live and what condition they may have. This policy involves planning to join up care for our patients and service users, helping staff to support the increasing numbers of people with care needs and organisations delivering these services to the local populations.

Fit for the Future: The Role of District Councils in Improving Health and Wellbeing[3]. District council services impact many aspects of local communities, underlining the key role in

[1] NHS Long Term Plan » The NHS Long Term Plan
[2] Health and social care integration: joining up care for people, places and populations - GOV.UK (www.gov.uk)
[3] FIT-for-the-Future-The-District-Role-in-Health-wellbeing.pdf (districtcouncils.info)

determining public health. This district councils' network document highlights the importance of districts in the health and wellbeing and early intervention for the populations they serve. It emphasises the importance of integration with healthcare and wider Partners.

The Fuller Report[4] was commissioned in November 2021 to provide specific and practical advice to all ICSs, as they assumed new statutory form, on how they could accelerate implementation of integrated primary care (incorporating the current four pillars of general practice, community pharmacy, dentistry and optometry), out of hospital care and prevention ambitions in the NHS Long Term Plan in their own geographies. It sets out a vision for the future of primary care which focuses on four main areas: neighbourhood teams aligned to local communities; streamlined and flexible access for people who require same-day urgent access; proactive, personalised care with support from a multi-disciplinary team in neighbourhoods for people with more complex needs, and a more ambitious and joined-up approach to prevention at all levels.

Local Context

The Leicestershire Joint Health and Wellbeing Strategy (JHWS) 2022-2032[5] has an overall vision of "Giving everyone in Leicestershire the opportunity to thrive and live happy, healthy lives". A life course approach has been used to identify high level strategic, multi-organisational priorities for the next ten years and provide clear accountability to the Leicestershire Health and Wellbeing Board (HWB).

Figure 1: The JHWS road map

The HWB have approved a 'do, sponsor, and watch' approach to allow the board to proactively set the agenda around key integration and partnership priority areas whilst allowing partners to continue to deliver and drive change through their subgroups and

[4] Microsoft Word - FINAL 003 250522 - Fuller report[46].docx (england.nhs.uk)
[5] Joint Health & Wellbeing Strategy | LSR Online (lsr-online.org)

organisations without blockages across the system. The approach is summarised in the full Leicestershire JHWS.

The Public Health Strategy 2022-2027[6]. Leicestershire's Public Health team is integral to the County Council's efforts to improve the health and wellbeing of our residents and the broader County Council's prevention 'offer'. The service mission and aim is, "To protect and improve the health and quality of life of everyone in Leicestershire. We will achieve this through our commitment to the Council's core values and behaviours which set out the vision for the Council's work". This strategy isn't intended to duplicate key strategies such as Leicestershire County Council's Strategic Plan or the JHWS. Public Health has responsibilities for commissioning services such as sexual health, substance misuse treatment services, school nursing, health visitors and NHS health checks. Partnership working and leadership is as important as the services provided. A range of organisations need to work together to make a joint contribution to good health, e.g., reducing health inequalities, improving air quality and providing safer communities.

The Melton Local plan (2011-36)[7] is the adopted Local Plan for the Melton Borough. It provides the framework for addressing housing needs across the district. This includes consideration of wider economic, social, environmental, and other local high priorities including Healthcare. The Melton Local Plan plans to deliver 6,125 new homes over a 25-year period and has identified allocations to deliver at least that many new homes alongside the infrastructure required to support them.

LLR Health Inequalities Framework (May 2021) outlines how LLR organisations will work and take collective action in places to improve healthy life expectancy across LLR by tackling not just the direct causes of health inequalities, but also the wider determinants of health. This framework is locally implemented across each place through an evidence-based and Partnership approach to inform local action. This approach is called Population Health Management (PHM).

Building Better Hospitals (2019)[8] is a significant programme of work led by the University Hospitals Leicester (UHL) and will mean fundamental changes in hospital provision across Leicester. There are many reasons why these changes at Leicester's hospitals are needed. Some of these reflect population health trends, while some relate more to the running of the hospitals themselves.

Driving Better Health Outcomes through Integrated Care Systems (2023) is an evidence led report that explores the importance of collaboration within the ICS to improve health outcomes. It reflects on the role and statutory powers of district councils in service areas including planning, housing, benefits, and leisure and green spaces, which affect many of the most significant determinants of health. It identifies five key principles the underpin successful involvement of district councils within the ICS. The development of Community Health and Wellbeing Plans represents a good practice approach in this context:

[6] https://www.leicestershire.gov.uk/sites/default/files/field/pdf/2022/7/28/public-health-strategy-2022-27.pdf
[7] Melton Local Plan
[8] Building Better Hospitals for the Future in Leicester (betterhospitalsleicester.nhs.uk)

- creating effective local partnership structures that can drive collective action on the wider determinants of health
- aligning agendas across levels within the ICS so there is a 'golden thread' connecting work at system level and more local partnership work
- embedding district council leadership throughout the system
- investing in relationships between partners
- building shared purpose and collective

The Council's current Corporate Strategy will come to an end in March 2024 and the process to develop a new Corporate Strategy to consider what it should focus on over the next four years has begun. This will be reflective of the borough and will be done in consultation with key stakeholders including those involved in the development of the Community Health and Wellbeing Plan.

Other supporting local strategies and key documents. There are a range of complementary supporting strategies that align to this Plan:

Melton Borough Council's Corporate Strategy 2020-2024 has the following priority areas and will have a key role in supporting healthy communities:

- Excellent services positively impacting on our communities.
- Providing high quality council homes and landlord services.
- Delivering sustainable and inclusive growth in Melton.
- Protect our climate and enhance our natural environment .
- Ensuring the right conditions to support delivery (inward)
- Connected and led by our community (outward)

The Council's current Corporate Strategy will come to an end in March 2024 and the process to develop a new Corporate Strategy to consider what it should focus on over the next four years has begun. This will be reflective of the borough and will be done in consultation with key stakeholders including those involved in the development of the Community Health and Wellbeing Plan.

Other supporting Place based strategies – there are a range of complementary supporting strategies at Leicestershire County level that align to this Plan. For example:

- Melton Borough Council Physical Activity & Sport Strategy
- Active Together Physical Activity Framework 2022 - 2031
- Healthy Weight
- Substance misuse
- Healthy Workplace
- Carers
- Mental Health
- Smoking cessation

Leicester, Leicestershire and Rutland 'One' Primary Care Strategy

Healthcare services across our places and district footprints are becoming more and more complex to deliver for our populations as the continuing challenge to navigate the changing primary care landscape, increased demand for local services, in an environment that is stretched and under pressure. There will always be new challenges for Health and Care services across the system, set against a backdrop of varying need, significant increase in cost of living, widening health inequalities gap and the pressing need to improve health outcomes.

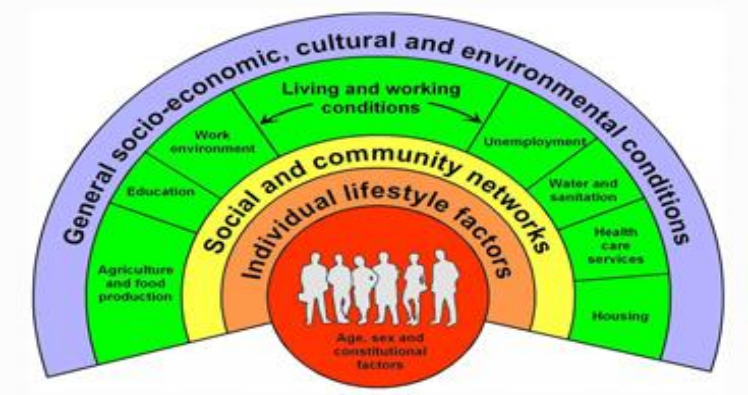
Our LLR Primary Care Strategy acknowledges that it will take time to remedy challenges we face and that the these are best tackled on a collective and integrated basis to provide the best chance of improvement in a sustainable way. Our Place based and Community Health and Wellbeing partnerships are proving to be great catalysts for this way of working and is aimed at enabling focused local improvement planning and delivery at pace, through innovative ways that work for the local population and workforce.

Strategic Vision and Approach

2.1 Strategic Vision & Goal

We want everyone in Melton to live happy, healthy, long lives without illness or disease for as long as possible. However, to achieve this, we must consider the social model of health (as defined by Dahlgren and Whitehead (1991)[9]) which highlights the significant impact of the wider determinants of health (including social, economic and environmental factors) on people's mental and physical health. It also identifies all but age, sex and hereditary factors are modifiable to change and therefore lying within the scope of this plan, particularly in relation to primary prevention.

Figure 2: The Dahlgren-Whitehead Health Inequalities Rainbow



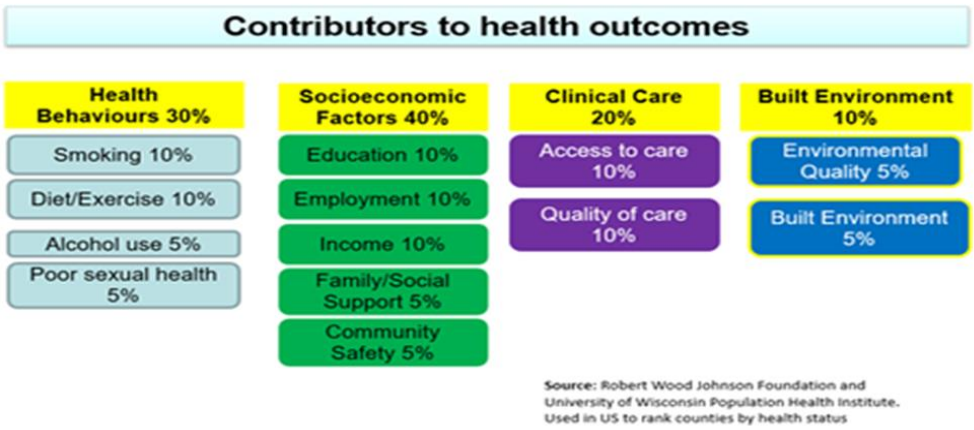
2.2 Our Strategic Approach

Evidence shows us that clinical care only contributes towards 20% of health outcomes, therefore improving the wider determinants of health (the "causes of the causes") will have

[9] European strategies for tackling social inequities in health – levelling up part 2 (WHO report, PDF), 1991, Dahlgren and Whitehead, https://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf

a much more significant effect on improving health outcomes and reducing inequities in health compared to NHS interventions alone. However, modifying these risk factors will take time to evolve and improve.

Figure 3: Contributors to health outcomes



Our strategic approach for the next three years has eleven priority areas for action which are described in section 5 of this report. These priorities are not standalone; they are mutually supported and may have interrelated actions where relevant to ensure the greatest overall impact on health and wellbeing outcomes.

2.3 Enablers – Shared Priorities, Governance, and Integrated Neighbourhood Delivery

Shared priorities, shared ownership and integrated working are all critical to achieving the desired outcomes for the people of Melton. By working together as a local partnership, we can achieve much more and have a significant impact on the lives and outcomes of the people that we serve. This Plan has therefore been developed collaboratively by the Melton Community Health and Wellbeing Partnership, and includes partners from the Public Sector, Health Service, Education and Voluntary Sector who all share collective accountability for the delivery of partnership priorities.

To develop the Plan for Melton, we have used a variety of information sources to create a robust needs assessment. Examples of sources of information used include:

- Evidence obtained from engagement with the local population.
- National data sets on health and care outcomes, including the Public Health Outcomes Framework, the Social Care Outcomes Framework and NHS metrics, including overall levels of healthy life expectancy, but also the prevalence of specific diseases and uptake of screening programmes and immunisations.
- Local and national performance and uptake data on health and care services.
- Geographical mapping of Health and Care Strategic Assets to understand the pockets of deprivation and provide a deeper population profile of people in receipt of local health and care services.

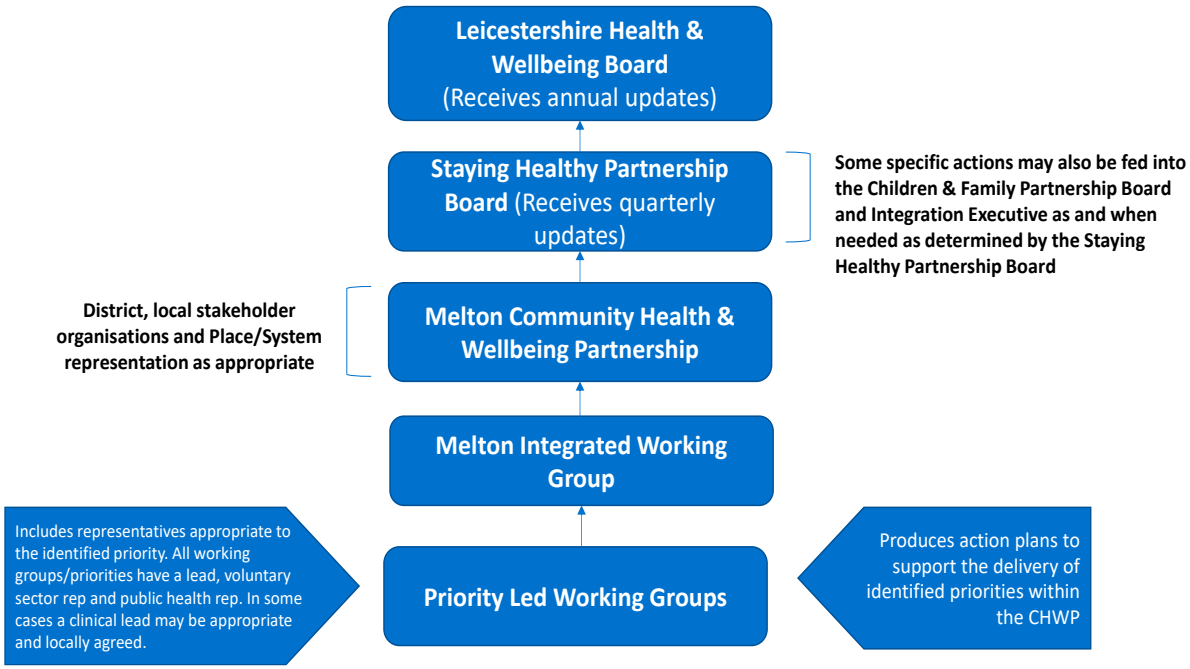
These insights into Melton's current health and wellbeing were shared and discussed at the Melton Integrated Working Group to understand emerging themes. Workshops took place in

June 2022 to ensure that as many stakeholders as possible fed into the Plan and to add to, develop and challenge the list of emerging themes. The workshops resulted in the identification of 23 priorities. A prioritisation exercise was undertaken with a wide range of stakeholders to determine which priorities would be focused on first within each life stage and form the basis of the one-year action plan supporting the CHWP document. The Melton Community Health and Wellbeing Plan (2023-2028) outlines 23 priorities but provides a spotlight on 11 key areas to ensure effective and efficient multiagency delivery and accountability for progress.

The Melton Community Health and Wellbeing Partnership does not have any formal strategic decision-making authority. However, it will make recommendations to their respective organisations, the Staying Healthy Partnership Board (SHP) for Leicestershire County and the Health and Wellbeing Board (HWB) for Leicestershire County, to inform decision making. The HPP will receive progress reports against the delivery plan at every meeting.

Figure 4 below shows the emerging governance at the time of writing, which will enable progression of local actions in a more integrated way.

Figure 4: Governance and Reporting



2.4 Plan Implementation and Monitoring

This document sets out the health and wellbeing priorities and principles to be progressed in Melton over the coming five years to 2028. Whilst we have been careful to select priorities for the Plan that reflect the future need and the present, the activities to achieve these may inevitably change over time. For this reason, our Partnership action planning will be reviewed

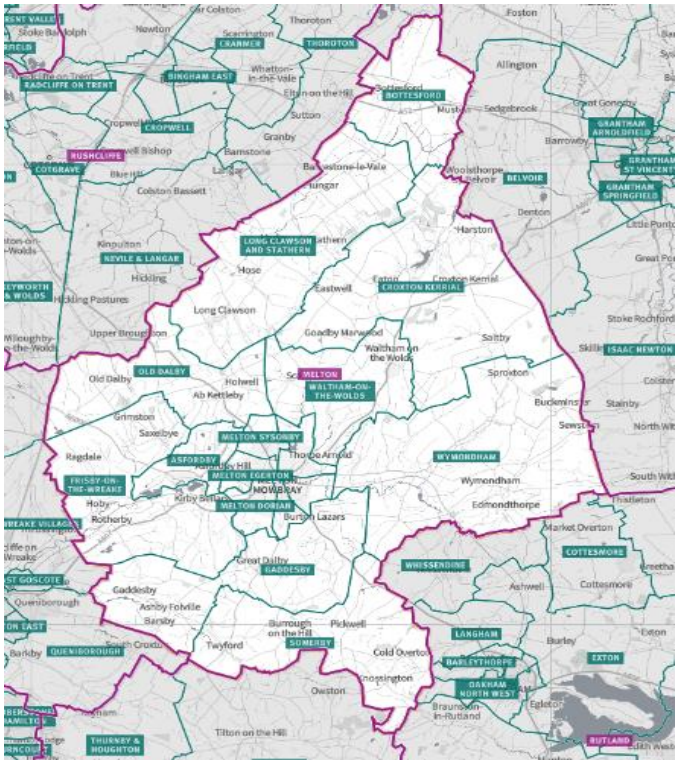
annually to ensure these priorities are still the right ones and enable us to make a noticeable difference for the population. We will develop a robust reporting and monitoring approach to support this.

3. Melton District Insights

3.1 Geography

Melton is a rural borough located in North Leicestershire. Melton Mowbray is one of the oldest market towns in the country with a reputation as the 'Rural Capital of Food'. The main activities of the borough are centred around farming, food, and manufacturing. Melton has an international reputation for high quality food products – notably Stilton cheese and Melton Mowbray Pork Pies – and is a Protected Designation of Origin (PDO) for these. Around half of the total 51,800 (Census 2021). population of the borough live in the town, Melton Mowbray which is surrounded by 70 small villages. Asfordby, Long Clawson, Waltham on the Wolds and Bottesford in the Vale of Belvoir are the largest of these villages. Tourism is a key economic sector for Melton and the town centre, with it being centrally located in the country and with good connections to the nearby County of Rutland and the town of Loughborough and cities of Leicester, Lincoln and Nottingham.

Figure 5: Melton District (SHAPE Atlas 2023)



3.2 Population Changes and Growth

The population of Melton is 51,800 (2021 Census) with 94% of people born in the UK. This is made up of 68% single family households which is higher than the England average and 28% of single person households which is lower than the England picture.

Over the last 10 Census Years (2011 – 2021), the district of Melton has seen a 30% increase in people aged 65 and over, with the biggest rise being in 70–74-year-olds. The over 65 population is projected to grow by 45% by 2040 which represents a significant growth in this cohort. Over the last 10 Census Years the district of Melton has seen a 4% decrease in people aged 15-64 and a decrease in children aged under 15 years old.

When compared to other areas across England, Melton has a higher % of people aged between 50 – 75 than national averages and a lower % of people aged between 20 – 40 than national averages. The overall median resident age is 47 years old.

Overall, Melton has a lower than England average population of 0–49-year-olds but has a higher than England average population over the age of 50 across all subsequent age bands. The priorities within this strategy take into consideration the historic and future projected population changes to ensure that action is focussed on greatest need in the local area.

In terms of future population growth in Melton, the number of persons aged 65 and over will increase by 13% during the period covered by this Plan, (2023 to 2028). Future projections for working age adults and children (0-19) are set to decline year on year between now and 2028. For working age adults, a 3% decrease is anticipated between now and 2028 and for children aged 0-19 a decrease of 2 % is expected. However, within the child age group, an increase of 9% the 15-19 age band is predicted.

3.3 Local Housing Need

The Melton Local plan (2011-36)[10] is the adopted local plan for the Borough and provides the framework for addressing housing needs across the district. This includes consideration of wider economic, social, environmental, and other local high priorities including Healthcare. The Melton Local Plan plans to deliver 6,125 new homes over a 25-year period.

A significant proportion of the 6,125 new homes are planned for development within the catchment area of Latham House, which is in the town of Melton Mowbray itself. Latham House is the largest general practice in Leicestershire with over 35,000 registered patients.

Key alignment of the following specific Melton local plans strategic objectives will be a key priority for the Melton Community Health and Well Partnership for the duration of this plan:

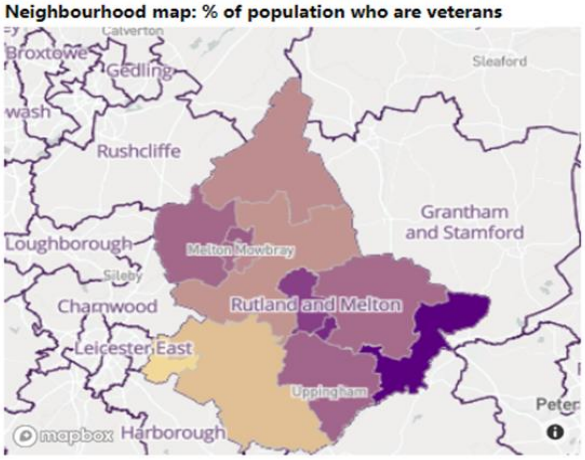
- Improve access to services and facilities including health
- Improve facilities for all the community
- Improve the health of the Borough and reduce health inequalities within the community

[10] Melton Local Plan

3.4 Veterans Population

The total number in reported in LLR that they had previously served in the UK armed forces is 29,923 making up 3.3% of the LLR Population. This population is at increased risk of health inequalities due to the unique nature of occupation.

Neighbourhood map: % of population who are veterans



Neighbourhoods: % of population who are veterans

Neighbourhood	% of population aged 16+
Ketton, Ryhall & Luffenham	8.5%
Oakham East	7.5%
Oakham West, Langham & Whissendine	7.0%
Melton Mowbray North	6.3%
Uppingham, Lyddington & Braunston	6.1%
Asfordby, Frisby & Old Dalby	6.1%
Market Overton, Cottesmore & Empingham	6.0%
Melton Mowbray West	6.0%
Melton Mowbray South	5.3%
Bottesford, Harby & Croxton Kerrial	5.2%
Waltham, Wymondham & Great Dalby	5.0%
Tilton, Billesdon & Great Easton	4.1%
Houghton, Thurnby & Scraptoft	3.5%

Rutland and Melton are reported to have the highest number of people that had previously served in the UK armed forces of 5,274, making up 5.9% of their population. 4,096 households in Rutland and Melton had at least one veteran. This represents 10.8% of the households in the constituency, compared to 7.9% in the East Midlands and 7.0% in England and Wales. Rutland and Melton, Bosworth, North West Leicestershire, South Leicestershire and Harborough are the top 5 constituencies reported to have the highest number of people that had previously served in the UK armed forces of 19, 172, making up 64.1% of the total number in LLR. Melton Mowbray North is 4th highest County ward across Rutland and Melton for population of Veterans with 6.3% of overall population self-reporting this during Census 2021.

3.5 Local Services

3.5.1 Primary Care

Melton has 5 GP surgeries forming the Melton, Syston and Vale PCN (Latham House Medical Practice, Long Clawson Medical Practice, The Welby Practice and Stackyard Surgery). Latham House is one of the largest GP practices in England. Combined these practices serve over 72,000 registered patients, some of which live over the nearby borders of Syston and Rushcliffe. From October 2022, practices provide an enhanced access service covering the hours of 6.30am to 8pm Monday to Friday and 9am to 5pm on Saturdays.

Prevention Services are also delivered locally across the area between Leicestershire County Council, Melton Borough Council, Melton, Syston and Vale PCNs and local service providers.

The Additional Roles Reimbursement Scheme (ARRS) provides funding for additional roles to create bespoke localised multi-disciplinary teams, (e.g., social prescribers, clinical pharmacists, mental health practitioners, physician's associates, nurse associates, first

contact physiotherapists). Practices are also trying to maximise the use of these roles to free up GP capacity.

As part of our work in developing care closer to home, there are active example of System level action already being taken, for example there are emerging plans for some key diagnostics being delivered more locally in the community via PCNs. This will enable an improvement in access to care closer to home from within local communities rather than having to travel to a hospital setting for diagnostics for Cardiorespiratory Diseases for example Spirometry, Feno, Electrocardiogram (ECG) and Blood Pressure Monitoring.

Below is an indication of the Melton Primary Care Workforce data inclusive of ARRS Staff to provide a context for the local picture in Melton:

MELTON, SYSTON AND VALE PCN (WTE)	March 2023	April 2023	May 2023
GPs excluding registrars	33.99	33.99	33.99
GP registrars	10.67	11.73	11.09
Nurses	0	0	0
Direct Patient Care roles (ARRS funded)	0	0	0
Other – admin and non-clinical	5.16	5.16	5.16
Total excluding registrars	39.15	39.15	39.15
Additional Roles & Reimbursement Staff Groups (WTE)			
Advanced Occupational Therapist Practitioner	0	0	0
Advanced Paramedic Practitioner	0	0	0
Advanced Pharmacist Practitioner	0	0	0
Advanced Practitioner	0	0	0
Care Coordinator	6.63	7.48	7.48
Clinical Pharmacist	12	9.49	8.6
Dietician	0	0	0
Digital and Transformation Lead	0	0	0
First Contact Physiotherapist	0	0	0
General Practice Assistant	2	2	1
Health and Wellbeing Coach	0	0	0
Mental Health Practitioner Band 6	0	0	0
Mental Health Practitioner Band 7	2	2	1
Mental Health Practitioner Band 8a	0	0	0
Nursing associate	1.84	2.83	2.83
Paramedic	2.99	1.99	1.99
Pharmacy Technician	2.93	2.93	2.93
Physician Associate	1.99	1.99	1.99
Podiatrist	0	0	0
Social Prescribing Link Worker	2	2	3
Trainee nursing associate	0.99	0	0
Total	35.36	32.71	30.81

3.5.2 Secondary Care Healthcare

Melton Mowbray Hospital is a community hospital and provides day-case procedures, diagnostics and outpatient services as well as a number of community and mental health services. The hospital includes one 17 bed in-patient ward providing rehabilitation, sub-acute and palliative care.

Main Hospital	Children's Community House	Maternity Building	PCT Building
Psychology Clinic	Children's Occupational Therapy and Physiotherapy	Musculoskeletal Physio	East Locality 0-19 Healthy Together Service
Community Mental Health Team	SIREN Study	Maternity Services	Looked After Children Service
Learning Disability			
Mental Health Services for Older People (MHSOP) Outpatient Service			
Care Programme Approach Staff			
District Nursing Leg Ulcer Clinic			
Speech and Language Therapy			
Dalgleish Ward – Community Hospital Ward			
Dental			
X Ray			
Minor Injuries			
Endoscopy / Theatre			

University Hospitals of Leicester (UHL) NHS Trust: UHL is one of the biggest and busiest NHS Trusts in the country, serving the residents of Leicester, Leicestershire, and Rutland, and increasingly specialist services over a much wider area. The trust activity is spread across the General, Glenfield and Royal Infirmary hospital sites. It has its own Children's Hospital and works closely with partners at the University of Leicester and De Montfort University, providing world-class teaching to nurture and develop the next generation of doctors, nurses, and other healthcare professionals, many of whom go on to spend their working lives with the trust. UHL is also home to a National Institute for Health Research (NIHR) Biomedical Research Centre, which supports critical research, including lifestyle, diabetes, and cardio-respiratory diseases. UHL also has an Experimental Cancer Medicine Centre. Its HOPE Unit is vital in delivering clinical trials of new cancer treatments. It is supported by the locally based charity Hope Against Cancer. Furthermore, Glenfield Hospital's heart centre continues developing new and innovative surgery techniques.

Nottingham University Hospitals (NUH) NHS Trust: NUH is another of the biggest and busiest acute Trusts in England, providing services to over 2.5 million residents of Nottingham and its surrounding communities. The Trust is made up of Queen's Medical Centre (QMC) (emergency care site), Nottingham City Hospital (cancer centre, heart centre, stroke services) and Ropewalk House (outpatients and hearing services). NUH has a national and international reputation for many specialist services, including stroke, renal, neurosciences, cancer services, and trauma. QMC is home to Nottingham Children's Hospital. NUH is at the forefront of many research programmes and new surgical procedures. Nottingham is the only NHS trust and university partnership in the country to have three successful bids for Biomedical Research Units in hearing, digestive diseases and respiratory medicine. As a teaching trust, it has strong relationships with the University of Nottingham and other universities across the East Midlands, including Loughborough University.

Rutland Memorial Hospital in Oakham includes Inpatient Community Hospital Stepdown Ward: which includes 16 beds, palliative care suite and complex rehabilitation. In addition, there are a range of Outpatient, Diagnostic and other services.

Where do Melton patients historically travel for their Secondary Care?

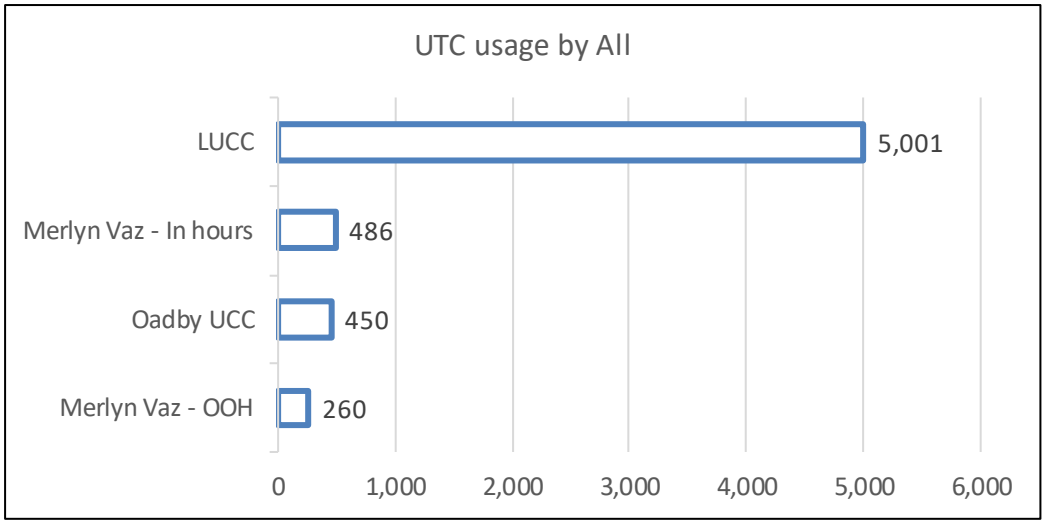
Overall, there has been a range of between 58,000 – 68,000 annual outpatient attendances across all secondary care settings both in and out of area for Melton registered patients. The majority of this, between 70% - 80% annually, of all secondary care outpatients for Melton patients takes place in an LLR setting. The vast majority of this is accessed at one of the three University Hospitals Leicester sites or around 11%-16% of activity has taken place at an LLR Community Hospital site. The vast majority of Melton Borough population can access Melton Community Hospital by Car within around 30 minutes (One way).

The table below shows driving travel times / distances for the other top 10 OP provider settings from the centre of Melton:

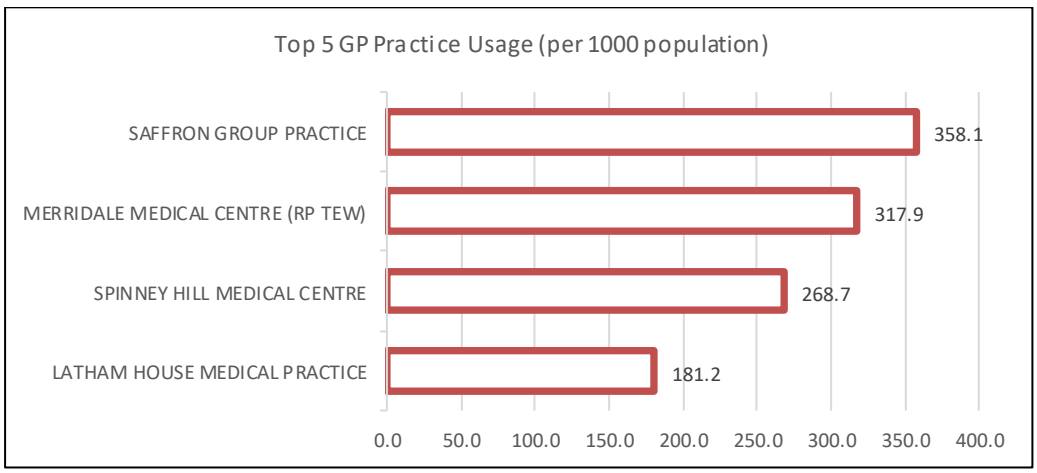
Secondary Care Provider Setting	One way distance/travel time from centre of Melton by Car
Rutland Memorial Hospital	10.6 miles, about 25 minutes
University Hospitals Leicester Glenfield	18.2 miles, about 37 minutes
University Hospitals Leicester General	16.4 miles, about 42 minutes
Loughborough CH	17 miles, about 44 minutes
Market Harborough Community Hospital	22.8 miles, about 48 minutes
University Hospitals Leicester Royal Infirmary	20.7 miles, about 48 minutes
Nottingham University Hospital City Hospital	24.6 miles, about 55 minutes
Coalville Community Hospital	26.3 miles, about 53 minutes
Fielding Palmer Community Hospital	34.5 miles, about 55 minutes
Hinckley & Bosworth Community Hospital	33.3 miles, about 1 hour 2 minutes

3.5.3 Urgent and Emergency Care (UEC)

For the Melton, Syston and Vale PCN, Latham House Medical Practice has the highest amount of activity at an Urgent Treatment Centre (UTC), with The County Practice and The Jubilee Medical Practice following, each having similar amounts of activity levels. The chart below shows that patients from the Melton, Syston and Vale PCN use the Loughborough Urgent Care Centre (UCC) significantly more than Merlyn Vaz and Oadby UCC.



In attendances at UHL Emergency Department (ED), Latham House Medical Practice was in the top 5 LLR GP practice usage (per 1000 population) with a value of 181.2 from May 2022 – May 2023. In comparison to other practices in the PCN, Lathan House Medical Practice had almost twice as much activity as The Jubilee Medical Practice and The County Practice (2nd and 3rd amounts of activity respectively from within Melton).



Furthermore, Latham House Medical Practice has the highest usage of Minor Injuries Unit (MIU) across Leicestershire. Of this, most of the activity took place at Melton Mowbray MIU.

3.5.4 Local Authority & Voluntary Sector Services

Leicestershire County Council and neighbouring organisations provides many critical services to the population of Leicestershire, including Adult Social Care, Public Health, Children's services, Family Hubs, Adults & Communities services (including Adult Learning), Environmental & Transport services.

Melton Borough Council provides and physically hosts many essential local and regional services delivered locally to Melton Residents. This is delivered from one of the most valuable community assets within Melton, the Local Community Support Hub. The Community Support Hub works with a wide network of statutory and VCSE partners, many of whom deliver from within the multi-agency setting at Phoenix House. Provider organisations who deliver services directly from the Hub are shown in the diagram below with those provided by Leicestershire County Council shown by a red border and those provided in conjunction with the NHS shown by a blue border.

Melton Borough Council has redesigned and coordinated many of its people / community focussed services through an Integrated People Offer, bringing together services and partnerships that support residents across the Borough through a focus on:

- **Healthy and Active Communities**: including managing the Council's leisure contract and supporting residents to remain active and well within our communities. Proactive partnership working with a range of partners, and delivery of activities and programmes through external funding.

- **Enabling and Connecting Communities**: including our customer services team and supporting some of our most vulnerable residents through our community support hub, through which mentors directly support residents with a range of needs. Leadership of our corporate responsibilities for safeguarding, equalities and armed forces covenant

- **Supporting Communities**: housing options, housing register, homelessness prevention, homelessness relief and reducing the risk of rough sleeping. Responsibility for the Council's statutory homelessness function and delivery of services in line with the homelessness reduction act. Leadership of our corporate responsibilities around domestic abuse

- **Empowering Communities:** Includes a range of services and functions that empower communities and individuals to live independently and to support community and voluntary sector partners to thrive. Services include community grants, refugee support, lifeline services, engagement with community groups and parish councils, and Melton Community Lottery. Key partnership for this service is the countywide Lightbulb Service (delivering Disabled Facilities Grants and a range of services to keep people safe and independent at home).

- **Safer Communities**: keeping communities safe through effective prevention and management of antisocial behaviour and crime (including envirocrime) and associated programmes, partnerships and initiatives including CCTV and the Safer Melton Partnership.

Furthermore, the Council have recently entered into a Partnership pilot with the Leicestershire Partnership NHS Trust (LPT) to host a Senior Mental Health Neighbourhood Lead to further support and develop the mental health offers and services across Melton district.

Enabling and ensuring decent and safe homes is another key role for Melton Borough Council as a strategic housing authority and as a landlord to tenants across approximately 1800 homes across the Melton Borough. Partnership working across a range of services supports this, and the complexity of housing needs means that no two cases are the same. The evidence is clear that living in familiar, safe, accessible and warm accommodation contributes to physical and mental wellbeing - having somewhere to call home is a fundamental pillar of good physical

and mental health. There are a number of ways in which the council and its partners contribute to this:

As a Landlord

- Through an asset management plan, to meet the decent homes standard across all council homes
- Investing in and improving council homes
- For all council homes to meet health and safety requirements
- Management of anti-social behaviour
- Tenancy management, including provision of support and onward referrals
- Engaging with tenants, listening to their needs and working with them to improve services
- The provision of support to tenants with additional support needs, including those in sheltered and extra care schemes
- Provision of aids and adaptations to support independence

As a Strategic Housing Authority

- Housing advice, assistance and preventing homelessness wherever possible, and supporting people to access suitable accommodation to meet their needs and fulfilling statutory homelessness duties
- Supporting eligible households to access the housing register, in order to help them to access affordable housing solutions relevant to their needs
- Supporting veterans in line with the Armed Forces Covenant
- Proactive support to victims of domestic abuse to remain safely in or to leave their accommodation
- Partnership with a range of organisations and services including the Lightbulb Service to prevent the escalation of needs and support people to live well, including access to the Disabled Facilities Grant to adapt homes
- Advice, assistance and intervention for the private rented sector to ensure homes are safe and free from hazards
- Supporting refugee resettlement into the community
- Preventing rough sleeping and taking swift action where this occurs. Taking additional measures to keep people safe during periods of extreme weather (Severe Weather Emergency Protocol)
- Working with other partners such as adult social care to ensure appropriate housing solutions for adults with health, care and support needs
- Supporting residents to access energy efficiency measures to insulate and improve the thermal efficiency of their homes

3.5 Health Inequalities

"Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies" (NHS England, 2021).

Health inequalities are underpinned by social determinants of health, or the circumstances in which people are born, live, work and grow. Evidence suggests that those living in the most deprived areas of the community often have poorer health outcomes, as do some ethnic minority groups and vulnerable/socially excluded people. In addition, the most disadvantaged are more likely to get ill and less likely to access services when unwell, known as the inverse care law.

Health inequalities have been further exposed by the Covid-19 pandemic, which has taken a disproportionate toll on groups already facing the worst health outcomes. For example, nationally, the mortality rate from Covid-19 in the most deprived areas has been more than double that of the least deprived. In addition, some ethnic minority communities and people with disabilities have seen significantly higher Covid-19 mortality rates than the rest of the population. The economic and social consequences of the pandemic response have worsened these inequalities further, with young people, informal carers, those in crowded housing, on low wage, and frontline workers experiencing a more significant disadvantage and transmission of the virus. We also know that older and more clinically vulnerable people have experienced extended periods of physical deconditioning through limited activity and social isolation, which may have longer-term impacts on their health and wellbeing.

It is important to explain what we mean by Inequalities vs inequity as the term is interchangeably used throughout the LLR framework. Health inequalities is the commonly used term; however we are actually referring to health equity and inequities in LLR. Equality means treating everyone the same/providing everyone with the same resource, whereas Equity means providing services relative to need. This will mean some warranted variation in services for different groups (see Figure 6).

Figure 6: Representation of equality and equity using adapted bicycle example

3.5.1 Core20PLUS5 Approach to Reducing Health Inequalities

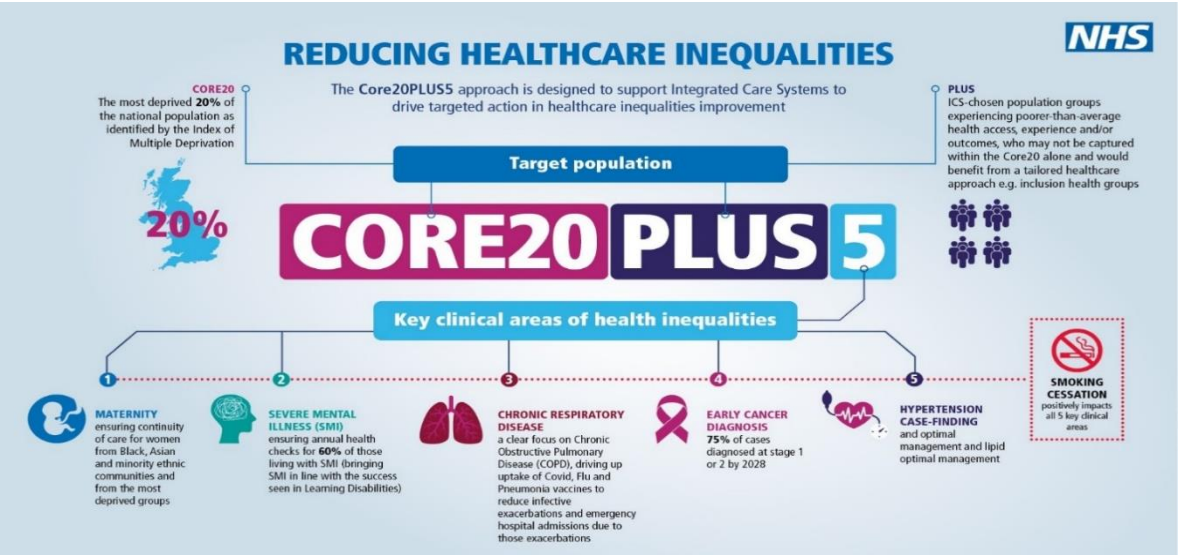
Core20PLUS5 is an NHS England approach for adults[11] and children[12] to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

'Core20' relates to the most deprived 20% of the national population as identified by the Index of Multiple Deprivation.

'PLUS' population groups are those identified at a local level. Populations NHS England would expect to see identified in these groups are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, (known as inclusion health groups) and coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence).
Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

'5' relates to the five clinical areas of focus which require accelerated improvement that sit within national programmes; national and regional teams coordinate activity across local systems to achieve national aims. For adults, the five clinical areas are Maternity, Severe Mental Illness (SMI), Chronic Respiratory Disease, Early Cancer Diagnosis and Hypertension Case Finding.

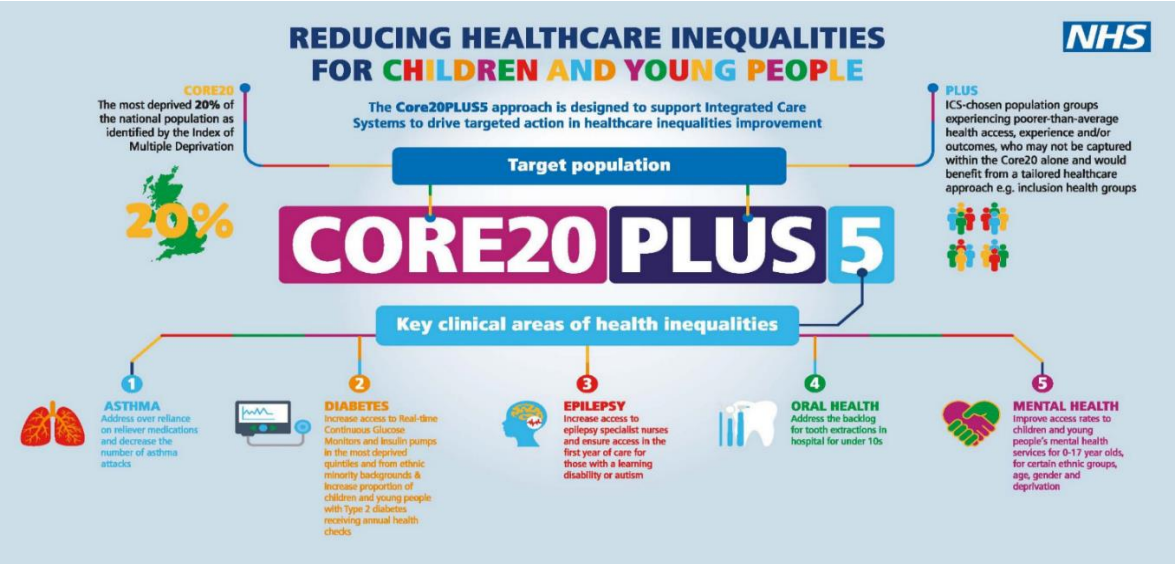
Figure 7: Core20PLUS5 approach for Adults



[11] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities
[12] NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

For children there is additional focus on young carers, looked after children/care leavers and those in contact with the justice system in the PLUS population. The 5 clinical areas are Asthma, Diabetes, Epilepsy, Oral Health and Mental Health.

Figure 8: Core20PLUS5 approach for Children and Young People

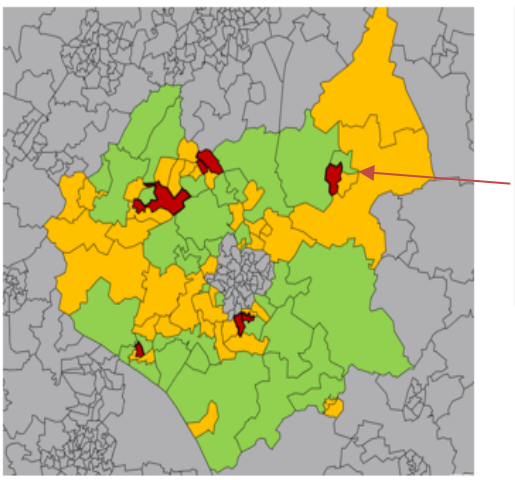


Life expectancy and healthy life expectancy are two key measures that help to identify where health inequalities exist. Indicators on inequality in life expectancy and healthy life expectancy identify the difference in the results for people in areas of highest deprivation and those in the areas of least deprivation using a national approach.

Across the districts, life expectancy is either significantly better (higher) than or similar to England on all indicators. However, when life expectancy data is viewed at MSOA level, we can see there are 8 areas where life expectancy is significantly worse (lower) than England.

The table below highlights that Male Life Expectancy at Birth for a Melton West resident (77.7) is significantly worse than the England average (79.4).

Figure 9: Life expectancy at birth (upper age band 90 and over) (male, 5 Year range) 2016-20 by MSOAs in Leicestershire



MSOAs significantly worse than England (79.4)		
MSOA name	Count	Value
Loughborough Lemyngton & Hastings	-	75.4
Loughborough Storer & Queen's Park	-	74.9
Agar Nook (NWL)	-	76.1
Coalville	-	76.4
Melton Mowbray West	-	77.7
Wigston Town	-	75.4
South Wigston	-	76.9
Hinckley Central	-	77.0

Better 95% | Similar | Worse 95% | Not compared

Overall Melton residents generally experience relatively low levels of deprivation with no residents living in the lowest 20% of areas of deprivation across the country. However, when looking across the range of domains that make up the index of multiple deprivation, Melton has at least one Lower Super Output Area (Melton Mowbray West) in the 10% most deprived areas for the following domains: Education, Living Environment and Barriers to Housing.

Melton Mowbray West is a County Ward and consists of the following local Borough Wards: Melton Dorian, Melton Egerton and Melton Sysonby by electorate wards with a total electorate of around 10,700.

3.6 What have Melton Residents Said

Anchor institutions are large organisations that are unlikely to relocate and have a significant stake in their local area. This includes having sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities. This definition is not limited to public sector organisations, as anchor institutions are defined more by their link to a place than their sector.

In LLR, our NHS Anchor institutions have a strong history of engagement and involvement with a range of stakeholders. Public and patient participation has been refined over time with the NHS undertaking more work to understand the needs of the local population to inform the design and delivery of care.

Much of this work dates from the last 3-5 years and provides an understanding of what people want from local services including our most vulnerable groups. The information that has been analysed has been used to shape the priorities within this plan and will be used further to guide partnership action going forward. Key themes from the analysis of this provided top line findings around information, access, GP services, Community understanding and location of services.

More specifically during the development of this plan, a key survey was undertaken, from 9th of May -19th of June 2022, with the local population and communities with the aim of looking at the future healthcare needs of local people to inform planning for services provided by local General Practice and other practice staff in and around Melton. A total of 4454 people attempted the survey (response rate of 8.7%), 3214 fully completed it (response rate of 6.25%) out of which 2919 were registered patients of Long Clawson and Latham House Medical Practice.

The feedback from the people of Melton is summarised below, along with a range of services residents would like to be provided closer to home if available:

- Health and Wellbeing Support (e.g., advice on eating healthily, exercising regularly, sleeping well, advice on emotional wellbeing)
- Mental health support groups
- Self-care
- Alzheimer/Dementia support groups

- Range of Preventative services provided by partner organisations
- Outpatient clinics
- Diagnostic tests
- Out-of-hours services (Monday – Friday before 8 am and after 6.30 pm and Saturday
- and Sunday)
- Day case surgery with a local anaesthetic (numbing an area of the body)
- Therapy services (e.g., physiotherapy, occupational therapy)

3.6.1 What does Melton Community Health and Wellbeing Partnership (MCHWP) want to achieve?

To support people living in Melton and reduce health inequalities, the Melton Community Health and Wellbeing Partnership want to focus on the following areas which were identified during the partnership relaunch in January 2023:

- ✓ Focus integrated partnership effort on those with complex care and multiple long-term conditions. This will enable us to understand and respond to the needs of the people of Melton with health and wellbeing professionals working with communities in their surroundings and adapting integrated working to their needs.

- ✓ Support the local population by being more proactive in prevention and promoting self care, starting with an outreach approach to NHS Health checks locally to prevent long term conditions and enable management for those that have them. By focusing efforts on socio-economically disadvantaged communities, we will identify individuals and communities who are less likely to attend their general practice and therefore be at greater risk.

- ✓ Consider young people in Melton and the associated cultural issues when delivering improvement locally including mental health and prevention services. Focus on tailored approaches and partnership working when delivering local actions to support this cohort, including anti-social youths and those not in employment. This can be enabled by developing stronger links with the Community Safety Partnership and their Community Safety Action Plan for Melton. Improvement in the local provision of Child and Adolescent Mental Health Service (CAMHS) would also be of benefit locally by reducing waiting lists of younger patients.

- ✓ Develop more effective communication with adults and children's communities to raise awareness of local services, including tailored approaches to local young people where there is the greatest concentration. We want to look at more co designed and innovative pathways, e.g. digital apps to engage this specific community to deliver local messages using terms and methods they understand and use. It will still be important to also include face to face interaction where needed. Also continue to develop engagement and partnership with communities to build rapport, share two-way learning and develop a directory of services for young people locally to enable self-care in the community. It will be important to Melton to link in with wider place developments around online social prescribing systems to support this. This will be underpinned with the ethos of being

specific to Melton and not result in duplication but effectively increasing awareness, information and guidance through locally meaningful accessibility.

The Life Course in Melton

In alignment with the Leicestershire JHWS a life course approach has been adopted for the plan:

4.1 Life Stage 1: Best Start for Life

We want to give our children the best start for a happy, healthy, long life. We want them to fulfil their potential, by allowing them to have positive educational attainment, emotional wellbeing and resilience, and life skills, enabling them to contribute to their community and thrive. We know that the families, communities and environments in which we are born, grow and develop significantly impact on health and wellbeing outcomes in later life.

Where we are now?

There are a number of different measures regarding best start in life that can be used to gain an indication of the current picture in Melton. One of these measures is breastfeeding initiation which is lower in Melton than England and regional values. More specifically, breastfeeding initiation is significantly lower in Melton Mowbray North, South and West in comparison to the LLR average. At 10-14 days, both Melton Mowbray North and West remain significantly lower than the LLR average for prevalence of breastfeeding and at 6-8 weeks, Melton Mowbray West remains significantly lower than the LLR average.

Another indicator of best start in life is the smoking status of mothers at time of delivery. This has improved in Melton from 2019/20 to 2021/22 from 8.4% to 6.5%.

The prevalence of overweight (including obese) pupils in Reception in Melton is 21.1% which is lower than the regional value but the prevalence of obesity, including severe obesity, in Year 6 pupils (ages 10-11) is increasing in Melton. The value is also higher when compared with the regional value and value for England.

The percentage of five-year-olds with experience of visually obvious dental decay is lower in Melton when compared to regional and England values.

What do we want to achieve?

- Support expectant and new mothers to initiate and sustain breastfeeding, especially within Melton Mowbray North, South and West.
- Support expectant mothers to stop smoking during pregnancy.
- Provide and expose expectant and new mothers with supportive information on lifestyle for the best start in life.
- Promote and support healthy eating in children.
- Support children to be physically active.

We will work together to further strengthen our approaches in 2023-28 to ensure that all children and young people get the best start for life that they can. Future plans to work together are outlined in the Children and Families Partnership Plan for Leicestershire, 2021-2023[13] with the following five priorities at the heart of it:

Figure 10: Children and Families Partnership Plan Priorities

4.2 Life Stage 2: Staying Healthy, Safe and Well

Prevention is always better than cure, and good health and wellbeing are assets to individuals, communities and the wider population. It improves health and care outcomes and saves money across the whole system. Therefore, we want everyone in Melton to live happy, healthy, long lives without illness or disease for as long as possible. However, to achieve this, we must consider the social model of health which confirms the importance of strong communities, healthy behaviour and the wider determinants of health (housing, work, education and skills, built and natural environment, income and transport).

Good mental health is an integral part of our overall health. The impacts of poor mental health are broad reaching, including lower employment, reduced social contributions and decreased life expectancy. The NHS 5-year forward view for mental health and, recently, the NHS Long-term plan have highlighted that mental health has been proportionally underfunded and had insufficient focus through statutory services.

The national strategies set out a commitment to achieve parity of esteem of funding and outcomes between what has traditionally been framed as offers to meet mental health needs in comparison to physical health needs. A sizeable investment programme was put in place for enhancing and increasing offers targeting mental health needs including:

- Accessible mental health self-management, guidance and support
- Joining up mental health, physical health, broader care, and voluntary sector around local geographical areas
- Increasing access and strengthening offers for children, young people, women and families before, during, and after pregnancy.
- Earlier intervention for people presenting with early signs of psychosis.
- Psychological offers for the full range of defined mental health conditions.
- Increasing retention and attainment of employment for people with mental health illness

[13] Leicestershire Children and Families Partnership Plan 2021-23

Where we are now?

Many people in Melton live healthy and safe lives already. Data shows that 70.7% of the population of Melton is more physically active than both the regional and national values, although the percentage of adults cycling for travel at least three times a week is the lowest of the Leicestershire districts. This suggests that alternative methods of exercise to cycling may be utilised by the population of Melton.

The percentage of adults classified as overweight or obese (62.8%) is in line with the England value and lower than the regional value.

Data shows that the smoking prevalence in adults is higher than both the regional and England values. This pattern is also replicated when comparing smoking prevalence in adults in routine and manual occupations to the regional and England values. Melton also has one of the highest prevalence of adults with a long-term mental health condition who smoke in the East Midlands.

During the Covid-19 pandemic, Covid-19 vaccination rates in Melton were well above the average England rates. However, Melton also has the highest John Hopkins University (JHU) risk score rate per 1000 population for at least one JHU COVID risk when compared to all other districts and places in LLR. Essentially this flag has broadly represented both local/national criteria for being classified as being at risk of contracting COVID. In the absence of national focus on COVID, we should see the flag (and at practice-level risk stratification reporting), as broadly indicative of increased vulnerability to infectious illness.

From April 2022 – March 2023, 301 referrals were made to Turning Point, the local substance misuse support service. This is 7.4% of all referrals made in Leicestershire in this time period. Around 45% of all clients are Opiate clients in receipt of treatment. This is the second highest district across all other LLR districts. Melton has the second lowest number of Alcohol clients in treatment when compared to all other LLR districts. However, data shows that Melton also has the highest proportion of alcohol successful completions from all those receiving treatment for alcohol. This shows that accessing such services is having a positive improvement in treatment outcomes and there could be potential to make even further improvement.

The percentage of people who “often or always” felt lonely in Melton is lower than in Leicestershire and England. The percentage of people who reported that they hardly ever or never feel lonely is generally higher than Leicestershire and England. The risk of loneliness in Melton is assessed as being relatively low.

Emergency hospital admissions for intentional self-harm and suicide are lower in Melton than Leicestershire and England averages. Referrals to the mental health urgent care services from 01/11/2020-31/10/2022 show that around 4% of total LLR contacts were from Melton residents. 72% of these referrals were from Melton Mowbray North, Melton Mowbray West and Melton Mowbray South. The recorded prevalence of patients with depression in 2020/2021 is 16.34% which falls in the upper quintile. A number of agencies, including the

Borough Council and local GP's have reported concerns about relatively low-level mental health needs in the community, possibly worsening following the Covid-19 pandemic.

Melton has a high level of economic inactivity at 26.7% of all 16–64-year-olds, compared to an East Midlands regional figure of 20.8% and a national figure of 21.3%. In Melton there are high levels of care worker demand and activity as well as a high dependence on food jobs which are mainly based around low skill/low wage jobs. For every job in food production and processing, in terms of the national average, there are 9 in Melton. It may be due to this that wages in Melton are lower than the national average of £613 per week at £455 per week.

At the more complex end, we know that people with Severe Mental Illness (SMI) are at higher risk of poor physical health. Compared with the general patient population, patients with severe mental illnesses are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. In July 2023, Melton had 346 individuals on the SMI register. In the 12 months up to July 23, only approximately 40% of these individuals had completed all six annual physical health checks, lower than the LLR average.

Impact of the Cost of Living

The cost-of-living crisis is impacting all demographic groups within the population. Due to increased travel costs, people may not be willing/able to travel to access required services.
The cost-of-living crisis is impacting all demographic groups within the population. Due to increased travel costs, people may not be willing/able to travel to access required services. Increases in costs such as fuel, energy and day to day living costs continue to impact on the financial resilience of households. This is reflected and observed through community engagement, services such as foodbanks reporting an increase in working families requesting support and increasing demand for financial support through schemes such as the Household Support Fund.

Fuel poverty will mean people have to choose between heating their homes or putting food on the table; this will have a profound negative impact on the physical well-being of the population, especially the vulnerable, elderly and those living with multiple long-term conditions.

We know that there are areas of Melton are in the highest quintile nationally for fuel poverty (2020). These borough wards are Wymondham, Croxten Kerial and Melton Egerton, with a range of between 14% and 16% of households being in fuel poverty.

The impact on the population's mental health is already being seen with increases in the number and acuity of people presenting with mental health issues, many of whom have never been in contact with services. Concern and worry around personal finances are resulting in a significant increase in cases of stress, anxiety and depression.

What do we want to achieve?

- Develop and embed a local Neighbourhood Mental Health offer
- Reduce smoking prevalence in adults

- Reduce substance misuse in adults through increasing access to services
- Reduce emergency admissions from violence linked to alcohol
- Support adults to be physically active
- Tackle and mitigate the impacts of fuel poverty

4.3 Life Stage 3: Living and Supported Well

As people age, become unwell or develop one or more Long Term Conditions (LTCs), they must be supported to live as independently as possible, for as long as possible, while maximising their quality of life. Due to an ageing population, there will be a corresponding anticipated increase in health conditions related to age, such as dementia, falls, cardiovascular disease and mobility issues. The more LTCs people have, the more significant health and social care support they will require. With a targeted population health management approach, we can focus on supporting those with disabilities and multiple LTCs (at any age) to help them live as well as possible for as long as possible and prevent or slow further decline into ill health.

Where we are now?

In Melton there is a recorded prevalence of patients with hypertension is 17.18%. The England wide GP mean prevalence is 14.19% with Melton's prevalence falling in the upper quintile. Other conditions that have a prevalence in the upper quintile include atrial fibrillation, heart failure and osteoporosis.

For Long Term Conditions (LTC) Melton has a 342 people per 1,000 population rate for patient population with managed Long-Term Conditions, this is the second highest rate across LLR places / districts with only Leicester City higher for this cohort. Hypertension is by far the most prevalent LTC in Melton with over 5,000 people (c.10% of overall population) having this condition, followed by Diabetes and Chronic Renal Failure.

For complex health issues Melton has 244 people per 1,000 population for those defined as having complex health issues often linked to having more than one condition, this is the second highest rate across LLR places / districts with only Rutland being higher for this cohort. Overall, there are circa 7,800 registered patient population across Melton that have 5 or more complex Long-Term Conditions. The highest age bands with patients in this cohort are age 34 – 64 and aged 80 plus and in both these categories there is a higher number of female patients than male. 4,000 people of this cohort are over 65 with the rest all being of working age.

Hip fracture rates in Melton are the highest of all areas across the East Midlands and are significantly above the East Midlands and England rates. Within Melton, Waltham-on-the-Wolds had the highest prevalence of emergency hospital admissions for hip fractures in patients aged 65 years and older.

With Melton being a rural area access to Digital Services can both be vital but also difficult to access in the hard-to-reach areas for technology infrastructure. Melton practices offer key NHS App functionality locally for those patients that are registered including appointment booking, repeat prescription ordering and viewing of the patients Detailed Care Record (DCR).

Melton patients have higher than England usage for Appointment booking / cancellation. For repeat prescription ordering there is variation with patients from Latham House using repeat prescriptions less than those in Long Clawson practice, where repeat prescription ordering is significantly higher than national figures. Viewing of the Detailed Care Record for Melton is lower than the national picture across Long Clawson and Latham House practices.
What the above shows is that the population of Melton can use Digital Technology to support access to Primary Care however we also know that Melton has the some of the most digitally excluded areas across LRR districts.

What do we want to achieve?

- Integrate the local community support model offer with health / wellbeing teams
- Prevent falls through supporting the frail or those at risk
- Target support for people with 5 or more complex health issues
- Deliver enhanced access enabled by additional roles in Primary Care
- Increase provision of care closer to home e.g., diagnostics
- Empower residents to access preventive and self-care approaches including through Digital channels
- Support development of community led groups to create local capacity for specific cohorts e.g., residents/ patients with dementia.
- Supporting people to live and age well

4.4 Life Stage 4: Dying Well

The end of life is an inevitable part of the life course. It is a challenging subject for many people to acknowledge and discuss openly. We want to normalise and plan for this stage of life to ensure everyone has choice about their care, treatment, and support for loved ones and carers. This care needs to be a dignified, personalised approach for the individual, their friends and family.

It is essential to understand the kinds of support people would like at this stage of life, whether this is accessing practical advice about financial affairs, knowing what bereavement support is available for friends and family to access or care planning as an option for all. We can then work with people to inform and support them in end-of-life planning.

Where we are now?

Approximately 32.5% of deaths for people of all ages in Melton occur at home with 41.4% of deaths of people of all ages occurring in hospital. Of the deaths that occur at home, 29.7% of these were older than 85 years old which is highest in the LLR districts.

Melton has the highest % rate per population for deaths occurring at home across all LLR districts and places for those aged 84 and over. Recent trends suggests that for all ages the % of deaths occurring at home are increasing.

Melton has the highest percentage of deaths with Cancer as an underlying cause in people aged 65-74 years old across the East Midlands region. The percentage of deaths with circulatory disease as an underlying cause for all ages is higher in Melton than the regional and England value.

In the Melton, Syston and Vale PCN, 24.73% of palliative patients do not have a care plan and 49.10% of vulnerable patients do not have a ReSPECT plan (September 2022 data).

What do we want to achieve?

- Obtain age friendly accreditation in Melton
- A better understanding of what dying well means to people in Melton. Normalise conversations about dying, undertake listening exercises around experiences and lessons learnt, and identify what actions can be taken to improve this.
- Provide support to family members and carers as well as the patient.
- Provide robust care planning with the patient and their family/carers. Care plans must be shared appropriately to ensure all relevant parties are informed and are aware of the patient's wishes. Empower patients and their families to determine how they die.
- Ensure easy transition between the hospital and the community/home with appropriate information sharing between different service providers.

5. Our Local Priorities

5.1 Agreed Priorities via Integrated Working Group

To support initial partnership focus, a prioritisation exercise was undertaken with a wide range of stakeholders on the 23 emerging priorities.

An online survey was shared with over 50 members. They ranked the priorities in order of those they would like to be a focus of collective partnership action through the development of the CHWB action plan (1 being most important, 7 being least important). The survey also provided the opportunity for stakeholders to highlight any additional areas they felt were important that did not feature in the emerging priority list.

To ensure that the voice of the community reflected our findings, the emerging priorities were aligned against the Melton insights, as referenced in section 3.6.

The results were taken to the Melton Community Wellbeing Partnership Board in Jan 2023 and follow-on integrated working group meetings and Melton Borough Council forum July 2023, with the resulting final set of priorities agreed as shown below.

Priorities for Melton 2023 – 2028

Figure 11: Priorities for the Melton Community Health and Wellbeing Plan

Melton CHWBP Strategic Theme	Strategic Priorities 2023 – 2028
A. BEST START IN LIFE	1. We will support Children to be Physically Active
	2. We will promote and support Healthy Eating in Children
	3. We will support expectant mothers with smoking cessation during pregnancy
	4. We will support expectant/new mothers with lifestyle for Best Start
	5. We will support expectant mothers - Breastfeeding initiation and prevalence
B. STAYING HEALTHY, SAFE AND WELL	6. We will develop and embed a local Neighbourhood Mental Health Offer
	7. We will reduce smoking prevalence in Adults
	8. We will reduce Substance Misuse in Adults through increasing access to services
	9. We will reduce emergency admissions from violence linked to alcohol
	10.We will support Adults to be Physically Active
	11. We will tackle and mitigate impacts of fuel poverty
C. LIVING AND SUPPORTED WELL (enabled by Integrated Health, Community Support and Wellbeing)	12. We will prevent falls through supporting the frail or those at risk of hip fractures
	13. We will Target support for people with 5 or more complex health issues
	14.We will deliver Enhanced Access enabled by additional roles in Primary Care
	15.We will increase provision of care closer to home e.g. Diagnostics
	16. We will empower residents to access preventive and self-care approaches including through Digital channels
	17.We will support development of community led groups to create local capacity for specific cohorts e.g. residents / patients with Dementia
	18.Supporting people to live and age well
D. FIT FOR THE FUTURE COMMUNITY	19.We will Integrate the local community support hub model further with health/wellbeing teams
	20. We will explore options for a 2nd Primary Care Site in Melton
	21.We will enhance digital infrastructure e.g. through Superfast Broadband Programme
	22.We will Work to improve economic inclusion and prosperity (by developing links with Levelling Up proposal)
	23.We will Locally embed Healthy design and development in new developments linked to local growth e.g. New Housing, Infrastructure and Employment land

Top Ranked/Agreed Priorities from Melton Survey Dec 2022 **("Do" Priorities)**

Figure 12: Strategic "Do" Priorities Summary for Melton

Priority 1: Support expectant mothers (Breastfeeding initiation and prevalence)

The levels of breastfeeding within Melton are below national averages. We therefore want to support expectant and new mothers to initiate and sustain breastfeeding, especially within Melton Mowbray North, South and West.

The Leicestershire JHWS includes a commitment to invest in evidenced based breastfeeding support for mothers across Leicestershire, supporting them to initiate and continue breastfeeding for as long as they choose. Support will be prioritised for those in white other ethnic groups and younger mothers.

We will support this Leicestershire wide commitment as well as identify specific local actions to improve the prevalence of breastfeeding within Melton, particularly in Melton Mowbray North, South and West.

Priority 2: Develop and embed a Melton Neighbourhood Mental Health Offer

Monitoring from the Office of National Statistics (ONS) found that the prevalence of moderate or severe depressive symptoms among adults in Great Britain rose after the start of the Covid-19 pandemic. In surveys taken between July 2019 and March 2020 prevalence was 10%, but this rose to 19% by June 2020 and 21% by January to March 2021.

Across the County, we will continue to listen and respond to the Leicestershire population as part of the 'Step up to Great Mental Health' programme as we deliver proposals for transformation. Our plans include the aim to increase the proportions of people with mental health challenges that have access to and take up high quality advice, support and access to local amenities, including activities and groups to strengthen mental health and wellbeing. This will enable them to live as independently as possible.

Several actions have already been identified in the Leicestershire JHWS which we will link in with to ensure the needs of Melton are taken into consideration. These actions aim to improve emotional and mental health support for residents of Leicestershire. We know that people with Severe Mental Illness (SMI) are at higher risk of poor physical health and outcomes. The delivery of our vision for improvement will therefore aim to make an increase in the number of checks completed to at least 60%. There is also focus on encouraging the take up of subsequent recommended interventions. Implementation of a new social prescribing website linked to Primary Care systems will support this.

A dedicated mental health neighbourhood lead has been recruited within the borough whose role is to support the development and implementation of a neighbourhood approach to mental health. They are currently overseeing the development of a collaborative approach between multiple partners and the people to plan, organise and implement a mental health offer that meets the needs of the residents of Melton. This has involved the setting up of a local Melton Mental Health Network which has over 75 invitees across a range of local and County wide delivery partners.

There are several areas that the network since being established has already identified that will help develop a better service for the residents of Melton Borough through actions over the course of this plan:

- Provide a voice and endorse relevant Mental Health plans in Melton Borough
- Understand local challenges and needs through service user voice
- Influence decision making by feeding back local experience
- Become a knowledge hub of mental Health for Melton and share best practice
- Proactively learn about services that are available and their referral processes
- Connect with each other and local/regional organisations
- Collaborative working to move local actions forward
- Enable greater focus on Prevention
- Increasing SMI Physical Health Checks
- Ongoing local Mental Health Network

Priority 3: Empower residents to access preventive and self-care approaches including through Digital channels

As Melton is such a rural area, access to digital and non-digital services can be difficult in some of the hard-to-reach areas for technology and transport infrastructure. The population of Melton can use digital technology; however, we also know that Melton has the some of the most digitally excluded areas across LLR districts. We therefore want to empower more residents to access preventative and self-care approaches including but not limited to, through digital apps and / or devices.

The Leicestershire JHWS commits to empower patients to self-manage their long-term condition(s) through a variety of routes for different needs, including the use of digital approaches, assistive technology, accessible diagnostics, and support. We will fully support this place level work.

Locally we will identify specific actions for the residents of Melton to ensure they are able to access appropriate preventative and self-care services. We will also need to ensure that people are aware of the range of methods in how to access these services including through digital channels which are available by ensuring appropriate communication channels are in place. The services that people need locally range from simple activities to promote healthy lifestyle choices such as exercising and eating healthily, to more complex actions to improve health such as receiving treatment and rehabilitation activities.

The focus of this priority will initially be enabling people to live a healthy lifestyle through the following key areas of need:

- Promote and support Healthy Eating in Children
- Reduce smoking prevalence in Adults
- Support Adults to be Physically Active
- Working age adults with or at risk of multiple long-term conditions and complex needs
- Adults with substance misuse and in need of Mental Health Support

Our developing integrated ways of working across local service partners involved in the above at a neighbourhood level will be imperative to the success of our improvement in Melton. This way of working will enable partners to build a more holistic view of local preventative and self-care services and their associated referral routes so that patients can promptly access services they need.

Priority 4: Prevent falls through supporting the frail and those at risk of hip fractures

There has been a 30.0% increase in people aged 65 years and over since the last census in 2011 and population projections to 2040 estimate significant growth of 45% in this age group. We are therefore facing an ageing population.

Melton has the highest levels of hip fractures across the East Midlands, with values significantly higher than both the regional and England averages. Within Melton, Waltham-on-the-Wolds had the highest prevalence of emergency hospital admissions for hip fractures in patients aged 65 years and older.

The Leicestershire JHWS identifies a number of county wide actions which are intended to reduce the number of falls and associated hip fractures that people over 65 experience, including people in residential and nursing care, including:

- Undertaking an assessment to look in more depth at the rates of hip fractures, causes for this and possible preventative measures.
- Scoping a self-assessment tool for falls risk for 60+ with onward signposting and app to help manage balance.
- Piloting of a falls crisis response service.
- Reviewing Assistive technology services to support Falls Risk.
- Building on the LLR Population Health Management framework and development programme, translating implications to Leicestershire to identify those at greatest risk of poor health outcomes including multiple hospital admissions.

Melton will review the services currently available, along with the Leicestershire wide actions and identify any local actions required to enable the reduction of falls and support the frail.

Priority 5: Integrate the local community support hub model further with health/wellbeing teams

Vertical integration of services at place or neighbourhood is a critical component of delivering high quality health and well-being services to the residents of Melton. There is a need to move away from single-disease clinics, into holistic care by providing multi-disciplinary team (MDT) clinics that are specific to local needs. We need to review how we make better use of our Voluntary and Community Sector Services and work with them together locally (e.g., food banks and support groups for substance misuse and Mental Health).

It will be important that there is the ability for professionals to share information between each other to understand underlying needs and behaviours of key population cohorts, for

example certain behaviours can be because of trauma leading to drug use or unhealthy lifestyle choices. Developing operational links such as between local Community partners at the Community Hub, MBC services and health and wellbeing partners including Adults Social Care can bring about a more holistic operational partnership approach in managing those in need and at-risk populations of a wider range of issues, more proactively.

The infrastructure needs to support this integration by making better use of existing space through co-location of teams and improving digital access and information-sharing between partners.

Figure 13: Example of an integrated Health and Wellbeing Centre

The following ICS initiatives will facilitate and enable the integration of health and social care across the system:

- ✓ Integrated Neighbourhood Teams
- ✓ Ease of Access
- ✓ Home First and Community Rehabilitation
- ✓ Better use of the Voluntary Sector and Local Communities
- ✓ Improve Communications and navigation of local services

Ultimately our starting point for action should and will be to build on local existing foundations to improve partnership culture around operational collaboration and population health and wellbeing improvement across the spectrum of need in Melton.

Our aims include the development of greater partnership understanding of future plans for delivery of not only local healthcare improvement but key neighbouring areas such as Lincolnshire and Charnwood where there is a local resident population accessing services over the border . We can achieve this through robust partnership working across LLR and with out of area Integrated Partnership functions, in the context of the improvement priorities of this plan. A key to this will be the transition of our working group that has driven the strategic planning to now oversee delivery of priorities improvement for the local population. This will be developed in close partnership with the local Community Health and Wellbeing partnership board and priority leads to enable coordinated dialogue and alignment of relevant delivery plans that impacts Melton residents. This will require key operational discussions and relationships to be built with partners on the border around opportunities to

collaborate including scope for greater integrated partnership working at neighbourhood level with Primary Care.

Priority 6: Explore options for a 2nd Primary Care Site in Melton

Access to a GP is consistently raised as a concern by Melton residents and stakeholders. The need for additional health care infrastructure (second GP surgery) to meet demand for primary care is recognised and there is a leadership commitment by the ICS to support an agreement in principle to work with MBC on considering future potential options.

The number of 'new' people moving into the borough from the housing growth identified in MBC's local plan is sizeable and will undoubtedly put additional strain on the current Primary Care services being delivered in the borough. Whilst the predicted population growth may not offer a viable stand-alone surgery it is anticipated that patients at LHMP may choose to migrate to a new practice based on the local concerns with access and choice.

There is therefore an established strong partnership approach in place with Melton Borough Council to explore the options for improving future Primary Care through developing a robust business case for change that consider the range of feasible options for future provision. We will bring in the right partners to facilitate robust discussions and development of options to ensure the right decision is made for the local population.

6. Melton Borough Community Health and Wellbeing Delivery Action Plan 2023 -2025 development

To ensure the Plan remains relevant, major review and evaluation gateways will take place on a three-year cycle. Whilst we have been careful to select priorities for the Plan that reflect the future need as well as the present, inevitably these may change over time. For this reason, the delivery action plan will be reviewed on an annual basis reflecting both stakeholder, residents and communities' feedback to ensure these priorities are still the right ones.

6.1 Transitioning to Integrated Delivery

For each priority theme, a delivery working group will be established. Where appropriate, the delivery groups will have representation from health, the district council, public health and the voluntary sector who will all have collective ownership of the priority, with one named representative identified as the lead to facilitate meetings and ensure that progress is being monitored. We expect that these groups will meet monthly.

Once established, the delivery group will review the feedback from the priority workshops, and the data associated with the priority to create the local action plan for delivery (to include a monitoring dashboard), using SMART performance measures. This will take place over the first two months.

6.2 Annual Reviews

Over the five-year period of this plan, at the end of each 12-month action plan cycle, a review of the actions plan will take place including understanding progress/improvement against planned improvement trajectories and/or key project deliverables to identify whether there are any areas of significant change in the borough and / or satisfactory progress is taking place with any longer term priorities. If required, a review of the action plan priorities will take place. Where the range of actions for a key priority area are delivered then the working group with support from the Melton Community Health and Wellbeing Partnership Board will consider bringing other priorities within the plan forward accordingly, for more locally focussed partnership delivery. An annual summary will be produced at the end of each 12-month cycle.

7. Stakeholders

Integrated planning and delivery, enhanced collaboration and smarter resourcing across the partnership will be imperative to the delivery of this plan. To deliver our ambitions for Melton, we as a partnership need to consider how we work together in the future through creating an enhanced local environment for better collaboration between stakeholders will be key to deliver our ambitions for the population of Melton through working towards a "whole systems approach" to community level health and wellbeing.

This shift in ways of working means that we will all need to offer joint working support alongside local and system partners and / or locally established groups to get their input on the priority delivery projects in line with our ambitions. This way of working over the life of the plan will include partners sharing feedback, offering skills, expertise, and knowledge to delivery of priorities, and sharing of resources. This is not an exhaustive list but illustrates what we mean by working together towards local shared delivery aims and objectives outlined within the Melton CHWB plan.

MBC are working with partners and local leads to re-introduce the Melton Community Health and Wellbeing Partnership Board. This board will play an important role with key membership to aid links in with local MBC Health Scrutiny committees and working closely with local Cllrs that hold portfolio links to key strategic priorities within the plan. The support from local electorate will be a key enabler for successful local strategic partnership delivery and strategic decision making, that will need to be underpinned by ongoing communication and robust progress updates to develop the ways of working between respective partners that are responsible delivery and council statutory functions linked to Health.

7.1 Collaboration

The following Stakeholders have been involved in the development of the Melton Community Health and Wellbeing Plan:

- MVS Primary Care Network
- Melton Borough Council (MBC)
- Leicestershire Partnership Trust (LPT)

- Leicestershire Public Health
- Leicestershire County Council
- Voluntary, Community and Social Enterprise (VCSE) colleagues
- Active Leicestershire
- Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB)
- Residents of Melton through engagement

7.2 Ongoing links to the Leicestershire Health and Wellbeing Board

It is envisaged that the strategic partnership Integrated working groups, made up of strategic stakeholder representatives, that are forming alongside the development of this Community Health and Wellbeing Plans will be the delivery arm of the plans noting that specific priorities will have their own focus sub-groups where required to drive daily activity and feed into this. This will be overseen by the Melton Community Health and Wellbeing Partnership Board, and the vision is that this will have oversight of the plan with regular reporting into Leicestershire Staying Healthy Partnership. Subsequently there is a requirement for Melton's progress to be reported into the Leicestershire Health and Wellbeing Board to ensure that there is synergy and sustained alignment with the Leicestershire Joint Health and Wellbeing Board (JHWB).