Meeting: Health and Wellbeing Board

Date/Time: Thursday, 30 May 2019 at 2.00 pm

Location: Framland Committee Room, County Hall, Glenfield

Contact: Mr. Matthew Hand (Tel: 0116 305 2583)

Email: matthew.hand@leics.gov.uk

Membership

Mr. L. Breckon JP CC (Chairman)

Mr. R. Blunt CC       Cllr Alan Pearson
Sue Elcock            Mike Sandys
Karen English         Frances Shattock
Sarah Hughes          John Sinnott
Cllr. J. Kaufman      Micheal Smith
Dr Andy Ker           Jane Toman
Harsha Kotecha        Caroline Trevithick
Dr Mayur Lakhani      Mark Wightman
DPCC Kirk Master      Supt Natalee Wignal
Jane Moore            Jon Wilson
Mr. I. D. Ould OBE CC

AGENDA

Item                                    Report by

1. Appointment of Chairman

   To note that Mr L. Breckon JP CC has been appointed Chairman.

2. Appointment of Vice Chairman.

   To note that Dr Mayur Lakhani (Clinical representative of West Leicestershire
   Clinical Commissioning Group which has responsibility for chairing the Integration
   Executive) has been appointed Vice Chairman.

3. Minutes of the meeting held on 14 March 2019

   (Pages 3 - 14) and Action Log.
4. To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.

5. Declarations of interest in respect of items on the agenda.

6. Position Statement by the Chairman.

**Strategy**

*Health and Care in the Place.*


*Prevention in the Place.*

8. Summary of Leicestershire and Rutland Locality Profiles. Director of Public Health (Pages 35 - 56)


10. Leicestershire Social Prescribing and Care Coordination Models. Director of Public Health (Pages 65 - 74)

**Performance: Placed Based Outcomes.**

11. Better Care Fund Q4 2018/19 Performance. Director of Health and Care Integration (Pages 75 - 84)


**Date of next meeting.**

The next meeting of the Health and Wellbeing Board will be held on 11 July 2019 at 2.00pm.

15. Any other items which the Chairman has decided to take as urgent.
Minutes of a meeting of the Health and Wellbeing Board held at County Hall, Glenfield on Thursday, 14 March 2019.

PRESENT

Mrs. P. Posnett MBE CC (in the Chair)

Leicestershire County Council

Mr. L. Breckon CC  Jane Moore
Mike Sandys  Jon Wilson

Clinical Commissioning Groups

Karen English
Spencer Gay
Dr Andy Ker

Leicestershire District and Borough Councils

Cllr. J. Kaufman
Jane Toman

In attendance

Mark Wightman  University Hospital of Leicester
Rachel Bilsborough  Leicestershire Partnership Trust
Wendy Holt  NHS England
Harsha Kotecha  Healthwatch
Adam Streets  Leicestershire Police

Apologies

Mr. R. Blunt CC, Dr Mayur Lakhani, Roz Lindridge, DPCC Kirk Master,
Mr. I. D. Ould OBE CC, Cllr Alan Pearson, John Sinnott, Caroline Trevithick and
Supt Natalee Wignal and Sue Elcock.

136. Minutes of the previous meeting and Action Log.

The minutes of the meeting held on 24 January 2019 were taken as read, confirmed and signed.

The Board also noted the Action Log, which provided an update on actions agreed by the Board at its previous meetings.

137. Urgent items.

There were no urgent items for consideration.
138. **Declarations of interest.**

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

No declarations were made.

139. **Position Statement by the Chairman.**

The Chairman presented a position statement on the following matters:

- Drop in sessions to discuss NHS improvements plans;
- ‘Within Your Gift to Give’ social media campaign;
- The new Integrated Care (Reablement) Team;
- ‘Start A Conversation’ Suicide Prevention Campaign;
- Radiographers at Leicester’s Hospitals national award;
- ‘Cervical Screening Saves Lives’ campaign.

A copy of the position statement is filed with these minutes.

140. **Strategic Growth Plan.**

The Board considered a presentation of the Chief Executive which provided an update on the delivery of the Leicester and Leicestershire Strategic Growth Plan (SGP) which had been jointly prepared and subsequently approved by the eight local planning authorities (the district councils), the County Council as the highway authority and Leicester City Council in late 2018. A copy of the presentation slides are filed with these minutes.

The Chief Executive reported that the SGP set out a strategy for the growth and development of Leicester and Leicestershire in the period to 2050, enabling partners to consider the longer term needs of the area and opportunities which extend beyond the conventional timeframe of a Local Plan.

Arising from discussion the following points were noted:

- The growth and development of the County would have considerable impact on Health and Care partners and it was therefore important for them to be able to have an input into the development process. It had been acknowledged that there was a need for greater engagement at a strategic level with such partners: it was expected that this would be improved in time for the next revisions to district-level Local Plans, which should reflect the strategic direction of the SGP;

- As well as ensuring new developments had the appropriate health infrastructure in place, it was important that planners considered the wider determinants of health as a fundamental part of the process, rather than a re-active afterthought. The recent development of New Lubbesthorpe, for which Blaby District Council had won a Local Government Chronical Award, was a good example of where this approach had been taken;

- The recently published Chief Medical Officer’s report promoted putting health and wellbeing at the forefront of policy making and prioritising investment to create active environments which enhanced health and helped prevent disease;
• Strategic Planning Groups were an ideal forum in which to discuss the importance of health considerations and ensure planning authorities and developers understood the benefits of active design;

• The Health and Wellbeing Board could play a significant role in the promotion of active design principles within new developments and it would consider at a future meeting the types of health considerations it wished for development plans to have regard for.

RESOLVED:

That a report concerning the promotion of active design within new county housing developments be considered at a future meeting of the Health and Wellbeing Board.

141. Delivering the Armed Forces Covenant in Leicestershire.

The Board considered a joint report of the Chief Executive and Director of Public Health which detailed the work of the Leicester, Leicestershire and Rutland Civil and Military Partnership Board (LLRCMPB) and the delivery of the Armed Forces Covenant (AFC) in Leicestershire. A copy of the report and accompanying presentation is filed with these minutes marked ‘Agenda item 6’.

Following a commitment to support those who serve or had served in the armed forces and their families better, the LLRCMPB was formed in 2017 to help deliver the initiative locally. In addition, some local organisations had signed covenants which set out their commitment to support the Armed Forces community.

There was a lack of data nationally as to the numbers of veterans in the community which it was hoped would be partially addressed by the introduction of a new veterans category in the census from 2021. In the meantime there was an opportunity locally to support and encourage veterans to make their status known when accessing services, particularly in health settings such as GP surgeries. It was noted that Leicestershire Partnership Trust had amended its patient template to include a military field.

GP surgeries were encouraged to register for the Armed Forces Veteran Friendly Accreditation which promoted improved medical care and treatment for former members of the armed services. Practices could qualify for veteran friendly status by offering extra support for ex-military personnel who might face additional challenges when they return to civilian life. It was noted that practice staff could benefit from additional veteran specific educational training, similar to that offered by some CCGs in other areas.

It was noted that a number of local organisations had been recognised as part of the Ministry of Defence’s employer recognition scheme for actively supporting their employees who were members of the armed forces family. Leicestershire County Council had attained the silver award and had expressed an interest in achieving the gold standard.

RESOLVED:

a) That the Health and Wellbeing Board seek to establish and maintain a link with the work of the Civil and Military Partnership Board through the Director of Public Health, to be aware of it and the purpose it has and seek its involvement in relevant areas of work;
b) That the Health and Wellbeing Board endorse and support the Armed Forces Covenant in relation to primary care particularly the promotion of the veteran friendly GP accreditation scheme;

c) That partners be encouraged to collectively continue to work on addressing the gaps in knowledge and data and encourage Armed Forces personnel, particularly veterans to identify themselves.

142. Strengthening Links Between the Health and Wellbeing Board and the Leicestershire Safer Communities Strategy Board.

The Board considered a report of the Director of Public Health which detailed progress made to strengthen links between community safety and health and wellbeing. A copy of the report marked ‘Agenda item 7’ is filed with these minutes.

The Director reported that work led by the Office of the Police and Crime Commissioner was ongoing to develop and implement ‘People Zones’ (geographically defined areas wherein public services work collaboratively to address the key social problems across the county) across the County. The outcomes of this project would help steer the work of partnership bodies such as the Unified Prevention Board and the Strategic Partnership Board.

RESOLVED:

a) That the progress made to date in strengthening links between community safety and health and wellbeing be noted;

b) That a report detailing the work of the Strategic Partnership Board and the People Zones Project be considered at a future meeting of the Health and wellbeing Board.

143. Mental Health Transformation Programme.

The Board received a presentation from Leicestershire Partnership NHS Trust (LPT) which provided information on the five year transformation programme to re-design its mental health services. A copy of the presentation is filed with these minutes.

It was noted that the transformation exercise which was still at a development stage would address the increasing demand and capacity issues currently experienced by the service to improve the quality, efficiency and overall experience of mental health services.

Arising from discussion the following points were raised:-

- Direct patient access to services would form an important part of the transformation project, including the development of a single point of access for mental health services and improvements to the way in which previously discharged patients could re-access support;

- GPs welcomed the ability to refer patients to urgent mental health care through the crisis team. However, there were limited options for patients who were assessed as not requiring urgent care, but requiring support within a fairly short timeframe;
• Patient engagement throughout the transformation exercise was essential. The consultation stage would include further co-design workshops and the opportunity for a draft model to be tested ahead of final implementation;

• With regard to social prescribing, it was confirmed that LPT had made links with the existing Leicestershire offer developed by the Unified Prevention Board and in particular the First Contact Plus provision. There was however an opportunity to improve the system further; for example an LLR-wide offer had not yet been developed;

• It was noted that the recent CQC inspection of LPT had identified concerns in a number of areas, including the Bradgate Unit. The Board was assured that this topic would be addressed through the Joint Health Overview and Scrutiny Committee.

RESOLVED:

That the presentation be noted.

144. Actions arising from the agreed outcomes of the Health and Wellbeing Board development session held on 30 November 2018.

The Board considered a report of the Director of Care and Integration which provided an update on the delivery of the actions agreed following the Health and Wellbeing Board Development session held in November 2018. A copy of the report marked ‘Agenda item 9’ is filed with these minutes.

The Director reported that the action plan would be revised in order to take into account the recent changes to the governance arrangements of mental health services across Leicester, Leicestershire and Rutland.

RESOLVED:

That the action log and the initial progress made be noted.


The Board considered a report of the Director of Health and Care Integration which provided an overview of the progress to refresh and submit the Leicestershire Better Care Fund (BCF) Plan, including an update on the refreshed spending plan and outcome metrics for 2019/20 as at 1 March 2019. A copy of the report marked ‘Agenda Item 10’ is filed with these minutes.

In response to questions concerning the proportion of the proposed BCF spend on acute services, and seeking confirmation optimum use was being achieved from the BCF, the Director confirmed the refreshed plan commissioning intentions and expenditure plan for 2019/20 had been consulted upon through multi agency workshops and individual partner governance structures, which included University Hospitals of Leicester (UHL) representation. Whilst the BCF spend totalled just short of £60m, BCF national policy requirements and conditions on expenditure types/amounts were fairly prescriptive giving limited scope for flexible spending within the Plan. It was noted that the total was considerably less than that spent overall on health across the County.
It was noted that whilst the proposals for 2019/20 were not fundamentally different from the 2018/19 Plan (as 2019/20 was seen as a continuation, with the BCF policy framework expected to operate in a similar basis as 2018/19), it was possible that future national guidance could lead to considerably different BCF policy framework affecting local plans from 2020 onwards. This was anticipated to respond to the new integrated care system requirements per the NHS Plan, driven both locally and through the Better Care Together (LLR) programme Plans. The revisions would lead to wider discussions amongst partner agencies as to the future approach to overall spend on Health and Social Care.

RESOLVED:

a) That the draft BCF Plan for 2019/20, as summarised in Appendix A and B, be approved for submission to BCF National Team in line with the national timetable, subject to the publication of the national BCF guidance and any further amendments required;

b) That the Chief Executive of Leicestershire County Council, following consultation with the Chairman of the Health and Wellbeing Board, be authorised to make any amendments to the BCF plan 2019/20 in light of the national guidance, prior to its submission to NHS England;

c) That the final submitted version BCF plan for 2019/20 be submitted to the next possible meeting of the Health and Wellbeing Board for assurance, along with a progress update on the process and timescales for national assurance via the BCF National Team;

d) That the Board notes that the members of the Integration Executive (a subgroup of the Health and Wellbeing Board responsible for the day to day delivery of the BCF Plan), will be asked to confirm their agreement to the final version of the plan to be submitted to NHS England.


The Board considered a report of the Director of Public Health which provided an overview of the achievements and outcomes that had been delivered by the Health and Wellbeing Board during 2018 and an update on the progress that had been made to meet the needs of the people of Leicestershire. The report also contained a look ahead to 2019. A copy of the report, marked ‘Agenda Item 11’, is filed with these minutes.

The Director encouraged partner representatives of the Board to share the Annual Report with their own management teams and consider the content when producing their own annual summaries.

RESOLVED:

a) That the Health and Wellbeing Board Annual Report be approved for publication;

b) That partners be encouraged to share the report with their own management teams;
c) That the progress made by the Board in 2018 be noted;

d) That the key workstreams that have been identified to further progress the impact of the Health and Wellbeing Board in 2019 be supported.

147. **Date of next meeting.**

It was noted that the next meeting of the Health and Wellbeing Board would be held on Thursday 30 May 2019.

2.00 - 3.40 pm  
14 March 2019  

CHAIRMAN
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<th>No.</th>
<th>Date</th>
<th>Action</th>
<th>Responsible Officer</th>
<th>Comments</th>
<th>Status</th>
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<tbody>
<tr>
<td>349(d)</td>
<td>05/01/17</td>
<td>Submit a report on the Local Digital Roadmap to a future meeting of the Health and Wellbeing Board.</td>
<td>Vikesh Tailor</td>
<td>A report is scheduled for a future meeting of the Health and Wellbeing Board.</td>
<td>GREEN</td>
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<tr>
<td>367(c)</td>
<td>16/03/17</td>
<td>Request the Unified Prevention Board to take forward Leicestershire specific work actions from the LLR Suicide Prevention Strategy and Action Plan and report back to the Health and Wellbeing Board when appropriate.</td>
<td>Mike Sandys</td>
<td>Six monthly updates from the Unified Prevention Board are scheduled for the Health and Wellbeing Board.</td>
<td>GREEN</td>
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<tr>
<td>66(c)</td>
<td>22/03/18</td>
<td>That the Director of Public Health and respective CCG Directors of Primary Care be requested to undertake some further work regarding how pharmacies should respond to future population changes and how pharmacies could fit into the Sustainability and Transformation Partnership, and report back to a future meeting of the Health and Wellbeing Board.</td>
<td>Mike Sandys</td>
<td>A report will be provided to a future meeting of the Health and Wellbeing Board</td>
<td>GREEN</td>
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<tr>
<td>75(b)</td>
<td>24/05/18</td>
<td>That the Health and Wellbeing Board receives a report outlining the work undertaken in localities to support people with dementia.</td>
<td>Jane Toman</td>
<td>A report will be provided to a future meeting of the Health and Wellbeing Board</td>
<td>GREEN</td>
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<tr>
<td>92 (b)</td>
<td>12/07/18</td>
<td>That the Board consider a further update on the progress of the Health and Social Care Sector Growth Plan in 12 months time</td>
<td>Jon Willson</td>
<td>A report will be provided to a future meeting of the Health and Wellbeing Board</td>
<td>GREEN</td>
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<tr>
<td>119 (a)</td>
<td>29/11/18</td>
<td>That the Director of Public Health be asked to meet with officers from the UHL to give further consideration to the targeted offer for secondary prevention;</td>
<td>Mike Sandys</td>
<td>A report will be provided to a future meeting of the LLR STP Prevention Board.</td>
<td>GREEN</td>
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<td>119</td>
<td>29/11/18</td>
<td>That the Health and Wellbeing Board receive a report in 2019 on the development of locality profiles, specifically how these have supported Integrated Locality Teams to target interventions more effectively to the needs of local populations.</td>
<td>Mike Sandys</td>
<td>A report will be provided to a future meeting of the Health and Wellbeing Board</td>
<td>GREEN</td>
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<td>120</td>
<td>29/11/18</td>
<td>That further analysis be undertaken to explore the responses to the GP Survey across the age demographic of those consulted to identify whether expectations of service provision altered depending on the patient's age, and that the findings of this additional analysis be reported to members of the Health and Wellbeing Board and constituent CCGs.</td>
<td>Healthwatch</td>
<td>The additional research has not yet been undertaken. Once available the information will be sent to Health and Wellbeing Board and constituent CCGs.</td>
<td>GREEN</td>
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<td>122</td>
<td>29/11/18</td>
<td>That the outcome of the review of joint funded packages be reported to a future meeting of the Board.</td>
<td>East Leics CCG</td>
<td>A report will be provided to a future meeting of the Health and Wellbeing Board</td>
<td>GREEN</td>
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<td>123</td>
<td>29/11/18</td>
<td>That the Health and Wellbeing Board consider a report at a future meeting which explores work being undertaken by Local Authorities and Leicestershire and Rutland Sport and other partners to encourage increased levels of physical activity.</td>
<td>Mike Sandys</td>
<td>A report will be provided to a future meeting of the Health and Wellbeing Board</td>
<td>GREEN</td>
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<td>134</td>
<td>24/01/19</td>
<td>That a copy of the Unified Prevention Board Communication Plan be shared with members of the Health and Wellbeing Board once finalised.</td>
<td>Mike Sandys</td>
<td>The Communications Plan will be considered at the next Unified Prevention Board on 12 March. In May the UPB will be asked to consider the campaign concepts, any upcoming barriers and opportunities. An update on those discussions will be provided to members of the Health and Wellbeing Board in May. In July the UPB and Health and Wellbeing Board will be asked to approve the campaign materials and next steps.</td>
<td>GREEN</td>
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<td>That a report detailing the work of the Strategic Partnership Board and the People Zones Project be considered at a future meeting of the Health and wellbeing Board.</td>
<td>Mike Sandys</td>
<td>A report will be provided to a future meeting of the Health and Wellbeing Board</td>
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Purpose of the report

1. The purpose of this report is to present a progress update on the Children and Families Partnership Plan 2018-21.

Link to the local Health and Care System

2. The Children and Families Partnership plan is aligned to the Leicestershire County Council Strategic Plan and focuses on the added value of approaching strategic priorities across the partnership to ensure consistent communication and service delivery to children and families.

Recommendation

3. The Health and Wellbeing Board is asked to note the report.

Policy Framework and Previous Decisions

4. In November 2016 the Health and Wellbeing Board approved the terms of reference for a Children and Families Partnership to replace the Supporting Leicestershire Families Executive as a subgroup of the Health and Wellbeing Board. The expanded remit included oversight of how the priorities for children and families as set out in the draft Joint Health and Wellbeing Strategy, are delivered.

5. In May 2018 the Health and Wellbeing Board approved the Children and Families Partnership Plan for 2018 – 21 and requested that it received regular progress updates.

Background

6. The Children and Families Partnership Plan is a strategic document which sets out the shared vision for children, young people and their families and the priority outcomes that need to be improved. The Plan is not intended to be a detailed description of the individual work of each partner, but rather a summary of key areas of work that are best delivered together to have the biggest impact on the lives of children and young people.

7. The Partnership has adopted the five supporting outcomes of the Joint Health and Wellbeing Strategy relating to children and young people as the priority areas for the Plan:
i. **Ensure the best start in life**— by developing an integrated early years pathway which ensures needs are assessed to enable appropriate interventions are offered and the development of a communication strategy to promote the 1001 critical days;

ii. **Keep children safe and free from harm**— by developing and embedding an integrated model of services to prevent harm to children and young people and make children safe by raising awareness of universal safety messages;

iii. **Support children and families to be resilient**— by developing an integrated approach to family resilience and self-sufficiency, provide joined up information and guidance to enable families to be self-sufficient and navigate services and support families to progress towards work;

iv. **Ensure vulnerable families receive personalised, integrated care and support**— by providing integrated, outcome-based, high quality, cost-effective provision and developing a post-16 multi-agency delivery model;

v. **Enable children to have good physical and mental health**— by developing a whole system approach based on ‘Making obesity everyone’s business’ and developing a partnership approach to emotional and mental wellbeing;

**Progress to date**

8. The Plan was officially launched on the 20 September with representatives from local councils, the police, schools, NHS, the voluntary sector and other agencies attending a special event at County Hall.

9. Priority leads are working with partners and other key stakeholders to deliver the action plans agreed against each outcome. The full action plan, including progress against each outcome at the end of year one of the plan (2018 – 19) is detailed in Appendix A. Key progress highlights are as follows;

**Priority 1 - Ensure the best start in life**

- Work has started on an e-learning module for the 0 - 5 sector for a graduated 4 step approach (Advice line, Drop-ins, Area SENCO support and Specialist Teaching input via panel);

- The training of Improvement Advisors to take on an Area SENCO role to provide support to early years providers;

- The release of the next stages of communications on school readiness, aimed at educating parents, which resulted in:
  
  i. September 2018 to the April 2019 - total of 1,440 views resulting in 416 requests for more information via Facebook and 17 via Twitter (mobile 56%, desktop 37%, tablet 7%).

  ii. 16 January to 28 February 2019 spring campaign – total of 2,840 views via Facebook and 19,317 Twitter impressions (representing the number of times the post showed up on people’s devices, including mobile and tablet).
Priority 2 - Keep children safe and free from harm

- The Child Sexual Exploitation (CSE) Operations Group have met to agree plans for expanding the CSE hub remit to include Child Criminal Exploitation (CCE);
- The Vulnerabilities Executive have agreed that the CSE Operations Group be re-formed into a Vulnerabilities Operations group, following wide recognition across the partnership that there is a need to develop and align operational responses to CCE;
- Funding has been secured for a partnership position of Strategic Lead for CCE which will work to develop the operational responses and make sure these are aligned across LLR.

Priority 3 - Support children and families to be resilient

- Workshops led by the Department of Work and Pensions (DWP) are taking place in the Hinckley and Bosworth area to understand the barriers to work for people living in the district. If this approach proves successful it will be rolled out across the County.

Priority 4 - Ensure vulnerable families receive personalised, integrated care and support

- A new ‘Promise’ to children in care and care leavers has been launched by Leicestershire County Council and its partners. The development of the promise, which has involved considerable input from young people from within the care system, accompanies a series of measures agreed by partners including the county’s seven district councils, the Office of the Police and Crime Commissioner and the Combined Fire Authority to support young people in, or who have left, the care system.

Priority 5 - Enable children to have good physical and mental health

- Public Health England have published a suite of Maternal Health resources which are being adapted for use at a local level (from pre-conception to post-natal);
- A Maternal Obesity stakeholder event held on 31 October 2018 has informed actions concerning how to raise the issue before, during and after pregnancy;
- Meetings have been held with Nottinghamshire and Lincolnshire County Councils to learn from how they have developed an Adverse Childhood Experience (ACE) trauma informed approach across their counties. A stakeholder event has been planned for 21 May to agree first steps for developing a Leicestershire approach to ACEs.

Future Developments

10. Action Plans for 2019 – 20 are being developed for the five priority areas and it is expected that by June 2019 progress will include:-

- The launch of leaflet to promote 1001 Critical Days key messages to parents;
- The launch of a new school readiness social media campaign and “toolkit” for professionals;
The remodelling of the LCC Inclusion Service and the Inclusion Pathway;
The agreement of a new Housing Protocol to enable housing applications from 17.5 year olds

11. A communications plan for 2019 – 20 is also being developed to improve cross-partnership and wider communication on progress against the partnership plan and to share other relevant information and updates, clearly and consistently across the partnership. A partnership logo is being developed for use on partnership related resources and communications and will be made available to be used by partners.

12. The partnership’s webpage will also be refreshed. The current partnership page is hosted on the Leicestershire County Council website: (https://www.leicestershire.gov.uk/leicestershire-children-and-families-partnership)
   The page incorporates the partnership’s branding and makes reference to the wide membership of the Board; however it has been acknowledged that it has the County Council’s corporate look. The ‘Better Care Together’ microsite has been identified by partners as a good example of a partnership approach. The Council expects the creation of a similar microsite would cost in the region of £10,000. Other options being considered are for a partner to develop and administer a microsite or for the Council to re-develop the current partnership page so the look and feel is less corporate, as has already been done for the special needs and disability page: (https://www.leicestershire.gov.uk/education-and-children/special-educational-needs-and-disability)
   It is expected that a decision concerning the refresh of the partnership’s webpage will be made following further discussion at the Partnership Board meeting on 26 June 2019.

**Background papers**


**Officer to Contact**

Jane Moore
Director of Children and Family Services
Tel: 0116 305 2649
Email: jane.moore@leics.gov.uk

Liz Perfect
Head of Service - Commissioning & Planning
Tel: 0116 305 4814
Email: liz.perfect@leics.gov.uk

Mala Razak
Children and Families Partnership Manager
Tel: 0116 305 8055
Email: mala.razak@leics.gov.uk

**List of Appendices**
Relevant Impact Assessments

Equality and Human Rights Implications

13. The Partnership has an interest in ensuring that there are effective arrangements in place so that the services provided meet the identified needs of local people. An EHIRA assessment has been carried out in relation to the impacts of the Plan.
### Appendix A – Children and Families Partnership Plan Annual Progress Update (2018 -2019)


**Priority Lead: Jane Moore, Director Children and Family Services**

<table>
<thead>
<tr>
<th>Focus areas</th>
<th>Actions</th>
<th>End of year 1 – Where are we now?</th>
<th>What’s working well?</th>
<th>What are we worried about?</th>
<th>Year 2 - What needs to happen?</th>
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<tbody>
<tr>
<td><strong>1.1</strong> To develop an integrated Early Years Pathway to ensure the needs of vulnerable children are identified</td>
<td>Development of a partnership pathway to ensure children are assessed and appropriate, proportionate interventions are offered. Draft pathway materials have been developed jointly (early help, health and education). Consultation to take place with parent/carers. Draft will then be shared with CFP Board for agreement. Work has begun on e-learning module on Quality First Teaching graduated 4 step approach for 0-5 sector (Advice line, Drop-ins, Area SENCO support, Specialist Teaching input via panel) Currently training Improvement Advisors to take on Area SENCO role.</td>
<td>The journey within LCC and with partners is progressing well and together we have been able to achieve a significant culture change: - beginning to consider new approaches - panel forms reviewed with stakeholder input - moving to working all year round to support children in provision</td>
<td>Currently an over reliance on specialist teacher support because of the dominance of the PVI sector (no QTS and SENCO support in Leicestershire). Some services/practitioners have a historical perception of ways of working with children (diagnosed children rather than early identification)</td>
<td>By June 19 - 70 providers to be accessing drop-ins (representing a 5% increase) By Sept 19 – All providers will have named Area SENCO with expectation of minimum 2 visits per term By Dec 19 – 30 children (10% of cohort) to be receiving specialist teacher support receive intensive support then moved to monitoring By March 20 – to see a 10% reduction in children coming to early years panel (baseline Aug ‘18 of 300 cases)</td>
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<td><strong>1.2</strong> To develop a shared understanding of the importance of the first 1001 Critical Days and school readiness</td>
<td>Develop a communication strategy to deliver a campaign to share key messages from 1001 Critical Days with professionals and parents Consultation undertaken with professionals to ascertain current understanding of the 1001 Critical Days which will inform the communication strategy Training and information sessions being delivered to on the importance of 1001 Critical Days. Work started on leaflet for parents to share key messages</td>
<td>4 sessions delivered to LCC early years, SEND, portage and further sessions planned to foster fostering team, foster carers, adoption team, ICPC conference chairs) 20 minute presentation resources ready to be rolled out. 2 working group meetings held to progress the parent</td>
<td>Experiencing challenges with engaging wider partners in the working groups</td>
<td>By June 19 - to launch parent leaflet - to establish quarterly steering group and 6 weekly working group meetings and to achieve buy-in and stable attendance from all partners in order to give the work momentum. By Sept 19 – LCC to re-commission Baby Beginnings programme (or similar if sent out to tender) and ensure 1001 days key messages</td>
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<td>Develop a shared definition of school readiness and the support required for children and families in order for them to be school ready</td>
<td>School Readiness definition leaflets for professionals and parents launched in Sept 18, materials shared across partnership and live on dedicated webpage 7000 leaflets distributed by health to parents with children due to start school in Sept 2019</td>
<td>Good engagement from health, social care and education. Media coverage - well received (feedback is it covers all children, including SEND)</td>
<td>Children from FSM cohorts are not achieving as well as their peers</td>
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<td>are strongly embedded. By Dec 19 – Training sessions to be delivered to staff across CFS and partners. -Pool of staff able to deliver training sessions to be identified across partners</td>
<td>By March 20 – 1001 days key messages to be included across CFWS and midwifery/health clinics and interventions such as bumps to babies -Sessions to be delivered to schools/early years settings</td>
<td>By June 19 – to hold school readiness conference to launch toolkit for professionals</td>
<td>By Sept 19 – portal to be put in place for parents to access eligibility for FSM which will increase pupil premium and support for foundation stage children and to contribute to improved EYFSP results (48% currently)</td>
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<tr>
<td>By Dec 20 – 30 practitioners from schools and PVI to be trained to support children at risk of delay with early language skills</td>
<td>By March 20 - Youtube video for parents to be launched - to help access activities to try at home to support school readiness</td>
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</table>
### Focus areas

| 2.1 | Explore opportunities for a Multi-Agency Safeguarding Hub (MASH) model to support the application of thresholds and accessibility to shared information. | Work undertaken to better integrate services and strengthen one front door approach. Steering group met in Sept to consider integrated front door approach. Partner briefing session held on police process mapping to identify any duplications and overlaps and agree pathway for DA. LCC and Police have reviewed effectiveness and efficiency of own internal processes in order to be a better position to align with partners. Police review will include designing improved pathways into health. | Have now embedded practice of joint reviewing and screening at front door (especially around DV and child concerns) that enable us to review concerns in a timely and effective way by of being co-located at Wigston Police Station. | The integrated model between Police and LCC has been developed as far as practicable within current resources. Embedding other colleagues into the co-located arrangement would enhance the model, however we recognise that budget constraints are a barrier to this. | Action now closed work will be progressed under new action: 2.1.6 Identify, implement and align operational responses to Child Criminal Exploitation (CCE) across LLR -which will include the analysis, collection, sharing of intelligence. Strategic Lead to be appointed (April/May ‘19). Strategic Lead to work with partners to develop operational responses to prevent, detect and deter CCE. Actions to be developed once Strategic Lead is in post. |

| 2.1.1 | To develop and embed an integrated model of services to prevent harm to children and young people. | Pilot has been implemented and is now being embedded within Police and CSE hub. A review will be undertaken by Police and LCC (Sept 2019) to assess how well this has been embedded. |  |  | Action now closed. Work will be progressed under new action 2.1.6 |

| 2.1.2 | To develop a multi-agency pathway for the review and analysis of domestic abuse incidents affecting children. | Daily MARAC implemented on 21\textsuperscript{st} January 2019. |  |  | Action completed and closed |

| 2.1.3 | Implement daily MARAC meetings (to align with S47) |  |  |  |  |

| 2.1.4 | Agree the future partnership plan for child criminal and sexual exploitation and missing from | Key members of CSE Ops group have met to agree future plans for expanding CSE hub remit to include CCE (Child Criminal Exploitation. Vulnerabilities Executive met on 1\textsuperscript{st} Feb 2019. Agreement for CSE Ops | Really positive that partners are coming together to discuss ways of working together and moving this agenda forward. There is agreement and recognition and all partners are |  | Action now closed. Work will be progressed under new action 2.1.6 |
| Home | Group to be formed into Vulnerabilities Ops group. Wide recognition across partnership that we need to develop and align our own operational responses to CCE. Funding has been secured for a partnership position of Strategic Lead for CCE which will work to develop the operational responses and make sure these are aligned across LLR. | on board and driving this through at pace. |  |

| 2.1.5 Analysis of intelligence in relation to all forms of child criminal exploitation to identify “threat and risk” to inform our preventative strategy and drive operational activity. | Work is underway across LCC and Police to develop a pathway and tool for identifying and mapping children and young people involved in criminal exploitation (links to work being led by Anita Gurry/Donna Smalley in the region). Tool is still being developed and paper will go to LSCB Board in March to inform/update partners on progress. | Dissemination of gang association tool across SC workforce. Pathway into prevention services that dovetails into existing safeguarding processes. | Sharing of concerns around County Lines and exploitation has increased – need to develop operational responses to tackle this. |

| 2.1.6 Timeframe for the development and launch of Child Criminal Exploitation tool and associated resources will be agreed by June '19. Roll-out will be managed through the Vulnerabilities Ops group and signed off by the Vulnerabilities Executive. | Knife crime has been identified by young people across Leicestershire as a key area of concern. All partners have a role to play in addressing knife carrying and related crime. Are agencies taking appropriate actions and making appropriate referrals when they identify children and young people carrying knives? Concerns around funding across the partnership for comms activity around universal safety messages. Have been able to cover CSE and CCE through existing resources | Action now closed. Work will be progressed under new action 2.1.6 |

| 2.2 To make children safe by raising awareness of universal safety messages | 2.2.1 Map gaps and duplication in universal activity delivered across the partnership and identify key learning to be delivered/priority cohorts. | Serious harm reduction unit in police have been promoting county lines and exploitation of children (internally and across partners and public) | Action now closed. Work will be progressed under new action in recognition of knife crime as an emerging issue and the risk of harm to children and young people. Actions to be developed once Strategic Lead is in post. |

<p>| 2.1.7 To develop and integrate a model across the partnership to recognise, respond to and prevent knife crime |  |  |  |
| 2.2.2 Develop a comms strategy, training plan and resources to support professionals in the delivery of safety messages (real and virtual world). | CSE communications strategy in place and will be expanded to encompass wider risk areas. (action aligned to existing CSE comms strategy). Police CSE comms lead is working on a directory of local and universal campaign materials. Have introduced an electronic, partnership CSE/CE newsletter. The bulletin will be issued every four months and include information about new initiatives, campaigns and projects, details of new legislation, a round-up of recent, successful investigations and convictions, national issues and details of good work and awards. The aim is to ensure all practitioners across the county are up-to-date with the work being undertaken by police and partners to raise greater awareness of CCE. Breck’s Last Game, the major new film aimed at protecting children from online grooming, along with a comprehensive resource pack, is currently being rolled out to schools across Leicester, Leicestershire and Rutland following its launch in September 2018. CSE briefings are being delivered to partners (including GPs) and preferred resources (posters etc) are being shared. | The feedback from schools on Breck’s Last Game is overwhelmingly positive. One teacher said she found it “interesting and vital to teach, especially from the angle that we were not trying to scare the pupils but instead empower them to understand how to use the internet safely and also, seek assistance, and know where to obtain help from, if required.” Have developed closer links with licensing by setting up a task and finish group to agree a new suite of CSE training materials for the night time economy including taxis and licensing which have been ratified by the CSE, Missing and Trafficked Ops group. They have now been distributed across LLR via the CSPs. Held a very successful partnership CSE/ CCE gangs and county lines training day on January 21st for professionals across LLR which was fully booked and received extremely well. | but if we are wanting to widen out we will need additional resources. Some issues communicating with secondary schools regarding the Breck’s Last Game offer. There are several channels for doing this but despite utilising all of these there are still some schools to claiming to know nothing about the film or resource pack. By June 19 - Refresh CSE/CCE comms plan |</p>
<table>
<thead>
<tr>
<th>Focus areas</th>
<th>Actions</th>
<th>End of year 1 – Where are we now?</th>
<th>What’s working well?</th>
<th>What are we worried about?</th>
<th>Year 2 - What needs to happen?</th>
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<tbody>
<tr>
<td><strong>3.1</strong> To develop an integrated approach to family resilience and self-sufficiency</td>
<td>Work with partners to understand needs, identify gaps and explore opportunities for integration and integrated commissioning</td>
<td>A collective mapping process will be undertaken to understand partners’ involvement. Future identified actions will follow once this work has been completed</td>
<td>Work is underway</td>
<td></td>
<td>Identify gaps and opportunities from the mapping exercise</td>
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<td><strong>3.2</strong> To enable families to navigate services</td>
<td>Provide joined up information and guidance to enable children, young people and families to be self-sufficient and navigate services</td>
<td>Named “champions” have been identified from partner organisations to ensure regular updating of re-vamped Directory. The new Leicestershire Information &amp; Support Directory (LISD) is now live and going through a soft launch for testing prior to a formal re-launch.</td>
<td>Complete</td>
<td>Some concerns that this is an LCC owned and that other information and guidance is being developed by other partners</td>
<td>Complete</td>
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<tr>
<td><strong>3.3</strong> To support families to progress towards work</td>
<td>Enterprise advisers linked to every secondary school / academy</td>
<td>Mapping of schools/academies linked to Enterprise Advisors complete and gaps identified. Numbers of EA’s are increasing. Some schools are participating as national pilots of the Careers Hub.</td>
<td>Regular updates on number of EA is provided by the LEP and numbers are increasing across the County</td>
<td>Nothing, progressing well</td>
<td>Every school has an EA</td>
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<td></td>
<td>Engage with businesses locally to build resilience and offer supported opportunities available for SEND children</td>
<td>Not started</td>
<td>This has been a difficult priority to progress as funding picture is unclear</td>
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<td>Raise profile and awareness of DWP work coaches to help overcome barriers to work</td>
<td>Workshops taking place to understand barriers to work for people in HBBC, being led by DWP. If successful, this will be rolled out across the County area</td>
<td>Working well</td>
<td>Limited number of work coaches within the DWP</td>
<td>Rollout of DWP work coaching sessions</td>
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<td></td>
<td>Encourage people to become part of their communities (volunteering)</td>
<td>Will ensure community and volunteering opportunities are link into the LSID when launched to ensure promotion</td>
<td>Not yet started</td>
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<tr>
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<td>4.1 To provide integrated, outcome-based, high quality, cost effective provision</td>
<td>4.1.1 Identify opportunities for integrated commissioning of direct payments, short breaks, play and leisure.</td>
<td>LCC CFS, CCG and LCC A&amp;C are working together to consider commissioning opportunities for Short Break residential provision that will ensure a joint pathway of care for Children/Young Adults with Disabilities</td>
<td>Joint Priorities have been agreed for the SEN Strategy and a meeting with the CCG has been arranged to consider the development of a Joint Strategic Commissioning Board and a review of the Complex Care Panel.</td>
<td>The Complex Care Panel is very health focused and is currently not considering all Integrated Commissioning. Terms of reference for the CCP appear to be about determining eligibility to Continuing Care. These need to be reviewed.</td>
<td>Amend wording of action 4.1.1 to reflect new focus: 4.1.1a Identify opportunities for integrated assessment and commissioning of appropriate resources (direct payments or complex care packages) 4.1.1b Review the current Complex Care Panel pathway/ protocol and develop an approach that considers complex needs and solution focused responses</td>
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</table>
|                                                | 4.1.2 Develop an Inclusion strategy to ensure a partnership approach in meeting the needs of vulnerable children and young people in inclusive settings. | LCC Inclusion Manager appointed on a 2 year fixed term contract from July 2018. The Inclusion Manager has direct reports from Elective Home Education (EHE), Children with Medical Needs, CME, Pupils Missing Education and Advice, Information and Guidance teams, and oversight of the primary and secondary behaviour partnerships. These service areas offer support back to schools, including the writing of inclusion pathways and inclusion strategy. | From September 2019 the work of the inclusion manager area has formed part of the High Needs Development plan, with updates being reported to the High Needs Board as appropriate. The pathway group have been meeting at regular points, and their work is being incorporated in the High Needs Development Plan work strands. Direct work and co-ordination where permanent exclusions have occurred to consider if needs have been met by the school prior to exclusions- enabling accountability around exclusions | The increase in number of young people in EHE with unmet SEN needs. Exclusions of vulnerable students with unmet SEN needs. Gaps in services around non-attendance for young people with SEMH There are times when it is difficult to get a LAC including UASC into a school provision (to include in inclusion pathway) | By June 2019 Remodelling of Inclusion Service Development of pathway structures (strategy, gather information for pathway design, identify gaps in services) Data development of identified needs of cohorts linking this to other services Development of Surgeries at secondary level Recruitment to Inclusion Coordinator Review of SEIPS agreement By Sept 2019 Process development for inclusion team following recruitment to new roles Consultation and Website development for pathway By Dec 2019 Promotions of Inclusion Pathway Extension of locality model for
| 4.1.3 | Develop a wraparound therapeutic services model to support step-downs from residential care | MISTLE contract awarded to Action for Children. Operational meetings have been set up to identify targeted young people and actively recruiting specialist carers. Continuing to publicise the pathway. Contract and referral panels in place and targeted young people being worked with. | Action for Children involved in the training and recruitment of foster carers. | Still early in the process to measure achievement/impact for young people. Challenge in recruiting level 6 carers. Continuing to work on this. | MISTLE contract includes performance targets against which performance will be monitored quarterly. |
| 4.2 | To develop a post 16 multi-agency delivery model | **16+ model:** Working group for design of 16+ model (including housing reps) meeting on a regular basis. Further review, visits and children’s voice work undertaken. Option paper prepared for consideration at LCC SMT in Dec ’18 (agreed to extend Adullam contract for further 12 months). The review of the housing protocol is in draft waiting for sign off by LCC SMT/DMT and will need to be presented to Cabinet. | Monthly meetings are held with a representative from the district councils to aid designing a new service specification. Looking at tying in the accommodation for young people at risk of homelessness with the accommodation that is currently provided by our 16+ providers. This will be achieved by including the requirements in the current framework that we have for providing accommodation for LAC aged 16/17. | Amend wording of action 4.2.1a to reflect new focus: “Development of multi-agency protocol for 16 and 17 year olds at risk of homelessness” | By Sept 2019 To continue with the joining up of the two contracts which support 16/17 year olds with a view to this being finalised and launched from August 2019 By Dec 2019- To have protocol and plan signed off by August 2019, with commissioning to follow |
| 4.2.1b | Development of Care Leaver Offer | Care Leavers: The Care Leaver Offer based on the extended duty was sent to Care Leavers aged 21-25. The LCC team was enhanced, through growth of personal advisors, with a clear drive for purposeful and ambitious relationships with our young people. Multi-agency High Risk Panel is now well embedded with clear evidence of impact on specific young people; EET has improved across all age groups Suitable accommodation has DWP engagement in High Risk Panel and C&F Partnership. Health Services commitment to Care Leavers and their offer. Mental Health responses to young people aged 17+ and the ‘cliff edge’ with adult mental health | by May 2019 – LCC 6 apprenticeships are used by June 2019 – Housing protocol agreed, including accepting housing applications at age 17.5 years by March 2020 - DWP is an active
people.

improved across all age groups
Care Leaver ring-fenced apprenticeships is up and running

SYPAC remains strong with increased attendance at the end of last year.

services
Pushing for the Housing Protocol to be empathetic
NEET and Suitable Accommodation is less effective for young people aged 21+
Ensuring that SYPAC is accessible for the most vulnerable of our Care Leavers.

member of Partnership
DWP is a member of Corporate Parenting Board
Agreed protocol with CAMHS and health about continuity of provision for older young people

Employment, training and sponsorship is created through LLEP

Mentoring scheme is established

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<tr>
<th>4.2.2 Review integrated pathways to adulthood for children with SEN and disabilities</th>
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<tr>
<td>LCC Pathway to Adulthood Protocol now developed by Children and Families and Adults and Communities. Transitions event held on 27th June to develop the pathway. Launched September 2018. As yet there is no systematic evidence of impact of the new pathway. However, there are emerging examples of good practice, including complex cases where there has been improved planning between children’s and adult services. An additional Service Manager is now being appointed within the Transitions Team (together with 6 additional Transitions Workers). The SM will have a 0.5fte responsibility to coordinate and drive this work forward.</td>
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<tr>
<td>The Pathway document is available on the Local Offer website and has been publicised through the schools newsletter, SENDC Net meetings and other Forums. Training has been provided to SENCOs and other practitioners on how to write good quality outcome focussed plans. Dialogue has taken place with FE providers about the post 19 offer and there is a shared vision about how to move forward. Early discussions with Adult Services about accommodation needs into the future, including a commitment to explore provision that could support young people into adulthood with greater continuity pre and post 18yrs.</td>
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<td>A governance structure is now in place, including a Transitions Board with LCC CFS, LCC A&amp;C, Parent Carer Forum and Health representation. The governance structure beneath the Transitions Board includes five sub groups. There has been a lack of capacity to drive the work of these groups forward. Adult Transition Team have started to work with some young people prior to 17yrs and priority cohorts are being identified. SENA now have an established ‘post 16’ Team (SENO and 2 casework officers) to prioritise transitions work</td>
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<tr>
<td>Each of the 5 work streams reporting to the Transitions Board to have an identified lead and pattern of meetings established by 30 April 2019. Paper to DMT to agree revised funding arrangements for FE Colleges by end of June 2019 Adult’s Transitions Team to be fully staffed by end of June 2019, including SM Lead for Transitions Pathway (by end of April 2019) Systematic process for evaluating service user views on EHCP/Annual Review process to be in place from September 2019</td>
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<tr>
<td>Focus areas</td>
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| 5.1 To make obesity everyone’s business | Develop a whole system approach to obesity based on “Making obesity everyone’s business” | Maternal Healthy Weight Actions are being implemented:  
- Leicestershire Partnership NHS Trust has agreed to embed Maternal Obesity as part of the Making Every Contact Count (MECC) conversation  
- The STP has agreed to include Maternal Obesity in the ‘MECC Workforce Capability Toolkit’ which is under development  
- A maternal obesity module is being developed for LPTs online MECC training offer – this can be used by other partners (e.g. UHL, LCC)  
- Public Health England have published a suite of Maternal Health resources which are being adapted for use at a local level  
- Maternal Obesity stakeholder event (31 October 2018) has informed actions going forward (how to raise the issue before, during and after pregnancy)  
- Literature Review of the evidence of what works completed Feb 19 and key messages will be summarised and disseminated through via a maternal obesity comms strategy. | Embedding maternal obesity into MECC  
Looking at health needs assessment and evidence | Getting whole system buy-in (a bit piecemeal currently) | Sept 19 - MECC training module completed  
Dec 19 – roll out of implementation across stakeholders (including protected learning time to GPs and UHL)  
March 20 – begin monitoring on maternal obesity being raised as part of MECC conversations |
| Develop a Schools Active Travel Action Plan | A mapping exercise / audit is underway  
7 Primary schools have been identified to receive ‘intensive support’ from the Active Travel Team to pilot different activities and interventions to identify what works - this will help to inform recommendations for District Councils etc  
Information on adopting a whole-school approach to active travel that has been developed and uploaded onto the updated healthy schools website in Dec 18  
Article on whole-school approach to active travel provided for School Governor Newsletter (Jan 19 edition) - [https://www.leicestershirehealthyschools.org.uk/active-travel](https://www.leicestershirehealthyschools.org.uk/active-travel)  
Article on whole-school approach to active travel provided for Headteacher briefing – (Jan 19 briefing) - [https://www.leicestershirehealthyschools.org.uk/active-travel](https://www.leicestershirehealthyschools.org.uk/active-travel) | Current actions going well. Need to wait until end of academic year for lessons learned  
Use the 7 schools as beacons of good practice to influence other heads and get buy-in | Influencing parents – need to engage with children and young people more and devise a campaign to help influence them | June 19 – collating feedback for the lessons learned from the 7 pilot schools  
Sept 19 – showcasing the lessons learned to other schools (feeding into headteacher meetings and briefings)  
Dec 19 - prep work and planning to engage with children and young people in pilot schools |
<table>
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<tr>
<th>travel</th>
<th>Information linking active travel to improved air quality information uploaded onto healthy schools website in Dec 18 - <a href="https://www.leicestershirehealthyschools.org.uk/active-travel">https://www.leicestershirehealthyschools.org.uk/active-travel</a></th>
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<tr>
<td>Partnership delivery of &quot;Active Families&quot; 4 year project funded by Sport England</td>
<td>Year 1 pilot delivered in Harborough and NW Leics as the implementation phase</td>
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<tr>
<td>Good partnership working between Districts, Physical Activity Development Officers, Home Start volunteers and SLF workers</td>
<td>Difficulties in recruiting families who meet the criteria</td>
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<td>April 19 - roll out of implementation across the County September 19 – monitoring &amp; County wide review of first 6 months. Update report to come to Partnership Board.</td>
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### 5.2 To develop a partnership approach to emotional health and wellbeing

| | Develop a partnership wide approach to emotional and mental wellbeing using Future in Mind as a framework Mind as a framework and focussing on the Adverse Childhood Experience base |
| | Currently meeting with partners to ‘map’ what is currently being delivered with a view to developing a County wide, multi-agency approach. A consensus needs to be reached re trauma informed care to address and prioritise ACEs |
| | Meetings with Nottinghamshire and Lincolnshire County Councils held in January to learn from how they have developed a trauma informed approach across their counties. |
| | Stakeholder event planned for 21st May on ACEs |
| | Starting to get buy-in and recognition from partners |
| | It is a slow process and buy-in takes time. Austerity and cuts impacting on services that will be needed to address ACEs |
| | May 19 – stakeholder event held to kick off a partnership wide conversation on the ACE approach Sept 19 – identify funding to deliver training and shared approach Complete training needs analysis to identify in relation to ACE awareness Dec 19 - comms plan developed |
Leicestershire Children and Families Partnership
Priorities 2018-2021

Our shared vision
Children & young people in Leicestershire are safe and living in families where they can achieve their full potential.

2 CROSS-CUTTING THEMES: COMMUNICATIONS STRATEGY, WORKFORCE DEVELOPMENT

1. Ensure the best start in life
   - To develop an integrated Early Years Pathway to ensure the needs of vulnerable children are identified
   - To develop a shared understanding of the importance of the First 1001 Critical Days and school readiness

2. Keep children safe and free from harm
   - To develop a shared understanding of the importance of the First 1001 Critical Days and school readiness
   - To develop and embed an integrated model of services to prevent harm to children and young people
   - To make children safe by raising awareness of universal safety messages

3. Support children and families to be resilient
   - To develop an integrated approach to family resilience and self-sufficiency
   - Provide joined up information and guidance to enable families to be self-sufficient and navigate services
   - To support families to progress towards work

4. Ensure vulnerable families receive personalised, integrated care and support
   - To provide integrated, outcome-based, high quality, cost-effective provision
   - To develop a post-16 multi-agency delivery model

5. Enable children to have good physical and mental health
   - To develop a whole system approach based on ‘Making obesity everyone’s business’
   - To develop a partnership approach to emotional and mental wellbeing

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<tr>
<th>VOICE OF CHILDREN AND YOUNG PEOPLE</th>
<th>OUTCOME-BASED PLANNING</th>
<th>INTEGRATED COMMISSIONING</th>
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<tbody>
<tr>
<td>1. Ensure the best start in life</td>
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<td>2. Keep children safe and free from harm</td>
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<tr>
<td>3. Support children and families to be resilient</td>
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<tr>
<td>4. Ensure vulnerable families receive personalised, integrated care and support</td>
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<tr>
<td>5. Enable children to have good physical and mental health</td>
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<tr>
<th>ENABLERS</th>
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- Blaby District Council
- Charnwood Borough Council
- Hinckley & Bosworth Borough Council
- Melton Borough Council
- North West Leicestershire Clinical Commissioning Group
- Policing
- NHS
- Leicestershire County Council
HEALTH AND WELLBEING BOARD: 30 May 2019

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

SUMMARY OF LEICESTERSHIRE AND RUTLAND LOCALITY PROFILES

Purpose of the report

1. The purpose of this report is to provide a summary of health-related data at a locality level using data from local health profiles that are published by Public Health England. The report also gives a progress update on the development of locality/PCN (Primary Care Network) profiles.

Recommendations

2. It is recommended that;
   a) The Health and Wellbeing Board notes the content of the report;
   b) A further report be considered by the Board once the Primary Care Network locality profiles have been developed.

Policy Framework and Previous Decisions

3. The NHS Long Term Plan was published in January 2019. It prioritises the need to develop a ‘Population Health Management’ approach to improving services at the locality level. This involves data driven planning and delivery of care to have the greatest impact on improving health, including segmentation and risk stratification of the population to understand the local needs. The Integrated Locality Team profiles are one element of a wider population health management approach that will be developed during 2019/20.

4. Developing the population health management approach is a priority for Leicester, Leicestershire and Rutland (LLR) Better Care Together (Sustainability and Transformation partnership) and is being developed through the Prevention Programme Board and LLR Business Intelligence Strategy with support from the Primary Care and Integrated Communities Boards.

Background

5. The following data has been sourced from Local Health and summarises health indicators for the 10 localities in Leicestershire. Included in the appendix is an example of a Locality Profile for Harborough. For access to other locality profiles, please contact Kajal Lad, Public Health Business Partner (Kajal.lad@leics.gov.uk). The table below shows how people’s health in each integrated locality team across Leicestershire and Rutland compares to the rest of England. For a large number of indicators, integrated locality teams have better health than the England average.
5.1 Analysis of summary profiles

Across Leicestershire and Rutland there are other indicators where performance could be improved. Syston, Long Clawson and Melton (SLAM) has seven indicators where performance is worse than the national average; Oadby and Wigston has three indicators where performance is worse than the national average; South Blaby and Lutterworth has two indicators where performance is worse than the national average; North Charnwood and Harborough has one indicator where performance is worse than the national average. North Blaby, North West Leicestershire, Hinckley and Bosworth, South Charnwood and Rutland have no indicators where performance is worse than the national average. See table 1 below:

Table 1: Health Indicator performance by Locality

<table>
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</table>

- **Significantly better than England average**
- **Not significantly different from England Average**
- **Significantly worse than England average**
5.2 Summary of key findings

It is clear that Leicestershire and Rutland perform well in many indicators. Leicestershire and Rutland have eight indicators that perform better than the England average across all locality areas. However, there is not an even spread across all areas and there is room to improve the overall health of the population.

The summary table identifies a number of areas where Leicestershire and Rutland can focus to improve health, through concentrating on locality areas where the performance of indicators are worse than the national average.

Issues of concern

Oadby and Wigston and SLAM have significantly worse rates of emergency admissions of 0-4 year olds compared to the national average.

Harborough and South Blaby and Lutterworth have significantly worse levels of breast cancer than the national average. There are no integrated locality team areas in Leicestershire or Rutland that perform significantly better than the national average for this indicator.

SLAM performs significantly worse for emergency hospital admissions for Coronary Heart Disease, Stroke and Myocardial Infarction (heart attack), when compared to the national average. Oadby and Wigston also performs significantly worse compared to the national average for emergency hospital admissions for MI.

Oadby and Wigston and South Blaby and Lutterworth perform significantly worse compared to England for elective hospital admissions for knee replacements. There are no integrated locality team areas in Leicestershire or Rutland that perform significantly better than the national average for this indicator.

When considering premature mortality indicators, SLAM performs significantly worse compared to the England average for rates of circulatory diseases in those aged under 75. When considering mortality and causes of death for all ages, this area also performs significantly worse when considering circulatory diseases for all ages, and also for stroke. North Charnwood performs significantly worse compared to the national average for all causes of mortality, with all cancer, all circulatory disease, coronary heart disease, stroke and respiratory diseases performing similar to the national average. This is the only area where none of the morality indicators perform better than the national average.

Proposals/Options

6. As discussed above, LLR is looking to develop a population health management approach to support integrated locality teams/Primary Care Networks to utilise data sources to effectively commission services for their local populations. Midlands and Lancashire Commissioning Support Unit currently produce locality intelligence packs for primary care, these are currently being reviewed and further developed with a view to include data from public health. These locality intelligence packs and local health profiles will be aligned to the PCN boundaries once they have been finalised and become chapters of the wider data pack available for PCN to embed the population health management approach.
Consultation/Patient and Public Involvement

7. Further consultation with the PCNs will be completed once established to ensure the population health management approach meets their needs and that of the local population.

Resource Implications

8. LLR Business intelligence and wider partner capacity will be needed to develop the wider population health management approach with PCNs. This may result in slightly different locality data reporting in the future, but is expected to be delivered within current Business intelligence capacity.

Appendix

9. Example of Locality Health Profile - Harborough

Background papers


Officers to Contact

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Kajal Lad
Public Health Business partner
Leicestershire County Council
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Email: kajal.lad@leics.gov.uk

Relevant Impact Assessments

Equality and Human Rights Implications
11. The locality profiles will support a population health management approach to local commissioning of services in the future. This will allow Integrated Locality Teams and Primary Care Networks to effectively define, plan and commission the most appropriate services for their local populations. This could result in slightly different commissioning across PCNs, however this should be targeted to their specific local needs and therefore help reduce health inequalities.
Population

Population by age group, 2015

<table>
<thead>
<tr>
<th>Ages</th>
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<th>Leicestershire (Upper Tier Local Authority)</th>
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<td>8,187</td>
<td>76,797</td>
<td>6,192,070</td>
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<tr>
<td>aged 25-64</td>
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<td>45,080</td>
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<td>aged 65-84</td>
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<td>16,171</td>
<td>116,340</td>
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<tr>
<td>aged 85 and over</td>
<td>1,595</td>
<td>2,379</td>
<td>17,093</td>
<td>1,295,289</td>
</tr>
<tr>
<td>Total</td>
<td>59,179</td>
<td>89,284</td>
<td>675,309</td>
<td>54,786,327</td>
</tr>
</tbody>
</table>

Source: ONS © Crown copyright 2016

Age pyramid for selection: male and female numbers per five-year age group, 2015

Source: ONS © Crown copyright 2016

www.localhealth.org.uk
### Ethnicity & Language indicators, 2011, numbers

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black and Minority Ethnic (BME) Population</td>
<td>3,395</td>
<td>4,066</td>
<td>55,722</td>
<td>7,731,314</td>
</tr>
<tr>
<td>Population whose ethnicity is not White UK</td>
<td>4,905</td>
<td>6,140</td>
<td>72,057</td>
<td>10,733,220</td>
</tr>
<tr>
<td>Population who cannot speak English well or at all</td>
<td>222</td>
<td>260</td>
<td>4,423</td>
<td>843,845</td>
</tr>
</tbody>
</table>

Source: ONS Census, 2011

### Ethnicity & Language indicators, 2011, %

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black and Minority Ethnic (BME) Population</td>
<td>6.1</td>
<td>4.8</td>
<td>8.6</td>
<td>14.6</td>
</tr>
<tr>
<td>Population whose ethnicity is not White UK</td>
<td>8.8</td>
<td>7.2</td>
<td>11.1</td>
<td>20.2</td>
</tr>
<tr>
<td>Population who cannot speak English well or at all</td>
<td>0.4</td>
<td>0.3</td>
<td>0.7</td>
<td>1.7</td>
</tr>
</tbody>
</table>

Source: ONS Census, 2011

### Ethnicity & Language Indicators, 2011, %, Selection

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black and Minority Ethnic (BME) Population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population whose ethnicity is not White UK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population who cannot speak English well or at all</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: ONS Census, 2011

// indicates missing or suppressed data
Report - Ward 2016: Harborough

**Deprivation**

### Indices of Deprivation, 2015, Score

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMD 2015 Score</td>
<td></td>
<td>8.3</td>
<td>12.5</td>
<td>21.8</td>
</tr>
</tbody>
</table>

Source: DCLG © Copyright 2015. Please see metadata for further guidance on how to interpret IMD score.

### Indices of Deprivation, 2015, numbers

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living in means tested benefit households</td>
<td>3,781</td>
<td>5,507</td>
<td>69,265</td>
<td>7,700,220</td>
</tr>
<tr>
<td>Children living in income deprived households</td>
<td>843</td>
<td>1,202</td>
<td>14,114</td>
<td>2,016,120</td>
</tr>
<tr>
<td>People aged 60+ living in pension credit households</td>
<td>1,369</td>
<td>2,014</td>
<td>16,488</td>
<td>1,954,617</td>
</tr>
</tbody>
</table>

Source: DCLG © Copyright 2015

### Indices of Deprivation, 2015, %

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Deprivation</td>
<td>6.3</td>
<td>6.4</td>
<td>9</td>
<td>14.6</td>
</tr>
<tr>
<td>Child Poverty</td>
<td>8</td>
<td>7.4</td>
<td>12</td>
<td>19.9</td>
</tr>
<tr>
<td>Older People in Deprivation</td>
<td>9.2</td>
<td>9</td>
<td>11.3</td>
<td>16.2</td>
</tr>
</tbody>
</table>

Source: DCLG © Copyright 2015

Indices of Deprivation, 2015, %, Selection (comparing to England average)

- **Green** Significantly better than England
- **Yellow** Not significantly different
- **Red** Significantly worse than England
- **Gray** England

Source: DCLG © Copyright 2015

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// Indicates missing or suppressed data
### Child Development, Education and Employment

#### Child development, education and employment indicators, numbers (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birth weight of term babies, 2011-2015</td>
<td>69</td>
<td>76</td>
<td>753</td>
<td>86,826</td>
</tr>
<tr>
<td>A good level of development at age 5, 2013/14</td>
<td>371</td>
<td>579</td>
<td>4,166</td>
<td>387,000</td>
</tr>
<tr>
<td>Achieving 5A*-C (inc. Eng &amp; Maths) GCSE, 13/14</td>
<td>369</td>
<td>596</td>
<td>4,020</td>
<td>315,795</td>
</tr>
</tbody>
</table>

Source: Public Health England, ONS, NOMIS, DFE.

Please note employment data for Wards is not available at this time.

#### Child development, education and employment indicators, values (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birth weight of term babies</td>
<td>2.5</td>
<td>2</td>
<td>2.4</td>
<td>2.8</td>
</tr>
<tr>
<td>Child development at age 5</td>
<td>62.2</td>
<td>61.7</td>
<td>57.9</td>
<td>60.4</td>
</tr>
<tr>
<td>GCSE achievement (5A*-C inc. Eng &amp; Maths)</td>
<td>63.8</td>
<td>64.3</td>
<td>57.7</td>
<td>55.5</td>
</tr>
</tbody>
</table>

Source: Public Health England, ONS, NOMIS, DFE.

#### Child development, education and employment indicators, Selection (comparing to England average)

- **Significantly better than England**
- **Not significantly different**
- **Significantly worse than England**
- **England**

Source: Public Health England, ONS, NOMIS, DFE.
Health and care indicators, 2011, numbers

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health: very bad</td>
<td>431</td>
<td>648</td>
<td>8,053</td>
<td>660,749</td>
</tr>
<tr>
<td>General health: bad or very bad</td>
<td>1,995</td>
<td>2,993</td>
<td>28,020</td>
<td>2,911,195</td>
</tr>
<tr>
<td>Limiting long term illness or disability</td>
<td>8,359</td>
<td>12,424</td>
<td>105,423</td>
<td>9,352,586</td>
</tr>
<tr>
<td>Provides unpaid care for 1 or more hours per week</td>
<td>5,978</td>
<td>8,983</td>
<td>70,728</td>
<td>5,430,016</td>
</tr>
<tr>
<td>Provides unpaid care for 50 or more hours per week</td>
<td>1,030</td>
<td>1,503</td>
<td>14,040</td>
<td>1,256,237</td>
</tr>
</tbody>
</table>

Source: ONS Census, 2011

Health and care indicators, 2011, %

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health very bad</td>
<td>0.8</td>
<td>0.8</td>
<td>0.9</td>
<td>1.2</td>
</tr>
<tr>
<td>General health bad or very bad</td>
<td>3.6</td>
<td>3.5</td>
<td>4.3</td>
<td>5.5</td>
</tr>
<tr>
<td>Limiting long term illness or disability</td>
<td>15</td>
<td>14.6</td>
<td>16.2</td>
<td>17.6</td>
</tr>
<tr>
<td>Provides 1 hour or more unpaid care per week</td>
<td>10.7</td>
<td>10.5</td>
<td>10.9</td>
<td>10.2</td>
</tr>
<tr>
<td>Provides 50 hours or more unpaid care per week</td>
<td>1.9</td>
<td>1.8</td>
<td>2.2</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: ONS Census, 2011

Health and care indicators, 2011, %, Selection (comparing to England average)

Source: ONS Census, 2011
www.localhealth.org.uk
// indicates missing or suppressed data
Housing and Living Environment

Housing and living environment indicators, 2011 and 2014, numbers

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fuel Poverty, 2014</td>
<td>2,055</td>
<td>2,993</td>
<td>24,100</td>
<td>2,379,357</td>
</tr>
<tr>
<td>Overcrowded households (at least 1 room too few)</td>
<td>775</td>
<td>1,088</td>
<td>9,791</td>
<td>1,928,590</td>
</tr>
<tr>
<td>Pensioners living alone</td>
<td>3,041</td>
<td>4,388</td>
<td>33,126</td>
<td>2,725,590</td>
</tr>
</tbody>
</table>

Source: ONS Census, 2011; Department of Energy and Climate Change 2014

Housing and living environment indicators, 2011 and 2014, %

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fuel Poverty, 2014</td>
<td>8.7</td>
<td>8.4</td>
<td>8.8</td>
<td>10.6</td>
</tr>
<tr>
<td>Overcrowded households (at least 1 room too few)</td>
<td>3.4</td>
<td>3.1</td>
<td>3.7</td>
<td>8.7</td>
</tr>
<tr>
<td>Pensioners living alone</td>
<td>28.6</td>
<td>28</td>
<td>28.7</td>
<td>31.5</td>
</tr>
</tbody>
</table>

Source: ONS Census, 2011; Department of Energy and Climate Change 2014

Housing and living environment indicators, 2011, %, Selection (comparing to England average)

- Significantly better than England
- Not significantly different
- Significantly worse than England
- England

![Chart showing housing and living environment indicators](chart.png)

Source: ONS Census

Please note Fuel Poverty cannot be displayed on chart as it does not have confidence limits.
Children's Weight

Children's weight indicators, 2013/14-2015/16, numbers (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese children (Reception Year)</td>
<td>145</td>
<td>204</td>
<td>1,667</td>
<td>160,362</td>
</tr>
<tr>
<td>Children with excess weight (Year 6)</td>
<td>351</td>
<td>523</td>
<td>4,327</td>
<td>404,465</td>
</tr>
<tr>
<td>Obese children (Year 6)</td>
<td>243</td>
<td>383</td>
<td>3,120</td>
<td>307,544</td>
</tr>
<tr>
<td>Children with excess weight (Year 6)</td>
<td>463</td>
<td>722</td>
<td>5,802</td>
<td>535,056</td>
</tr>
</tbody>
</table>


Children's weight indicators, 2013/14-2015/16, % (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese children (Reception Year)</td>
<td>8.4</td>
<td>7.8</td>
<td>8</td>
<td>9.3</td>
</tr>
<tr>
<td>Children with excess weight (Reception Year)</td>
<td>20.2</td>
<td>19.9</td>
<td>20.8</td>
<td>22.2</td>
</tr>
<tr>
<td>Obese children (Year 6)</td>
<td>14.3</td>
<td>14.5</td>
<td>16.4</td>
<td>19.3</td>
</tr>
<tr>
<td>Children with excess weight (Year 6)</td>
<td>27.3</td>
<td>27.6</td>
<td>30.4</td>
<td>33.6</td>
</tr>
</tbody>
</table>


Children's weight indicators, %, Selection (comparing to England average)


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# Public Health England

## Local Health

**Report - Ward 2016: Harborough**

## Children's health care activity

### Children's health care activity, numbers, 2013/14 - 2015/16 (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Admissions 0-4 year olds</td>
<td>850</td>
<td>1,235</td>
<td>9,384</td>
<td>1,533,272</td>
</tr>
<tr>
<td>A&amp;E attendances 0-4 year olds</td>
<td>4,215</td>
<td>5,947</td>
<td>44,823</td>
<td>5,670,099</td>
</tr>
<tr>
<td>Admission for injury 0-4 year olds</td>
<td>128</td>
<td>213</td>
<td>1,562</td>
<td>236,081</td>
</tr>
<tr>
<td>Admission for injury 0-14 year olds</td>
<td>341</td>
<td>550</td>
<td>4,148</td>
<td>527,519</td>
</tr>
<tr>
<td>Admission for injury 15-24 year olds</td>
<td>202</td>
<td>462</td>
<td>3,967</td>
<td>470,265</td>
</tr>
</tbody>
</table>

*Source: Public Health England, NHS Digital, 2017*

### Children's health care activity, values, 2013/14 - 2015/16 (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Admissions 0-4 year olds, rate per 1,000</td>
<td>91.8</td>
<td>90.4</td>
<td>85.3</td>
<td>149.2</td>
</tr>
<tr>
<td>A&amp;E attendances 0-4 year olds rate per 1,000</td>
<td>455.3</td>
<td>435.3</td>
<td>407.4</td>
<td>551.8</td>
</tr>
<tr>
<td>Admission for injury 0-4 year olds rate per 10,000</td>
<td>82</td>
<td>92.8</td>
<td>85</td>
<td>138.8</td>
</tr>
<tr>
<td>Admission for injury 0-14 year olds rate per 10,000</td>
<td>68.8</td>
<td>72.1</td>
<td>75</td>
<td>110.1</td>
</tr>
<tr>
<td>Admission for injury 15-24 year olds rate per 10,000</td>
<td>97.9</td>
<td>100.5</td>
<td>93.1</td>
<td>137</td>
</tr>
</tbody>
</table>

*Source: Public Health England, NHS Digital, 2017*

### Children's health care activity, Selection (comparing to England average)

- **Green**: Significantly better than England
- **Yellow**: Not significantly different
- **Red**: Significantly worse than England
- **Gray**: England

*Source: Public Health England, NHS Digital, 2017*

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Adults’ Behavioural Risk Factors

Adults’ Behavioral Risk Factors, 2006-08, numbers (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese adults</td>
<td>9,875</td>
<td>15,214</td>
<td>127,221</td>
<td>9,933,436</td>
</tr>
<tr>
<td>Binge drinking adults</td>
<td>8,025</td>
<td>13,097</td>
<td>100,652</td>
<td>8,290,798</td>
</tr>
<tr>
<td>Healthy eating adults</td>
<td>14,484</td>
<td>22,427</td>
<td>158,697</td>
<td>11,907,157</td>
</tr>
</tbody>
</table>

Source: Public Health England © Copyright 2010

Adults’ Behavioral Risk Factors, 2006-08, % (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese adults</td>
<td>22.7</td>
<td>23</td>
<td>24.3</td>
<td>24.1</td>
</tr>
<tr>
<td>Binge drinking adults</td>
<td>18.8</td>
<td>19.8</td>
<td>19.2</td>
<td>20</td>
</tr>
<tr>
<td>Healthy eating adults</td>
<td>34</td>
<td>33.9</td>
<td>30.3</td>
<td>26.7</td>
</tr>
</tbody>
</table>

Source: Public Health England © Copyright 2010

Adults’ Behavioral Risk Factors, %, Selection (comparing to England average)

- Significantly better than England
- Not significantly different
- Significantly worse than England
- England

Source: Public Health England © Copyright 2010

www.localhealth.org.uk
# Emergency hospital admissions

Emergency Hospital Admissions, numbers, 2011/12 to 2015/16 (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency hospital admissions for all causes</td>
<td></td>
<td>22,974</td>
<td>34,672</td>
<td>283,357</td>
</tr>
<tr>
<td>Emergency hospital admissions for CHD*</td>
<td></td>
<td>809</td>
<td>890</td>
<td>7,802</td>
</tr>
<tr>
<td>Emergency hospital admissions for stroke</td>
<td></td>
<td>428</td>
<td>591</td>
<td>4,397</td>
</tr>
<tr>
<td>Emergency hospital admissions for MI*</td>
<td></td>
<td>383</td>
<td>551</td>
<td>4,483</td>
</tr>
<tr>
<td>Emergency hospital admissions for COPD*</td>
<td></td>
<td>501</td>
<td>735</td>
<td>6,355</td>
</tr>
</tbody>
</table>

Source: Public Health England, NHS Digital © Copyright 2017

*CHD: Coronary Heart Disease; MI: Myocardial Infarction (heart attack); COPD: Chronic Obstructive Pulmonary Disease

Emergency Hospital Admissions, Standardised Admission Ratios (SAR), 2011/12 to 2015/16 (estimated from MSOA data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency hospital admissions for all causes</td>
<td></td>
<td>78.2</td>
<td>78.8</td>
<td>83.7</td>
</tr>
<tr>
<td>Emergency hospital admissions for CHD</td>
<td></td>
<td>71.7</td>
<td>70.1</td>
<td>82.7</td>
</tr>
<tr>
<td>Emergency hospital admissions for stroke</td>
<td></td>
<td>88.7</td>
<td>81.3</td>
<td>83.1</td>
</tr>
<tr>
<td>Emergency hospital admissions for MI</td>
<td></td>
<td>87.5</td>
<td>89</td>
<td>100</td>
</tr>
<tr>
<td>Emergency hospital admissions for COPD</td>
<td></td>
<td>69</td>
<td>68.2</td>
<td>81</td>
</tr>
</tbody>
</table>

Source: Public Health England, NHS Digital © Copyright 2017

Emergency Hospital admissions, SAR, 2011/12 to 2015/16, Selection (comparing to England average)

- **Green Bar:** Significantly better than England
- **Yellow Bar:** Not significantly different
- **Red Bar:** Significantly worse than England

Source: Public Health England, NHS Digital © Copyright 2017
## Cancer incidence

### Cancer incidence, numbers, 2011-2015 (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cancer</td>
<td>1,712</td>
<td>2,555</td>
<td>18,686</td>
<td>1,460,163</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>305</td>
<td>465</td>
<td>3,043</td>
<td>221,700</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>216</td>
<td>316</td>
<td>2,214</td>
<td>173,299</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>157</td>
<td>230</td>
<td>2,088</td>
<td>186,030</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>199</td>
<td>308</td>
<td>2,195</td>
<td>106,749</td>
</tr>
</tbody>
</table>

Source: England cancer registration data from the National Cancer Registration and Analysis Services' Cancer Analysis System (AV2015 CASREF01)

### Cancer incidence, Standardised Incidence Ratios (SIR), 2011-2015 (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cancer</td>
<td>95</td>
<td>94.8</td>
<td>95.2</td>
<td>100</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>113.3</td>
<td>115.3</td>
<td>104</td>
<td>100</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>100.7</td>
<td>98.8</td>
<td>95.2</td>
<td>100</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>87.9</td>
<td>86.8</td>
<td>83.2</td>
<td>100</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>80.9</td>
<td>82.1</td>
<td>81.3</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: England cancer registration data from the National Cancer Registration and Analysis Services' Cancer Analysis System (AV2015 CASREF01)

### Cancer incidence, SIR, 2011-2015, Selection (comparing to England average)

- Green: Significantly better than England
- Yellow: Not significantly different
- Red: Significantly worse than England

Source: England cancer registration data from the National Cancer Registration and Analysis Services' Cancer Analysis System (AV2015 CASREF01)
### Hospital admissions - harm and injury

#### Hospital admissions - harm and injury, numbers, 2011/12 to 2015/16 (estimated from MSOA level data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital stays for self-harm</td>
<td></td>
<td>374</td>
<td>522</td>
<td>4,065</td>
</tr>
<tr>
<td>Hospital stays for alcohol related harm</td>
<td></td>
<td>1,718</td>
<td>2,565</td>
<td>19,149</td>
</tr>
<tr>
<td>Emergency admissions for hip fracture aged 05+</td>
<td></td>
<td>324</td>
<td>457</td>
<td>3,382</td>
</tr>
<tr>
<td>Elective hospital admissions for hip replacement</td>
<td></td>
<td>444</td>
<td>840</td>
<td>4,704</td>
</tr>
<tr>
<td>Elective hospital admissions for knee replacement</td>
<td></td>
<td>475</td>
<td>706</td>
<td>5,411</td>
</tr>
</tbody>
</table>

Source: Public Health England, NHS Digital © Copyright 2017

#### Hospital admissions - harm and injury, Standardised Admission Ratios (SAR), 2011/12 to 2015/16 (estimated from MSOA)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital stays for self-harm</td>
<td></td>
<td>69.6</td>
<td>63.5</td>
<td>62.6</td>
</tr>
<tr>
<td>Hospital stays for alcohol related harm</td>
<td></td>
<td>93.5</td>
<td>91.7</td>
<td>91.9</td>
</tr>
<tr>
<td>Emergency admissions for hip fracture aged 05+</td>
<td></td>
<td>91</td>
<td>88.8</td>
<td>90.3</td>
</tr>
<tr>
<td>Elective hospital admissions for hip replacement</td>
<td></td>
<td>105.8</td>
<td>101.9</td>
<td>103</td>
</tr>
<tr>
<td>Elective hospital admissions for knee replacement</td>
<td></td>
<td>101.8</td>
<td>101.2</td>
<td>106.7</td>
</tr>
</tbody>
</table>

Source: Public Health England, NHS Digital © Copyright 2017

#### Hospital admissions - harm and injury, SAR, 2011/12 to 2015/16. Selection (comparing to England average)

- Green: Significantly better than England
- Yellow: Not significantly different
- Red: Significantly worse than England

Source: Public Health England, NHS Digital © Copyright 2017

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// indicates missing or successsed data
## Mortality and causes of death - all ages

### Causes of deaths - all ages, numbers, 2011-2015

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes</td>
<td>2,637</td>
<td>3,819</td>
<td>28,888</td>
<td>2,357,381</td>
</tr>
<tr>
<td>All cancer</td>
<td>764</td>
<td>1,109</td>
<td>8,469</td>
<td>666,658</td>
</tr>
<tr>
<td>All circulatory disease</td>
<td>604</td>
<td>1,015</td>
<td>7,848</td>
<td>646,138</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>311</td>
<td>452</td>
<td>3,599</td>
<td>289,738</td>
</tr>
<tr>
<td>Stroke</td>
<td>165</td>
<td>250</td>
<td>1,877</td>
<td>165,375</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>317</td>
<td>478</td>
<td>3,769</td>
<td>325,764</td>
</tr>
</tbody>
</table>

Source: Public Health England, produced from CNS data Copyright © 2017

### Causes of deaths - all ages, Standardised Mortality Ratios (SMR), 2011-2015

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes</td>
<td>89.8</td>
<td>89.1</td>
<td>92.8</td>
<td>100</td>
</tr>
<tr>
<td>All cancer</td>
<td>92</td>
<td>90.8</td>
<td>95</td>
<td>100</td>
</tr>
<tr>
<td>All circulatory disease</td>
<td>85.6</td>
<td>86.1</td>
<td>91.8</td>
<td>100</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>85.6</td>
<td>85.3</td>
<td>93.5</td>
<td>100</td>
</tr>
<tr>
<td>Stroke</td>
<td>79.1</td>
<td>83.2</td>
<td>88.1</td>
<td>100</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>77.3</td>
<td>80.5</td>
<td>87.5</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Public Health England, produced from CNS data Copyright © 2017

### Causes of deaths - all ages, SMR, 2011-2015, Selection (comparing to England average)

- **Significantly better than England**
- **Not significantly different**
- **Significantly worse than England**

Source: Public Health England, produced from CNS data Copyright © 2017
### Mortality and causes of death - premature mortality

#### Causes of deaths - premature mortality, numbers, 2011-2015

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes, aged under 65</td>
<td></td>
<td>363</td>
<td>518</td>
<td>4,112</td>
</tr>
<tr>
<td>All causes, aged under 75</td>
<td></td>
<td>748</td>
<td>1,085</td>
<td>8,842</td>
</tr>
<tr>
<td>All cancer, aged under 75</td>
<td></td>
<td>315</td>
<td>473</td>
<td>3,801</td>
</tr>
<tr>
<td>All circulatory disease, aged under 75</td>
<td></td>
<td>181</td>
<td>249</td>
<td>1,940</td>
</tr>
<tr>
<td>Coronary heart disease, aged under 75</td>
<td></td>
<td>101</td>
<td>133</td>
<td>1,080</td>
</tr>
</tbody>
</table>

Source: Public Health England, produced from ONS data Copyright © 2017

#### Causes of deaths - premature mortality, Standardised Mortality Ratios (SMR), 2011-2015

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Selection</th>
<th>Harborough (Lower Tier Local Authority)</th>
<th>Leicestershire (Upper Tier Local Authority)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes, aged under 65</td>
<td></td>
<td>82.7</td>
<td>77.6</td>
<td>84.8</td>
</tr>
<tr>
<td>All causes, aged under 75</td>
<td></td>
<td>82.7</td>
<td>78.3</td>
<td>85.7</td>
</tr>
<tr>
<td>All cancer, aged under 75</td>
<td></td>
<td>82.9</td>
<td>81.2</td>
<td>90.1</td>
</tr>
<tr>
<td>All circulatory disease, aged under 75</td>
<td></td>
<td>88.8</td>
<td>80.1</td>
<td>88</td>
</tr>
<tr>
<td>Coronary heart disease, aged under 75</td>
<td></td>
<td>90.4</td>
<td>77.7</td>
<td>87.2</td>
</tr>
</tbody>
</table>

Source: Public Health England, produced from ONS data Copyright © 2017

#### Causes of deaths - premature mortality, SMR, 2011-2015, Selection (comparing to England average)

- **Green**: Significantly better than England
- **Yellow**: Not significantly different
- **Red**: Significantly worse than England

Source: Public Health England, produced from ONS data Copyright © 2017

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Note: // indicates missing or suppressed data
Purpose of the report

1. The purpose of this report is to update the Board on the work of the Unified Prevention Board (UPB) in delivering the prevention offer in conjunction with partners across Leicestershire during the 2018/19 financial year. It includes plans for 2019/20 and an updated communications plan for the next financial year.

Link to the local Health and Care System

2. The Unified Prevention Board (UPB) is a sub-group of the Leicestershire Health and Wellbeing Board. It oversees the development and delivery of prevention activities underpinning the health and wellbeing strategy for Leicestershire and ensuring that this aligns with the prevention workstream of the STP.

Recommendation

3. The Health and Wellbeing Board is asked to note the contents of the report.

Background

4. This report is for information to advise the board of the work of the Unified Prevention Board (UPB) over the last financial year and to inform on the future work programme of the UPB. It details the priorities for the next six months and partnership plans to deliver against these to create a fully developed prevention offer. The board has developed a clear plan to deliver the prevention offer with a work programme for 2019/20.

5. The Unified Prevention Board (UPB) was created as a sub-group of the Leicestershire Health and Wellbeing Board. It oversees the development and delivery of prevention activities underpinning the Health and Wellbeing Strategy for Leicestershire.

6. In 2017, the UPB discussed and agreed four key outcome pillars that it was felt all partners contributed to in helping residents maintain their own health and wellbeing. These were:
   - Keep Well;
   - Keep Safe;
   - Stay Independent
   - Enjoy life
7. From this the UPB partners developed the following prevention offer for Leicestershire:
8. Three cross-cutting programmes of work were identified as the focus in developing the unified prevention offer:
   - Joined up comms
   - Healthy workforce
   - Lessons learned from key integration programmes

9. In addition to the above, the UPB has also focused on the following areas throughout 2018/19:
   - Delivering the Local Government Association’s (LGA) funded projects – Prevention at Scale (PAS) and Local Investment Programme (LIP)
   - Linking the UPB’s Social Prescribing offer to support the emerging national model for PCNs
   - Working with district health leads to develop partnership approaches to delivering the Making Every Contact Count (MECC) methodology and supporting the reduction in locality health inequalities detailed in the Health Profiles of each area.
   - Collaborating with the Blue Light Services on the developments of the Falls prevention services and People Zones
   - Building on the current prevention offer to support the Integrated Locality Teams pilot.

2018/19 Achievements

Joined Up Communications

10. A key principle of the Health and Wellbeing Board is ‘Supporting people to avoid ill health, particularly those most at risk, by facilitating solutions, shifting to prevention, early identification and intervention.’

11. The core objectives of the Self-Care Communications campaign for Leicestershire through the UPB are:
   - To re-enforce key approved national and local public health messages that encompass a focus on agreed self-care themes throughout the calendar year.
   - To drive support and participation in self-care and self-care promotion amongst primary and secondary audiences as well as partners and stakeholders.
   - To encourage behaviour change and perception through self-care actions and increase awareness and understanding of healthcare navigation – reducing the impact on resources at a local and regional level.

12. Activity levels during the winter campaign were positive with a total 2,990 Twitter impressions and 31 engagements through the Health and Wellbeing Board account (@leicsHWB).

13. The top tweet during the winter campaign was published on 12 March, with a focus on preventing loneliness and isolation and generated a total 538 impressions and 8 engagements. Traffic to the campaign page was also encouraging with data showing the page within the top 10 visited on the site and an increase in unique visitors spending at least three minutes on the page itself.
14. The current campaign will focus on lifestyle and wellbeing improvement through the core theme of raising awareness of diabetes in Leicestershire. These messages will build upon and continue the diabetes awareness campaign introduced in autumn 2017.

15. Seasonally relevant messages will seek to increase activity levels and encourage healthier eating and drink awareness. A campaign e-toolkit containing posters and social media messages and images has been distributed to partners and stakeholders and we would ask partners to support us in sharing these messages.

Lessons Learned from key integration programmes

Healthy Workforce = Healthy Leicestershire

16. Funding for the Healthy Workforce programme is supported by six district councils (Hinckley and Bosworth, North West Leicestershire, Charnwood, Melton, Harborough and Blaby) and the County Council’s Public Health Department. LRS has been supporting the Workplace Health agenda through delivery of the Workplace Challenge and on behalf of UPB through the development of the Workplace Health Needs Mapping exercise.

17. Recently it has focused on the development of a web based Health Needs Assessment tool with a short version of the national Workplace Health Needs Assessment has been developed to support organisations to identify areas of concern within the health and wellbeing of their staff.

18. Due to the success and high levels of interest, LRS currently have a waiting list of 15 workplaces wanting to conduct the workplace health needs assessment. UPB is working on a delivery model to pilot a new Leicestershire Workplace Health Offer. This involves the development and delivery of three Workplace Health strands, all of which interlink and complement each other as the Leicestershire Workplace Health offer:

- Workplace Health Needs Assessment
- Workplace Wellbeing Charter
- Action Plan and Interventions

19. To date, LRS have provided in kind capacity to support this programme through:

- Performance, Research and Insight Officer - Development of the online function of the Workplace Health Needs Assessment and support with production of the Analysis Reports
- IT Platform to host the Workplace Health Needs Assessment
- Sports Development Manager /LRS Director; Programme oversight of the Workplace Health Agenda

20. In order to continue to deliver the Workplace Health Needs Assessment, develop the Workplace Charter and provide a bespoke offer to organisations (where required), additional capacity is required. The intention is to appoint an Assistant Development Offer to add additional capacity to the team, part funded by Leicestershire County Council Public Health and part funded through district council support.
Development of the Social Prescribing offer for Leicestershire

21. From January – May 2019, the Board has worked on requirements to support the social prescribing model for Leicestershire. The local definition for social prescribing was agreed in April 2017 as:

“A mechanism for empowering people to help themselves and link individuals that need it, with non-medical sources of support within the community. It will ensure that the response given is appropriate to the individual and allows them choice and influence over their wellbeing”.

22. In 2018 further work began to develop the social prescribing model as the wrap-around prevention offer to support Integrated Locality Teams (ILT). This initially focussed around pockets of need e.g. people with multiple long-term conditions.

23. The UPB has continued to develop links between the prevention/social prescribing offer in Leicestershire and Integrated Locality Teams. Work has focussed on strengthening the engagement between UPB partners and Integrated Locality Teams (ILT) in each locality. District council and Public Health representatives are now part of each integrated locality team board helping shape the prevention focus of ILTs and build local join up.

24. The recent ILT Organisation Design (OD) workshop with Leicester, Leicestershire and Rutland partners provided further opportunity for ILT’s to be aware of the prevention offer in Leicestershire and consider further actions on prevention for ILT’s particular cohort of patients.

25. Hinckley and Bosworth, along with North East Leicester and Rutland were chosen as early implementer sites to test integrated multi-disciplinary team working at a neighbourhood level (defined as a population of around 30,000-50,000). The intention is...
to build on previous work within the Integrated Locality Teams programme, and move
towards testing models for the delivery of integrated community, primary and social care
services, and to evaluate how this integrated approach can support better care for the
cohort of patients with complex care needs

26. Previous key integration programmes have helped to shape the development of the
prevention offer to support ILT’s. This programme of work will support the Hinckley pilot
particularly in the first three months of delivery. For example, learning on developing the
outcomes framework for Lightbulb is helping to influence the data collation and user
experience measures for ILT Care Co-ordinators.

27. Local Area Co-ordinators are working as Care Co-ordinators within the Hinckley pilot.
They support the delivery of the prevention offer for Leicestershire for patients in the ILT
cohorts, using the social prescribing model detailed above.

28. Testing of this model began in January 2019. Early indications show that around 80% of
the patients identified required non-clinical interventions which the LACs as care co-
ordinators have been ideally placed to deliver. The most common kinds of interventions
are around loneliness, isolation and housing adaptations.

**Preventions at Scale (PAS) and Local Improvement Partnership (LIP)**

29. The LGA have funded two areas of development of prevention activity throughout
Leicestershire. The first, PAS aims to look at the reasons why patients visit GP’s for non-
medical interventions. The project collates and analyses qualitative information from
patients directly and uses this to determine what improvements could be made to ensure
that people can access the right information from the right sources at the right time.

30. Learning from the project will help to develop prevention activity to ensure it is marketed
appropriately and that in-depth, qualitative understanding of personas is used to build
appropriate pathways into prevention service. This methodology will be used as part of
the qualitative information gathering from patients using the prevention offer within ILT’s
with the programme training LAC’s to carry out this type of qualitative research.

31. Initial findings from the first round of interviews found that:

- People respond to find solutions when support is from a trusted source – GP, friends or family
- All participants had mental health problems
- People want a tangible output from the GP or service visit
- A holistic understanding to address peoples needs was
- Services that were fragmented in many different layers and access criteria which
diffs geographically
- Risk not assessed from a holistic perspective – eg social care only accessed at the
point of crisis
- People were left with nothing when funding for short term community support
projects finished, exacerbating issues

32. Next steps for the project include, completing up to 17 further interviews and picking out
the common themes and using the findings to understand key areas for improvement
and how the research links into other initiatives and to add to the evidence base for
those initiatives. The findings will then be communicated across partners and different organisations.

33. The LIP project is supporting the application for partners to share NHS data to prove where prevention services may have reduced the usage of more costly health services. New mechanisms for measuring this are being developed again, building on the learning of the Lightbulb project that successfully showed the reduction housing interventions could have on the usage of hospital and social care services.

**Delivery of the Mental Health Action plan**

34. The actions from the Health and Wellbeing Board workshop on Mental Health were discussed at the March 2019 meeting of the Board and will be further considered at the Board’s meeting in July. The actions will be fed into the current UPB workstreams such as joined up comms and workplace health. The mental health offer within localities will also be used as part of the wrap-around prevention offer that will link to the Social Prescribing model that is emerging.

**Future work programme**

35. The draft Communications plan up until March 2020 has been produced and will be co-ordinated with partners to ensure join up with subjects and timings; creating a coordinated approach across areas of prevention. Some of the main themes in the plan include the self-care campaign, reducing loneliness and social isolation, volunteering activity and Better Care Together activity.

36. The top priorities/issues for the workplace health programme include poor sleep management, low physical activity levels and poor fruit and vegetable consumption. As the work continues into 2019, the programme will aim to address these priorities with organisations to achieve better outcomes for the Leicestershire workforce with a workplace health tool being developed for use by partners and staff within their organisation and the workplace charter.

37. The UPB partners will be focusing on a joined up social prescribing model across Leicestershire that will either support or be part of the new emerging framework for social prescribing outlined in the NHS 10 year plan.

38. This will support the development of Primary Care Network (PCN’s) Social Prescribing Link Worker roles and ensure that the existing model for Leicestershire is positioned to provide access to the services available in local communities. The board has forged excellent working relationships with the Clinical Commissioning Groups over the previous 12 months and will be further supporting the CCG’s in development of future prevention services for patients across Leicestershire.

39. Continuing the development of the wrap-around prevention offer for ILT’s will be one of the core activities of the UPB for the next six months. Further utilising LAC’s as Care Coordinators and creating a framework for access to services specific to the three cohorts of patients within ILT’s.

40. The board will be working with the Police to look at the developments around People Zones and building on the learning from previous initiatives such as Braunstone Blues. This will be the focus of the July 2019 meeting. The emerging People’s Zones initiative
through the Strategic Partnership Board has provided opportunity for discussion at UPB on how the lower levels of prevention detailed in the Leicestershire model could complement the People’s Zones model.

41. Making Every Contact Count (MECC) is about encouraging and helping people to make healthier choices to achieve positive long-term behaviour change and to build a culture and operating environment that supports continuous health improvement through the contacts it has with individuals.

**Officers to Contact**

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Director of Public Health  
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Telephone: 0116 305 4239

Jane Toman  
Chief Executive, Blaby District Council  
Email: jane.toman@blaby.gov.uk  
Telephone: 0116 272 7576

**Relevant Impact Assessments**

**Equality and Human Rights Implications**

42. The work being undertaken would have a positive impact on the health of the population.

**Partnership Working and associated issues**

43. This report focuses on actions across agencies that will improve the population’s health. The basis of the report is improving population health in partnership with other key agencies.
HEALTH AND WELLBEING BOARD: 30th MAY 2019

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

LEICESTERSHIRE SOCIAL PRESCRIBING AND CARE COORDINATION MODELS

Purpose of report

1. The purpose of this report is to update the Health and Wellbeing Board on the progress made in Leicestershire to develop the existing social prescribing and care coordination models and detail potential options to further develop the models aligned with developments of the NHS Long Term Plan (LTP).

Link to the local Health and Care System

2. Prevention and specifically social prescribing is a key component of the NHS LTP, published in January 2019. The plan specifically mentions implementation of over 1,000 trained social prescribing link workers within Primary Care Networks (PCNs) across the country by the end of 2020/21. This will rise further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes.

3. One of the key developments in the new NHS LTP service model is to boost ‘out-of-hospital’ care and dissolve the historic divide between primary and community health services through an integrated care system. This will ensure services are more joined up, proactive and differentiated to support individual needs. The new model will involve the development of PCNs, which are groups of local GP practices and community teams managing the needs of a 30-50,000 population. These will be supported by risk stratification and predictive prevention tools which generate lists of individuals for multidisciplinary teams (MDT). To support the management of these patients GP practices use care coordination/ navigation roles to integrate health, social care, prevention and community services around the patient’s needs.

Recommendation

4. It is recommended that the Board supports the development of the social prescribing and care coordination models across Leicestershire which would include identifying a systematic approach to embedding these roles into the existing social prescribing system (as detailed in paragraph 19 of the report), engagement with PCNs through planned PCN engagement events and the newly established care coordination task and finish group.

Policy Framework and Previous Decisions

5. The Health and Wellbeing Board endorsed the model for social prescribing at its meeting of the 5th May 2016. A further update was provided in the Unified Prevention Board update on the 25th January 2018.
**Background**

**Social Prescribing Nationally**

6. The King’s Fund and Local Government Association define social prescribing, (sometimes referred to as community referral or locally as the unified prevention offer) as a means of enabling GPs, nurses and other professionals to refer people with social, emotional or practical needs to a range of local, non-clinical services. In April 2017, this was adapted locally by the Unified Prevention Board who define social prescribing as; “A mechanism for empowering people to help themselves and link individuals that need it, with non-medical sources of support within the community. It will ensure that the response given is appropriate to the individual and allows them choice and influence over their wellbeing”.

7. Social prescribing takes a holistic person-centred approach that recognises that people’s health is determined by a range of social, economic and environmental factors. It aims to support individuals to take greater control of their own health by involving individuals into a variety of activities which are typically provided by public, voluntary and community sector and social enterprise organisations. Examples include public health services (stop smoking, weight management, substance misuse, physical activity), fire alarms, volunteering, arts activities, group learning, gardening, befriending, housing/benefits support, home first safety checks and debt management. Across the country there are different models for social prescribing, but most involve a link worker or navigator role who works with people to access local sources of support and build local community capacity.

**The Leicestershire Social Prescribing Model**

8. In 2017 Leicestershire partners at the Unified Prevention Board developed a vision for social prescribing stating, ‘We will work together to create a coherent social prescribing offer across Leicestershire that will benefit citizens by allowing them greater access to our menu of services and community resources, to enhance their health and wellbeing’.

9. The Council’s ‘First Contact Plus’s service acts as the coordinating “front door” for accessing a range of social prescribing solutions, as illustrated by Figure 1. The social prescribing model recognises that the ‘offer’ would not be the same in the two areas as, for example, the physical activity services and approach to community development vary by district council.
10. First Contact Plus provide information, advice and guidance over the telephone or email by making a referral to preventative services. (Further details available at http://www.firstcontactplus.org.uk/). If vulnerable individuals require more in-depth face to face interventions, they may be referred to a Local Area Coordination (LAC). LAC is an approach to supporting people and their families to have a good life as part of their local community and hence is a central part of the social prescribing model. Rather than waiting for people to fall into crisis, assessing deficits, testing eligibility and fitting people into more expensive (and increasingly unaffordable) services, it works alongside people to:

- Build and pursue their personal vision for a good life,
- Stay strong, safe and connected as contributing citizens,
- Find practical, non-service solutions to problems wherever possible, and
- Build more welcoming, inclusive and supportive communities.

N.B. There are currently a limited number of LACs operating across the County, meaning that not all localities or neighbourhoods have a dedicated resource.

11. There has also been substantial work completed across Leicestershire GP practices with regards to the NHS England Active Signposting training. This training has support practice staff (including reception) to complete a social prescribing role within the practice to signpost and refer patients into the existing Leicestershire social prescribing model or specific local interventions.

**Care Coordination Nationally**

12. Due to the publication of the NHS Long Term Plan, further work has been completed to explore and align the social prescribing offer and Integrated Neighbourhood Teams (INTs) building blocks (population profiling (including risk stratification), multi-disciplinary team (MDT), care coordination and prevention) with the latest NHS link worker guidance (which suggests that each PCN should have a social prescribing link worker by
the end of 2020/21 and that a risk stratification, predictive prevention approach should be implemented in GP using a care coordination role.)

13. Health Education England (HEE) have developed a three-tiered care navigation competency framework which describes the core competencies for people providing care navigation or coordination across a wide range of health, social and voluntary care sectors. The framework recognises three success levels; essential, enhanced and expert (see Figure 2)ii.

**Figure 2** Care navigation competency frameworkii.

![Care navigation competency framework](image)

**Leicestershire Care Coordination Model**

14. As discussed in a review of care coordination across LLR, there are many services/models in place which provide care navigation/coordination across the three levels. However there is scope to develop the ‘essential’ offer and aspects of the ‘enhanced’ offer, as analysis shows this is an area where there are gaps and/or limited resource.

15. In East Leicestershire and Rutland Clinical Commissioning Group (CCG) have commissioned a Clinical Case Manager from Leicestershire Partnership Trust to manage clinical care coordination and work closely with the Integrated Care Coordinators (known as link workers) provided by adults social care in Leicestershire County Council for non-clinical support.

16. In West Leicestershire CCG a hybrid LAC/ care coordinator model has been piloted with the Hinckley/ Bosworth early implementer site. Results from the pilot have suggested that 80% of the role utilises the traditional LAC strength-based approach, while 20% has involved more targeted support including linking with the wider MDT. Due to the positive results seen, a business case has been developed by West Leicestershire CCG and partners to expand the pilot.

17. A review of care coordination across LLR identified six key principles that should be consistent in a model of care coordination across LLR. These include providing a local interface between partners/ organisations, management of the MDT, patient identification, care planning and delivery, maintenance of IT and performance data and personal development. Both Leicestershire models discussed above are able to meet these principles and illustrate that within INTs care coordinators are currently providing a similar but distinct role to the proposed new social prescribing link workers. The main
difference of which is that care coordinators take a more clinical case management and trusted assessor approach than the social prescribing link worker role.

**Future Development**

18. The Leicestershire social prescribing model is well established. It is well received with referrals to First Contact Plus increasing 20% year on year. It is therefore important that the Health and Wellbeing Board partners are aware of the opportunities for, and risks to further expanding social prescribing and care coordination across Leicestershire. These are summarised in Table 1 below.

**Table 1** Opportunities and risks of further expansion of the social prescribing and care coordination offer across Leicestershire

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduces pressure on existing services. (For example, ~30% of GP practice appointments are for none medical reasons.)</td>
<td>• Step change to increase prevention referrals could destabilise preventative services with current resources.</td>
</tr>
<tr>
<td>• Increased health and wellbeing, improved healthy life expectancy and reduced health inequalities.</td>
<td>• Not enough services available to meet the social prescribing demand. Reduces quality or increased waiting times for prevention services.</td>
</tr>
<tr>
<td>• Increased access and uptake to prevention services.</td>
<td>• Increased risk to individuals if there is not the correct quality framework to make informed choices about services/activities available through social prescribing.</td>
</tr>
<tr>
<td>• Improved community cohesion and social capital, reduction in loneliness.</td>
<td></td>
</tr>
<tr>
<td>• Savings to the Leicestershire system with regards to taking a preventative approach (including reducing hospital, social care etc demand.)</td>
<td></td>
</tr>
</tbody>
</table>

**Proposals/Options**

19. As discussed above, a significant amount of work has already been completed to develop a successful Leicestershire social prescribing offer. With the latest NHS LTP and NHS England guidance there are opportunities to further develop this model through the PCNs social prescribing link workers and consider the implications for care coordination, without destabilising the existing social prescribing system. Table 2 below summarises the range of potential approaches that could be taken to embedding the social prescribing link workers and care coordinators, with the advantages and disadvantages for each option. N.B. if different approaches are taken for social prescribing link workers and care coordinators this will add further complexity to the options.

**Table 2** Summary of approaches to embedding link workers and care coordinators into the current Leicestershire social prescribing model.

<table>
<thead>
<tr>
<th>Social worker/option</th>
<th>Prescribing Link Care Coordinator</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| A. Each PCN to recruit own link worker or care coordinator | • PCN flexibility  
• Very local offer | • Higher cost model of social prescribing |
<table>
<thead>
<tr>
<th>Option</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Each PCN to recruit own link worker or care coordinator to act specifically in their PCN area, develop community capacity. The post would work independently but link into the wider Leicestershire social prescribing system.</td>
<td></td>
</tr>
</tbody>
</table>
| - Currently integrated care coordinators established in ELR CCG.  
- Easy link to current practice work completed on Active Signposting.  
- Can engage in local Patient Participation Groups (PPGs) to deliver low level social prescribing. |
| **B.** Each PCN to recruit own link worker or care coordinator to act specifically in their PCN area, develop community capacity. The post would work independently but link into the wider Leicestershire social prescribing system. |
| - Similar to option A plus;  
- Ability to link into wider Leicestershire social prescribing model.  
- Potential option for link workers to be based in areas without a LAC and work closely with them. |
| **C.** Each PCN to commission link worker or care coordinator from another broader organisation (examples include local health trust, federations, Public Health, voluntary sector, etc.) Options A&B could then be repeated. |
| - Similar to options A&B plus;  
- Ability to link/ integrated into other parts of social prescribing system. Less likely to cause duplication of resource.  
- Professional management and development of link workers. |
| **D.** Develop a consistent local link worker/ care coordinator definition that encompasses the currently piloted LAC/ link worker/ care coordinator model across Leicestershire. Current hybrid role is delivered by Public Health in Leicestershire County Council. |
| - Efficient and cost-effective model. Results demonstrate reduction in duplication across the roles and system.  
- One approach across Leicestershire, avoids fragmentation across the place.  
- Well connected posts to the wider social prescribing system, developing a more integrated and cohesive delivery than the existing system. (Previously piloted in NWL) |
| | - Lose connectivity and potential for silo working. Patient's may not get access to the wider social prescribing offer.  
- Confusing for the patient. Potential duplication of LAC, care coordinator and link worker are in the same neighbourhood, locality. |
| | - Similar to option B but reduced silo working. (However the system would not be fully integrated.)  
- If link worker just passed all referrals to FC+ this would recreate duplication. |
| | - Similar to options A&B plus;  
- Ability to link/ integrated into other parts of social prescribing system. Less likely to cause duplication of resource.  
- Professional management and development of link workers. |
| | - Duplication of capacity and social prescribing function.  
- Higher cost model of social prescribing delivery than the existing system. (Previously piloted in NWL)  
- PCNs potentially have less control of specific link worker recruitment and management.  
- PCN/ federations would need to complete a procurement and have contract management of link worker contract.  
- PCNs may not be able to use the funding for overheads. |
| | - Only piloted in one area of West CCG.  
- PCNs potentially have less control of specific link worker recruitment and management.  
- PCN/ federations have contract management of link worker contract.  
- Complexities of PCNs all contributing towards LAC model with varying needs |
approach.
• Truly holistic approach. One combined role, therefore no need for individuals to navigate the system/ different people or agree funding decisions across health and social care. i.e. adult care trusted assessor.
• Can utilise the active signposting and PPGs within PCNs.
• Lasting trusted LAC relationships so individuals can go back to worker directly for follow up if needed.
• Strong evidence from H&B early implementor from clinical, and social care partners.
• Economies of scale with regards to larger LAC team and ability for cover/ flexibility.
• LAC roles already employed by local authority so processes in place.
• PH have evidence to flex capacity as reflected by local needs.

E. Proportion of social prescribing link worker funding is diverted to develop and implement very local social prescribing initiatives and programmes. Applicable for all options A-D.

• Current estimated NHS funding (~£34,000) is unlikely to be needed for one link worker per PCN.
• Increases prevention capacity.
• Ability to develop a very local social prescribing offer.
• Options B-D could build on existing system.
• Could be delivered/ supported through a range of providers including the PCN itself.

• PCNs may not be able to allocate funding to services (potentially salary costs only, additional national guidance is needed.)
• Reduces proportion of link worker/ care coordinator role etc within the PCN.

Consultation/Patient and Public Involvement

20. A range of consultations and patient and public involvement have been arranged regarding the social prescribing model including;
  i. Leicestershire County Council are currently completing the Prevention at Scale research which includes approximately 30 qualitative interviews with patients across Leicestershire about what non-clinical conditions they are currently accessing their GP for.
ii. Partner engagement was completed when developing the Leicestershire social prescribing model through the Unified Prevention Board in 2016/17.

iii. Health Watch are planning to consult the local population on social prescribing in summer 2019.

iv. Options in table 2 were discussed with health and local authority partners at a Leicestershire social prescribing workforce meeting on 3rd May 2019.

v. The draft paper was discussed at Unified Prevention Board on 14th May 2019. Partners welcomed the opportunity to further develop the social prescribing model across Leicestershire but confirmed potential risks regarding fragmentation and the need for additional prevention capacity. Whilst acknowledging that PCNs are independent organisations, partners would want to ensure the social prescribing system is joined up and capacity appropriately supported across Leicestershire. Further work is also needed regarding varying language across the model. UPB are keen to engage with PCNs to further develop the model collectively and maximise the impact of the social prescribing link worker funding across the system.

**Resource Implications**

21. The current social prescribing model is funded by a range of partners across Leicestershire including the County Council, district councils, health, police, fire, voluntary and community sector. First Contact Plus, the prevention front door, is funded 50:50 between Public Health and Better Care Fund (BCF). This funding has been approved for 2019/20 however risks are associated with this due to uncertainty on the continuation of the BCF beyond 2019/20. LAC’s are currently funded 90% Public Health and 10% district councils. ELR CCG commission the clinical case management role and Leicestershire County Council provide the integrated care coordinators. West CCG do not specifically currently commission any care coordination resource but are piloting the LAC/ care coordination hybrid model with Public Health.

22. Additional funding will be made available to PCN’s in 19/20 through the NHS Long Term Plan for the social prescribing link workers. This should initially be equivalent of one link worker per PCN ~45,000 population (~£34,000 per PCN). PCN’s will decide how this funding is to be spent within their neighbourhood. Additional national guidance is needed regarding how this funding is spent as initial discussions suggest this may only cover salary costs.

23. There is also likely to be further demand on prevention services, including First Contact Plus as the social prescribing offer continues to build momentum. Additional pathway and capacity and demand modelling will help identify the implications of this, however it is an important risk that needs to be considered.

**Timetable for Decisions**

24. PCNs are currently agreeing their geographies across Leicestershire. PCN boundaries are to be submitted to NHS England by the end May and new contracts will start on 1st July 2019. Social prescribing link worker funding can be drawn down and implemented from the 1st July 2019.
Conclusion and Next Steps

25. Overall Leicestershire has a well-established social prescribing model but varying care coordination approach. This paper highlights the key options for potential future development following implications of the NHS LTP with regards to embedding link workers and care coordinators into the existing social prescribing model. Decisions regarding link worker employment will be made by PCNs, however an approach that embeds the PCN social prescribing link workers and care coordinators seamlessly into the current social prescribing model is preferable to avoid fragmentation of the established system. Next steps will include further developing conversations from the social prescribing workforce meeting through the PCN engagement events and newly established care coordination task and finish group.

Background papers


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Relevant Impact Assessments

Equality and Human Rights Implications

26. Social prescribing takes a proportionate universal approach, in that the system is available to the whole population but it targeted at those most in need. This should therefore support a reduction in health inequalities. Due to many services involving volunteering within the local community it will also support development of stronger communities and social cohesion.
Crime and Disorder Implications

27. Social prescribing will also support improving social cohesion, reducing anti-social behaviour and work completed by the people’s zones.

Environmental Implications

28. Social prescribing services include active travel, gardening and volunteering which will help reduce air pollution and improve the local environments.

Partnership Working and associated issues

29. As discussed above the social prescribing model was developed with Unified Prevention partners and is delivered in partnership across Leicestershire. Therefore, significant changes to the social prescribing offer are likely to impact on the entire Leicestershire system.

Risk Assessment

30. As discussed in paragraph 18 and 23, the key risk associated with social prescribing include the potential step increase in demand for prevention services. Anecdotal evidence from the Hinckley and Bosworth pilot has suggested that as the social prescribing and care coordination system gathers momentum, more complex patients are identified (i.e. those that no longer meet previous eligibility thresholds for health and social care services). These individuals can take longer to unpick and may put further pressure on the prevention system. If these are not appropriately funded by a range of Leicestershire partners current and future services are likely to see a reduction in quality and increased waiting times.

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HEALTH AND WELLBEING BOARD: 30 MAY 2019

REPORT OF DIRECTOR OF HEALTH AND CARE INTEGRATION

BETTER CARE FUND Q4 2018/19 PERFORMANCE

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board with an update on the Better Care Fund (BCF) programme, including assurance on the national quarterly reporting requirements for the BCF.

Recommendation

2. The Health and Wellbeing Board is asked to note the contents of the report, that the BCF achieved its target for all four BCF outcome metrics, and the positive progress made in transforming health and care pathways in 2018/19.

Policy Framework and Previous Decisions

3. The BCF policy framework was introduced by the Government in 2014, with the first year of BCF plan delivery being 2015/16. The County Council’s Cabinet in February 2014 authorised the Health and Wellbeing Board to approve the BCF Plan and plans arising from its use.

4. The Board received the last BCF progress report at its meeting on 24th January 2019. An update on progress to refresh the BCF Plan for 2019/20 was reported to the Board at its meeting on 14th March 2019.

5. The BCF National Team published the Operational Guidance on 18th July 2018 to refresh the two-year plan for 2018/19. The Board approved the BCF plan refresh for 2018/19 at its meeting on 12th July 2018.

6. NHS England issued BCF implementation guidance for 2017-19 in July 2018, https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/ which set out the requirements for quarterly reporting along with the draft templates and analytical tools that are required to be used for this purpose.

Background

7. The Leicestershire BCF Plan for 2017-19 was submitted on 8th September 2017 to the BCF National Team. Confirmation was received on 20th December 2017 that the plan was fully approved.

8. In line with the national process and timetable for 2018/19, refreshed BCF metrics were submitted, along with confirmation that the plan was otherwise unchanged, to NHS England on 19th October 2018.
**Financial Outturn for 2018/19**

9. The budget for the BCF Plan in 2018/19 totals £55.9million. This comprises the following income streams:

<table>
<thead>
<tr>
<th>BCF Approved Budget</th>
<th>WLCCG</th>
<th>ELRCCG</th>
<th>LCC/DC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG Minimum Contributions</td>
<td>21,240</td>
<td>16,139</td>
<td>-</td>
<td>37,379</td>
</tr>
<tr>
<td>CCG Additional Contribution</td>
<td>1,367</td>
<td>1,196</td>
<td>-</td>
<td>2,563</td>
</tr>
<tr>
<td>Disabled Facilities Grants (DFG)</td>
<td>-</td>
<td>-</td>
<td>3,632</td>
<td>3,632</td>
</tr>
<tr>
<td>Improved BCF Autumn 2015</td>
<td>-</td>
<td>-</td>
<td>5,582</td>
<td>5,582</td>
</tr>
<tr>
<td>Improved BCF Spring 2017</td>
<td>-</td>
<td>-</td>
<td>6,837</td>
<td>6,837</td>
</tr>
<tr>
<td><strong>Total Funding</strong></td>
<td>22,607</td>
<td>17,335</td>
<td>10,469</td>
<td>55,993</td>
</tr>
</tbody>
</table>

10. The actual outturn position for 2018/19 was for £55.8m, with the £196,000 underspend released back to the county Clinical Commissioning Groups (CCG) by agreement to off-set other system/financial pressures through substituting suitable schemes into the BCF Plan. The expenditure plan included a £2m contingency and cost improvement allocation.

**Performance against BCF Outcome Metrics at the end of 2018/19**

11. The BCF plan is measured against four outcome metrics. For Leicestershire, progress against the key targets is shown in Appendix A, and the following paragraphs summarise the position for each target.

12. The BCF target for the number of **permanent admissions of older people (aged 65 and over) into residential and nursing care homes** is for fewer than 890 admissions (or 624.1 per 100,000 population) during 2018/19. By the end of March 2019, there was a total of 877 permanent admissions (or 615.0 per 100,000 population) into residential and nursing homes.

13. The target for the **proportion of older people who were still at home 91 days after discharge** has been set at 87% for 2018/19. The latest data, which relates to discharges between October and December 2018, showed that 87.7% of people discharged from hospital into reablement/rehabilitation services were still at home after 91 days. The target was achieved for 11 of the 12 months during 2018/19, with April only falling slightly under target.

14. The BCF target for total **non-elective admissions into hospital (general and acute)** was set for up to 70,569 (or 850.34 per 100,000 population) for 2018/19. During 2018/19, there have been a total of 68,001 non-elective admissions, which is a variance of 2,568 admissions lower than the target.

15. **Delayed Transfers of Care (DTOC)** – the Government's mandate to the NHS for 2018/19 set an overall ambition for reducing delays to around 4,000 hospital beds occupied by patients delayed without discharge by September 2018. The national target was apportioned across each Health and Wellbeing Board area and translated into a rate per 100,000 population for each local area.

16. By September 2018, Leicestershire was required to achieve a rate of no more than 7.88 average days delayed per day per 100,000 population and maintain this rate
through to March 2019. Leicestershire achieved the monthly target for 11 of the 12 months, with October only being slightly over target.

17. The graph below highlights the performances during 2018/19 against the BCF target:

![BCF Target - Leicestershire - Total Delays](image)

**Progress update of the Leicestershire BCF Plan 2018/19**

18. The following is a summary of current progress within the integration programme for Leicestershire.

**Unified Prevention Offer**

19. During 2018/19, the Unified Prevention Board (UPB) has focused on developing the asset-based offer in localities around tier zero (universal) and tier one (primary) prevention. This has included Leicestershire’s social prescribing offer which includes First Contact Plus (a one-stop shop for a multitude of prevention services – via telephone and online) and face to face support via Local Area Coordinators.

20. One of the key programmes of work for the UPB is developing the wrap-around prevention offer to support Integrated Teams. This is a multi-disciplinary approach to delivering health care to patients who are in one of the three cohorts (frail, five or more long term conditions and high cost care needs – further information in para 23-26). The work of the UPB is helping support patients by ensuring that prevention services are available and aligned to their care needs so that they are able to stay in their own homes and prevent further acute care.
Integrated Community Services Programme

21. The Integrated Community Services programme is developing the integrated health and social care offer across Leicester, Leicestershire and Rutland (LLR) by taking a home first approach.

Home First (Integrated Rehabilitation and Reablement)

22. Partners developed a blueprint for integrated intermediate care services. Work to design and implement the integrated health and care reablement offer including referral and access points, skill mix, triage and service delivery commenced during 2018 and continues into 2019, aligned to the redesign of community nursing and therapy services. The integrated approach is offered to adults when they have a change in need, requiring additional or new interventions that if not met, will result in admission to hospital/care home or the person having to remain in hospital when they are medically fit for discharge.

23. Within Leicestershire, the pilot commenced in October 2018 and will run to the end of June 2019 before commencing roll-out through to February 2020. Work to evaluate the scheme is being undertaken during Q1 2019/20. Also, during Q1 2019/20, nursing and social care staff will be co-located into a decision unit to manage referrals and workload jointly into the team and through into its care pathways.

Integrated Teams

24. Twelve Integrated Teams were established across LLR to provide more coordinated and comprehensive multidisciplinary team support in the community. These teams are comprised of GPs, community nurses, social care staff and partners from a number of organisations including the voluntary sector.

25. The programme identified four building blocks that will underpin a consistent approach to integrated care in the community. These building blocks are:

a. Population profiling (including risk stratification);

b. Operating model/multi-disciplinary teams working (focusing initially on three cohorts of patients – frail, five or more long term conditions and/or high care costs);

c. Care coordination – based on the nine key features of care coordination developed as part of service design in LLR);

d. Prevention – setting the core prevention offer for each community, for benefit of locality teams, and the wider population in each locality.

26. Currently three early implementer sites across LLR are setting up improved methods of multi-disciplinary working, so that care is planned, coordinated and delivered more effectively for patients, families, carers and the professionals supporting them.

27. For Leicestershire, the early implementer site is the Fosseway locality within Hinckley and Bosworth, who are setting up multi-disciplinary team working at a neighbourhood level, focusing on a practice population of 45,000 people. Care Coordinators were appointed by adapting the role of the existing Local Area
Coordinators; the pilot commenced in January. The evaluation of the three locality teams early implementer sites is underway and findings will be reported back during Q1 2019/20. Meanwhile, the redesign of community services will enable the commissioning health services in line with the building blocks of the LLR model.

Reducing Delayed Discharges

28. The LLR-wide Discharge Working Group has led on implementing the High Impact Change Model, which is a national self-assessment tool that tracks local achievement against eight categories of high impact changes which are evidenced on having the greatest impact on reducing delayed discharges. An action plan was developed for 2018/19 and progress monitored throughout the year.

29. Some of the key areas of progress and achievements for the current financial year are detailed below. These are the actions that have had the greatest impact either on collaborative working, system redesign or that have led to DTOC reductions.

30. Discharge to Assess (D2A) and Reablement: A comprehensive piece of work was undertaken to revise the D2A pathways, which included the consolidation of the previous D2A pathway. A multiagency workshop to define the new proposed two pathway model, taking in learning and best practice from other areas took place to help redefine pathways with partners.

31. A new bed based reablement service began on the 1st July 2018. Procurement of framework D2A beds began on 1st August with implementation in Q3 2018/19. A process is now in place to enable non-admission and base wards at Leicester Royal Infirmary to refer directly into Crisis Response Service/HART reablement services to support the Home First initiative. This has been reported as working well initially but further future evaluation will be required. It is hoped that this will reduce length of stay for patients as the process is now shorter.

32. The out of county D2A offer to be developed and implemented: connections with out of area providers have been established to improve flow of patients into D2A beds when coming from providers outside of LLR.

33. SAFER stranded patient review - a process to undertake the stranded patient review for those with a length of stay over six days, to resolve delays across University Hospitals Leicester (UHL) and Leicestershire Partnership trust (LPT). This is underway with Clinical Management Groups. UHL have implemented Long Stay Wednesdays and have made a real impact in reducing their stranded and super stranded patients. LPT have been looking at super-stranded and reducing these with appropriate care-planning. The action plan in place to reduce stranded and super-stranded saw a significant improvement in Q4 2018/19 against the trajectory.

34. Red2Green – Adult Mental Health: Red2Green has been rolled out onto two wards within the Bradgate Mental Health Unit. Fortnightly steering meetings develop the system with the ability to identify barriers and work to resolve them or escalate issues and roll-out to two further wards took place in March 2019.
35. Work is currently underway to finalise the Discharge Working Group action plan for 2019/20, which should be completed by the end of May 2019.

**Falls Programme**

36. The aim of the LLR falls programme, which has been led from the Leicestershire BCF, is to improve the treatment pathway for those identified as being at risk of falling or who have experienced a prior fall. The programme provides five core elements developed on the basis of NICE guidance and other evidence. These are: postural stability/falls prevention classes, therapy triage, non-conveyance to hospital/onward referral into community services for patients assessed on scene by East Midlands Ambulance Service (EMAS), falls prevention in care homes, and a range of new technology and equipment supporting assessment and treatment across the whole pathway including the EFRAT (electronic falls risk assessment tool) smart phone app/tool developed with EMAS. The technology aspects are being delivered in conjunction with East Midlands Academic Health Science Network with a view to evaluation and potential roll-out across the East Midlands.

37. The specialist therapy triage part of the pathway provides assessment for all referrals into consultant falls clinic and has proved highly successful in diverting consultant outpatient activity. During 2019/20, the final elements of the implementation/evaluation linked to CCG QIPP (savings) plans, upon which decisions will be made about transitioning to business as usual.

**Integrated Housing Service - Lightbulb**

38. Leicestershire’s Lightbulb Service has both community-based and hospital-based components.

39. The hospital Housing Enablement Team, funded by the BCF plan, was created to work inside Leicester's acute hospitals and the Bradgate Mental Health Unit. Since April 2015, the service has helped in excess of 2,000 patients and, over time, demand for the service has risen. The team offers up to 28 different types of interventions to support patients in local hospitals, many of which relate not only to housing but also to other community support offers.

40. In the community-based Lightbulb Service there is also access to a full housing needs assessment with Lightbulb’s housing support coordinators carrying out “housing MOTs” and acting as case managers to arrange solutions to the full range of housing support including aids and adaptions, tenancy and welfare advice, hoarding, house clearing and cleaning, furniture packs, affordable warmth, home safety and falls prevention. The Lightbulb service has won three accolades for innovation and partnership working.

41. The Lightbulb business case, a refresh for 2019/20, set out the outputs and outcomes achieved in year one of the service and the recurrent funding position for each partner. The business case has been approved for all eight Local Authority partners for a further three years, which commenced in April 2019. The recurrent funding for the hospital Housing Enablement Team element of the Lightbulb Service is subject to further decisions by CCGs during Q2 2019/20.
**Assistive Technology (AT)**

42. Currently in Leicestershire a telecare service is provided based on pendant alarms systems. Nearly 6,000 alarms are in place in homes across the county. The BCF AT project is looking at how the service offer in Leicestershire can be enhanced by maximising opportunities offered by new technology. An initial market appraisal exercise was completed during 2018, which looked at experience elsewhere and is aiming to establish a standardised approach across the county to AT.

43. The work has identified three priority areas – mental health, dementia and managing demand. A recent meeting of the pilot planning group mapped the current AT offer for people living with dementia and identified where there are opportunities for new technology to enhance this. The key objective for the pilot was agreed as helping people with dementia to stay at home for longer and three key priorities were identified:
   a. Being safe at home – including responding to falls for people who are not able to use a pendant alarm;
   b. Being safe outside the home – considering how GPS can be used for people who go missing;
   c. Increase participation in social or leisure activities – addressing loneliness and isolation.

**Integrated Commissioning**

44. Leicestershire County Council and the County CCGs put in place a workplan for joint commissioning during 2018/19 which included activities in support of priority areas such as domiciliary care, reablement, personal budgets and learning disabilities. The following provides a brief update on some of the areas of joint commissioning.

**Domiciliary Care**

45. Since November 2016, home care in the county has been delivered through the Help to Live at Home service. The service is commissioned jointly by the Council and two county CCGs with lead providers appointed to deliver home care services in each geographical area. The existing three-year framework contract expires in November 2019, with work undertaken during Q4 to extend this, using the initial plus one contract facility, through to November 2020. Work on how the future model of domiciliary care (post November 2020) will look in relation to current review work across health and social care partners currently underway.

**Personal Health Budgets**

46. The Leicestershire BCF proposed and led an LLR-wide workshop at the beginning of April 2019 to consider the future approach for personal health budgets and opportunities for integrated health budgets. The workshop reviewed the current position for all partners and considered joint working opportunities, including specific cohorts to work with, to optimise the integrated personal budgets offers. Outcomes of the workshop are being followed up during Q1 by a small working group who will scope and oversee delivery of the workplan.
Health and Social Care Protocol

47. Following a workshop in November 2018 to review the health and social care protocol and consider the strategic approach needed to the future content of the protocol and training model, further work has been undertaken to gauge market interest, skill and capacity for the training. One of the outputs of the work was to complete a more fundamental review of the protocol itself which will be undertaken in 2019 and align to the wider integrated community work.

Integrated Data

48. In December 2018, approval was received from NHS Digital to join and link health and care data to assist in the planning, transformation, design and evaluation of health and care services across LLR. The plan is to develop and implement an integrated data warehousing tool for this purpose during 2019.

49. The LLR business intelligence (BI) strategy, developed by a multiagency group during 2018, was approved in Q3 and work on the delivery plan is now well underway. The strategy sets a framework for how organisations in LLR could work differently as BI partners in the health and care system and sets out the opportunity to join forces on a number of important priorities and investments, where it makes sense to do so.

50. The initial focus for implementation is developing and testing the new data integration warehousing tool with Midlands and Lancashire Commissioning Support Unit and progressing the population profiling workstream in conjunction with Public Health and the emerging Primary Care Networks. The next stage is to consolidate the workforce, analytics and tools workstream into one programme of work, which commenced during April 2019.

BCF Plan for 2019/20

51. The BCF Policy Framework for 2019/20 was published on 10th April 2019 but, at the time of writing this report, the BCF technical guidance and CCG minimum allocation into the BCF pooled budget is still awaited.

52. Work to review the BCF Plan for 2019/20 in line with annual financial planning arrangements for CCGs and Leicestershire County Council commenced in September 2018. A report that summarised progress to update the BCF plan was provided to the Health and Wellbeing Board at its meeting on 14th March. The BCF expenditure plan has been reviewed by Partners and agreed, subject to the technical guidance being published. Following the publication of the technical guidance, the work that has been completed to date will be reviewed and submitted back through the appropriate governance route for final approval.

Circulation under the Local Issues Alert Procedure

None.
Officer to Contact

Cheryl Davenport
Director of Health and Care Integration (Joint Appointment)
0116 305 4212
Cheryl.Davenport@leics.gov.uk

Appendix
Appendix – BCF Metrics as at March 2019

Relevant Impact Assessments

Equality and Human Rights Implications

53. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

54. An equalities and human rights impact assessment has been undertaken which is provided at http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf. This finds that the BCF will have a neutral impact on equalities and human rights.

55. A review of the assessment was undertaken in March 2017.

Partnership Working and associated issues

56. The delivery of the BCF plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

57. Day to day oversight of delivery is via the Integration Executive through the scheme of delegation agreed via the Integration Executive’s terms of reference which have been approved by the Health and Wellbeing Board.

58. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the plan to transform health and care in Leicestershire, known as the Sustainability and Transformation Partnerships – http://www.bettercareleicester.nhs.uk/
## Appendix – Better Care Fund Metrics as at March 2019

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>Latest Data</th>
<th>RAG-rated data</th>
<th>Data Trend</th>
<th>Aim / Polarity</th>
<th>DOT</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population, per year</td>
<td>624.1</td>
<td>51.9</td>
<td>615.0</td>
<td>Green</td>
<td>Good performance is represented by a fall in the figures</td>
<td>☝️</td>
<td>The RAG-rated data shows the year end actuals for 2018/19, based on CPLIs. The BCF target for 18/19 is a maximum of 890 admissions. The current actual position is 877 admissions (or 615 per 100,000 population), please note this position will increase with any late recordings. Performance is RAG-rated green and is statistically similar to the target.</td>
</tr>
<tr>
<td>METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</td>
<td>87.0%</td>
<td>n/a</td>
<td>87.7%</td>
<td>Green</td>
<td>Good performance is represented by a rise in the figures</td>
<td>☝️</td>
<td>For hospital discharges between Oct and Dec '18, 87.7% of people discharged from hospital into reablement / rehabilitation services were still at home after 91 days. This is above the 18/19 target of 87%. Performance is RAG-rated green and is statistically similar to the target.</td>
</tr>
<tr>
<td>METRIC 3: Delayed transfers of care from hospital per 100,000 population</td>
<td>244.38</td>
<td>n/a</td>
<td>217.44</td>
<td>Green</td>
<td>Good performance is represented by a fall in the figures</td>
<td>☝️</td>
<td>In March there were 1,182 days delayed, a rate of 217.44 per 100,000 population against a target of 244.38. This is RAG-rated as green and is statistically better than the target. For the different attributable organisations (NHS, social care, and jointly attributable), 78% of these delays were attributable to the NHS, 17% attributable to Social Care and 5% Jointly attributable.</td>
</tr>
<tr>
<td>METRIC 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, per month</td>
<td>868.67</td>
<td>819.4</td>
<td>856.49</td>
<td>Green</td>
<td>Good performance is represented by a fall in the figures</td>
<td>☝️</td>
<td>For the period Apr-18 to Mar-19 there have been 68,001 non-elective admissions, against a target of 70,569 – a variance of -2,568. This is RAG-rated as green. For the month of March there has been 5,956 non elective admissions, against a target of 6,041 - a variance of -85. The monthly rate is 856.49 against a monthly target of 868.67 and this is RAG-rated green. The RAG methodology is green if non-elective admissions/rate is less than or equal to the monthly target, amber if non-elective admissions/rate is between the monthly target and monthly minimum, and red if non-elective admissions/rate is greater than the monthly minimum.</td>
</tr>
</tbody>
</table>
HEALTH AND WELLBEING BOARD: 30th May 2019

REPORT OF LEICESTERSHIRE & RUTLAND SAFEGUARDING ADULTS BOARD (LRSAB)

SAFEGUARDING ADULT BOARD DEVELOPMENT PLAN 2019/20

Purpose of report

1. The purpose of this report is to set out the Development Plan for the Leicestershire and Rutland Safeguarding Adult Board (LRSAB) for 2019/20 for noting and comment by the Health and Wellbeing Board.

Link to the local Health and Care System

2. Safeguarding is everyone’s responsibility. Health and care needs can be linked to safeguarding risk for adults and children and health and care practitioners can have opportunities to identify and respond to safeguarding risk not available to workers in other agencies.

3. Previously connectivity between the LRSAB and the Better Care Together (BCT) Programme was established during 2014/15 when the Board was a consultee during the process of formulating the BCT Five Year Strategic Plan 2014-19. At that stage it was agreed that safeguarding would be a cross-cutting theme across the BCT Programme and agreement was secured in to ensure that the BCT Programme would incorporate, promote, measure and evaluate safeguarding outcomes within its improvement plans.

Recommendation

4. It is recommended that the Board comments on the proposed Development Plan 2019/20 for the Leicestershire and Rutland Safeguarding Adult Board.

Policy Framework and Previous Decisions

5. The LRSAB is a partnership that is required by regulation as a result of the Care Act 2014. One requirement of the Care Act 2014 that the Annual Reports of the LRSAB be presented to the Chair of the Health and Wellbeing Board. In Leicestershire and Rutland there is, in addition, a protocol between both safeguarding boards and the Health and Wellbeing Board that requires the presentation of the draft business plans of the safeguarding boards with an expectation that the Health and Wellbeing Board will consider any implications of these plans for the health and well-being strategies of both counties.

**Background**

**Statutory Framework**

7. The LRSAB became a statutory body on 1st April 2015 as a result of the Care Act 2014. The Act requires that it must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. It requires the LRSAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal'. It should also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:
   - The safety of people who use services in local health settings, including mental health
   - The safety of adults with care and support needs living in social housing
   - Effective interventions with adults who self-neglect, for whatever reason
   - The quality of local care and support services
   - The effectiveness of prisons in safeguarding offenders
   - Making connections between adult safeguarding and domestic abuse.

8. These points have been addressed in drawing up the Development Plan for 2019/20.

9. Safeguarding Adult Boards have three core duties. They must:
   - Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute;
   - Publish an annual report detailing how effective their work has been
   - Commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

10. It is the first of these duties to which the Development Plan relates since this plan outlines the strategy for improvement.

**Formulation of the Business Plans for 2019/20**

11. At the start of 2019, Robert Lake, the Independent Chair of the LRSAB resigned from his position as Chair for health reasons. The Board has appointed a new Independent Chair, Fran Pearson who will start her role in June 2019.

12. The future improvement priorities identified in the Annual Report 2017/18 have been built into the Development Plan for 2019/20. In addition to reflecting issues arising from the Annual Report the new Business Plan priorities have been identified against a range of national and local drivers including:
   a. national safeguarding policy initiatives and drivers;
   b. recommendations from regulatory inspections across partner agencies;
   c. the outcomes of serious case reviews, serious incident learning processes, domestic homicide reviews and other review processes both national and local;
   d. evaluation of the business plans for 2018/19 including analysis of impact afforded by the quality assurance and performance management framework;
e. best practice reports issued at both national and local levels;
f. the views expressed by both service users and front-line staff through the Boards’ engagement and participation arrangements;

13. The new Development Plan has been informed by discussions that have taken place in a number of forums since the autumn of 2018. These include:
   a. Meetings of the Scrutiny bodies in both Leicestershire and Rutland at which both the LRLSCB and LRSAB Annual Reports 2017/18 and future priorities for action have been debated.
   b. Meetings of the Leicestershire and Rutland Health and Wellbeing Boards at which both the LRLSCB and LRSAB Annual Reports 2017/18 and future priorities for action have been debated.
   c. Discussions within individual partner agencies.

14. The strategic priorities and content of the plan were formulated through the annual development session of the LRSAB held on 31 January 2019.

Development Plan 2019/20

15. The LRSAB Development Plan Priorities for 2019/20 are outlined in the table below.

<table>
<thead>
<tr>
<th>LRSAB Business Priorities.</th>
<th>Development Priority</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Effective Multi-Agency meetings</td>
<td>Multi-agency meetings regarding vulnerable adults are effective in supporting safeguarding adults and prevention of safeguarding need.</td>
<td></td>
</tr>
<tr>
<td>2. Mental Capacity</td>
<td>Be assured that people without capacity to consent are being safeguarded in current practice and with the introduction of Liberty Protection Safeguards.</td>
<td></td>
</tr>
<tr>
<td>3. Adult Exploitation</td>
<td>Improve the recognition and co-ordinated partnership response to ‘adult exploitation’.</td>
<td></td>
</tr>
<tr>
<td>4. Safeguarding in Transitions</td>
<td>Be assured that work with young people who have been assessed as requiring additional support to reduce risk and vulnerability assists prevention of adult safeguarding need.</td>
<td></td>
</tr>
</tbody>
</table>

16. The first and fourth priorities are specific joint priorities shared with Leicester Safeguarding Adults Board (LSAB). The work on the second and third priorities will be considered across the two SAB areas, but are not specific joint priorities.

17. Key outcomes for improvement and the actions that will need to be taken over the next year to achieve these improved outcomes are included in the Development Plan (attached as Appendix A to the report)

Consultation/Patient and Public Involvement

18. The views of a range of forums have being sought on the Development Plan. This includes the Cabinet’s, Children and Adults and Scrutiny Committees and the Health and Wellbeing Boards in both local authority areas.
19. The priorities in the plan have taken into account findings of local surveys about safeguarding adults and views from Healthwatch.

**Resource Implications**

20. There are no resource implications arising from the recommendation in this report. The LRSAB operate with a budget to which partner agencies contribute under an agreed formula.

21. The LRLSAB has a budget of £102,152 in 2019/20.

**Timetable for Decisions**

22. The Development Plan was agreed by the LRSAB at its meeting on 25th April. The next SAB meeting is scheduled for 25th July 2018 when an update on the plan will be presented.

**Background papers**


**Appendix**

Safeguarding Board Development Plan 2019/20

**Officer to Contact**

James Fox, Business Manager SAB & LSCB
Telephone: 0116 305 7130
Email: James.Fox@leics.gov.uk

**Relevant Impact Assessments**

**Equality and Human Rights Implications**

23. The LRSAB seek to ensure that a fair, effective and equitable service is discharged by the partnership to safeguard vulnerable adults. At the heart of the Boards work is a focus on any individual or group that may be at greater risk of safeguarding vulnerability and the performance framework tests whether specific groups are at higher levels of risk. Some of the priorities are focussed on adults with specific needs and vulnerabilities, such as Adult Exploitation and Transitions. Human Rights are central to the work on Mental Capacity and Deprivation of Liberty/Liberty Protection. Individual needs and the impact of work on people with differing needs will be considered in the development of work regarding Multi-Agency Meetings and Adult Exploitation.

**Crime and Disorder Implications**
24. There is a close connection between the work of the LRSAB and that of community safety partnerships in Leicestershire. For example the SAB works closely with community safety partnerships to scrutinise and challenge performance in community safety issues that affect the safeguarding and well-being of individuals and groups e.g. Domestic Abuse. The LSAB also supports community safety partnerships in carrying out Domestic Homicide Reviews and acting on their recommendations.

Environmental Implications

25. None

Partnership Working and associated issues

26. Safeguarding is dependent on the effective work of the partnership as set out in Care Act 2014.
Leicestershire and Rutland Safeguarding Adults Board Business Development Plan 2019-20
**Priority: SAB1 Effective Multi-Agency meetings / Effective Support Pathways (Joint with Leicester SAB)**

**Priority Statement:** _Multi-agency meetings regarding vulnerable adults are effective in supporting safeguarding adults and prevention of safeguarding need_

**Rationale:**
- Lack of clear structure to support practitioners working with adults at risk that do not meet thresholds for Vulnerable Adult Risk Management process (VARM) or safeguarding.
- Practitioners outside of specialised teams are not confident and fully aware of mechanisms available to support them in working with at risk adults outside of VARM/Safeguarding and lack confidence in:
  - Recognising safeguarding need
  - Knowing what appropriate responses are when the threshold for safeguarding is not met.
  - Knowing their responsibilities in relation to MSP/VARM/Multi-agency processes
- Multi-agency meetings regarding adults at risk are not functioning effectively: gaps in attendance; a lack of presence of the voice of the service user or of advocacy; lack of evidence of risk.
- Lack of formal structure to carry out Multi-agency meetings relating to adults at risk.
- Lack of awareness amongst multi-agency practitioners of JAGs and how to access.

**What do we want to be different?**
Practitioners are more confident regarding risk assessment and working in partnership to safeguard adults. Multi-agency meetings are effective: Relevant partners and service users contribute; Risks are clearly identified incorporating information from a variety of agencies and the individuals; Clear outcomes and actions are identified and followed up.
Clear guidance and structure for multi-agency working beyond safeguarding enquiries and VARM is in place.

**Partnership Lead:** Local Authority – Laura Sanderson

**Board Officer:** Gary Watts

**Key delivery mechanism:** Procedures Subgroup

<table>
<thead>
<tr>
<th>Objective</th>
<th>What are we going to do?</th>
<th>When is it going to be done by?</th>
<th>Who is responsible?</th>
<th>How will we measure progress and impact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>An effective structure is in place to support multi-agency working to prevent safeguarding need.</td>
<td>Review and report on the current variety and operation of multi-agency meetings considering vulnerable adults / adults at risk including approaches regarding adult exploitation. Develop a self-assessment framework to assess agency awareness of multi-agency approaches and pathways for ‘adults at risk’. Develop a process and guidance (considering the Signs of Safety model) for Multi-agency meetings regarding ‘adults at risk’ where the thresholds/criteria are not met for Safeguarding enquiries / VARM including</td>
<td>Sept 2019</td>
<td>Procedures Subgroup</td>
<td>Process and guidance in place Guidance disseminated to practitioners Feedback from practitioners on awareness of approach and confidence. Review outcomes of cases considered under new approach</td>
</tr>
<tr>
<td>Multi-agency meetings to safeguard adults or prevent safeguarding need for vulnerable adults are effective in identifying risk and action to take.</td>
<td>Measure current levels of confidence regarding safeguarding adults across a variety of practitioners. Develop guidance across multi-agency meetings to support improved engagement and involvement for all involved in meetings (including service users) and support the development of risk management and confidence in professional, defensible decision making.</td>
<td>Jul 2019</td>
<td>Procedures Subgroup</td>
<td>Process/guidance in place. Guidance disseminated to practitioners Re-measure confidence Audit engagement in meetings.</td>
</tr>
</tbody>
</table>
**Priority: SAB2 Mental Capacity**

**Priority Statement:** Be assured that people without capacity to consent are being safeguarded

**Rationale:**
- The SAB is developing guidance to support practitioners to assess and respond to capacity to consent appropriately and consistently.
- The SAB needs ongoing assurance that people without capacity to consent are being safeguarded, including a large cohort of people without capacity, who that are not subject to Deprivation of Liberty Safeguards.
- The Draft MCA amendment Bill outlines plans to replace DoLS with Liberty Protection Safeguards. The MCA amendments Bill is currently passing through parliament and could receive royal assent in April 2019. The move to LPS will result in significant changes to how we work locally to safeguard individuals who lack capacity to consent to care and treatment that amounts to a deprivation of liberty.

**What do we want to be different?**
- Be assured that people without capacity to consent are being safeguarded
- Support an effective change to LPS locally that safeguards people who do not have capacity to consent.

**Partnership Lead:** CCG - Rachel Garton (Guidance work only) and LIN  
**Board Officer:** Helen Pearson

**Key delivery mechanism:** MC Task and Finish Group and Local Improvement Network (LIN) with Board

<table>
<thead>
<tr>
<th>Objective</th>
<th>What are we going to do?</th>
<th>When is it going to be done by?</th>
<th>Who is responsible?</th>
<th>How will we measure progress and impact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respond to the introduction of Liberty Protection Safeguards.</td>
<td>Keep informed regarding the progress and timescales for implementation of Liberty Protection Safeguards. When required initiate work to implement and supplement LPS locally</td>
<td>Mar 2020</td>
<td>Board Office</td>
<td>Update reports into Board. LPS implemented locally in a planned way with clear consideration of safeguarding principles and requirements and local need.</td>
</tr>
<tr>
<td>Front line practitioners are able to assess and respond to capacity to consent appropriately and consistently</td>
<td>Finish current work to develop and disseminate guidance for practitioners</td>
<td>September 2019</td>
<td>MC Task and Finish Group</td>
<td>Guidance completed and disseminated. Practitioner feedback on guidance. Test implementation</td>
</tr>
<tr>
<td>Be assured that people without capacity to consent are being safeguarded</td>
<td>Case file audit</td>
<td>Mar 2020</td>
<td>Audit Subgroup</td>
<td>Audit findings and follow up actions</td>
</tr>
</tbody>
</table>
### Priority: SAB3 Adult Exploitation

#### Priority Statement: Improving the recognition and partnership response to ‘adult exploitation’

#### Rationale:
- There is a notable growth in cases of multiple vulnerable adults being exploited in the community by individuals or groups. This can include, but is not restricted to criminal, sexual and financial exploitation.
- Often a number of partnership approaches are aware of these people, and there may be multiple ways to take these forward, but these are not always well co-ordinated.
- These issues can be hidden as recent cases suggest that people who are exploited are often socially isolated.
- The public and practitioners are not always aware of indicators of adult exploitation.

#### What do we want to be different?
Practitioners are confident in identifying and responding to adult exploitation
The public are more aware of how to identify adult exploitation and inform public agencies of concerns they have so these can be identified and responded to earlier.
There is a clear route for involving agencies in a multi-agency approach to adult exploitation cases when it does not meet safeguarding thresholds

<table>
<thead>
<tr>
<th>Partnership Lead: Police – Matt Ditcher</th>
<th>Board Officer: Sanjiv Pattani</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key delivery mechanism:</strong> Task and Finish Group linked to Procedures Subgroup</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective</th>
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<th>How will we measure progress and impact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioners are aware of and confident to work as part of the multi-agency approach to adult exploitation</td>
<td>Within review of services and multi-agency approaches (SAB Priority 1) specifically consider services and multi-agency approaches regarding ‘adult exploitation’ to understand what approaches are in place, what partnerships and agencies have an interest or involvement in this and identify gaps. Develop a multi-agency approach regarding Adult Exploitation within the broader multi-agency framework being developed (SAB Priority 1). Develop guidance on recognising and responding to adult exploitation. Develop a training/case study pack to be used across agencies (eg in meetings) to roll-out guidance and awareness.</td>
<td>Sept 2019</td>
<td>Procedures Subgroup</td>
<td>Guidance developed Case study disseminated Practitioner feedback on guidance Outcomes in reported cases of adult exploitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>March 2020</td>
<td>Task and Finish Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>March 2020</td>
<td>Task and Finish Group</td>
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<tr>
<td></td>
<td></td>
<td>March 2020</td>
<td>Task and Finish group</td>
<td></td>
</tr>
<tr>
<td>Raise public awareness of how to respond to indicators of adult exploitation</td>
<td>Public campaign to promote what to look out for regarding adult exploitation and what to do.</td>
<td>March 2020</td>
<td>Task and Finish Group</td>
<td>Measure number of concerns of adult exploitation raised by members of the public</td>
</tr>
</tbody>
</table>
Priority: SAB4 Transitions (Joint with Leicester SAB)

Priority Statement: Prevention of Safeguarding need through building resilience and self-awareness in adults with care and support needs.

Rationale:
- Effective transition from children’s services, such as Looked After Children, Children on Child Protection Plans, and those affected by CSE, may support prevention of adult safeguarding need.
- RiPIfA (Research in Practice for Adults) has recently published a strategic briefing outlining learning and challenges regarding safeguarding adults and transitions.

What do we want to be different?
The Board is assured that work with young people who have been assessed as requiring additional support to reduce risk and vulnerability (including LAC, CIN, CP, CSE) assists prevention of adult safeguarding need.

Partnership Lead: Leicester City Council – Teodora Bot
Board Officer: Chris Tew

Key delivery mechanism: LLR Transitions Task and Finish Group

<table>
<thead>
<tr>
<th>Objective</th>
<th>What are we going to do?</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Be assured that the needs of young people who have been assessed as requiring additional support to reduce risk and vulnerability (including LAC, CIN, CP, CSE) are reviewed and supported in preparation for adulthood. (16+)</td>
<td>Develop local guidance for practitioners where victims of child exploitation (i.e. CSE, gangs, county lines, cuckooing, domestic abuse, extremism, modern slavery and trafficking) are transitioning between child and adult safeguarding. Ensure that other relevant groups across LLR i.e. LLR Strategic Partnership Executive group, LLR Exploitation Group, LLR Modern Slavery Action Group, and respective transitions groups across LRR (i.e. City Transitions Board) are briefed on, and aware of, the group’s work. Provide an overview of local and national ‘safeguarding transitions’ good practice for consideration by the SABs.</td>
<td>March 2020</td>
<td>Transitions Task and Finish Group</td>
<td>Guidance developed Learning considered by SABs Actions from learning identified and implemented. Assess impact e.g. through audits.</td>
</tr>
<tr>
<td>Build a shared understanding across Leicester, Leicestershire and Rutland (LLR) safeguarding partners about ‘safeguarding transitions’ where it applies in relation to young adults transitioning from children’s safeguarding who have experienced abuse (including where relevant, Looked After Children)</td>
<td></td>
<td>June 2019</td>
<td>Transitions Task and Finish Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>January 2020</td>
<td>Transitions Task and Finish Group</td>
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</table>
HEALTH AND WELLBEING BOARD:

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH PROTECTION ASSURANCE REPORT

Purpose of report

1. The purpose of this report is to provide a summary of the assurance functions of the Leicestershire, Leicester and Rutland (LLR) Health Protection Assurance Board. It also updates the Health and Wellbeing Board on health protection performance, key incidents and risks and other significant matters considered in the past year that have emerged from January 2018 to December 2018.

Link to the local Health and Care System

2. Health protection assurance is a statutory duty of the local authority, via the Director of Public Health. It is therefore a key element of the Joint Health and Wellbeing Strategy and of Leicestershire County Councils core business. It is an essential element in local health and social care strategies and initiatives including Better Care Together/Sustainability Transformation Plan, and to urgent care work streams.

Recommendations

3. It is recommended that;

   a) The Health Protection Board Report January 2018- December 2018 be noted;

   b) That in noting the report, The Health and Wellbeing Board recognise the specific health protection issues that have arisen locally and the steps taken to deal with them, and the particular areas of focus for the coming year.

Policy Framework and Previous Decisions

4. On 1st April 2013 implementation of the new NHS and Social Care Act (2012) resulted in most of former NHS Public Health responsibilities being transferred to upper tier and unitary local authorities (LAs) including the statutory responsibilities of the Director of Public Health.

5. Each local authority is now required, via its Director of Public Health to assure itself that relevant organisations have appropriate plans in place to protect the health of the population and that all necessary action is being taken. The scope of health protection in this context includes these key domains:

   1. prevention and control of infectious diseases
2. national immunisation and screening programmes

3. health care associated infections

4. emergency planning and response (including severe weather and environmental hazards)

6. The Local Authority does not commission the majority of services which contribute to protecting the health of the population, but the Director of Public Health should be absolutely assured that arrangements are robust and that they are implemented in a way which meets the needs of the population for which they are responsible.

7. This is a local leadership function which requires the Director of Public Health and wider public health team to identify issues and advise appropriately; and to work in close liaison and cooperation with other contributing organisations. Responding to the Director of Public Health’s information and advice is the responsibility of these other contributing organisations, who will also be accountable should unheeded advice result in any adverse impact.

8. It is considered beneficial for the Health and Wellbeing Board to have an understanding of the assurance functions of the Leicestershire, Leicester and Rutland (LLR) Health Protection Assurance Board and an overview of the health protection performance, key incidents and risks and other significant matters which have arisen during 2018.

**Background**

9. The Leicestershire, Leicester and Rutland Health Protection Assurance Board is a sub-group of the three Health and Wellbeing Boards for Leicester, Leicestershire and Rutland (LLR) and enables local authorities to discharge their health protection assurance responsibilities,

10. Quarterly dashboards, reports and/or updates are received and reviewed at the quarterly Assurance Board. They cover the key domains identified above. This data is reviewed by the group and if needed, stakeholders are asked to produce more detailed assurance for the group on an exception basis. The Health Protection Assurance Committee is linked into a number of other Health Protection groups across the local system:
Key domains of health protection assurance

Prevention and Control of Infectious Diseases

Organisational Roles/Responsibilities

11. Public Health England (PHE) leads on the epidemiological investigation and the specialist health protection response to public health outbreaks/incidents and has responsibility to declare a health protection incident, major or otherwise.

12. NHS England is responsible for ensuring that their contracted providers are mobilised to deliver an appropriate clinical response to outbreaks/incidents. This responsibility devolves down to local Clinical Commissioning Groups to use contractual arrangements with provider organisations to make relevant resources available (includes screening/diagnostic and treatment services).

13. The Local Authority through the Director of Public Health has overall responsibility for the strategic oversight of an incident/outbreaks and to gain assurance that the local health protection system is robust enough to respond appropriately.

Sexual Health

Table 1 in Appendix 1 summarises the latest diagnostic and treatment rates for the main sexually transmitted infections in Leicestershire.

14. Leicestershire Public Health commission the integrated sexual health services which detect, prevent and treat sexually transmitted infections in the local population. The service has comprehensive arrangements including online testing for Sexually Transmitted Infections and a variety of testing options for HIV.
15. The main Sexual Health contract covering Leicestershire, Leicester and Rutland was re-tendered in 2018 and the new contract commenced 01/01/19. There is a now a greater emphasis on self-managed care whilst preserving the quality of testing, results notification and partner notification. The main site of delivery of services has moved to the Haymarket Shopping Centre, Leicester.

16. Chlamydia Screening:
Whereas the chlamydia detection rate is lower than the benchmark and England average, the prevalence rate in Leicestershire is lower than national average and therefore screening is being undertaken for those at highest risk. The newly procured Sexual Health Service model of delivery will provide increased access to self-sampling tests, including distribution via vending machines, pick up points and sexual health clinic sites.

Key Issues for 2019 (Sexual Health)

17. An action plan has been developed with key actions for 2019/20 relating to:
• Improve promotion of offer of tests using wider range of social media options.
• Review of screening in wider services such as prisons, termination of pregnancy services and maternity pathways to improve offer and uptake.
• Improve partner notification systems in integrated sexual health service to increase uptake of partner testing and retesting.

Tuberculosis (TB)

18. Although prevalence of TB remains relatively low in Leicestershire, outbreaks do occur and there has been a recent increased prevalence of virulent strain of TB in Loughborough. Appendix 2 contains information concerning the number of TB cases during 2018.

19. Key issues for 2019 (TB)
• Continue to explore options and opportunities to provide TB screening and active case finding among migrants and other under-served populations.
• Review commissioning arrangements for paediatric TB patients.
• Explore the potential for use of mobile x-ray units (MXUs) for use in prison.
• Clearly agree and outline local sustainable funding arrangements for TB incidents and outbreaks.

Other Outbreaks

Multi-Drug Resistant Organisms (MDROs)

20. During the summer of 2018 there was an outbreak of a Carbapenemase Resistant Organism (CRO), at the University Hospitals of Leicester (UHL). Further outbreaks have occurred sporadically over recent months. CRO are increasingly prevalent pathogens in hospitalized patients and can cause a variety of infections such as urinary tract infections, wound infections and respiratory tract infections.

21. The importance of CRO derives from the fact that they can spread rapidly in the hospital setting, and that they are commonly multidrug resistant (MDR). There are
still few therapeutic options available to treat these MDR pathogens. Health and care partners across LLR are working collaboratively to (1) screen for CRO in high risk patients and (2) effectively manage those patients who are shown to be positive whether in hospital or community settings. Public Health England have developed a set of toolkits to support this work: https://www.gov.uk/government/publications/carbapenemase-producing-enterobacteriaceae-non-acute-and-community-toolkit.

Key issues for 2019 (CRO):

22. Fully embed practical advice to prevent or reduce the spread of Carbapenemase Resistant Organisms (CRO) in community and non-acute healthcare settings.

Immunisation and Screening

Organisational Roles/Responsibilities

23. NHS England commission most national screening and immunisation programmes through their Local Area Teams.

24. PHE is responsible for setting screening and immunisation policy through expert groups (the National Screening Committee and Joint Committee on Vaccination and Immunisation). At a local level, specialist public health staff, employed by PHE are embedded in the NHS Local Area Teams to provide accountability for the commissioning of the programmes and provide system leadership. PHE provides quarterly surveillance reports for each of the national immunisation and screening programmes.

25. Local Authorities through the Director of Public Health require assurance that screening and immunisation services are operating safely whilst maximising coverage and uptake within their local population.

Immunisation

26. Coverage of childhood immunisations continues to be relatively high and stable in Leicestershire (mostly over 90%, against a national target of 95% for some programmes). Good coverage helps ensure that the local population is protected and does not become susceptible to outbreaks of vaccine preventable diseases. See Appendix 3 for childhood immunisation cover.

Seasonal flu

27. Flu uptake rates remain sub-optimal and there is an ongoing need to strengthen flu vaccine uptake. See Appendix 4 for Flu Vaccine uptake rates.

Key issues for 2019 (Immunisation)

28. 
- Increase uptake of MMR
- Increase uptake of influenza vaccine
- Introduction of HPV vaccine for boys in year 8

Screening
29. Both cancer and non-cancer screening coverage continues to be higher than the national average in Leicestershire.

30. Cervical screening coverage remains below the national target of 80% and this reflects recent national trends. Breast screening coverage in 2017/18 is stable and meets the national target of 80%. Bowel screening coverage increased in 2017/18 in all areas and also remains above the national target of 60% and above the national average. Performance in the abdominal aortic aneurysm (AAA) screening programmes continues to be excellent, and coverage is stable and meets acceptable national standards.

**Key issues for 2019 (Screening)**

- Continue to strengthen collaborative multi-agency action plans to target areas of poor uptake and coverage for each of the screening programmes.
- Work with NHS England to improve areas of performance where national targets are not being met.
- Review performance indicators to determine the measure are relevant to Health Protection
- Need to build on relationships between local authority, NHS England and CCGs
- Move to primary HPV testing for cervical screening
- Introduction of FIT testing to bowel screening programme

**Health Care Associated Infections**

31. Many healthcare associated infections are preventable. When they do occur, they can have a significant impact on patients and on the wider NHS and care systems

**Organisational Roles/Responsibilities**

32. The NHS Outcomes Framework (NHS OF) is a set of indicators developed by the Department of Health and Social Care to provide a framework in which to measure and monitor how well the NHS is performing. NHS England hold local CCGs to account for performance against indicators under this domain, which includes incidence of preventable healthcare associated meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia and incidence of *Clostridium difficile*.

33. PHE through its consultants in communicable disease control will lead the epidemiological investigation and the specialist health protection response to health care associated infection outbreaks and has responsibility to declare a health protection incident.

34. The Local Authority through the Director of Public Health has overall responsibility for the strategic oversight of a health care associated infections impacting on their population’s health. See Appendix 5 for information concerning screening programmes uptake during 2018.
MRSA

35. NHS Improvement has continued to set healthcare providers the challenge of demonstrating a ‘zero’ tolerance of MRSA blood stream infections (BSI) however in March 2018 NHS Improvement announced a change in how MRSA BSI cases were to be reviewed. From April 2018 University Hospitals of Leicester (UHL) and the three local Clinical Commissioning were exempt from completing a formal post infection review as this was now only for organisations with the highest rates of infection.

MSSA

36. Mandatory reporting of all Meticillin Sensitive Staphylococcus Aureus (MSSA) has been a requirement for provider organisations since January 2011. However to date national trajectories to reduce these cases have not been set. Locally, the Clinical Commissioning Groups continue to hold providers to account for the number of reported MSSA cases.

C.difficile infection

37. From April 2017 NHS providers were required to input additional information to the PHE data capture system relating to information prior to admission to hospital. This additional information is intended to allow the categorisation of non-hospital onset cases based upon the timing of prior admissions to the reporting Trust. Locally, the CCGs continue to hold providers to account where, following a review of individual cases, a lapse in care was identified that may have contributed to the person acquiring a Clostridium difficile infection. During 2017/2018 both UHL and the three local commissioning groups achieved their nationally set trajectories.

E.coli bacteraemia

38. E.coli bacteraemia rates, chiefly community acquired, were static or increasing during the year and are a focus for ongoing infection prevention and control work. Efforts are underway to engage the whole local health and social care economy continue to assess the overall approach to reducing E.coli blood stream infections.

Key issues for 2019 (Health Care Associated Infections)

- Need to strengthen role of Sustainability Transformation Plan in terms of governance and oversight of Health Care Associated Infections
- Work to reduce Gram negative bacteraemia
- Strengthen outbreak monitoring to ensure timely patient transfers, system flow and resilience.
- Aim for and achieve the zero target for pre 48-hour MRSA blood stream infections – there are currently no trajectories set relating to pre 48hrs MRSA BSI cases.
- Reduce the number of Clostridium difficile pre 72hour community cases – There are currently no national CDI objectives for community services providers.

Anti-microbial resistance (AMR)
Antimicrobial resistance happens when microorganisms (such as bacteria, fungi, viruses, and parasites) change when they are exposed to antimicrobial drugs (such as antibiotics, antifungals, antivirals, antimalarials, and anthelmintics). Microorganisms that develop antimicrobial resistance are sometimes referred to as “superbugs”. As a result, the medicines become ineffective and infections persist in the body, increasing the risk of spread to others.

Antimicrobial resistance occurs naturally over time, usually through genetic changes. However, the misuse and overuse of antimicrobials is accelerating this process. System-wide action to address anti-microbial resistance. Oversight of efforts to tackle AMR sits with the LLR Infection Prevention and Control (IPC) Programme Board and also with the LLR IPC Multiagency Delivery Group (MADG).

Key issues for 2019 (Anti-microbial Resistance)

- Further progress is required to develop and implement an LLR AMR strategy
- Increase focus on tackling CRO
- Reduce overall prescribing of antibiotics in primary care.
- Specifically reduce prescribing of cephalosporin, quinolone and co-amoxiclav
- Review arrangements for oversight of infection prevention and control outside hospital settings.

Emergency planning and response (including severe weather and environmental hazards e.g. air quality)

Organisational Roles/Responsibilities

Emergency planning has been a Local Authority function since before the Health and Social Care Act (2012), however with Public Health in the Authority there are additional opportunities to consider around the health protection aspects of this function.

The local authority continues to engage with the Local Resilience Forum in undertaking their annual exercise programme, responding to incidents and undertaking learning as required.

Key issues for 2019 (Emergency Planning)

- Build on the LHRP Survey capabilities survey to address gaps in the system, particularly related to capacity, resources and governance
- Work to ensure partners are clear on the response structure to major incidents, the causes of delays in action and on the coordination of groups.
- Further discussions are needed at Local Health Resilience Partnership (LHRP) to confirm major incident cover especially over longer term major incidents.
- Continue to review contingency plans as appropriate according to national and local guidance and ensure further testing response arrangements.
- Ensure that there is an on-going approach to learning from experience and that issues identified from real events are acted upon.
- Clarify psychological support requirements in the event of mass casualty events

**Air quality**

43. Poor air quality is the largest environmental risk to the public's health, leading to significant levels of morbidity and premature mortality. Annually in the UK, particulate matter (PM) air pollution causes 29,000 deaths and 340,000 life years lost. Meanwhile Nitrogen dioxide (NO2) air pollution shortens lives by an average of around 5 months and causes nearly 23,500 deaths in the UK per year.

44. Public Health England, in its 2014 publication ‘Estimating Local Mortality Burdens Associated with Particulate Air pollution’, assesses that annually over 300 deaths in Leicestershire can be attribute to PM2.5 pollution. Combined with pollution from Nitrous Oxides, this figure could be around 430 deaths each year.

45. Air pollution was identified as an ‘emerging national risk to health’ in Leicestershire’s DPH 2017 Annual report. Data, and related analysis, was used to illustrate the scale of the problem across the County.

46. Air Quality has also been chosen as a topic for refresh within Leicestershire’s Joint Strategic Needs Assessment. The refreshed JSNA chapter concludes: By its nature, air quality cannot be controlled by geographical boundaries or by a single individual alone. Instead collective, systematic efforts are required to reduce air pollution and its harmful effects on health. The JSNA posits 26 recommendations which focus on four key areas:
- Aligning and collaborating on local air quality initiatives
- Prioritising structural efforts to reduce emissions of air pollutants
- Universal and focused efforts to reduce exposure to poor quality for all and specifically those most at need
- Strengthening cross organisational working

47. The Health and Wellbeing Board will consider the findings of the Air Quality JSNA Chapter in detail at its meeting in September.

48. A cross Leicestershire air quality partnership has now been formed and the steering group has been meeting since January 2019. The emerging partnership action plan for air quality in Leicestershire will focus on better data and intelligence, active travel promotion in identified hot spots, and a communications campaign to educate the wider public on both the acute and longer-term effects of poor air quality so that they can better protect themselves and their families. At present the Air Quality and Health partnership action plan is Leicestershire focused but join up with Leicester and Rutland colleagues may happen in due course.

49. Health and Wellbeing is also a core aspect of the Leicestershire Environment Strategy and members of the public health department are supporting delivery. Good links have also been developed with Leicestershire Environmental Health Managers group.

**Key issues 2019 (Air Quality)**

- To be determined by both the JSNA and action plan steering group committee but likely to focus around campaigns, active travel and advocacy (e.g. for green fleet review etc)
**Conclusions**

50. Overall the Leicestershire Director of Public Health is assured that the correct processes and systems are in place to protect the health of the population.

Areas to continue to focus further progress on include:

- Ensuring local health and care systems have the capacity to respond to major incidents (national issue)-including emergency planning and response (e.g. severe weather and environmental hazards)
- Maintaining and improving progress on key health protection indicators particularly relating to:
  - Communicable disease
  - Environmental hazards especially air quality
  - Screening
  - Immunisation
  - Hospital Acquired Infections

**Background papers**


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Appendix 3 Childhood Immunisations Leicestershire 2018

Appendix 4 Seasonal Flu uptake (Immform Monthly data January 2019)

Appendix 5 Screening programmes uptake Leicestershire, 2018

Appendix 6 Healthcare association infections incidence 2017-18

Appendix 7 Leicestershire Health Protection Risk Matrix

**Relevant Impact Assessments**

A health protection risk matrix has been produced and is attached as Appendix 7.

**Equality and Human Rights Implications**

Certain socially excluded groups are at greater risk of environmental hazards e.g. poor air quality in areas of socio-economic deprivation. Some groups are at increased risk of particular infectious diseases e.g. TB in some migrants and asylum seekers.

Certain groups and individuals are also less likely to avail of the protection afforded by immunisation and screening e.g. in areas of socio-economic deprivation

**Environmental Implications**

Air quality is an important element within the Leicestershire Environment Strategy

**Partnership Working and associated issues**

Partnership working across health, local authorities, police, fire, districts etc is essential to ensure robust health protection and emergency planning arrangements are in place

_________________________
Appendix 1

Table 1 Leicestershire sexual health indicators, 2018

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Polarity</th>
<th>Target</th>
<th>Latest Time Period</th>
<th>CIPFA Rank</th>
<th>England Value</th>
<th>Latest Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.02 - Chlamydia detection rate (15-24 year olds)</td>
<td>High</td>
<td>≤1,900</td>
<td>2017/4/16</td>
<td>1,881.90</td>
<td>1,886.50</td>
<td></td>
</tr>
<tr>
<td>3.04 - HIV late diagnosis</td>
<td>Low</td>
<td>≤25%</td>
<td>2015-17</td>
<td>N/A</td>
<td>41.1*</td>
<td></td>
</tr>
<tr>
<td>Gonorrhoea diagnostic rate / 100,000</td>
<td>Low</td>
<td>England</td>
<td>2017/9/16</td>
<td>78.8</td>
<td>33.5</td>
<td></td>
</tr>
<tr>
<td>HIV diagnosed prevalence rate per 1,000 aged 15-59</td>
<td>Low</td>
<td>≤2 to 5</td>
<td>2017/8/16</td>
<td>2.3</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>HIV testing coverage, total (%)</td>
<td>High</td>
<td>England</td>
<td>2017/11/16</td>
<td>65.7</td>
<td>63.1</td>
<td></td>
</tr>
<tr>
<td>New HIV diagnosis rate / 100,000 aged 15+</td>
<td>Low</td>
<td>England</td>
<td>2017/6/15</td>
<td>8.7</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td>Syphilis diagnostic rate / 100,000</td>
<td>Low</td>
<td>England</td>
<td>2017/13/16</td>
<td>12.5</td>
<td>5.3</td>
<td></td>
</tr>
</tbody>
</table>

Appendix 2:

Table 2. TB epidemiology Leicestershire 2018

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Polarity</th>
<th>Target</th>
<th>Latest Time Period</th>
<th>CIPFA Rank</th>
<th>England Value</th>
<th>Latest Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.05i - Treatment completion for TB</td>
<td>High</td>
<td>England</td>
<td>2016/12/16</td>
<td>84.40</td>
<td>68.40</td>
<td></td>
</tr>
<tr>
<td>3.05ii - Incidence of TB</td>
<td>Low</td>
<td>England</td>
<td>2015-17/9/16</td>
<td>9.9</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>Proportion of pulmonary TB cases starting treatment within four months of symptom onset</td>
<td>High</td>
<td>England</td>
<td>2017/2/15</td>
<td>68.8</td>
<td>79.2</td>
<td></td>
</tr>
<tr>
<td>Proportion of TB cases offered an HIV test</td>
<td>High</td>
<td>England</td>
<td>2017/13/16</td>
<td>96.1</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 3.

### Childhood Immunisations Leicestershire 2018

#### Table 3. immunisation uptake at 12 months

<table>
<thead>
<tr>
<th>Immunisations</th>
<th>Leicestershire County</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months DTaP/IPV/Hib %</td>
<td></td>
</tr>
<tr>
<td>Q1 17/18</td>
<td>96.7%</td>
</tr>
<tr>
<td>Q2 17/18</td>
<td>97.1%</td>
</tr>
<tr>
<td>Q3 17/18</td>
<td>97.1%</td>
</tr>
<tr>
<td>Q4 17/18</td>
<td>96.8%</td>
</tr>
<tr>
<td>Q1 18/19</td>
<td>96.9%</td>
</tr>
<tr>
<td>Q2 18/19</td>
<td>96.7%</td>
</tr>
<tr>
<td>Q3 18/19</td>
<td>97.0%</td>
</tr>
</tbody>
</table>

| 12 months Rotavirus % |                         |
| Q1 17/18          | 94.5%                 |
| Q2 17/18          | 94.5%                 |
| Q3 17/18          | 95.3%                 |
| Q4 17/18          | 94.4%                 |
| Q1 18/19          | 95.7%                 |
| Q2 18/19          | 95.3%                 |
| Q3 18/19          | 95.0%                 |

| MenB two doses (%), for infants assessed at six months of age |                         |
| Q1 17/18         | 96.3%                 |
| Q2 17/18         | 96.5%                 |
| Q3 17/18         | 97.1%                 |
| Q4 17/18         | 96.8%                 |
| Q1 18/19         | 97.2%                 |
| Q2 18/19         | 96.7%                 |
| Q3 18/19         | 97.6%                 |

**National Standard/Target:**

≥95%.

#### Table 4. Immunisation uptake at 24 months

<table>
<thead>
<tr>
<th>Immunisations</th>
<th>Leicestershire County</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 months PCV booster %</td>
<td></td>
</tr>
<tr>
<td>Q1 17/18</td>
<td>95.8%</td>
</tr>
<tr>
<td>Q2 17/18</td>
<td>96.0%</td>
</tr>
<tr>
<td>Q3 17/18</td>
<td>97.5%</td>
</tr>
<tr>
<td>Q4 17/18</td>
<td>97.0%</td>
</tr>
<tr>
<td>Q1 18/19</td>
<td>96.4%</td>
</tr>
<tr>
<td>Q2 18/19</td>
<td>96.7%</td>
</tr>
<tr>
<td>Q3 18/19</td>
<td>95.7%</td>
</tr>
</tbody>
</table>

| 24 months MMR % |                         |
| Q1 17/18       | 95.6%                 |
| Q2 17/18       | 95.6%                 |
| Q3 17/18       | 97.0%                 |
| Q4 17/18       | 96.4%                 |
| Q1 18/19       | 96.3%                 |
| Q2 18/19       | 96.4%                 |
| Q3 18/19       | 95.4%                 |
Table 5. Immunisation Uptake at 5 years

<table>
<thead>
<tr>
<th></th>
<th>Leicestershire County</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 years DTaP/IPV booster %</td>
<td></td>
</tr>
<tr>
<td>Q1 17/18</td>
<td>92.8%</td>
</tr>
<tr>
<td>Q2 17/18</td>
<td>93.7%</td>
</tr>
<tr>
<td>Q3 17/18</td>
<td>93.4%</td>
</tr>
<tr>
<td>Q4 17/18</td>
<td>93.8%</td>
</tr>
<tr>
<td>Q1 18/19</td>
<td>92.2%</td>
</tr>
<tr>
<td>Q2 18/19</td>
<td>91.1%</td>
</tr>
<tr>
<td>Q3 18/19</td>
<td>92.6%</td>
</tr>
<tr>
<td>5 years MMR 2nd dose %</td>
<td></td>
</tr>
<tr>
<td>Q1 17/18</td>
<td>93.9%</td>
</tr>
<tr>
<td>Q2 17/18</td>
<td>94.0%</td>
</tr>
<tr>
<td>Q3 17/18</td>
<td>94.1%</td>
</tr>
<tr>
<td>Q4 17/18</td>
<td>94.2%</td>
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<tr>
<td>Q1 18/19</td>
<td>94.3%</td>
</tr>
<tr>
<td>Q2 18/19</td>
<td>94.1%</td>
</tr>
<tr>
<td>Q3 18/19</td>
<td>94.8%</td>
</tr>
</tbody>
</table>

Appendix 4.

Table 5. Seasonal Flu uptake (Immform Monthly data January 2019)

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>65 and over %</th>
<th>Under 65 (at-risk only) %</th>
<th>All Pregnant Women %</th>
<th>All 2-year olds %</th>
<th>All 3-year olds %</th>
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</thead>
<tbody>
<tr>
<td>Leicestershire</td>
<td>73.2</td>
<td>46.7</td>
<td>47.9</td>
<td>59.7</td>
<td>61.6</td>
</tr>
<tr>
<td>England</td>
<td>71.2</td>
<td>46.7</td>
<td>45.0</td>
<td>44.8</td>
<td>43.0</td>
</tr>
<tr>
<td>National Aspiration</td>
<td>75</td>
<td>55</td>
<td>55</td>
<td>48</td>
<td>48</td>
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</table>

Appendix 5.

Table 6 Screening programmes uptake Leicestershire, 2018

<table>
<thead>
<tr>
<th>Screening indicator</th>
<th>Indicator</th>
<th>Polarity</th>
<th>Target</th>
<th>Latest Time Period</th>
<th>CIPFA Rank</th>
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<th>Latest Value</th>
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<td>Breast cancer screening coverage</td>
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<td>Newborn bloodspot screening coverage</td>
<td>High</td>
<td>Not compared</td>
<td>2017/13/4/16 N/A</td>
<td>96.7</td>
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Appendix 6.

Healthcare association infections incidence 2017-18

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<th>Apr 18/19</th>
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<th>June 18/19</th>
<th>July 18/19</th>
<th>Aug 18/19</th>
<th>Sept 18/19</th>
<th>Oct 18/19</th>
<th>Nov 18/19</th>
<th>Dec 18/19</th>
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### Appendix 7. Leicestershire Health Protection Risk Matrix

**November, 2018**

<table>
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<tr>
<th>Main issue(s)</th>
<th>Mitigation</th>
<th>Anything more to do locally at this point</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anti-microbial resistance</strong></td>
<td><em>(1) Lack of progress made on AMR strategy -&gt; increased prevalence of AMR infections. (2) CRO</em></td>
<td>Need to strengthen role of STP in terms of governance and oversight of this issue</td>
</tr>
<tr>
<td>Healthcare associated infections (HCAI)</td>
<td>Healthcare associated infections are preventable and have significant impact on patients and on wider NHS and care systems</td>
<td>Need to strengthen role of STP in terms of governance and oversight of this issue</td>
</tr>
<tr>
<td>Emerging and re-emerging infectious diseases</td>
<td>Increased prevalence of virulent strain of TB in Loughborough and Leicester City.</td>
<td>Communicable Disease Outbreak Management (PHE) recently published-needs further discussion and dissemination.</td>
</tr>
<tr>
<td>Pandemic influenza</td>
<td>Pandemic influenza is the most significant civil risk facing the UK</td>
<td>Links to emergency planning (see below)</td>
</tr>
<tr>
<td>Emergency planning*</td>
<td>Partners not always clear on the response structure to major incidents, causing delays in action and coordination of groups. Capacity, resources and governance</td>
<td>Further discussions needed at Local Health Resilience Partnership (LHRP) to confirm major incident cover especially over longer term major incidents. Additional input needed from regional HP network Need to follow up on LHRP audit of health protection capability, 2017</td>
</tr>
<tr>
<td>Climate change and extreme events-floods, heat, cold</td>
<td>See emergency planning above</td>
<td></td>
</tr>
<tr>
<td><strong>Immunization</strong></td>
<td>Intermittent supply issues</td>
<td>Need good communication between NHSE, CCGs and pharmacies</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td>On-going sub-optimal uptake of different screening programmes e.g. cervical screening</td>
<td>Continued oversight at HP Assurance Board</td>
</tr>
<tr>
<td><strong>Air Quality</strong></td>
<td>Causes significant premature mortality</td>
<td>Leicestershire Air Quality Strategy now in place</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td>Lack of capacity in LLR, environmental health &amp; regulatory teams to deliver statutory functions.</td>
<td>Continued oversight at HP Assurance Board</td>
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