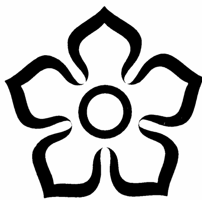


MEETING OF THE CABINET

DATE: MONDAY, 11 APRIL 2011
TIME: 1:00 pm
PLACE: THE COUNCIL CHAMBER - FIRST FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER

Members of the Committee

Councillor Patel (Chair)
Councillor Dempster (Vice-Chair)

Councillors Bhatti, Cooke, Dawood, Naylor, Osman, Russell, Westley and Wann

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

H Kent

for Director, Corporate Governance

MEMBERS OF THE PUBLIC:

YOU ARE VERY WELCOME TO ATTEND TO OBSERVE THE PROCEEDINGS. HOWEVER, PLEASE NOTE THAT YOU ARE NOT ABLE TO PARTICIPATE IN THE MEETING.

Officer contact: Julie Harget/Heather Kent
Democratic Support,
Leicester City Council
Town Hall, Town Hall Square, Leicester LE1 9BG
(Tel. 0116 229 8809/ 8816 Fax. 0116 229 8819)
Email: julie.harget@leicester.gov.uk / heather.kent@leicester.gov.uk

INFORMATION FOR MEMBERS OF THE PUBLIC

ACCESS TO INFORMATION AND MEETINGS

You have the right to attend Cabinet to hear decisions being made. You can also attend Committees, as well as meetings of the full Council. Tweeting in formal Council meetings is fine as long as it does not disrupt the meeting. There are procedures for you to ask questions and make representations to Scrutiny Committees, Community Meetings and Council. Please contact Democratic Support, as detailed below for further guidance on this.

You also have the right to see copies of agendas and minutes. Agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk or by contacting us as detailed below.

Dates of meetings are available at the Customer Service Centre, King Street, Town Hall Reception and on the Website.

There are certain occasions when the Council's meetings may need to discuss issues in private session. The reasons for dealing with matters in private session are set down in law.

WHEELCHAIR ACCESS

Meetings are held at the Town Hall. The Meeting rooms are all accessible to wheelchair users. Wheelchair access to the Town Hall is from Horsefair Street (Take the lift to the ground floor and go straight ahead to main reception).

BRAILLE/AUDIO TAPE/TRANSLATION

If there are any particular reports that you would like translating or providing on audio tape, the Democratic Services Officer can organise this for you (production times will depend upon equipment/facility availability).

INDUCTION LOOPS

There are induction loop facilities in meeting rooms. Please speak to the Democratic Services Officer at the meeting if you wish to use this facility or contact them as detailed below.

General Enquiries - if you have any queries about any of the above or the business to be discussed, please contact Julie Harget or Heather Kent, Democratic Support on (0116) 229 8809/8816 or email julie.harget@leicester.gov.uk or heather.kent@leicester.gov.uk or call in at the Town Hall.

Press Enquiries - please phone the Communications Unit on 252 6081

PUBLIC SESSION

AGENDA

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATIONS OF INTEREST**

Members are asked to declare any interests they may have in the business to be discussed and/or indicate that Section 106 of the Local Government Finance Act 1992 applies to them.

3. **LEADER'S ANNOUNCEMENTS**

4. **MINUTES OF PREVIOUS MEETING**

The minutes of the meeting held on 21 March 2011 have been circulated to Members and the Cabinet is asked to approve them as a correct record.

5. **MATTERS REFERRED FROM COMMITTEES**

6. **HEALTH SCRUTINY COMMITTEE'S REVIEW OF ADULT MENTAL HEALTH SERVICES IN THE CITY** **Appendix A**

Councillor Cooke, Chair of the Health Scrutiny Review, submits a report that presents the findings of the Health Scrutiny Committee's review into how working-age adult mental health services are currently being delivered in Leicester. Cabinet is recommended to endorse the report and its recommendations in Paragraph 2 of the report.

A minute extract from the meeting of the Health Scrutiny Committee, held on 1 December 2010 is attached.

The Joint Commissioning Strategy document is attached for Cabinet Members only. This document can be viewed on the Council's website at www.cabinet.leicester.gov.uk , or by calling Democratic Support on 0116 2298816.

7. **ANNUAL CONSULTATION ON ADMISSION ARRANGEMENTS FOR ENTRY IN 2012/13** **Appendix B**

Councillor Dempster submits a report that briefs Cabinet on the outcome of the recent consultation exercise on the admission arrangements for 2012/2013. Cabinet is asked to approve the recommendations in Paragraph 2 of the report.

A minute extract from the meeting of the Children & Young People Scrutiny Committee, held on 5 April 2011 will be circulated as soon as it is available.

8. OUTCOME OF THE UNANNOUNCED SAFEGUARDING INSPECTION 2010 **Appendix C**

Councillor Dempster submits a report that advises on the outcome of the Ofsted Unannounced Safeguarding Inspection of Duty and Assessment Services in Social Care and Safeguarding Division on 16th and 17th November 2010 and summarises the findings of the Inspection, the recommendations and the response of the Division. Cabinet is asked to approve the recommendations in Paragraph 3 of the report.

A minute extract from the meeting of the Children & Young People Scrutiny Committee, held on 5 April 2011 will be circulated as soon as it is available.

9. ARRANGEMENT FOR EXTENDING THE SERVICES CONTRACT WITH LEICESTER SHIRE CONNEXIONS SERVICE LIMITED **Appendix D**

Councillor Dempster submits a report that advises Cabinet of the current position regarding Leicester Shire Connexions Service Limited ("Connexions") and seeks approval for the recommendations extending the services contract between Leicester City Council, Leicestershire County Council and Connexions for the provision of the Connexions Services (the "Services Contract") for 6 months from 1st April 2011 (with an option to extend further to 31 March 2012) and make consequential amendments to its Members' Agreement. Cabinet is asked to approve the recommendations in Paragraph 2 of the report.

10. ILLEGAL MONEY LENDING AND DELEGATION OF POWERS TO BIRMINGHAM CITY COUNCIL **Appendix E**

Councillor Russell submits a report that seeks to approve the delegation of enforcement and prosecution powers to Birmingham City Council to enable the Illegal Money Lending Section within Birmingham Trading Standards (IMLS) to undertake investigations into illegal money lending in the Leicester City area and take appropriate enforcement actions. Cabinet is asked to approve the recommendations in Paragraph 2 of the report.

A minute extract from the meeting of the Overview & Scrutiny Management Board, held on 7 April 2011 will be circulated as soon as it is available.

11. PLANNING APPLICATIONS - REVISED LOCAL VALIDATION REQUIREMENTS **Appendix F**

Councillor Osman submits a report that seeks Cabinet approval for the Council to adopt a revised list of details to be submitted with planning applications to make them acceptable in line with Government advice. Cabinet is asked to approve the recommendations in Paragraph 2 of the report.

A minute extract from the meeting of the Overview & Scrutiny Management Board, held on 7 April 2011 will be circulated as soon as it is available.

12. DRAFT GREEN SPACE SUPPLEMENTARY PLANNING DOCUMENT — Appendix G

Councillor Osman submits a report that reports on the outcome of the public consultation for the draft Green Space Supplementary Planning Document (SPD), presents the final version and seeks formal adoption. Cabinet is asked to formally adopt the Green Space SPD as Council policy.

A minute extract from the meeting of the Overview & Scrutiny Management Board, held on 7 April 2011 will be circulated as soon as it is available.

Appendices to the report are attached for Cabinet Members only. They can be viewed on the Council's website at www.cabinet.leicester.gov.uk , or by calling Democratic Support on 0116 2298816.

13. IMPROVING HEALTH IN LEICESTER: THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH — Appendix H

Councillor Naylor submits the Director of Public Health's Annual Report. Cabinet is recommended to receive the Annual Report of the Director of Public Health and Health Improvement 2010 and to note that there will be a more detailed workshop to be held later in the year.

A minute extract from the meeting of the Health Scrutiny Committee, held on 29 March 2011 will be circulated as soon as it is available.

The Annual Report has previously been circulated to Cabinet Members. This document can be viewed on the Council's website at www.cabinet.leicester.gov.uk , or by calling Democratic Support on 0116 2298816.

14. CREATION OF THE 2011/2012 PROCUREMENT PLAN — Appendix I

Councillor Patel submits a report that seeks Cabinet's approval to the Procurement Plan for 2011/2012. Cabinet is asked to approve the recommendations in Paragraph 3 of the report.

A minute extract from the meeting of the Performance & Value for Money Select Committee, held on 6 April 2011 will be circulated as soon as it is available.

15. REDUCING THE COST AND USE OF AGENCY STAFF (VACANCY MANAGEMENT SERVICE) — Appendix J

Councillor Dawood submits a report that provides Cabinet members with an update on the drive to reduce the cost and use of agency staff throughout the authority during 2010/2011 and informs Cabinet members that the same approach has been adopted to manage the cost and use of consultants. Cabinet is asked to approve the recommendations in Paragraph 2 of the report.

16. BME WORKFORCE TASK GROUP: IMPROVING BME SENIOR MANAGEMENT REPRESENTATION **Appendix K**

Councillor Dawood submits a report that sets out the investigation and findings of the cross party BME (Black and Minority Ethnic) Workforce Task Group into the issue of low BME Senior Management representation within the Council. Cabinet is asked to approve the recommendations in Paragraph 2 of the report.

17. NEW AFFORDABLE HOUSING FOR LEICESTER 2011-2015 **Appendix L**

Councillor Westley submits a report that seeks decisions on how the Council wishes to respond to the Government's new approach to enabling new affordable housing as set out in its "2011-15 Affordable Homes Programme Framework". Cabinet is recommended to confirm the affordable housing needs of the City for the period 2011-15.

A minute extract from the meeting of the Overview & Scrutiny Management Board, held on 7 April 2011 will be circulated as soon as it is available.

18. ANY OTHER URGENT BUSINESS

19. PRIVATE SESSION

AGENDA

MEMBERS OF THE PUBLIC TO NOTE

Under the law, the Cabinet is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

The Cabinet is recommended to consider the following reports in private on the grounds that they contain 'exempt' information as defined by the Local Government (Access to Information) Act 1985, as amended and consequently that the Cabinet makes the following resolution:-

"that the press and public be excluded during consideration of the following reports in accordance with the provisions of Section 100A(4) of the Local Government Act 1972, as amended, because they involve the likely disclosure of 'exempt' information, as defined in the Paragraphs detailed below of Part 1 of Schedule 12A of the Act and taking all the circumstances into account, it is considered that the public interest in maintaining the information as exempt

outweighs the public interest in disclosing the information.

NEW AFFORDABLE HOUSING FOR LEICESTER 2011-2015 (COUNCIL NEW BUILD, EXTENSION AND CONVERSIONS)

Paragraph 3
Information relating to the financial or business affairs of any particular person (including the authority holding that information).

LEICESTERSHIRE COUNTY CRICKET CLUB LIMITED – VARIATION OF COVENANTS

Paragraph 3
Information relating to the financial or business affairs of any particular person (including the authority holding that information).

20. NEW AFFORDABLE HOUSING FOR LEICESTER 2011-2015 (COUNCIL NEW BUILD, EXTENSION AND CONVERSIONS) **Appendix B1**

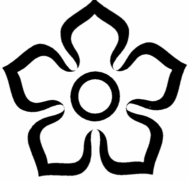
Councillor Westley submits a report.

21. LEICESTERSHIRE COUNTY CRICKET CLUB LIMITED – VARIATION OF COVENANTS **Appendix B2**

Councillor Patel submits a report.

This page is left blank intentionally.

Appendix A



WARDS AFFECTED
All

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:

Health Scrutiny Committee	**1st December 2010**
Cabinet Briefing	**21st March 2011**
Cabinet	**11th April 2011**

Health Scrutiny Committee's Review of Adult Mental Health Services in the City

---

Report of the Health Scrutiny Committee

1. Purpose of Report

1.1.1. The purpose of this report is to present the findings of the Health Scrutiny Committee's review into how working-age adult mental health services are currently being delivered in Leicester

1.1.2. To provide recommendations to Cabinet as regards any gaps and / or potential improvements in provision of adult mental health services that exist

2. Recommendations

2.1.1. Members of Cabinet are asked to endorse the report and its recommendations

2.1.2. A percent investment target for the community and voluntary sector (VSC) needs to be established and worked towards to address the low investment levels currently seen, to ensure that they receive funding consummate with the vital frontline services that they provide. The VCS have a role to play in building capacity and capability to support the development and delivery of mental health services but their role or budgets have not specifically been defined or identified

2.1.3. The "bundling" of the Leicestershire Partnership block contract is viewed as a stumbling block by many in the voluntary and community sector. Therefore the "unbundling" of the block contracts would assist them in being able to apply for more contracts

2.1.4. A time frame has now been provided by which the new Strategy will be approved (March 2011) but this time frame must not be allowed to slip any further. There has been no clear strategy over the last 4 years by the City Council and the PCT. This is seen by some as having led to the deterioration in a consistent and meaningful dialogue between the commissioners and themselves

2.1.5. A consultation framework is required, together with a clear and realistic timeframes. This needs to be established in consultation with the community and voluntary sector. This needs to be completed and attached to the back of this report when it goes to Cabinet in January 2011

2.1.6. Clear leadership, accountability and better governance is required by LCC and PCT, together with an open and transparent dialogue. This includes holding meaningful consultations with realistic timescales, where users and carers feel that they are being listened to, targets set and worked towards. Progress against this should be reported back to HSC within the next 6 months and there after if required

2.1.7. The HSC asks that the following comments made by representatives of the community and voluntary sector, be considered by Cabinet;

- It only had been possible to consider general mental health issues under the review as it was not known how many people came within each category of mental illness;

- A number of national frameworks for dealing with mental health illness had been established and these were outlined in the report;

- Ethnicity seems to be significant. People from black and ethnic minority groups were over-represented in segregated / closed units but were under-represented amongst those taking up services. This is an area that could benefit from further scrutiny

- It is important to recognise that the commissioning and delivery of mental health services has been transformed over the last 10 years. However, more recently changes in strategic direction has caused uncertainty for users and providers and there appears to have been a tendency to marginalise the voluntary sector

- The “bundling” of the Leicestershire Partnership block contract is seen as inhibiting the work of many in the voluntary and community sector

- The voluntary sector has done important things that other organisations are unable to do but the voluntary sector is often neglected

- It is important to identify mental health problems earlier than is currently being done. For example, young people still in education can be taught how to identify and cope with problems early on (rather than receiving education specifically about mental health) which could provide information on things such as support networks and coping strategies

- Care needs to be taken to ensure that healt care workers communicate effectively and act professionally at all times

- The problems that working with people traditionally marginalised creates needs to be recognised. For example they often have less trust in the service providers. Therefore it becomes paramount to have “door openers” who can help them to access and understand the support they need

- Consideration needs to be given to ho mental health services can be provided after the forthcoming re-organisation of health services provision

- The provision of services should not be seen as separated between that of clinical services and support services such as those provided by the community and voluntary sector

3. FINANCIAL, LEGAL AND OTHER IMPLICATIONS

3.1. Financial Implications

There are no direct financial implications arising from this report which is primarily concerned with commissioning issues. Overall future investment in Adult Mental Health by both the City Council and the NHS will be agreed through their respective budget strategies with decisions taken in the light of competing demands on scarce resources.

Legal Implications

The report identifies the current arrangements under the "section 75" partnership.

Cabinet, in September 2008, also approved the procurement methodology for re-contracting a number of services for adults with mental health needs, and their carers, via the new form of contract for community based services with voluntary sector providers.

The award of contracts is subject to compliance with the Councils' Contract Procedure Rules and the rules on EU procurement. The steps proposed in this report will inform such process.

Further legal advice should be sought on the packaging of re-provision of these services. In particular issues have previously arisen over TUPE and pension provision.

3.2. Climate Change Implications

This report does not contain any significant climate change implications and therefore should not have a detrimental effect on the Council's climate change targets.

Helen Lansdown, Senior Environmental Consultant - Sustainable Procurement

4. Other Implications

OTHER IMPLICATIONS	YES/ NO	Paragraph/References Within the Report
Equal Opportunities	Y	4.1.4, 4.1.5, 4.1.6, 4.1.7, 4.1.17, 4.1.21, 4.1.22, 4.1.42
Policy	Y	4.1.8, 4.1.9, 4.1.11, 4.1.16, 4.1.23, 4.1.24, 4.1.25, 4.1.26, 4.1.27, 4.1.28, 4.1.31, 4.1.32, 4.1.33, 4.1.34, 4.1.35, 4.1.36, 4.1.37, 4.1.38, 4.1.39, 4.1.40, 4.1.41, 4.1.42

Sustainable and Environmental	N	
Crime and Disorder	N	
Human Rights Act	N	
Elderly/People on Low Income	Y	4.1.4, 4.1.13, 4.1.14, 4.1.20,
Corporate Parenting	N	
Health Inequalities Impact	Y	

5. Background Papers – Local Government Act 1972

Modernising Mental Health Services; Safe, Sound and Supportive (1998)
The National Service Framework for Mental Health (1999)
2004-07 Strategy for Mental Health Services for Working-Age Adults in Leicester (2003)
National Indicators for local Authorities and Local Authority Partnerships: Annex 3 (2008)
Leicestershire Joint Strategic Needs Assessment: Core Dataset (Sept 2009)
Improving Health in Leicester – Annual Report of the Director of Public Health (2008/09)
New Horizons: A Shared Vision for Mental Health (2010)
Enabling Effective Delivery of Health and Wellbeing (2010)
Joint Commissioning Strategy Mental Health 2011-13 (October 2010)
Mental Health: Britain's Biggest Social Problem? (Sainsbury Centre for Mental Health, 2005)

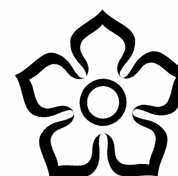
6. Consultations

6.1. Consultations were carried out in a number of ways over a six month period (Apr-Sep 2010) including writing to all mental health groups in the City inviting them to participate in the review, holding meetings with users and carers (represented by GENESIS), the community & voluntary sector (Network4Change / Savera and LAMP) and receiving presentations from the providers including Adults & Social Care (LCC), NHS Leicester City (PCT), University Hospitals Leicester (UHL) and Leicester Partnership Trust (LPT). Where it was not possible to meet with interested parties such as GP's, they were corresponded with via e-mails

7. Report Author

7.1. Councillor Michael Cooke

Key Decision	No
Reason	N/A
Appeared in Forward Plan	N/A
Executive or Council Decision	Executive (Cabinet)



FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:

Health Scrutiny **1st December 2010**

WORKING-AGE ADULT MENTAL HEALTH SERVICES REVIEW

Report of the Health Scrutiny Committee

1. PURPOSE OF REPORT

1.1.1 The purpose of this report is to present the findings of the Health Scrutiny Committee's review into how working-age adult mental health services are currently being delivered in Leicester

1.1.2 To provide recommendations to Cabinet as regards any gaps and / or potential improvements in provision of adult mental health services that exist

2. RECOMMENDATIONS / CONCLUSIONS

2.1.1 Members of Cabinet are asked to endorse the report and its recommendations. In so doing, the Committee is asked to commend this report it to Cabinet and to request a response from Cabinet to these recommendations

2.1.2 The community and voluntary-sector agencies (VCS) have a role to play in building capacity and capability to support the development and delivery of mental health services but their role or budgets have not specifically been defined. A percent investment target needs to be established and worked towards to address the low investment levels currently seen, to ensure that they receive funding consummate with the vital frontline services that they provide

2.1.3 The "bundling" of the Leicestershire Partnership block contract is viewed as a stumbling block by many in the voluntary and community sector. Therefore the "unbundling" of the block contracts would assist them in being able to apply for more contracts

2.1.4 There has been no clear strategy over the last 3 years by the City Council and the PCT. This is seen by some as having led to the deterioration in a consistent and meaningful dialogue between themselves and the voluntary and community sector. A time frame has now been provided by which the new Strategy will be approved (March 2011) but this time frame must not be allowed to slip any further

2.1.5 A consultation framework is required, together with a clear and realistic timeframe. This needs to be established in consultation with the community and voluntary sector. This needs to be completed and attached to the back of this report when it goes to Cabinet in January 2011

2.1.6 Clear leadership, accountability and better governance is required by LCC and PCT, together with an open and transparent dialogue. This includes holding meaningful consultations with realistic timescales, where users and carers feel that they are being listened to, targets set and worked towards. Progress against this should be reported back to HSC within the next 6 months and there after if required

3. BACKGROUND

3.1.1 In February 2010, the Health Scrutiny Committee (HSC) agreed to set up a working group to look at how adult mental health services are currently being delivered in Leicester

3.1.2 This comprised of Councillor Michael Cooke as Chair on behalf of Councillor Andy Bayford (Chair HSC) and Councillor Manjula Sood (Vice Chair HSC). A letter was then sent out to all Members informing them of the review. As a result, there has been considerable interest in the outcome of this review

3.1.3 The review set out to achieve the following;

- Identify the current provision of adult mental health services across the city
- Benchmark users and carers perceptions of that service
- Highlight any gaps in current and planned provision of the service
- Identify potential improvements to the service

3.1.4 The working group met on 6 occasions including holding focus groups with commissioners, service providers, as well as users and carers for the purpose of gathering evidence

3.1.5 The Health Scrutiny Committee has received regular progress reports on the work of the sub working group

4. REPORT

4.1.1 At any one time, one adult in six suffers from one form or another of mental illness. This can range from more common conditions such as anxiety or deep depression to severe illnesses such as schizophrenia[1].

4.1.2 Mental illness often occurs as a result of complex interactions between biological, social and psychological factors, but is still usually discussed in medical terms.

[1] National Service Framework for Mental Health (NHS 1999), Page 1

Most mental health symptoms have traditionally been divided into groups called either 'neurotic' or 'psychotic' symptoms. 'Neurotic' covers those symptoms which can be regarded as severe forms of 'normal' emotional experiences such as depression, anxiety or panic.

4.1.3 Less common are 'psychotic' symptoms, which interfere with a person's perception of reality, and may include hallucinations such as seeing, hearing, smelling or feeling things that no-one else can. Some mental health problems feature both neurotic and psychotic symptoms. As well as distinguishing between neurotic and psychotic symptoms, psychiatrists sub-divide different kinds of mental health disorders in other ways:

- Organic (identifiable brain malfunction) versus Functional (not due to simple structural abnormalities of the brain)
- ICD-10 Classification, which lists major groups of disorders in related families e.g. mood disorders, which includes depression and manic depression[2]

4.1.4 Mental health problems are more likely to occur in certain groups of people:

- People with poor living conditions
- People from ethnic minority groups
- Disabled people
- Homeless people
- Offenders

4.1.5 Women are more likely than men to suffer from anxiety disorders and depression, whilst drugs and alcohol problems are more common in men

4.1.6 The UK has one of the highest rates of self-harm in Europe with British men three times more likely than British women to die by suicide

4.1.7 Despite this however, mental illness is not well understood and all too often carries a stigma[3]

4.1.8 Following the publication of the previous Government's strategy "Modernising Mental Health Services; Safe, Sound and Supportive" (1998), the delivery of mental health services in the UK have been transformed. Underpinned by the *National Service Framework for Mental Health 1999 – 2009* (NSF-MH), the aim was to tackle what it saw as unacceptable variations in service delivery whilst providing a better focus and direction for the NHS and social services[4];

- Involve service users and their carers in planning and delivery of care
- Deliver high quality treatment and care which is known to be effective and appropriate
- Be well suited to those who use them and non-discriminatory

[2] Mental Health Foundation website
[3] ibid
[4] Modernising Mental Health Services (NHS 1998), Chapter 5

- Be accessible so that help can be obtained when and where it was needed
- Promote their safety and that of carers, staff and the wider public
- Offer choices that promote independence
- Be well co-ordinated between all staff and agencies
- Deliver continuity of care as long as this is needed
- Empower and support their staff
- Be properly accountable to the public, service users and carers

4.1.9 Ten years after the NSF-MH was published, *New Horizons: A Shared Vision for Mental Health (2010)* was produced. This set out the future vision for service providers, including the advocating of a more holistic approach towards mental health policies and service delivery – ensuring good mental health in childhood, through to promoting and protecting continued well-being into adulthood and beyond, in supporting and maintaining resilience in older age.[5] The need for continued service improvement together with the broader agenda of improving the wellbeing of the population was seen as the way forward – early prevention, detection and intervention through to treatment and recovery from mental illness

4.1.10 With regard to service provision, guidance from the National Institute for Clinical Health & Excellence (NICE) advocates the availability of treatments to all people with problems such as depression, anxiety or schizophrenia unless the problem is mild or recent

4.1.11 Whilst these changes have led to many positive outcomes especially for people with the most severe illnesses, people who experience mental health problems still encounter significant difficulties in their daily lives, experience gaps in services and variation in the support available to them

4.1.12 Leicester has an estimated population of 292,600 with a larger proportion of younger people (15-24) than England as a whole and a slightly smaller proportion of older people aged 65 or over. In addition, Leicester has a diverse population with 39% being from a black or ethnic minority background [6]

4.1.13 Under the Index of Multi-Deprivation 2007 (IMD) Leicester was ranked the 20th most disadvantaged Local Authority area in England out of a total of 354. There is a strong link between deprivation and poor health, with people from Leicester's most deprived areas having a life expectancy lower than both the national average and the less deprived areas of the City

4.1.14 In addition to unequal levels of mortality, there are persisting inequalities[7] in morbidity and access to care for chronic diseases such as diabetes and coronary

---

[5] New Horizons: A Shared Vision for Mental Health (NHS 2010), Page 9

[6] Improving Health in Leicester: Annual Report of the Director of Public Health and Health Improvement 2008/09 (NHS Leicester City) Page 4

[7] Ibid, Page 6 – the term "health inequality" refers to such unacceptable and avoidable differences in health outcome between groups

heart disease (CHD). There are also significant gaps in mental ill-health and in the provision of care for people with mental health problems[8]

4.1.15 National surveys suggest that 16-18% of working age adults might be expected to experience a common mental health problem at any time. Applied to Leicester, that equates to between 29,000 and 33,000 people of working age will suffer from mental ill-health at some point during their lifetime. 60% of these will be women

4.1.16 Nearly 23,000 of these residents will need some form of support, particularly from primary care providers, of which 3,500 to 7,000 people will have a much greater need for specialist support

4.1.17 Each year, nearly 1,700 people in the City are admitted to hospital with a diagnosis of severe mental illness (SMI). Suicide rates are high in the City with most people who take their own lives suffering from depression. About 2% of the population have a learning disability and there is a high prevalence of mental health and behavioural problems in people with learning disabilities

4.1.18 In terms of more serious mental illness it is estimated that around 1,600 people of working-age in Leicester will experience psychosis in a year, with equal numbers of men and women

4.1.19 Given this prevalence and incidence, the burden of mental illness on working age adults is such that innovation in commissioning is required to ensure that people who experience mental health have access to appropriate treatment, with minimal waiting times[9]

4.1.20 Mental illness not only has an emotional, mental and social impact on individuals, families and friends but it also can have a wider impact on society. People with mental health problems have the lowest employment rate of any disabled group and mental illness is more prevalent in deprived or disadvantaged areas

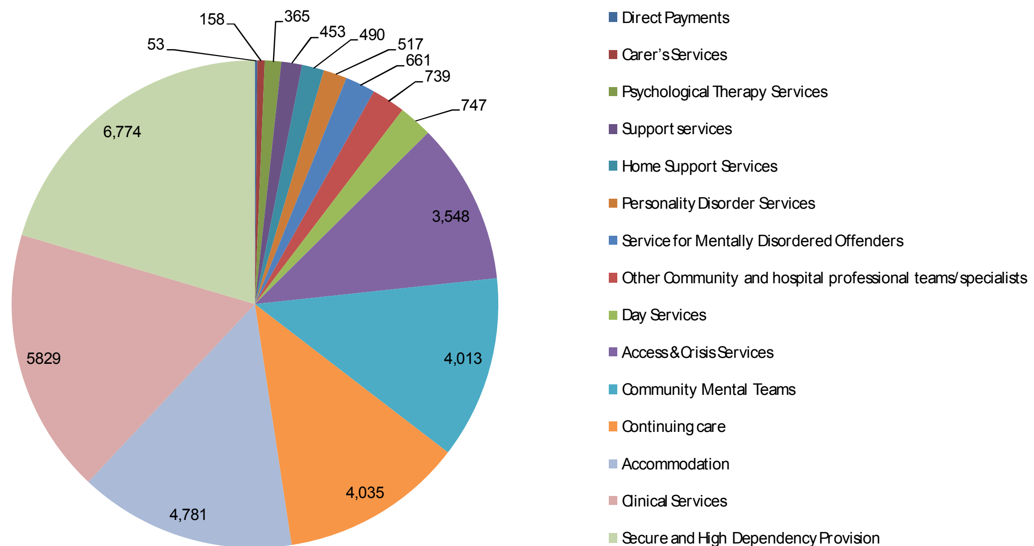
4.1.21 Ethnicity may also be an important issue in mental health because of the variations between ethnic groups in underlying morbidity, diagnosis and management. Equality in the provision of appropriate mental health services is obviously important with nationwide evidence suggesting that people from BME backgrounds are particularly dissatisfied with the mental health services they receive

4.1.22 In addition, they are over-represented in incidents of violence, restraint and seclusion in psychiatric inpatient settings but tend to be under-represented in the take-up of counseling and psychotherapy services and tend to be less involved in the planning and delivery of mental health services[10]

[8] Improving Health in Leicester: Annual Report of the Director of Public Health and Health Improvement 2008/09 (NHS Leicester City) Page 8
[9] Ibid, Page 29
[10] Ibid, Page 17

4.1.23 The three leading organisations of mental health services in the City are the Leicester Partnership Trust (LPT) NHS Leicester City (PCT) and Leicester City Council (LCC) with an approximate annual identifiable budget of £32,710,453 (2007/8):

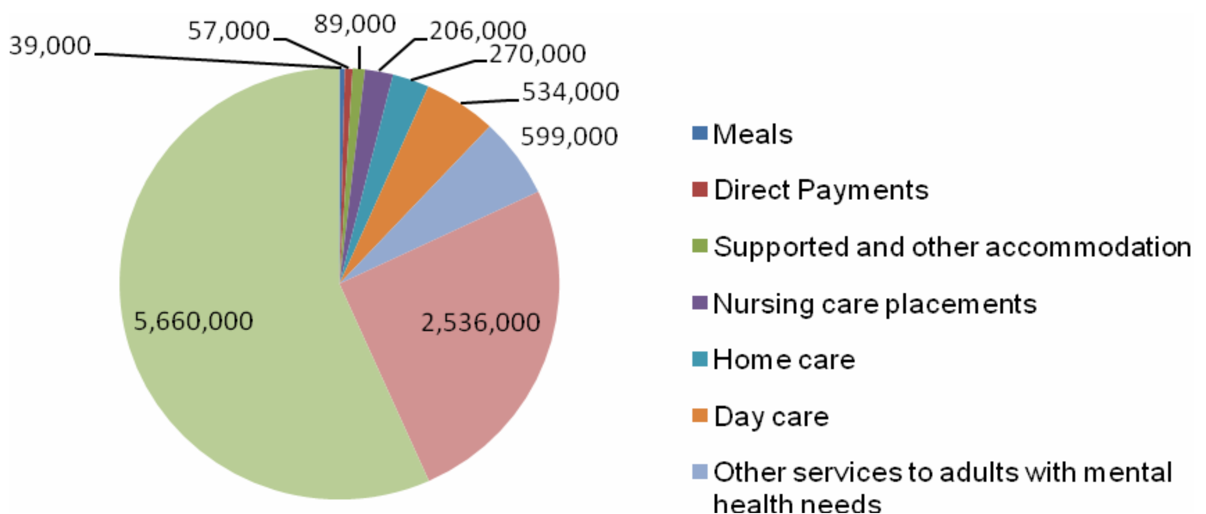
Figure 1: Total identifiable expenditure on mental health services (£000's – adults of working age)



4.1.24 Adult and Community Services have a responsibility for helping people who have mental health problems. Total expenditure for adults (18-64) in 2007/08 was £9,951,000. This was offset by income of £1,582,000

4.1.25 In addition, the Leicester Supporting People Annual Plan (2007/08) includes 270 places for people with mental health problems with a budget of £1.67m

Figure 2: Gross expenditure by LCC by category (£s)



4.1.26 Research carried out by GENESIS[11], the users and carers organisation in Leicester has established that total spends on mental health 10/11 was £45,199,276 – if this was divided on a per capita basis for the City population statistic of 303,800 the results were:

NHS provider at £139.50 per annum = £2.68 a week per capita
Voluntary Sector – £2.11 per annum = £0.04 a week per capita

4.1.27 Until 2008, Local Implementation Teams (LIT) led by the Primary Care Trusts were introduced to oversee the implementation of the NSF-MH. Leicester City Council was represented alongside other stakeholders including service users and carer representatives

4.1.28 In 2008, a Charter for Mental Health in Leicester, Leicestershire & Rutland was developed. Signed up by service users and key mental health commissioners / provider organisations it set out 12 key strategic priorities to ensure that "every person in Leicester, Leicestershire & Rutland has the right to mental health services" (see Annex 1 for details)

4.1.29 The majority of mental health services in Leicester are commissioned under a lead commissioner arrangement across the City, Leicestershire and Rutland with the main health provider being Leicester Partnership NHS Trust. Specialist cost / low volume mental health services such as low secure provision, are commissioned by the NHS Specialised Commissioning Group (see Annex 2 for a breakdown of services provided across the City)

4.1.30 General Practice Doctor's (GP) through nationally negotiated contracts are commissioned to provide the majority of primary care response to common mental health disorders such as mild depression, distress caused by life events etc. With regard to service provision and demand, people with mental health problems have on average 13 – 14 consultations with their GP's per year in comparison with 3 – 4 for the population in general

4.1.31 Leicester City Adult Social Care has statutory responsibility for commissioning individual assessments and care packages as part of the Health & Social Care Act (2008) responsibilities as well as assessing the needs of carers

4.1.32 Adult Social Care also provides the Approved Mental Health Service, when people require an assessment under the Mental Health Act (2008), has responsibility for compliance with the deprivation of Liberty obligations and ensuring that Safeguarding Adults (2005) responsibilities are discharged

4.1.33 In addition, Adult Social Care directly provides some mental health services such as the Social Inclusion Team (previously City Day Services). However, they also commission community-based services such as Orchard House – a supported living provider

[11] Berni Martins – GENESIS advocate on behalf of GNESIS Committee (11.11.10)

4.1.34 In Leicester, mental health social work is undertaken by Care Management Teams. Integrated into the Leicestershire Partnership NHS community services, they work jointly together under the Care Programme Approach (CPA), which is the national over-arching policy for delivering adult mental health services

4.1.35 This integrated working relationship is set out in a formal Section 75 Partnership Agreement (Department of Health), providing the legal framework for Leicester Partnership Trust to formally operationally-manage mental health staff within their management structure. This Agreement is due to expire in 2012

4.1.36 The City Mental Health Strategy Group – a joint planning group involving service users and carers, together with voluntary and statutory organisations (see Annex 3 for details) was originally tasked with drawing up a new Mental Health Strategy for the City

4.1.37 A new Governance Structure is currently being developed by Leicester Partnership for the Health & Wellbeing Partnership / Health & Wellbeing Executive under which the Mental Health Group will sit. The first meeting of the Health & Wellbeing Partnership took place December 2010 in which it discussed re-appraising it's purpose

4.1.38 Locally, the World Class Commissioning agenda has identified mental health as a public health priority for NHS Leicester City. The Layard Report[12] initiated an agenda for the further development of effective treatment for those with anxiety and depression disorders. One response to this has been the Improving Access to Psychological Therapy programme (IAPT). This is based on "clinical" excellence in line with NICE guidance

4.1.39 The IAPT agenda is currently being rolled out across the City and has meant a significant change in how mental health services are commissioned and delivered. IAPT aims include;

- Improving access to mental health care in GP surgeries and community settings, particularly for BME communities
- Opportunities for patients to determine their own treatment choices
- Early intervention to support people to return to work and maintain employment

4.1.40 NHS Leicester has increased the number of therapists and re-designed the existing common mental health programmes. IAPT services are provided by a combination of Leicestershire Partnership Trust and small voluntary and community sector mental health services in the City

4.1.41 In Leicester there are a range of services available that could provide clinical and life outcomes for working-age adults suffering from depression and which could be developed into a local infrastructure for an IAPT care framework[13]

[12] Mental Health: Britain's Biggest Social Problem? (Sainsbury Centre for Mental Health, 2005)
[13] NICE Guidance: Stepped Care Approach to the Management of Depression in Primary & Secondary Care (2007)

Who is responsible for care?	What is the focus?	What do they do?
Step 5: Inpatient	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4: mental health specialists including crisis teams	Treatment resistant, recurrent atypical and psychotic depression and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3: Primary Care Team, primary care mental health service worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2: Primary Care Team, primary care mental health service worker	Mild depression	Watchful waiting, guided self-help, computerized CBT, exercise, brief psychological interventions
Step 1: GP, practice nurse, primary care clinicians	Recognition	Assessment

4.1.42 In addition, in response to the Delivering Race Equality (DRE), NHS Leicester has directly commissioned a BME Community Development Worker Service (CDW) from Age Concern. Established in 2007, the primary focus of this project has been to increase access, together with the outcomes and experiences of people of BME origin. In addition, some one-off funding to specialist mental health voluntary sector groups for specific events or programmes have been awarded

4.1.43 Another intervention open to sufferers of mental ill health is provided by the voluntary and community sector. Reviews suggest that services in this sector provide a valuable service, meeting gaps in statutory provision and acting as an alternative source for those reluctant to use statutory services

4.1.44 Organisations in the third sector provide generic and specialist counselling, day services, housing related support, empowerment of service users, advocacy and support for carers

4.1.45 In discussions with the Community and Voluntary Sector concern was raised with the lack of commitment in investment in community-based provision to prevent crisis and admission – currently only 1.4% of the total mental health budget is being spent on the voluntary sector as opposed to the recommended target of 15% as set out in National Service Framework for Mental Health (2008)

4.1.46 Following the closure of hospital day services in 2008 and failure to invest in alternative community-based provision as promised and the failure to tender social care day services the same year as Leicestershire County Council, has left a paucity of drop-in, peer support networks etc available to tackle isolation, early intervention, crisis prevention etc - early intervention and prevention provision that could minimise a persons clinical needs and assist them with early recovery.

This is a gap that the voluntary and community sector could fill, particularly in light of the potential cuts being made to public sector services in the future

5. LESSONS LEARNT

5.1.1 Over the last 10 years the commissioning and delivery of mental health services have been transformed beyond recognition. The pace of this change does not look as if it is about to slow down

5.1.2 In recent months, the new coalition Government has published a new Health White paper and is soon set to publish a further white paper on the future of public health in December. This will be followed in the new year by a report on mental health to replace *New Horizons*

5.1.3 This will mean further disruption and uncertainty for all of the statutory organisations as well as the community and voluntary sector. However, what is clear, is that they must work together to reduce the risk of mental ill-health in some of Leicester's most vulnerable communities (see paragraph 4.1.4)

5.1.4 Whilst it is acknowledged by the service commissioners that the third sector and voluntary agencies have a role to play in building capacity and capability to support the development and delivery of mental health services, their role or budgets have not yet specifically been defined, with currently only 1.4% of the mental health budget being spent on services provided by the voluntary and community service

5.1.5 What if any, is the correlation between the lack of a clear strategy over the last 3 years and a perceived deterioration in a meaningful dialogue between the commissioners, providers, service users and carers. In addition

5.1.6 In addition, the decline in medium to long-term contracts being tendered has lead to financial uncertainty for some of Leicester's service providers. Whilst this may be inevitable due to the uncertainty of budgets in the health sector, this needs to be better managed

5.1.7 The *2004-2007 Strategy for Mental Health Services for Working-Age Adults in Leicester* stated that "previously, service user groups had long held criticisms of the nature of services – including lack of choice and lack of control over their treatment"[14]

5.1.8 In discussions over the course of this review with representatives from several of Leicester's community and voluntary sector, concern was consistently raised regarding the lack of meaningful engagement between the statutory organisations and themselves. Many felt that the effective engagement once enjoyed several years ago had significantly deteriorated resulting in what they saw as a lack of accountability and weak governance

[14] 2004 – 2007 Strategy for Mental Health Services for Working-Age Adults in Leicester (LCC, October 2003), Page 2

5.1.9 Evidentially, it is difficult to determine if these concerns will be addressed with the new *Joint Commissioning Strategy: Mental Health 2011-13* (see Annex 4 for details) only recently having been signed-off for consultation (October 2010). It is anticipated that this will be ready to go to Cabinet in March 2011

5.1.10 Clear leadership and better governance is needed, together with a much more meaningful dialogue between commissioners and providers. This includes holding meaningful consultations with realistic timescales, where users and carers feel that they are being listened to

6. BACKGROUND PAPERS – LOCAL GOVERNMENT ACT 1972

Modernising Mental Health Services; Safe, Sound and Supportive (1998)
The National Service Framework for Mental Health (1999)
2004-07 Strategy for Mental Health Services for Working-Age Adults in Leicester (2003)
National Indicators for local Authorities and Local Authority Partnerships: Annex 3 (2008)
Leicestershire Joint Strategic Needs Assessment: Core Dataset (Sept 2009)
Improving Health in Leicester – Annual Report of the Director of Public Health (2008/09)
New Horizons: A Shared Vision for Mental Health (2010)
Enabling Effective Delivery of Health and Wellbeing (2010)
Joint Commissioning Strategy Mental Health 2011-13 (October 2010)
Mental Health: Britain's Biggest Social Problem? (Sainsbury Centre for Mental Health, 2005)

9. REPORT AUTHOR

Councillor Michael Cooke (Chair of the Sub-Group)

E-mail: **michael.cooke@leicester.gov.uk**

Mary-Louise Harrison (Member Support Officer)

Tel: internal - 39 8829 / external - 0116 229 8826

E-Mail: **mary-louise.harrison@leicester.gov.uk**

This page is left blank intentionally.

WARDS AFFECTED: All

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:

Cabinet Briefing	**21st March 2011**
Cabinet	**11thApril 2011**

Response to Health Scrutiny Committee's review of Working Age Adult Mental Health Services 1st December 2010

Report of the Strategic Director for Adults and Communities

1. Purpose of Report

1.1 The purpose of this report is to respond to the findings of the Health Scrutiny Committee's review into how working-age adult mental health services are currently being delivered in Leicester.

1.2 It is important to acknowledge the work of the Health Scrutiny Committee in completing the review, which has highlighted the need for a co-ordinated health and social care commissioning approach to mental health needs for working age adults with mental health needs within the City.

2. Recommendations

2.1 Cabinet is recommended to endorse the following actions to address the concerns raised by the Health Scrutiny Committee's report of the 1st December 2010:

2.1.1 Recommendation: *The community and voluntary-sector agencies (VCS) have a role to play in building capacity and capability to support the development and delivery of mental health services, but their role or budgets have not specifically been defined. A percent investment target needs to be established and worked towards to address the low investment levels currently seen, to ensure that they receive funding consummate with the vital frontline services that they provide*

2.1.2 Response: The Council acknowledges the role of the community and

voluntary sector in providing services to people with mental health needs. With the introduction of the personalisation agenda and the transformation of Adult Social Care (ASC), people assessed as needing care and support will be given a personal budget in the future. This means that individuals will be able to buy services directly from a range of providers.

2.1.3 In order to shift resources into more preventative services ASC will be undertaking a review of all funded services, including the voluntary sector. The voluntary sector, through Voluntary Action Leicester (VAL) will be involved in this process, as there will need to be a reduction in the level of block contracts. However, this will give community and voluntary sector organisations opportunities to develop their services to provide a more person centred and outcome based approach. Although, it is not possible to provide a target figure for investment, because individuals will decide what services they choose to buy, there will be a net investment of a further £80,000 for 2011/12 to develop preventative services within the community and voluntary sector.

2.1.4 In addition ASC is proactively working with specific mental health voluntary sector organisations such as Network for Change to enable them to have a business model that is sustainable. The NHS also, through its Increasing Access to Psychological Therapies (IAPT) commissioning, has tried to strengthen the voluntary sector by commissioning some activity with some of the small mental health voluntary sector providers.

2.1.5 Recommendation: *The "bundling" of the Leicestershire Partnership block contract is viewed as a stumbling block by many in the voluntary and community sector. Therefore the "unbundling" of the block contracts would assist them in being able to apply for more contracts.*

2.1.6 Response: The existing block contract will remain in place at this time, but will be subject to continued monitoring and improving data quality. However, the contract monitoring arrangements will change once the health service 'Payment by Results' programme is fully implemented by 2013/14 and will provide opportunities for service re-design where appropriate. This means that payment will only be made where the LPT is performing at the required level, if not then payments will not be made. This also links to improved quality of services, which is monitored by the Department of Health.

2.1.7 Recommendation: *There has been no clear strategy over the last 3 years by the City Council and the PCT. This is seen by some as having led to the deterioration in a consistent and meaningful dialogue between themselves and the voluntary and community sector. A time frame has now been provided by which the new Strategy will be approved (March*

2011) but this time frame must not be allowed to slip any further.

2.1.8 Response: A joint 3 year Commissioning Strategy has been developed between Health and ASC as detailed at Appendix 1. The draft strategy was presented to the Heath Scrutiny Committee on 9th February 2011. The only comments related to the need to support carers, which is covered by the Carers Strategy. The Joint Commissioning Strategy was signed off by the Mental Health Wellbeing Partnership Group on 16th February 2011 and will be presented to the PCT Board for endorsement in the near future. Therefore, Cabinet is asked to endorse the Joint Commissioning Strategy.

2.1.9 This commissioning strategy is also set in the context of the wider 2014, 3 year commissioning strategy for ASC, which shifts commissioning focus to prevention and early intervention, confirms the commitment to personalisation through self directed support, giving more choice and control.

2.1.10 The ASC vision places increased emphasis on the promotion of social inclusion, a major issue for people with mental health needs and developing local community based alternatives. Mental health is a priority in this strategy, with ASC contributing to improving the health and well being of local populations alongside other agencies and communities to develop in every locality a single community based support system. Key to this will be tackling the stigma and discrimination often faced by individuals with mental health needs so that they can reach their potential and contribute to local community development.

2.1.11 It is acknowledged that there has been no strategy for period of time. However, a range of partners have been involved in the development of the new joint commissioning strategy, which has identified a number of key priorities for people with mental health problems, as follows:

a) <u>Prevention & Early Intervention</u>

- Improving access to psychological therapies, early intervention for people with long-term health conditions
- Supporting people with mental health conditions to move from residential homes into independent housing and maintaining people to continue to live in their own home with support
- Strengthening crisis intervention within health and social care in order to prevent people from requiring admission to hospital and maintain and support them safely within the community

b) Transforming Social Care

- Personalisation, providing individuals with greater choice and control over the support/services they need
- Personalised Budgets, so people can buy services directly from a range of providers

c) Supporting the Mental Health of Older People

- Dementia - Our priority is to develop an integrated dementia care pathway, covering the spectrum of need for people with dementia from early diagnosis and intervention to end of life care. The development of this pathway will take into consideration local needs, data on existing service provision, evidence from best practice models in dementia care and the outcomes of a series of workshops involving service providers, patients and carers to look at improvements in the dementia pathway.

2.1.12 The strategy is underpinned by a comprehensive implementation plan and associated work streams, which includes the development of integrated care pathways to improve services for people with mental health needs, and will ensure no one falls through the gap between health and adult social care.

2.1.13 Recommendation: *A consultation framework is required, together with a clear and realistic timeframe. This needs to be established in consultation with the community and voluntary sector. This needs to be completed and attached to the back of this report when it goes to Cabinet in January 2011.*

2.1.14 Response: Numerous consultation exercises have been undertaken with users and then carers/families, facilitated through the voluntary sector to determine the commissioning priorities for the next 3 years. There have also been communication sessions for staff and partner agencies to ensure they are engaged in the development of the joint commissioning strategy. Appendix 2, details the outcome of Communication and Consultation Plan 12/1/2011.

2.1.15 Further consultation and engagement activities are currently underway with provider organisations to look at innovative models of service delivery. This will also include further engagement with the voluntary sector to review existing contracts, to ensure that future provision is aligned to preventative services, including those for people with mental health needs. ASC has identified that mental health service users are less likely to be offered the opportunities offered by self directed support and this is also reflected in national statistics. Led by Network for Change

and supported by ASC an event is being planned in April 2011 to hear more from service users and carers about the challenges they face in accessing self directed support and work with them to resolve these barriers.

2.1.16 Recommendation: *Clear leadership, accountability and better governance s required by LCC and PCT, together with an open and transparent dialogue. This includes holding meaningful consultations with realistic timescales, where users and carers feel that they are being listened to, targets set and worked towards. Progress against this should be reported back to Health Scrutiny Committee within the next 6 months and thereafter if required.*

2.1.17 Response: There is clear leadership, accountability and commitment from both Leicester City Council and the NHS Leicester to drive forward the Joint Commissioning Strategy. There is currently a Mental Health and Wellbeing Partnership Group, which is being re-configured to ensure the commissioning intentions outlined in the strategy are delivered. This group will feed into the new statutory Health and Wellbeing Partnership Board, which is currently being set up to develop joint strategies to improve outcomes for health and social care users across the City. Membership of the Board will include the chair of the GP consortia, the Chief Executives for NHS Leicester and Leicester City Council, the chair of the Local Involvement Network (LINK's soon to change to HealthWatch), the Lead Cabinet Member for Adults and other key partners, including a representative from the voluntary sector.

3. Changes to National Context

3.1 It is also important to highlight that new guidance No Health without Mental Health was published on 2nd February 2011, which replaces New Horizons (2010). The new guidance details six key objectives to improve the outcomes for people with mental health needs, including how communities can promote independence and choice, which reflects the personalisation agenda for Adult Social Care. These objectives align with the One Leicester priorities and those detailed in the Joint Commissioning Strategy. The six priorities are:

i. Improve the mental health and wellbeing of the population and keep people well. More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well**.**

ii. Improve outcomes for people with mental health problems through high-quality services that are equally accessible to all.

More people who develop mental health problems will have a good quality of life and greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

iii. More people with mental health problems will have good physical health, fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

iv. More people will have a positive experience of care and support. Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment and should ensure that people's human rights are protected.

v. Fewer people will suffer avoidable harm. People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

vi. Fewer people will experience stigma and discrimination. Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

4. FINANCIAL, LEGAL AND OTHER IMPLICATIONS

4.1 Financial Implications (Rod Pearson – Head of Finance Health & Wellbeing 29 8800)

4.1.2 There do not appear to be any direct financial implications arising from the report. Its main conclusion seems to be that more consultation and dialogue should take place with community and voluntary sector agencies and a greater share of the budget should be spent with them. The amount of spend will increasingly be determined by service users as they receive personal budgets and with their enhanced choice and control decide how this money will be spent to meet their needs.

4.1.3 The council's overall financial position is largely determined by central government through the mechanism of the comprehensive spending review and then by Councillors through the budget setting process. This has recently been completed for 2011/12 with ASC like nearly all other services being required to find savings

4.2 Legal Implications - Awaiting information from Joanna Bunting

5. Background Papers – Local Government Act 1972

The White Paper Equity and Excellence: Liberating the NHS, (July 2010)

No Health Without Mental Health (February 2011)

6. Climate Change Implications - Helen Lansdown, Senior Environmental Consultant - Sustainable Procurement

6.1 This report does not contain any significant climate change implications and therefore should not have a detrimental effect on the Council's climate change targets.

7. Other Implications

OTHER IMPLICATIONS	YES/NO	Paragraph References Within Supporting information
Equal Opportunities	Yes	Detailed throughout the report
Policy		
Sustainable and Environmental		
Crime and Disorder		
Human Rights Act		
Elderly/People on Low Income		
Corporate Parenting duties		

8. Consultations

8.1 There has been no direct consultation in relation to this report, although the PCT have contributed to the responses to the recommendations of the Health Scrutiny Report of 1st December 2010.

8.2 Consultations have taken place in respect of the original recommendations/findings, which is detailed at Appendix 2.

9. Report Author

9.1 Jane Forte - Planning and Service Development Officer (Adult Mental Health) e-mail: jane.forte@leicester.gov.uk

This page is left blank intentionally.

Appendix 2. Communication and Consultation Plan

1. Introduction

At the highest level, Leicester City Council and NHS Leicester City consult with and engage partners & stakeholders, the wider public, as well as staff and people who use services, in the development of strategies and priorities for all health services and public services that they deliver, as set out in One Leicester and One Healthy Leicester. Both organizations also set out their intentions and commitment to engagement and consultation in their main strategies and framework documents.

The Mental Health & Well Being Implementation Group brings together a range of partners who are engaged in planning for future services for people

There has been consultation about the commissioning priorities with service users and family carers facilitated through voluntary organisations and existing forums. Following completion of the draft strategy, a communication plan was approved to engage with all key stakeholder groups including:

- Staff and clinicians working for LCC and LPT
- Services users and carers
- Residential Care providers within Leicester City
- Other independent Providers of mental health services within Leicester City
- GPs and primary care staff
- Voluntary organisations

The main aims of the Communication Plan were:

- ➢ to raise awareness of the Joint Commissioning Strategy and specifically the commissioning intentions and implementation plans
- ➢ to provide opportunities for stakeholders to comment on the plans and consider the implications
- ➢ to begin the process of engagement in the development of detailed action plans for implementation

Key Findings

Overall, the Joint Commissioning Strategy was well received and there was a positive response to the proposals. Voluntary sector engagement was central to the process and informed the development of the priorities, as well as facilitating focus groups. There have been some delays in engaging LPT in the process though there is now better engagement. It is of concern that few adult social care staff attended the workshop with a general lack of ownership of the need to change services by front line managers. The process also highlighted the fact that mental health staff are also less engaged in the personalisation agenda and less aware of the positive risk taking policy, presenting a significant risk to delivery.

The consultation process highlighted the importance of ensuring that the work is linked to personalisation and positive risk taking and also emphasised the importance of integrated working across health and social care.

Residential providers have generally recognised the opportunity (and need) to diversify and offer a wider range of services, tempered by some fears about the impact on businesses. There has been follow up contact from a number fo providers who wish to open negotiations on working together to provide different sorts of services in the future.

Finally, ongoing communication will be the key to further engagement to take forward delivery.

Adult Mental Health Joint Commissioning Strategy Priorities
Engagement with services users and carers August/September 2010

The engagement process was by an on-line survey, which could also be completed in paper form.

Initial contact was made to groups by telephone to elicit interest and advise that information would follow. This was in early August with the survey going live mid August to mid September 2010

The following groups were circulated with explanatory information, the survey document and web links. They were encouraged to undertake focus groups supported by themselves and/or with help from the two commissioners undertaking the work. The response time for the Universities was extended to allow for returning students in term time.
Only one group did not respond to a follow up call following the distribution of the information.

Participating Groups
Adhar
Akwaaba Ayeh
LAMP
Genesis Project
Leicester Lesbian, Gay and Bisexual Group
Network for Change
Savera Resource Centre
City Social Inclusion Team (Leicester City Council)
Community Development Workers (Black and Minority Ethnic communities) (NHS Leicester City)
The Universities of Leicester, Loughborough and Demontfort (via their mental health support services)
Managers and social workers in the CMHTs who were asked to ensure that patients on wards were able to participate, as well as those in the community.

The online survey was accessible via the NHS Leicester City, Leicester City Council and LAMP websites.

The Web links that were sent out with the literature, also linked to where help could be access if required.

Focus Groups

The following held specific focus groups or had sessions to assist individuals to complete paper forms:
Adhar,
Savera,
City Social Inclusion Team
Community Development Workers (BME)
Network for Change
Genesis Project

The focus groups were held with groups, that the statutory organisations often do not engage with directly: the South Asian community, a Bengali women's group and the Somalian Community. An interpreter was on hand to assist as required.

What information did the consultation want from those who participated?

The consultation was to seek the views of service users and their carers on the proposed joint commissioning priorities, people's current experiences and the type of services they would like in the future.

The Vision of the Strategy.

Our vision is to improve the wellbeing of the people of Leicester by strengthening resilience, reducing health and social barriers to good mental health and wellbeing and strengthening the communities within which we live.

- Promoting positive mental wellbeing through reducing stigma, building strength, resilience and safety in individuals, families and communities. Providing early and timely access to services that will promote positive wellbeing.

- Developing responsive and accessible support for those who need specialist support
  - Focusing on vulnerable groups (inc Black, Asian Minority Ethnic groups, offenders, asylum seekers, victims of violence, substance misuse) and people with life limiting/life threatening illnesses

- Having choice and control over your services
  - providing individuals with greater choice and control over the support/services they need

The Mental Health & Well Being Programme Board identified, based on local needs and gaps in services, and consultation with service users,

the following top priorities for the next eighteen months. These are the 3 proposed priority areas on which comments were requested.

1. **Prevention & Early Intervention**
    - Improving access to psychological therapies (this includes specialist Cognitive Behavioural Therapy (CBT), Personality Disorder and Psychodynamic Therapy) steps 1-5 including early intervention with people who have long-term health conditions (diabetes / Chronic Obstructive Pulmonary Disease (COPD).
    - Supported Living – supporting people with mental health conditions to move from residential homes into independent housing and maintaining people to continue to live in their own home with support
    - Strengthening crisis intervention within health and social care in order to prevent people from requiring admission to hospital and maintain and support them safely within the community

2. **Transforming Social Care**
    - Personalisation – providing individuals with greater choice and control over the support/services they need
    - Personalised Budgets

3. **Supporting the Mental Health of Older People**
    - Dementia

Break down of the response information

Demographic data

Overall there were over 240 responses to the survey. 79% of the respondents were mental health service users and 21% were carers. 65% of the respondents were female and 35% were male. The ethnic breakdown of the respondents is as follows:

- Asian/Asian British – 56%
- Black/Black British – 8%
- Chinese – 0%
- Mixed/dual heritage – 1%
- White – 23%
- Other Ethnic Group 4%
- Non respondents 8%

When analysing the ethnicity data it is pleasing that there was such a high percentage response from the Black Minority Ethnic Groups. This level of engagement is vital in a diverse city like Leicester.

Just fewer than 54% of the respondents considered themselves to have a disability.

Mental Wellbeing

Over 96% of the respondents considered their mental wellbeing to be very important. The respondents considered that the following were **very important** to their wellbeing:

- Physical Health – 86%
- Housing – 86%
- Financial Position – 76%
- Local Environment – 73%
- Employment – 59%

Access to mental health services

Over 86% of the respondents felt that access to mental health support was important. When asked what type/s of services/support people accessed when they or a family member/friend needed support; we received the following responses:

- GP – 70%
- Family members – 54%
- Psychiatrists – 41%
- Friends – 40%
- Counselling Services – 28%

39% of the respondents indicated that they/friend/family member were an inpatient in a mental health hospital. Only 4% did not access any support for their mental health issue/s.

Over 83% of the respondents felt it was very important to have mental health services that are local i.e. within 3-5 miles of where they live. Over 89% said that services need to be easily accessible i.e. convenient opening hours, parking, meets their specific cultural and religious requirements, good disability access and public transport links.

People were asked what types of services would have met/would meet their or their family member/friend's needs. The following types of support were highlighted by the respondents:

- Group Support – 64%
- Drop-in services – 56%
- 1:1 Support – 49%
- Community based services – 49%
- Peer Groups – 39%

- Support into Education – 24%

Only 42% wanted hospital based services.
Just over 68% felt it was important to be able to choose the services or packages of support would help maintain their mental wellbeing if they were given the money to do so. This is particularly encouraging in respect of the roll out of personal budgets.

Conclusion

The Focus groups were a far more successful way of engaging with service users and carers than the larger launch events. People were much more comfortable in familiar surroundings and felt more able to talk, both in a specific response to the survey, and in general terms about their experience of services.

The results of the engagement process are included in the Joint Commissioning Strategy, and will be used to further develop and target future service provision.

Leicester City Council and NHS Leicester City would like to thank all who participated and facilitated these events.

Communication Schedule

Stakeholder Group	Event/meeting	Date
LD & MH Residential providers	Half day workshop for providers with most residents, city based. Letter sent to all smaller providers with exec summary and web link	11th November
MH Adult Social Care Staff	2 x staff sessions with commissioners	30th November
MH Service users, carers & vol orgs	Adhar Akwaaba Ayeh LAMP Genesis Project Leicester Lesbian, Gay and Bisexual Group Network for Change Savera Resource Centre City Social Inclusion Group (LCC) Community Development Workers	Original consultation process was between July and September – feedback and ongoing engagement through the same groups and forums during November and December.

	(BME) (PCT) The Universities of Leicester, Loughborough and Demontfort (via their mental health support services) Patients on wards via Managers and social workers in the CMHTs **Focus groups held by** Adhar, Savera, Social Inclusion Team (LCC) Community development workers (BME) (PCT) Network for Change	
LPT & clinicians	Presentation to LPT corporate management team and strategy sub group of LPT Board. Roll out to LPT staff via management groups	November and 1st December
GPs	Report to Clinical Cabinet Report to Commissioning Exec Exec summary to County MH Clinical Forum GP Forum (LD) – will be linked to meeting re Health Action Plans	October December – date tbc November – date tbc November – date tbc

Outcome of Communication Plans for Joint Commissioning Strategies for Learning Disabilities and Mental Health

Stakeholder	Date of event or response	Summary of comments or questions	Management/commissioning response
LD Care Management Team	30.11.2010 Team meeting	Agree with the priorities. General concerns around quality of SL provision Really important that we involve families and carers so that they support our work to enable people to become more independent and take positive risks. Real need for step down services – move from Agnes Unit to independent living often too great. Real need for buy in from LPT – concerns around community staff raising lots of risks and not supporting positive risk taking. Need availability of 'urgent' accommodations (separate from respite). Query about short breaks strategy – where this is and what the plans are.	Talked about the pathways work underway Senior managers to continue to work with LPT Talked around options and how difficult it is to balance levels of need and block purchasing. Sarah to follow up and feed back.
Transitions Team	30.11.2010 Team meeting	Agree with priorities. Concern about importance of ensuring that specific needs of people coming through Transitions are fed into any work arising out of strategy.	Transitions Team Manager to be part of Enablement workstream. Sarah Morris to liaise with Shirley Jones re specific needs around SL

MH Service users and carers Approx 240 responded via Focus groups, written submission or on-line.	August/September 2010 – On-line survey and Focus groups.	Focus of questions was on the four main priorities for the JCS. The majority of respondents were happy with the priorities which reflect the sort of services people want A number are adding additional information which will help in the development of future services.	Consultation took place prior to publication of draft strategy which has been further circulated
MH Adult Social Care Staff 25 out of 80 ASC staff attended	30/11/10 2 workshop sessions were held.	Presentation focus was on the four priorities and how things need to change in the delivery of personalised services JCS – not enough detail on specific services. Need more info on Personalisation, more community resources to meet the required outcomes with quality services. Concern about cuts in services Things need to change There is a good emphasis on positive risk taking and focus on recovery.	Further opportunities will be offered to those unable to attend previously, to attend the LPT staff communication events. Detailed action plans are being developed for each commissioning priority JCS will be directly linked to the council programme to transform ASC The JCS sets out the framework for future services and identifies where money needs to be targeted thus ensuring that efficiencies are managed better – regardless of the financial position the JCS sets out how services need to change to improve outcomes for local people
MH & LD Residential care providers Workshop	11/11/10	Generally positive response with comments raised about the future viability of residential care. Need to keep providers well informed. Greater choice and opportunities for	Agreed that new residential provider forum to be used for communicating and explore

attended by approx 20 providers		independence seen as positive Positive feedback from some providers about how they could develop their services in line with future vision – opportunities to diversify, offer enablement services, outreach and community based support services Other large providers concerned for future of their businesses. Questions and suggestions about the need for better procurement and contracting processes, that enable small providers to compete for business	possibility of specific LD & MH Forum Following workshop several providers contacted commissioners wishing to take forward discussions for future service development – a follow up surgery style workshop is planned for January Council committed to looking at procurement processes, with a view to establishing approved provider lists for provision of community support services
LD Voluntary Sector JCS sent out for comments with most vol orgs having been involved in LDPB or other service user forums	November 2010	No comments received in response to JCS but to note that people's views have been incorporated in other forums	Voluntary Action new Health & Social Care Forum to be re-established in New Year and will be used as the main forum for future engagement and communication
LPT – LD	16.11.10	Generally positive regarding plans LD Senior management Team asked how they could be involved in the delivery of	Marcus Callaghan to send TOR and project brief and other JCS docs to LPT LPT will identify work stream leads

		the health work stream – TOR and project brief sent to LPT	LPT will circulate JCS to LD teams through management communication systems
LD Carers Presentation on Short Breaks Strategy	17/11/10	Supplementary to separate delivery of the JCS presented to carers by JH/KM Carers were positive about being involved in strategy and delivery of action plans of JCS and short breaks	
LD Short break Group work stream of JCS	23/11/10	Short break group met the providers who will pilot the short breaks new services the JCS and short breaks strategy shared with providers	Meeting with providers and group again on 20/12/10 to discuss models in more depth and contract issues
PCT Board	30/11/10	PCT CEO asked this item be deferred from agenda and paper circulated re LD/MH JCS outside of meeting to be signed off by Board	Marcus Callaghan/Yasmin Sidyot to circulate briefing paper to Board members by 10/12/10
LPT Strategic Programme Board	01/12/10	The LD/MH JCS presented to Board for consultation, in principle Board support both strategies and will forward comments on both JCS	LPT Board to feedback to commissioners – *not received at time of writing this report*
LPT LD SMT	07/12/10	LPT returned TOR and identified work stream leads, Meeting dates provisionally set for 2010	LPT will by 16/12/10 input into action plans for all 6 LD work streams.
LD: Carer leads	22/10/10	- Need to specify the date the LD Register was last updated. - Need to say the Leicester is recognised for its good work with BME communities. - The strategy needs a glossary of abbreviations and the text needs to be ‘unjustified’ to make it easier to read.	Figures used form LD Register stated as April 2010 Included Will be addressed at publication

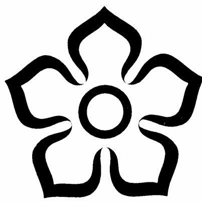
		- page 15: Table 1, the headings 'upper' and 'lower' don't make sense and need explaining. - page 16: FACS criteria needs to be removed. - page 19: debate about the % figures used, might need clarifying. - They were all to read the strategy and pass on comments directly to Yasmin & Kathy.	As these refer to the needs assessment, will be feedback to public health. The accessible version of the presentation was also amended.
LD Partnership Board	28/10/10	- Members of the board welcomed the strategy and will comment in the separate consultation meetings.	
Disabled Children's Programme Board	01/11/10	- The group welcomed the presentation and said how useful it was to understand the direction ASC will be taking. - Found the structure very helpful and will use a similar style when writing the children's version. - They stressed the need for appropriate information for carers and young people going through transition. - Questions about assistive technology and needed examples to help inform understanding. They could see the benefits and potential savings for young people. - need facilities to be accessible out-of-	Issues to be incorporated in the relevant workstreams

		hours such as Hastings Rd centre, as it has a sensory room that could be used. - Better use of universal services such as leisure centres, if these are reduced will have a negative impact on families. - Better use of public transport: clear accessible maps on buses that show the journey such as those on tube trains. - travel training and transport might need more emphasis. - safety on transport, crime reduction and anti-bullying posters. - what are the figures for the national average that Leicester is compared to? State them. - Lead Health Professional: each young person going through transition with high health needs will have a named health professional to support them. Sam Shaw is leading this piece of work.	Figures for comparator LAs are more relevant than national figures – both are available in source documents and within the public domain.
LD - Carers Action Group	17/11/10	The group welcomed the strategy. **RISK:** They thought it was important to support people to take small risks in order to learn and develop. They want to be involved in developing a strategy that enables workers to support people in taking risks. They agreed that certain parts of people's lives could be enhanced though structured risks, such as travel training to enable someone to use the	**Risk:** The group were told that would be consulted in any policy change or developed strategy.

		bus. **Moving People On:** A specific issue was raised by a carer relating to a situation where someone was moved from a residential home without prior consultation with the individual and their family. The group wanted reassurance that where people were to be moved on they would be consulted with plenty of notice, and the family would be involved.	**Moving People On:** The specific carer issue was taken forward to the relevant senior officer. Reassurance was given to the group that reasonable time would be given to consult with people that are moving on.
LD - Ansaar carers group	24/11/10	The group were happy with the overall strategy and understood what it was for. The issues raised by individuals within the group related to specific work streams not the actual strategy. These were: **Short Breaks:** **-**Information was requested about what is available and what can be requested. -Carers want to have flexibility in the support available, having support to keep the person at home while the family go on holiday. -Having a support person to go on holiday with the family to support the person with an LD. -Children's short break strategy needs to match/dove tail with the adults strategy. -One carer said she'd "…never been for a girly night out because I'm always looking after my family"	**Universal services:** A request was sent to Paul Edwards to clarify if disabled people need to have a doctors letter to use a leisure centre. Pauls reply: Customers are asked to complete a medical questionnaire before they are able to participate in gym work. Where there are contra indicators of any sort our insurers and risk management expect us to ask for a letter from their GP stating they are medically fit to attend the gym. There are no exclusions to this and this has nothing to do with having a disability, the same issue applies to everyone. Some GP's offer to prepare these letters free of charge, others charge, £50 seems excessive.

		-Some families have multiple caring responsibilities i.e. older relatives and siblings with LD. -Flexible support to meet changing needs, some weeks people need less support and other weeks they need more: services don't allow this to happen, if the support is reduced it is very difficult to get it back. **Access to universal services:** One carer reported going to her local leisure centre with her disabled daughter, she was told she needed to have a doctor's letter in order for her daughter to use the facilities. **Information** They need more information about what a direct payment and a personal budget can and can not be used for.	So to get around this we usually ask customers to ask their GP's to refer their patient under the GP referral scheme. That way there is no charge levied. I don't know why that didn't happen in this case. So, we have to ask for the disclaimer letter. We can't meet the cost as we have no budget for it and its a requirement for everyone who has a contra indicator on the medical questionnaire. Leicester is not on its own with this requirement. It is common practice nationwide. Marcus Callaghan and Dr Kumar will follow this up with GPs as it links in the work they are doing on Health Checks.

This page is left blank intentionally.



MINUTE EXTRACT

Minutes of the Meeting of the
HEALTH SCRUTINY COMMITTEE

Held: WEDNESDAY, 1 DECEMBER 2010 at 5:00 pm

P R E S E N T :

Councillor Bayford - Chair
Councillor Sood - Vice-Chair

Councillor Clayton	Councillor Cooke
Councillor Cleaver	Councillor Newcombe

ALSO PRESENT:

Councillor Naylor – Cabinet Member for Health and Community Safety

IN ATTENDANCE

Mandy Ashton	Interim Director of Healthcare Change
Darren Hines	Leicester City Local Involvement Network
Bernie Martins	Genesis
David Riley	Head of Primary Care Improvement, Leicester City Primary Care Trust
Deb Watson	Director of Public Health and Health Improvement

* * *   * *   * * *

41. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Gill and from Sarah Cooke of NHS Leicester City.

42. DECLARATIONS OF INTEREST

Councillor Bayford declared a personal interest in agenda item 8, "Balanced Scorecards (BSC) and Annual Quality Review (AQR) Programme for General

Practices", in that his wife was a salaried GP, although she was not a partner in the practice.

Councillor Manjula Sood declared personal interests, in relation to the general business of the meeting, as she was a patron of CLASP, the Chair of the Leicester Council of Faiths and an ambassador for the East Midlands for Sporting England.

46. WORKING AGE ADULT MENTAL HEALTH SERVICES REVIEW

Councillor Cooke, the leader of the Working Age Adult Mental Health Service Review, presented the final report of that review, explaining that it had been undertaken in response to concerns raised by service users. In summary, the review had found that there were gaps between the service required and that received.

The meeting noted that the "Joint Commissioning Strategy Mental Health 2011-2013", produced by NHS Leicester City, and submitted at Annex 4 of the report, currently was being consulted on, so had not yet been adopted. It therefore was suggested that it could be useful for the Committee to scrutinise the Strategy.

The Committee welcomed the report and thanked the Members Support Officer for her help in preparing it. The following points were then made in discussion:-

- Membership of the review comprised the whole Health Scrutiny Committee, not just those Members named in paragraph 3.2 of the report, plus Councillors Allen and Joshi. Councillor Naylor also took an active interest in the review in his capacity as Cabinet Member for Health and Community Safety;

- It only had been possible to consider general mental health issues under the review, as it was not known how many people came within each category of mental illness;

- A number of national frameworks for dealing with mental health illness had been established and these were outlined in the report;

- Ethnicity seemed to be significant. People from black and minority ethnic groups were over-represented in segregated / closed units, but were under-represented amongst those taking up services. This was an area that could benefit from further scrutiny;

- It was important to recognise that the commissioning and delivery of mental health services had been transformed over the last ten years. However, more recently, changes in strategic direction had caused uncertainty for users and providers and there appeared to have been a tendency to marginalise the voluntary sector;

- The "bundling" of the Leicestershire Partnership block contract was seen

as inhibiting the work of many in the voluntary and community sector;

- The voluntary sector did important work on the mental health issues that other organisations were unable to do, but the voluntary sector often was neglected;

- One of the most important things that needed doing was the removal of stigma for mental health patients and their families;

- Mental Health problems needed to be identified earlier than currently was done. For example, young people still in education could be taught how to cope with problems, (rather than receiving education specifically about mental health), which could provide information on things such as support networks and coping strategies;

- Care needed to be taken to ensure that health care workers communicated effectively and acted professionally at all times;

- The problems that working with people traditionally marginalised could create needed to be recognised. For example, they could have less trust in the service providers. It therefore became important to have “door openers”, who could help them access support; and

- Consideration needed to be given to how mental health services could be provided after the forthcoming reorganisation of health service provision.

At the invitation of the Chair, Bernie Martins, of Genesis, addressed the Committee, thanking those undertaking the review for enabling Genesis to participate. She stated that:-

- The provision of services should not be seen as separated between clinical services and services provided by the voluntary sector. Voluntary services could be the “door openers” referred to above, and for a long time had been helping people to live a fulfilled life;

- The suggestion that work should be done in conjunction with schools was welcomed, as Genesis had wanted to do this for some time; and

- It was hoped that the work done though this review could be used to help develop a vision for the provision of mental health services for Leicester.

The Committee welcomed the report and expressed the hope that the findings of the review would be used. It further suggested that, for future reviews, it would be advisable to:-

- Have very clear objectives for the review from the outset;

- Receive support from Democratic Support staff; and

- Give more focus to discussions by identifying in advance specific questions that needed to asked of those giving evidence; and

- Take more time over the review.

RESOLVED:

1) that the Joint Commissioning Strategy Mental Health 2011-2013, produced by NHS Leicester City, be added to the Committee's work programme for scrutiny in February 2011;

2) that the report of the Working-Age Adult Mental Health Services Review and the recommendations contained in that report be endorsed;

3) that when considering the report "Working-Age Adult Mental Health Services Review", the Cabinet be requested to take account of the comments recorded above; and

4) that Cabinet be requested to give a response to this Committee to the recommendations made in the report.

Appendix 1.

NHS
Leicester City

Joint Commissioning Strategy
Mental Health
2011-2013

INDEX

Section	Contents	Page
	Charter for Mental Health	3
1	Foreword / Introduction	4
2	Purpose of this document	5
3	Mental health & mental illness	7
4	Our vision & strategic aims	7
5	Policy framework	11
6	What sort of services people want	14
7	Local needs	16
8	Performance and quality of current services	23
9	Current resources	28
10	The future model for mental health services	31
11	Commissioning priorities 2010-2013	36
12	Resource implications	39
13	Risk analysis	43
	Appendices	
A	Commissioning implementation plan	
D	Risk Assessment	

Charter for Mental Health
In Leicester, Leicestershire and Rutland

Every person in Leicester, Leicestershire and Rutland has the right to mental health services that:

1. Make a positive difference to each person they serve.
2. Stop doing things that are not working.
3. Are guided by the individual's views about what they need and what helps them.
4. Treat everyone as a capable citizen who can make choices and take control of their own life.
5. Work with respect, dignity and compassion.
6. Recognise that mental health services are only part of a person's recovery.
7. Recognise, respect and support the role of carers, family and friends.
8. Communicate with each person in the way that is right for them.
9. Understand that each person has a unique culture, life experiences and values.
10. Give people the information they need to make their own decisions and choices.
11. Support their workers to do their jobs well.
12. Challenge "us and them" attitudes both within mental health services and in the wider society.

1. Foreword / Introduction

Health and social care services have a key responsibility in supporting people who experience mental ill health. They also have lead role in improving health and wellbeing.

Mental health services have changed a great deal over the last twenty years. Whilst these changes have led to many positive outcomes, especially for people with the most severe illnesses, people who experience mental health problems still encounter significant difficulties in their daily lives, experience gaps in services and variation in the support available to them. For too long many people have had to wait too long for treatment, many find that they are not treated as individuals or with dignity and respect and services are not as well aligned as they might be to meet the diverse needs of local communities. While secondary care services have improved, the development of primary and out of hospital services has not proceeded at the same pace; we need to shift the focus and the balance of investment towards primary and out of hospital services.

While this new strategy builds on what has already been achieved it provides a refreshed strategic direction, particularly in light of the Governments programme of action for mental health: *New Horizons: a shared vision for mental health,* which sets out a unique dual approach. This approach, coupled with *Leadership for personalisation and social inclusion in mental health (* SCIE 2009) combines service improvement with a new partnership of central and local government, third sector and the professions, with the aim of strengthening the mental health and wellbeing of the population, through prevention and helping individuals and communities to bring the best out of themselves, with all the health, social and economic benefits that follow.

The traditional service-led approach has often meant that people have not received the right help at the right time and have been unable to shape the kind of support they need. Personalisation is about giving people much more choice and control over their lives in all social care settings including those integrated with health. It is far wider than simply giving personal budgets to people eligible for council funding.

Personalisation means addressing the needs and aspirations of whole communities to ensure everyone has access to the right information, advice and advocacy to make informed choices about the support they need. It means ensuring that people have services such as transport, leisure and education, housing, health and opportunities for employment regardless of age or disability. Personalisation offers the opportunity to further break down mental health stigma and institutionalisation through increasing self-determination, independence, choice and control for and with people with mental health problems themselves. But there are specific challenges of implementation within mental health. These include the need to manage particular types of risk, fluctuations in mental capacity and the mechanics of effective social care delivery within integrated NHS provider organisations.

Essential to NHS Leicester City and Leicester City Council achieving its vision for high quality mental health services is the need for strengthening the prevention agenda and early identification to promote emotional resilience. The way health and social care services are commissioned is changing and we expect to see the market for services expand with new providers entering the market.

The strategic ambitions for mental health services must be delivered against a backdrop of change and a significantly challenging financial landscape. In order to realise these ambitions productive commissioning is essential, through the Quality, Innovation, Productivity and Prevention (QIPP) Programme, and commissioning preventative and people centred services.

Finally, this strategy is intended to provide the framework for effective commissioning to improve the outcomes of care for individuals. It is also intended to build strong leadership and innovative approaches to improving mental health and emotional well-being and redress inequalities, social exclusion and discrimination.

2. Purpose of this document

2.1 The Joint Commissioning Strategy for Mental Health sets out the commissioning intentions of NHS Leicester City and Leicester City Council in respect of services for people with mental health. As the key partners to this plan NHS Leicester is responsible for commissioning health services locally and Leicester City Council is responsible for commissioning social care services.

The White Paper Equity and Excellence: Liberating the NHS, published in July 2010, means that responsibility for commissioning health services will transfer to new bodies of GP led consortia, with the current primary care trust, NHS Leicester City being phased out in 2012. Though the commissioning partners will change, by jointly commissioning services, we can make the best use of shared resources and make sure that no-one falls through the gap between health and social care services.

NHS Leicester City has the lead and is responsible for:

- The commissioning of mental health services for Leicester – children,
- Public health
- Commissioning of primary and secondary care which includes commissioning heath services from acute hospitals, General Practice, community health services

Leicester City Council is responsible for:

- the provision of Community Care Services and Childcare services when required

- the provision of suitably trained and qualified workers by the local authority under the Mental Health Act and the Mental Capacity Act

- the provision social housing either directly or via a social landlord

- the transfer from primarily commissioned services to personalised budgets

This strategy has been developed through the NHS Leicester City Mental Health Programme Board – which brings together a range of stakeholders who are interested in mental health and wellbeing. The role of the Programme Board is to develop the strategic direction for commissioning and delivery of mental health services in Leicester and monitor its implementation.

This strategy is based on an approach to whole population mental health. The focus on prevention and maintaining good mental health is particularly relevant today with people leading more hectic lifestyles and going through the economic uncertainty.

2.2 The Commissioning Strategy explains how NHS Leicester City and Leicester City Council plan to work together with all stakeholders to improve mental health outcomes for the population of Leicester. The focus of the strategy will be on those areas that come within the compass of the two agencies.

The Strategy builds upon the previous local Joint Mental Health Strategy 2005 – 2010 and the National Service Framework for mental health - widely acknowledged as the catalyst for a transformation in mental health care over the last ten years, which comes to an end in 2009.

The main policy drivers for Adult Mental Health over the next 10 years are:

- 'New Horizons' (but noting that a new government policy is due for publication)
- The Transformation of Social Care

This strategy is over arching and covers the following people, linking into other more specific strategies

- People aged between 16-64
- People in transition from child to adult services
- Adult mental health services
- Services for those aged 65 and over.
- People with autistic spectrum conditions (Aspergers)
- People with a dual diagnosis – drugs and alcohol
- People with a dual diagnosis including a learning disability
- People with early on-set dementia

3. Mental Health & Mental Illness

Good mental health is precious, it is fundamental to our well being, yet mental health problems are commonplace and living with the burden of a mental illness can exact a heavy price on individuals and those who care for them. It is well recognised that good mental health is linked to good physical health (New Horizons 2009) and is fundamental to achieving improved educational achievement, increased employment opportunities, reduced criminality, social exclusion, and reduced health inequalities.

The term "mental health problems" covers a range of conditions ranging from anxiety, depression through to severe and enduring mental illness. While some people will recover quickly from their particular problem for some the journey to recovery is long and difficult and is important that services are flexible and personalised so as to maximise the benefits for individuals. Furthermore whilst the impact of mental health problems can be detrimental for individuals, families and communities, there is a lack of understanding that about such problems which often results in people with mental illness being stigmatised by attitudes that in turn exacerbate the problems of people living with mental ill health.

This joint strategy forms part of a suite of plans encompassed by the NHS Leicester City's- One Healthy Leicester, intended to complement strategies for children and young people, and older people with mental health problems. This dovetails with Leicester City Council's vision being developed through the Leicester Partnership and it's seven priority areas.

In drawing up this strategy we have taken account of the needs of service users, expert and clinical knowledge, evidence of what works and most importantly how the people who use services would like to see them developed. Inevitably not everything can be tackled so the strategy sets out the key priorities for investment and action.

4. Our Vision & Strategic Aims

Local Vision

Our local vision for Leicester is:

> Improving the wellbeing of the people of Leicester by strengthening resilience, reducing health and social barriers to good mental health and wellbeing and improving the communities within which we live.

Priorities

The Mental Health & Well Being Programme Board identified, based on local needs and gaps in services, and consultation with service users, the following top priorities for the next eighteen months:

1. **Prevention & Early Intervention**

    - Improving access to psychological therapies (this includes specialist CBT, Personality Disorder and Psychodynamic Therapy) steps 1-5 including early intervention with people who have long-term health conditions (diabetes/COPD).
    - Supported Living – supporting people with mental health conditions to move from residential homes into independent housing and maintaining people to continue to live in their own home with support
    - Strengthening crisis intervention within health and social care in order to prevent people from requiring admission to hospital and maintain and support them safely within the community

2. **Transforming Social Care**

    - Personalisation – providing individuals with greater choice and control over the support/services they need
    - Personalised Budgets

3. **Supporting the Mental Health of Older People**

    - Dementia - Our priority is to develop an integrated dementia care pathway, covering the spectrum of need for people with dementia from early diagnosis and intervention to end of life care. The development of this pathway will take into consideration local needs, data on existing service provision, evidence from best practice models in dementia care and the outcomes of a series of workshops involving service providers, patients and carers to look at improvements in the dementia pathway.

      We are working with our strategic partners across Leicester, Leicestershire and Rutland to progress this work and deliver an integrated dementia care pathway which includes GPs, primary and secondary health staff, social care staff and voluntary sector staff. We will continue to engage with patients and carers throughout this development to ensure that the services developed will meet their needs.

The following principles/values will underpin the strategy and the delivery of services

- Delivering Race Equality in Mainstream Services

- Implementing the Mental Health Charter
- Value User/Carer experience and use this to inform service design/redesign
- Strengthen partnership working with all key stakeholders including voluntary sector and partners

Strategic aims

In order to achieve our vision the aims of the strategy are to:

- Promote good mental health and well-being,
- Improve services for people who have mental health problems.
- Help people to look after their mental health and prevent them from becoming ill.
- Tackle the stigma that's associated with mental ill health by focussing on whole population mental health.
- Recognise that mental health and well-being is everybody's business
- Work in partnership with service users and their carers throughout the commissioning process.
- Commission services of a high quality that will meet the needs of the service users.
- Ensure Mental Health services are closely integrated with general health services
- Develop services closer to home, where ever possible.
- Develop well planned care which will aim to support people in achieving recovery.
- Implement personalised care plans for people assessed as needing services.

Improving Mental Health Outcomes

Improving how we commission mental health services is central to improving mental health outcomes and quality of care.

The mental health outcomes to be achieved through the One Healthy Leicester strategy include:

- **Strengthening individuals**: increasing emotional resilience through acting to promote self esteem and develop communication, negotiation, relationships and parenting skills.

- **Strengthening communities**: increasing social support, inclusion and participation to protect mental wellbeing. Tackling the stigma and discrimination associated with mental health will be critical to promoting increased participation.

- **Reducing social barriers to good mental health**: increasing access to opportunities like employment that protect mental well being.

- **Support Service users** to purchase some or all of their social care services through Direct Payments or an Individual Budget.

This strategy sets out the joint commissioning plan for the future development of health and social care services for adults with mental health needs over the next 18 months.

The key partners to this plan are NHS Leicester and Leicester City Council. NHS Leicester is responsible for commissioning health services locally and Leicester City Council is responsible for commissioning social care services. **The White Paper Equity and Excellence: Liberating the NHS**, published in July 2010, means that responsibility for commissioning health services will transfer to new bodies of GP led consortia, with the current primary care trust, NHS Leicester City being phased out in 2012. By jointly commissioning services, we can make the best use of shared resources and make sure that no-one falls through gap between health and social care services.

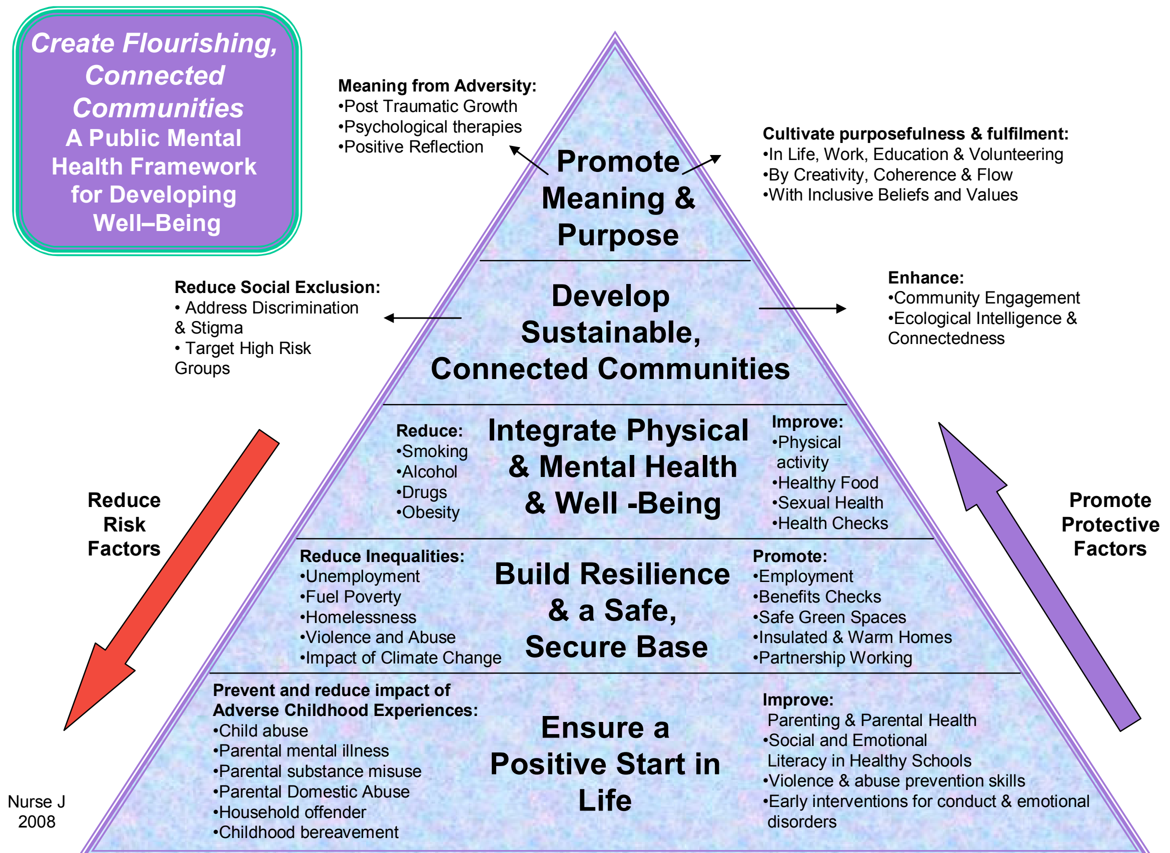
This plan will set out:

- the shared vision and strategic aims of the partners
- the policy framework underpinning the strategy
- an analysis of the current and future needs of people with mental health needs in Leicester
- what sort of services people with mental health needs and their carers want in the future
- what services are currently provided, what they cost and how they perform
- how services need to change to meet future needs and deliver what people want
- the commissioning intentions and priorities of both agencies
- a detailed delivery plan with costs and timescales

As this strategy sets out the joint commissioning plan for the future development of health and social care services for adults with mental health needs, it considers that mental health outcomes will only be improved with more partnership working, a shared understanding of the issues to be addressed and the outcomes to be achieved, maximum co-operation between the stakeholders involved, a consistent approach to dealing with mental well-

being and mental ill health and arrangements to ensure that commissioning of services and other interventions is effective.

A model of care for promoting protective factors and reducing risk factors is shown below. The benefit of integrating this approach is to shift the focus from illness to well-being, towards earlier intervention for high risk groups and to promote well-being in the whole population. It also helps to focus on preventing mental ill health, improved physical health, increased emotional resilience, increased social inclusion and participation and improved productivity.



5. Policy Framework

In developing this strategy, we recognised both the wider national imperatives driving the development of commissioning and services, as well as local strategic priorities including the following:

5.2 New Horizons - Towards a shared vision for mental health (2009). Currently archived – it should be noted that the government is intending to issue a new policy on the future development of mental health services and this Strategy will be reviewed to ensure compliance with new guidance.

New Horizons is the Government Strategy which sets out the next stage for improving mental health in England. It takes a cross Government approach and aims to:

- Take forward what was learnt in the lifetime of the National Service Framework for Mental Health 1999-2009 (NSF) about what works, and broaden our scope to include all groups in society, including children and young people and older people.
- Build on the principles and values set out in the NHS Constitution
- Support the delivery of the NHS Next Stage Review (the Darzi report) and its vision of local commissioners working with providers, the public and service users and carers to devise local approaches to mental health and mental health care.
- Use the growing understanding of the wider determinants and social consequences of mental health problems and mental well-being to influence priorities in other parts of central and local government.
- Reinforce commitment to key mental health policy aims, including delivering race equality and improving access to psychological therapies.

5.4 Transforming Social Care and Personalisation

Across Government, the shared ambition is to put people first through a radical reform of public services. It will mean that people are able to live their own lives as they wish; confident that services are of high quality, are safe and promote their own individual needs for independence, well-being, and dignity.

Personalisation, including a strategic shift towards early intervention and prevention, will be the cornerstone of public services. This means that every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings.

In Leicester, as well as nationally, more and more adults with social care needs are saying they want a greater say and more choice in the way they live their lives. Published in 2007, Putting People First is an agreement between central and local government about the future direction of adult social care. It provides the policy framework for guiding the transformation of adult care services and improving people's experience of local support services.

Over the next two-years we will be transforming adult social care in Leicester so that services are truly centred on what the people who use them want. We will work with people who need help and support to provide a much more personal approach to care.

With the new commissioning framework, the focus to date has been on looking at different commissioner models to see what might work well for us

and to establish what skills we need to deliver an effective commissioning service. Understanding what services people want will be key to developing a strategy for future commissioning activity.

Engagement with stakeholders continues to be essential, if we are to deliver the transformation agenda.

5.5 A Commissioning Framework for Health and Wellbeing (DH 2007)

This established 8 steps to effective commissioning which would link into Sustainable Community Strategy, Local Area Agreement and strategies which would improve Health & Well-Being and reduce health inequalities. These are:

- Putting people at the centre of commissioning
- Understanding the needs of populations and individuals
- Sharing and using information more effectively
- Assuring high quality providers for all services
- Recognising the independence of work, health and wellbeing
- Developing incentives for commissioning for health and wellbeing
- Making it happen: local accountability
- Making it happen: capability and leadership

The idea is for statutory and voluntary organisations to work together to not only meet existing health & welfare needs but also to plan for the future, to look at future housing aspirations and the needs of vulnerable members of the community. Partnership working enables a pro-active approach to meeting and sustaining people's support needs and prevents the duplication of resources and a crisis management approach which can be costly in terms of finances, human respect and dignity.

5.6 Service delivery by Health and Social Care in Partnership.

The national policy on public service and the NHS Constitution encourages joined up working and the delivery of care and support that is coordinated, and delivered through cooperation at an organisational and practitioner level. Partnership working in Leicester has been strengthened by the use of a Section 75 Partnership Agreement between the City and County Councils and the Leicestershire Partnership Trust, the NHS provider, for the integrated provision of mental health services. The development of this Joint Commissioning Plan is essential to ensuring sound partnership working at a commissioning level.

5.7 Social Inclusion

The Government has introduced a requirement for Local Partnerships to ensure that the most socially excluded adults are offered the chance to get back on a path to a more successful life by increasing the number of adults who are in contact with secondary mental health services who are in settled

accommodation and in employment, education or training (Public Service Agreement PSA16). This key public service agreement applies to Health and Social Care and aims to increase the proportion of:

- Socially excluded adults in settled accommodation, employment, education or training.
- Vulnerable people achieving independent living
- Vulnerable people who are supported to maintain independent living

This is because people with mental health problems experience a greater degree of social exclusion than the general population. For example, only 24% of adults with long-term mental health problems are in work. This is measured by Social Care through performance indicators (PI) NI149 and 150. The Future Jobs Fund is a new initiative which will enable people to gain experience of coming into or returning to work, through a fixed term contract. This will enable people to update their skills and experience if they have been out of work for a while, and to receive a current reference. Leicestershire Partnership Trust will be offering 30 such job opportunities.

5.8 Mental Health Payment by Results (PbR)

The implementation of the Mental Health PbR is to create a new approach to fund mental heath care in the NHS based on grouping service users into 21 clusters. It focuses on the characteristics of individual service users, allowing a tailored approach to care. This means that it is in tune with the need for personalised care. Service users will benefit from an informed discussion of their care options and a clear understanding of the support they will receive.

The first stage with mental health is to make national currencies available for use, with prices continuing to be set locally. The aim is to fully implement Mental Health PbR by 2012/13.

6. What sort of services people want

Consultation about the priorities, their current experiences and the type of services they would like in the future took place over August and September 2010.

An online survey was developed including the provision of paper based surveys to gather people's views. Furthermore a series of focus groups took place across the City. The focus groups were held with groups that the organisations often do not engage with. Focus groups were held with the South Asian community, Bengali women's group and the Somalian Community.

Demographic data

Overall there were 240 responses to the survey. 79% of the respondents were mental health service users and 21% were carers.
65% of the respondents were female and 35% were male. The ethnic breakdown of the respondents is as follows:

- Asian/Asian British – 56%
- Black/Black British – 8%
- Chinese – 0%
- Mixed/dual heritage – 1%
- White – 23%
- Other Ethnic Group - 4%
- Non-respondents – 8%

When analysing the ethnicity data it is pleasing that we had such a high percentage response from the Black Minority Ethnic Groups. This is vital in a diverse city like Leicester.

Just fewer than 54% of the respondents considered themselves to have a disability.

Mental Wellbeing

Over 96% of the respondents considered their mental wellbeing to be very important. The respondents considered that the following were **very important** to their wellbeing:

- Physical Health – 86%
- Housing – 86%
- Financial Position – 76%
- Local Environment – 73%
- Employment – 59%

Access to mental health services

Over 86% of the respondents felt that access to mental health support was important. When asked what type/s of services/support people accessed when they or a family member/friend needed support; we received the following responses:

- GP – 70%
- Family members – 54%
- Friends – 40%
- Psychiatrists – 41%
- Counselling Services – 28%

39% of the respondents indicated that they/friend/family member were an inpatient in a mental health hospital. Only 4% did not access any support for their mental health issue/s.

Over 83% of the respondents felt it was very important to have mental health services that are local i.e. within 3-5 miles of where they live. Over 89% said that services need to be easily accessible i.e. convenient opening hours, parking, meets their specific cultural and religious requirements, good disability access and public transport links.

People were asked what types of services would have met/would meet their or their family member/friend's needs. The following types of support were highlighted by the respondents:

- Group Support – 64%
- Drop-in services –56 %
- 1:1 Support –49%
- Community based services – 49%
- Peer Groups – 39%
- Support into Education –24 %

42% wanted hospital based services.

Just over 68% felt it was important to be able to choose the services or packages of support would help maintain their mental wellbeing if they were given the money to do so.

7. Local needs

7.0 What We Know – Health & Social Care Needs in Leicester

Mental ill health is the largest single source of burden of disease in the UK. The Layard[1] report suggested that the output lost from sickness resulting from depression, anxiety and stress in Britain is around £4 billion per year. People with mental health problems have the lowest employment rate of any disabled group and mental illness is more prevalent in the most deprived areas. Perinatal Maternal Mental Illness may be harmful for mothers, children and their families; the mental wellbeing of children is likely to have an impact on their present and future health. For older people, a range of mental health issues from depression to dementia are projected to increase. There is a need to develop appropriate mental health care for people from Black and Minority Ethnic (BME) communities. In particular it is necessary to address the over-representation of people from Black/Black British ethnic backgrounds in

[1] Layard, R., 2005. *Mental Health: Britain's Biggest Social Problem?* London, Sainsbury Centre for Mental Health

the take up of services, the under-representation of people from South Asian backgrounds and a need to meet the challenges presented by new population, some of whom have experienced trauma and abuse prior to their arrival. In addition, prisoners and offenders have higher levels of mental illness than the general population.

7.1 Demography

The total population of Leicester city is 350,000 as registered with Leicester City general practices. The number of people aged 16 to 64 registered with Leicester City GPs circa 200,000. Leicester has a demographic profile that is younger than the national picture. It also has an ethnically diverse population which is outlined below in table 1.

Table 1: Population of different ethnic groups in Leicester compared with England (Source: Mid-year population estimate 2007)

Ethnic Group	Leicester	England
White/White British	61.3%	88.2%
Mixed	2.6%	1.7%
Asian/Asian British	29.6%	5.7%
Black/Black British	4.9%	2.8%
Chinese/Other Ethnic Group	1.6%	1.5%

People who experience mental health difficulties also experience significant problems: social isolation; economic disadvantage; stigma and discrimination; social exclusion; significant differences in access to services according to ethnicity, gender and age. Major gaps mentioned by people who use mental health services include access to talking therapies, peer support initiatives, and more holistic models of care.

7.2 Ethnicity

The estimated proportions of people from different ethnic backgrounds shown in the 2007 mid-year estimate above shows how diverse a city is Leicester is.

People from an Asian/Asian British ethnic background comprise the largest BME group. Since the 2001 census, there have been a number of new arrivals in the city, most significantly the Somali community and people from Eastern Europe. Current assessments suggest that the Somali community in the city numbers between 8-10,000 and that there are now between 3–5,000 Polish people and other economic migrants, including people from Slovakia and Portugal living in the city.

There is evidence to suggest that compared to the general population some ethnic minority groups carry a higher burden of poor health, premature death and reduced access to services. Ethnicity is an important issue in mental health because there are variations in underlying morbidity, diagnosis, and management. Equality in the provision of appropriate mental health services is therefore a vital requirement. In addition, nationwide evidence suggests

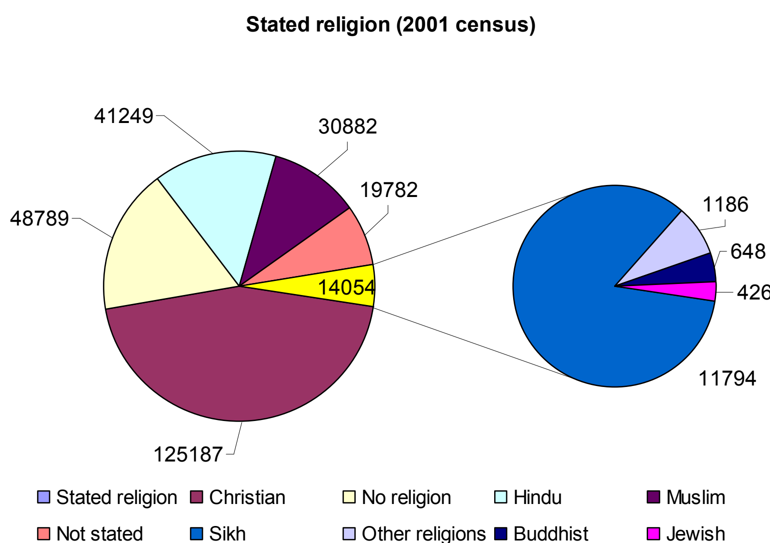
that people from BME communities are particularly dissatisfied with the mental health services they receive, they are over-represented in compulsory detention under the *1983 Mental Health Act*, are overrepresented in incidents of violence, restraint and seclusion in psychiatric inpatient settings, and are under-represented in counselling and psychotherapy, and in involvement in planning and delivering mental health services.

7.3 Culture and religion

This diversity extends to religion. Religion is an important factor in mental health service planning as traditionally religious institutions have played an important role in mental health and the different religions have different perspective on mental health.

Past analyses of the *Count Me In* census of inpatients in mental health institutions show that more people on mental health wards in Leicester state their religion than the national average. This is perhaps indicative of the importance of religion to the people of Leicester. The chart below identifies the main religions practised in local communities.

Figure 2: Stated religion according to the 2001 census



7.4 Mental Health in Leicester

Demand for services

Calculating the prevalence of mental health problems is not an exact science. There is no evidence to suggest any change in the prevalence of serious and enduring metal illness though the numbers of people with mental health problems is expected to rise in line with population growth.

7.5 Risk factors for mental health problems

Measures of deprivation and disadvantage, such as unemployment, overcrowding, few educational qualifications and those who are lone parents with dependent children have been shown to have a detrimental impact on mental health. On such measures Leicester has a rate which is higher than the national average[2]. Leicester scores highly on factors such as employment, poor educational levels and overcrowding. Compared to the national picture, more people in Leicester report that their health is poor or they have limiting long-term illnesses, and a higher proportion of working-age adults live alone.

The relationship between unemployment and mental ill health is a complex one because an individual suffering the onset of mental illness is more likely to leave employment compared with other health conditions. Indeed, as a group those who suffer mental ill health have the lowest proportion of employment of any group with a disability. The number of adults receiving Incapacity Benefit/Severe Disablement Allowance (IB/SDA) because of mental or behavioural disorders may be an indicator of the extent of severe or disabling mental health problems amongst working-age adults. In February 2008, there were 15,820 people aged 18-64 years claiming IB/SDA in Leicester, of these it is estimated that around 6,000 people claiming IB/SDA on the basis of mental ill health or a behavioural disorder.

There is a possibility that mental health problems are increasing in local communities. The percentage of Incapacity Benefit claims in the East Midlands on the basis of 'mental or behavioural disorders' rose from 27% in February 2000 to 38% in February 2008. If replicated in Leicester, this would suggest that the numbers of people claiming Incapacity Benefit on the grounds of 'mental or behavioural disorder' would have risen from 3423 in the year 2000 to 5459 in 2008; a rise of almost 60%. Economic recession would compound this problem raising the likelihood of an even greater increase in the burden of mental ill health in the next few years.

Poor quality of life resulting from physical illness is also closely related to mental health problems. People with mental health problems are twice as likely to report a long term illness or disability, and over two thirds of people with a persistent mental health problem also have a long term physical illness. Physical illness of those with severe and enduring mental health problems often go undetected, contributing to increased morbidity and lower life expectancy.

7.6 Common mental health problems

Mental health problems are common and disabling. The spectrum of mental ill health ranges from problems of depression and anxiety with a prevalence of

[2] Sainsbury Centre for Mental Health, 2003. Leicester had an average score on the York Psychiatric Index of 138. This score was higher than average (100) and indicated a high level of mental health need.

about 14% to less common psychotic disorders such as schizophrenia with a prevalence of less than 0.5%. The table below shows the estimated prevalence of common mental health problems in Leicester City

Table 2: Prevalence of common mental health disorders

	Rates per /1000 *	Estimated cases p.a.
All phobias	1758	3553
Depressive episode	2864	5788
Generalised anxiety disorder	4609	9313
Mixed anxiety depression	9449	19093
Obsessive compulsive disorder	1000	2020
Panic disorder	582	1175
Any neurotic disorder	17820.	36009

- *Source Mental Health Observatory, Durham University 2006 all adults16 - 64 population 199932

7.7 Maternal Mental Health

Evidence suggests that between 3% and 5% of women who have recently delivered will suffer with moderate to severe depressive illness. As there are around 5,000 births in Leicester annually this would suggest that between 150 and 250 women are likely to have a major depressive illness in the area.

Further studies have revealed an incidence of admission to hospital for puerperal (affective) psychosis of 2 per 1000 women delivered. About 2 per 1000 women delivered are admitted to hospital suffering from non-psychotic conditions and clinical experience suggests that about 2 per 1000 women delivered will be suffering from severe, chronic or enduring mental illness, predominately schizophrenia. Women who have experienced an episode of perinatal mental illness will have an increased risk of reoccurrence with subsequent pregnancies.

A study of the experience of motherhood of female service users of Leicester rehabilitation services concluded that many women in long-term psychiatric care experienced multiple loss of contact with their children with 68 % permanently separated from at least one child before the age of 18 years. (Dipple, Smith, Andrews, Evans Social psychiatry and psychiatric epidemiology 2002)

The impetus of change in the care of women with perinatal maternal illness is the NICE Guidelines on the management and service guidance for antenatal and postnatal mental health (NICE 2007) and the Confidential Enquiry into maternal and child deaths. A regional steering group is looking at the way in which perinatal mental health services will be commissioned in the future.

7.8 The mental health of prisoners and offenders

Psychiatric morbidity among prisoners indicates that approximately 90% of prisoners have a psychotic, neurotic or personality disorder or suffer with a substance misuse problem which has an effect on their mental health. As a category B local prison for male prisoners, HMP Leicester has a large throughput of prisoners, including those on remand, making mental health services for offenders a major challenge.

A recent review of prisoners in HMP Leicester showed that 343 out of 368 prisoners had been prescribed medication for mental illness. This equates to 93.2% of the prison population. In another study 60.6% of the prison population had a mental health problem which required referral to mental health services.

A survey of prolific and priority offenders in Leicestershire showed that about 50% were currently or previously known by the local mental health services. The greater the risk the offenders posed, the more likely they were to require mental health services.

There is a need for a joint approach to resolve the management of offenders with mental ill health needs. Achieving better outcomes for offenders will require joint initiatives between NHS Leicester City, Leicester City Council, HMP Leicester and the Leicestershire and Rutland Probation services and other stakeholders.

7.9 Mental health of older people

Provision of mental health care for the elderly is an urgent problem. Between 10% and 16% of people over the age of 65 will develop clinical depression, whilst 25% of people over 85 suffer with dementia. Such problems exert a large socio-economic cost, with treatments for Alzheimer's disease likely to exceed the costs of treating illnesses such as heart disease and cancer.

There are approximately 37000 people over the age of 65 living Leicester. By 2025 this population is projected to exceed 45,000 people, with 22,000 over 75 years of age. Average life expectancy is longer for women, and women comprise the majority of the current and projected elderly population, although the number of male elderly will increase as life expectancy for men improves. As the population of older people increases so it will be important to maintain a sense of wellbeing and quality of life, with social interaction, motivation and self-confidence being important in sustaining a person's mental health.

The National Dementia Strategy (2009) identified a number of key objectives across a whole –system designed to improve the quality of care people with dementia and their carers receive, increase independence and delay the need for institutional forms of care and enable people to '*live well with dementia'* at all stages of their pathway. The strategy emphasised the importance of early diagnosis, information and support, improved community

and housing-related support as well as better care for people in institutional settings.

The prevalence of dementia is expected to increase both nationally and locally due to an ageing population and better diagnosis. The Leicester City dementia profile 2009 states that there were estimated to be 2579 people with dementia, projected to rise to 3272 in 2025. In order to meet the challenges of the increased prevalence of dementia, taking into consideration the current economic climate, we are clear that we must look to deliver services differently to ensure we deliver high quality care for people with dementia. The report ***Dementia UK*** projected that by 2016 there will be 3023 people suffering from dementia. This will increase to 3462 by 2025. The local Dementia Strategy outlines in detail how the priorities outlined above will be addressed and implemented in Leicester.

The diversity of Leicester is also reflected in the elderly population of the city. At the time of the 2001 Census 8,282 people (21.9%) over the age of 65 were from a minority ethnic background. Of these 5245 were between the ages of 65 and 74, 2,456 were between 75 and 84 and those who were aged over 85 numbered 581. It remains a challenge to ensure that mental health services for older people from minority ethnic groups are accessible and appropriate.

The mental health of older people may be affected by issues such as income and housing. Older people require access to an adequate income and appropriate independent housing that meets their needs for as long as possible. In order to ensure that this is done effectively the agenda for Local Authority includes the transformation of adult social care to a personalised system.

The report Dementia UK projected that by 2016 there will be 3023 people suffering from dementia. This will increase to 3462 by 2025. The local Dementia Strategy outlines in detail how the priorities outlined above will be addressed and implemented in Leicester.

7.10 Eating Disorders

Eating disorders including anorexia nervosa and bulimia nervosa and related conditions generally have an onset in childhood and adolescence. However they can have an onset in working age adults. They include a variety of types of disordered eating and range in severity.

Overall 6.4% of adults screened positive for and eating disorder. 9.2% of women were more likely to than men (3.5%) to screen positive for an eating disorder. The prevalence decreases with age and the pattern was particularly pronounced for women.

Eating Disorders has been flagged as a priority at an East Midlands regional level and a steering group is existence to deliver service redesign and improvements at a regional level. This will feed into local delivery of services.

7.11 Autism including Aspergers

Towards fulfilling and rewarding lives: a strategy for adults with autism in England sets a direction for long-term change to realise our vision but also identifies specific areas for action over the next three years. These are:

- increasing awareness and understanding of autism among frontline professionals
- developing a clear, consistent pathway for diagnosis in every area, which is followed by the offer of a personalised needs assessment
- improving access for adults with autism to the services and support they need to live independently within the community
- helping adults with autism into work, and
- enabling local partners to plan and develop appropriate services for adults with autism to meet identified needs and priorities.

The approach taken in the strategy is to make existing policies work better for adults with autism. This approach reflects the fact that there is already a wealth of government policy and initiatives that should support adults with autism. Therefore the emphasis of the strategy is to avoid placing additional statutory requirements or financial burdens on frontline staff delivering public services, on businesses or on local planners.

Leicester has a joint strategy for adults with Asperger syndrome, in partnership with Leicestershire and Rutland and the respective Primary Care Trusts, NHS Leicester and NHS Leicestershire County and Rutland.

The Strategy focuses on adults; however the transition from children's services into adult services is considered a critical and integral element of the Strategy. It is a three year Strategy with a delivery action plan, however it is recognised that change will be a long-term process. The Strategy incorporates some of the requirements of the National Autism Strategy "Fulfilling and rewarding lives" (2010) and covers areas which will be the subject of statutory guidance in line with the Autism Act (2009). Further work is required locally, however, to address all requirements resulting from the National Strategy and the Autism Act; this Strategy lays the foundation for this work.

Each Local Authority in partnership with the NHS will be responsible for delivering the Strategy. The delivery plan identifies key partnerships and programmes of work that are common to all and includes suggested time frames.

7.12 Delivering Race Equality

At the time of the 2001 Census 34% of the population of Leicester came from a black minority ethnic (BME) background. There is evidence to suggest that compared to the general population some ethnic minority groups carry a higher burden of poorer health. Ethnicity is an important issue in mental health because of underlying morbidity, diagnosis and management. Equality in the provision of appropriate mental health services is therefore a vital requirement.

Delivering race equality in mental health care is a national and local priority which is aimed at achieving equality and tackling discrimination in mental health services in England. Nationwide evidence suggests that people from BME communities are over-represented in compulsory detention under the Mental Health Act. People from BME backgrounds are under-represented in counselling and psychotherapy including involvement in planning and delivery of mental health services.

Since 2001 Leicester City has also seen the arrival of new communities such as Somali (current numbers 8-10,000) and people from Eastern Europe (current numbers 3-5000). In the review of Count me In Census on inpatients at Leicestershire Partnership Trust) 2006 identified that there were a high proportions of Polish and Somali speakers having inpatient mental health care. These particular groups may suffer with a deficit in relation to those factors which are protective against mental illness such as accommodation, social isolation, poverty etc. For those people seeking refuge in the UK issues of mental health and wellbeing maybe additionally affected by post traumatic stress and abuse.

Given these issues we intend to through this strategy ensure that there is timely access to mental health services for people from BME communities and that these services are appropriate and responsive. There will be continued engagement with people from BME communities and we will look at different ways in which organisations including the voluntary sector can have a real impact on improving mental health for people from BME communities.

8. Performance and Quality of Current Services

The Audit Commission were commissioned by NHS Leicester City (NHSLC) to undertake a benchmarking audit of the local mental health service delivered by LPT. This Audit was undertaken for NHS LC and NHS Leicestershire County & Rutland (NHSLCR).

The Data sources used to undertake the benchmarking were:

- Programme Budgets
- Hospital Episode Statistics (HES)
- Mental Health Minimum Data Set (MH MDS)
- World Class Commissioning Indicators

A workshop was held in April 2010 where there was further discussion regarding the initial findings and graphs.

The main conclusions the audit commission came up with were as follows:

- There are some data quality issues in some of the datasets which raise a number of questions that need to be discussed further
- The report contains some more detailed follow up analysis which needs to be shared more widely within the PCT
- As the lead commissioner NHS LC needs to investigate the questions raised about the mental health services delivered to the population of both Leicester City and Leicestershire County and Rutland.

Spend

NHS Leicester has a slightly above spend on secondary mental health when Primary Care Trust spend was benchmarked against the National Programme Budgeting data. Conversely the total primary care spend for mental health is below the national average.

The World class commissioning data set includes an indicator showing the proportion of adult mental health spend committed on out of area placements. According to this data NHS LC appears to have a higher than national average proportion of spending. However there does appear to be some data quality issues with this data as some Primary Care Trusts appear to have all their spending on out of area placements. Furthermore the East Midlands Strategic Health Authority data suggests that across the East Midlands region the out of area placements spend for Leicester City is below average.

Prevalence Data

The prevalence data shows that between the City and the County there are significantly differing levels of severe mental illness with Leicester City being in the highest quarter nationally.

The prevalence rates for dementia are less extreme. However both Primary Care Trusts in Leicestershire have recorded a slight increase in dementia between 2007/08 and 2008/09.

Inpatient Activity

According to the benchmarking data NHS LC has higher than average working age adult mental health admissions compared to Primary Care Trusts nationally. NHS LC appears to have just above the median number of occupied bed days. This is particularly low when compared to the need.

For Older Adults admissions does not follow the pattern for dementia prevalence. However this may not be the only condition that requires admission for older adults in mental health. The City has a particularly higher rate of admission compared to the County.

NHS Leicester City is at a lower comparative level for bed days than for admissions. This maybe because there are a high number of short stay admissions.

This could be interpreted in 2 ways either that the service is stabilising and discharging patients straight into the community or that there are a high number of admissions because of a lack of service alternatives for people in crisis in the community.

The average length of stay was analysed using the Mental Health Minimum Dataset (MHMDS 2008/09). The data showed that NHS LC has just under 20% of working age adults admitted for 91 days or more. The Proportion for NHS LCR is 10%.

When this is compared nationally it shows that the above numbers relate to median and lower quartile position relative to the population size.

Access to Services

The MHMDS also records patient contacts for a number of groups of staff. Analysis of this data showed that for both of the PCTs there is a high level of contacts with consultant psychiatrists for adults and older people. Although the data shows high access rates to consultants, it appears that patients are not subject to excessive numbers of follow up appointments.

However CPN contacts per thousand population for adults and older people are below the national average. In addition to this the East Midlands Mapping data identified that Leicester Community Mental Health Teams (CMHT) are the most costly in the East Midlands.

Performance

The following Care Quality Commission target is a key performance measure within mental health:

- Number of separate episodes of home treatment completed by crisis resolution team

In addition the following vital sign is still currently monitored:

- Suicide and injury of undetermined intent and mortality rate

Also included in the regular review of the performance of mental health services is the following key performance areas that form the performance dashboard against

which the main provider of mental health services for Leicester is performance managed against:

- Percentage of people on New Care Programme Approach (CPA) receiving follow up within 7 days of discharge
- Rate of delayed transfers of care per 100,000 population
- Number of people with newly diagnosed cases of 1st episode psychosis receiving early intervention in psychosis
- Number of patients on assertive outreach caseload
- Percentage of patients coded with ethnicity category

Full details of these indicators can be found in the appendix.

As part of an ongoing process there is also a data quality improvement plan in place to support with the future commissioning of services and also to support the implementation of Mental Health Payment by Results.

Adult Social Care Performance

The National Indicators and PAF indicators that are most relevant to Mental Health services are (benchmarked Leicester performance in brackets based on provisional NIS 09/10):

- NI 149 Adults in contact with secondary mental health services in settled accommodation (average, ranked 10/18 – slightly above average for comparator group and just below England average)
- NI 150 Adults in contact with secondary mental health services in employment (poor – ranked 13/18 and well below both comparator group and England averages)
- PAF C31 Adults with MH problems helped to live at home

A sample of the universal indicators for all adults that are set out below – however, without the data being disaggregated to client group there needs to be caution in applying the benchmarked findings against MH services:

- NI 135 Carers receiving a needs assessment or review and a specific carers service, or information & advice (above average)
- NI 136 People supported to live independently through social services (just below average comparator group and well below England average)
- NI 132 & NI 136 (timeliness of social care assessments and provision of social care packages (both poor ranking 17/18 and 16/18, below comparator and England averages)

Leicester places more people with mental health problems in residential and nursing care than comparators, part of which includes the legacy of people on “preserved rights” from prior to the Community Care Act 1993. The Mental Health Opportunity Assessment shows that residential and nursing placements have remained fairly

constant at just over 200 people over the last 4 years whilst there has been a 37% decrease in community based services during the same period.

This makes Leicester at 4.9 per ‘000 (aged 18-64) the highest user of residential care in its comparator group. Leicester however also is one of the highest providers of home care to adults of working age with mental health difficulties.

Leicester spends significantly more than other local authorities (highest nationally and second highest in comparator group) on residential/nursing care, and less on community support.

Quality

In addition to performance the quality of the services are also measured and monitored regularly. The following key indicators of quality form part of the Quality Schedule that is used to monitor the quality of services:

- Infection Prevention and Control
- Patient Safety
- Privacy and dignity in Care
- Safeguarding children and adults
- Compliance with CQC full registration requirements
- Demonstration of implementation of best practice
- Compliance with NICE Guidelines
- Full compliance with delivering the Race Equality Agenda

Commissioning for Quality and Innovation (CQUIN)

Commissioning for Quality and Innovation (CQUIN) is a payment framework which makes a proportion of the provider’s income conditional on quality and innovation. These are used to drive and further improve quality within certain areas that are identified as key areas of need for improvement locally and regionally. This is done through providing a financial incentive to the provider which they receive once they have achieved the identified key improvements.

With our main provider the following CQUIN have been identified. Some of these are regionally identified and some have been locally identified.

- Percentage of patients (18>) with a delayed transfer of care - Non Acute
- Percentage of people on CPA who have had a HONOS assessment within 12 months
- Mean length of Stay for MH inpatients
- Percentage of adults receiving secondary mental health services in paid employment at the time of their most recent formal review or other multidisciplinary meeting care planned meeting
- Percentage of adults receiving secondary mental health services in settled accommodation at the time of their most recent formal review or other multidisciplinary meeting care planned meeting

9. Current Resources

a) Financial Analysis

The total budget spent on adult mental health services during 2009/10 was spilt as follows:

- NHS Leicester City spent a total of **£45 million** on adult mental health services. The breakdown is outlined in the table below:

- Leicester City Council spent a total of **£9.7m**.

Health Spend
Mental Health Spend 09/10

Spend on NHS Provider	Spend on Voluntary Sector	Spend on Other e.g. LA	Total Spend
£44,115,476	£632,000	£451,800	£45,199,276

Mental Health Budget for 2010/11

Budget for NHS Provider	Budget for Voluntary Sector	Budget for Other e.g. LA	Total Budget
£42,377,322	£642,000	£453,000	£43,472,322

Due to the major changes as per the White Paper (DH 2010) to the way health services will be commissioned in the future, subsequent financial plans from 2011 onwards are yet to be determined.

Adult Social Care Spend

The Adult Mental Health Opportunities Assessment identifies that Leicester City spends more than comparators on adult social care services overall, a high proportion of which is spent on residential care.

As shown in table 1 below, of the £9.7m adult social care budget, 24% was spent on assessment & care management and 49% on residential & nursing care.

Of the £3.8m spent on in-house services, 60% was spent on assessment & care management, 22% on day services and 1% respectively on residential care and supported accommodation. Of the £6m spent on independent sector provision, 80% of this is spent on purchasing residential care compared to 3% on purchasing supported accommodation packages.

Table 1: City Council spend on Adults with Mental Health Needs

The data is gross spend and direct cost of the service. Therefore, it excludes overheads and capital charges.

Service Type	In-House £'000	Independent £'000	Total £'000
Assessment and Care Management	2,290.5	0	2,290.5
Direct Payments	-	200.1	200.1
Supported & Other Accommodation	46.5	157.2	203.7
Home Care	129.8	300.6	430.4
Day Care & Services	829.2	96.1	925.3
Residential and Nursing	34.8	4,722.6	4,757.4
Meals	30.8	8.6	39.4
Other Services	448.5	434.0	882.5
Total - Direct Gross Spend	**3,810.1**	**5,919.2**	**9,729.3**

Leicester spends an above average £58.07 per head on support for adults aged 18-64 with mental health difficulties, this representing 10% of its ASC budget compared to 7% England average. Spending has increased by 22% over the past 5 years, the second highest rate of increase after learning disability spend. However, the spend per head on residential/nursing care is a very high £32 per head. This is £15 per head higher than comparator authorities and £24 per head higher than average. Reducing placements to meet these averages would reduce spend on residential/nursing care by between £1.4m and £2m.

The Opportunities Assessment shows that Leicester now spends 55% of its total budget on residential care, compared to the median average of 30%. Spending on residential care increased by 31% over the past 5 years with a 34% increase in community spend.

The majority of ASC unit costs in Leicester are higher than other unitary councils. With high day care costs and lower than average residential care and home care unit costs.

This needs to be considered within the local context with the money available to spend on mental health services reducing significantly in future years – in addition to the economic position and potential additional efficiencies of 30%-40% needing to be identified, the impact of personal budgets and the new Resource Allocation System (RAS) may also result in a reduction in funding that is available for both existing and new individual packages of support.

b) Market Analysis;

The majority of Adult Social Care Services are commissioned from the independent and voluntary sector, with over 60% of the budget in 2009/10 being spent on services provided externally to the council. The over-reliance on residential care is reflected in the market share, with independent sector residential providers dominating the local market. There are a small number of providers of community services, providing packages to people in supported living tenancies, which are mostly in the form of supported housing schemes that are buildings based on licenses rather than secure tenancies.

There is a lack of market capacity generally for all levels of community support. Based on a continuum, supported living needs to include a full range of options from low level floating support to more intensive specialist outreach support. Currently there are few low level support options, and specialist outreach services are undeveloped. An undeveloped market limits the supply of housing options and choice for service users as well as increasing spending through the over provision in residential care. The under use of support related housing is limiting the range of efficient and cost effective service solutions available.

There is a significant under use of telecare which is further limiting the range of service solutions that are available i.e. efficiency opportunities are being missed.

Most day services are provided by the voluntary sector. Day service provision provided by the local authority has been modernised and operates as a Social Inclusion Team. Though there are supported employment services, these are limited.

Internal working procedures and processes are also impacting on the market, reinforcing the current market share and depressing market development by the lack of demand for new types of services.

The Opportunities Assessment case file analysis identified a risk averse culture that is leading to over provision, which then fails to stimulate the market to offer low level support options. A lack of planning with service users, carers and providers may lead to the inappropriate continuation of placements often with long term financial commitment. Interim placements in residential care due to crises drift and become long term causing institutionalisation and incurring longer-term costs. Premature placements of people with minimum support needs into residential care may lead to long-term institutionalisation and incur longer-term costs. A lack of goal setting and evaluation leads to low through put with some people getting stuck in ‘the system’ and resources remaining static. This is leading to over supply and over provision. This quickly becomes a vicious circle – risk averse practice results in higher cost and traditional provision, and the lack of market capacity and availability of alternative options results in further over-dependence on traditional models and high cost provision. Inadequate support to carers sometimes leads to family breakdown and crises that are resulting in more expensive care needs.

c) Workforce Analysis

There is no overarching workforce plan for mental health services and no co-ordinated approach to mapping the existing workforce across all services. Work needs to be undertaken to identify recruitment, retention and workforce issues and pull together intelligence from providers. There is currently no data on the total number of people working in mental health services within Leicester City, the skill mix, or demographic profile of the workforce. Each agency currently arranges its own training and staff development programme.

Apart from a limited inter agency training programme co- delivered with people with experience of mental health problems that includes Good Practice In Mental Health, Person Centred Planning, Values Based Practice, Aspergers Awareness and Strategies, and Mental Health awareness.

10. The future model for MH services

The broad approach to the delivery of mental health services is based on the Recovery Model, underpinned by the development of personalised services based on self directed care, including self assessment and supported self assessments, personal budgets and personalised services. This needs to be aligned to CPA, and incorporate the stepped care approach and use of care pathways. This document does not describe the CPA model, as this is well established practice within mental health services, or the assessment and care management process in detail as this is set out in other documents outlining the new customer journey for all service users receiving adult social care services.

Furthermore, the model needs to align with Prevention and Early Intervention Strategy and be based on the DH framework with 5 key elements of intervention:

- Promoting health & wellbeing
- Maximising independence and functionality
- Delaying or reversing deterioration
- Reducing risk of crisis or harm
- Providing care & support closer to home

This aligns well with the Mental Health Stepped Care Approach and the care pathway approach, which is recognised best practice as a means of determining locally agreed multi-disciplinary practices based on guidelines and evidence for a specific service user group or need. An agreed sequence of procedures ensures better management of clinical processes and outcomes for service users & patients. Good care pathways ensure a high quality patient/service user experience, improves team working across providers, avoids duplications and ensures improved continuity of care.

This is set out in the example below on the NICE guidance on the Stepped Care Approach to the Management of Depression:

Who is responsible for care?	What is the focus?	What do they do?
Step 5: Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4: Mental health specialists, including crisis teams	Treatment resistant, recurrent atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3: Primary Care Team, primary care mental health service worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2: Primary care team, primary care mental health service worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1: GP, practice nurse, primary care clinicians	Recognition	Assessment

In mental health, ‘recovery‘ has a range of meanings and does not always refer to the process of complete recovery from a mental health problem in the way that we may recover from a physical health problem.

For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem. Professionals in the mental health sector often refer to the ‘recovery model’ to describe this way of thinking.

Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on managing their symptoms.

There is no single definition of the concept of recovery for people with mental health problems, but the key idea is one of hope that it is possible for meaningful life to be restored, despite serious mental illness. Recovery is often referred to as a process, outlook, vision, conceptual framework or guiding principle.

The recovery process:

- provides a holistic view of mental illness that focuses on the person, not just their symptoms

- believes recovery from severe mental illness is possible
- is a journey rather than a destination
- does not necessarily mean getting back to where you were before
- happens in ‘fits and starts’ and, like life, has many ups and downs
- calls for optimism and commitment from all concerned
- is profoundly influenced by people’s expectations and attitudes
- requires a well organised system of support from family, friends or professionals
- requires services to embrace new and innovative ways of working

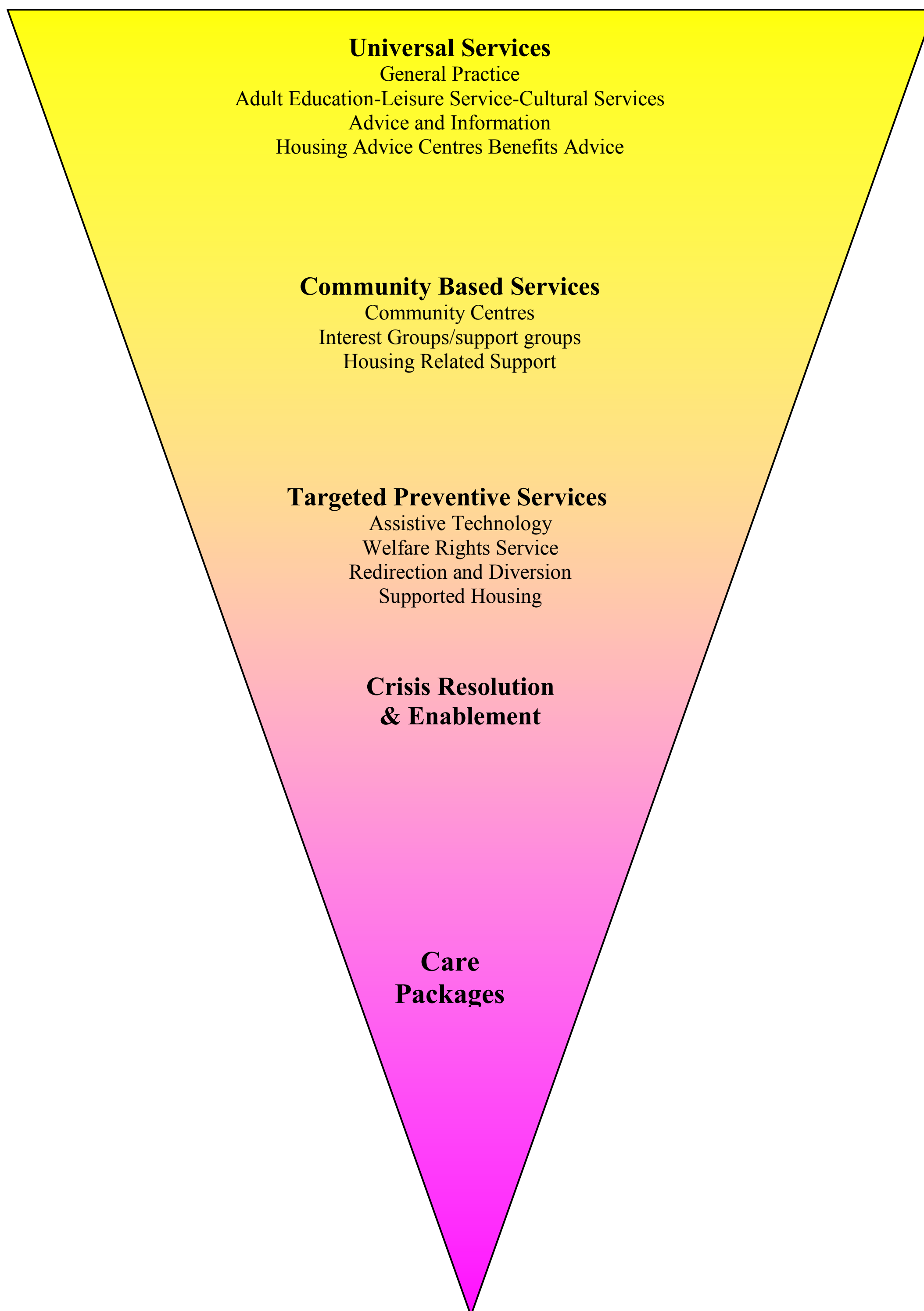
The recovery model aims to help people with mental health problems to move beyond mere survival and existence, encouraging them to move forward and carry out activities and develop relationships that give their lives meaning.

Recovery emphasises that while people may not have full control over their symptoms, they can have full control over their lives. Recovery is not about ‘getting rid’ of problems. It is about seeing people beyond their problems, recognising and fostering the opportunities that harness their abilities, interests and dreams. Mental illness and social attitudes to mental illness often impose limits on people experiencing ill health. Recovery looks beyond these limits to help people achieve their own goals and aspirations.

In line with government policy, adult social care services provided to people who meet the Fair Access to Services criteria will be limited more effectively to those people who cannot be supported through universal services and targeted community services. The support and assistance available to people must first and foremost keep them safe from abuse irrespective of where they live, will involve people in decision making, and will promote choice based on clear and timely information. Services will focus on retaining and regaining people’s place in the community, avoiding wherever possible institutional forms of care and based on the least intrusive options available. This will require adult social care services, other council services and health services to be integrated and co-ordinated.

This approach is illustrated in the inverted triangle below which highlights the types of interventions needed to achieve key outcomes against each level.

The aim is to ensure that all people with mental health difficulties can access the full range of public services that are available to all. Some people will also need to access targeted community and preventative services that are available without an assessment, and could also be purchased using personal budgets. For those people requiring a needs based assessment, the first tier is to access crisis resolution, enablement and assertive outreach services with a focus on trigger points within the customer journey for those with higher levels and complexity of needs accessing care managed specialist services – which can also be purchased using personal budgets.



Services need to move from:	**To**:
High cost residential care	Specialist supported housing Intensive supported living packages Limited specialist residential/nursing

	care Improved health outreach and step down services Intermediate care
Medium cost residential care	Sheltered housing Supported living opportunities Health outreach services Intermediate care
Low cost residential care	Sheltered housing Supported living opportunities Increased support for carers and families Reablement & intermediate care
Buildings based respite care beds provided by NHS and independent sector	Jointly commissioned short breaks services including some independent sector bed provision, holiday breaks, and home based support
Home care services	Reablement, enablement & intermediate care Community support packages
Day Care	Enablement Community support services Low level preventative services Supported employment

The new model of providing adult social care services will be aligned to the new operating model and customer journey – that is, direct access to preventative and low level services, use of personalised budgets determined by the Resource Allocation System (RAS) and the purchase of social care services from a range of independent and voluntary sector providers rather than the local authority or NHS. When care packages are developed the opportunity to utilize universal provision will be maximised and the approach is predicated on the assumption that barriers to

inclusion will come down. Health services will need to be remodelled to reduce the need for hospital admission.

11. Commissioning Priorities 2010-2013

Based on the analysis of needs and consultation with service users on priorities, these have been identified as:

Prevention & Early Intervention

- Improving access to psychological therapies (this includes specialist CBT, Personality Disorder and Psychodynamic Therapy) steps 1-5 including early intervention with people who have long-term health conditions (diabetes/COPD).
- Supported Living – supporting people with mental health conditions to move from residential homes into independent housing and maintaining people to continue to live in their own home with support
- Strengthening crisis intervention within health and social care in order to prevent people from requiring admission to hospital and maintain and support them safely within the community

Transforming Social Care

- Personalisation – providing individuals with greater choice and control over the support/services they need
- Personalised Budgets

Supporting the Mental Health of Older People

Dementia - The National Dementia Strategy (2009) identified a number of key objectives across a whole –system designed to improve the quality of care people with dementia and their carers receive, increase independence and delay the need for institutional forms of care and enable people to '*live well with dementia'* at all stages of their pathway. The strategy emphasised the importance of early diagnosis, information and support, improved community and housing-related support as well as better care for people in institutional settings.

The prevalence of dementia is expected to increase both nationally and locally due to an ageing population and better diagnosis. The Leicester City dementia profile 2009 states that there were estimated to be 2579 people with dementia, projected to rise to 3272 in 2025. In order to meet the challenges of the increased prevalence of dementia, taking into consideration the current economic climate, we are clear that we must look to deliver services differently to ensure we deliver high quality care for people with dementia.

Our priority is to develop an integrated dementia care pathway, covering the spectrum of need for people with dementia from early diagnosis and intervention to end of life care. The development of this pathway will take into consideration local needs, data on existing service provision, evidence from best practice models in dementia care and the outcomes of a series of workshops involving service providers, patients and carers to look at improvements in the dementia pathway.

We are working with our strategic partners across Leicester, Leicestershire and Rutland to progress this work and deliver an integrated dementia care pathway which includes GPs, primary and secondary health staff, social care staff and voluntary sector staff. We will continue to engage with patients and carers throughout this development to ensure that the services developed will meet their needs.

The commissioning plan for dementia is being developed separately and the Commissioning Implementation Plan addresses the priority areas of prevention & early intervention and transforming social care.

The **Commissioning Implementation Plan** focuses on 6 key work streams within the commissioning strategy:

- The development of **psychological therapies** to improve access and provide earlier intervention and support
- The redesign of **crisis intervention services** to support people at home during crisis, maintain independence and reduce unnecessary hospital admissions
- The development of an **enablement service** for all existing residents moving out of residential care and all new service users referred to mental health services
- Development of the **supported living model** for both new service users and to move on those already living in residential care
- The redesign of the **residential care model** for adults of working age, based on a premise that no-one is placed permanently within a residential establishment
- The remodelling of **community support** services to move away from existing in-house provision (Social Inclusion team) and low level "home care" to RAS funded packages and increased targeted community services provided by the voluntary sector.

Psychological Therapies

Partnership working will be strengthened and IAPT rolled out across the city and so better manage demand. Actions will include

- moving from a block contract to activity based contracts based on completed treatments
- a full service evaluation by February 2011 – if the service is not delvering the desired outcomes, it will be re-tendered
- Psychological therapies level 4 and 5 will be incorporated into the IAPT stepped care model.

Crisis Resolution

The future model for crisis intervention will be redesigned to include a better interface with social care and better cross working between all LPT services (crisis resolution, assertive outreach, PIER, acute recovery). Actions will include:

- Identifying and addressing barriers
- Developing a broader interface with community services
- Identifying model of best practice
- Developing a new care pathway that integrates health and social care
- A revised service specification

Enablement Services:

A MH enablement service will work with all service users prior to and/or as part of any assessment. This has already been trialled within MH services until end August, when the funding for the MH OT post delivering the services was withdrawn. People moving out of residential care will also receive enablement pre and post move. Enablement will be delivered within their own home or new supported living arrangement post discharge from residential care or hospital supported by step down facilities where appropriate. Enablement will consist therefore of 2 elements:

- In reach enablement service from MH OT/other support staff (not part of costed care package)
- Intensive care package from community provider for first 6 weeks (average) focussing on developing daily living skills and coping mechanisms

In addition some people moving out of residential care may receive an outreach service with residential staff working alongside community staff during the transition period.

Residential Care:

The model for residential care for people with mental health difficulties will be redesigned and based on an enablement model. The commissioning plan includes a Moving On Programme which aims to move a minimum of 50% of existing residents out of residential care over the next 3 years, and through the development of Supported Living options, reduces the number of future residential placements. However, it needs to be assumed that most, if not all, of existing residents of working age will eventually move on, to live in their own homes. Though residential placement will reduce significantly in future years, an approach will be adopted that assumes that any new residents will not be placed “for life” but would actively work towards moving on. The action plan will therefore include:

- Development of a new pathway for residential/nursing care
- A new service spec and contract
- Working with residential providers to change working practices and retrain residential care staff
- Encouraging providers to diversify and offer outreach services
- The provision of in-reach therapeutic support from a MH enablement team

People Moving On would therefore receive an enablement service pre-move whilst still in residential care, followed by a period of enablement following discharge to their own home. This would be critical to success as a significant number of

residents have been living in residential care for long periods (c16 years) and need to develop daily living skills and confidence.

Supported Living:

The future model for supported living will be further developed to include a wider range of types of accommodation and levels of support as current provision of supported living services tend to be based on the more expensive models. This will include:

- Pathways for both accessing housing and accessing community support packages
- Development of new service specifications
- A broader range and type of accommodation based predominantly on individual tenancies/home ownership with possibly some limited buildings based “supported housing” schemes of a “sheltered” nature.
- A wider range of levels of support including floating support/low level support to more intensive outreach services (health & social care), both of which are gaps in current provision.

The model would be based on a low level/low cost core support service (floating support) and a RAS based package based on individual need to cover additional community support if required.

Community Support Services:

The future model for community support will be based on a mixture of 2 elements:

- Low level flexible support from the voluntary sector providing links to access universal services, self help support and supported employment.
- Personal budgets being used for a range of community support services linked to moving on to employment, provided externally to the council

12. Resource Implications

a) Financial Implications

The commissioning plan will result in a shift from investment in residential care and high cost placements to targeting resources on the provision of enablement and an increased range of community support/supported living services filling the current gap of a lack of low level support services. Planned redesign of adult social care services between 2011 and 2014 will include the following key changes which will be planned into a three year programme.
Restructuring of services to reduce the number of residential care placements and increase the range of supported living options will impact on budgets and activity by reducing residential placements by 50% over the next 3 years.

This will require short term investment for a “Moving On” team to work with people currently in residential placements who wish to move into supported living options.

Investment into the commissioning of new floating support services will provide lower level support options within the community, reduce current over-provision and target resources more effectively to maintain independence.

The impact of personalisation will include:

- Increased community opportunities from voluntary sector
- Increased access to and use of assistive technology to promote independence and security
- Development of enablement and reablement approaches, which maximise independence and self reliance

To summarise, resources will need to be invested in enablement and support services such as floating support, to enable people to retain their independence and avoid unnecessary admissions to residential care. This will also require some short term investment in a “Moving On” project to provide opportunities for people to move out of residential care over the next 3 years. However, the cost of the investment will be offset by significant savings through the reduction in the reliance on residential care and high cost supported living. Care Packages will be funded though personal budgets in line with the Resource Allocation System (RAS) which will provide a much fairer resource allocation process for all adults receiving social care services. The overall funding allocation for mental health services will be determined through the council’s budget strategy, which in itself will be determined by the October spending review and public sector efficiencies.

Table 1: current pattern of spend on adult social care services:

MENTAL HEALTH	AS IS	14 SEPTEMBER		
		No Client Nos	Average net unit cost £ per week	Net Cost £'000s
ACCOMMODATION BASED SERVICES				
Long Term Residential Care		180	339.9	3,181.2
Short Term Residential care		6	136.4	42.6
Supported Living		18	177.0	165.7
Extra Care		3	298.3	41.8
COMMUNITY BASED SERVICES				
Home Care		75	59.8	233.0

Day Care	161	57.7	483.2
Direct Payments and Care Packages	41	85.2	181.6
Meals etc	53	30.1	82.8
TOTALS	537		4,411.9

Table 2: forecast pattern of spend on adult social care services following implementation of commissioning strategy

MENTAL HEALTH TO BE 14 SEPTEMBER	No Client Nos	Average net unit cost £ per week	Net Cost £'000s
ACCOMMODATION BASED SERVICES			
Long Term Residential Care	96	333.8	1673.1
Short Term Residential care	6	136.4	42.6
Supported Living	18	159.3	149.1
Extra Care	0	0.0	0.0
Assisted Accommodation	87	183.1	824.7
Intermediate care	0	0	0
Adult Placements	0	0	0
COMMUNITY BASED SERVICES			
Home Care	0	0	0
Day Care	25	40.7	52.9
Direct Payments and Care Packages	55	65.7	189.4
Enabling/Reablement			51.2
Assistive Technology			13.5
Voluntary/Community Services	189	26.9	264.2
TOTALS	476		3,260.7

b) Market Development Implications

The commissioning plan has significant implications for market development. There will be a reduced need for residential provision and a need for increased capacity in the voluntary and independent sector for the provision of care packages and community support services that support people's independence. The use of personal budgets will see a culture change with a reduction in large block contracts and "in-house" provision and replaced by a greater market mix and more flexible services that people will choose to spend their money on.

Current residential providers will need to change the way they work and diversify to provide out reach and community support services that either replace or supplement a smaller residential market. All independent sector and voluntary sector providers will need to develop new ways of working to respond to the new demands of people using personal budgets. Delivery of the plan will be dependent on the ability of the third sector to respond and develop capacity.

(c) Workforce implications

The workforce implications include:

- A greater role for mainstream staff in primary and secondary health care and public services
- Development of new skill mixes within integrated services
- Community support staff needing to be multi-skilled and able to support people with varying levels of need. Development of a learning plan for workers across sectors, including Carers and those directly employed by individuals, around responding appropriately to people who require support.
- All staff being developed as a "public health" workforce at all levels – from mainstream to specialist roles
- Person centred approaches fully rolled out to all staff across all organisations with access to good and creative support planning and brokerage.
- Assessment & care management staff will be required to deliver against the new customer journey and personal budgets including improved delivery and quality of Carers Assessments.
- Requirement to address current risk averse practice, ensuring that people are supported by accessing mainstream and preventative services and the lowest level of intervention required to maintain and support independence
- The significant shift from residential care to supported housing options will require local housing and support providers having appropriately skilled and trained staff
- The shift from council managed social inclusion activities to a range of community services funded from personal budgets will require existing staff to work in different ways and independent and voluntary sector organisations to have appropriately skilled and trained staff
- Training and development of personal assistants and the needs of people with who become employers
- The ongoing pivotal role of people with mental health difficulties and carer trainers in paid employment in the areas of learning and development, advocacy, recruitment, planning and quality.
- Universal services that can respond positively and inclusively to people with mental health difficulties. Considerable investment in market development

and community capacity building and associated workforce requirements in relation to new roles in this area.

- Workforce development support and learning and development for both mainstream and specialist employment/supported employment services
- Development of a Carers Learning Plan to analyse Carer's learning needs and respond in a variety of ways including signposting to existing provision, multi-agency response, commissioning opportunities
- Response to Autism Act 2010 including work with Leicestershire County Council and Leicestershire Partnership Trust to develop a learning plan across sectors in relation to people with Aspergers Syndrome who do not have a learning disability.
- Staff are appropriately qualified to meet statutory, regulatory and legislative requirements including programmes that deliver national induction standards, adult mental health practitioners and other professional training needed to deliver specific mental health services

13. Risk Analysis

The Risk Assessment is attached as a separate document and outlines key risks, likelihood and impact, and mitigating actions. These are summarised as follows:

- There is currently a gap in the local authority commissioning infrastructure which is under review. Any delay in filling the lead commissioning post combined with limited capacity of existing commissioning & planning staff due to other work commitments will impact on delivery.
- Impact of the White Paper and loss of continuity in health commissioning arrangements both in the short term and long term
- Concerns about the accuracy of available data and information may impact on some of the assumptions regarding future service delivery options
- There is evidence of risk averse practice and a need to engage assessment staff in new ways of working that needs to be addressed through operational services
- There will be a risk to implementation if the components of transformation across adult social care are not fully joined up – i.e. personalisation, joint commissioning strategies, efficiency plans and financial strategy plus the cultural change that is required to change practice.
- Resistance to change from existing providers, service users, carers, staff, clinicians and politicians could all impact on delivery
- Public sector efficiencies impact on the availability of universal services as well as reducing funding available for personal budgets
- Some new services commissioned may cost more than existing residential services
- Lack of capacity within voluntary and independent sector to meet demands for increased community services
- Potential gaps in the current workforce regarding the skills and skill mix to deliver new ways of working
- Current contracting and procurement arrangements aren't aligned to new ways of working

APPENDIX A

1. Commissioning Implementation Plan

Action	Lead	Co-dependencies	Resources	Success criteria	Timescale
Improving access to **psychological therapies** ➢ Strengthen partnership ➢ Roll out IAPT ➢ Change contract ➢ Evaluate service ➢ Implement business case for psychological therapies ➢ Bring level 4 & 5 into stepped care model	**Lead Commissioner (PCT)**	LPT Vol sector partners Clinical engagement	Within existing investment for IAPT Business case target £255k savings	Improved access to therapies Improved recovery and prevention of crises	IAPT roll out by Sept 2010-09-08 service evaluation Feb 2011 Business case implemented 2011/12 Stepped care model 2011/12
Redesign **crisis intervention** ➢ Identify barriers	**Lead commissioner**	LPT Vol Sector	Within existing resources	prevent people from requiring admission to hospital and maintain	2011/12

➢ Identify model of best practice ➢ Develop a care pathway that integrates health and social care to meet all needs ➢ Develop new service spec ➢ Assess market capacity				support them safely within the community and	
The development of an **enablement service** for all new service users referred to MH services ➢ Develop model ➢ Develop service spec	**Planning officer & Service Manager MH**	Redesign of community health services to re-focus therapy services; Engagement of LPT Advocacy;	Develop within existing resources within integrated community team and home care – investment in 1 wte OT shared with Moving On (SL) Project	More people accessing universal services; fewer people receiving RAS funded package; Care packages cost less;	Model developed by end Jan 11. Staff training Mar – June 11 Implementation 2011/12

Remodel Residential Care based on an enablement approach ➢ Develop new Pathway for entering res care ➢ Develop new Pathway for leaving res care ➢ Develop new Service Spec and revise & reissue contracts and bandings ➢ Develop and agree policy relating to out of area residents accessing community services (with LD) ➢ Develop strategy for managing residential market to mitigate impact of inwards migration to fill released capacity (with LD) ➢ Engage providers and retrain res care staff	**ASC lead/Planning officer**	Engagement of existing res care providers in new way of working. Development of Enablement Service above to provide in reach support. Contracts capacity and input; Regional and County links	Within existing resources other than funding to retrain residential care staff (will need to support providers); Reduction in spend on residential care	Achieve targets to move people on from existing residential placements over the next 3 years, with commensurate 50% reduction in beds – thus resulting in fewer new admissions to res care; and shorter lengths of stay;	Moving On Project to deliver by 2014 Pathways developed by end Jan 11. New service spec and contracts developed during 2011/12 and issued from 1st April 2012.
Develop more **supported living** options and move on existing residents	**ASC Lead** **& Housing lead**	Housing; Access to Advocacy,	Moving on team requires investment (spend	Improved quality of life outcomes; increased independence;	SL model developed and approved by end

➢ Moving On Project (SL Pilot) ➢ Develop pathway for accessing housing options ➢ Develop SL model and specifications ➢ Develop new contractual processes to replace block contract approach ➢ Commission floating support services ➢ Review current high cost SL packages, using Care Funding Calculator and renegotiating existing contracts/retendering	**(via SL Project Board)**	Welfare Rights & enablement Access to primary care and community health services including outreach Contracts input; Care Pathways Personal budgets (& RAS) Supporting People	to save) to deliver cashable savings in future years	maximised life opportunities of both service users and carers; Achieve targets to move people on from existing residential placements as outlined above; fewer new admissions to res care; shorter lengths of stay in res care; more people supported to live at home. Services delivering better value for money and greater efficiency.	of November 10; Pathways developed by end Jan 11; New floating support services commissioned by end 2011/12 (linked to moving on project); Moving On project completed by 2014; Existing services reviewed and, where necessary, re-tendered during 2010/11; new contracts issued April 2012.
Refresh and develop plan for next phase of remodelling in-house **Social Inclusion**	**Planning Officer**	Market development and ability of vol	Reinvestment of existing budget into personal	More people supported appropriately through	Refresh and new action plan in place by Mar

Team to continue development of flexible 24/7 services, supported employment and better market mix ➢ Refresh service spec ➢ Decide procurement route		sector to develop capacity; Advocacy; Workforce development; Link to supported employment developments Link to Carers Strategy;	budgets and in line with overall PCT and LA budget strategy	accessing universal services and low level targeted community services; more people in or moving towards employment; implementation of workforce changes and resolution of issues; Improved quality of life outcomes; increased independence; maximised life opportunities of both service users and carers;	2011; Complete delivery by Mar 2012.
To improve **data accuracy, and performance monitoring**	**commissioning leads**	Data systems; IT; performance management;	Within budget strategy	improved commissioning intelligence, more effective decision making	2011/12
Development of **quality monitoring** and QA processes, especially for	**Commissioning leads**	better co-ordination of quality related information;	Within budget strategy	improved commissioning intelligence, more effective decision	2011/12

social care		contractual requirements relating to customer feedback and quality audits		making	
Put in place a **Market Development Plan,**	**Transformation Group on Market Development**	Contracting, contract monitoring, procurement	Within budget strategy	Improved market capacity; better partnership working with providers; mitigation of risks.	2011/12
Put in place a **workforce development plan**	**Head of workforce development**	Working with independent sector, LPT and in-house services	Within budget strategy	Workforce skilled up to meet future demands, improved recruitment and retention,	2011/12

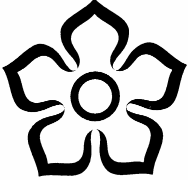
APPENDIX B

Risk Log

Risk No.	Date Raised	Risk Owner	Description of Risk	Impact on Project / Programme	Impact (I)	Probability (P)	Rating (I x P)	Risk Rating	Mitigating Actions	Target Resolution Date	Action Owner	Date Last Updated	Status
R - 1	15.9.10	Director of commissioning	gap in the LA commissioning infrastructure and potential delay in filling lead commissioner post	no leadership to drive forward the programme and slippage in delivery, with financial implictions	3	2	6	High	Interim lead commissioner appointed for 2 days week until Dec 20101; New structure approved by SLT but risk wont reduce until post advertised	31st Dec 20101	Dir of Commissioning	21.9.10	No Change
R - 2	15.9.10	PCT Dir of ommissioning	NHS White Paper and related interim changes to local commissioing arrangements	loss of continuity in leadership from PCT resulting in slippage	3	2	6	High	planned handover inthe event of change of lead	31st October 2010	PCT Dir of Commissioning	21.9.10	No Change
R - 3	15.9.10	Lead Commissioner	concerns about accuracy of data and information	impacts on assumptions contained in delvery plans	2	2	4	Medium	Project Groups will double check information; to addressin commissioiing cycle	31st March 2011	lead commissioners	21.9.10	No Change
R - 4	15.9.10	service manager	risk averse practice and staff anxieties about changes	failure to reduce reliance on residential care	3	1	3	Medium	Staff Communication Plan and cultural change	31st March 2011	service manager	21.9.10	Decreasing
R - 5	15.9.10	Director of commissioning	components of personalisation, ASC transformation, JCS and efficiancy plans not joined up	failure to implement changes	2	1	2	Low	lead commissioner working closely with ASC redesign prgramme	31st March 2011	Dir of Commissioning	21.9.10	No Change
R - 6	15.9.10	Lead Commissioner	resitance to change from exisitgn providers, service users, staff, carers, clinicians	failure to implement changes	2	2	4	Medium	Communication Plan	31st Dec 20101	lead commissioners	21.9.10	Decreasing

R - 7	15.9.10	Director of commissioning	proposed changes not approved by Cabinet; resistance from politicians to change traditional service delivery or support outsourcing	failure to implemet	3	3	9	High	Link to budget setting process	31st March 2011	Dir of Commissioning	21.9.10	No Change
R - 8	15.9.10	PCT commissioner	NHS White Ppaer and lack if engagement from GPs	difficulty in implementing changes to health services	2	1	2	Low	Commication Plan and leadership from clinical champion; priorities taken to clinical cabinet 23rd Sept	31st Dec 20101	PCT Commissioner	21.9.10	No Change
R - 9	15.9.10	Director of commissioning	impact of public sector cuts	reduced availability of universal services to support people in the community	3	3	9	High	Link to budget setting process	31st March 2011	Dir of Commissioning	21.9.20	Increasing
R - 10	15.9.10	Lead Commissioner	some new services cost more than residential services	supported living options are not affordable	2	2	4	Medium	more robust SL model implemented; use of RAS and tighter contrals for approving new developments, using business case process	31st March 2011	lead commissioners	21.9.10	No Change
R - 11	15.9.10	Lead Commissioner	lack of capacity within vol sector to meet demands	slippage on development of supported living opportunities	2	2	4	Medium	Market Development Plan; reinvestment of resources as traditional services are decommissioned	31st March 2011	lead commissioners	21.9.10	No Change
R - 12	15.9.10	Head of workforce development	potential gaps in current workfroce regarding skills and skill mix	unable to deliver new ways of working	2	2	4	Medium	development of Workforce Development Plan	31st March 2011	head of workforce development	21.9.10	No Change

R - 13	15.9.10	head of contracts	current contract arrangements aren't aligned to new ways of working	slippage in delivery	2	2	4	Medium	implementation of new contracts and contractual arrangements	31st March 2012	head of contracts	21.9.10	No Change



WARDS AFFECTED
All

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:

Scrutiny Committee	**5 April 2011**
Cabinet	**11 April 2011**

ANNUAL CONSULTATION ON ADMISSION ARRANGEMENTS FOR ENTRY IN 2012/13

Report of the Strategic Director, Children

1. Purpose of Report

1.1 As the Admission Authority for Community and Voluntary Controlled Schools in the City, Leicester City Council is required to consult upon and publish its admission arrangements for entry to schools in September 2012/2013 by 15 April 2011.

1.2 This report briefs Cabinet on the outcome of the recent consultation exercise on the admission arrangements for 2012/2013.

2. Recommendations

2.1 Recommendations for consideration are detailed in Section 4 and are summarised below.

2.2 Comments from the Children and Young People Scrutiny Committee will be considered by Cabinet.

2.3 Cabinet is asked to approve the admission arrangements for the academic year 2012/2013, incorporating the proposed changes which were consulted upon as detailed below:

-Increase the Admission Number at Mellor Primary School to 90.
- Support the principle of federated schools.
- Remove extended closing dates and maintain a single National Closing Date.

3. Summary

3.1 As the admission authority for the Community schools and the Voluntary Controlled school in the city, the Council must consult annually on admission arrangements to its schools.

3.2 The Consultation took place between 22 December 2010 and 28 February 2011 and was carried out by way of a Public Notice, circulation to all schools via the Extranet, and publication on the Council website.

3.3 No comments have been received on the proposal to increase the Published Admission Number at Mellor Primary School. One comment has been received from Beaumont Leys against the federation proposal; one request from Catherine Junior School that its Published Admission Number should be reduced; one comment from Green Lane Infant School suggesting that children who have a sibling attending the nearby (but not linked) junior school should have priority when applying for an F2 place in an infant school; one comment from Abbey Primary School to increase their Published Admission Number and one comment from a parent requesting a change in their priority area. There have been no responses relating to the policies of Voluntary Aided, Trust or Free Schools.

Proposer	Comment	Outcome
Governing Body at Beaumont Leys School	Concern that 'popular' schools take all students thus weakening the position of schools with falling rolls	Each individual federation would require formal consultation and the Authority will have the opportunity to assess the impact of each request before implementation.
Catherine Junior School	Requested a decrease in their Published Admission Number from 110 to 90	Unable to authorise due to current numbers in the adjacent Infant School currently exceeds 90 and the requirement for school places in that area.
Green Lane Junior School	Requested sibling priority from FS1 to FS2 if they have a sibling at a Junior School near by but not linked.	Not applicable as a number of schools occupy same priority area.
Abbey Primary School	Request to increase their Published Admission Number as potential housing development in area	Unable to comply due to sufficient capacity in neighbouring schools and no decision on housing development location taken.
Parent	To review the Priority Area lines for Primary Schools.	Project to review both Primary and Secondary Priority Areas commenced 1 March 2011

4. Report

4.1 Proposed changes

4.1 The general information about Leicester's policies and arrangements for School Admissions can be found within out three information booklets (*Starting School, Transfer to Junior School,* and *Transfer to Secondary School*). These booklets can be obtained from the School Admissions Service and are available online at www.leicester.gov.uk/admissions

4.2 Proposed changes to the admissions arrangements for the academic year 2012/2013 for Community and Voluntary Controlled schools in the City of Leicester are as follows:

4.2.1 Change the Published Admission Number at Mellor Primary School.
It is proposed that the admission number at Mellor Primary School should increase to 90 due to the fact that classroom building works have increased the capacity of the school.

School	**Current PAN 2011/2012**	**Proposed PAN 2012/2013**	**Rationale**
Mellor Primary School	60	90	To reflect the physical capacity of the site and built environment

4.2.3 The Council supports the principle of federated schools within the City and would seek to give existing children a higher preference for a school place at another school within the federation (whilst taking into account the requirements for Looked After Children and children subject to protection plans). This will result in children at a federated school being allocated as Criteria 3. If a specific Federation is planned, the council will consult on the specific admission arrangements for the schools involved. This principle is only in relation to admission to schools.

4.2.4 Maintain the single National Closing Dates for receipt of applications. Remove the extended closing dates for children moving into or within Leicester after the National Closing Dates to comply with the legal requirements in the School Admissions Code – Secondary Transfer applications.

4.2.5 Maintain temporary increase in Published Admission Numbers in the following schools, subject to admission pressures and parental preference and capacity in the surrounding area:

Kestrels' Field Primary School - 10
Eyres Monsell Primary School - 15
Braunstone Community Primary School - 15
Scraptoft Valley primary School – 15

Should the temporary increase in 2010/2011 Published Admission Numbers be perpetuated, formal consultation to make the increase permanent will take place in the next Annual Consultation of Admission Arrangements.

5. Financial, Legal and other Implications

5.1 Financial Implications

There are no specific financial issues arising from this report.
Colin Sharpe, Head of Finance, Investing in our Children, Tel: 0116 252 7750

5.2 Legal Implications

In relation to the increase in Admission Number outlined at 4.2.1 consultation has been required due to the fact that the increase exceed the limit of 26 places (1.19 Admissions Code 2010)

The temporary increases to Admission Numbers outlined at 4.2.5 will have to be the subject of formal consultation where the temporary increases cumulatively (in each school) amount to more than 26 places extra being offered over 3 years. The report identifies that this trigger point would be reached for next year's consultation round.

The proposal is to make the "Federated School" criteria number 3 in the rank order is potentially justified under paragraphs 2.16a) and 2.72 of the Admissions Code if the schools are designated as named feeder primaries, and also as long as they do not breach paragraph 1.72 of the Code by unfairly disadvantaging social or racial groups or a child with disabilities or special educational needs. Policies should also aspire to promote social equity. Such proposals would need to be properly consulted upon on the future.
Kamal Adatia, Barrister, Head of Community Services Law, Leicester City Council, Tel: 0116 252 7044

5.3 Climate Change Implications

This report does not contain any significant climate change implications and therefore should not have a detrimental effect on the Council's climate change targets.
Helen Lansdown, Senior Environmental Consultant - Sustainable Procurement , Tel: 0116 252 6770

6 Other Implications

OTHER IMPLICATIONS	YES/ NO	Paragraph/References Within the Report
Equal Opportunities	YES	Section 4.1
Policy	NO	
Sustainable and Environmental	NO	
Crime and Disorder	NO	
Human Rights Act	NO	
Elderly/People on Low Income	NO	
Corporate Parenting	NO	
Health Inequalities Impact	NO	

7 **Background Papers – Local Government Act 1972**

Consultation with schools on Annual Admission Arrangements 2012/13

8 Consultations

Consultation was carried out from 4 January 2011 to 1 March 2011 in accordance with statutory requirements. A Public Notice was issued and details of the consultation circulated to all schools. An on-line response Form was posted on the Council's website.

9 Report Author

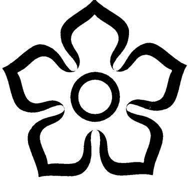
Cathy Dobb
Head of School Organisation and Assets
Tel: 0116 221-654, 39 1654 email: cathy.dobb@leicester.gov.uk

Dr Trevor Pringle
Divisional Director
Planning & Commissioning
Tel: 0116 252-7702, 29 7702

Key Decision	Yes
Reason	Is significant in terms of its effect on communities living or working in an area comprising more than one ward
Appeared in Forward Plan	Yes
Executive or Council Decision	Executive (Cabinet)

This page is left blank intentionally.

Appendix C



WARDS AFFECTED
Type in Ward

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:

Scrutiny	**5th April 2011**
Cabinet	**11th April 2011**

Outcome of the Unannounced Safeguarding Inspection 2010

Report of the Strategic Director, Children

1. Purpose of Report

1.1 To advise on the outcome of the Ofsted Unannounced Safeguarding Inspection of Duty and Assessment Services in Social Care and Safeguarding Division on 16th and 17th November 2010.

1.2 To summarise the findings of the Inspection, the recommendations and the response of the Division.

2. Summary

2.1 The Social Care & Safeguarding division was subject to an unannounced Inspection by Ofsted on 16th and 17th November 2010. The findings were made public on 15th December. This Inspection was the second annual unannounced inspection completed by Ofsted and followed on from the first inspection carried out in August 09. These inspections are being undertaken across the country as a response to the Case of Baby 'P' and the subsequent findings of the Ofsted Inspection of Haringey Council in London in 2008. Inspectors focused on Frontline Duty and Assessment Services with a particular emphasis on whether children and the work being done with them and their families by social work staff was safe, timely and minimized risk.

2.2 The Inspection concluded that there were no areas for priority action, 3 areas of strength and 6 areas for further development. A finding of an area for priority action means that there is a significant shortfall in service and one that may place children at risk. A significant difference from the previous inspection is that in highlighting areas of strength Ofsted are now stating that these areas of strength are noteworthy on a national basis. Ofsted also stated that: "The areas of development identified at the previous inspection of contact, referral and assessment arrangements in August 2009 have been addressed in part or fully".

2.3 Progress has been made with all of the areas of development, and most have been effectively addressed.

2.4 This Inspection was particularly positive for us given the very significant rises in demand particularly referrals and complexity of child protection work to the Authority over the last 2 years. This has been recognised by the Council as a priority area and one where additional investment and budget protection has been agreed at a time of considerable budget reductions overall.

3. Recommendations

3.1 That Cabinet notes the findings of the inspection and in particular the considerable strengths of the service as identified by the Inspectors and the hard work and dedication of staff who helped ensure the inspection was a success.

3.2 That Cabinet notes the identified areas for development, the steps being taken in relation to some of the areas identified and the intention to ensure that all areas so identified are actioned as soon as possible.

4. Report

4.1 On the 16th and 17th November 2010 Ofsted conducted an Unannounced Inspection of contact, referral and assessment arrangements within Leicester City Council Children's Services and specifically within the Social Care and Safeguarding Division.

4.2 This Inspection was the second annual unannounced inspection completed by Ofsted. These inspections are being undertaken across the country as a response to the Case of Baby 'P' and the subsequent findings of the Ofsted Inspection of Haringey Council in London in 2008. The Inspections are designed to determine whether a Council's initial response to issues of risk to children are adequate and that the Council delivers a safe service in accordance with national guidance.

4.3 The Outcome of the Inspection significantly contributes to Ofsted's annual review of the performance of the Authority's Children's Services.

4.4 The inspection was rigorous and robust, and was led by three Inspectors over two days. It involved sampling the quality and effectiveness of contact, referral and assessment arrangements and their impact on minimising the incidence of child abuse and neglect. Inspectors considered a range of evidence, including: electronic case records; supervision files and notes; observation of social workers and senior practitioners undertaking referral and assessment duties; and other information provided by staff, managers and professionals from some partner agencies. Inspectors also spoke to a range of staff including managers, social workers, other practitioners and administrative staff.

4.5 Outcome of the Inspection

4.5.1 Overall the Inspection identified no areas for priority action, 3 areas of strength and 6 areas for further development.

4.5.2 From the evidence gathered, the inspection also identified a number of areas where the contact, referral and assessment arrangements were delivered satisfactorily in accordance with national guidance.

i) Child protection enquiries are prioritised, with effective action taken by the response team. Section 47 enquiries are always undertaken by qualified social workers in a timely way, resulting in clear outcomes, and urgent action is taken when required.

ii) Inter-agency thresholds are applied appropriately resulting in a balanced provision of assessment and services through the common assessment framework and the children in need arrangements. The substantial increase in children with identified needs has impacted on all stages of intervention.

iii) Procedures and practice to protect children and manage risks are appropriately established and implemented. Additionally there are specifically targeted procedures and approaches, for example in situations involving child trafficking, sexual exploitation and honour based violence.

iv) The qualified and experienced practitioner workforce in the duty and assessment and disabled children's teams is well established and skilfully provides consistently effective outcomes. Staff have challenging but manageable workloads.

v) There are constructive and robust inter-agency relationships between social care and key partner agencies resulting in appropriate information sharing and contributions to assessments and plans.

vi) Senior managers use a range of quality audit, case monitoring and performance assessment mechanisms to identify and report on the effectiveness of service processes, arrangements and workforce related issues. These inform and support service improvement plans.

vii) Out-of-hours duty arrangements are responsive and timely, addressing risks to children in an appropriate way. There are also good links to daytime services, although the emergency duty team does not have the facility to record outcomes of interventions directly into the central database.

4.5.3 Strengths Identified

i) The views, wishes and feelings of children are given significant priority. Substantial efforts are made to enable and ensure that all children are fully engaged in assessment processes. Examples of excellent practice were seen where practitioners sought the child's view in challenging circumstances and fully represented them even where the views were contrary to the professional assessment of risk.

ii) Supervision is of a high standard being regular, assured, clearly recorded and supportive of practitioners' performance, enabling critically reflective consideration of practice. It is further linked to a wide range of other training and developmental opportunities including a strong focus on supporting the development of newly qualified social workers. This is a particularly significant area to have been identified as a strength as in 2009 it was identified as an area for development. It demonstrates the considerable progress made in this area in only a year.

iii) Very good, timely responses are made by experienced practitioners in the Disabled Children's Team to address child protection concerns. The service is further strengthened by practitioners regularly and effectively screening referrals across the duty and assessment service for any concerns regarding other disabled children.

4.5.4 Areas for Development Identified

i) There is still insufficient managerial oversight of those contacts and referrals that do not proceed to either initial assessment or to child protection enquiries. This was one aspect of an area for development at the previous unannounced inspection.

ii) Assessments continue to be variable in quality. Many fail to sufficiently or clearly identify risk factors, or evaluate the impact on the safeguarding needs of children within an analysis of risks, strengths and needs. This was an area for development at the previous unannounced inspection.

iii) The ethnicity, religion and culture of children are well recorded and their importance is recognised by practitioners, resulting in some good examples of sensitive and insightful work. However, the specific impact of these factors on the strengths and vulnerabilities of individual children is not consistently considered in assessments.

iv) Child protection strategy discussions between social care and the police child abuse investigation unit are inappropriately used as a means of general information sharing outside of Section 47 enquiries. While records of these discussions are kept they are not routinely shared.

v) There is an absence of an effective screening mechanism to address the many domestic violence notifications, adding unnecessary pressures to the duty and assessment service.

vi) There had been some delays in starting and completing a small number of child in need assessments. While not initially indicating a risk of harm, some initial assessments subsequently identified child protection concerns.

4.6 Response to the Inspection

4.6.1 The Division and Children's Services have accepted the Inspection findings as accurate and in accordance with our own evaluation of our services. We are particularly pleased that the hard work and commitment given by our staff has been recognised by Inspectors and that staff have continued to deliver a quality service despite a difficult national climate regarding child protection and social work in general. The Division also accepts the areas for development and has already taken a number of steps to address the issues identified.

4.6.2 <u>Action already taken in relation to developmental areas</u>

i) The inspectors again highlighted an issue of managerial oversight in relation to those referrals where the service makes a decision not to take further. The Division did recognise this issue at our first inspection and subsequent to that inspection had initiated a review of the Duty and assessment structure which reported in December 2010 just after the second inspection. We will be making changes to our Assessment structure from April of 2011 which aims in part to ensure that there is greater managerial capacity to ensure oversight and that all signoffs of referral will have to be authorised electronically by a manager from that point.

ii) Variable assessment quality is being addressed through the division's series of case file audits and senior management inspections of teams. Our findings indicate that whilst we believe that our assessments are robust, staff in some cases are not providing sufficient detail in their written work of the 'thinking' behind their findings and recommendations. This is an ongoing area of work development where we expect and will need to see further improvements.

iii) The impact of cultural and diversity issues not being consistently considered in assessments is in a similar vein to the previous issue. This has also been recognised in our internal inspection work and all team managers have had their attention drawn to this area as one which they need to ensure is clearly present in all our assessments. It would also be fair to say that whilst there are gaps here we have also seen some very good examples of how culture and diversity issues have been included in assessments and subsequent work with service users.

iv) Use of Strategy discussions between the Police and Social Care. The purpose of such discussions is to plan whether and how we will jointly approach a child protection investigation. The inspectors felt that in the two discussions that they observed we and the police should have been more focused and not used the discussion for more general information sharing. We accept this and will shortly be introducing an agreed format for recording of strategy discussions designed to ensure that all the salient issues and points are both discussed and recorded electronically. This will be used from March 2011.

v) The inspectors noted an absence of an effective screening mechanism to address Domestic Violence notifications. This essentially is a matter for the police, who currently notify our Duty and Assessment service of every domestic violence incident irrespective

of whether children are involved or not. The head of safeguarding is in dialogue with the Police about this matter.

vi) The Inspectors identified some delays in starting and completing a 'small' number of assessments. We expect that this will to be addressed in our re-structure of the Duty and Assessment Service. Increased managerial oversight should ensure that all assessments are started in a timely manner.

4.7 Overall the Inspection determined that our services in Duty and Assessment were child focused, timely in their responses and sought to identify and minimise risk through concerted and co-ordinated intervention by skilled and motivated staff. We are particularly pleased that a development area identified in the first inspection, supervision of staff, has now been identified as strength in the second inspection.

5. FINANCIAL, LEGAL AND OTHER IMPLICATIONS

5.1 Financial Implications
There are no financial implications arising from this report.
Colin Sharpe, Head of Finance, ext 7750

5.2 Legal Implications
There are no direct legal implications arising from this report. Whilst Safeguarding obligations are heavily intertwined in statutory and case law principles, the inspection report acknowledges that the Safeguarding Division has robust practices in this regard and strong links with the Legal Division.
Kamal Adatia, Barrister, ext 7044

5.3 Climate Change Implications
This report does not contain any significant climate change implications and therefore should not have a detrimental effect on the Council's climate change targets.
Helen Lansdown, Senior Environmental Consultant - Sustainable Procurement

6. Other Implications

OTHER IMPLICATIONS	YES/NO	Paragraph References Within Supporting information
Equal Opportunities	No	
Policy	Yes	Entire report
Sustainable and Environmental	No	
Crime and Disorder	No	
Human Rights Act	No	
Elderly/People on Low Income	No	
Corporate Parenting	No	
Health Inequalities Impact	No	

7. Background Papers – Local Government Act 1972

None.

8. Consultations

None.

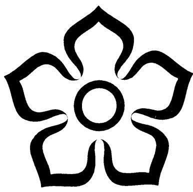
9. Report Author

Peter McEntee, Head of Service, Children's Fieldwork, Social Care & Safeguarding
0116 2568252

Andy Smith, Divisional Director, Social Care & Safeguarding
0116 25238306

Key Decision	Yes
Reason	Is significant in terms of its effect on communities living or working in an area comprising more than one ward
Appeared in Forward Plan	Yes
Executive or Council Decision	Executive (Cabinet)

This page is left blank intentionally.



Appendix D

WARDS AFFECTED
All Wards

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:
Cabinet **11 April 2011**

Arrangement For Extending The Services Contract With Leicester Shire Connexions Service Limited

---

Report of the Divisional Director (Access, Inclusion & Participation)

1. Purpose of Report

1. i) To advise Cabinet of the current position regarding Leicester Shire Connexions Service Limited ("Connexions").

ii) To seek approval for the recommendations extending the services contract between Leicester City Council, Leicestershire County Council and Connexions for the provision of the Connexions Services (the "Services Contract") for 6 months from 1st April 2011 (with an option to extend further to 31 March 2012) and make consequential amendments to its Members' Agreement.

2. Recommendations

2.1 It is recommended that the Strategic Director, Children and Young People's Service in consultation with the Director, Legal Services is authorised:

(a) To agree and enter into a Deed of Variation to extend the term of the Services Contract for the period 1st April 2011 to 30th September 2011.

(b) To agree an option within the Deed of Variation to further extend the Services Contract for the period 1st October 2011 to 31st March 2012 and exercise that option where the Strategic Director, Children and Young People's Service, considers it appropriate.

(c) To agree as part of the Deed of Variation Business Plans to detail the extent of the Connexions Service under the Services Contract (as extended) and the Service Fee to be paid in consideration for its performance by the Council.

3.1 Summary

3.1 The three year Services Contract with Connexions is due to expire on 1st April 2011 and the proposed Deed of Variation will provide for extension by agreement of the parties.

3.2 It is anticipated that legislation will be passed this year, establishing all age careers services. In this event, Connexions would need to evolve in order to meet this

expectation and therefore another three year contract would not be deemed appropriate.

4. Report

4.1 The Coalition Government has stated its intention to introduce an all age Careers Service. Currently adult careers guidance is provided through Next Steps and locally delivery is on an East Midlands regional basis. The new all age service is intended to start in September 2011, with full implementation from April 2012. Councils will receive funding through the new Early Intervention Grant from April 2011 to support transitional arrangements to ensure that young people have access to impartial careers guidance in advance of the all-age careers service being fully operational. In the medium to longer term, as the Government maintains the commitment to raise the participation age to 18 by 2015, the grant will help local authorities to support vulnerable young people to engage in education and training, intervening early with those who are at risk of disengagement.

4.2 It is acknowledged that Government proposals will involve a change in the role of local authorities who are currently responsible for ensuring all young people receive careers guidance through the Connexions service. It is intended that the schools inspectorate will carry out a thematic review of careers education and guidance prior to the implementation of any new arrangements.

4.3 The government intends to revitalise the professional status of careers guidance, establishing a register of providers and kite mark quality assurance system, with progress overseen by the careers profession taskforce. It is anticipated that the role of schools will be central to working in partnership with providers to ensure access to independent careers advice for all school pupils. Local Authorities will maintain a responsibility for ensuring vulnerable young people participate in education, training and employment, and for maintaining accurate data on participation to ensure that support is appropriately targeted.

4.4 The Education Bill proposes a duty on schools to secure independent and comprehensive advice and guidance for pupils (and on LAs to provide in PRUs) and the duty on LAs to ensure both core and additional entitlements to diplomas is revised to only include core entitlements and no longer includes 14 – 19 diplomas at KS4. Schools will no longer have a duty to allow access to Connexions staff, whilst the local authority will retain a duty to make available services that they deem appropriate to young people, to encourage, enable or assist them to stay in education.

4.5 The present three year contract for Connexions Leicester Shire is due to expire on 31 March 2011. Given the proposed changes to both future funding and models of delivery, early consideration will need to be given in partnership with schools, to future commissioning arrangements beyond September 2011.

5. FINANCIAL, LEGAL AND OTHER IMPLICATIONS

5.1 The report reflects Government proposals for the future of careers services, which will clearly impact upon councils, schools and Connexions companies. This impact cannot be accurately quantified at this time, and should become clearer with details of the Government's plans. The Council's core budget in 2011/12 for planning purposes ahead of the future changes is £3.163m, therefore a contract for the first half of the year would be to the value of £1.582m. It should be noted that this is some 15% less

than the original 2010/11 funding, as approved in the 2011/12 budget set by Council. - Colin Sharpe, Head of Finance, Investing in Children, ext. 29 77502

5.2 The Connexions Service can be re-procured from Leicester Shire Connexions Service Limited without the need to go to the market because it is a *Teckal* company (effectively an internal department of both the City and County Councils). It is recommended that legal advice is sought during future consideration of the Connexions Service beyond September 2011. Advice on the broader aspects of the future of the Connexions Service was provided to officers in December 2010 for further consideration by the Leadership Team and Lead Member.

6. Other Implications

OTHER IMPLICATIONS	YES/ NO	Paragraph/References Within Supporting information
Equal Opportunities	Yes	Access to Information, Advice & Guidance
Policy	Yes	Supports narrowing the gap
Sustainable and Environmental	No	
Crime and Disorder	Yes	Rehabilitation of young offenders
Human Rights Act	No	
Elderly/People on Low Income	No	
Corporate Parenting	Yes	Supports LAC services
Health Inequalities Impact	Yes	Currently some targeted health services

Climate Change Implications

6.1 This report does not contain any significant climate change implications and therefore should not have a detrimental effect on the Council's climate change targets.

Helen Lansdown, Senior Environmental Consultant - Sustainable Procurement
29-6770

7. Risk Assessment Matrix

Risk	Likelihood L/M/H	Severity Impact L/M/H	Control Actions (if necessary/appropriate)
1. Uncertainty regarding future funding arrangements leading to current provision being at risk beyond March 2011.	High	High	Dialogue with Connexions, schools and County Council in regard to future delivery models.
2. Core funding for IAG transfers to schools' budgets without additional funding for specialist support for targeted groups.	Medium	High	Discussion with both Connexions and County Council in relation to maintaining joint funded services for targeted groups from 2011/12.

3 Financial liabilities in relation to potential redundancy payments, together with projected pension fund short-fall within Connexions Service.	High	High	Detailed legal and financial advice being sought on behalf of both City and County Councils.

8. Background Papers – Local Government Act 1972

Learning and Skills Act (2000)
Education and Skills Act (2008)
Employment and Training Act (1973)
Education Bill (2011)

9. Consultations

Chief Executive, Leicester Shire Connexions
Leicestershire County Council Children's Leadership Team
Greg Surtees, Senior Solicitor, Legal Services

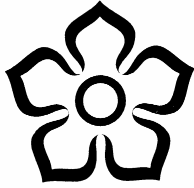
10. Report Author

David Thrussell
Head of Leicester City Youth Offending Service & Youth Service
Ext: 29 6506

Andrew Bunyan
Divisional Director, Access, Inclusion and Participation
Ext: 29 7704

Key Decision	Yes
Reason	Is significant in terms of its effect on communities living or working in an area comprising more than one ward
Appeared in Forward Plan	Yes
Executive or Council Decision	Executive (Cabinet)

Appendix E



WARDS AFFECTED
All Ward

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:

OSMB	**7th April 2011**
Cabinet	**11th April 2011**

Illegal Money Lending and Delegation of Powers to Birmingham City Council

---

Report of the Strategic Director, Development, Culture and Regeneration

1. Purpose of the Report

To approve the delegation of enforcement and prosecution powers to Birmingham City Council to enable the Illegal Money Lending Section within Birmingham Trading Standards (IMLS) to undertake investigations into illegal money lending in the Leicester City area and take appropriate enforcement actions.

2. Recommendations

Cabinet are recommended to:

2.1 Delegate to Birmingham City Council the discharge of the enforcement function and powers under the Consumer Credit Acts 1974 and 2006 and any legislation which amends or succeeds the same, including any secondary legislation made there under in so far as they relate to illegal money lending in Leicester City and for such cases and investigations as are agreed between the Authorities.

2.2 Delegate to Birmingham City Council, for the exercise of this function and in so far as the law allows, powers in respect of any associated offence which may become apparent under other legislation or at Common Law including, but not limited to:

- The Administration of Justice Act 1970
- The Business Names Act 1985
- The Consumer Credit Act 1974
- The Criminal Attempts Act 1981
- The Criminal Justice and Police Act 2001
- The Criminal Law Act 1977
- The Fraud Act 2006
- The Malicious Communications Act 1988
- Consumer Protection Act 1987
- Offences Against the Person Act 1861

- Theft Act 1968 and 1978
- Proceeds of Crime Act 2002
- Perverting the course of justice
- False imprisonment
- Kidnap
- Blackmail

2.3 To authorise the Divisional Director Environmental Services to sign the Protocol subject to the Head of Legal Services being satisfied as to its contents.

2.4 To authorise the Divisional Director Environmental Services to agree any amendments to the Protocol in the light of how the project develops, subject to consultation with the Cabinet lead.

3. Introduction

3.1 Money lending in the UK is subject to statutory requirements and compliance is controlled by the Financial Services Authority, the Office of Fair Trading and also by local authorities through their trading standards services. The statutory requirements apply to the whole business process from advertising, canvassing of loans, information provision, loan settlement and debt collection. The price of loans – the interest rates – while not subject to any statutory interest ceilings must not be extortionate and are challengeable in courts.

3.2 Money lenders must be licensed by one of the authorising bodies before they can trade and a license can be refused or subsequently removed if they are found to be unfit to work in this sector, for example, because they have convictions for fraud or assault.

3.3 Government funded pilot illegal money lending units in Birmingham and Glasgow have confirmed the existence of money lenders who are unlicensed and engaged in unfair conduct including the charging of extortionate rates of interest and using intimidation and violence to recover loans.

3.4 The Government estimates that as many as 10,000 households in the East Midlands are exploited by loan sharks every year and believes that many of these will be located in the cities of Leicester, Derby and Nottingham.

4. Illegal Money Lending Pilots

4.1 The illegal money lending pilot was set up in autumn 2004 in response to the 2001 Labour election manifesto commitment to tackle illegal money lending. Under the pilot, DTI funded two dedicated teams based in the Trading Standards Services (which have responsibility for enforcement against unlicensed lenders) in Glasgow City Council and Birmingham City Council, primarily to investigate offences of illegal money lending.

4.2 The work of the two illegal lending teams made a huge contribution to raising awareness of the nature and impact of illegal lending; understanding how best to tackle the problem; knowing where there are likely to be concentrations of illegal lending; and understanding the need to provide victims of loan sharks with help to access affordable credit and other sources of support.

4.3 Illegal moneylenders operate primarily in urban areas with high proportions of rented accommodation. They tend to target the most vulnerable in society, such as single mothers in receipt of benefits, people with drug dependency and people with mental health issues, although the profile of victims varies widely. Illegal lenders often impose penalty charges for missed payments and "top up" loans, with the result that borrowers do not know how much they need to repay nor for how long. Some loan sharks draw their victims into a criminal lifestyle if they are unable to pay their debts, for example receiving stolen goods, shop-lifting, providing false alibis and even prostitution. Investigations into illegal money lending have also uncovered offences relating to benefit and mortgage fraud, blackmail, drugs, firearms and counterfeit goods.

4.4 The evaluation of the pilots showed that the pilot teams had a clear impact in identifying cases of illegal money lending, instituting proceedings against illegal money lenders, and securing prosecutions (with others expected to follow

5. East Midlands Public Protection Project Team

5.1 In January 2007 the Government announced the funding of a network of regional Illegal Money Lending Units to tackle illegal money lending directly and to facilitate access to alternative sources of information, advice and finance. The Government envisaged these Units being delivered by local government and working in close with Trading Standards Services and partners.

5.2 In the absence of any suitable regional local government institutional vehicle, Nottingham City Council volunteered to host the Illegal Money Lending Unit for the East Midlands and received the support of all the Heads of Trading Standards in the East Midlands.

5.3 In May 2008 Cabinet delegated enforcement of laws against illegal money lending to Nottingham City Council. An outline of their activity in Leicester is in Appendix B.

6. Establishment of the England Illegal Money Lending Team

6.1 On the 29 December 2010 Business Minister Edward Davey announced that £5.2 million in funds will be available to continue the national Illegal money lending project for 2011/12 through the trading standards service.

6.2 In addition, the minister also announced that the Department For Business Innovation And Skills (BIS) intended to restructure the illegal money lending regional network by creating a three national team model. The Minister indicated that BIS were looking to maintain front line services whilst providing a value for money project.

6.3 Birmingham City Council were chosen to host the England team and provide the capability to investigate illegal money lending across England. The decision was made on the basis of the efficiencies associated with the expansion and the excellent track record of the Birmingham unit.

6.4 Since its establishment the Birmingham Unit has:

- Identified over 1,700 illegal lenders

- Arrested over 500 illegal money lenders (loan sharks)
- written off over £37 million of illegal debts (money victims would have paid back to illegal lenders if the had not acted)
- secured over 182 prosecutions, resulting in prison sentencing totalling over 107 years and one indefinite helped over 16,000 victims of loan sharks including the most hard to reach individuals
- referred over 600 victims to alternate (legal) sources of financial support

6.5 The benefit that this team can bring to Leicester City is significant. Leicester City Council, like most local authorities, is not able to provide and sustain the level of specialist resource to deliver this function. This is a good example of how sharing resources on specific issues can bring benefits otherwise unavailable in providing support to vulnerable consumers and tackling rogues.

7. Delegation of Powers

7.1 The Consumer Credit Acts 1974, 2006 and associated legislation place duties on local authorities to enforce the provisions on those acts in their area and enable them to authorise their officers to utilise certain powers such as powers of entry to commercial premises, power to access and seize documentation, to undertake surveillance, to apply for warrants.

7.2 The duties of a local authority, and the officer powers that flow from them, are generally confined to tackling legislative breaches occurring in the geographical area. An officer of one local authority is not able to investigate a legislative breach that occurs in another local authority area.

7.3 Therefore, in order to benefit from this new consumer protection resource Leicester City Council, on the advice of Legal Services, must delegate the enforcement function to Birmingham City Council. This delegation will enable Birmingham City Council to authorise IMLS (TS) staff to undertake investigations in Leicester City and to commence associated legal proceedings including prosecution of offenders.

8. The Protocol and operational arrangements

8.1 The intended operational arrangements between BCC and LCC are documented in the **PROTOCOL FOR ILLEGAL MONEY LENDING SECTION INVESTIGATIONS** (see Appendix A) and, subject to the agreement of the Head of Legal Services, the Protocol will be signed by the Divisional Director Environmental Services. From time to time, changes may be necessary to the Protocol. These will be agreed by the Divisional Director Environmental Services following consultation with the Cabinet lead.

8.2 The Protocol contains the following key provisions:

- BCC will be liable for the competence and actions of all persons employed within the IMLS.
- BCC will brief LCC on any operations underway and their conclusion
- BCC and LCC may agree for LCC officers to be transferred to work with the IMLS
- BCC may withdraw the delegation at any time but not unreasonably
- LCC will appoint a Contact Officer to liaise with BCC

8.3 Leicester City Business Regulation will assist in investigations and, by agreement, investigations may be transferred to and from Leicester City Trading Standards Service for further action including legal proceedings.

8.4 Birmingham City Council and the IMLS will adhere to statutory codes of practice including those relating to the use of regulatory powers, surveillance and information processing and disclosure.

8.5 The Divisional Director Environmental Services recommends that Cabinet approve the recommendations as set out in paragraph 2.

9 Financial Implications

9.1 Birmingham City Council are hosting the ILMS and are responsible for its financial management.

9.2 Funding for the East Midlands Illegal Money Lending Unit is being provided from the Government's Financial Inclusion Fund and will cease at the end of March 2011. There are no financial implications for Leicester City Council.

9.3 The funding agreement between Birmingham City Council and HM Treasury covers all the running costs of the ILMS and provisions to cover the costs of expected legal proceedings and no resources will be required from Leicester City Council.

Martin Judson, Head of Finance, x297390

10 Legal Implications

10.1 Section 161 of the Consumer Credit Act 1974 requires each local weights and measures authority to enforce the provisions of that Act within their local authority boundary. Under the provisions of the Local Government Act 2000 and the Local Authorities (Functions and Responsibilities) (England) Regulations 2000, it is necessary for the Cabinet, as the current Leicester City Council Executive to formally delegate this function to Birmingham City Council under sections 13 and 19 of the Local Government Act 2000 and the Local Authorities (Arrangements for the Discharge of Functions) (England) Regulations 2000

10.2 The enforcement Powers under the various consumer credit acts and associated legislation is an Executive Function and requires Cabinet approval for its delegation to another local authority.

10.3 Delegation of the enforcement Powers in respect of illegal money lending is necessary from Leicester City Council to Birmingham City Council in order to enable Birmingham City to properly authorise its employees to undertake investigations, including surveillance, in the area of Leicester City and to commence legal actions against identified offenders and their assets.

Anthony Cross, Head of Litigation, x296362

11 Other Implications

OTHER IMPLICATIONS	YES/NO	Paragraph References within this report

Raising Standards	NO	
Equal Opportunities	NO	It is often the poorer and more vulnerable members of society who become victims of illegal moneylenders and find it difficult to access appropriate support and help.
Policy	NO	
Sustainable and Environmental	NO	
Crime and Disorder	YES	4.5, 5.2 Illegal moneylenders invariably target low-income households and the most vulnerable members of society. This can mean that their activities have disproportionate implications for the more deprived areas and action taken against them therefore supports the policy priorities associated with crime and disorder and protecting the more vulnerable members of the community. Illegal money lending has a serious detrimental effect on both individuals and the community. Tackling the root causes and providing legitimate alternative sources of credit will contribute to reducing stress and pressures on many individuals and communities. Marginalising rogue traders creates an environment which supports and encourages legitimate credit providers and reduces the fear of crime.
Human Rights Act	YES	6.3 Birmingham City Council as a public body complies with HRA, DPA, RIPA.
Elderly/People on Low Income	YES	4.3
Corporate Parenting	No	
Health Inequalities Impact	No	

12.

RISK ASSESSMENT MATRIX			
Risk	**Likelihood L/M/H**	**Severity Impact L/M/H**	**Control Actions (if necessary/or appropriate)**
Breaches of investigation	L	M	IMLS reports on current investigations channelled through

confidentiality			LCCCO.
Threats to health & safety of victims and officers	M	H	Assured confidentiality for complainants and data; Single Points of Contact between local authority and IMLS; secure liaison with police and other law enforcement agencies through LCC Intelligence Officer; documented protocols.
Inappropriate use of investigatory powers in Leicester	L	L	Recruitment of suitably qualified and trained staff and managers; specialist legal advice available.
Disproportionate use of statutory sanctions against Leicester based offenders	L	M	Application of the Regulators Compliance Code and Prosecutors Code.

L - Low	L - Low
M - Medium	M - Medium
H - High	H - High

13. Background Papers – Local Government Act 1972

Illegal Money Lending and Delegation of Powers to Nottingham City Council, Report of the Corporate Director (Regeneration and Culture), Cabinet 12 May 2008

14. Consultation

Heads of Trading Standards for Leicestershire County Council, Northamptonshire County Council, Derbyshire County Council, Lincolnshire County Council, Nottingham City Council and Derby City Council.

15. Report Author/Officer to contact:

Roman Leszczyszyn
Head of Business Regulation
Leszr001@leicester.gov.uk
0116 252 6590

Key Decision	No
Reason	N/A
Appeared in Forward Plan	N/A
Executive or Council Decision	Executive (Cabinet)

Appendix A

DEPARTMENT FOR BUSINESS INNOVATION AND SKILLS (BIS)
ILLEGAL MONEY LENDING PROJECT

PROTOCOL FOR ILLEGAL MONEY LENDING SECTION INVESTIGATIONS

Interpretation

For the purposes of this Protocol –

"BCC" means Birmingham City Council

"LCC" means Leicester City Council

"IMLS" means the Illegal Money Lending Section

"Delegated Power" means the discharge of the function of the Enforcement of Part III of the Consumer Credit Act 1974 granted to BCC by LCC in pursuance of section 101 and 222 of the Local Government Act 1972, Regulation 7 of the Local Authorities (Arrangements for Discharge of Functions) (England) Regulations 2000, sections 13 to 19 of the Local Government Act 2000 and any other legislation enabling the discharge

"Commencement Date" means the date the Delegated Power is granted

"Term" means from the date of signing of this protocol to 31st March 2015

"Birmingham Trading Standards" means Regulatory Services of BCC

"LCC Contact Officer (LCCCO)" means the relevant person appointed by the Head of Business Regulation of LCC to liaise with the Head of Illegal Money Lending Section on matters relating to and in connection with the Illegal Money Lending Project

"Appropriate Contact Officer" means The Director of Regulatory Services, Head of
Trading Standards or the Head of Illegal Money Lending of Birmingham
Regulatory Services or any person nominated by the Council or authorised by them

1. Application

1.1 This Protocol applies to the DBIS / HM Treasury funded 'Illegal Money Lending Project' and covers the following issues:-

- The conduct of investigations and associated working practices for the IMLS officers when conducting investigations or operating in LEICESTER.
- The mechanisms whereby LEICESTER CITY COUNCIL is updated on the progress of the project and any significant issue relating thereto.
- The exchange of intelligence and information between the IMLS and LCC
- The institution of legal proceedings.

2. Protocol

2.1 The purpose of this protocol is to facilitate the delegation of powers to BCC and officers employed within BCC's IMLS to enforce the provisions of the Consumer Credit Act 1974 within the area of LEICESTER CITY COUNCIL. The protocol encourages the exchange of information and a working partnership approach between BCC and LCC in relation to the Consumer Credit Act 1974.

2.2 This Protocol will come into force on the Commencement Date and terminates at the end of the Term.

2.3 Notwithstanding the terms and conditions of this Protocol, this Protocol does not prejudice the right of LCC to withdraw the Delegated Power at any time during the Term. However LCC undertakes not to withdraw the Delegated Power unless it considers there is good reason to do so. The Delegated Power is not to be unreasonably withdrawn by LCC.

3. The IMLS

3.1 It is recognised that officers in the IMLS will need authority to initiate and/or undertake investigations and/or the prosecution of potential offences falling within the scope of the 'Illegal Money Lending Project' where such potential offences fall entirely outside of the BCC boundaries. This protocol and also the Delegated Power is deemed to provide such authority to BCC and its officers regarding all matters.

3.2 The IMLS will comprise of a team manager and up to 45 staff directly employed by BCC. The Head of Illegal Money Lending Section will be responsible for the day-to-day operation and supervision of the IMLS.

3.3 The Head of Illegal Money Lending Section will report directly to the Director of Regulatory Services or nominated officer as appropriate.

3.4 The Head of the Illegal Money Lending Section BCC will, when required, provide quarterly progress reports, from the Commencement Date, to the Head of Business Regulation of LCC giving details of investigations, (unless there is a significant risk that any such disclosure may jeopardise an investigation, such a decision is within the discretion of the Director of Regulatory Services or Head of Trading Standards BCC) prosecutions being pursued or concluded and developments concerning or affecting the Illegal Money Lending Project in LEICESTER.

3.5 It is recognised that after Delegated Power is granted to BCC, all decisions concerning the pursuance of relevant investigations, decisions to prosecute and the laying of charges and/or information on such relevant matters within LEICESTER Council, shall be taken by BCC and in accordance with the relevant Code for Crown Prosecutors and BCC's Enforcement Policy.

4. Working Arrangements in the LEICESTER CITY COUNCIL Area

4.1 LCC will designate and appoint a LEICESTER City Contact Officer (LCCCO).

4.2 The Head of Illegal Money Lending Section will at any time the Head of Illegal Money Lending Section considers necessary and prudent, or at the request of the LCCCO, brief the LCCCO on any intelligence gathered, any progress made on investigations and/or prosecutions pending or otherwise, relating to or affecting LEICESTER City and/or its residents.

4.3 Further to Clause 4.2 above, all reasonable steps will be taken by the Head of Illegal Money Lending Section to keep the LCCCO updated on the progress of investigations and enquiries being carried out in LEICESTER City and any changes made or introduced by BERR concerning the 'Illegal Money Lending Project'. It is incumbent on the Head of Illegal Money Lending Section to maintain regular dialogue/communication with the LCCCO.

4.4 The IMLS will have regular contact with the Police and other Government agencies. The Head of Illegal Money Lending Section will consult the LCCCO to identify any local arrangements, investigations and protocols before any investigation is commenced in pursuance of the 'Illegal Money Lending Project'. Wherever possible, the Head of Illegal Money Lending Section will actively involve the LCCCO and seek to develop close links between those agencies and BCC.

4.5 The Head of Illegal Money Lending Section will as soon as reasonably practicably inform the LCCCO of the outcome of any concluded prosecution proceedings conducted within LEICESTER City.

4.6 BCC, where possible, will consult with LCC in good time before issuing any press release concerning any prosecution pursued by BCC pursuant to this Protocol. Any contact with local government bodies, other police forces, credit unions or similar organisations that may be locally funded or may involve local sensitivities will be agreed with the LCCCO in advance. Upon being notified of an intention to contact such a body, LEICESTER City Trading Standards may arrange for one of their own officers to accompany the relevant officer of the IMLS on any visit.

4.7 Where the Head of Illegal Money Lending Section and the Head of Business Regulation of LEICESTER CITY COUNCIL agree that an officer or officers of LEICESTER City Business Regulation will be actively involved in an investigation, that officer will remain an employee of LCC but for the purpose of that investigation, will come under the control of the IMLS team manager. Such agreement will be subject to the Head of Illegal Money Lending Section being satisfied that the officer's or officers' participation will not compromise any investigation or endanger any member of the IMLS, supporting staff or witnesses, that the officer has the appropriate training and experience to undertake the task; and upon any other terms that the Head of Illegal Money Lending Section and the Head of Business Regulation of LEICESTER CITY COUNCIL consider necessary and/or appropriate.

4.8 Unless there is prior agreement with the Head of Illegal Money Lending Section for assistance in an investigation, which is accompanied by an official purchase order from BCC, no reimbursement will be made for time spent on activities supporting the 'Illegal Money Lending Project' or expenditure incurred by any LCC officer.

4.9 The exercise by BCC of these arrangements shall be at no cost to LCC

4.10 BCC shall have an Appropriate Contact Officer.

4.11 In the absence of the IMLS Head of Service, the role, duties, and responsibilities of the Head of Illegal Money Lending Section shall be discharged and carried out by the other Appropriate Contact Officers as nominated.

5. Referral of Information/Intelligence to the Illegal Money Lending Section

5.1 It is recognised that the IMLS will rely on receiving information about Illegal Money Lender activities.

5.2 LCC will endeavour to provide as much relevant information and intelligence as reasonably and practicably possible to the IMLS concerning any investigation being carried out within LEICESTER City having regard to any statutory limitations/restrictions, the time likely to be expended, resources available and costs likely to be incurred by LCC in providing the same.

5.3 Information and intelligence will be provided by the LCCCO to the Head of Illegal Money Lending Section or a person designated by him/her.

5.4 BCC IMLS will not, as a matter of routine, investigate individual complaints received concerning alleged Illegal Money Lender activities. However, such complaints may be used by the IMLS as a source of intelligence.

5.5 BCC, IMLS and LCC agree to process personal data only in accordance with the requirements of the Data Protection Act 1998 and to disclose information only in accordance with the requirements of the Enterprise Act 2002.

6. Conduct and Control of Investigations

6.1 The conduct and control of all investigations undertaken and prosecutions by the IMLS in LEICESTER City will be the responsibility of BCC. Investigations will be undertaken in line with the BCC's published Enforcement Policy and subject to the policies and procedures approved and adopted by Birmingham Trading Standards.

6.2 BCC will be responsible for all aspects of the investigations and responsibilities under the Criminal Procedure and Investigations Act 1996, Regulation of Investigatory Powers Act 2000, the Data Protection Act 1998, the Freedom of Information Act 2000 and the Enterprise Act 2002.

6.3 BCC will be solely responsible for the Health and Safety of IMLS officers and any other officer or person within the direct management of the IMLS providing support and assistance in any investigation undertaken by the IMLS.

6.4 Where breaches of Part III of the Consumer Credit Act 1974 are identified, action will be taken in accordance with the enforcement policy and procedures adopted by Birmingham Trading Standards.

6.5 When the Head of Service, IMLS BCC, recommends a prosecution under Part III of the Consumer Credit Act 1974, if required, LCC will be provided with a copy of the relevant prosecution file, which will consist of a detailed case summary, schedule of issues, aggravating and mitigating factors, reasons justifying prosecution and any other material fact that LCC ought

reasonably to be aware of. LCC will be invited to communicate any comments it considers appropriate and necessary concerning the intended prosecution to the Director of Regulatory Services, the informant for BCC. Such comments will be given due attention and consideration by the informant for BCC.

7. Responsibilities and Actions of the Authorities

7.1 BCC shall be liable for the actions and competence of the persons employed within the IMLS and shall ensure that the IMLS shall comply with all legislative requirements and take all reasonable steps to ensure any actions taken are lawful and within the spirit of the protocol.

7.2 LCC shall be liable for the actions and competence of persons within its employ and shall take all reasonable steps to ensure the competence of those persons in carrying out their functions and that they comply with legislative requirements and the spirit of this protocol.

7.3 Information / intelligence provided between BCC and LCC shall be used for the purpose intended and shall not be divulged to third parties unless to do so would be lawful and in pursuant of an investigation / enquiry subject to this protocol.

7.4 BCC and LCC endorse a joined up working approach to the enforcement of the Consumer Credit Act 1974. The partners will attempt to promote consistency in enforcement. However, this protocol does not attempt to restrict the powers of authorised officers of the IMLS or BCC from discharging their duties, as appropriate.

Commencement date: April 2011

Signed

Adrian Russell
Divisional Director Environmental Services
LEICESTER CITY COUNCIL

Signed

Jacqui Kennedy
Director of Regulatory Services
BIRMINGHAM CITY COUNCIL

Appendix B: East Midlands Public Protection Project Team activities

Awareness Raising
Objective: to raise awareness of illegal money practices and impacts on individuals

Activities: Leaflet delivery, presentation at team and management meetings, talks to multi agency meetings, conference speeches

Extract of recent activity:

Leicester	Spinney Hill Police Station	Police	November 2010
Leicester	Hinckley Police Station	Police	November 2010
Leicester	Leicester ARC Team	Police	November 2010
Leicester	Blaby Police Station	Police	November 2010
Leicester	Leicester Mercury	Media	November 2010
Leicester	Leicester Money Advice	Advice Centre	November 2010
Leicester	Hinckley Road Police Station	Police	October 2010
Leicester	Leicester City Council	Council	September 2010
Leicester	MAC	Advice	September 2010
Leicester	Leicester City Council	Council	September 2010
Leicester	Leicester Adult Education College	Colleges	September 2010
Leicester	Salvation Army New Parks	charity	September 2010
Leicester	Leicester Customer Service Point	Council	September 2010
Leicester	Leicester City Council Revenue Benefits	Council	September 2010
Leicester	Leicester Library New Parks	Council	September 2010
Leicester	Sure Start New Parks	Surestart	September 2010
Leicester	Neighbourhood Manager	Housing	September 2010
Leicester	LILAC	Advice	August 2010

Intelligence Gathering
Objective: to increase understanding of who is involved in illegal money lending, their modus operandi and victims.

Activities: receipt and analysis of tip offs from public, community and public organisations, businesses; interviews with debtors; surveillance and intelligence sharing.

15 hotline calls in total from a variety of sources including police authorities and the public in 2010. 5 pieces of intelligence being followed up in Leicester/Leicestershire.

Enforcement Operations
Objectives: To protect debtors
To disrupt and stop illegal money lending

Operations undertaken since April 2009 in Leicester: 14

Case Studies

Operation Angel was an investigation into an allegation of illegal money lending by Sushil Darji, 102 Edward Avenue, Leicester LE3 2PD. On 7th January 2008, a father of a victim called on the hotline but no details of the illegal lender were given. Another call was taken from a victim the following day, which resulted in the lender

still remaining anonymous.

On 27th August of 2008 a victim called. He stated he had been assaulted by a male named 'Gary' who had been in the company of Sushil Darji. He stated he had borrowed money from Sushil Darji and Gary had told him he had 4 days to pay.

On 3rd September 2008, the same victim gave the team a witness statement, stating the following:

- In 2003, the victim borrowed £20 from Darji. Around October 2006 the victim had developed a gambling problem and was in financial difficulties. He called Darji and asked for £150. He was given the money the following day and was told he had a month to repay the money.

- He repaid the money six weeks later and when Darji asked if the victim was going to give him any on top, the victim gave him a further £20.

- Around April 2007 the victim asked Darji for another loan this time £2000. This time he stipulated that the money must be repaid within six weeks and the victim would need to repay £3000. Six weeks later the victim gave £3000 in repayment of the debt to Darji's sister in law at her home address.

- Further to this Darji made a series of loans to the victim mainly in India totalling £11,750. However there were two loans that took place in England; £500 in June 2008 and a further £500 in mid August 2008.

- The victim now believed he owed £17,750 to DARJI £11,750 in loans (£1,000 of which was loaned in England) and £5,500 in interest.

- On 26th August 2008 the victim met with Darji, and asked him for £10,000 and was subsequently assaulted by a man named Gary who was with Darji. Gary told the victim to pay the money and struck a blow to his left ear and jaw.

- The victim's brother had made a token payment of £500 to start paying off his brother's debts.

Enquiries commenced and a Warrant was executed at Darji's home address on 10th November 2008 resulting in various items being seized due to possible offences under other legislation. Those items being:

CS Spray (*analysed and found to be CS*)
Bag containing white rock *(analysed and found to be 9.99 grams of Cocaine)*
Rolled up bank notes with white powder at both ends *(analysed and found to have traces of Cocaine)*
Self Seal bag containing traces of white powder *(analysed and found to have traces of Cocaine)*
Bin Bag containing large quantity of Tadalafil Tablets *(counted and found to be 12859 tablets, analysed and found to contain Sildenafil)*
Box containing boxes of Kamagra Tablets *(counted and found to be 1,344 sachets Kamagra Oral Jelly, analysed and found to contain Sildenafil)*
Box containing numerous 'Kamagra' Tablets Blister Packs *(counted and found to be 6,396 tablets, analysed and found to contain Sildenafil)*

Also seized at that time:
Bank of England Notes (uncounted) *(counted and found to be £2,665 in Bank of England Notes)*
Container containing cash *(counted and found to contain £88.12 in cash)*
Uncounted Dollars *(counted and found to contain $600 [American])*

Sushil Darji was sentenced on 10th December 2010. He got a 9 month sentence suspended for 18 months plus a residence order for 3months, after pleading guilty.

Operation Balloon

Richard Jordan of 55 Amadis Road, Leicester pleaded guilty at Leicester Crown Court to operating an illegal money lending business without the appropriate Consumer Credit Licence between January 2000 and August 2009. He received a 6 month custodial sentence suspended for 18 months, resident's condition to reside at a designated address for a period of 18 months and the sum of £4,175 to be confiscated within 28 days. No order was made for court costs.

Richard Jordan lent money to 4 victims living in the Leicester area over the period and it was calculated that he benefitted to the sum of £20,000 - £25,000. A victim living in Leicester had rang the team in 2009 on the Hotline making a complaint about Richard Jordan acting as an illegal lender.

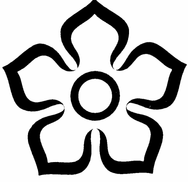
Over the course of 8 years, the victim and his wife had taken out 7 to 8 loans of around £1000 each. Interest had been paid on each loan. The victim's mother had also taken out 4 loans that she had paid interest on. Also his friend had had 7 or 8 loans over a period of time, each for around £1000. One of his loans was given jointly by Jordan and his partner. Repayments had been made via envelopes containing money being posted through the front door.

Search warrants were executed by the team and evidence relating to the offences found at his property. These included a white board where figures/names had been written down in a list format.

The Judge residing at the Leicester Crown Court felt that although there was no evidence of any violence towards his victims he felt that Jordan had clearly exploited them by charging extremely high rates of interest and knew full well that his victims could not get access to legal affordable forms of lending but they felt that they had no option but to use his services.

This page is left blank intentionally.

Appendix F



WARDS AFFECTED: All

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:

OSMB	**7th April 2011**
Cabinet	**11th April 2011**

Planning Applications - Revised Local Validation Requirements

---

Report of the Strategic Director, Development, Culture and Regeneration

1. Purpose of Report

Cabinet approval is sought for the Council to adopt a revised list of details to be submitted with planning applications to make them acceptable in line with Government advice.

2. Recommendations

2.1 Cabinet is requested to note the requirement to revise the list of submissions for planning applications as set out in the report and the proposed consultation exercise.

2.2 Delegated authority is sought from Cabinet for the Director, Planning & Economic Development, in consultation with the Cabinet Lead, to make appropriate amendments to the validation list to take into account consultation responses, following which the list will be adopted.

3. Summary

3.1 Government guidance requires the list of details to be submitted with planning applications to be reviewed, consulted on and adopted.

3.2 A revised list has been prepared jointly with other planning authorities in Leicestershire and Rutland.

3.3 The list will be subject to 8 weeks consultation period commencing in early April. Delegated authority is sought from Cabinet to approve any subsequent amendments to the list and adopt it.

4. Report

4.1 In 2008 the standard planning application form ('1APP') and validation requirements (list of documents to be submitted) for planning applications was introduced. The City Council with other local authorities in the County and Rutland adopted a local list of requirements to supplement national validation requirements.

4.2 In March 2010 the Government issued revised guidance on information requirements and validation for planning applications. This stated that where local authorities wish to maintain their own distinct local list, in addition to the national list of information, this should be reviewed, consulted on and adopted. The revised document subject to this report (see Appendix 1 for index and Appendix 2 for a sample validation list) is being published to take account of these requirements, and to reflect changes in national, regional and local planning policy as applicable to Leicester, Leicestershire and Rutland.

4.3 The local planning authorities which adopted the initial list have sought through this document to set down a consistent and proportionate approach to the information that is required for all different types of applications. This will be kept under review to ensure that it is meeting its objectives. In setting out these new requirements, the aim is to minimise the number of applications which have to be treated as invalid due to insufficient information, whilst ensuring that we have the information needed to make decisions on the applications.

4.4 This revised list takes full account of the Department of Communities and Local Government document 'Guidance on Information Requirements and Validation' and its key principles of necessity, precision, proportionality, fitness for purpose and assistance to applicants. The revisions to the list simplify the local requirements. It removes items that cannot be taken into account in determining an application and where the information is of limited value for most applications. The adoption of a new list does not prevent the City Council requesting additional information not on the list to assess applications where this is required, or refusing permission on the basis of a lack of evidence to determine an application.

4.5 This new approach is intended to assist applicants by providing clearer information about what would normally be expected to be submitted with different types of planning application. Appendix 2 shows an example of what would be required to be submitted for a standard planning application. Adopting a local list with other local authorities in the area provides a consistent approach and service to our customers, especially agents and consultees that work across the City, County and Rutland.

4.6 The regulations require a minimum of 8 weeks consultation on the local list. This is due to start in early April. There will be a link to the consultation documents on the city council web site. Cabinet is requested to note the proposed information/validation requirements in Appendix 1. Delegated authority is sought for the Director, Planning & Economic Development, in consultation with the Cabinet Lead, to make appropriate amendments to the validation list in Appendix 1 to take into account consultation responses, following which the list will be adopted.

4.7 The Planning and Development Control Committee will be consulted on 13 April 2011.

5. <u>FINANCIAL, LEGAL AND OTHER IMPLICATIONS</u>

5.1. Financial Implications

There are no direct financial implications from the adoption of the revised list.

Martin Judson, Head of Finance, Ext 297390

5.2 Legal Implications

Guidance on information requirements and validation March 2010 by Department for Communities and Local Government sets out legal requirement for local planning authority to review, consult and adopt the list.

Anthony Cross, Legal Services, Ext 296362

5.3 Climate Change Implications

This report does not contain any significant climate change implications and therefore should not have a detrimental effect on the Council's climate change targets.

Helen Lansdown, Senior Environmental Consultant - Sustainable Procurement, Ext 296770

6. Other Implications

OTHER IMPLICATIONS	YES/ NO	Paragraph/References Within the Report
Equal Opportunities	No	
Policy	Yes	need for appropriate environmental information for planning applications
Sustainable and Environmental	Yes	Whole report – need for appropriate environmental information for planning applications
Crime and Disorder	Yes	need for appropriate information for planning applications
Human Rights Act	No	
Elderly/People on Low Income	No	
Corporate Parenting	No	
Health Inequalities Impact	No	

7. Risk Assessment Matrix

Delete if not required and renumber paragraphs.

This only needs to be included if appropriate with regard to the Council's Risk Management Strategy

Risk	Likelihood L/M/H	Severity Impact L/M/H	Control Actions (if necessary/appropriate)
A delay in the adoption may result in applications being received without the necessary information and thus cause delays in the service or result in more applications being refused.	Medium	Low	Delegated authority is sought to ensure that the revised list is adopted without delay

8. Background Papers – Local Government Act 1972

Guidance on information requirements and validation March 2010
Department for Communities and Local Government

9. Consultations

Anthony Cross, Legal Services
Martin Judson, Finance

10. Report Author

Sarbjit Singh
Team Leader – North West Team
Planning Management & Delivery

Key Decision	No
Reason	N/A
Appeared in Forward Plan	N/A
Executive or Council Decision	Executive (Cabinet)

Appendix 1

SECTION 3

NATIONAL AND LOCAL REQUIREMENTS

Page	Application type
8	Householder application for planning permission for works or extension to a dwelling
9	Householder Application for planning permission for works or extension to a dwelling and Conservation Area consent for demolition in a Conservation Area
10	Householder Application for planning permission for works or extension to a dwelling and Listed Building consent
11	Application for Planning Permission
13	Application for Outline Planning Permission with some matters reserved
15	Application for Outline Planning Permission with all matters reserved
17	Application for Planning Permission and Conservation Area consent for demolition
19	Application for Planning Permission and Listed Building consent
21	Application for Planning Permission and Advertisement consent
23	Conservation Area consent for demolition in a Conservation Area
24	Listed Building consent for alterations, extension or demolition of a listed Building
25	Application for Advertisement consent
26	Listed Building consent for alterations, extension or demolition of a listed building and advertisement consent
27	Application for a Lawful Development Certificate for an existing use or operation or activity including those in breach of a planning condition
28	Application for a Lawful Development Certificate for a proposed use or development
29	Application for prior notification of proposed agricultural development – proposed building
30	Application for prior notification of proposed agricultural development – proposed road
31	Application for prior notification of proposed agricultural development – proposed excavation/deposit of waste material from the farm
32	Application for prior notification of proposed agricultural development – proposed fish tank
33	Application for prior notification of proposed development in respect of permitted development by electronic communications code operators
34	Application for Hedgerow Removal Notice
35	Application for prior notification – proposed demolition
36	Application for Approval of Reserved Matters following outline approval
37	Application for removal or variation of a condition following grant of planning permission (Section 73 of the Town and Country Planning Act 1990)
38	Extension of time applications
39	Non-material minor amendment
40	Useful Supporting Information – Application for Approval of Details Reserved by Condition
41	Application for Tree Works: Works to Trees Subject to a Tree Preservation Order (TPO) or Notification of Proposed Works to Trees in Conservation Areas (CA)

Appendices

Page	No.	Title
42	I	Explanation of requirements of National Validation Requirement
45	II	Explanation of requirements of Local Validation Requirements
	III	Biodiversity Survey and Report / Ecological Survey / Protected Species Survey and Report
53		○ PART I - Protected Species
54		○ Table 1 - Protected Species: (Trigger List)
55		○ PART II - Designated Sites and Priority Habitats
56		○ Table 2 - Designated Sites and Priority Habitats (Trigger List)
57		○ Table 3 - Designated Geodiversity Sites (Trigger List)
58		○ Table 4 - Ecological Survey Seasons

Appendix 2

Application for Planning Permission

NOTE For clarification

- The Site plan shall include both existing and proposed development.
- All plans shall include critical dimensions

NATIONAL REQUIREMENTS	
Requirement	**Threshold**
Standard application form	All applications
Design and access statement	Where required by Article 8 of The Town and Country Planning (Development Management Procedure) (England) Order 2010
Location Plan	All applications – scale 1:1250 or 1:2500
Site Plan	Most application – recognised metric scale
Ownership Certificates	All applications – included in 1APP form
Notices	As required depending on ownership of site
Agricultural Land declarations	All applications – included in 1APP form
Fee	All applications
LOCAL REQUIREMENTS	
Requirement	**Threshold**
Existing and proposed elevations	As necessary to clearly show the proposed works in relation to what is already there. Scale 1:50 or 1:100
Existing and proposed floor plans	As necessary to clearly show the proposed works in relation to what is already there. Scale 1:50 or 1:100
Existing and Proposed Site Sections, Finished Floor and Site Levels	As necessary to clearly show the proposed works in relation to what is already there. Scale 1:50 or 1:100
Roof Plan	Where the roof design is not simple single dual or mono pitches, to clearly show the proposed works in relation to what is already there. Scale 1:50 or 1:100
Affordable housing statement	If development meets Local Planning Authority threshold. A Housing Market Assessment is also required where specified in LPA's DPD's.
Air quality assessment	Where the development is proposed inside, or adjacent to an air quality management area (AQMA),
Biodiversity Survey and Report (Ecological Survey) / Protected Species Survey and Report	Where the proposed development may have possible impacts on designated sites and important habitats, a full biodiversity survey and report may be needed. Please refer to '*Biodiversity Survey and Report: Local Requirements for Designated Sites and Priority Habitats*'. Some proposed development may need a protected species survey if a) the site contains or is close to a known location for a species, or b) there is a high probability that a protected species will be present. Please refer to '*Protected Species Survey and Repor : Local Requirements for Protected Species*'.
Building for life assessment	All major residential developments in Charnwood, Leicester City and North West Leicestershire areas
Economic statement	Where viability is an issue. This may be included where appropriate in the Design and Access Statement. (Should be clearly identified)
Environmental statement	Environmental Impact Assessment is required for schedule 1 developments and maybe required for schedule 2 developments as specified by the Environmental Impact

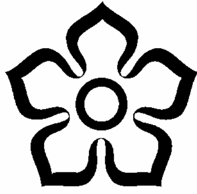
	Regulations 1990.
Town Centre Uses –Evidence to accompany applications	A Retail Assessment to accompany all applications as identified in PPS4 or in the development plan. A sequential assessment is required for all applications as identified in PPS4 or in the development plan. Developments affected include retail, leisure, office, cultural and tourist uses located in and outside town centres.
Flood risk assessment	Where the development is proposed within Main river bye-law distance or where the development is within flood zones 2 & 3 or the site is greater than 1 hectare within Flood Zone 1. (see Environment Agency's www.environment-agency.gov.uk website for further information on Flood Risk Standing Advice and Flood Risk assessments) In accordance with PPS25.
Heritage Statement (including Historical, archaeological features and Scheduled Ancient Monuments)	All Major applications and any site with an entry in the Leicestershire and Rutland Historic Environment Record. This may be included in the Design and Access Statement. (Should be clearly identified)
Land Contamination assessment	Where contamination is known or suspected.
Landfill statement	Only required in respect of a County Matter Application
Lighting assessment	Where proposal includes floodlighting or where illumination is proposed for particularly sensitive proposals (e.g. illumination of carparks)
Noise impact assessment	Where developments are close to existing sources of noise or proposal will generate significant noise levels.
Open Space assessment	All major applications. This may be included where appropriate in the Design and Access Statement (Should be clearly identified)
Planning obligations – Unilateral undertaking or Draft agreement or Heads of Terms for S106 agreement required	If development triggers contributions within Development Plan Documents and/or the developer wishes to either: • Voluntarily propose contributions • Present a case for an exception from a triggered requirement
Planning Statement	All major applications. This may be included where appropriate within the Design and Access Statement (Should be clearly identified)
Statement of Community Involvement	All major applications. This may be included where appropriate within the Design and Access Statement (Should be clearly identified)
Structural Survey	Barn conversions or demolition and rebuild or when the justification for demolition is based on structural condition / soundness
Telecommunications Development – supplementary information	All developments proposing telecommunications development (see Prior notification application)
Transport assessment	Leicestershire and Rutland County Councils Highways define the different types of transport statement needed depending on the size of development - see their web sites For Leicestershire County Council http://www.leics.gov.uk/index/highways/road_improvements/htd/highway_req_development_part2.htm For Rutland County Council http://www.rutland.gov.uk/pp/gold/viewGold.asp?IDType=Page&ID=21890.
Travel Plan – Draft required	Leicestershire and Rutland County Councils Highways define

	when a Travel Plan is required depending on the size of development - see their web site For Leicestershire County Council http://www.leics.gov.uk/index/highways/road_improvements/htd/highway_req_development_part2.htm For Rutland County Council http://www.rutland.gov.uk/pp/gold/viewGold.asp?IDType=Page&ID=21890.
Ventilation/Extraction statement and design.	For all A3/A4/A5 uses and any retail, business, industrial or leisure or other developments where ventilation or extraction equipment is proposed. This may be included where appropriate within the Design and Access Statement. (Should be clearly identified)
SAC report	Any proposal located in catchment area of the River Mease Special Area of Conservation (SAC) North West Leicestershire District.
Rutland Water Special Protection Area (SPA) report	Any proposal located in the Rutland Water Special Protection Area (SPA) Rutland County Council

Explanation of requirements of Validation
back to index page

Appendix G

WARDS AFFECTED: All



OSMB | **7th April 2011**
Cabinet | **11th April 2011**

Draft Green Space Supplementary Planning Document (SPD)

Report of the Strategic Director Development Culture and Regeneration

1 Purpose of Report

1.1 To report on the outcome of the public consultation for the draft Green Space Supplementary Planning Document (SPD), present the final version and seek formal adoption.

2 Recommendations

2.1 i) Cabinet is asked to formally adopt the Green Space SPD as Council policy.

3 Summary

3.1 The Draft Green Space SPD and accompanying “Calculations” document (See appendices 1 & 2) have been produced to support Core Strategy Policy 13: Green Network. When adopted, the SPD will assist planning applicants and developers who are seeking to secure residential development to calculate the amount and/ or cost of green space, sport or recreation facilities that would be required. It will also provide a defensible mechanism for the Council to secure developer contributions to improve the quality of the green spaces in the City.

3.2 The draft document was published for a 4 week period of public consultation from the 15th November to 13th December 2010. A summary of comments received and the Council’s response including proposed amendments, can be seen in appendix 3.

4 Report

Purpose of Supplementary Planning Documents

4.1 Supplementary Planning Documents (SPDs) form part of the Council’s Local Development Framework. They support policies contained in Development Plan Documents, including the adopted Core Strategy.

Relationship to the Core Strategy

4.2 This Supplementary Planning Document supports Policy CS13 “Green Network” of the Core Strategy, which aims to maintain and enhance the quality of the green network in the City. The SPD clarifies the Council’s approach to the provision of green space, sport and recreation facilities to assist applicants and developers who are seeking to secure residential development where such provision would be required.

What the SPD will do

4.3 The Draft Green Space SPD focuses on the impact that new residential development will have on the green network and sets out the amount of green space and/ or level of developer contributions that would be required to make the development acceptable. In particular it considers the need to provide new on-site green space provision, contributions to enhance the quality of provision and maintenance costs. The "Calculations" document which accompanies the SPD, gives information on how the developer contribution figures have been calculated.

Wider Context

4.4 The amount of green space provision is based on local green space provision standards. These were derived from the Council's "Open Space, Sport and Recreation Study for Leicester (2007), which assessed the amount and variety of open spaces in the City (quantity), how well the spaces were maintained (quality) and how easy they are to get to and use (accessibility). At the time public consultation was undertaken to inform the study and develop the local standards of provision.

4.5 The study provided an important evidence base for the Core Strategy and has also informed the development of the Council's Green Space Strategy. The Green Space SPD is important for both the Core Strategy and the Green Space Strategy as it will help to implement the policies and strategies of both these documents. This will be through securing new open space provision and developer contributions to improve the quality of the green space network, where this is required, in respect of new housing development.

Public Consultation

4.6 Formal public consultation on the draft SPD took place for 4 weeks between the 15th November and 13th December 2010. During this time comments were invited from a wide range of organisations which included: statutory bodies, key stakeholders, developers, house builders, agents and environmental organisations. Planning and Development Control Committee were consulted on the 30th November 2010. A Public Notice was placed in the Mercury newspaper to advertise the consultation. People could also view the draft documents on the Council's website and as hard copies in the Customer Service Centres.

4.7 As a result of the consultation four amendments have been made to the draft document to correct inaccuracies and clarify matters related to designing out crime, heritage assets and university sports grounds. A summary of comments received and the Council's response can be seen in Appendix 3. The final version of the document is attached in Appendices 1 & 2. A sentence has since been added to Appendix 1 to clarify the purpose of the figures in the tables. This reads: - "They show only the quantitative aspect of green space and do not reflect the quality audits undertaken as part of the study".

5.1 Financial Implications

"Any additional section 106 contributions and commuted sums will be managed under existing procedures."

Martin Judson, Financial Services, ext 297390

5.2 Legal Implications

"Once adopted, the SPD will be a material consideration in the determination of planning applications."

Dina Nathwani, Legal Services

Climate Change Implications

5.3 It is important that the Council maintains and improves both the quantity and quality of green spaces to enable the City to adapt to the potential impacts of climate change. Green spaces are central to efforts to adapt to the effects of climate change, such as providing areas of shade and cooling, and the Green Spaces SPD should assist in ensuring these important areas so space are provided.

Helen Lansdown, Senior Environmental Consultant – Sustainable Procurement

6 Other Implications

OTHER IMPLICATIONS	YES/NO	Paragraph References Within Supporting information
Equal Opportunities	**Yes**	The SPD considers accessibility to open space for all parts of Leicester by wards area.
Policy	**Yes**	Para 4.2 – The SPD supports the implementation of Policy CS13 of the Council's Core Strategy.
Sustainable and Environmental	**Yes**	Maintaining and enhancing open space provision is a key objective of the SPD.
Crime and Disorder	**Yes**	The document has been revised to refer to "Secure by Design" principles.
Human Rights Act	**No**	
Elderly/People on Low Income	**No**	
Corporate Parenting	**No**	
Health Inequalities Impact	**No**	

7 Background Papers – Local Government Act 1972

7.1 None

8 Consultations

8.1 We have worked closely with the Parks and Green Spaces Service to produce this Draft Green Space Supplementary Planning Document. Other departments e.g. Planning Management and Delivery, the Development Team, Sports, Legal Services, Housing and Property Services have also been consulted as part of internal consultation.

8.2 Formal public consultation on the draft SPD took place between 15th November and 13th December 2010.

9 Report Author

9.1 Elizabeth Oxborough
Senior Planner – Planning Policy and Design
Extension: 297229

Key Decision	Yes
Reason	Is significant in terms of its effect on communities living or working in an area comprising more than one ward
Appeared in Forward Plan	Yes
Executive or Council Decision	Executive (Cabinet)

Leicester City
local
development
framework

Supplementary
Planning Document

GREENSPACE SPD

PRE-ADOPTION DRAFT
January 2011

CONTENTS

Introduction 5

Policy context 5

Green space policy 5

Core strategy policy 13 green network 6

Developer Contributions Policy 6

Objectives of the green space SPD 7

Green space definitions 7

Green space standards 9

When will the SPD be applied? 10

How are contributions calculated for the provision of green space? 11

Where are the green spaces to be provided? 14

Pooled contributions 14

Minimum sizes of new green spaces 14

Adopting areas of green space 15

Biodiversity 15

Crime and Green Space 15

Heritage Assets 15

Additional services 15

Appendix 1. Green space provision by ward 16

Appendix 2. Developer contributions: costs for enhancement and new off-site provision 22

Appendix 3. Commuted sum payments 23

Other languages and large print

اگر آپ اس دستاویز کی وضاحت چاہتے ہیں، یا اگر آپکو اپنی آرا لکھنے کیلئے مدد چاہیے تو براہ مہربانی (0116)2527233 پر ٹیلیفون کریں

আপনি যদি চান - এই ডকুমেন্টটি (দস্তাবেজ) আপনার কাছে ব্যাখ্যা করা হোক বা আপনার মন্তব্য লেখার জন্য সাহায্যের প্রয়োজন হলে, অনুগ্রহ করে (0116) 252 7233 নম্বরে টেলিফোন করুন ।

જો આ દસ્તાવેજ તમને સમજાવવાની જરૂર હોય, અથવા તમારી ટીકાઓ લખવામાં તમને મદદ જોઇતી હોય તો મહેરબાની કરી (0116) 2527233 ઉપર ફોન કરો.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਸਮਝਣ ਵਿੱਚ ਮਦੱਦ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਜਾਂ ਜੇਕਰ ਤੁਹਾਨੂੰ ਆਪਣੇ ਵਿਚਾਰ ਲਿਖਣ ਵਿੱਚ ਮਦੱਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ (0116) 252 7233 ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ ।

如果你需要有人給你解釋這文件，或如果你需要人協助填寫你的意見請致電（0116）2527233

Haddii aad u baahan tahay in dukumentigan laguu sharxo, ama haddii aad u baahan tahay in lagaa caawino qoraalka wixii fikrad dhiibasho ah fadlan soo wac teleefoonka ah (0116)2527233

Eğer bu belgenin size açıklanmasını istiyorsanız, ya da yorumlarınızı yazmada yardıma ihtiyacınız varsa lütfen (0116) 2527233’e telefon ediniz.

ئەگەر پێویستت کرد شروڤە کردنی ئەم دوکیومەنتە ،یان پێویستی یارمەتي بۆی بو نۆسینی هەر شتێك تکایە پەیوەندی بەم ژمارە تەلەفونە بکە (0116) 252 7233

Jeśli chcesz by ten dokument tobie wytłumaczyć lub potrzebujesz pomocy z napisaniem twoich uwag proszę dzwonić pod numer (0116) 2527233

اگرنیاز دارید که این مدرک برای شما توضیح داده شود یا اگربرای نوشتن نظراتتان نیاز به کمک دارید لطفا با شماره 0116 2527233 تماس بگیرید.

If you require this document in large print, audio cassette, Braille or languages other than English please telephone (0116) 2527233 or email planning.policy@leicester.gov.uk

Introduction

The benefits of open space and green networks throughout a City are well documented. They lift the spirits and offer opportunities for healthy activities for children and adults alike, as well as having a positive impact on climate change, air quality, surface water management and biodiversity value. Green spaces contribute towards the priorities of the One Leicester Vision for the City:

- Planning for people not cars;
- Reducing our carbon footprint;
- Improving wellbeing and health;
- Creating thriving, safe communities;
- Investing in our children;
- Talking up Leicester; and
- Investing in skills and enterprise.

Leicester is fortunate in having rivers and canals that thread through its heart, which include and link to an extensive network of green spaces and parks which extend into the countryside beyond.

This Supplementary Planning Document concerns developer contributions towards the maintenance, enhancement and provision of the green space network within Leicester City. It is supplementary to the policies in the Core Strategy which set out the context for the green network. The Core Strategy's Key Diagram (Map 1) shows how the green network is integral to the overall strategy for the City and links it to the surrounding countryside.

The SPD sets out:

- The policy context, nationally and locally;
- The objectives of this guidance/SPD;
- The current picture of green space provision in the city;
- New standards to be applied and how green space matters will be dealt with in planning applications for development and the use of land; and
- How developer contributions will be calculated.

Policy context

Green space policy

National policy found in Planning Policy Guidance 17 (2002) "Planning for Open Space, Sport and Recreation" aims to deliver networks of accessible, high quality open spaces and sport and recreation facilities with an appropriate balance between providing new spaces and enhancing existing provision. Paragraph 33 of PPG17 goes on to state: "Planning obligations should be used as a means to remedy local deficiencies in the quantity or quality of open space, sport and recreational provision. Local authorities will be justified in seeking planning obligations where the quantity or quality of provision is inadequate or under threat, or where new development increases local needs…"
(http://www.communities.gov.uk/planningandbuilding/planningsystem/planningpolicy/planningpolicystatements/ppg17/)

The City Council commissioned a (PPG17 compliant) study into green space provision within the City, which resulted in green space standards and definitions being provided for the City. These have helped to inform this Supplementary Planning Document. A Green Space Strategy has also been produced for the City Council which sets out the authorities' vision for using its green space, the goals it wants to achieve, plus the resources, methods and time needed to meet these goals.

Leicester City Council's Core Strategy, adopted in November 2010, contains policies to help determine planning applications in the City http://www.leicester.gov.uk/corestrategy/). This Supplementary Planning Document supports Policy CS13 "Green Network" which seeks to maintain and enhance the network of green spaces within the City. The policy is as follows:

Core strategy policy 13 green network

"The Council will seek to maintain and enhance the quality of the green network so that residents and visitors have easy access to good quality green space, sport and recreation provision that meets the needs of local people. A Supplementary Planning Document will be prepared to provide detailed guidance and information on green space, sport and recreation provision and to support the following principles:

- *The Council will safeguard and improve green space, sport and recreation facilities that are of value to the green network, local communities and biodiversity, especially those that are of strategic importance i.e. green wedges, the River and Canal Corridor;*
- *Green wedges will be maintained as areas of land that prevent the merging of built up areas of the City and adjoining settlements, guide the development and provide a "green lung" into the inner urban area. Their function as open space for leisure or recreational purposes will be maintained and enhanced. Development within a green wedge will be expected to serve the open space, be of high design quality and of an appropriate scale and size for its location to minimise the visual and environmental impact of the development;*
- *The Council will pursue opportunities to address the imbalances in green space provision by making green space, sport and recreation facilities more accessible and improving links and connections between spaces;*
- *New development proposals should meet the need for provision arising from the development, taking account of local qualitative and quantitative deficiencies in green space, sport and recreation provision. New on-site-provision or S106 contributions to improve the quality of, or access to, existing open space, will be expected and commuted maintenance sums will be sought; and*
- *Where there are proposals that affect green space, outdoor sport or recreation facilities, land should not be released, either in total or in part, for development unless it is:*
  - *a) Surplus to requirements for its current green space function; and*
  - *b) Not needed for another type of green space use; or*
  - *c) Equivalent or better replacement green space would be provided in the local area."*

PPS9 and Core Strategy Policy CS17 Biodiversity are also relevant to the objectives of this SPD. Their principles include ensuring that development maintains, enhances or strengthens connections for wildlife. Green spaces can also support a wide variety of biodiversity and they should be provided, maintained and enhanced to support the aims of the city and county Biodiversity Action Plans, where possible.

Developer contributions policy

Circular 05/2005 on planning obligations (http://www.communities.gov.uk/publications/planningandbuilding/circularplanningobligations) states that developer contributions can only be sought in relation to a planning permission when they are:

- Necessary;
- Relevant to planning;
- Directly related to the proposed development;
- Fairly and reasonably related in scale and kind to the proposed development; and
- Reasonable in all other respects.

In addition to contribution(s) meeting the above tests, the recent Community Infrastructure Levy Regulations which came into effect on 6 April 2010 also state that S106 obligations may only be imposed where the following tests are met:

That the contributions are:
- Necessary to make the development acceptable in planning terms;
- Directly related to the development and;
- Fairly and reasonably related in scale and kind to the development.

It is important to note that planning permissions cannot be bought or sold through developer contributions and that unacceptable development will not be approved simply to secure a favourable level of contribution.

Core Strategy Policy CS19 explains that developer contributions will be sought where needs arise as a result of development. It states that contributions will be used to mitigate the adverse impacts of development and the City Council will where appropriate, seek to secure such measures through planning obligations. It is therefore clear that developer contributions are an important mechanism for securing green space as a result of development.

The City Council will prioritise developer contributions according to its policies whilst taking into account the viability of the development.

As well as the above policies, Supplement to Planning Policy Statement 1, Planning and Climate Change (http://www.communities.gov.uk/publications/planningandbuilding/ppsclimatechange) outlines the contribution open space and green infrastructure can make to urban cooling, sustainable drainage systems, and conserving and enhancing biodiversity. The City Council has also adopted Supplementary Planning Guidance on Biodiversity (http://www.leicester.gov.uk/your-council-services/ep/planning/plansandguidance/citywideplanningguidance/biodiversity/) and a Supplementary Planning Document on Climate Change, (http://www.leicester.gov.uk/your-council-services/ep/planning/plansandguidance/ldf/spd/climate-change-spd/) both of which are relevant to the objectives of the Green Space SPD.

Objectives of the green space SPD

The objectives of the SPD relate to the spatial objectives of the Core Strategy and the aims of Core Strategy Policy 13. The objectives are as follows:
1. To ensure that all households are within an appropriate distance of a full range of green spaces;
2. To ensure that an adequate amount of green space is provided across the City;
3. To ensure that all green spaces are interlinked and accessible by attractive walking and cycling routes;
4. To ensure that all publicly accessible green spaces are of a high quality and well maintained and have provision for ongoing maintenance;
5. To ensure that green spaces are inclusive spaces which everyone can use safely, easily and with dignity;
6. To ensure that green spaces are well designed, safe, secure and well used; and
7. To ensure that green spaces maintain, enhance and/or strengthen connections for wildlife across the city.

Green space definitions

Many green spaces are multi functional, which means they serve several different purposes, for instance there may be an Equipped Children and Young Peoples Space, Outdoor Sports Space and Natural Green Space within a Park or Garden. The types of green space that were identified in the City Council's PPG17 compliant study refer to their **'primary purpose'** so that each green space is counted only once in an audit of provision.

The types of green space that were identified in the City Council's PPG17 compliant study are:

Parks and gardens

Public parks and gardens take on many forms, but for the purposes of this document their main functions include:

- Informal recreation and outdoor sport;
- Play space of many kinds (including for sport and children's play);
- Providing attractive walks to work, community facilities and other destinations;
- Offering landscape and amenity features;
- Providing areas for 'events'; and
- Providing habitats for wildlife.

Informal/amenity green space

These areas include those spaces open to free and spontaneous use by the public, but neither laid out or managed for a specific function such as a park, public playing field or recreation ground, nor would it be managed as a natural or semi-natural habitat. It is:

- Unlikely to be physically demarcated by walls or fences;
- Predominately laid out to mown grass;
- Unlikely to have identifiable entrance points (unlike parks);
- Unlikely to have planted flower beds or other formal planting layouts, although they may have tree and shrub planting;
- Generally no other recreational facilities and fixtures (such as play equipment or ball courts), although there may be items such as litter bins and benches;
- Examples might include both small and larger informal grassed areas in housing estates and general recreation spaces. They can serve a variety of functions dependent on their size, shape, location and topography.

Equipped children and young people's space

This includes:

- Equipped playgrounds for children;
- Skate parks and areas for wheeled sports;
- Designated space for youth and young adults e.g. multi use activity area; and
- Small ball courts for football or basketball. (Larger space will be classed as Outdoor Sports Space).

Outdoor sports space

This includes:

- Marked out pitches for a variety of sports including football, cricket, hockey, rugby, bowls etc;
- Equipment associated with the sports pitches (such as goalposts and nets) may not be provided at all times of year;
- These spaces will often include changing facilities and drainage; and
- Larger ball courts for football or basketball. (Smaller spaces will be classed as Equipped Children's and Young People's Space).

(Accessible) natural green space

These areas:

- Provide a variety of habitats including meadows, river floodplain, woodland and copse, all of which are managed primarily for wildlife value;
- These areas are reasonably accessible providing open access for the public use and enjoyment; and
- These areas can also make important contributions to local Biodiversity targets, outlined in City and County Biodiversity Action Plans.

Allotments

The Allotment Act of 1922 defines the term 'allotment garden' as: "An allotment not exceeding 40 poles[2] in extent which is wholly or mainly cultivated by the occupier for the production of vegetable or fruit crops for consumption by himself or his family."

The Allotments Act of 1925 gives protection to land acquired specifically for use as allotments, so called Statutory Allotment Sites, by the requirement for the need for the approval of the Secretary of State in event of sale or disposal. Some allotment sites may not specifically have been acquired for this purpose. Such allotment sites are known as "temporary" (even if they have been in use for decades) and are not protected by the 1925 legislation.

Allotment areas often provide taps for water and sometimes communal buildings for meeting areas and toilets.

Green space standards

The Leicester Open Space, Sport and Recreation Study (2007) found that the overall minimum area standards for the provision on green space within the city are as follows.

Parks and Gardens:	0.5 ha per 1,000 population
Informal Green Space:	0.5 ha per 1,000 population
Equipped Children and Young People's Space:	0.08 ha per 1,000 population
Outdoor Sports Space:	1.0 ha per 1,000 population
Natural Green Space:	0.5 ha per 1,000 population
Allotments:	0.3 ha per 1,000 population
This gives an overall green space area standard of 2.88 ha per 1,000 population	

The Open Space, Sport and Recreation Study also gave access standards for each type of green space which describe how far it is reasonable to expect people to travel to an area of green space. They are as follows:

District and City Parks:	1,000m
Local Parks:	300m
Informal Green Space:	100m
Equipped Children and Young Peoples Space:	Pre Teen: 300m Teen: 1,000m
Outdoor Sports Space:	3,000m
Natural Green Space:	300m
Allotments:	1,000m

When will the SPD be applied?

The standards for the provision of green space will be applied to all applications for new residential development that result in a net gain in residential units. This includes applications that involve:

- New dwellings;
- Conversions;
- Changes of use to residential;
- Flat developments;
- Bedsits;
- Affordable Housing;
- Revised planning permission (where the number of dwellings increases as a result of the revision);
- Student accommodation;
- Elderly care homes; and
- Sheltered housing.

Exceptions

Replacement dwellings, house extensions and residential annexes will not be required to provide green space. One bedroom flats or houses, student accommodation, elderly care homes and sheltered housing will not be required to make a contribution towards equipped Children's and Young Peoples Space. This is because children and teenagers are unlikely to live in these types of properties. Purpose built student accommodation will also not be required to contribute towards allotments as students are not permanent residents in the City and are therefore unlikely to cultivate allotments. These developments will be required to contribute to all other types of green space, as outlined below.

How are contributions calculated for the provision of green space?

Developers should contact the Planning Management and Delivery Section (0116 2527000) at Leicester City Council who will be able to support and assist with the application of this SPD.

STAGE ONE: Does the housing development create the need for new green space?

A. Estimate the number of people that would live in the proposed development.

This will be calculated by reference to the following assumed occupation rates for different dwelling sizes:

Table: Occupation Rates	
Number of Bedrooms	**Assumed Number of Residents**
1	1.5
2	2
3	2.5
4+	3
Unknown Dwelling Size	2.5
Student Accommodation, Care Homes and Elderly and Sheltered Housing	Number of People to be Accommodated

Example:

Number of Units	Multiplied by Assumed Number of Residents	Equals Total No. of People
50 (2 beds)	x 2	= 100
75 (3 beds)	x 2.5	= 187.5
75 (4 beds)	x 3	= 225
	Overall Total	**= 512.5**

B. Appendix 1 indicates the green space provision by ward for each category of green space. Find the table for the ward where the development is located. For each type of green space it will either state that there is "sufficient supply" (go to section C) or an "under supply" (go to section D).

C. If the table states that there is "sufficient supply" (a positive figure):

Would the increase in population from the development change this to an under supply? To calculate the amount of green space required by the development use the following formula:

E.G. For Parks and Gardens Standard and assuming 512.5 people in the development:

Overall Total Number of People	Multiplied by Green Space Standard	Divided by 1,000	Equals Amount of Green Space Required by the Development
512.5	x 0.5 (Parks and Gardens)	/ 1,000	= 0.256 ha

Now subtract the amount of green space required by the development (0.256 ha) from the appropriate surplus/deficiency (ha) column in the ward tables in Appendix 1.

For instance, if the development is in Latimer ward:

LATIMER

Typology	Existing Provision (ha)	Required Provision (ha)	Surplus/ Deficiency (ha)	Surplus/ Deficiency
Parks and Gardens	4.39	5.79	-1.4	Under Supply

Surplus/Deficiency of P & G in Ward	Subtract Amount of Green Space Required by the Development	Equals Revised Ward Total
-1.4 ha	0.256 ha	= -1.656 ha

- If the figure is negative or changes to be negative - new provision would be needed; or
- If the figure remains positive - there is no quantitative need…BUT there may still be a need to improve the quality of provision. Go to Stage Two below.

N.B. Remember to do this for each category of green space.

D. If the table states "under supply" (as is the case in the worked example above) new provision would be needed.

Enhancement and new provision

The area calculated above should be accommodated on-site as a priority. There may be several types of green space that are shown as having an under supply. If this is the case, provision will be sought in accordance with the City Councils Green Space Strategy. The Planning Management and Delivery section (0116 2527000) are the first contact point for developers and will contact the Parks and Green Spaces Service regarding the priorities for on-site green space provision. The Nature Conservation Officer should also be consulted if there is a requirement for natural green space.

In some circumstances it may not be feasible to provide on-site provision. If this is the case, the developer should consider, as a priority, green space on an alternative site to serve the development. However, if the site has access to existing green space and falls within or near to a catchment of a piece of green space (see the Open Space Study Appendix, http://www.leicester.gov.uk/your-council-services/ep/planning/plansandguidance/ldf/ldfevidence-base/openspacestudy/), a contribution to the enhancement of that space may be appropriate (go to stage TWO). In the case of accommodation provided by the Universities, access to the University's own sports grounds will be considered in negotiation. For larger development areas (e.g. Waterside, Ashton Green) new off-site green space provision will be sought in accordance with site development guidance, strategies or masterplans for the area in order to address local need.

Cross boundary issues

If the development site is close to a ward boundary check whether or not the site falls within the catchment of a piece of green space in the adjoining ward (see the Open Space Study Appendix). If the development is within a catchment, it may not be necessary to provide that type of space, but a contribution to the enhancement of existing green space may be necessary (go to stage TWO).

STAGE TWO: Is there a need to enhance the quality of green space provision?

A. The quality of green spaces has been assessed as part of the PPG17 Study and Green Space Strategy. Parks and Green Spaces Service will periodically update the quality audits and advise whether or not a contribution to improve the quality of particular green spaces is appropriate. The Nature Conservation Officer should also be consulted if there is a requirement for natural green space.

B. If it is not possible to provide on-site green space, enhancements will be made to upgrade existing green space so it is of a quality that is equivalent to new on-site green space, in order to serve the development. If they are necessary, contributions will be calculated by the figures in Appendix 2. This is calculated by multiplying the total number of each different type of house by the financial contributions for enhancement shown in Appendix 2. The tables in the appendix provide guidance for the calculation of payments by developers for the provision or enhancement of green space. The payments may be adjusted according to the particular planning application. They provide a starting point for negotiations between the City Council and developers.

Number of Units	Multiplied by Financial Contribution (£) – E.G. Enhancement of Parks and Gardens	Payment Required
50 (2 beds)	x 372.31	= £18,615
75 (3 beds)	x 465.39	= £34,904.25
75 (4 beds)	x 558.47	= £41,885.25
	Overall Total	**= £95,404.05**

The costs for enhancements, shown in Appendix 2, will be linked to the RICS Building Cost Information Service Tender Price Index and revised annually, to ensure that account is taken for inflation.

STAGE THREE: Are there any significant barriers to access of green space?

Developer contributions secured for enhancements may also be used to improve access to green spaces. This might include new access points, improving signage or altering gradients to make them wheelchair accessible.

The Highway Authority may also seek developer contributions for works to the highway, such as pedestrian crossings, which can improve the accessibility of green spaces.

Where are the green spaces to be provided?

Any new green space provision should, as a priority, be provided on-site within the new development. However, there may be some cases where it would not be possible to provide the green space on the application site. If this is the case, the developer should consider, as a priority, green space on an alternative site to serve the development. Alternatively an off-site contribution will be sought either for the improvement in the quality of an existing piece of green space, or to allow the City Council to change the type of an existing piece of green space to one that may be more appropriate. As green spaces can be multi functional (i.e. they serve several different functions) there may be instances where it is appropriate to spend contributions for different types of green space within one green space. For instance, a contribution to improve the quality of an equipped children's play area (Children and Young Peoples Space) within an "Amenity Green Space" or to improve the quality of football pitches (Outdoor Sports Provision) that are located on a Park (Parks & Gardens).

For larger development areas (e.g. Waterside, Ashton Green) new off-site provision will be sought in accordance with site development guidance, strategy or masterplan for the area in order to address local need. In some instances the Council may look to purchase a piece of land to provide a new piece of green space, and will expect the developer to contribute towards the cost of the purchase of the land and provide a commuted sum for the maintenance of the green space, for twenty years.

Pooled contributions

If several small developments are located in close proximity to one another and provide developer contributions, the council may choose to pool the contributions. The council may then spend them to either provide a new area of green space or to enhance an area of green space that will serve all the developments that contributed.

Minimum sizes of new green spaces

In order to provide usable green spaces which can be easily and economically maintained, green spaces below the minimum sizes below would not normally be acceptable:

Park and Garden:	0.25 hectares
Informal Green Space:	0.25 hectares
Equipped Children's and Young Peoples Space:	0.04 hectares
Outdoor Sports Space:	0.8 hectares
Natural Greenspace:	0.25 hectares
Allotments:	0.2 hectares

Adopting areas of green space

The City Council will consider adopting areas of green space, subject to this being in the public and Councils interest. If the Council is to adopt green space, it will require a commuted sum to be paid to provide for the maintenance cost of the green space for 20 years. The commuted sum is to be paid at the time the Council takes over ownership of the land through a land transfer agreement. Before the council will consider adopting a piece of green space, it will need to be satisfied that the equipment and facilities have been installed and maintained to an acceptable standard. The level of contribution will vary by the type of green space, and guideline costs are shown in Appendix 3 and are calculated on the area of green space to be adopted. The costs shown in Appendix 3 will be index linked to the RICS Building Cost Information Service Tender Price Index and revised annually to take account of inflation.

The figures shown in Appendix 3 are calculated by multiplying the cost of maintenance works and equipment for different green spaces. The individual cost of the works and equipment for each type of green space is shown in the calculations document accompanying this SPD. It should be noted that the figures shown in Appendix 3 are an illustrative guide only to allow an early estimate of the cost of commuted sums. Exact commuted sums will be calculated based on the actual site and facilities to be adopted. It should be noted that the City Council may not provide all of the equipment shown in the calculations document, but may choose to spend the money on other equipment or maintenance to ensure that the green spaces are well equipped and maintained.

As the calculation of on and off-site contributions for green space can be a complex process, Officers in Planning Management and Delivery (0116 252 7000) will confirm to the developer the total contribution required.

Biodiversity

When undertaking works to green spaces, protected species, Biodiversity Action Plan species and biodiversity must be considered. Native species will be preferred in planting schemes for the creation of new green spaces and habitats should be managed in order to enhance biodiversity. Please contact the Nature Conservation Officer on (0116) 252 7222 for more information.

Crime and Green Space

Green spaces and their relationship to developments should be designed and maintained in accordance with "Secured by Design" principles in order to reduce crime, the fear of crime and to promote public safety.

Heritage Assets

Heritage assets are sometimes found in green spaces. Proposals to enhance heritage assets should be considered in parallel with green space enhancements. Please contact the Building Conservation Officer on (0116) 252 7222 for more information.

Additional services

Leicester City Council offers a service to design and build Equipped Children and Young Peoples Spaces. This can save time in negotiating and building facilities to a standard that the Council is prepared to adopt. Please contact the Play and Development Officer on (0116) 2914491 for more details on this service.

Appendix 1

Green space provision by ward

These figures have been provided by the Leicester City Council Open Space, Sport and Recreation Study. They show only the quantitative aspect of green space and do not reflect thequality audits undertaken as part of the study. They will be updated as the above study is updated.

ABBEY				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	39.81	6.36	33.45	Sufficient supply
Informal Green Space	10.51	6.36	4.15	Sufficient supply
Equipped Children and Young People's Space	1.63	1.02	0.61	Sufficient supply
Outdoor Sports Space	10.36	12.71	-2.35	Under supply
Natural Green Space	3.1	6.36	-3.26	Under supply
Allotments	10.43	3.81	6.62	Sufficient supply

AYLESTONE				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	1.74	5.4	-3.66	Under supply
Informal Green Space	8.1	5.4	2.7	Sufficient supply
Equipped Children and Young People's Space	0.75	0.86	-0.11	Under supply
Outdoor Sports Space	24.73	10.8	13.93	Sufficient supply
Natural Green Space	63.37	5.4	57.97	Sufficient supply
Allotments	4.42	3.24	1.18	Sufficient supply

BEAUMONT LEYS				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	47.92	6.92	41	Sufficient Supply
Informal Green Space	29.83	6.92	22.91	Sufficient Supply
Equipped Children and Young People's Space	1.16	1.11	0.05	Sufficient Supply
Outdoor Sports Space	2.4	13.84	-11.44	Under supply
Natural Green Space	106.4	6.92	99.48	Sufficient Supply
Allotments	2.37	4.15	-1.78	Under supply

BELGRAVE				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	2.24	5.15	-2.91	Under Supply
Informal Green Space	0	5.15	-5.15	Under Supply
Equipped Children and Young People's Space	0.55	0.82	-0.27	Under Supply
Outdoor Sports Space	0	10.3	-10.3	Under Supply
Natural Green Space	1.59	5.15	-3.56	Under Supply
Allotments	3.21	3.09	0.12	Sufficient Supply

BRAUNSTONE PARK AND ROWLEY FIELDS				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	72.59	8.31	64.28	Sufficient Supply
Informal Green Space	7.28	8.31	-1.03	Under Supply
Equipped Children and Young People's Space	0.63	1.33	-0.7	Under Supply
Outdoor Sports Space	0.3	16.61	-16.31	Under Supply
Natural Green Space	8.55	8.31	0.24	Sufficient Supply
Allotments	17.52	4.98	12.54	Sufficient Supply

CASTLE				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	36.26	6.73	29.53	Sufficient Supply
Informal Green Space	2.64	6.73	-4.09	Under Supply
Equipped Children and Young People's Space	0.73	1.08	-0.35	Under Supply
Outdoor Sports Space	5.13	13.47	-8.34	Under Supply
Natural Green Space	0.72	6.73	-6.01	Under Supply
Allotments	0	4.04	-4.04	Under Supply

CHARNWOOD				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	0	5.33	-5.33	Under Supply
Informal Green Space	4.05	5.33	-1.28	Under Supply
Equipped Children and Young People's Space	0.67	0.85	-0.18	Under Supply
Outdoor Sports Space	0	10.66	-10.66	Under Supply
Natural Green Space	0	5.33	-5.33	Under Supply
Allotments	2.88	3.2	-0.32	Under Supply

COLEMAN				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	12.74	6.05	6.69	Sufficient Supply
Informal Green Space	0.19	6.05	-5.86	Under Supply
Equipped Children and Young People's Space	0.78	0.97	-0.19	Under Supply
Outdoor Sports Space	0.8	12.1	-11.3	Under Supply
Natural Green Space	2.35	6.05	-3.7	Under Supply
Allotments	7.05	3.63	3.42	Sufficient Supply

EVINGTON				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	28.1	4.89	23.21	Sufficient Supply
Informal Green Space	1.1	4.89	-3.79	Under Supply
Equipped Children and Young People's Space	0.53	0.78	-0.25	Under Supply
Outdoor Sports Space	13.97	9.79	4.18	Sufficient Supply
Natural Green Space	6.02	4.89	1.13	Sufficient Supply
Allotments	6.82	2.94	3.88	Sufficient Supply

EYRES MONSELL				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	0	5.61	-5.61	Under Supply
Informal Green Space	22.52	5.61	16.91	Sufficient Supply
Equipped Children and Young People's Space	0.85	0.9	-0.05	Under Supply
Outdoor Sports Space	8.96	11.23	-2.27	Under Supply
Natural Green Space	2.43	5.61	-3.18	Under Supply
Allotments	0	3.37	-3.37	Under Supply

FOSSE				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	0	5.37	-5.37	Under Supply
Informal Green Space	8.42	5.37	3.05	Sufficient Supply
Equipped Children and Young People's Space	0.62	0.86	-0.24	Under Supply
Outdoor Sports Space	0.45	10.74	-10.29	Under Supply
Natural Green Space	0	5.37	-5.37	Under Supply
Allotments	0	3.22	-3.22	Under Supply

FREEMEN				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	0	4.99	-4.99	Under Supply
Informal Green Space	16.11	4.99	11.12	Sufficient Supply
Equipped Children and Young People's Space	0.27	0.8	-0.53	Under Supply
Outdoor Sports Space	3.09	9.98	-6.89	Under Supply
Natural Green Space	1.66	4.99	-3.33	Under Supply
Allotments	7.38	2.99	4.39	Sufficient Supply

HUMBERSTONE AND HAMILTON				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	7.96	5.95	2.01	Sufficient Supply
Informal Green Space	19.07	5.95	13.12	Sufficient Supply
Equipped Children and Young People's Space	0.81	0.95	-0.14	Under Supply
Outdoor Sports Space	1.71	11.89	-10.18	Under Supply
Natural Green Space	18.54	5.95	12.59	Sufficient Supply
Allotments	2.48	3.57	-1.09	Under Supply

KNIGHTON				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	25.98	8.13	17.85	Sufficient Supply
Informal Green Space	1.29	8.13	-6.84	Under Supply
Equipped Children and Young People's Space	1.05	1.3	-0.25	Under Supply
Outdoor Sports Space	4.03	16.27	-12.24	Under Supply
Natural Green Space	6.46	8.13	-1.67	Under Supply
Allotments	6.16	4.88	1.28	Sufficient Supply

LATIMER				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	4.39	5.79	-1.4	Under Supply
Informal Green Space	4.3	5.79	-1.49	Under Supply
Equipped Children and Young People's Space	0.58	0.93	-0.35	Under Supply
Outdoor Sports Space	0.88	11.58	-10.7	Under Supply
Natural Green Space	0	5.79	-5.79	Under Supply
Allotments	0	3.47	-3.47	Under Supply

NEW PARKS				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	0	8.01	-8.01	Under Supply
Informal Green Space	5.14	8.01	-2.87	Under Supply
Equipped Children and Young People's Space	0.86	1.28	-0.42	Under Supply
Outdoor Sports Space	7.5	16.02	-8.52	Under Supply
Natural Green Space	17.7	8.01	9.69	Sufficient Supply
Allotments	9.2	4.81	4.39	Sufficient Supply

RUSHEY MEAD				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	17.23	7.57	9.66	Sufficient Supply
Informal Green Space	4	7.57	-3.57	Under Supply
Equipped Children and Young People's Space	1.12	1.21	-0.09	Under Supply
Outdoor Sports Space	2.45	15.13	-12.68	Under Supply
Natural Green Space	61.35	7.57	53.78	Sufficient Supply
Allotments	4	4.54	-0.54	Under Supply

SPINNEY HILLS				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	14.37	10.62	3.75	Sufficient Supply
Informal Green Space	1.72	10.62	-8.9	Under Supply
Equipped Children and Young People's Space	1.62	1.7	-0.08	Under Supply
Outdoor Sports Space	0	21.25	-21.25	Under Supply
Natural Green Space	0	10.62	-10.62	Under Supply
Allotments	5.07	6.37	-1.3	Under Supply

STONEYGATE				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	0	10.62	-10.62	Under Supply
Informal Green Space	0	10.62	-10.62	Under Supply
Equipped Children and Young People's Space	0.51	1.7	-1.19	Under Supply
Outdoor Sports Space	0	21.25	-21.25	Under Supply
Natural Green Space	0	10.62	-10.62	Under Supply
Allotments	1.22	6.37	-5.15	Under Supply

THURNCOURT				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	11.57	4.97	6.6	Sufficient Supply
Informal Green Space	6.56	4.97	1.59	Sufficient Supply
Equipped Children and Young People's Space	0.08	0.79	-0.71	Under Supply
Outdoor Sports Space	3.07	9.94	-6.87	Under Supply
Natural Green Space	0	4.97	-4.97	Under Supply
Allotments	1.18	2.98	-1.8	Under Supply

WESTCOTES				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	2	4.33	-2.33	Under Supply
Informal Green Space	0	4.33	-4.33	Under Supply
Equipped Children and Young People's Space	0.39	0.69	-0.3	Under Supply
Outdoor Sports Space	3.35	8.65	-5.3	Under Supply
Natural Green Space	0	4.33	-4.33	Under Supply
Allotments	0	2.6	-2.6	Under Supply

WESTERN PARK				
TYPOLOGY	**Existing Provision (ha)**	**Required Provision (ha)**	**Surplus/ Deficiency (ha)**	**Surplus/ Deficiency**
Parks and Gardens	68.36	4.33	64.03	Sufficient Supply
Informal Green Space	0	4.33	-4.33	Under Supply
Equipped Children and Young People's Space	1.57	0.87	0.7	Sufficient Supply
Outdoor Sports Space	0	8.65	-8.65	Under Supply
Natural Green Space	0	4.33	-4.33	Under Supply
Allotments	2.73	2.6	0.13	Sufficient Supply

Appendix 2

Developer contributions:
Costs for enhancement and new off-site provision

Type of Green Space	Financial contribution (£)						
	Student	Elderly persons dwelling	1 bedroom dwelling	2 bedroom dwelling	3 bedroom dwelling	4+ bedroom dwelling	Unknown dwelling size
Parks & Gardens	186.16	186.16	279.23	372.31	465.39	558.47	465.39
Informal Green Space	68.48	68.48	102.72	136.96	171.20	205.44	171.20
Equipped Childrens & Young People's Space	0.00	0.00	0.00	292.87	366.09	439.31	366.09
Outdoor Sports Space	318.39	318.39	477.58	636.77	795.96	955.16	795.96
Natural Green Space	31.53	31.53	47.29	63.06	78.82	94.59	78.82
Allotments	0.00	21.69	32.54	43.38	54.23	65.07	54.23
Maximum Total Contribution	604.55	626.24	939.36	1252.48	1565.60	1878.72	1565.60

For the provision of new off-site green space, in addition to the costs above, a contribution towards land acquisition costs will also be expected.

These costs will be index linked to the RICS Building Cost Information Service Tender Price Index and revised annually to take account of inflation.

Appendix 3

Commuted sum payments

Provision	Annual Cost (£/per Ha)	Commuted Sum (£/per m² x CSM)
Parks & Gardens	22,017	54.45
Informal Green Space	6,249	15.45
Equipped Children & Young Peoples Space	36,772	90.94
Outdoor Sports Space	9,260	22.90
Natural Green Space	4,243	10.49
Allotments	1,346	3.33
Commuted sum period	20 years	
Commuted Sums Multiplier (CSM)	24.73	

(CSM = Commuted Sum Multiplier (period for contributions + inflation - interest earned))

These costs will be index linked to the RICS Building Cost Information Service Tender Price Index and revised annually to take account of inflation.

It should be noted that the figures shown in Appendix 3 are an illustrative guide only to allow an early estimate of the cost of commuted sums. Exact commuted sums will be calculated based on the actual site and facilities to be adopted and the current inflation and interest rates.

Leicester City
local
development
framework

Supplementary
Planning Document

GREENSPACE SPD
Calculations Document

PRE-ADOPTION DRAFT
January 2011

CONTENTS

Introduction	**5**
Developer contributions formula	**6**
Summary	**6**
Costs for enhancement and new off-site provision	**6**
Parks & gardens	**7**
Informal green space	**8**
Equipped children's & young people's play space	**9**
Outdoor sports space	**11**
Natural green space	**12**
Allotments	**13**
Commuted sums	**14**
Summary: Costs for enhancement and new off-site provision	**14**
Commuted sum payments	**14**
Parks & gardens	**15**
Informal green space	**17**
Equipped children's & young people's play space	**19**
Outdoor sports space	**20**
Natural green space	**21**
Allotments	**22**
References for S106 cost model	**23**

Other languages and large print

اگرآپ اس دستاویز کی وضاحت چاہتے ہیں، یا اگرآ پکو اپنی آرا لکھنے کیلئے مدد چاہیے تو براہ مہربانی (0116)2527233 پر ٹیلیفون کریں

আপনি যদি চান - এই ডকুমেন্টটি (দস্তাবেজ) আপনার কাছে ব্যাখ্যা করা হোক বা আপনার মন্তব্য লেখার জন্য সাহায্যের প্রয়োজন হলে, অনুগ্রহ করে (0116) 252 7233 নম্বরে টেলিফোন করুন ।

જો આ દસ્તાવેજ તમને સમજાવવાની જરૂર હોય, અથવા તમારી ટીકાઓ લખવામાં તમને મદદ જોઈતી હોય તો મહેરબાની કરી (0116) 2527233 ઉપર ફોન કરો.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਸਮਝਣ ਵਿੱਚ ਮਦੱਦ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਜਾਂ ਜੇਕਰ ਤੁਹਾਨੂੰ ਆਪਣੇ ਵਿਚਾਰ ਲਿਖਣ ਵਿੱਚ ਮਦੱਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ (0116) 252 7233 ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ ।

如果你需要有人給你解釋這文件，或如果你需要人協助填寫你的意見請致電（0116）2527233

Haddii aad u baahan tahay in dukumentigan laguu sharxo, ama haddii aad u baahan tahay in lagaa caawino qoraalka wixii fikrad dhiibasho ah fadlan soo wac teleefoonka ah (0116)2527233

Eğer bu belgenin size açıklanmasını istiyorsanız, ya da yorumlarınızı yazmada yardıma ihtiyacınız varsa lütfen (0116) 2527233’e telefon ediniz.

ئەگەر پێویستت كرد شروڤە كردني ئەم دوكیومەنتە،یان پێویستی یارمەتي بۆی بو نۆسینی هەر شتێك تكایە پەیوەندی بەم ژمارە تەلەفونە بكە (0116) 252 7233

Jeśli chcesz by ten dokument tobie wytłumaczyć lub potrzebujesz pomocy z napisaniem twoich uwag proszę dzwonić pod numer (0116) 2527233

اگرنیاز دارید که این مدرک برای شما توضیح داده شود یا اگربرای نوشتن نظراتتان نیاز به کمک دارید لطفا با شماره 0116 2527233 تماس بگیرید.

If you require this document in large print, audio cassette, Braille or languages other than English please telephone (0116) 2527233 or email planning.policy@leicester.gov.uk

Introduction

This calculations document contains figures for enhancement and the provision of different types of green space. It also contains an illustrative guide to figures for commuted sums. The figures for the enhancement and provision of new green space are calculated by multiplying the cost of providing facilities and equipment found in green spaces per hectare. The price per hectare is then converted into the price per person, based on the open space standards. This then allows the total cost to be calculated as per house type, based on the number of people each house is expected to support. For the provision of new off-site green space, the enhancement cost is used, and a contribution towards land acquisition costs will also be expected.

The commuted sum figures were calculated by calculating the cost of maintaining the different types of green space per year per hectare. The projected inflation and interest rates are then applied to this figure to give the total commuted sum to allow maintenance of the green space for 20 years. It should be noted that the figures shown for commuted sums are an illustrative guide only to allow an early estimate of the cost of commuted sums. Exact commuted sums will be calculated based on the actual site and facilities to be adopted and the current inflation and interest rates.

Developer contributions formula

Summary

Costs for enhancement and new off-site provision

Type of Green Space	Financial contribution (£)						
	Student	Elderly Persons dwelling	1 bedroom dwelling	2 bedroom dwelling	3 bedroom dwelling	4+ bedroom dwelling	Unknown dwelling size
Parks & Gardens	186.16	186.16	279.23	372.31	465.39	558.47	465.39
Informal Green Space	68.48	68.48	102.72	136.96	171.20	205.44	171.20
Equipped Children’s & Young People's Space	0.00	0.00	0.00	292.87	366.09	439.31	366.09
Outdoor Sports Space	318.39	318.39	477.58	636.77	795.96	955.16	795.96
Natural Green Space	31.53	31.53	47.29	63.06	78.82	94.59	78.82
Allotments	0.00	21.69	32.54	43.38	54.23	65.07	54.23
Maximum Total Contribution	604.55	626.24	939.36	1,252.48	1,565.60	1,878.72	1,565.60

For the provision of new off-site green space, in addition to the costs above, a contribution towards land acquisition costs will also be expected. These costs will be index linked to the RICS Building Cost Information Service Tender Price Index and revised annually to take account of inflation.

Open Space Standards	Ha per 1000 Population
Parks & Gardens	0.50
Informal Green Space	0.50
Equipped Children’s & Young People’s Space	0.08
Outdoor Sports Space	1.00
Natural Green Space	0.50
Allotments	0.30
Overall open space standard	2.88

Occupation Rates	
Number of Bedrooms	Estimated Number of Residents
1	1.5
2	2.0
3	2.5
4+	3.0
Unknown Dwelling Size	2.5
Student Accommodation	No. of students to be accommodated

Parks & gardens

Item	Works/Goods Description	Rate	Unit	Provision per Ha	Cost per Ha
Clearing	Clear site/ground	£0.56	m^2	10,000	£5,600.00
Pathways	Provide and install 1.5m tarmac path (10%)	£50.00	m^2	1,000	£50,000.00
Planted areas (15%)	Provide Shrubs (80%) & Roses/Bedding Plants (20%)	£20.00	m^2	1,500	£30,000.00
	Supply and spread topsoil up to 150mm	£40.00	m^3	225	£9,000.00
	Cultivate and plant shrubs & bedding plants	£3.00	m^2	1,500	£4,500.00
Grass (70%)	Supply and spread topsoil up to 150mm	£40.00	m^3	1,050	£42,000.00
	Supply & spread grass seed with fertiliser	£0.65	m^2	7,000	£4,550.00
Trees	Supply and establish trees (16/18 minimum)	£415.00	no.	70	£29,050.00
Signage	Supply & install notice board with graphics & info	£1,800.00	no.	1	£1,800.00
	Supply & install descriptive signs (contacts/ closing times etc)	£200.00	no.	3	£600.00
Features*	Cost of features e.g. bandstand/toilets	£105,000.00	no.	1	£105,000.00
Fencing	Supply & erect perimeter cast iron boundary fence & gates	£100.00	lin metre	400	£40,000.00
Seating	Supply and install benches	£525.00	no.	10	£5,250.00
Bins	Supply & install litter bins	£360.00	no.	6	£2,160.00
	Supply & install dog bins	£325.00	no.	3	£975.00
Car Parking	Construct visitor car parking	£60.00	m^2	133	£7,980.00
				Subtotal	£338,465.00
Professional fees	Landscape architect/Quantity surveyor/ planning fees etc	10	%	1	£33,846.50
				Total cost per Ha	£372,311.50
				Provision rate per 1,000/Ha	0.50
				Rate per person	£186.16

* Indicative facilities/features to be found on a District Park	
Toilet Block	£120,000
Bandstand	£90,000
Average Cost Total	£105,000

Informal green space

Item	Works/Goods Description	Rate	Unit	Provision per Ha	Cost per Ha
Clearing	Clear site/ground	£0.56	m^2	10,000	£5,600.00
Pathways	Provide and install 1.5m tarmac path (10%)	£50.00	m^2	1,000	£50,000.00
Grass (80%)	Supply and spread topsoil up to 150mm	£40.00	m^3	1,200	£48,000.00
	Supply & spread grass seed with fertiliser	£0.65	m^2	8,000	£5,200.00
Planted areas (5%)	Provide Shrubs	£20.00	m^2	500	£10,000.00
	Supply and spread topsoil up to 150mm	£40.00	m^3	75	£3,000.00
	Cultivate and plant shrubs	£3.00	m^2	500	£1,500.00
Hedging	Supply field hedge (5 plants per m)	£1.75	lin metre	200	£350.00
	Clear debris/cultivate/plant	£1.00	lin metre	200	£200.00
Trees	Supply and establish trees (16/18 minimum)	£415.00	no.	20	£8,300.00
	Supply tree whips (60/80)	£0.60	no.	150	£90.00
	Whip planting with rabbit guards	£0.85	no.	150	£127.50
Signage	Supply & install descriptive signs (contact information etc)	£200.00	no.	2	£400.00
Seating	Supply and install benches	£525.00	no.	4	£2,100.00
Bins	Supply & install litter bins	£360.00	no.	4	£1,440.00
	Supply & install dog bins	£325.00	no.	2	£650.00
				Subtotal	£136,957.50
				Provision rate per 1,000/Ha	0.50
				Rate per person	£68.48

Equipped children's & young people's play space

Item	Works/Goods description	Rate	Unit	Provision per Ha	Cost per Ha
Clearing	Clear site/ground	£0.56	m^2	10,000	£5,600.00
Pathways	Construct breedon gravel footpath (15%)	£61.00	m^2	150	£9,150.00
Excavations	Excavate area for loose-fill safer surfacing	£3.50	m^2	450	£1,575.00
Mounding	Form evenly graded mounds from excavated topsoil/subsoil	£12.00	m^2	100	£1,200.00
Drainage	Excavate and form new soakaway	£186.00	m^3	4	£744.00
	Excavate and lay new land drain	£106.00	m	30	£3,180.00
Safer Surfacing	Supply and lay precast concrete edging to edge of surfacing area	£25.00	m	150	£3,750.00
	Supply and lay graded stone subbase for wet pour rubber surfacing	£22.00	m^2	450	£9,900.00
	Supply and lay wet pour rubber safety surfacing	£88.00	m^2	450	£39,600.00
Play Equipment	Supply and install polyethylene tunnel	£2,500.00	no.	1	£2,500.00
	Supply and install toddler multi-play unit	£11,078.00	no.	1	£11,078.00
	Supply and install 3 seat swing	£3,367.00	no.	1	£3,367.00
	Supply and install toddler seesaw	£972.00	no.	1	£972.00
	Supply and install spinner	£540.00	no.	1	£540.00
	Supply and install junior multi-play unit	£18,203.00	no.	1	£18,203.00
	Supply and install basket/flat seat swing	£5,005.00	no.	1	£5,005.00
	Supply and install junior roundabout	£5,449.00	no.	1	£5,449.00
	Supply and install track aerial runway	£6,789.00	no.	1	£6,789.00
	Supply and install five-a-side goals	£5,800.00	no.	1	£5,800.00
Fencing	Supply and erect 1.2 m high railings	£75.00	m	120	£9,000.00
	Supply and install hydraulic self-closing pedestrian gate	£155.00	no.	3	£465.00
	Supply and install 3m wide maintenance gate	£350.00	no.	1	£350.00
Landscape Furniture	Supply and install DDA complaint benches	£1,011.00	no.	3	£3,367.00
	Supply and install flared top metal bin with lid	£695.00	no.	2	£1,390.00
Natural Play	Supply and position granite play boulders	£350.00	no.	5	£1,750.00
	Supply and install natural balance trail	£2,500.00	no.	1	£2,500.00
	Supply and lay grass matting	£38.00	m^2	100	£3,800.00
Horticultural works	Cultivate and grass seed	£10.20	m^2	300	£3,060.00

Item	Works/Goods description	Rate	Unit	Provision per Ha	Cost per Ha
	Cultivate and plant	£30.00	m^2	100	£3,000.00
	Excavate tree pit, supply and plant	£415.00	no.	8	£3,320.00
				Subtotal	£166,404.00
Professional fees	Landscape architect/Quantity surveyor/ planning fees etc	10	%	1	£16,640.40
				Subtotal	£183,044.40
	Model is based on a play area of 1,000 m2 therefore the subtotal is multipled by 10 to generate the cost per hectare	10			
				Total	£1,830,444.00
				Provision rate per 1,000/Ha	0.08
				Rate per person	£146.44

Outdoor sports space

Item	Works/Goods description	Rate	Unit	Provision per Ha	Cost per Ha
Based on costs of providing 1 new grass football pitch and associated facilities as per Sport England guidelines		£318,385.00		1	£318,385.00
				Subtotal	£318,385.00
				Provision rate per 1,000/Ha	1.00
				Rate per person	£318.39

Notes
Costs from Sport England facility costs Q1 2010. To provide one pitch, changing room, car parking and access road will cost £355,000 and requires 11,150 m^2 of space. Therefore a site area multiplier of 1.115 is used to calculate the provision cost per Hectare.

Natural green space

Item	Works/Goods Description	Rate	Unit	Provision per Ha	Cost per Ha
Pathways	Provide and install 1.5m wide tarmac path	£50.00	m^2	150	£7,500.00
	Provide and install 1.5m wide path with MOT 1 stone base and 50mm wood chip top cover	£10.00	m^2	300	£3,000.00
Signage	Supply & install notice board with graphics & info	£1,800.00	no.	1	£1,800.00
Seating	Supply and install benches	£525.00	no.	2	£1,050.00
Bins	Supply & install litter bins	£360.00	no.	1	£360.00
	Supply & install dog bins	£325.00	no.	1	£325.00
Hedging	Supply field hedge (5 plants per m)	£1.75	lin metre	200	£350.00
	Clear debris/cultivate/plant	£1.00	lin metre	200	£200.00
Fencing	Supply & erect post and rail fencing	£21.00	lin metre	394	£8,274.00
Woodland	Supply tree whips (60/80)at 1m centres	£0.60	no.	5,000	£3,000.00
	Whip planting with guards	£0.85	no.	5,000	£4,250.00
Meadows	Supply & spread wildflower grass seed	£0.65	m^2	3,000	£1,950.00
	Cultivate ground for seed sowing	£3.00	m^2	3,000	£9,000.00
Wetlands and Ponds	Provide scrape, ponds, reed beds and marginal planting	£22.00	m^2	1,000	£22,000.00
				Subtotal	£63,059.00
				Provision rate per 1,000/Ha	0.50
				Rate per person	£31.53

Allotments

Item	Works/Goods description	Rate	Unit	Provision per Ha	Cost per Ha
Clearing	Clear site/ground	£0.56	m^2	10,000	£5,600.00
Fencing	Supply and erect 1.8m triple spiked palisade perimeter fencing with access gates	£70.00	Lin metre	400	£28,000.00
Pathways	Provide and install 1.5m wide path with MOT 1 stone base and scalpings top cover	£10.00	m^2	600	£6,000.00
Access Road/Car Parking	Provide 4m access road and car parking for 30 plots. Hardcore and scalpings construction	£10.00	m^2	950	£9,500.00
Toilets	Install composting toilet facility	£8,000.00	no.	1	£8,000.00
Signage	Site sign with contact details	£200.00	no.	1	£200.00
Water supply	Supply and install water standpipes	£1,500.00	no.	10	£15,000.00
				Subtotal	£72,300.00
				Provision rate per 1,000/Ha	0.30
				Rate per person	£21.69

Commuted sums

Summary

Commuted sum payments

Provision	Annual Cost (£/per Ha)	Commuted Sum (£/per m² x CSM)
Parks & Gardens	22,017	54.45
Informal Green Space	6,249	15.45
Equipped Children & Young Peoples Space	36,772	90.94
Outdoor Sports Space	9,260	22.90
Natural Green Space	4,243	10.49
Allotments	1,346	3.33
Commuted sum period	20 years	
Commuted Sums Multiplier (CSM)	24.73	

(CSM = Commuted Sum Multiplier (period for contributions + inflation - interest earned))

These costs will be index linked to the RICS Building Cost Information Service Tender Price Index and revised annually to take account of inflation.

It should be noted that the figures shown above for commuted sums are an illustrative guide only to allow an early estimate of the cost of commuted sums. Exact commuted sums will be calculated based on the actual site and facilities to be adopted and the current inflation and interest rates.

Open Space Standards	Ha per 1000 Population
Parks & Gardens	0.50
Informal Green Space	0.50
Equipped Children’s & Young People’s Space	0.08
Outdoor Sports Space	1.00
Natural Green Space	0.50
Allotments	0.30
Overall open space standard	2.88

Parks & gardens

Main Operation	Maintenance Specification	Rate (£)	Measure / per Ha	Unit	Cost per Ha
Years 1-2					
Maintain Grass	Ornamental Grass (A)	1.621037500	1,000	m²	1,621.04
	Ornamental Grass (C)	0.221143264	6,000	m²	1,326.86
Maintain Planted Areas	Ornamental Shrub Beds (A)	3.656175000	1,200	m²	4,387.41
	Rose Beds (A)	7.305380000	150	m²	1,095.81
	Annual Bedding (A)	26.896717500	150	m²	4,034.51
	Replacement plant stock (10%)	20.00	150	m²	3,000.00
	Plant replacement stock	3.00	150	m²	450.00
Maintain Paths	Paths & Hard Surfaces (A)	0.518240	1,000	m²	518.24
Maintain Car Park	Paths, Hard Surfaces,Car Parks (A)	0.518240	133	m²	68.93
Maintain Features	Toilets	94.605450	30	m²	2,838.16
General Maintenance	Litter Bins (A)	132.286500	6	no.	793.72
	Dog Bins (A)	135.659160	3	no.	406.98
	Litter General (A)	0.159759332	8,500	m²	1,357.95
	Graffiti Removal/Clean signs,bins etc	250.00	1	no.	250.00
Inspections/Security	Weekly patrol by Parks Officer	12.77	52	visits	664.04
			Total cost		**22,813.64**
Years 3 onwards					
Maintain Grass	Ornamental Grass (A)	1.621037500	1,000	m²	1,621.04
	Ornamental Grass (C)	0.221143264	6,000	m²	1,326.86
Maintain Planted Areas	Ornamental Shrub Beds (A)	3.6561750	1,200	m²	4,387.41
	Rose Beds (A)	7.3053800	150	m²	1,095.81
	Annual Bedding (A)	26.8967175	150	m²	4,034.51
Maintain Trees	Remedial work & surveying 1/5 years	13.00	14	no.	182.00
Maintain Paths	Paths & Hard Surfaces (A)	0.5182400	1,000	m²	518.24
	Repair/resurface hard surface (4%)	25.00	40	m²	1,000.00
Maintain Car Park	Paths,Hard Surfaces,Car Parks (A)	0.5182400	133	m²	68.93
	Repair/resurface hard surface (4%)	25.00	5.32	m²	133.00
Maintain Features	Toilets	94.6054500	30m	m²	2,838.16

Main Operation	Maintenance Specification	Rate (£)	Measure / per Ha	Unit	Cost per Ha
General Maintenance	Litter Bins (A)	132.286500	6	no.	793.72
	Dog Bins (A)	135.659160	3	no.	406.98
	Litter General (A)	0.159759332	8,500	m^2	1,357.95
	Graffiti Removal/clean signs, bins etc	250.00	1	no.	250.00
	Clean & repaint fencing 1/20 years	60.00	20	lin metres	1,200.00
	Paint Seats 1/5 years	25.00	2	no.	50.00
Inspections/Security	Weekly patrol by Parks Officer	12.77	52	visits	664.04
		Total cost			**£21,928.64**
		Average cost per year/per hectare			**£22,017.14**
		Cost x CSM			**£544,477.46**
		Commuted sum per m^2			**£54.45**
CSM = Commuted Sum Multiplier (period for contributions + inflation - interest earned)					

Informal green space

Main Operation	Maintenance Specification	Rate (£)	Measure / per Ha	Unit	Cost per Ha
Years 1-2					
Maintain Grass	Amenity Grass (E)	0.214237259	8,000	m^2	1,713.90
Maintain Planted Areas	Amenity Shrub Beds (A)	1.044644254	500	m^2	522.32
	Replacement plant stock (10%)	20.00	50	m^2	1,000.00
	Plant replacement stock	3.00	50	m^2	150.00
Maintain trees	Replacement whip planting (10%)	0.60	15	no.	9.00
	Whip planting with guards	0.85	15	no.	12.75
Maintain Paths	Paths & Hard Surfaces (B)	0.518082	1,000	m^2	518.08
General Maintenance	Litter Bins (A)	132.286500	4	no.	529.15
	Dog Bins (A)	135.659160	2	no.	271.32
	Litter General (B)	0.05330	10,000	m^2	533.00
	Graffiti Removal/clean signs,bins etc	150.00	1	no.	150.00
Inspections/Security	Weekly patrol by Parks Officer	12.77	52	visits	664.04
			Total cost		5,673.32
Years 3 onwards					
Maintain Grass	Amenity Grass (E)	0.214237259	8,000	m^2	1,713.90
Maintain Planted Areas	Amenity Shrub Beds (A)	1.044644254	500	m^2	522.32
Maintain Trees	Remedial work & surveying 1/5 years	13.00	4	no.	52.00
	Whip (new planting) establishment maintenance	0.1444	150	m^2	21.66
Maintain Hedgerow	Hedgerow (B)	0.4413650	800	m^2	353.09
Maintain Paths	Paths & Hard Surfaces (B)	0.518082	1,000	m^2	518.08
	Repair/resurface hard surface (4%)	25.00	40	m^2	1,000.00
General Maintenance	Litter Bins (A)	132.286500	4	no.	529.15
	Dog Bins (A)	135.659160	2	no.	271.32
	Litter General (B)	0.053300000	8,500	m^2	453.05
	Graffiti Removal/clean signs,bins etc	150.00	1	no.	150.00
	Paint Seats 1/5 years	25.00	0.8	no.	20.00

Main Operation	Maintenance Specification	Rate (£)	Measure / per Ha	Unit	Cost per Ha
Inspections/Security	Weekly patrol by Parks Officer	12.77	52	visits	664.04
		Total cost			**£6,268.61**
		Average cost per year/per hectare			**£6,249.10**
		Cost x CSM			**£154,538.48**
		Commuted sum per m^2			**£15.45**
CSM = Commuted Sum Multiplier (period for contributions + inflation - interest earned)					

Equipped children's & young people's space

Main Operation	Maintenance Speciifcation	Rate (£)	Measure / per 1,000m²	Unit	Cost / per 1,000m²
Maintain Grass	Amenity Grass (E)	0.214237259	300	m²	64.27
Maintain Planted Areas	Amenity Shrub Beds (A)	1.044644254	100	m²	104.46
	Replacement plant stock (10%)	20.00	10	m²	200.00
	Plant replacement stock	3.00	10	m²	30.00
Maintain Paths	Paths & Hard Suraces (A)	0.518240	600	m²	310.94
General Maintenance	Litter Bins (A)	132.286500	2	no.	264.57
	Dog Bins (A)	135.659160	1	no.	135.66
	Litter General (B)	0.05330	1,000	m²	53.30
	Graffiti Removal/clean signs,bins etc	150.00	1	no.	150.00
Maintain Trees	Remedial work & surveying	65.00	8	no.	520.00
Visual Inspections	Weekly inspection by Play & Youth Team	21.00	52	visits	1,092.00
Operational Inspections	Monthly inspection by Play & Youth Team	21.00	12	visits	252.00
Play Equipment repairs	Contingency sum	500.00	1	no.	500.00
		Total Cost			**£3,677.20**
		Cost x CSM			**£90,936.08**
		Commuted sum per m²			**£90.94**
CSM = Commuted Sum Multiplier (period for contributions + inflation - interest earned)					

Outdoor sports space

Main Operation	Maintenance Specification	Rate (£)	Measure / per Ha	Unit	Cost per Ha
Maintain Pitch	Football Pitch (A)	1016.5325	1	pitch	1,016.53
	Vertidrain	0.1450	6,400	m^2	928.00
	Sand top dress 1/2 years	0.3000	3,200	m^2	960.00
	Overseed	0.0640	6,400	m^2	409.60
Maintain Grass buffer	Amenity Grass (E)	0.214237259	3,680	m^2	788.39
Maintain Pavilion	Changing Room Cleaning (A)	16.56564	65	m^2	1,076.77
	Showers Cleaning (A)	41.14678	20	m^2	822.94
	Toilets Cleaning (A)	27.0301	15	m^2	405.45
	General building maintenance/security	7.50	100	m^2	750.00
Maintain access road & car park	Paths, hard surfaces & car parks (A)	0.51824	950	m^2	492.33
	Repair/resurface hard surface (4%)	25.00	38	m^2	950.00
Goal Posts	Paint (pair)	50.00	1	no.	50.00
	Replace posts & nets 1/10 years	775.00	0.1	no.	77.50
Litter	Litter (A)	0.159759332	10,000	m^2	1,597.59
		Total cost			**£10,325.10**
		Total cost per Ha			**£9,260.18**
		Cost x CSM			**£229,001.53**
		Commuted sum per m^2			**£22.90**
A site area multiplier of 1.115 is used to calculate the provision cost per Hectare.					
CSM = Commuted Sum Multiplier (period for contributions + inflation - interest earned)					

Natural green space

Main Operation	Maintenance Specification	Rate (£)	Measure / per Ha	Unit	Cost per Ha
Maintain Meadow	Meadow (A)	0.13366	3,000	m^2	400.98
Maintain Wetlands & Ponds	Waterbody (B)	0.9625775	1,000	m^2	962.58
Maintain Hedgerow	Hedgerow (A)	0.4413650	200	m^2	88.27
Maintain Woodland	Woodland (new planting) establishment maintenance	0.1444	5,000	m^2	722.00
Maintain Paths	Paths & Hard Surfaces (B)	0.518082	150	m^2	77.71
	Topdress mulched paths @20%	1.10	60	m^2	66.00
	Repair/resurface hard surface (4%)	25.00	6	m^2	150.00
Maintain Fence	General repairs	250.00	1	no.	250.00
General Maintenance	Litter Bins (A)	132.286500	1	no.	132.29
	Dog Bins (A)	135.659160	1	no.	135.66
	Litter General (B)	0.05330	10,000	m^2	533.00
	Paint Seats 1/5 years	25.00	0.4	no.	10.00
	Graffiti Removal/clean signs,bins etc	50.00	1	no.	50.00
Inspections/Security	Weekly patrol by Parks Officer	12.77	52	visits	664.04
		Total cost			**£4,242.53**
		Cost x CSM			**£104,916.48**
		Commuted sum per m^2			**£10.49**
CSM = Commuted Sum Multiplier (period for contributions + inflation - interest earned)					

Allotments

Main Operation	Maintenance Specification	Rate (£)	Measure / per Ha	Unit	Cost per Ha
Maintain Fence	General repairs	250.00	1	no.	250.00
Maintain Paths & Car Park	Paths, hard surfaces & car parks (B)	0.518081721	1,550	m^2	803.03
General Maintenance	Litter General (C)	0.027841316	1,550	m^2	43.15
	Repair water supply	250.00	1	no.	250.00
			Total cost		**£1,346.18**
		Cost x CSM			**£33,290.65**
		Commuted sum per m^2			**£3.33**
CSM = Commuted Sum Multiplier (period for contributions + inflation - interest earned)					

References for S106 cost model

1. Suggested framework for valuing parks & gardens: Making the invisible visible: the real value of park assets, Cabe Space 2009.

2. Costs for enhancement and new off site provision are based on the laying out of one hectare of each different green space typology, identified as part of PPG17 study and Green Space Strategy. In addition to the costs for enhancement and new off site provision, a contribution towards the cost of land acquisition for the provision of new off site green space will be expected.

3. Formal definitions of park categories - based on Association of Public Excellence's (APSE) criteria.

4. Tree information supplied by LCC Tree Officer from EZYTrees database. Average cost of new tree / Average number of trees per Ha on LCC Green Flag parks & gardens.

5. Furniture prices based on standard parks furniture from Broxap.

6. PPG17 para 33. Planning obligations should be used as a means to remedy local deficiencies in the quantity or quality of open space, sports and recreational provision. Local authorities will be justified in seeking planning obligations where the quantity or quality of provision is inadequate or under threat, or where new development increases local needs. It is essential that local authorities have undertaken detailed assessments of needs and audits of existing facilities, and set appropriate local standards in order to justify planning obligations.

7. PPG17 companion guide para 6.22: Where a developer contributes to off-site provision there is a need for a normalised **capital cost per unit of provision** to establish the payment required. This cost can include any or all of:

    - Land costs and related legal fees;
    - Construction costs (where appropriate, including both the open space or facility and any essential related works, such as fencing, security or floodlighting, CCTV, changing accommodation, car parking and road access) and related design fees;
    - Essential equipment e.g. goalposts or sightscreens;
    - VAT, if this will be non-recoverable.

8. Professional fees in line with recommendations from LCC Property Services (Project Group).

9. Car Park figure based on average area of car parking space at LCC Green Flag parks & gardens. AP 97m^2/Ha, AHG 247 m^2/Ha, EP 136.5 m^2/Ha, KP 50 m^2/Ha = 132.6m^2 per Ha (excludes Abbey Meadows).

10. Outdoor sports space costs based on Sport England Facility Costs (updated Q1 2010) for providing one grass pitch with two team changing pavilion and car parking and access road. Sport England costs used as independent and updated on a quarterly basis.

11. Natural green space based on enhancing a matrix of habitats as advised by LCC Nature Conservation Officer.

12. Allotment costs from refurbishment of sites at Groby Road and Walshe Road 2009/10 provided by LCC Allotments Manager.

APPENDIX 3

Consultation Draft Green Space SPD (15.11.2010 and 13.12.2010) - Responses received and Council response

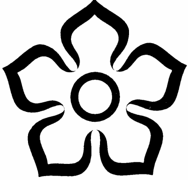
Consultee	Comment	Council Response
P + DC Committee	It was noted that there would be a four week period of public consultation and Members questioned whether enough time had been allowed for this.	The consultation period of four weeks is in accordance with central government regulations. **No Change.**
P + DC Committee	Officers explained that the strategy considered the quantity, quality and the accessibility and links between the green spaces. Members heard that the study could be used as a tool to aid S106 negotiations. Members commented that it was important to protect rights of access.	The SPD seeks to improve the accessibility and links between green spaces, although access rights to individual green spaces is considered on a site by site basis and is therefore not considered in the document. **No Change.**
P + DC Committee	Members thanked officers for the report and asked them to note that Humberstone Ward as referred to in Appendix 1, should read Humberstone and Hamilton.	This section of the Green Space SPD has been corrected to "Humberstone and Hamilton." **Amend Document.**
English Heritage	While the SPD focuses mainly on standards of provision, including the shortfalls in specific areas of the City, there is reference to the opportunities for enhancement, particularly for biodiversity (page 15). It should not be forgotten that Abbey Park, Belgrave Hall, New Walk and Victoria Park are all Grade II registered parks and gardens (as are Saffron Hill and Welford Road cemeteries).They also include a large number of listed structures and buildings and the scheduled abbey remains at Abbey Park. There are also extensive scheduled monuments within the Castle Hill recreational area in the north of the City; at the Jewry Wall site and Leicester Castle. There will be other undesignated parks of local historic interest. It is therefore suggested that a small section should be added on page 15 to highlight the opportunities to enhance the designated heritage assets within these parks; this could include improvements to	Sentence added to page fifteen: "Heritage assets are sometimes found in green spaces. Proposals to enhance heritage assets should be considered in parallel with green space enhancements. Please contact the Building Conservation Officer on (0116) 252 7222 for more information." **Amend Document.**

	their care and maintenance or their interpretation. It should also be made clear that when works are being undertaken, the advice of English Heritage or the City heritage team should be sought, as appropriate.	
Environment Agency	The Environment Agency welcomes the paragraph regarding Biodiversity on page 15 of the document which states that, "*When undertaking works to green spaces, protected species, Biodiversity Action Plan species and biodiversity must be considered. Native species will be preferred in planting schemes for the creation of new green spaces and habitats should be managed in order to enhance biodiversity.*"	Support noted. **No Change.**
Member of public	Make sure the Green Ringway is a site specific indication in the document.	It is not possible to set site specific allocations through an SPD. **No Change.**
Leicestershire Police	The relationship between green spaces and crime needs to be considered in the document. Your policy which also deals with enhancement of existing green spaces should include mitigating crime and threats to community safety as eligible items for expenditure and I would suggest that this is specifically mentioned at Stage 3 page 14. Leicestershire police fully support your proposals for adoption and maintenance as unkempt land can generate crime. Apart from a clear function and maintenance the following are also important in planning new spaces- - Understanding existing patterns of crime. - Relationship to public realm and accessibility in the scheme and the overall mix of public/semi private and private spaces. - Oversight and proximity to other uses particularly where facilities are proposed. - Sentinels, boundary treatment and gating, juxtaposition to other uses.	Sentence added to page fifteen which reads: "Green spaces and their relationship to developments should be designed and maintained in accordance with "Secured by Design" principles in order to reduce crime, the fear of crime and to promote public safety." **Amend document.**

	- Landscaping and crime. - Footpaths and surface treatments. - Lighting. It is appreciated that this is not a design document however these aspects are highlighted to exemplify the need for mention in policy and certainly as you seek to identify different types of green spaces.	
Natural England.	Natural England would like the SPD to follow their accessible natural green space standards (ANGst) which are quite widely defined but which set the amount of green space provision in terms of the distance from where people live. Natural England urges your Authority to review the draft Green Space SPD to take account of the ANGst standards and principles.	The ANGst standards were considered during the production of the Core Strategy. However it was found that due to the built pattern of Leicester, some of the ANGst standards would be impossible to achieve. This accords with Paragraph 10.17 of the PPG17 companion guide which states that the ANGst standards can be difficult and sometimes impossible to achieve. It was therefore decided not to adopt these standards. The City Council therefore commissioned a PPG17 compliant Open Space Study which has set local standards for Green Space provision. These standards have been adopted through the Councils adopted Core Strategy and are reflected in the Green Space SPD. **No Change.**
Leicestershire County Council	No comments	Noted. **No Change.**
Ward Councillor	Concerned that there is no mention of the minimum distances that off site green space should be located from the proposed development.	Page 9 of the SPD gives access standards in terms of reasonable distances to travel to green space. The council would generally expect off site green spaces to be located within these

		distances to serve the development. **No Change.**
	Can the SPD have a requirement that the S106 funding is only spent in the ward where the development is located?	Developer contributions must be directly related to the proposed development. Therefore we would expect enhancement contributions to be spent within the vicinity of the development, and would use the access distances outlined above as a guide. It may be the case that green space in the same ward would fall well outside the access distances and would therefore not serve the development. Therefore it would be unreasonable to insist that developer contributions are spent in the same ward as the development. **No Change.**
University of Leicester	The calculations exclude UoL sports provision at Oadby. It should be considered as part of the assessment of open space need relating to new development because it is an acceptable distance from the central campus. The SPD should include wording to reflect the consideration of whether students would have access to specific University/college sports facilities	A sentence should be added to the first paragraph on page 13 and inserted before the last sentence that reads: "In the case of accommodation provided by the Universities, access to the University's own sports grounds will be considered in negotiations." **Amend document.**

Appendix H



WARDS AFFECTED
ALL

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:

Health Scrutiny Committee — **29 March 2011**
Cabinet — **11 April 2011**

IMPROVING HEALTH IN LEICESTER: THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2010

Report of the Director of Public Health and Health Improvement

1. PURPOSE OF REPORT

1.1 Currently, within the NHS, there is a requirement for the Director of Public Health and Health Improvement to produce an independent annual report on the health of the population. It is regarded as an essential component of the commissioning cycle and a key part of the evidence of assessment of need of the population.

1.2 In future, it is expected that this will become a requirement of the Director of Public Health within the Local Authority.

2. SUMMARY

2.1 Each year the Director of Public Health and Health Improvement is required to produce a report on the state of health of the population. This is an independent professional report and aims to:

- Inform the Board of NHS Leicester City, Leicester City Council and other partners about the health of the resident population of Leicester, identifying areas for improvement, particularly where health concerns depend on coordinated action from many agencies to tackle them
- Provide information on health needs to inform the planning and commissioning of healthcare, health protection and health improvement by relevant agencies
- Act as a source of epidemiological information about the population of the city for comparison over time and with other places

2.2 Improving Health in Leicester: the Annual Report of the Director of Public Health and Health Improvement 2010 has a health inequalities theme and has the following sections:

- Update on the Annual Report of the Director of Public Health and Health Improvement 2009
- Health Inequalities
- Infant Mortality
- Health-related behaviour, knowledge and attitudes in Leicester
- Health Protection
- Health Facts

2.3 This report is only being published electronically, in Adobe Acrobat format on the Internet, and as such, the Cabinet copies have been printed in-house.

2.4 The Director of Public Health Annual Report was considered at the meeting of the NHS City Trust Board on 10 March 2011 and it was recommended that the DPH should provide a development session or workshop at a suitable future date to which key colleagues in the local authority and the City GP Consortium should be invited.

3. RECOMMENDATIONS

3.1 Members are asked to:

a) **RECEIVE** the Annual Report of the Director of Public Health and Health Improvement 2010 and to note that there will be a more detailed workshop to be held later in the year.

4. REPORT AUTHOR

Deb Watson
Director of Public Health and Health Improvement
NHS Leicester City and Leicester City Council
Tel 0116 295 1435/252 6095
e-mail: deb.watson@leicestercity.nhs.uk

Key Decision	No
Reason	N/A
Appeared in Forward Plan	N/A
Executive or Council Decision	Executive (Cabinet)

Improving Health in Leicester

Annual Report of the Director of Public Health and Health Improvement 2008/09

Contents

Introduction 2

Demographic Profile of Leicester 4

Measuring and Addressing Health Inequities (Health Equity Audit) 6

Mental Health in Leicester 12

- Mental Health Promotion 14
- Delivering Race Equality in Mental Health 17
- Perinatal Maternal Mental Health 20
- Child and Adolescent Mental Health 24
- The Mental Health of Working Age Adults 28
- The Mental Health of Older People 32
- Suicide 35
- The Mental Health of Offenders 38
- Domestic Violence and Mental Health 40
- Dual Diagnosis 44

Alcohol 46

Oral Health 50

Health Protection 53

Health Facts 55

Glossary 64

Introduction

I am pleased to introduce this report on the state of health of the population of Leicester. It is my first Annual Report following my appointment as the Joint Director of Public Health and Health Improvement for both NHS Leicester City and Leicester City Council. As in previous reports a number of topics are considered in the main body of the report and the Health Facts section at the back of the report again provides a range of health related information, some of it at ward level, continuing the series established in the 2005 Annual Report.

Health Challenge

As can be seen from the demographic profile, Leicester is a city with a diverse population, more younger people and fewer people aged over 65, than is to be found in England as a whole. It is a city also that faces considerable health challenges. It ranks as the 20th most deprived of 354 Local Authority districts and, in Leicester as a whole, both men and women are likely to have a significantly shorter lifespan, by some 2 years, when compared to the national average (see figures 1 & 2). This, of course, masks differences, particularly in ethnicity and socio-economic status and health experience across the city, which can be identified in people living in different geographical areas and also in disadvantaged population groups. As is shown in this report the life expectancy gap with England is greatest in the most deprived 5th of the Leicester population, where the difference in life expectancy is 5.3 years for men and 3.5 years for women.

Figure 1. Male Life Expectancy for Leicester City and England, 1997 - 2007
Source: National Centre for Health Outcomes Development, 2007

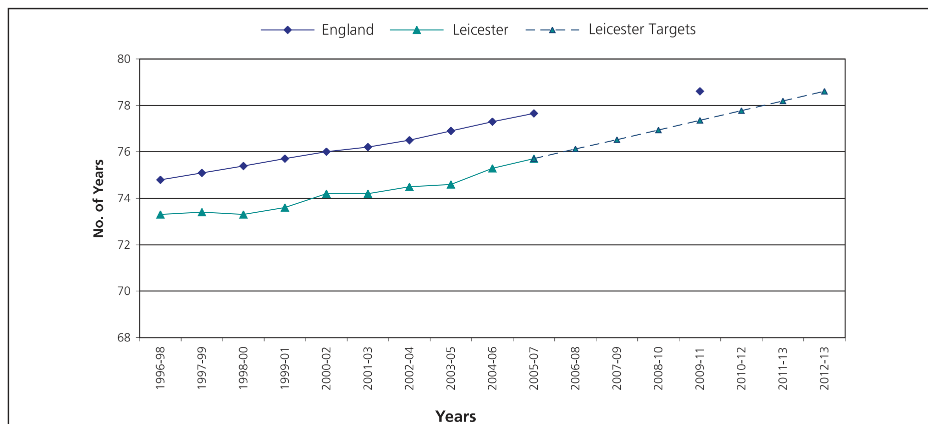
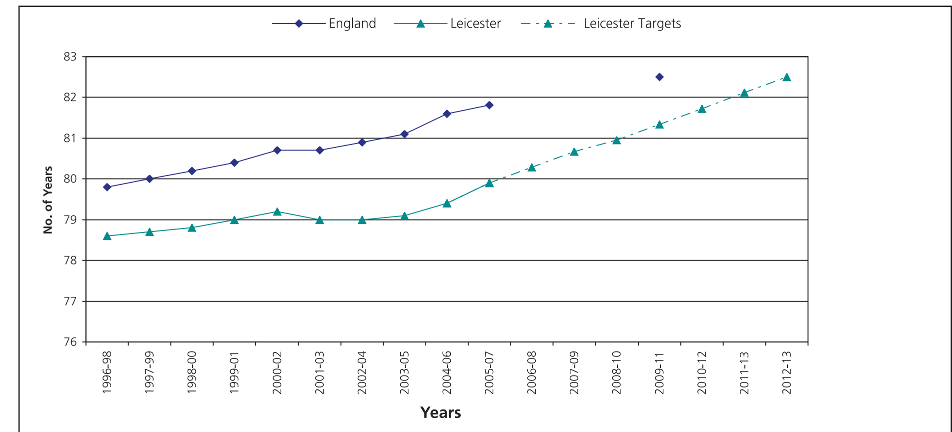


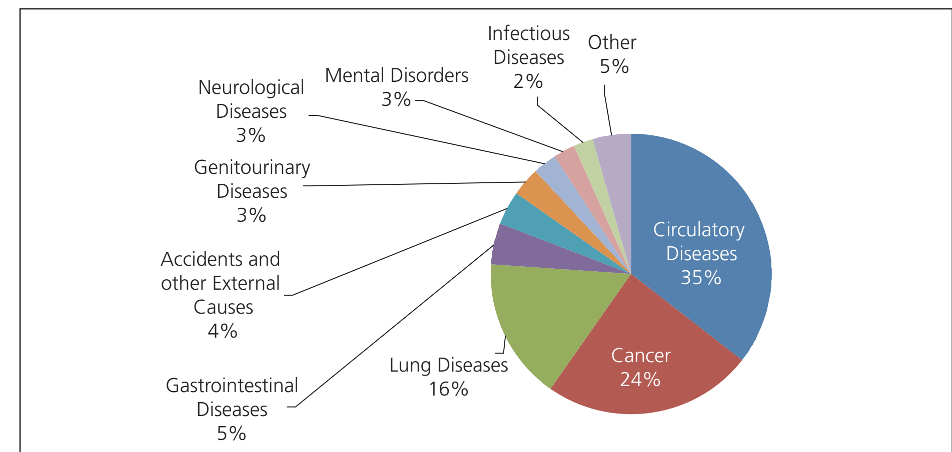
Figure 2. Female Life Expectancy for Leicester City and England, 1997 - 2007
Source: National Centre for Health Outcomes Development, 2007



Health Inequalities

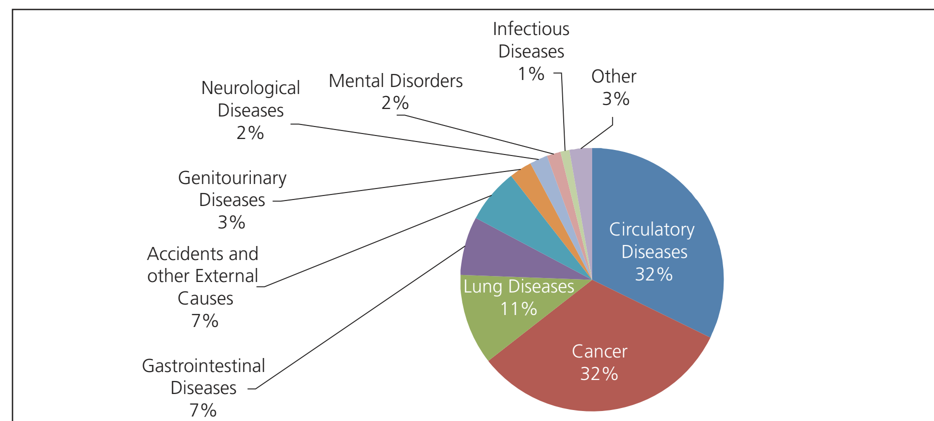
Reducing such health inequalities remains the key health challenge for the city so that both the life expectancy gap and the life expectancy variation within Leicester is reduced. The major causes of death at all ages (see figure 3) in the city remains circulatory disease – coronary heart disease and strokes (36%), cancer (24%) and respiratory disease (16%).

Figure 3. Main Causes of Death in All Persons, All Ages (2005-2007)
Source: ONS Public Health Mortality File, 2007



The major causes of premature mortality, that is death under the age of 75, are shown in figure 4 and these mirror the causes of death at all ages, although there are differences by gender. The main causes of premature death in men are circulatory disease (35%) followed by cancer (28%) and for women cancer (37%) followed by circulatory disease (27%). The causes of death however that make the major contribution to the life expectancy gap between Leicester and England have been shown to be circulatory disease in men (36%) and women (35%), while deaths from cancer makes up only 6% of the life expectancy lost in men and 4% in women. While reducing deaths from cardiovascular causes is a clear priority for the city, maintaining effort on reducing deaths from cancer and other avoidable causes of premature death is essential. There is a shared prevention agenda for both Cardiovascular Disease (CVD) and Cancer – reducing smoking, moderation in alcohol consumption, increasing physical activity, improving diet and maintaining a healthy weight – which are key to the reduction in premature mortality in the city. There is also a clear need to maintain a focus on reducing infant mortality in Leicester.

Figure 4. Main Causes of Death in All Persons, Under 75 (2005-2007)
Source: ONS Public Health Mortality File, 2007



Priorities for Health

As in previous years all issues considered in this report are important and need to be acted upon but the need for prioritisation is clear. Priorities for health improvement and reducing health inequalities have been identified in previous DPH Annual Reports[1], the Joint Strategic Needs Assessment 2008/09[2], the NHS Leicester City Commissioning and Investment Strategy 2008 – 2013, and reflected in the Local Area Agreement 2008-2011[3]. This unity of purpose around improving Leicester as a place to live finds its fullest expression in 'One Leicester', the city's Sustainable Communities Strategy, agreed and published in 2008[4].

This Report

This Annual Report has a particular focus on mental health, with sections on associated issues of domestic violence and alcohol harm. These are areas that have received less attention in previous DPH Annual Reports and it is intended that their inclusion in this report will be helpful to the development of services and responses to the issues they raise. There is also a section on Oral Health which follows a recent assessment of Oral Health needs. Communicable disease continues to be an important cause of ill-health within Leicester and the Health Protection Agency again contribute an overview of the issues for the city.

Acknowledgements

Finally, I would like to acknowledge the contributions made to this report by many people. All direct contributors are acknowledged in different sections of the report and the range of these reflects the partnerships involved within the city. However, I would particularly want to acknowledge the contributions of Mark Wheatley for his work on the mental health sections and Rod Moore, Helen Reeve, Hanna Blackledge and Nia Reeves for their work in pulling together and checking the data presented in this report. Sandie Nicholson has again played a key role in managing the production of this report.

Contributor

Deb Watson
Director of Public Health and Health Improvement
NHS Leicester City and Leicester City Council

References

1 *Director of Public Health Annual Reports 2005, 2006 and 2007*
Available at: http://www.phleicester.org.uk/annualreport.htm

2 *Joint Strategic Needs Assessment 2008/09*
Available at: http://www.oneleicester.com/leicester-partnership/jsna

3 *Local Area Agreement 2008-2011*
Available at: http://www.oneleicester.com/leicester-partnership/leicesters-local-area-agreement

4 *Leicester Partnership, 2007. One Leicester: Shaping Britain's sustainable city.*
Leicester: Leicester Partnership
Available at: http://www.oneleicester.com/one-leicester-vision

Demographic Profile of Leicester

Population Structure

Leicester has an estimated population of 292,600[1] with a larger proportion of younger people (aged 15-34) than England as a whole and a slightly smaller proportion aged 65 and over (see Appendix 1 - Health Facts 1).

The population structure and predictions for the future all have implications for planning services to meet health needs. Overall, Leicester's population has been increasing annually and is predicted to continue to rise, reaching around 356,500 in 2031[2]. An increase is expected across all ages, with larger increases in the younger population and smaller increases in people aged over 75 years. Nationally, fertility rates have risen by 4.1% (1997-2007), whilst in Leicester births have soared by 15.2% (1997-2007)[3].

Leicester has a very diverse population. In the 2001 Census, around 36% of the population classified themselves as coming from a Black or Minority Ethnic (BME) background. The largest ethnic minority community is the South Asian community, which is predominantly of Indian origin and the majority of Leicester's South Asian population are of Hindu faith. Since the 2001 Census, there has been further migration into the city, including people of Somali origin (2002-4), people from Poland and other countries joining the European Union since 2005 and a number of refugees and asylum seekers.

Leicester has some of the most disadvantaged areas in the whole of England, as measured by the *Index of Deprivation 2007* and ranks as the 20th most deprived of 354 local authority districts.

There is a strong link between deprivation and ill-health, explored in more detail in Chapter 1 of the report. Average life expectancy is a good proxy indicator of the population's general health and is calculated from current data on death rates. In Leicester (Figures 1 & 2, p. 2), both men and women are likely on average, to have a significantly shorter life expectancy (by 2 years) when compared to the national average. In addition, there are inequalities in life expectancy between the affluent and deprived populations of Leicester. While the most affluent fifth of Leicester's population has a life expectancy similar to the national average, the most disadvantaged fifth of Leicester's population has a much lower life expectancy than the national average (of 5.3 and 3.5 years for men and women, respectively).

Figure 5: Male Life Expectancy in 2006

Source: ONS Life Expectancy at Birth for the UK, 2008, and Leicester Health Equity Audit, 2007

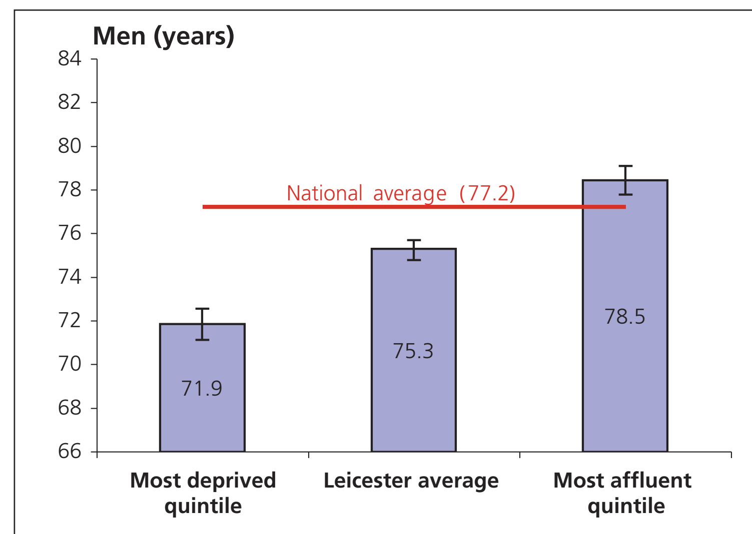
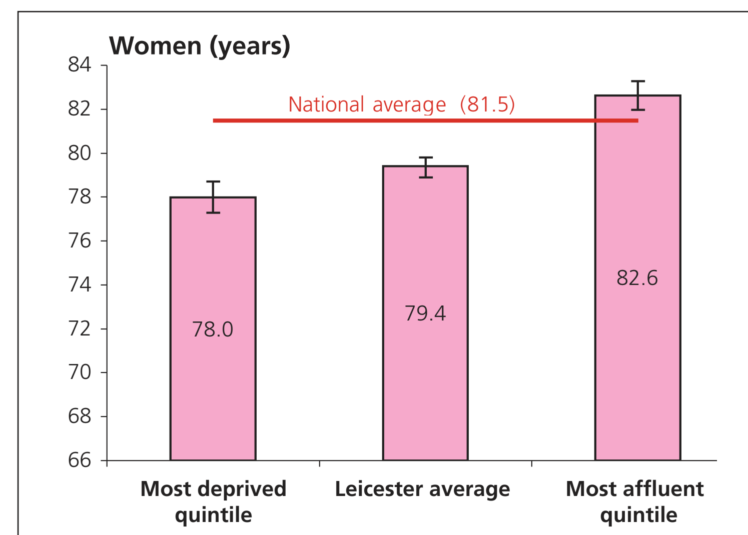


Figure 6: Female Life Expectancy in 2006

Source: ONS Life Expectancy at Birth for the UK, 2008, and Leicester Health Equity Audit, 2007



Lead Author
Helen Reeve
Senior Public Health Analyst
Tel: 0116 295 1515
Email: helen.reeve@leicestercity.nhs.uk

Contributor
Dr Hanna Blackledge
Public Health Specialist (Clinical Effectiveness and Commissioning)
Tel: 0116 295 1524
E-mail: hanna.blackledge@leicestercity.nhs.uk

References:

1 Office for National Statistics, 2008. *Provisional mid-2007 Population Estimates*. London: Office for National Statistics
2 Office for National Statistics, 2008. *2006-based Subnational Population Projections*. London: Office for National Statistics
3 Clinical and Health Outcome Knowledge Base, 1999 and 2008. *Compendium of Clinical and Health Indicators*. Available at: www.nchod.nhs.uk

Measuring and Addressing Health Inequities (Health Equity Audit)

Description of the Issue: Health Inequality and Equity of Health Care

People who experience disadvantage in some way, be it through their ethnicity, age, gender, poverty, social exclusion or a combination of these and other factors, are much more likely to fall ill and even die earlier than their more privileged counterparts. The term **health inequality** refers to such unacceptable and avoidable differences in health outcome between groups. In addition, access to healthcare is often hampered by the very same factors that affect health, an observation fittingly described over 30 years ago as the **'inverse care law'** (see Box 1). The term **health inequity** is used to express the level of unfairness in the distribution of many aspects of health or health-related services.

Socio-economic differentials in health and healthcare delivery have long been acknowledged in many countries, affecting even centrally funded healthcare systems such as the NHS which is based on the principle of delivery at the point of need.

> **Box 1: The Inverse Care Law**
>
> "The availability of good healthcare tends to vary inversely with the need for it in the population served."
>
> Tudor Hart[1]

Our knowledge of health inequality is by no means new. The effect of poor working and living conditions on rates of illness and mortality was first described in England in the early 1830s. Since then, wide disparities were documented in many countries and in all types of social and health systems. Throughout the 19th and 20th centuries mortality rates were significantly higher in the North and West, compared to South and East UK, as well as in urban, compared to rural areas. By 1946, this evidence of a growing health divide was strong enough to make equality a central objective for the new National Health Service. However, in the following decades it became clear that health inequalities in Britain were growing rather than diminishing[2] , demanding more targeted action by the health service in partnership with local authorities and other agencies[3].

Explanations of Health Inequalities

Why are health inequities so universal and resistant to change despite the overall improvement in health in many countries, including the UK? Many explanations have been proposed, most of them widespread and not mutually exclusive. They include material causes, such as poor diet, housing, pollution levels or adverse working conditions; psycho-social factors, such as lack of social status, community support or low level of control over one's life; and often complex cultural or political roots, emerging from the distribution of power in society. In some cases, genetic causes are equally important. Any or all of these factors may affect a person's health in a cumulative way throughout their life. It is now widely recognised that exposures in early childhood or even before birth can have a particularly strong impact on later health[4]. It seems inevitable that tackling inequalities is complex – both at a macro level, through political and redistributive initiatives and at micro level through effective community development and individual modification of health-related behaviour.

Addressing Inequalities in Health: National and Local Priorities

The last decade saw some significant political initiatives involving both NHS and social care in the UK. In 2002 tackling inequalities became a statutory public health objective for all primary care trusts with a national target of a 10% reduction in infant mortality and a 10% increase in life expectancy by 2010.[5] Action on health inequality includes national and local initiatives (Table 1) and is based on our understanding of the root causes.

Table 1. Examples of Policy Initiatives to Reduce Health Inequalities

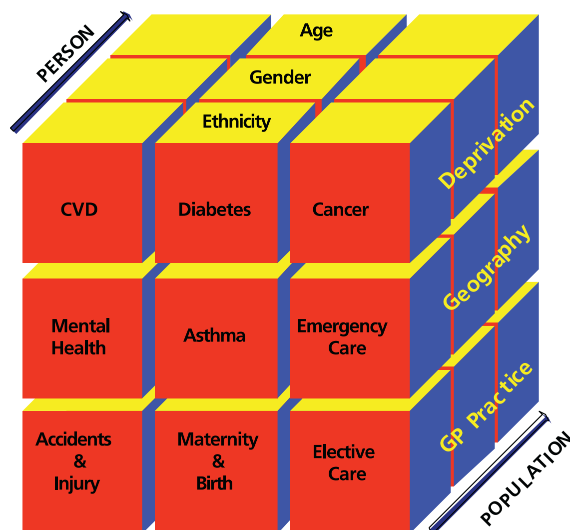
Initiative	Rationale
Health Action Zone (HAZ)	There is distinct geography to health inequalities
Sure Start and the Child Poverty Strategy	Inequalities affecting children have a powerful effect on their future health as adults
Public Service Agreement (PSA) targets	Health inequalities have their roots in wider social and lifestyle determinants of health
Child and Working Tax Credits	There is a strong link between economic and health inequalities

At the same time, the concept of **health equity audit** emerged, as a process of identifying how fairly services and other resources are distributed in relation to the health needs of different population groups, with the intention of initiating priority actions to provide services more closely aligned with identified need[6] . Thus health equity audit is a formal process of identifying and reducing inequities in health through appropriate intervention.

In Leicester, a comprehensive annual assessment of health equity is carried out using a common framework of outcomes across a variety of individual and population dimensions (Figure 7) for the following health topics:

- Chronic diseases, including cardiovascular diseases, diabetes, asthma and chronic obstructive airway disease (COPD), and cancer
- Mental health
- Health of the elderly
- Maternal and child health
- Access to healthcare

Figure 7. A Framework for Health Equity Audit Assessment in Leicester
Source: Health Equity Audit, 2007



This process gives a comprehensive cross-sectional snapshot of health inequities and allows for an annual re-evaluation of progress in tackling inequalities locally.

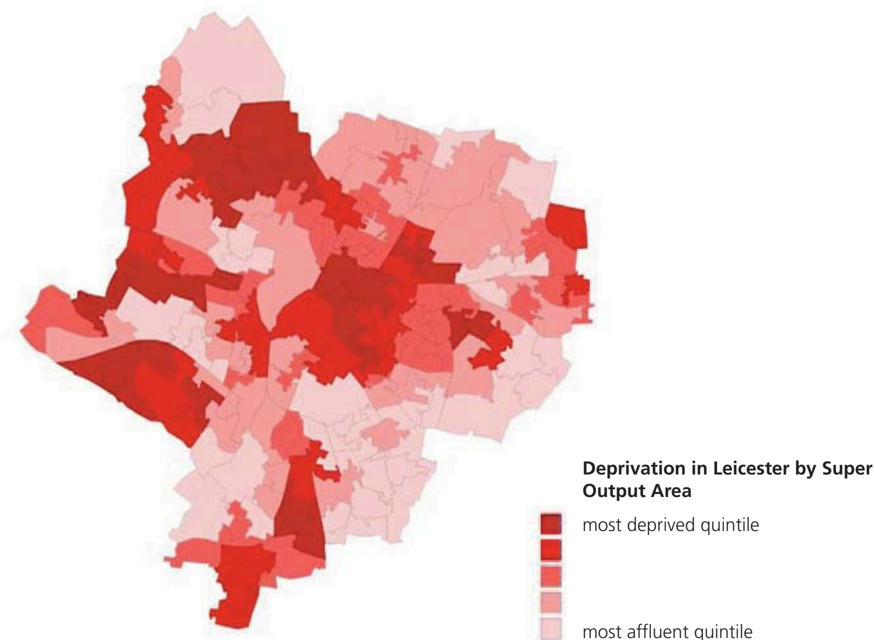
Issues Identified

Socio-economic Deprivation

As the 20th most deprived local authority in the country[7], Leicester is a spearhead area, targeted for a reduction in mortality and ill-health of the population. Nearly half of Leicester's population (48%) can be described as highly disadvantaged and there are pockets of very high deprivation (Figure 8) with significantly more violent crime, poor quality housing, higher proportion of children living in poverty and lower educational attainment levels.

Figure 8 shows the distribution of socio-economic disadvantage in the city, using small geographic areas, known as Super Output Areas (SOAs), ranked into quintiles (fifths) according to the value of their Index of Deprivation. This SOA classification allows us to compare health care provision and health outcome in the resident population in order to evaluate the level of inequity locally.

Figure 8. Deprivation in Leicester
Source: Department for Communities and Local Government, 2007



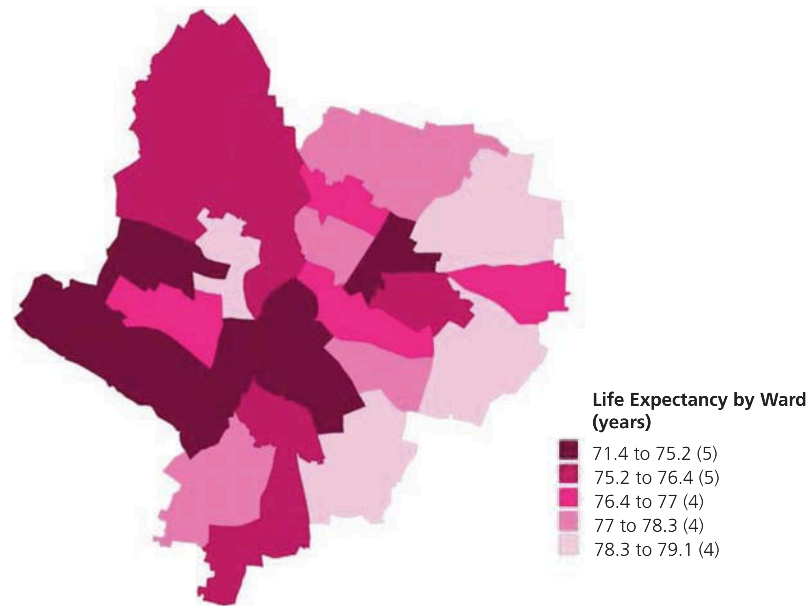
Life Expectancy - The Big Picture of Inequality

Life expectancy is the average number of years a newborn baby is expected to live if current death rates continue and is a good proxy indicator of the current health of the population.

Gaps in life expectancy between different groups can provide the most startling evidence of health inequalities, whether at a geographical level, or between groups classified by their socio-economic status.

Figure 9. Life Expectancy by Geographical Area (ward) in Leicester in 2007 (Average for Men and Women)

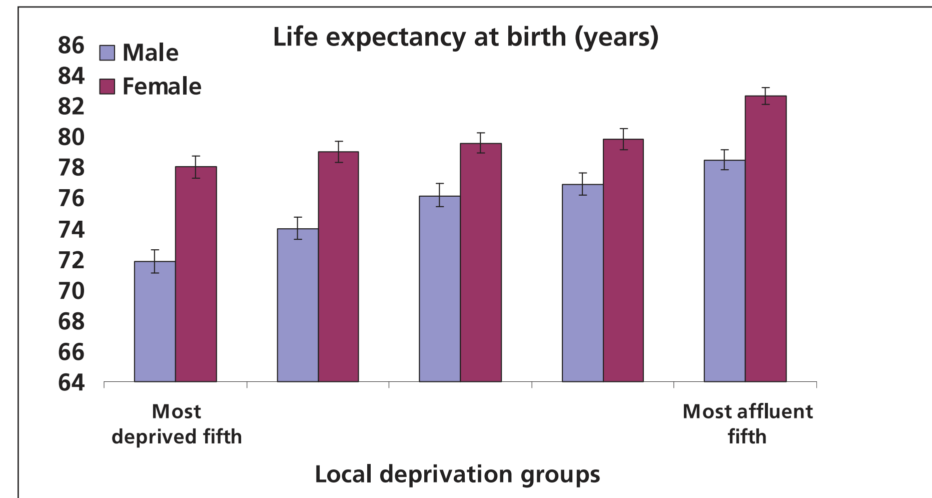
Source: Office for National Statistics, 2007



In the most disadvantaged wards of Leicester the average expected survival can be more than 7 years shorter, when compared to the most affluent wards (Figure 9). Women can expect to live longer than men, regardless of their level of deprivation (Figure 10) and women in the most disadvantaged groups have a similar life expectancy to the most affluent men.

Figure 10. Deprivation Gap in Life Expectancy, 2006

Source: Leicester Health Equity Audit, 2007



Health Inequities in Leicester

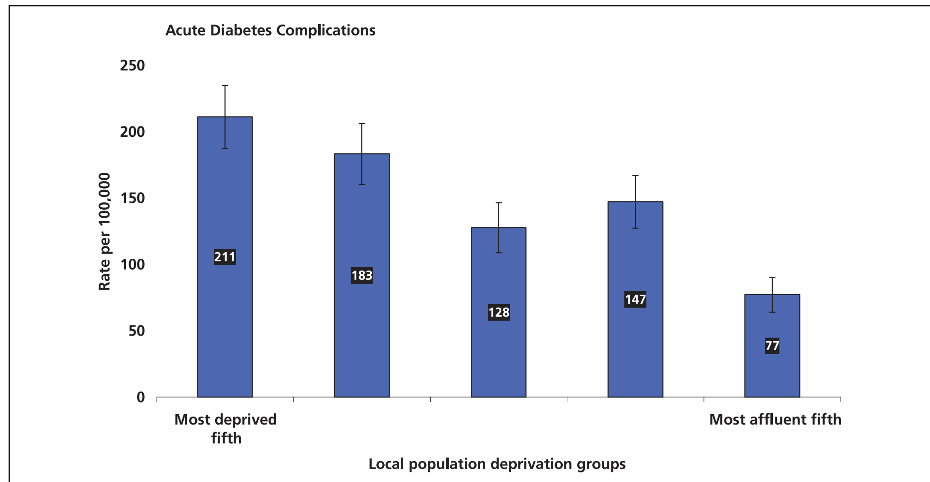
In addition to unequal levels of mortality, the audit shows persisting inequalities in morbidity and access to care for chronic diseases, such as diabetes and coronary heart disease (CHD). There are also significant gaps in mental ill-health and in the provision of care for people with mental health problems.

Chronic Diseases

The rates of acute diabetes complications, for example, are three times as high in the most disadvantaged fifth of the population when compared to the most affluent fifth (Figure 10). A number of other diabetes-related indicators reveal marked inequalities in diabetes care, including high emergency hospital admission rates. The results of the audit allow us to estimate that each year at least 500 emergency admissions for diabetes can be attributed to deprivation. Together with a significant gap in diabetes mortality, this picture indicates a marked inequity in the burden of disease combined with an inadequate focus on preventive treatment and care.

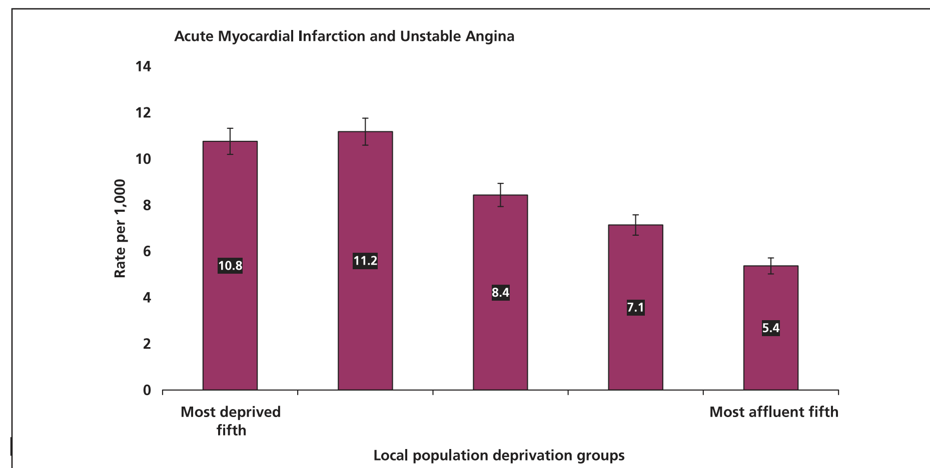
Poor outcomes are significantly higher among men with rates up to twice as high when compared with women. Also, many of the city practices have outcomes worse than the local or the national average for their populations.

Figure 11. Rates of Acute Complications of Diabetes by Level of Deprivation in Leicester, 2005 - 2007
Source: Leicester Health Equity Audit, 2007



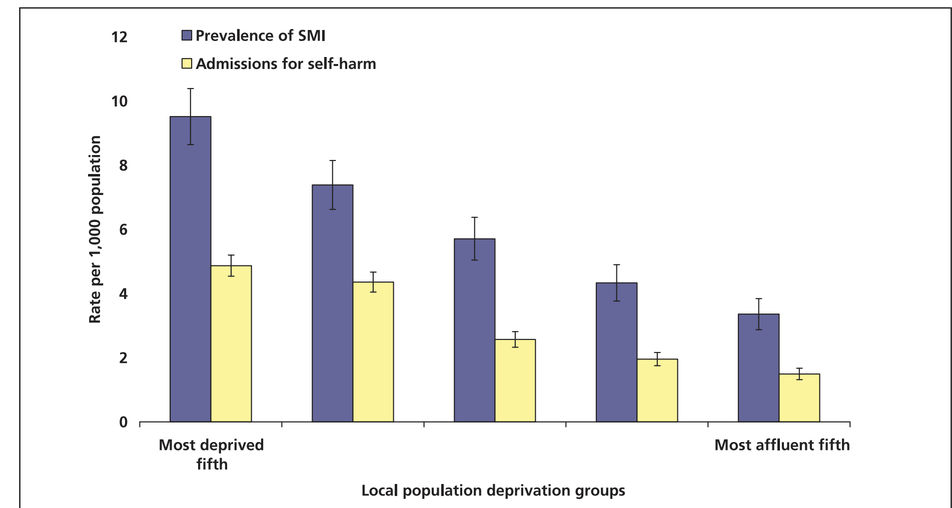
Perhaps less striking, but equally significant, are inequalities in cardiovascular disease, with a particular gap in premature mortality, incidence of acute coronary events (myocardial and unstable angina) (Figure 12) and heart failure in the more deprived populations. However, the impact of deprivation on cancer rates is much lower in relative terms, when compared with cardiovascular disease or diabetes.

Figure 12. Inequalities in Acute Heart Disease in Leicester, 2005 - 2007
Source: Leicester Health Equity Audit, 2007



There are very substantial gaps in mental health across the deprivation divide in Leicester, represented by up to four times higher rates of severe mental illness in the most deprived areas (Figure 13). There are equally substantial differentials in the rates of self-harm and in rates of registration with local health services for a variety of mental health problems.

Figure 13. Inequalities in Severe Mental Illness and Self-harm in Leicester, 2005 - 2007
Source: Leicester Health Equity Audit, 2007



Ethnic Inequalities in Health

As introduced in the demographic profile, a substantial proportion of Leicester's population is from a Black or Minority Ethnic (BME) background (36% of the total population in 2001), with South Asians being the largest group (Indian: 26%, Pakistani and Bangladeshi: 1% each), followed by Black minority groups (3% of the total) and mixed and other BME (5% of the total).

Ethnic differentials in cardiovascular disease and its determinants have been described in the UK in the past[8] and Leicester's ethnic minority populations have similarly increased risks of emergency hospitalisation for diabetes, heart failure and acute coronary events (Table 2). However, despite higher morbidity, survival following an admission with a heart attack or stroke is no worse for ethnic minority patients than white patients (the relative risks of death following such events for Black or Minority Ethnic (BME) populations are 1 and 0.94 respectively).

Heart disease is particularly prevalent in the local South Asian population. However, the rate of surgery (coronary revascularisation) is also higher, demonstrating equity of care. South Asian patients tend to present with more acute forms of coronary heart disease (CHD) and at an earlier age, in which management by a coronary procedure (whether percutaneous intervention or coronary bypass) is more appropriate, so we might expect to see the higher revascularisation rates among the South Asian population.

Hip fractures and falls appear to be significantly lower in BME populations, matched by lower rates of hip replacement (Table 2) in these groups.

Table 2. Significant Differentials in Health Outcome and Access to Elective Care for BME Populations in Leicester, 2007

	Rate Ratio*	Number**
Emergency admissions for diabetes	2.76	1600
Admission rate for heart failure	2.08	390
Acute complications of diabetes	1.89	60
Admissions for CHD	1.75	900
Coronary Events	1.70	500
Incidence of hospitalised CHD	1.64	300
Hip replacement	0.22	-30
Revascularisation	1.87	100
Knee replacement	2.41	50
Cataract operation	3.05	360

*All BME groups, compared to white population

** number of excess health events across all BME population when compared with white populations per year.

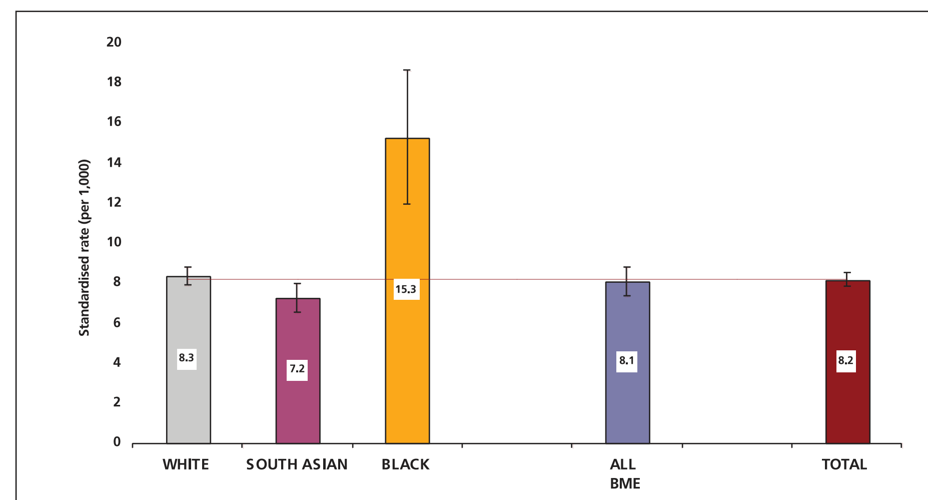
Source: Leicester Health Equity Audit, 2007

Although in the South Asian population, the rates of severe mental illness with an admission to hospital are lower than the Leicester average (Figure 14), they are almost twice as high in the black community.

Despite some advances in ethnicity coding of admission records in acute care, where its completeness exceeds 85%, equivalent up to date population figures and referral data from general practice are not available routinely. As a result, robust monitoring of ethnic equality in health is currently difficult, particularly for groups in transition or those harder to reach.

Figure 14. Prevalence of Severe Mental Illness by Ethnic Group, 2008

Source: Leicester Health Equity Audit, 2007



Commissioning equitable healthcare

The world class commissioning (WCC) competencies require commissioners to
a) manage knowledge and assess needs and
b) prioritise investment according to local need.

This includes investment in healthcare as well health promoting public health interventions at population level.

Practice-based commissioning (PBC) is an important tool to help address health inequalities by providing crucial link to local communities. Both the levels of ill-health and prevalence its determinants are taken into account in commissioning decisions for practice populations locally.

Recommendations

It is recommended that:

- Health inequities within Leicester should be addressed more explicitly by local policies and when implementing national priorities particularly for cardiovascular conditions and mental health
- Methods for monitoring inequalities affecting hard-to-reach groups and new arrivals should be developed

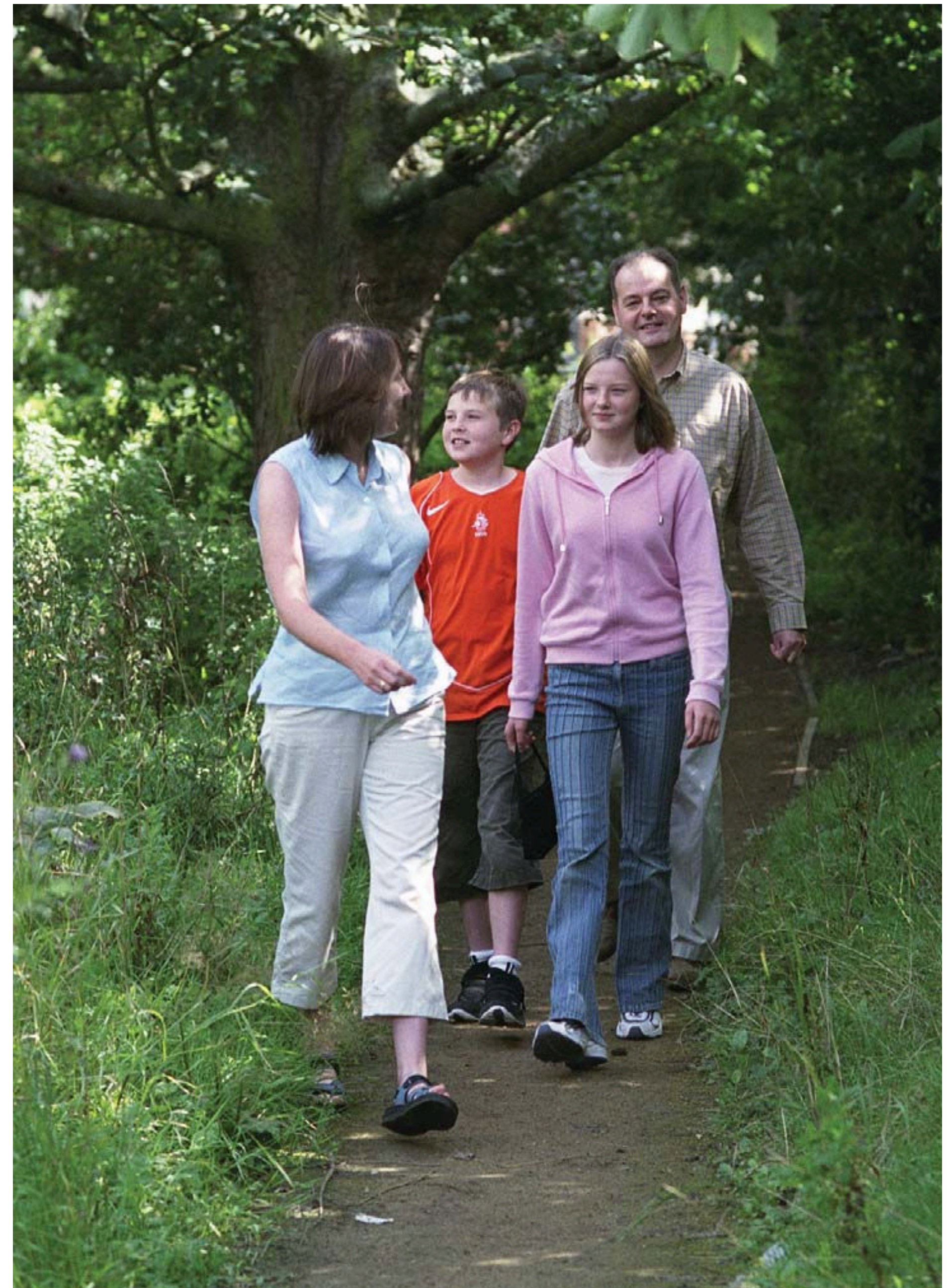
- Local NHS commissioning, particularly practice-based commissioning, should have clearly specified objectives to reduce documented inequities in healthcare delivery
- The evidence base of inequalities among harder to reach communities should be strengthened
- There is a need for robust ethnicity data collection by GP practices

Lead Author

Dr Hanna Blackledge, Public Health Specialist (Clinical Effectiveness and Commissioning)
Tel: 0116 295 1524
E-mail: hanna.blackledge@leicestercity.nhs.uk

References

1 Hart, J.T., 1971. *The inverse care law*. The Lancet,1(7696): 405-12
2 Connely, J., Worth C., 1997. *Individual social and economic status and health. In: Making sense of public health*. Oxford: Radcliffe Medical Press
3 Acheson, D., 1998. *Independent Inquiry into Inequalities in Health*. London: HMSO
4 HMSO, 1946. *The National Health Services Act*. London: HMSO
5 Black, D., (Chairman), 1980. *Inequalities in health: report of a research working group*. London : Department of Health and Social Security
6 Barker, D. J. P., 1994. *Mothers, babies and disease in later life*. London: BMJ Publications
7 Department of Health., 2002. *Tackling Health Inequalities: Cross-Cutting Review*. London: Department of Health. pp. 1-73
8 Department of Health, 2003. *Health Equity Audit. A Guide for the NHS*. London: Department of Health
9 Department for Communities and Local Government, 2007. *Indices of Deprivation 2007*. London: Department for Communities and Local Government
10 Bhopal, R. *Epidemic of cardiovascular disease in South Asians (editorial)*. BMJ, 2002; 324: 625-6



Mental Health in Leicester

Introduction

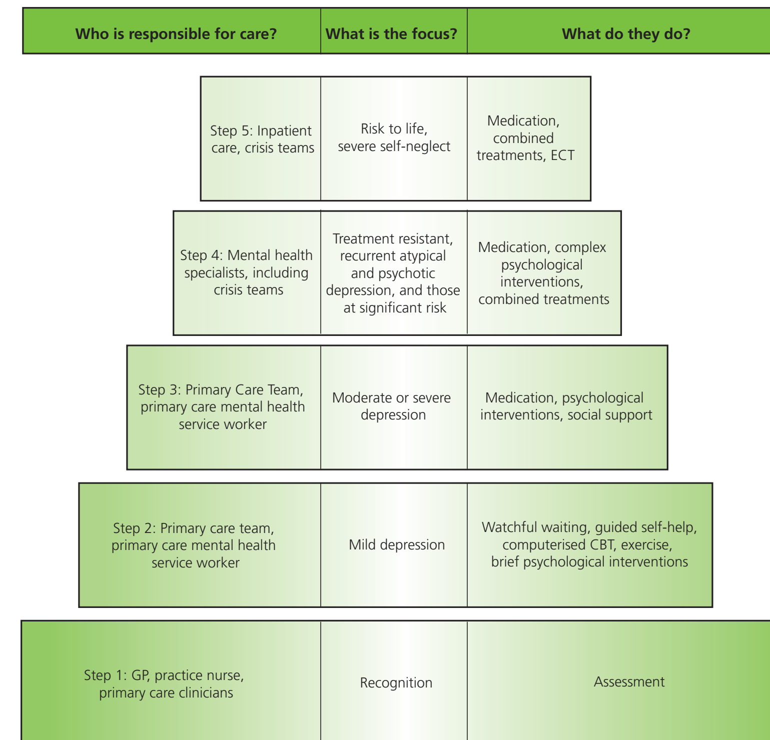
The Annual Report of the Director of Public Health and Health Improvement provides a timely opportunity to reflect on mental health need in Leicester. The *National Service Framework for Mental Health (NSF for Mental Health)* will expire in 2009 and decisions about the direction of mental health policies and services need to be made. Assembling the current information on the risk factors linked to poor mental health, the mental health status of the local population and the provision of interventions of care for those with mental ill-health, will enable informed decision-making concerning those policies locally.

Mental illness not only has an emotional, mental and social impact on individuals, families and friends, it has an impact on wider society. The Layard report[1] suggests that the output lost from sickness resulting from depression, anxiety and stress in Britain is around £4 billion per year. People with mental health problems have the lowest employment rate of any disabled group and mental illness is more prevalent in the most deprived areas. Perinatal maternal mental illness may be harmful for mothers, children and their families; the mental well-being of children is likely to have an impact on their present and future health. For older people, a range of mental health issues from depression to dementia are projected to increase. There is a need to develop appropriate mental healthcare for people from Black or Minority Ethnic (BME) communities, as there is over-representation of people from Black ethnic backgrounds in the take-up of services and under-representation of people from South Asian backgrounds. There is also a need to meet the challenges presented by new arrivals to Leicester, some of whom have experienced trauma and abuse prior to their arrival. In addition, prisoners and offenders have higher levels of mental illness than the general population.

It is imperative to continue to promote mental health in order to strengthen individuals and communities and reduce the structural barriers to mental well-being. It is also incumbent upon the health and social care community to provide better access to treatment for those with mental health problems. One initiative to facilitate better mental health is the national *Improving Access to Psychological Therapies Programme*. As Figure 15 shows part of this approach is to design a stepped care system of delivering and evaluating mental healthcare so that the most effective treatment is delivered to the patient. In addition to the promotion of mental health for the community as a whole, this will require the provision of low intensity treatments with more intensive therapy for those who do not recover.

Figure 15: Stepped Care Approach to the Management of Depression as Outlined in NICE Guidance

Source: Depression (amended): management of depression in primary and secondary care, 2007



Another key innovation for improving mental healthcare is the personalisation agenda, set out in *Putting People First*. By using mechanisms such as direct payments and individual budgets it is hoped that care will be radically transformed, with people deciding the form of their own care, who delivers it and how to spend the funds allocated to meet their needs.

The information presented in the following sections will be of interest to service commissioners, providers, users and carers. It identifies priorities by investigating

current needs and recognising future trends in mental health and providing information to assist stakeholders in healthcare to meet the challenges raised by *Our NHS, Our Future: Next Stage Review*. We know that social and economic factors influence the duration of mental illness and the length of time it takes to recover and these issues need to be addressed. Each section will make recommendations for action by NHS Leicester City (NHSLC) and its partners.

The Future Vision Coalition, a collaboration of seven national mental health organisations, has produced the discussion paper *A New Vision for Mental Health*. This suggests that the aims of future mental health policy should be to:

- overcome persistent barriers to social inclusion that continue to affect those with experience of mental health problems
- improve the whole-life outcomes of those with experience of mental health problems
- improve the mental health of the whole-population

This vision of change concentrates on four areas, all of which are important to mental healthcare in Leicester. Firstly, there is a need to develop an integrated approach to mental healthcare which incorporates the social determinants of mental health. Secondly, it places importance on promoting good mental health and well-being. Thirdly, services should support the recovery of a good quality of life. Finally, systems of support should be built by the person who is the focus of care and their advocates.

By collaborating with partner organisations, this section of the Annual Report of the Director of Public Health 2008/09 covers all of those areas and has resulted in the core priorities shown in Box 2.

Box 2: Priorities for the Delivery of Mental Health Care in Leicester

- The stepped care approach to the delivery of mental health services should be developed to ensure that there is a clear care pathway and effective working between different professionals which always hold the patient at the centre of consideration
- Addressing the determinants of inequality and ill-health through mental health promotion, as set out by Standard 1 of the *NSF for Mental Health*, will benefit the mental health of the population. This work should continue to receive priority after the expiry of the NSF in 2009 and should be a priority of the health and social care community
- Work to develop indicators which reflect the importance of health and well-being to mental health should continue and should be adopted by NHSLC and partner organisations
- There should be increased support for the involvement of service users and carers in the planning, development and delivery of mental health services
- Developments in mental health care, such as Improving Access to Psychological Therapies are used to address the needs of people from BME backgrounds, ensuring that all patients have access to the appropriate level of care
- The implementation of NICE guidelines for the assessment of maternal mental health
- The implementation of the Joint Strategy for Promoting the Mental and Emotional Health of Children and Young People in Leicester, Leicestershire and Rutland
- Developing services which provide appropriate and accessible mental health care for older people according to the nature of their illness rather than their age
- Continued efforts to raise awareness about suicide and self-harm amongst the general public and professionals
- There should be improved care pathways for prisoners and offenders
- Care pathways should be developed to ensure that service users with mental health and substance abuse co-morbidity are able to access primary care from both general mental health and drug or alcohol services

Lead Author

Mark Wheatley
Public Health Specialist (Mental Health and Vulnerable Groups)
Tel: 0116 295 1583
Email: mark.wheatley@leicestercity.nhs.uk

Reference

1. Layard, R., 2005. *Mental Health: Britain's Biggest Social Problem?* London: Sainsbury Centre for Mental Health

Mental Health Promotion

Description of the Issue

Mental health is more than just an absence of mental illness. It influences how we think about ourselves and others. It affects our ability to learn and communicate, to form and sustain relationships and to interpret and cope with change and life events. How we think and feel also impacts on our physical health. Mental health promotion looks at how individuals, families, organisations and communities think and feel and the factors which influence this, on an individual and collective level. Mental health promotion is any action designed to enhance mental well-being and can be aimed at the general population or targeted at individuals at greater risk, vulnerable groups and those with mental health problems.

Promoting mental health carries significant social, economic and health benefits. These include preventing mental ill-health particularly depression, anxiety, self-harm including drug and alcohol dependence, suicide and improving the health and well-being of individuals with mental health problems. It has wider universal benefits including improved physical health, increased emotional resilience, increased social inclusion and participation and improved productivity. It supports action to challenge the stigma of mental illness and suicide.

National and Local Priorities

Standard 1 of the *National Service Framework for Mental Health* relates to mental health promotion and seeks "to promote mental health for all, working with individuals, organisations and communities". This was reinforced in the 2004 White Paper on *Choosing Health*. Activity to tackle the risk factors for mental health sits with a range of agencies and partnerships. Other national and local priorities to improve employment, social inclusion, crime prevention, the environment, physical health, education, the environment and housing are capable of delivering mental health promotion. In order to structure this, the Health Education Authority (HEA) publication *Mental Health Promotion: A Quality Framework*[1] sets out a framework through which these can be delivered.

Mental Health Promotion in Leicester: Epidemiology and Interventions

Locally the Leicester, Leicestershire and Rutland Mental Health Promotion Group is responsible for developing a strategy and developing and monitoring an action plan to deliver Standard 1. It reports to the Local Implementation Teams for Mental Health.

The HEA quality framework has three strands:

Strengthening individuals - or increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, for example, communicating, negotiating, relationship and parenting skills.

Strengthening communities - increasing social inclusion and participation, improving neighbourhood environments, developing health and social services, which support mental health, anti-bullying strategies at school, tackling violence and abuse of children and adults, workplace health, community safety, childcare and self-help networks.

Reducing structural barriers to mental health - through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

The Leicester, Leicestershire and Rutland Mental Health Promotion Strategy is in the process of being reviewing in the light of national good practice guidance.

This guidance suggests the following headline themes for targeted mental health promotion activity and these are:

- Marketing Mental Health
- Equality and Inclusion
- Tackling Violence and Abuse
- Parents and Early Years
- Employment
- Workplace
- Communities
- Schools
- Later Life

A revised action plan is being drawn up to capture current and proposed work in these areas, for example, publicity campaigns, production of information, workshops and packs for employers.

Issues Identified

Mental health is a central part of our health and well-being and yet is dogged by stigma and prejudice. The *NSF for Mental Health* seeks to ensure that mental health promotion is recognised as an important activity in its own right, contributing significantly to the health of the general population and vulnerable groups. It reinforced the shift from an ill-health service to a health service. Mental health promotion at population level and for those in the mental health system, needs to be systematically addressed, prioritised and resourced.

In addition to focusing on the mental health of the general population and those at greater risk of mental ill-health the 2004 Social Exclusion Unit report on mental health and social exclusion recognised the need for a massive shift in the attitudes of the public and employers "to enable people to fulfil their aspirations and to significantly improve opportunities and outcomes for people with mental health problems."[2]

The other great challenge in mental health promotion is also the breadth of activity that is required. Mental health needs are met in a wide range of environments including:

- School
- Home and Relationships
- Work
- Community

- Neighbourhood and Environment
- Where we feel safe, included, valued and respected

This requires the initiation and maintenance of activity to improve mental well-being across a wide range of partnerships and agencies in the public, voluntary and commercial sector and with communities. Whilst some NHS Vital Signs indicators support mental health promotion, much of the work to improve mental health lies beyond the NHS. A significant proportion will relate to the broader public health agenda and fall within the wider remit of the Local Area Agreement (LAA). This requires cross-sectoral and multi-professional ownership as well as the engagement with communities. Measuring improvements in mental well-being in the population require a long term approach and robust indicators are still in development.

Recommendations

It is recommended that:

- The Leicester Partnership explicitly recognises the key role it has to play across all of the LAA in the promotion of mental health and well-being and develops shared indicators to measure progress
- The Local Implementation Team (LIT) for Mental Health endorses an approach that includes mental health promotion as an integral part of commissioning arrangements for all services
- There are effective links between the LIT, the Leicester Health and Wellbeing Partnership, the Mental Health Promotion Group and structures to deliver the Social Inclusion agenda
- NHSLC and partner organisations develop robust mental health in the workplace policies and review internal procedures to promote the employment and retention of individuals with mental health problems

Lead Author

Carole Devaney
Public Health Programme Manager
Tel: 0116 295 1514
Email: carole.devaney@leicestercity.nhs.uk

References

1 Health Education Authority,1997. *Mental Health Promotion*: *A Quality Framework*. London: Health Education Authority
2 Social Exclusion Unit, 2004. *Mental Health and Social Exclusion: Social Exclusion Unit Report*. London: Office of the Deputy Prime Minister

Delivering Race Equality in Mental Health

Description of the Issue

At the time of the 2001 Census 39% of the population of Leicester came from a Black or Minority Ethnic (BME) background. Ethnicity is an important issue in mental health because there are variations between ethnic groups in underlying morbidity, diagnosis and management. Equality in the provision of appropriate mental health services is obviously important and in addition, nationwide evidence suggests that people from BME backgrounds are particularly dissatisfied with the mental health services they receive. People from BME backgrounds are over-represented in compulsory detention under the *1983 Mental Health Act* and are over-represented in incidents of violence, restraint and seclusion in psychiatric inpatient settings. People from BME backgrounds tend to be under-represented in the take-up of counselling and psychotherapy services and tend to be less involved in the planning and delivery of mental health services.

National and Local Priorities

Delivering Race Equality in Mental Health Care (DRE) is a national and local priority, driven by the National Institute for Mental Health in England (NIMHE) and aimed at achieving equality and tackling discrimination in mental health services in England. Many of the actions described in DRE have their roots in existing legislation and guidance such as the *Race Relations (Amendment) Act 2000*. The DRE programme brings together such requirements and guidance, sets them in a mental health context and adds the focused activity required to ensure rapid progress. The DRE programme is based on three 'building blocks':

- more appropriate and responsive services
- community engagement
- better information

The programme highlights 12 key actions, which should be achieved by 2010, including a reduction in the disproportionate rates of admission and compulsory detention of people from BME communities, less fear of mental healthcare, increased satisfaction with services, fewer incidents of violence and a more active role for communities and service users in the planning and provision of treatment.

Leicester, Leicestershire and Rutland together comprise a Focus Implementer Site (FIS) for the DRE programme. In 2006, five mental health Community Development Workers were commissioned from Age Concern specifically to liaise with and improve mental healthcare for people from BME communities in Leicester.

Delivering Race Equality in Mental Health in Leicester: Epidemiology and Interventions

The *Ethnic Minority Psychiatric Illness Rates in the Community* (EMPIRIC) 2002 study gives prevalence of common mental problems among people aged 16-74 years from different backgrounds: White, Black Caribbean, Bangladeshi, Indian and Pakistani. It found prevalence rates of 12% - 14% for men from Indian, Pakistani, Bangladeshi or Black Caribbean backgrounds, were not significantly different from the rates for White men. However, significantly higher rates were found amongst Indian and Pakistani women (23.8% and 26% respectively). There was a lower rate for Black Caribbean and Bangladeshi women.

There were minor differences between the different ethnic groups on measures of social functioning, chronic strain and personality difficulties. These aspects correlated more with social class than with ethnicity for all BME groups. People from the Bangladeshi community reported slightly more difficulties with social functioning and chronic strain. Those from Pakistani, Bangladeshi and Black Caribbean communities were more likely to have poor physical health and significantly less likely to have approached their GP about a stress-related or emotional problem. Asian/Asian British groups provided more informal care within their homes than other ethnic groups. Although the Bangladeshi participants reported strong emotional and practical support from close relationships, those who had higher scores on measures of common mental health problems reported lower levels of social support. People from Black Caribbean backgrounds reported receiving less confiding, practical or emotional support.

The period since the 2001 census has seen the arrival of new communities to the city. Current estimates suggest that the Somali community in Leicester numbers 8,000-10,000, the Polish community between 3,000 and 5,000 and there are other substantial groups including people from Slovakia and Portugal. In the 2006 *Count Me In Census* of inpatients in Leicestershire Partnership Trust (LPT) institutions 3% of inpatients came from Polish, French or Portuguese backgrounds.

The mental health needs of people in new communities are likely to be complex. A study of Somali immigrants aged 18 and over in the Netherlands showed that over 36% of respondents reported moderate to major anxiety or depression and 31.5% post traumatic stress disorder (PTSD). A key source for information regarding the mental health and well-being of the Somali population is the project called MAAN Somali Mental Health operating in Sheffield and Liverpool (MAAN means mind in Somali). The project observed that most Somalis suffer the mild to moderate forms of mental health disorders such as depression, anxiety and PTSD. They noted that these

are rarely recognised as mental ill-health although many patients visit their GPs repeatedly for physical health problems.

There are a few projects specifically commissioned to provide support to people from BME communities in Leicester, such as Foundation Housing, Akwaaba Ayeh, Savera Resource Centre and Adhar project. There is a need for more groups representing the Black Caribbean/Black British and new communities.

With regard to the statutory sector, people from Black Caribbean/Black British communities in the city are generally over-represented in many of the secondary and tertiary mental health services and people from South Asian communities under-represented. One way of showing the pattern of over representation of people from Black/Black African Communities is to refer to the Count Me Census data for 2007; this is shown in Table 3. This data covers four different groups: White, South Asian, Black African/British and other for Leicester, Leicestershire and Rutland and mirrors the findings from the Health Equity Audit reported in Figure 14. The inpatient rate for Black African/British groups is significantly higher than average, with this group forming 1.2% of the local population according to the 2001 Census, and 4.2% (95% CI 2.6, 6.5) of the inpatient population in Leicestershire Partnership Trust institutions on March 30th 2007.

Table 3: LPT Inpatients by Ethnic Group 2007 compared with 2001 Census Population Estimate for Leicester, Leicestershire and Rutland (Sources: Count Me In and ONS)

Ethnic Group	Count Me In Census 2007 Observed	% Inpatients 2007 Count Me In Census	95% Confidence Interval		% Population of Leicester, Leicestershire and Rutland 2001 Census
			Lower	Upper	
White	356	82.2	78.3	85.5	85.5
South Asian	36	8.3	6.1	11.3	10.7
Black African /British	18	4.2	2.6	6.5	1.2
Other	23	5.3	3.6	7.8	2.6
Total	433				

People from Asian/Asian British communities are under-represented in assessments and detentions under the *1983 Mental Health Act* and less likely to be referred for assessment by a psychiatric inpatient facility or by the criminal justice system. People from Black communities are over-represented in social care assessments and reviews and mental health advocacy.

People from BME communities who were admitted to psychiatric wards were significantly less likely to have a diagnosis of personality disorder compared to people from white communities but were more likely to have a diagnosis of schizophrenia compared to white inpatients. People from Asian communities were significantly under-represented in use of the Common Mental Health Problems Service and the eating disorders service.

In 2006, 2 studies were commissioned to validate baseline assessments about race equality and mental health in Leicester, Leicestershire and Rutland. The evidence presented in the reports suggested that there was a lack of information and explanation to patients about mental health conditions and about medication and its side-effects; mental illness was stigmatised; services were dominated by a medical model of mental illness; there was a need for talking therapy and there were patient experiences of being misinterpreted and over-medicated on wards.

Similar issues were highlighted in a recent consultation of the Somali community's views on mental health. These consultations showed a lack of awareness about the seriousness and frequency of mental health problems. People regarded the stigma associated with mental illness as a serious obstacle to seeking help. It also became clear from these consultations that most Somali families are particularly concerned about the mental health of children and young people, given the vulnerability and exposure of this group to group pressure, bullying and racism.

This work is augmented by the activities of the Community Development Project, facilitated by Age Concern. The mental health-focused Community Development Workers have been engaged in analysing the needs of the community and identifying the gaps in service, by establishing relationships in the community. They have organised well-being and relaxation programmes and facilitated different groups, such as the African Consortium.

Issues Identified

Leicester has a diverse and dynamic population. There are disparities amongst BME populations in the city in terms of access to mental health services. Studies have shown a general dissatisfaction among BME communities with such services, a requirement for a more balanced range of effective therapies and a need for improved access to services, including culturally appropriate psychotherapeutic treatments and more appropriate use of pharmacological interventions.

The mental health workforce and organisation needs to be capable of delivering appropriate and responsive services to BME communities. Although there are voluntary groups currently playing a role in mental healthcare there is a need to develop this sector, specifically with more support for black communities and new communities. There should also be a development of the role and function of such organisations beyond advocacy for BME communities and service users, so that they may be involved in the referral process, training professionals, developing mental health policy and planning the provision of services.

Recommendations

It is recommended that:

- Developments in mental health care, such as Improving Access to Psychological Therapies are used to address the needs of people in BME communities, and ensure that they have access to the appropriate level of care
- There should be more support for third sector organisations which represent BME communities, in particular those organisations which support people from Black/Black British ethnic backgrounds and new arrivals
- Third sector organisations should be supported to have a real impact on mental health by developing their capacity and capability to provide care and by including them on the referral pathway and involving them in mental health service planning
- There is better information concerning the mental health of people from BME backgrounds, including improved monitoring of ethnicity to show the use of different services and their effectiveness

Lead Authors

Kala Subbuswamy
Leicester City Council

Dr Jama Warsame
Specialist Registrar in Public Health Medicine

Mark Wheatley
Public Health Specialist (Mental Health and Vulnerable People)
Tel: 0116 295 1583
Email: mark.wheatley@leicestercity.nhs.uk

Perinatal Maternal Mental Health

Description of the Issue

Psychiatric disorder following childbirth is common and often serious. Many women are at increased risk of suffering with a mental illness following childbirth, and those women who have had mental ill-health in the past are at risk of a relapse or recurrence of their condition following childbirth. In addition to the impact on the woman herself, suffering with mental ill-health following childbirth is likely to have an adverse impact on her family and the future development of her child. Confidential enquiries into maternal and child health, which audit all maternal deaths over a three year period, show that severe mental illness is the second most common cause of maternal mortality[1]. Yet many women who experience perinatal mental health problems do not receive the care that they require.

Mental ill-health is often prolonged by a delay in diagnosis or ineffective treatment. However, when care is delivered promptly the response to treatment can be effective. Successful treatment, which may be a combination of talking therapies and medication, is likely to require:

- the co-ordination of primary and secondary care services, social services and third sector organisations
- effective provision and use of information for women with an existing mental health disorder, those who are pregnant or planning a pregnancy
- healthcare professionals to be better in predicting and detecting mental health problems
- offering support to family members
- management of depression by utilising cognitive therapy and interpersonal therapy as well as anti-depressants

National and Local Priorities

As with most mental healthcare, the impetus for change was set by the *National Service Framework for Mental Health (NSF for Mental Health)*. However, subsequent reports have shown continued shortfalls in service provision, so more recent, relevant policy initiatives have focused on the particular issue of perinatal maternal psychiatry[2]. These have highlighted the need for every maternity locality to have a perinatal maternal mental health strategy in place to ensure better outcomes for women who experience maternal mental health problems.

In 2007 the NICE guideline on clinical management and service guidance for antenatal and postnatal mental health highlighted five key priorities for implementation[3]:

- **Prediction and detection:** At a woman's first contact with antenatal and postnatal services healthcare professionals should ask screening questions about past mental health, past treatment and family history, with specific questions highlighted for primary care clinicians
- **Psychological treatments:** Women requiring treatment should be seen for treatment normally within one month of initial assessment, not delayed by more than three months

- **Explaining risks:** Before decisions about care are made, healthcare professionals should discuss with the woman the absolute and relative risks of treatment for mental ill-health in pregnancy and the postnatal period
- **Management of depression:** The guidance gives information for clinicians to consider when choosing an antidepressant for pregnant or breastfeeding women
- **Organisation of care:** The guidance recommends that clinical networks should be established for perinatal mental health services, managed by a co-ordinating board of healthcare professionals, commissioners, managers, service users and carers. As a result there will be a specialist multidisciplinary perinatal service in each locality, with clear referral and management protocols, providing pathways of care and access to expert advice on the risks and benefits of medication

Perinatal Mental Health in Leicester: Epidemiology and Interventions

Depression is a common disorder in the population generally, with the gender ratio inclined towards females; lone parents have higher rates than those in a couple relationship and couples with children have higher rates than those without[4]. Gavin et al[5] systematically reviewed evidence on the prevalence and incidence of perinatal depression and compared the rates with those of depression in women at non childbearing times. Although they concluded that studies with larger and more representative samples were required, they found that the prevalence of depression was 3.8% at the end of first three months of pregnancy rising to 4.9% at the end of the second, before dropping to 3.1% at the end of the third. They also estimated that in the first year after birth depression was prevalent in between 1% and 5.7% of women, with the highest rates at 2 and 6 months after the birth.

A rare but serious mental health problem related to pregnancy is puerperal psychosis. This condition usually starts in the first two weeks after the baby is born. A woman who has puerperal psychosis may be suffering insomnia, hallucinations, agitation, rapid mood swings between depression and happiness, and delusions often about the baby. They may be at risk of harming themselves or their babies, or both, and as a result they are usually cared for in hospital with their babies. They are usually given antipsychotic drugs. With regard to the incidence rate of puerperal psychosis, the NICE guidelines suggest that the most commonly quoted figure is also 1 per 1000 deliveries, although this is dependent upon the diagnostic criteria[6]. There are other mental ill-health problems which may be related to pregnancy. For instance, Olde et al[7] found that the prevalence of symptoms of Post Traumatic Stress Disorder (PTSD) in women after child birth was between 2.8% and 5.6% at around 6 weeks postnatal, reducing to 1.5% by 6 months.

According to the Royal College of Psychiatrists[8], evidence suggests that between 3% and 5% of delivered women will meet the criteria for moderate to severe depressive illness. Those who are at increased risk include the young, those who experience conflict in their family life, those who have been anxious and depressed before and those who have little or no social support. When the illness is not treated the outcomes can be devastating for individuals. For instance, *Why mothers die* suggested that whilst suicide and self-harm is rare, suicide and deaths which result from substance misuse are believed to account for 10% of maternal deaths in the UK. In addition, Oates suggests that many mothers who non-accidentally injure or neglect their children are found to have been suffering with depression or anxiety.

The Leicester Perinatal Psychiatry Service covers Leicester, Leicestershire and Rutland. It was established in 2003 to meet the complicated clinical challenges associated with perinatal mental illness. At present it comprises a half time equivalent of a consultant liaison psychiatrist and 2 whole time community psychiatric nurses. The service receives 300-350 referrals per year, which reflects the expected perinatal morbidity for the 11,600 births in Leicester, Leicestershire and Rutland. Based on a prevalence of 3% and 5000 births annually, it can be estimated that 150 women are likely to have a major perinatal depressive illness in the city of Leicester.

Figures 16 & 17 show that most referrals to the Leicester Perinatal Psychiatry Service are from primary care and that the three main reasons for referral are depression, neurosis or a history of severe mental illness.

Figure 16: Referrals to Leicester Perinatal Psychiatry Service
Source: Leicester Perinatal Psychiatry Service, 2006

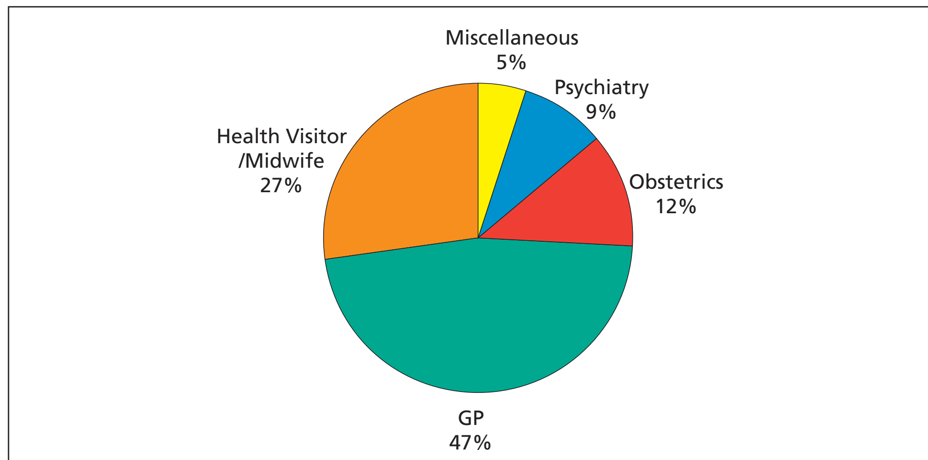
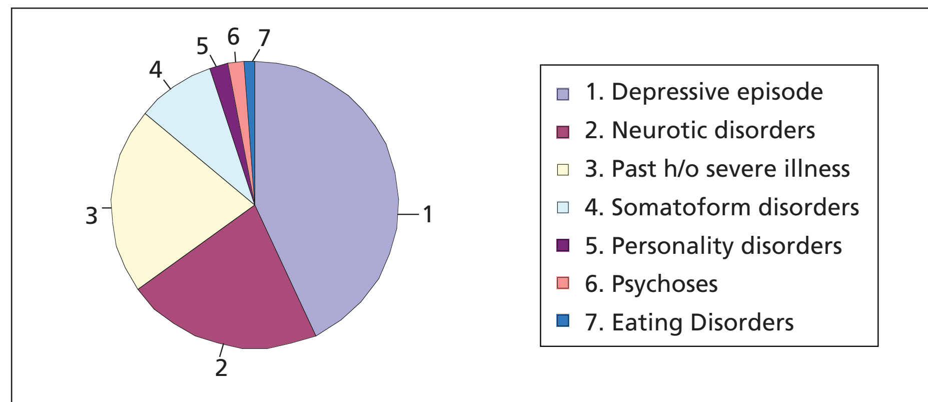


Figure 17: Diagnosis of Females Referred to Leicester Perinatal Psychiatry Service
Source: Leicester Perinatal Psychiatry Service, 2006



Research by Lazarus and colleagues has shown that ethnic minority populations are under represented in the perinatal psychiatry clinic population.

In Leicester women see obstetricians and midwives regularly throughout their pregnancy and most deliver their babies in hospital. During the period after the birth women are seen by General Practitioners and Health Visitors.
These universal services are involved in the identification of emotional health problems, making referrals when necessary. The specialist perinatal psychiatry service accepts referrals from these services and when they are made, the referrals are often urgent and complicated by child protection issues. In addition to developing specialist services therefore, there is a requirement to develop the capacity of universal services, for example GPs, health visitors and community midwives, to enable those in most regular contact with women in this period to develop therapeutic relationships and support emotional resilience.

It is necessary to develop clear care pathways as in the stepped care approach (figure 15, p.12) to ensure that women have access to appropriate treatment.

The Leicester Perinatal Psychiatry Service holds outpatient clinics at Leicester Royal Infirmary and at Leicestershire Partnership Trust. Patient satisfaction surveys have shown that when the clinics are held in the maternity unit patients feel reduced levels of stigma associated with mental illness and higher levels of acceptance. The service also has a three bedded mother and baby unit and conducts community follow up in association with local community healthcare teams. The staff conduct obstetric liaison, offer second opinions, specialised advice on medication and child protection and are involved in the training of other clinicians.

The mother and baby in-patient unit exists primarily to manage women with acute perinatal mental illness and their babies, where there are no viable alternatives to admission. The aim is therapeutic and ensures that no woman is separated from her baby because of admission to a psychiatric unit. It is currently staffed by nurses from the adjoining general psychiatric ward. Community based psychiatric activity provides support for childbearing women with serious mental illness. Clinicians assess and manage the significant mental illnesses that complicate pregnancy and the period after birth and which cannot be managed effectively and safely by primary care services. They also assist in the detection and proactive management of those at risk of becoming seriously ill and support primary care, maternity and psychiatric services. The East Midlands Perinatal Mental Health Network suggests that there needs to be more specialised nurses for both the community and in-patient elements of the service.

Issues Identified

Perinatal maternal mental illness may be harmful for mothers, children and their families. More capacity needs to be created for women to have timely access to specialised therapy and to enable those professionals who regularly see women during and after pregnancy to build therapeutic relationships with women as part of their preventative work.

The potential benefits of a robustly commissioned effective antenatal and postnatal mental health service include an improvement in the mother-child relationship and timely access to appropriate services. It would also facilitate a reduction in the risk of relapse, the risk of self-harm and suicide and the prevention of avoidable separation of mother and baby.

Recommendations

It is recommended that:

- A protocol for the implementation of NICE guidelines for the assessment of maternal mental health should be adopted, which focuses on better identification of women with common mental health disorders, the provision of more information about the risks and benefits of treatment before conception and access to timely and appropriate care

The stepped care model should be developed to include:

- The development of low-intensity psychiatric services as part of the stepped-care framework for mental healthcare
- The development of the capacity and capability of generalist primary care and maternity services to ensure that vulnerable women are offered effective help in a timely and appropriate way
- More flexible referral systems to specialised mental healthcare
- Consideration of the development of the Leicester Perinatal Psychiatry Service in accordance with regional network recommendations

Lead Authors

Julia Austin
Consultant Midwife (Public Health)
University Hospitals Leicester

Mark Wheatley
Public Health Specialist (Mental Health and Vulnerable People)
Tel: 0116 295 1583
Email: mark.wheatley@leicestercity.nhs.uk

Contributors

Dr Ranuka Lazarus
Consultant Perinatal Psychiatrist

Liz Mair
CAMHS Strategy and Commissioning Manager
NHS Leicester City

References

1 Oates, M.R. 2004. *Why Mothers Die Confidential Enquiry into Maternal and Child Health*. London: RCOG Press
2 Lewis, G. (ed.)., 2007. *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer - 2003-2005: The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom*. London: CEMACH
3 NICE, 2007. *Antenatal and Postnatal Mental Health Guidelines*. London: NICE
4 Meltzer, H. et al., 1995 *Economic Activity and Social Functioning of Adults with Psychiatric Disorders*. London, HMSO
5 Gavin, N. et al, 2005. *Perinatal Depression: A Systematic Review of Prevalence and Incidence*. Obstetrics & Gynaecology, 106: 1071-1083
6 National Collaborating Centre for Mental Health, 2007. *Antenatal And Postnatal Mental Health: The Nice Guideline On Clinical Management And Service Guidance*. London: The British Psychological Society
7 Olde, E., et al., 2006. *Posttraumatic stress following childbirth: A review.* Clinical Psychology Review, 26, 1-16
8. Oates, M., 2000. *Perinatal Maternal Mental Health Services*. Council Report CR88. London: Royal College of Psychiatrists
9 Ali, A., Lazarus, R., in Tanner, J., 2008. *Leicester Perinatal Service Power point Presentation*

Child and Adolescent Mental Health

Description of the Issue

The health and well-being of children and adolescents and the collaboration between statutory and voluntary organisations involved in their care are intrinsic elements to the *One Leicester* vision. Good emotional, psychological and social health can protect young people from emotional and behavioural problems, violence and crime, teenage pregnancy and substance misuse. Poor mental health may affect childhood development, a young person's capacity to establish long-term relationships and the adequacy of parenting their own children. It may also affect their chances of gaining employment.

National and Local Priorities

The national and local agendas concerning the mental health of children and adolescents are underpinned by a number of strategic initiatives, aimed at ensuring that young people with mental health problems have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support for them and their families. This can be seen, for example, in the *National Service Framework for Children* and the drive from Young People and Maternity Services to integrate the delivery of all local children's services towards improving health. *Every Child Matters* focuses on achieving better outcomes for children under headings such as being healthy, staying safe, enjoying and achieving through learning, making a positive contribution to society and achieving economic well-being. *The Children Act 2004* gives a particular role to local authorities in securing co-operation amongst local partners, who in turn have a duty to co-operate. These partners include local NHS organisations, Youth Offending Teams, the Police, District Councils and others. The Act also encourages the involvement of schools, GPs and the third sector in the co-operative arrangements.

Appropriate integrated care for children spans tiers from universal services through to very specialist services for those with serious mental illness. Moves towards co-ordinating such services are already underway. One of the tools used to ensure the necessary co-operation between professionals is the *Common Assessment Framework*. This will promote more effective and earlier identification of additional needs and take into account the role of parents, carers and environmental factors on the child's development. It will also enable practitioners to be better placed to agree, with the child and family, any necessary and appropriate support.

Child and Adolescent Mental Health in Leicester: Epidemiology and Interventions

Building and sustaining good mental health in children is affected by the child's stage of development and their cultural, social and economic background. The dynamic demographic profile of children and adolescents in Leicester is most recently exemplified by the increased local presence of people from Sub-Saharan Africa, Eastern Europe, the Middle East and the European Union. Data from the Joint Steering Group for Children and Adolescents shows that in 2001, there were 70,109 children and young people (aged under 18 years) in the City of Leicester. Of these, it is estimated that over 55% (38,000) of these children and adolescents are from BME communities[1].

Approximately 10-15% of children and adolescents in the general population suffer from mental ill-health, equivalent in Leicester to approximately 3,500 to 5,250 individuals. The prevalence of particular disorders varies according to age and to some extent gender with higher rates among boys. Meltzer found that 10% of boys aged 5-10 years and 6% of girls in the same age group had a

mental disorder. Amongst 11-15 year olds the proportions were 13% for boys and 10% for girls. The spectrum of mental illness from which they may suffer is wide. Estimates of the prevalence of specific disorders suggest that diagnosable anxiety disorders affect around 12% of those aged 4 to 20, disruptive disorders around 10%, attention deficit disorder 5%, specific developmental disorders and substance abuse up to 6% depending on age group. In Leicester 3 in every 1000 residents under the age of 20 are registered with mental health services, a figure which reaches 5 in every 1000 in the most deprived areas.

Mental health problems may also be associated with issues such as education, crime, hyperactivity disorders and whether a child is in local authority care. The report *Count Us In* cites a 40% prevalence of mental health problems amongst those diagnosed as having a learning disability. Dolan[2] found that 25% of juvenile offenders aged 10 to 17 appearing before the Manchester Youth Court had recent contact with psychology or psychiatric services. If applied to the same age range on the Youth Offending Team caseload, this equates to 500 individuals who may have had recent contact with Child and Adolescent Mental Health Services (CAMHS). Meltzer[3] found that the rate of mental ill-health disorders amongst looked after children in residential units to be significantly higher than that in the general population.

Attention deficit and hyperkinetic (for example, hyperactivity) disorders, can result in inattentiveness, hyperactivity and impulsiveness. Attention deficit hyperactivity disorder (ADHD) has an estimated prevalence of 5% in those aged 4-16, or 2,300 children in Leicester; whilst the prevalence of hyperkinetic disorder is accepted as approximately 1.5% of the UK school aged population, which equates to 700 children in Leicester. Children with severe ADHD often have low self-esteem, emotional and social problems and under-achieve at school. ADHD persisting into adolescence and adulthood may be associated with continuing emotional and social problems, substance misuse, unemployment and crime. Commissioning intentions are therefore being developed to ensure the appropriate transition of adolescents into adult care.

Self-harm is a particular mental ill-health issue among adolescents. Approximately 7% of adolescents will harm themselves at some point whilst 20% will think seriously about it. Between 2% and 4% of adolescents will attempt suicide and 40% of those who survive a first attempt will repeat it. In Leicester there were 3 suicides registered amongst people aged 18 or under in 2007. The self-harm admissions for 15-19 years olds vary roughly between 200 and 300 per year (based on 2004/5-2006/7 data) for the Leicester, Leicestershire and Rutland area.

The integrated approach between mental health services, social services, education, offender management services and adult mental health is crucial to enable children and adolescents to reach their full potential. Only a small proportion of the mental health needs of children will be met by specialist mental health services. In Leicester a tiered model of care is already in place to meet the mental health needs of children and adolescents (figure 18).

Figure 18: Tiered Model of Mental Health Services for Children and Adolescents
Source: Joint Strategy for promoting the emotional and mental health of children and young people in Leicester, Leicestershire and Rutland 2008-2011.

According to this framework, children and their carers are supported on the first tier by other family members, primary care professionals and schools, Sure Start and Family Centre workers. These services are essential in the promotion of mental health and emotional resilience. It is planned that by 2010 in Leicester 99% of schools aspire to achieve National Healthy Schools status, that schools will be supported in implementing the Social and Emotional Aspects of Learning and the Personal and Social Education curricula and that there will be an increase in parents participating in a parenting group in Leicester, Leicestershire and Rutland.

The second tier comprises targeted early intervention services, such as the Leicester City Child Behaviour Intervention Initiative (CBII), Primary Mental Health Workers and Specialist Child Health Services. These services train carers and other groups to manage symptoms of mental distress and provide brief targeted interventions aimed at preventing those symptoms from escalating. The number of direct work cases seen by CBII in 2006/07 was 593. At tier 2, there is also a CAMHS Professional Advisory Service, a telephone service to support those involved in tier 1 care. Of all the calls taken in the period 2006-7, 35% were followed up by input from primary mental health and 11% suggested a referral to specialist CAMHS. The majority of those seeking advice were health professionals although 7.5% were made from the third sector. In 2006/07 269 calls were received concerning issues relating to children and services in Leicester.

Third tier services are targeted towards children and young people with significant mental health problems. Interventions at this level are instigated by a referral from services in tiers 1 or 2, or by a transition from tier 4 as the acute phase of illness eases. Services at this level are provided by Leicestershire Partnership Trust and the local authority and include the CAMHS community teams, the Young Persons Team, the Learning Disability Outpatients Team, the Joint Therapeutic Social Work Team and the Family Welfare Association. They cover the whole of Leicester, Leicestershire and Rutland and comprise a range of professionals such as consultant psychiatrists and psychologists, social workers, community psychiatric nurses and occupational therapists. In the period 2006-7 these services saw 1,674 new cases in total in Leicester, Leicestershire and Rutland.

The final tier provides very specialist services for those children whose needs are complex, intensive and interfere with a child's social functioning. The number of clients seen in 2006/07, requiring treatment at this level totalled 249 for Leicester, Leicestershire and Rutland. Local services operating at this level include Tanglewood, the Psychosis Intervention and Early Recovery (PIER) team, Oakham House and the CAMHS Assessment and Intervention Treatment Service.
These teams offer expertise from consultant psychiatrists, psychiatric nurses, psychologists and a care co-ordinator. The CAMHS Assessment and Intervention Treatment Service offers nurse-led intensive behaviour intervention in educational and social care settings. PIER is a service for young people aged 14-35 during the first three years of a psychotic illness this offers a low-stigma approach focusing on psychological adjustment and the prevention of relapse. Tanglewood is a service for children up to 12 years old and their families, offering intensive interventions aimed at boosting children's self-esteem, managing behaviour and caring for children with specific problems, such as ADHD and autism. Oakham House is an 8 bedded psychiatric in-patient unit offering assessment and treatment for children and adolescents aged between 12 and 16. Referral to this service is for children whose clinical needs are too severe or complex to be managed appropriately at out-patient level.

Issues Identified

The mental well-being of children is likely to have an impact on their present and future physical health. It can determine whether or not children develop healthy lifestyles and how well they do at school. Good emotional, psychological and social health protects against emotional and behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol. Emotional and behavioural disorders may affect childhood development, a young person's future capacity to develop and maintain long-term relationships and the adequacy of parenting their own children. It may also affect their capacity to enter employment. Although service co-ordination has progressed, more integration is required to develop care pathways as a means of overcoming fragmentation and ensuring the continuity of good mental healthcare into adulthood.

Recommendations

It is recommended that:

- There are benefits in commissioning a range of services to meet the needs of children and young people, including more integrated work at Tier 1 and improved timely access to specialised services
- All professionals involved in the identification of mental and emotional health require development to improve the mental health care of children and young people
- The role of schools and third sector organisations in developing emotional resilience and community capacity to deal with the mental health problems of children and adolescents should be encouraged
- All mental health services must provide non-stigmatising, age appropriate, treatment of young people's mental health difficulties and disorders
- The Joint Strategy for Promoting the Mental and Emotional Health of Children and Young People in Leicester, Leicestershire and Rutland 2008 – 2011 is implemented

Lead Authors

Mark Wheatley
Public Health Specialist (Mental Health and Vulnerable People)
Tel: 0116 295 1583
Email: mark.wheatley@leicestercity.nhs.uk

Mel Thwaites
Assistant Director of Children and Family and CAMHS Strategy and Commissioning Manager
Tel: 0116 295 1149
Email: mel.thwaites@leicestercity.nhs.uk

Contributors

Liz Mair
CAMHS Strategy and Commissioning Manager
NHS Leicester City

Judith Hurwood and Nick Humphreys
Principal Psychotherapists
Dynamic Psychotherapy Service

References

1 Leicester, Leicestershire and Rutland CAMHS, 2008. *Joint Strategy for promoting the emotional and mental health of children and young people in Leicester, Leicestershire and Rutland 2008 -2011*. Leicester: Leicester, Leicestershire and Rutland CAMHS

2 Dolan, M., et al. 1999. *Health status of juvenile offenders. A survey of young offenders appearing before the juvenile courts*. Journal of Adolescents, 22 (1) 137-144

3 Meltzer, H., 2003. *The mental health of young people looked after by local authorities*. London: Office for National Statistics

The Mental Health of Working Age Adults

Description of the issue

For working age adults mental illness is common and can be disabling. The spectrum of illness ranges from problems of depression and anxiety with a prevalence of about 14% in the UK, to less common psychotic illnesses such as schizophrenia with a prevalence of less than 0.5%. It is estimated that one in four people will experience mental illness at some time in their lives and while most will make a full recovery a number of people will continue to experience varying degrees of disability and distress for prolonged periods. Murray and Lopez[1] estimated that by 2020 depression will be the second most common source of disability in the world.

With regard to service provision, NICE guidance suggests that treatments should be available to all people with problems such as depression, anxiety or schizophrenia, unless the problem is very mild or recent. However only one in four who suffer from depression or chronic anxiety receive any kind of treatment.

National and Local Priorities

People with mental illness are amongst the most vulnerable and socially excluded groups in society. Effective mental health services focus on enabling such people to take a greater part in the community and realise their full potential. This agenda has been facilitated by a number of programmes both locally and nationally.

The *NSF for Mental Health* established priorities for mental health care which ultimately led to the development of new services, such as the Common Mental Health Problems Service, Crisis Resolution and early intervention in psychosis (PIER). In the intervening period there have been a number of initiatives such as the *National Suicide Prevention Strategy*, the *Mental Health and Social Exclusion* report, *Delivering Race Equality* and NICE guidance.

Locally, the *World Class Commissioning* agenda has identified mental health as a public health priority for NHS Leicester City. In addition, in March 2008 a *Mental Health Charter*, developed by service users and staff was formally signed by NHS Leicester City, Leicestershire Partnership NHS Trust, Leicester City Council, Leicestershire County Council and Rutland County Council, NHS Leicestershire County and Rutland and the local voluntary sector. The charter lays out twelve statements concerning what people should expect from mental healthcare and support services in Leicester, Leicestershire and Rutland (see Box 3).

Box 3: Charter for Mental Health in Leicester, Leicestershire and Rutland

Every person in Leicester, Leicestershire and Rutland has the right to mental health services that:

- Make a positive difference to each person they serve
- Stop doing things that are not working
- Are guided by the individual's views about what they need and what helps them
- Treat everyone as a capable citizen who can make choices and take control of their own life
- Work with respect, dignity and compassion
- Recognise that mental health services are only part of a person's recovery
- Recognise, respect and support the role of carers, family and friends
- Communicate with each person in the way that is right for them
- Understand that each person has a unique culture, life experiences and values
- Give people the information they need to make their own decisions and choices
- Support their workers to do their jobs well
- Challenge "us and them" attitudes both within mental health services and in the wider society

The Layard report[2] initiated an agenda for the further development of effective treatment for those with anxiety and depression disorders. One response to this agenda has been the Increasing Access to Psychological Therapy (IAPT) programme as a way of coordinating investment, implementing NICE guidance and assisting the return to work of those people on incapacity benefit as a result of mental ill-health. IAPT focuses on increasing the number of people trained in Cognitive Behavioural Therapy (CBT) and developing clinical services in which these new therapists will function.

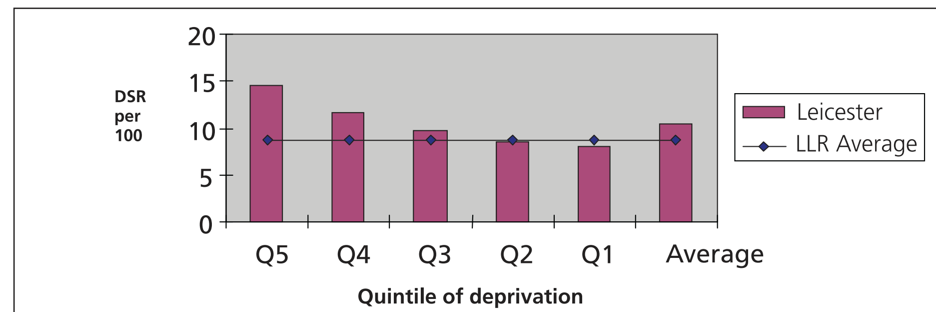
Mental Health of Working Age Adults in Leicester: Epidemiology and Interventions

National surveys[3] suggest that 16-18% of working-age adults might be expected to experience a common mental health problem at any time. Applied to the Leicester population, this equates to between 29,000 and 33,000 people of working age. Around 60% of those experiencing common mental health problems will be women. A recent report by the Sainsbury Centre for Mental Health indicates that around 11,000 working-age adults will develop a common mental health problem each year. In terms of more serous mental illness it is estimated that around 1,600 people of working-age in Leicester will experience psychosis in a year, with equal numbers of men and women[4]. Given this prevalence and incidence, the burden of mental illness on working age adults is such that innovation in commissioning is required to ensure that people who experience mental ill-health have access to appropriate treatment, with minimal waiting times.

Measures of deprivation and disadvantage, such as unemployment, overcrowding, few educational qualifications and those who are lone parents with dependent children are strongly associated with poor mental health. On such measures Leicester has a rate which is higher than the national average[5]. Leicester has an average score on the York Psychiatric Index of 138. This score was higher than average (100) and indicates a high level of mental health need[5].

Figure 19 shows the association between deprivation and the rate of mental health service registration by quintiles of deprivation, with Q5 being the most deprived. It shows the rate in comparison with the Leicester, Leicestershire and Rutland community and how the rate for the city is above average in quintiles 3,4 and 5.

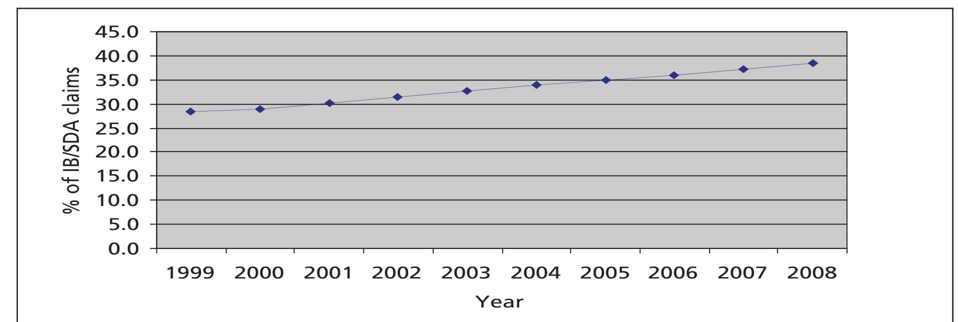
Figure 19: Mental Health Service Registration Rate 2006 Leicester compared to Leicester, Leicestershire and Rutland (LLR) Average
Source: National Centre for Health Outcomes Development



The relationship between unemployment and mental ill-health is a complex one because an individual suffering the onset of mental illness is more likely to leave employment compared with other health conditions. Indeed, as a group those who suffer mental ill-health have the lowest proportion of employment of any group with a disability. The number of adults receiving Incapacity Benefit/Severe Disablement Allowance (IB/SDA) because of mental or behavioural disorders may be an indicator of the extent of severe or disabling mental health problems amongst working-age adults. In February 2008, there were 15,820 people aged 18-64 years claiming IB/SDA in Leicester. Of these it is estimated that around 6,000 people were claiming IB/SDA on the basis of mental ill-health or a behavioural disorder.

This pattern reflects the increase in the number of claims for IB/SDA in the East Midlands region as a whole (Figure 20).

Figure 20: IB/SDA Claims on the Grounds of 'Mental or Behavioural Disorder', East Midlands, 1999-2008
Source: Department of Work and Pensions



Poor quality of life resulting from physical illness is also closely related to mental health problems. People with mental ill-health are twice as likely to report a long term illness or disability and over two thirds of people with a persistent mental health problem also have a long term physical illness. Physical illness of those with severe and enduring mental health problems often go undetected, contributing to increased morbidity and lower life expectancy.

With regard to service provision and demand, people with severe mental health problems have on average 13-14 consultations with their General Practitioner per year in comparison with 3-4 for the population in general. In Leicester, there are a number of services to support primary care in the management of mental illness with

treatments ranging from observation, medication and therapy; including brief interventions, group and one-to-one therapy. Although, generally patients prefer to receive talking therapy rather than medication there were 143,872 anti-depressant items prescribed by Leicester primary care practices in 2005/06, at a total cost of £1.64 million. Nationally, psychiatric medication as a whole made up 7.2% of total items prescribed and 7.1% of the total prescribing budget in 2006/07.

In Leicester there are a range of services available which could produce effective clinical and life outcomes for working age adults with mental ill-health and which may be developed to provide an effective local infrastructure for improving access to psychological therapies, in line with the stepped care framework (figure 15, p.12). These include universal services, third sector organisations, through to Community Mental Health Care Teams and inpatient care.

The Crisis Resolution and Home Treatment Service is a gate keeper and alternative to acute inpatient hospital care for service users with serious mental illness, providing acute home treatment for people whose mental health crisis is so severe that they would otherwise require hospital admission. Users of the service typically suffer from psychoses, severe depression or bipolar affective disorder (manic depression).
It enables people to be discharged earlier from inpatient wards and receive treatment in their homes whilst still in the acute phase of their illness.
The service has helped to reduce admissions for mental ill-health and in the period 2006/7 the service saw 778 patients, of whom the majority suffered either with depression or schizophrenia.

Service delivery has been enhanced by low-intensity interventions at general practice level. The Common Mental Health Problems Service (CMHPS) was developed to improve mental healthcare in primary healthcare settings by providing assessment, psychological treatment and advice on the management of patients with a common mental health problem over the age of 16 years. GPs refer patients whose main presenting problems are depression and anxiety resulting from a myriad of triggers and causes. CMHPS also provides therapeutic input to two specialist practices in the City. The first is the ASSIST Service, a specialist primary healthcare setting for asylum seekers and refugees, some of whom have experienced multiple trauma and many losses. The second specialist practice is the Dawn Centre, a specialist service for the homeless, who present many challenges due to the complexity of their psychological and mental health needs. Practice Therapists engage in mental health promotion and partnership working with community projects such as Healthy Community Lifestyle Promotion on the Saffron Estate and the Feeling Good Project in Braunstone, where they have given practical advice on subjects such as managing stress.

The Cognitive Behavioural Therapy (CBT) Service treats a range of people with neurotic disorders who are unable to be managed by the CMHPS because of severity, complexity or associated risk. The current referral rate for the city is approximately 440 per year, with an annual increase of about 10%. The majority of patients are treated in diagnosis-specific groups of up to 15, usually with two therapists. Outcomes from such innovative group treatments are encouraging, attracting outside interest in the approach and recognition that local CBT therapists have valuable expertise for education, training and supervision.

Another specialist resource is Psychodynamic Psychotherapy. This service offers treatment for adults with severe and complex neuroses, affective and personality disorders. Many people who require psychotherapy have had previous psychiatric treatments, have experienced additional risk factors such as self-harm and suicide ideation and have long standing impairment to their work, social roles and well-being. It is a service which specialises in the management of suicide risk and the provision of training on sexual abuse. The therapeutic treatments delivered by this service are at a level that is too complex, specialised and time consuming to be addressed in primary care or by general psychiatric services. An internal audit of referrals from 2004-2006 showed that 26.4% came from primary care or common mental health problems service, 56.7% from secondary care, 6.5% from specialist services and 10.4% self referral. The service received 223 referrals and recorded 5,868 attendances in 2007/08. Therapy is offered in once weekly group or individual sessions. Internal cost effectiveness studies undertaken in 2003 and repeated in 2008, indicate that 5-8 years after psychotherapy, 70.2% and 85.7% of patients respectively had no further contact with mental health services, suggesting lasting benefits not only for service users but also the local health economy. Service research also supports the efficacy of its training for mental health clinicians, demonstrating[6] improved abilities to work with difficult cases, improving quality and safety of treatment for patients in other services.

The third sector is an important provider of mental healthcare. Reviews suggest that services in this sector provide a valuable service, meeting gaps left in statutory provision and acting as an alternative for those who are reluctant to use statutory services. Indeed the Department of Health supports increased commissioning from this sector. Organisations in the third sector support a large number of people suffering from a range of mental illness from the common to severe and enduring. It does so by providing generic and specialist counselling, day services, housing related support, empowerment of service users, advocacy and support for carers.

Issues Identified

A number of factors can effect mental health. Some increase risk of mental illness whilst others have a protective effect. Employment and engagement within society may be associated with better health, chances of employment and educational attainment. Other factors, such as deprivation, illness and isolation may act to increase the risk of mental illness. It is estimated that between 29,000 and 33,000 people of working age in Leicester could be suffering with common mental health problems and that the majority of them are likely to be women. Although services exist to treat people with mental health problems, the prevalence is such that innovation is required to make use of psychological therapies. Access to such therapies can help to treat depression and encourage participation in work. Patients prefer to receive such therapies, rather than medication.

Recommendations

It is recommended that:

- There should be increased support for the involvement of service users and carers in the planning, development and delivery of mental health services
- Services should be developed, using initiatives such as the Improving Access to Psychological Therapies Programme, to develop integrated patient pathways and a stepped-care framework in which patients have timely appropriate interventions
- The Mental Health Charter is fully implemented in order to provide effective interventions, enhance quality of life, prevent deterioration, and support social inclusion
- Work should continue to reduce the stigma which surrounds mental ill-health, within health services and the community as a whole

Lead Authors

Mark Wheatley
Public Health Specialist (Mental Health and Vulnerable People)
Tel: 0116 295 1583
Email: mark.wheatley@leicestercity.nhs.uk

Kala Subbuswamy
Leicester City Council

Contributors

Marie Bradley
Consultant Practice Therapist
Common Mental Health Problem Service

Dr Peter Caunt
Clinical Director
Department of Cognitive and Behavioural Psychotherapy

Tim Colman
Manager
Crisis Resolution Team

Jan Moore
Senior Practice Therapist
Common Mental Health Problem Service

Dr John Ryder
Consultant Psychotherapist
Dynamic Psychotherapy Service

Graham Twist
Senior Practice Therapist
Common Mental Health Problem Service

References

1 Murray, C. J., Lopez A.D., 1997. *Psychiatric Morbidity among adults living in private households*. London: Stationery Office

2 Layard, R., 2005. *Mental Health: Britain's Biggest Social Problem?* London: Sainsbury Centre for Mental Health

3 Singleton, N., Lewis, G., 2003. *Better or worse: a longitudinal study of the mental health of adults living in private households in Great Britain*. London: TSO

4 Sproston, K., Nazroo, J., 2002. *Ethnic Minority Psychiatric Illness Rates in the Community quantitative report*. London: TSO

5 Knowles, K., et al., 2003. *Leicestershire Partnership NHS Trust future bed requirements report*. London: Sainsbury Centre for Mental Health

6 Morton, M., Bailey, J., 1995. *The Efficacy of Training in Dynamic Psychotherapy*. Psychiatric Bulletin, 19, 1-4

The Mental Health of Older People

Description of the Issue

Provision of mental healthcare for older people is an urgent problem. Between 10% and 16% of people over the age of 65 will develop clinical depression, while some 25% of people over 85 suffer with dementia. Such problems exert a large socio-economic cost, with the *Dementia UK* report suggesting that dementia currently costs the UK over £17billion per year.[1]

National and Local Priorities

National and local policy reflects the fact that the numbers of older people and the proportion of the population they comprise, are increasing. In addition to the key mental health policy documents, such as *The National Service Framework for Mental Health (NSF for Mental Health)*, the *National Service Framework for Older People* and the *National Suicide Prevention Strategy*, there are numerous policy initiatives which aim to ensure that older people have access to general and mental healthcare services that are appropriate to their needs, that they do not suffer age discrimination and that older people are treated with respect and dignity, with zero tolerance of abuse.

The recent publication of the consultation document *Transforming the Quality of Dementia Care* highlights the need for greater awareness of dementia amongst professionals and the general public. It also emphasises the importance of early diagnosis, intervention and high quality care and support for those with dementia and the people who care for them. As the mental health of older people may be affected by issues such as income and housing, national and local priorities aim to provide older people with an adequate income and decent independent housing for as long as possible. In order to ensure that this is done effectively, the agenda for local authorities includes the transformation of adult social care to a personalised system and the funding of continuing care packages.

Mental Health of Older People in Leicester: Epidemiology and Interventions

Based on Office for National Statistics mid 2007 population estimates there are approximately 35,600 people over the age of 65 living in Leicester.
By 2025 this population is projected to exceed 44,400 people, with 21,300 over 75 years of age. Average life expectancy is longer for women and women comprise the majority of the current and projected population of older people, although the number of older men will increase as life expectancy for men improves. As the population of older people increases, it will be increasingly important for older people to maintain a sense of well-being and quality of life, with social interaction, motivation and self-confidence being important in sustaining individual mental health.

The diversity of Leicester is also reflected in the older persons population of the city. At the time of the 2001 Census, 8,282 people (21.9%) over the age of 65 were from a Black or minority ethnic background. Of these 5,245 were between the ages of 65 and 74, 2,456 were between 75 and 84 and those who were aged over 85 numbered 581. It remains a challenge to ensure that mental health services for older people from minority ethnic groups are accessible and appropriate.

Of older people living in Leicester at the time of the 2001 census some 15, 000 were living alone. In a recent survey of older people 43% reported a long term illness or disability and 87% did not have a carer. Older people tend to live around the edge of Leicester. According to the *Annual Report of the Director of Public Health and Health Improvement 2007* the wards that have the highest concentration of older people are Evington, Thurncourt, Eyres Monsell and Abbey.

These factors are important because isolation and limiting physical illness have been shown to exacerbate mental illness. There is a considerable need for care services suggested by the fact that a majority of older people currently living with a limiting illness are not seen by social or healthcare services and that approximately 12% of people over 60 years of age are themselves carers. In addition, there is limited capacity in Leicester care establishments for those aged over 65 years, with one 9 bedded local authority unit providing respite for all older people with mental ill-health.

As with the general population, depression is the most common cause of mental ill-health among older people. Depression in the elderly not only leads to greater impairment in physical function than most chronic physical conditions, it can also be caused by chronic physical illness. Yet depression in older people is often undiagnosed because many elderly patients do not primarily present with psychological symptoms. Even when depression in older people is recognised, the prescribed treatment is often ineffective. In Leicester, it is estimated that there are between 3,600 and 5,400 older people with depression, a number which is projected to rise to 7,000 by 2029. Severe depression is less common, affecting 3% of older people, or about 1,100 people in Leicester. It is estimated that by 2025 this total could be between 1,347 and 2,245 people.

Dementia is a devastating illness which has an impact on the mental health of older people. Given the ageing population, it is a challenge which is growing in size. There are many causes of the disorder, including amongst others Vascular Dementia resulting from strokes, Lewy-body Dementia, the presence of abnormal substances in parts of the brain and Alzheimer's disease. These illnesses can cause memory loss, hallucinations, depression and paranoia. For the person suffering with dementia, the illness can result in changes in behaviour including aggression, changes in levels of activity and impairment in their ability to carry out activities of daily living. For their carers, the impact of looking after someone in this situation can result in a significant deterioration in their own mental well-being. Although many people with dementia live in institutional care, the majority live in private accommodation and many live alone. The report *Dementia UK* projected that by 2016 there will be 3,023 people suffering from dementia in Leicester[1], whilst local estimates suggest that currently there are 2,842 people with cognitive impairment which results from a dementia, a figure which is projected to increase to 3,462 by 2025.

The government has identified dementia as a national priority and has produced a national dementia strategy called *Living well with dementia*. The key priorities in this strategy include early intervention and diagnosis, an informed and effective

workforce for people with dementia, improved care for people with dementia in care homes and implementation of the New Deal for Carers.

Suicide and suicide prevention is a priority area in the mental health and well-being of older people. Social isolation and loneliness are important contributing factors to suicide in older people, particularly where triggered by bereavement, in the first year of widowhood and particularly among men. There are other important factors in predicting suicide in older people such as depression and the presence of physical ill-health. In Leicester, over the seven-year period between 1999 and 2005, there were 25 deaths resulting from suicide and undetermined injury in people who were aged 65 and above. This amounted to 12% of the 206 deaths from suicide and undetermined injury over the same period for the whole population of the city. Of the 25 deaths from suicide and undetermined injury in the elderly, by far the majority (16 or 64%) were in men.

There are other conditions which have an impact on the mental health of older people, such as schizophrenia and bipolar disorder. Schizophrenia is a condition which results in delusions and hallucinations as well as apathy, blunting or incongruity of emotional responses and a reduced level of social functioning.

Most older people with schizophrenia will have developed the illness before the age of 45. In the past, many of these patients have remained in long stay psychiatric beds. Schizophrenia affects about 1% of the older person population, which would equate to about 400 people over the age of 65 in Leicester. Bipolar disorder is characterised by mood swings that are far beyond what most people experience in their lives. These include episodes of intense depression and despair and feelings of elation. Bipolar disorder affects about 1% of adults at some time in their life, although it is unusual for it to start after the age of 40.

For the majority of older people with mental ill-health and their carers, the first contact with health services is through general practice. In addition, many older people with a physical long term condition will be seen by Community Matrons and other specialist services such as Community Mental Health Teams (CMHT), of which there are two covering the city undertaking clinics and domiciliary support. There are 48 inpatient beds for people with functional illnesses such as depression. For people with dementia, although their first contact is with primary care, Leicestershire Partnership Trust provides expertise in establishing a diagnosis and prescribing treatments. Memory clinics are supported by CMHTs and consultants and are run on an outpatient basis. There are 80 inpatient beds for people suffering from an organic illness, such as dementia.

Issues Identified

The number and proportion of older people are increasing. The older population of Leicester reflects the diversity in the population in general. Many older people live alone, some in residential accommodation and many are looked after by informal carers. The care of older people will be enhanced by the alleviation of loneliness and isolation. Life events are likely to have a large impact on an older person's mental health. National and local policies accept that older people require care which is appropriate to their needs. The mental health of older people can be affected by chronic physical disease and dementia type illnesses. There is a need to develop services for older people which recognise the need for integrated working practices between health, social care and wider community services.

Recommendations

It is recommended that:

- Progress should be made in achieving the goals of the national dementia strategy
- There should be strong advocacy to support carers of older people with mental illness, particularly with planned respite, individual counselling and ensuring that carers have access to the benefits to which they are entitled
- Wider services should recognise the importance of involving older people in order to reduce loneliness and isolation and to enable older people to make a positive contribution to the community

Lead Author

Mark Wheatley
Public Health Specialist (Mental Health and Vulnerable People)
Tel: 0116 295 1583
Email: mark.wheatley@leicestercity.nhs.uk

References

1 Personal Social Services Research Unit, 2007. *Dementia UK*. London: Alzheimer's Society

Suicide

Description of the issue

Suicide has been selected nationally as an indicator[1] of mental ill-health because the majority of suicides are committed by depressed people; it is a vital sign indicator for NHS Leicester City. The number of suicides includes deaths from self-inflicted injury and deaths for which the cause of the injury was undetermined. These are decided on the judgement of the coroner. It is acknowledged that from a medical/psychiatric perspective that some verdicts, including open and misadventure verdicts, may have been viewed as suicide when considering a suicide as a self-harm act that resulted in death.

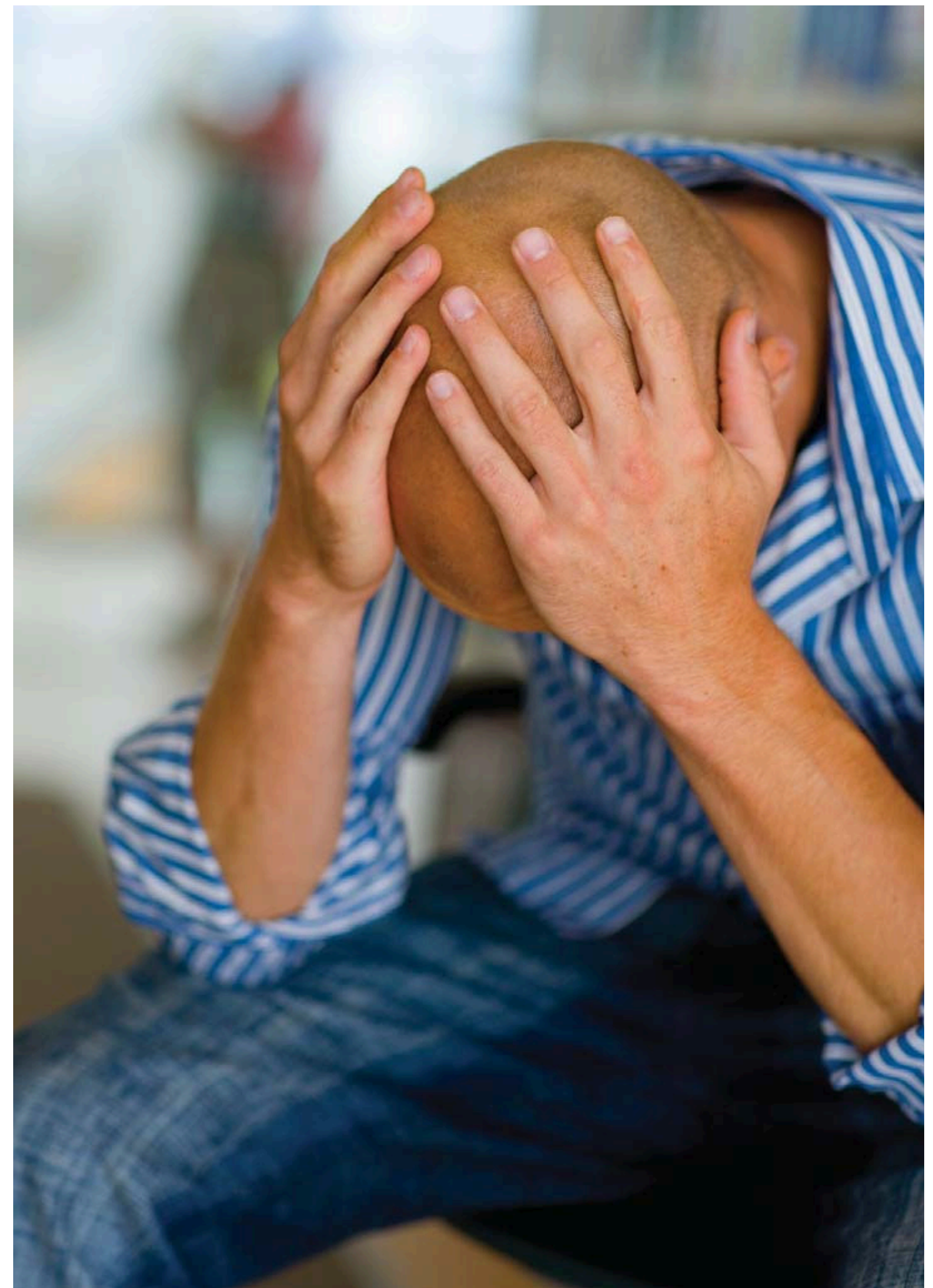
Evidence suggests that the likelihood of a person taking their own life depends on many different factors. These include the presence of a physically disabling or painful illness or a mental illness; alcohol and drug misuse; deprivation and the level of support that a person receives. Stressful life events such as the loss of a job, imprisonment, a death or divorce may also play a significant part. For many people who commit suicide it is the combination of factors which may be important.

National and Local Priorities

Suicide prevention is a key national priority for all health and social services.
The target, set out in Saving Lives: *Our Healthier Nation* (OHN), reinforced by Standard 7 of *The National Service Framework for Mental Health (NSF for Mental Health)* and a Public Service Agreement, is to reduce the death rate from suicide and undetermined injury by at least one fifth by 2010.
The target is measured by using collective rates over a three year (rolling average) period. These are used in preference to single year rates in order to produce a smoothed trend from the data and to avoid drawing undue attention to annual variations instead of the underlying trend. There is also a NICE guideline for the short term physical and psychological management and secondary prevention of self-harm.

Suicide in Leicester: Epidemiology and Interventions

In Leicester, there are between 25 and 30 deaths from suicide every year. Whilst suicide rates in England have shown a downward trend since 1993, Figure 21 shows that the rate in Leicester has been fluctuating and has increased above the mean for England and the East Midlands since 2002. In Leicester the highest suicide rate is amongst those people in the most deprived quintile of the local

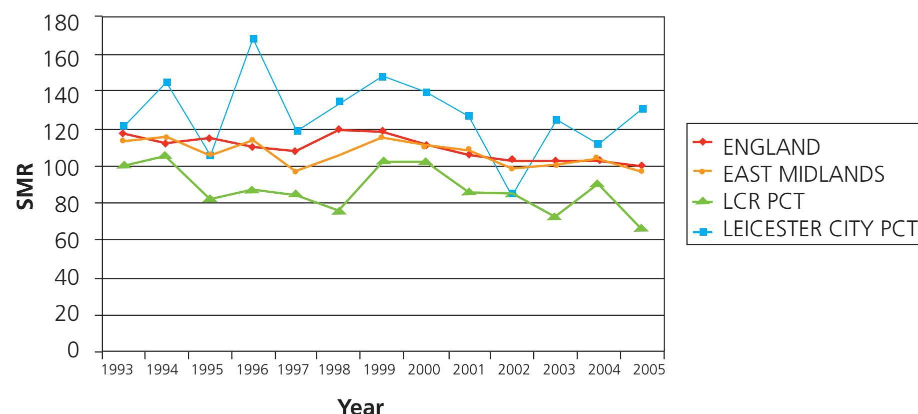


population. It is also highest amongst men, with the highest rate amongst men aged between 35 and 64.

A review of 25 cases of those who took their own lives, registered in Leicester in 2007, showed that there were 20 male and 5 female deaths. The median age was 43 years, with the largest number of deaths (6, 24%) among people aged between 56 and 65. Most of the 25 deaths occurred as a result of hanging (15, 60%), with self poisoning as the next frequently used method, resulting in 7 cases.

Figure 21: Mortality from Suicide and Injury Undetermined in All Ages 1993-2005, Comparing Local PCTs with East Midlands and England.

Source: Health Informatics Service



The likelihood of an act of suicide taking place can depend to some extent on the ease of access to and knowledge of an effective means. One reason for this is that suicidal behaviour is sometimes impulsive; if a lethal method is not immediately available then an act of self-harm may still occur but without its lethal consequence. Therefore there has been health promotion activity in the importance of reducing access to domestic gas, installing catalytic converters to reduce carbon monoxide emissions from vehicles, reducing the pack size and availability of analgesics and installing barriers at sites that are hotspots for suicide. According to the annual report on progress for the *National Suicide Prevention Strategy 2006* improving the evidence base about, for example, high-risk groups and successful preventative interventions can only increase the effectiveness of the national suicide prevention strategy.

Being a prisoner increases the risk of suicide, because the prison population comprises vulnerable individuals, many of whom have experienced negative life events that increase the likelihood of harming themselves, such as drug and alcohol abuse, social disadvantage or isolation, previous sexual or physical abuse and mental health problems. In 2007, there were 4 prisoner suicides in HMP Leicester. In order to deal with the issue of suicide and self-harm in prison, the Department of Health, the Prison Service and National Offender Management Service collaborated in devising and introducing a revised care-planning system for at-risk prisoners (Assessment, Care in Custody and Teamwork). Furthermore, the National Institute for Mental Health in England (NIMHE) has continued to improve the skills and knowledge of prison staff through training courses, particularly around mental health and family liaison and has promoted the expansion of prison mental health in-reach services.

It is difficult to establish the risk of suicide for people from minority groups, such as ethnic minorities, lesbians or gay men as these factors are not recorded when the death is registered or at the inquest. In response to this NIMHE has commissioned research into the risk of suicide and self-harm amongst lesbians, gay men and bisexual people (LGB) and the risk factors for suicide and suicide attempts in different ethnic minorities.

NIMHE has also been working across government departments on non-legislative action which might be taken to discourage internet sites related to suicide. The internet could be used to encourage people to take their own lives by giving detailed information about methods of suicide and allowing those who may be contemplating suicide to communicate with each other. For the media in general, one of the main activities for suicide prevention is to ensure that reports communicate how to find preventative support for those who are contemplating suicide. The overview commissioned by the Department of Health indicates that although the majority of LGB people do not experience poor mental health, research suggests that some LGB people are at higher risk of mental disorder, suicidal behaviour and substance misuse[2].

Evidence suggests that mental health service users are a high-risk group in terms of suicide and undetermined injury. However, 75% of suicides are committed by people who are not in contact with mental health services. Therefore, it is important to make health promotion messages concerning suicide more widely known.

A history of self-harm is also associated with an increased risk of suicide. Around 40% of people who have committed suicide have a history of self-harm and at least one per cent of people who self-harm take their own lives within a year. NIMHE has established four centres to study the incidence of self-harm in England to provide accurate data on national trends and patterns in self-harm in order to inform interventions and detect changing patterns or local variations.

Issues Identified

Suicide prevention is a key national priority for all health and social services. Evidence suggests that the likelihood of a person taking their own life depends on many things, such as a mental illness or physically painful illness and access to an effective means.

Recommendations

It is recommended that:

- There should be continued efforts to raise awareness about suicide and self-harm amongst the general public and professionals
- There should be support for those who self-harm or who are affected by acts of self-harm
- The NICE guidelines on self-harm should be followed so that all individuals who self-harm receive an assessment of need and access to relevant support
- Work with the media about suicide and suicide prevention should be prioritised
- Local trends in suicide continue to be audited in order to inform local delivery and actions

Lead Authors

Keith Waters
Suicide Prevention Manager (East Midlands)

Mark Wheatley
Public Health Specialist (Mental Health and Vulnerable People)
Tel: 0116 295 1583
Email: mark.wheatley@leicestercity.nhs.uk

References

1 Department of Health, 1999. *Saving Lives: Our healthier nation*. London: TSO
2 Fish, J., 2007. *Mental health issues within lesbian, gay and bisexual (LGB) communities, Briefing* 9. London: Department of Health. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078347

The Mental Health of Offenders

Description of the issue

The report *Psychiatric Morbidity among Prisoners* indicated that approximately 90% of prisoners have a psychotic, a neurotic or a personality disorder or suffer with a substance misuse problem which has an effect on their mental health. Prisoners are also likely to have more than one problem concurrently, with remand prisoners more likely to suffer with multiple problems. HMP Leicester is a Category B Local Prison for adult men. It has a large throughput of prisoners, including those on remand, awaiting transfer to other prisons or serving short sentences. The transient nature of the prison's population makes the provision of effective mental healthcare a major challenge. In addition, studies have shown a higher level of need for mental health services for offenders in the community than in the general population[1].

With regard to suicide, a problem related to mental ill-health, the risk is heightened particularly for those on remand or new to a prison, with evidence suggesting that those who have been in prison for less than one month have higher rates of suicidal thoughts. Studies have also shown that the rate of suicide amongst offenders in general is approximately 4 times that in the general population, with death most likely to occur within 12 weeks of release from prison.

Initiatives to improve mental healthcare for prisoners and offenders include the development of mental health in-reach teams and the transfer of prison healthcare to the NHS. There has also been guidance concerning how to improve mental health provision for offenders in general and in particular how to improve access to mental health services for 16 and 17 year olds, as this age group is responsible for the majority of youth crimes.

National and Local Priorities

National and local priorities are guided by the agenda that people with mental ill-health who require specialist medical treatment or social support should, wherever possible, receive it from health or social services. Partnership work between the Prison Service, Probation Service, local social services and the NHS is required in order to achieve this for offenders. Commissioning arrangements for all healthcare services in public sector prisons moved to local Primary Care Trusts in 2006. Efforts to improve the quality of prison mental healthcare include those initiatives which are specific to prisons, such as *The Future Organisation of Prison Health Care and Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons* which set out the vision for the development of prison mental health services so that services more closely match those in the community. Those efforts also include priorities for the general population, such as *The National Service Framework for Mental Health (NSF for Mental Health)* which applied to all working age adults, including prisoners.

In addition, the government has recently conducted a consultation on the health needs of all offenders, including mental health needs, entitled *Improving Health, Supporting Justice*. The government strategy for change is due for release and will be linked to the outcome of the Bradley Review on the diversion from prison of offenders with mental health problems and learning disabilities.

Mental Health of Offenders in Leicester: Epidemiology and Interventions

Those who offend have greater mental health needs than the population generally. A recent review of prisoners in HMP Leicester[2] showed that 343 out of 368 prisoners had been prescribed medication for mental illness, 93.2% of the prison population. In another study of the prison population, 60.6% had a mental health problem which required referral, such as depression, panic attacks and insomnia, a similar prevalence of such conditions nationally was reported in *Psychiatric Morbidity among Prisoners*. The studies of the prisoners also suggested that there are high rates of drug and alcohol dependency, suicide ideation or self-harm and homelessness prior to sentencing. Prevention of suicide and self-harm is a high priority for HMP Leicester which has a number of prisoners on remand, newly sentenced and a high turnover of prisoners.

Mental health needs of offenders in general are wide. According to Howard[3], 45% of all offenders were identified as having a need in the 'emotional well-being' part of the Offender Assessment System. Women were more likely to report problems of emotional well-being such as depression, anxiety and feeling stressed or lonely. Many prisoners suggest that depression contributed to their offending behaviour. An analysis carried out by the National Offender Management Service[4] found that 7% of all offenders were at risk of suicide and 7.3% were at risk of self-harm and these risks were higher among offenders convicted of criminal damage and women committing arson and robbery. Hagell[5] suggests that young offenders have approximately three times the rate of mental health problems as the population in general, with high levels of

personality disorder and psychosis. Female offenders also have high levels of mental ill-health, including psychosis.

A survey of Prolific and Priority Offenders in Leicestershire showed that about 50% were currently or previously known by the Leicestershire Partnership Trust (LPT) for a range of illnesses or disorders, including alcohol or drug misuse. A similar proportion of offenders in Approved Premises (Probation Hostels) were also known to LPT. The greater the risk the offenders posed, the more likely they were to require these services. Brooker's[1] study also showed that about 15% of offenders faced difficulties in accessing health services, which was concerning given the higher level of need. Offenders were more likely to attend hospital accident and emergency departments than the general population.

Issues Identified

There is a need for a joint approach to resolve the management of offenders with mental ill-health needs. Achieving better outcomes for these offenders is dependent upon joint initiatives between the PCT, local social services, HMP Leicester, the Leicestershire and Rutland Probation Trust and other stakeholders. The local Reducing Re-offending Board brings together most of these partners and could assist in co-ordinating activity on a Leicester, Leicestershire and Rutland basis.

Recommendations

It is recommended that:

- There should be improved care pathways for offenders in the community and on release from prison, with particular focus upon health and social care services, in particular those which relate to mental health. This should include improved access and co-ordination with Probation Services
- The healthcare provision in HMP Leicester matches the range and level of service of that in the community, and meets the needs of individual prisoners
- There should be greater monitoring of services and arrangements for offenders with mental ill-health
- The mental health needs of offenders should be considered and addressed collaboratively by the Health and Well-Being and Safer Leicester Partnerships
- There should be an accessible pathway into alcohol and drug treatment for offenders in the community, building on treatment which has been undertaken in prison

Lead Authors

Mark Wheatley
Public Health Specialist (Mental Health and Vulnerable People)
Tel: 0116 295 1583
Email: mark.wheatley@leicestercity.nhs.uk

Trevor Worsfold
ACO Operational Support
Leicestershire and Rutland Probation Area

Contributor

Carl Finch
CSIP Programme Lead

References

1 Brooker, C. et al., 2008. *Health Needs Assessment of Probation Caseloads in Nottinghamshire and Derbyshire: Report of a Pilot Study*. Lincoln: Centre for Clinical and Academic Workforce Innovation
2 Wheatley, M., 2008. *An analysis of the population of HMP Leicester*. Leicester: Directorate of Public Health and Health Improvement
3 Howard P., 2006. *The Offender Assessment System: an evaluation of the second pilot*. London: Home Office
4 NACRO, 2007. *Effective mental healthcare for offenders: the need for a fresh approach*. London: NACRO. Available at: http://www.nacro.org.uk/data/resources/nacro-2007101000.pdf
5 Hagell, A., 2002. *The Mental Health of Young Offenders – Bright Futures: Working with vulnerable young people*. London: Mental Health Foundation

Domestic Violence and Mental Health

Description of the Issue

Domestic violence which, also referred to as domestic abuse, is "the physical, sexual, emotional, psychological, economic abuse or neglect of an individual by a partner, ex-partner, carer or one or more family members, in an existing or previous domestic relationship"[1]. Domestic violence also encompasses forced marriage, "honour crimes" and female genital mutilation of adults[2].

Domestic violence includes a range of coercive and controlling behaviours used to dominate an individual or individuals and to maintain that power. It is an abuse of human rights. Some perpetrators move from one relationship or family to another, continuing to abuse. *The Adoption and Children Act 2002* extended the definition of significant harm to include children living with and witnessing harm to others. National guidance for MPs had identified that 75% of children on the child protection register were living with domestic violence[3]. In 2005 31% of safeguarding adult cases in Leicester, Leicestershire and Rutland concerned alleged abuse by family members[3].

Domestic violence has a significant impact on the physical, emotional, psychological health and well-being of both victims and witnesses. It cuts across all social, economic, religious and cultural boundaries. Domestic violence is rarely a single event but often escalates in frequency and severity over time. It can take many forms including:

- Physical violence
- Sexual violence and abuse
- Destruction of property
- Intimidation, such as threats to kill or harm the victim and or other family members including children and family pets
- Threatening to report victims to Social Services or Immigration Authorities
- Restricting of the victim's liberty
- Isolating the victim from friends and families

Individuals present with a range of symptoms and issues including bruises, burns, cuts, stab wounds, broken bones, damage to teeth and jaw and bites. Prolonged stress impairs the immune system, increases vulnerability to a range of conditions and inhibits recovery. Abuse may be the underlying cause, trigger or exacerbate a range of conditions and chronic illnesses including coronary heart disease, irritable bowel syndrome, respiratory diseases or gastro-intestinal conditions[4,5]. Domestic violence may result in long or short-term disability. Individuals may present over a long period of time with a range of vague and undefined symptoms or they may not attend for appointments[5]. Sufferers or survivors of abuse are likely to have higher levels of admissions to hospital and more prescriptions[5].

Over 50% of adult rapes are committed by a current or ex-partner and the most severe forms of domestic violence are likely to be found among victims of sexual violence.[6] The violence may result in pregnancy or impact on reproductive health. Sexual violence may cause severe emotional trauma and long-term sexual dysfunction, especially when sexual violence is a frequent experience.

Abuse can continue through stalking and harassment for many years, even when partners are separated, especially where perpetrators are granted contact access to children. Mental health problems can also arise, after separation from the perpetrator, as individuals contemplate with anger or sorrow what has been taken from them.

Abuse is a known risk factor for long-term mental illness, especially depression and anxiety. Women are at greater risk of violence than men and it is suggested that the high incidence of abuse may relate directly to the high prevalence of depression in women[7]. Women use alcohol and to a lesser extent, drugs, as a mechanism to cope with current or past abuse[5].

Parental mental illness is known to increase the risks for the mental health and development of infants and children[5]. Depression, which prevents the bonding between mother and child (attachment), can have long-lasting effects on children leading to poor attention skills, lack of control over emotions, difficulties with personal interactions and aggression. There is a greater risk that infants do not receive the stimulation they require to develop language and cognitive skills, particularly if these are not in place by the time they attend school.

Witnessing domestic violence in infancy and childhood can have a traumatic effect, which stimulates the brain stem (used for primitive functioning) to violently over-react. If the complex cerebral cortex has not been developed sufficiently to moderate this, children are more likely to be impulsive and violent and to see aggression as the normal means of resolving conflict[8].

There are increased risks of self-harm, teenage pregnancy, alcohol and substance misuse, truancy, anti social behaviour, bullying and eating issues in young people who are affected by domestic violence.

The extent to which children, even within the same family, are affected by domestic violence will be mitigated or exacerbated by a range of factors including the availability of supportive interventions[8].

Pregnancy has been identified as a risk factor for domestic violence and is linked to:

- Maternal death due to homicide or suicide
- Increases in rates of miscarriages
- Poor pregnancy outcomes
- Low birth-weight and pre-term labour
- Foetal distress[8]

Maternal stress during pregnancy is associated with an increased risk of behavioural problems through infancy to adolescence[8]

National and Local Priorities

Drivers for action to tackle domestic violence include:

- Standard 1 of *The National Service Framework for Mental Health (NSF for Mental Health)*
- *Leicester Local Area Agreement 2008-2011*
- The development by the Home Office of a Co-ordinated Community Response to domestic violence to improve the safety of victims and reduce revictimisation including Specialist Domestic Violence Courts, Independent Domestic Violence Advisors (IDVAs) and Multi-Agency Risk Assessment Conferences (MARACs)
- The *National Domestic Violence Delivery Plan*
- Guidance for health professionals and Trusts on responding to domestic violence[2]
- The key five outcomes for *Every Child Matters*

Domestic Violence in Leicester: Epidemiology and Interventions

The World Health Organisation (WHO) identifies tackling violence as a public health priority which is both predictable and preventable[9]. The estimated prevalence of domestic violence varies, but it is frequently quoted that about one in four women and one in seven men had experienced physical abuse during their lives[10]. However, studies have found differences in the experiences of women and men with higher rates of injury reported in female victims[11]. Nationally on average, 2 women a week are killed by a current or former spouse or partner as a result of domestic violence. This equates to about 50% of all women killed in England[12]. In most cases these deaths have been preceded by a history of abuse. There is significant gender variation in mortality associated with domestic violence with a rate of about 8% for male victims of homicide[5]. In comparison, rates of homicide for women and men associated with domestic violence in Leicester are lower than the national average. Limited research has been carried out into the prevalence of domestic violence in gay and lesbian relationships, but a national study and a study in Leicester indicated this may be as high as 1 in 4 individuals in the lesbian, gay and bisexual community[10].

The police receive an average of 500 reports of domestic violence per month in Leicester[10]. Data shows that the majority of victims are women abused by male partners or ex-partners but 25% of individuals are abused by other family members.[10] Domestic violence accounts for up to 25% of all violent crime in Leicester[1] and has the highest rate nationally and locally of revictimisation of any crime[13].

National research estimates the cost to hospital, ambulance, GP and prescription healthcare services is £1.2 billion per year. Physical injuries are estimated to cost about 3% of the NHS budget and the treatment of mental disorder associated with domestic violence is £176 million[14].

We have limited data locally on the interrelationship between domestic violence and mental health, but a national report[15] identified that:

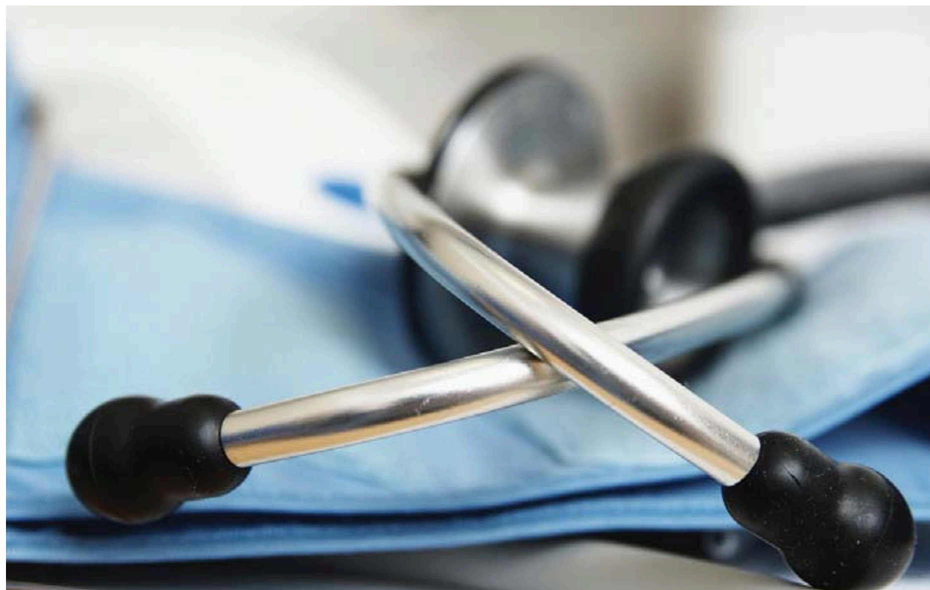
- Alcohol consumption is associated with both the perpetration and experience of domestic violence (this has been clearly demonstrated in the cases which have come to the local Multi Agency Risk Assessment Conferences for Domestic Violence)
- Substance use is frequently associated with domestic violence and it increases the risk to partners and children of the household of both physical and psychological harm occurring

Additional information taken from the *Sane Responses* guidance showed:

- Across a range of settings (psychiatric, primary care, A&E or refuges) the rates of depression amongst abused women varied from 38%-83%. The mental distress resulting from domestic violence can continue for many years after the abuse has stopped

- 70% of female psychiatric inpatients and 80% of those in secure settings have experienced physical or sexual abuse in child or adulthood
- Women experiencing domestic violence were found to be 3.55 times more likely to be suicidal than women in the general population
- On average 64% of abused women have Post Traumatic Stress Disorder (PTSD) which is characterised by intrusive memories or flashbacks, switching off/general numbing and anxiety/fear/hyper-vigilance. PTSD is a response to a traumatic event in which a person fears for the life and safety of themselves or others. Abuse victims are more vulnerable to severe and enduring PTSD when they remain in dangerous relationships, experience multiple incidents of abuse and are stigmatised through the negative reactions of others including communities
- 50% of Asian women who survive suicide or self-harm have experienced domestic violence
- Research has shown that perpetrators come from a range of social, economic and cultural backgrounds and many do not have mental health problems but there is some evidence of an increased association with morbid jealousy and personality disorder[5]

Activity to address domestic violence occurs through the NHS Domestic Violence Group. The Group is currently finalising a local NHS Domestic Violence Strategy.



The Leicestershire Partnership NHS Trust is a committed and active partner in this group. The Trust was one of the first to develop a specialist nurse post for safeguarding adults and children to provide a catalyst for change. The Chief Executive of Leicestershire Partnership NHS Trust is the local NHS domestic violence champion. In addition the multi-agency Leicester Domestic Violence Forum Partnership, has undertaken significant activity to develop the Co-ordinated Community Response.

The *Mental Health Promotion Action Plan for Leicester, Leicestershire and Rutland* includes activity to tackle domestic violence and abuse. Focus groups were held to explore issues around self harm, suicide and domestic violence with BME women. Participants indicated that experiences of domestic violence impacted particularly on the mental health of women from BME communities who may feel less able to seek help because of cultural pressures and perceptions of the availability and accessibility of services. There was some anecdotal evidence of links to using immolation as a form of self harm or suicide. Findings from the focus groups informed the suicide prevention awareness training programme.

The Leicester, Leicestershire and Rutland Safeguarding Children Board recognises the impact of domestic violence on children within its business plan. It set up a working group to look at improving communication and responses across children's and adults' services, particularly in relation to issues around parental mental health, drug and alcohol usage and where there is domestic violence. These factors have consistently emerged as key factors in serious case reviews into child deaths in Leicester and elsewhere in the country.

Issues Identified

Domestic violence has a significant impact on the physical, emotional, psychological health and well-being of both victims and witnesses. It cuts across all social, economic, religious and cultural boundaries.

Domestic violence is a hidden and often unreported issue.

Individuals face additional barriers in reporting domestic violence and accessing information and/or services because of, cultural norms and taboos, age, disability, gender, fear of racism or homophobia[16]. This is compounded by stigma around mental health, self-harm and suicide.

Prevention and early intervention around domestic violence have significant, long-term financial benefits for the NHS. Major employers also experience hidden costs in relation to employees' sickness, absence and reduced productivity. However,

additional activity to tackle domestic violence may incur costs in one service which result in savings in other parts of the economy.

Domestic violence has many similarities with chronic disease management - it is difficult to cure and has to be managed with the aid of a multi-disciplinary/agency team including the service user and specialist services.

Service users and staff experiencing domestic violence in Leicester still experience variations in responses unrelated to need.

Recommendations

It is recommended that:

- NHS Trusts sign up to the local NHS Domestic Violence Strategy and Action Plan and the Leicester Multi-Agency Domestic Violence Strategy
- NHS Trusts, the local authority and other partners identify leads for domestic violence at a sufficiently senior level to influence policy across the whole organisation
- The implementation of the NICE guideline on the management and prevention of self-harm in primary and secondary care is reviewed
- All commissioned services are aware of and implement best practice in the prevention of and response to domestic violence and this is included in contracts and service specification as a clear expectation

Lead Author

Carole Devaney
Public Health Programme Manager
Tel: 0116 295 1514
Email: carole.devaney@leicestercity.nhs.uk

References

1 NHS Domestic Violence Group, 2008. *Leicester, Leicestershire and Rutland Strategy NHS Domestic Violence Strategy 2007-2009*. Leicester: NHS Leicester City
2 Department of Health, 2005. *Responding to Domestic Abuse: A handbook for Health professionals*. London: Department of Health
3 Leicester Domestic Violence Forum Partnership, 2008. *Domestic Violence Data Collection in Leicester 2004/5-2005/6*. Leicester: Leicester Domestic Violence Forum Partnership and Safer Leicester Partnership
4 Taylor-Browne, J., (ed). 2001. *What works in reducing domestic violence? A comprehensive guide for professionals*. London: Whiting and Birch
5 Greater London Domestic Violence Project, 2008. *Sane Responses: good practice guidelines for domestic violence and mental health services*. London: Greater London Domestic Violence Project
6 HM Government, 2007. *Cross Government Action Plan on Sexual Violence and Abuse*. London: HM Government www.crimereduction.homeoffice.gov.uk/sexualoffences/finalsvaap.pdf
7 Department of Health, 2002. *Women's Mental Health: Into the Mainstream Strategic Development of Mental Health Care for Women*. London: Department of Health
8 McVeigh, C., et al., 2005. *Violent Britain People, Prevention and Public Health*. Liverpool: John Moores University
9 World Health Organisation, 2002. *World Report on Violence and Health*. Geneva: World Health Organisation
10 LDVF and Leicester Partnership against Crime and Disorder, 2004. *Domestic Violence Data Collection in Leicester 2003-2004*. Leicester: Leicester Partnership Against Crime and Disorder
11 Archer, J., 2000. *Sex differences in aggression between heterosexual partners: A meta-analytic review*. Psychological Bulletin, 126, 651-680
12 Home Office Crime Reduction website accessed 22 August 2008 www.crimereduction.homeoffice.gov.uk/dv/dv01.htm
13 Dodd, T., et al., 2004. *Crime in England and Wales 2003/2004*. London: Office of National Statistics
14 Walby, S., 2004. *The Cost of Domestic Violence*. London: DTI
15 Royal College of Psychiatrists, 2002. *Domestic Violence Council Report April 2002*. London: Royal College of Psychiatrists
16 BMA Science Department and the Board of Science and Education, 1998. *Domestic violence: a healthcare issue?*, London: BMA

Dual diagnosis

Description of the Issue

The co-existing problems of mental ill-health and substance misuse represent a difficult challenge for mental health services. Elements of care such as diagnosis and treatment are difficult and service users represent high risk of relapse, readmission to hospital, self-harm and suicide. Evidence suggests that substance misuse among people with mental health problems is usual rather than exceptional; that treatment for substance misuse problems often improves mental health problems; and the healthcare costs of untreated people with dual diagnosis are likely to be higher than for those receiving treatment[1]. People with co-existing mental illness and substance misuse issues have high rates of physical ill-health. The provision of integrated care for people with a combination of mental health problems and substance misuse requires effective links across health, social care, the voluntary sector and criminal justice services.

National and Local Priorities

National guidance suggests that Dual Diagnosis services should be delivered within mental health services, with the aim that people should not fall between the gaps of the various organisations which may provide services for them. The *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide* and the *National Service Framework for Mental Health* underpin the planning and development of integrated services. The priorities established in such guidance aim to ensure that Mental Health and Substance Misuse services do not use the identification of a primary diagnosis as a means to exclude people from services. Thus, the provision of dual diagnosis services should take place within mental health services and should be supported by specialist substance misuse services.

Dual Diagnosis in Leicester: Epidemiology and Interventions

People with co-morbidity of substance misuse and mental ill-health have a poor prognosis. There is a reciprocal relationship between the two issues. The most consistent predictor of a poor outcome for those receiving treatment for substance misuse is the presence of psychopathology whilst substance misuse is a predictor of poor treatment outcome for mentally ill patients. Research evidence suggests that drug treatment outcomes improve if mental disorders are treated.

Other problems which result from dual-diagnosis include self-destructive and antisocial behaviours which may lead to homelessness and high-risk behaviours such as offending, intravenous drug use, needle-sharing, suicide attempts, unsafe sex and binge consumption. There is also an increased risk of anxiety, depression and even early mortality. Substance misuse is also associated with increased rates of violence and suicidal behaviour. Also important are those ailments that result more directly from the administration of substances regardless of a coexistent mental illness. Intravenous drug misuse, for example, can result in venous or arterial thrombosis, blood-borne infections including HIV and Hepatitis B and C and cardiac disease. Smoking substances such as crack and heroin can result in respiratory diseases including pneumonia and emphysema. Long-term excessive use of alcohol is also associated with similar debilitating conditions.

People with a dual-diagnosis place a heavy burden on public services. Severe psychotic disorder and substance misuse may be accompanied by a range of social issues, such as homelessness, poverty, criminality, unemployment and marginalisation. A particular strain is placed on acute psychiatric services. The costs of providing treatment for those with co-morbidity are disproportionately higher than for those with psychiatric disorders that do not misuse substances.

The Office of National Statistics study of the prevalence of mental disorder in prisoners found high rates of drug use and dependence prior to coming into prison. Ten percent of male remand prisoners had a moderate drug dependency and 40% severe dependency. High levels of co-morbidity were also common. In a recent needs assessment of prisoners at HMP Leicester[3], drug dependent prisoners were nine and alcohol dependent prisoners six times more likely to have mental illness.

Local services are ranged from universal services, separate mental health and drug services; the Community Drug Service has bases in Leicester and Loughborough. The team has a full time team leader, consultant psychiatrist, a consultant psychologist and full time and part time clinical specialists in substance abuse. With respect to mental health services, it is recommended that teams identify a clinician with a special interest in dual diagnosis to act as a resource, conduct audits and monitor substance use incidents. There is a nurse consultant in dual diagnosis based at Glenfield Hospital who offers additional expertise which could be drawn upon to enhance and assist current care.

Issues Identified

Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. This client group presents clear increased risks to their own and to public safety, with documented risk of increased crime, death and family breakdown. Individuals with these dual problems deserve high quality, patient focused and integrated care which is delivered within mental health services and treats both elements of their dual diagnosis. Providing an integrated dual approach to their treatment is essential to achieve sustainable improvement.

Recommendations

It is recommended that:

- Mental health teams and services should identify a clinician with a special interest in dual diagnosis
- All staff in mental health and substance misuse teams are trained and equipped to work with dual diagnosis with appropriate support and supervision
- Clients with severe mental health problems and substance misuse are subject to the Care Programme Approach and have a full risk assessment
- Local priorities are shaped by a robust needs assessment of the dual mental ill-health and substance misuse co-morbidity
- Integrated governance, roles and responsibilities of the different agencies involved are defined by clear local protocols

Lead Authors

Mags Walsh
Models of Care Manager
LLR DAATs

Mark Wheatley
Public Health Specialist (Mental Health and Vulnerable People)
Tel: 0116 295 1583
Email: mark.wheatley@leicestercity.nhs.uk

References

1 Abdulrahim, D., 2001. *Substance misuse and mental health co-morbidity (dual diagnosis): standards for mental health services*. London: Health Advisory Service

2 Singleton, N., Meltzer, H., et al., 1995. *Psychiatric Morbidity among prisoners in England and Wales*. London, Office of National Statistics.

3 Wheatley, M., 2008. *An analysis of the population of HMP Leicester*. Leicester: Directorate of Public Health and Health Improvement

Alcohol

Description of the Issue

The harm caused by alcohol represents a major challenge to the whole community in Leicester. It is estimated that around 33,000 people in Leicester are hazardous drinkers, 11,000 are harmful drinkers and about 3,500 are dependent on alcohol. This contributes to a range of significant problems for the individuals, families and communities living in the city.

Alcohol misuse can be directly linked to deaths from certain types of disease, such as liver cirrhosis and in some cases, it may be associated with other causes of death, such as stroke.

Impacts are also seen in alcohol-related hospital admissions to University Hospitals of Leicester. An analysis of the number of bed days attributable to alcohol and estimated costs showed that in 2005/06 the cost in Leicester was just under £10 million.

The recent review published by the Association of Public Health Observatories[1] showed that at the regional level in England there is a strong association between higher rates of deprivation and greater evidence of alcohol-related harm. Leicester exhibits patterns of harm consistent with its higher level of deprivation.

National and Local Priorities

In order to address issues around alcohol, strategies need to be linked into both local and national priorities for them to be effective.

There is a range of national drivers to which alcohol links into:

- *Safe Sensible Social* - the 2007 update on the *National Alcohol Harm Reduction Strategy*
- *Choosing Health* has alcohol harm reduction as a major theme and identifies a number of 'big wins' related to combating alcohol misuse
- *Models of Care for Alcohol Misuse* – which sets the framework for the development and delivery of alcohol treatment services
- Regionally, the East Midlands public health strategy[2] commits to local participation in the national strategy and *Changing Ways,* the national offender management service east midlands reducing re-offending plan, contains a specific pathway for tackling alcohol problems

The issue of alcohol is broad and links are made with the Home Office's Public Service Agreement (PSA) priorities 14, 23 and 25, which all link to issues around alcohol and also within the context of safer communities.

Addressing alcohol has been identified as a priority in the following documents:

- *Leicester Local Area Agreement 2008-2011*
- *Leicester Community Safety Strategy*
- *One Leicester, Sustainable Community Strategy*
- *NHS Leicester City Commissioning and Investment Strategy 2008-2013*

To take forward this priority, the *Leicester Alcohol Harm Reduction Strategy and Action Plan* 2008 has been approved by the Safer Leicester Partnership focusing on:

- Prevention - preventing alcohol harm by promoting coherent education and harm reduction programmes to reduce the negative impacts of alcohol use
- Community Safety – protecting the community from the negative impact of alcohol through reducing re-offending, alcohol-related violent crime and the incidence of anti-social behaviour and by ensuring that those involved in the production and sale of alcoholic drinks act within the law and with an appropriate sense of social responsibility and that the city uses the powers at it's disposal to achieve this
- Treatment – making it easier for people affected by alcohol misuse, including offenders in the criminal justice system, to access appropriately structured and effective alcohol treatment and support services

In addition the strategy addresses three cross-cutting themes:

- Meeting the needs of children and young people
- Setting a strategic framework
- Addressing equality and diversity

Alcohol in Leicester: Epidemiology and Intervention

Alcohol consumption in Leicester

- Some 75 to 80% of the Leicester population are either low risk drinkers who drink within the recommended limits, or are non-drinkers
- More men than women drink alcohol. Older people drink more regularly, whilst younger people drink more heavily
- Nationally the proportion of young people who drink alcohol increases from around 3% of 11 year olds to 46% of 15 year olds. A survey in Leicester found

fewer young people drinking alcohol than the national average, though the proportion of those who binge drink was higher
- There are lower rates of alcohol consumption in parts of the South Asian population, compared with the white populations though there is a similar prevalence of dependence in BME populations as in the white population
- Consumption appears to be very low amongst asylum seekers and refugees

Problem drinkers
Some drinking patterns are associated with harmful outcomes. The city has around 33,000 hazardous drinkers - women drinking more than 14 and up to 35 and men more than 21 and up to 50 units of alcohol per week, either as regular excessive consumption or in less frequent sessions of heavy drinking. Around 11,000 harmful drinkers are women drinking over 35 and men over 50 units of alcohol per week and who show clear evidence of some physical or mental alcohol-related harm. The numbers of hazardous and harmful drinkers are increasing and it is estimated that Leicester has around 3,650 dependent drinkers.

Impact of alcohol misuse in Leicester
Leicester exhibits patterns of harm consistent with its higher level of deprivation as measured by the Index of Deprivation 2007.

Indications of Public Health in the English Regions 8: Alcohol shows that at a regional level there is a strong association between higher rates of deprivation and evidence of greater alcohol-related harm. "The poorest local authorities (those with the highest measures of multiple deprivation) also tend to have the highest recorded levels of health and social outcomes related to alcohol use: crime, anti-social behaviour orders, teenage conceptions, chronic liver disease, incapacity benefit claimant rates and unauthorised school absences."[3] Leicester, in comparison with the rest of Leicestershire and Rutland, has lower rates of hazardous alcohol consumption, but significantly higher levels of harm, as seen below in alcohol-related and specific deaths and alcohol-related hospital admissions.

The North West Public Health Observatory provides 17 statistical indicators of alcohol-related harm broken down by local authority area[4]. Leicester is above the national average for all the health and crime indicators with the exception of hospital admissions for young people.

Health
The *National Alcohol Strategy* estimates that up to 22,000 preventable deaths per year are associated in some way with alcohol misuse in England and over 30,000

hospital admissions due to alcohol dependence syndrome. Alcohol misuse accounts for up to 70% of A&E admissions at peak times.

Impacts are to be seen in high alcohol-related hospital admissions to University Hospitals of Leicester. Leicester has significantly worse rates than the average for England with regard to:

- Alcohol specific mortality (where alcohol consumption is thought to be a contributory factor for all cases) and chronic liver disease in men
- Alcohol specific hospital admissions
- Alcohol attributable hospital admissions in males and females (where alcohol is thought to be a contributory factor for a varying proportion of cases)

Alcohol-related hospital admissions (a combination of the latter two categories) have doubled since 2002 and Leicester has the highest rates of such admissions in the East Midlands.

Crime and disorder
Nationally, alcohol consumption is involved in around half of all violent crimes (1.2 million) and a third of all reported incidents of domestic abuse (360,000). In England around £7.3 billion is spent each year in tackling alcohol-related crime and public disorder.

Leicester is significantly worse than the average for England with regard to alcohol-related recorded crimes, violent crimes and sexual offenses. Just under half of all violent offenses in Leicester are committed under the influence of alcohol. A higher volume of violent crime is non-domestic, though domestic crime is believed to be under-reported to a greater extent than non-domestic.

The highest volume category of violent crime committed under the influence of alcohol is Actual Bodily Harm (ABH) followed by harassment.

Offenders

In England, over a third (37%) of offenders have been found to have a current problem with alcohol use and 37% with binge drinking. Of the 500 offenders under Probation Service supervision with an alcohol problem in Leicester, initial screening results from AUDIT suggests that up to 50% of these (or 250 per year) will be dependent to some extent on alcohol. In the first 6 months that it has been available, the courts in Leicestershire and Rutland have made 61 Alcohol Treatment Requirement orders on offenders who were identified as dependent drinkers.

Road traffic accidents

Nationally up to 22,000 premature deaths, at a cost of £2.4 billion to the economy, were reported as a result of alcohol. Just over 4% of all road traffic accidents in Leicester, Leicestershire and Rutland are alcohol-related. While the casualty rate per accident is similar for alcohol-related and non-alcohol-related accidents, alcohol-related accidents are more likely to result in serious or fatal injuries.

Those affected by others' alcohol misuse

In England it is estimated that up to 1.3 million children are affected by parental alcohol problems. A recent mapping of services for young people affected by parental substance misuse indicated that some young people accessing services need support. For example the Leicester Youth Offending Service estimated that about 6% of their client group (70-80 young people) need specific intervention for issues related to parental substance misuse.

Issues Identified

Much work has been undertaken in Leicester to tackle alcohol misuse. However, a local strategy has been developed that recognises that more needs to be done and has identified a number of gaps with an action plan to address these issues using a partnership approach.

The strategy will be supported by the development of an investment plan with identified funding and an overall communication plan to support the dissemination of the strategy.

A strategic priority will be to collect and share data about alcohol misuse to ensure that there is robust baseline data available for planning and performance management. The recent extension of the National Drug Treatment Management System (NDTMS) is a major development in providing performance data from alcohol services in Leicester. Particular importance will be given to ensuring that data is used to assess the needs of diverse groups. Data from A&E will also be helpful in identifying licensed premises breaching licensing laws or selling alcohol to under-aged drinkers.

The National Support Team (NST) for Alcohol Harm Reduction visited Leicester in December 2008 to provide critical assistance with the city's plans to reduce alcohol related harm in general and alcohol related hospital admissions in particular.

Following interviews with key personnel from NHS Leicester City, Leicester City Council and other partners the NST provided a report and recommendations covering: vision, strategy and commissioning; data; communication; alcohol interventions and treatment services; targeted interventions; criminal justice, licensing and availability; workforce training and awareness; and work with families.

Key priority actions identified include; clarifying commissioning arrangements, an integrated commissioning plan, continued use and improvements in local and national data, and an initial focus on improved internal communications within the city.

In order to secure ownership and to capitalise on the NST it was agreed with the Chief Executives of the City Council and NHS Leicester that an Alcohol Executive be established to oversee implementation of the strategy and action plan. This will not replace existing partnership or governance arrangements, but rather augment them to secure progress and provide assistance.

Recommendations

It is recommended that the Leicester Alcohol Harm Reduction Strategy and Action Plan and the findings of the NST visit are implemented including the following:

- A robust system to collect all relevant data from all partners involved in tackling issues related to alcohol harm reduction needs to be developed
- A system for collecting data on alcohol-related admissions to A&E needs to be developed and understood by all partners involved
- A mechanism to clearly understand the joint commissioning arrangements with the county is developed

- A whole integrated treatment system of Tiers 1-4 be designed and commissioned by the alcohol commissioning group, reflecting the needs assessment and evidence base
- A forum is convened comprising representatives from Police, Courts, and the Licensing Authority to explore further actions and define proposed local policy towards community safety in relation to alcohol

Lead Author

Priti Raichura
Public Health Specialist (Substances)
Tel: 0116 295 1469
Email: priti.raichura@leicestercity.nhs.uk

References

1 North West Public Health Observatory, 2008. *Local Alcohol Profiles for England*. Liverpool: North West Public Health Observatory
2 East Midlands Regional Assembly, 2003. *Investment for Health: A public health strategy for the East Midlands*. Melton Mowbray: East Midlands Assembly
3 Deacon, L., Hughes, S., Tocque, K., Bellis, M. A., eds., 2007. *Indications of Public Health in the English Regions 8: Alcohol.* York: Association of Public Health Observatories
4 North West Public Health Observatory, 2008. *Local Alcohol Profiles for England*. Liverpool: North West Public Health Observatory

Oral Health

Description of the Issue

Oral health can be defined as: "a standard of health of the oral and related tissues without active disease. This state should enable the individual to eat, speak and socialise without discomfort or embarrassment and contribute to general well-being"[1].

Dental decay is totally preventable, but is strongly influenced by lifestyle and socio-economic factors. Oral health in children is poor in Leicester and there are substantial inequalities geographically, where there is a direct relationship with material deprivation and in terms of geographically limited access to services.

Many vulnerable groups receive limited support in terms of treatment, care and prevention. 5 year old children living in Leicester have more dental disease than in almost any other part of the East Midlands. The oral health of 5 year olds in an area reflects the oral health of the overall population. An area which has a high 'decayed, missing and filled teeth' (dmft) score for the 5 year old population will show high levels of decay in the rest of the population.

National Priorities

The 1994 *Oral Health Strategy for England* outlined objectives for oral health for the year 2003 which concentrated on the prevalence of tooth decay, specifically in children.

The targets were that:

- 70% of children should not have experienced decay
- On average, 5 year old children should have no more than one decayed, missing tooth due to decay, or filled primary tooth

Oral Health in Leicester: Epidemiology and Interventions

Since 1986, local epidemiological surveys to monitor the dental health of children, have been undertaken on an annual basis nationally by the British Association for the Study of Community Dentistry (BASCD). As part of this programme, 5 year old children are surveyed every four years.

The dmft index is the mean number of deciduous teeth affected by caries and it is made up of 3 constituent parts:

dt	The mean number of teeth that are decayed and require treatment
mt	The mean number of teeth missing due to decay
ft	The mean number of decayed teeth that have been filled
Care Index	The percentage of teeth affected by decay that have been filled (ft X 100) dmft

The dmft and its three components for Leicester and regional average are shown in Table 4. The dmft of 5 year old children is the mean dmft of children in the area. In reality, children with decay experience tend to have a higher dmft than the mean. For Leicester the overall mean dmft was 2.06 whilst the dmft for those children who had experience of decay was 4.08.

Table 4: Dental Caries Prevalence in 5 Year Old Children

Source: The British Association for the Study of Community Dentistry (BASCD) Survey Report 2005/2006

	Leicester City	East Midlands
dt	2.06	1.04
mt	0.09	0.13
ft	0.12	0.12
dmft	2.28	1.30
dt for dt >0	4.08	3.31
% sepsis	6.8	2.8
Care Index	5	10

Table 5 shows the geographical variation in mean dt. The general tendency is for dental health to worsen the further north a child lives, but this is confounded by the water fluoridation scheme in the West Midlands.

Table 5: The Variation in dt Across the English Regions (2006)

Source: The British Association for the Study of Community Dentistry (BASCD) Survey Report 2005/2006

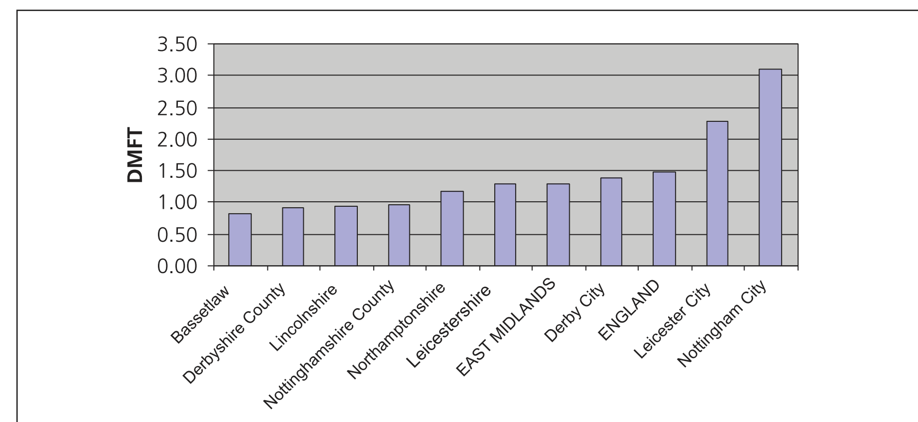
Region	dt
London	1.25
East Midlands	1.04
East of England	0.87
West Midlands	0.79
North East	1.39
North West	1.62
Yorkshire and Humberside	1.37
South Central	0.94
South West	1.11

5 year old children in Leicester have more decayed teeth than the East Midlands' or national average. The extent of active, decayed teeth in this age group was 51.9% in 2005/06 compared with 34% in England as a whole.

Figure 22 shows the dmft for 5 year old children within Primary Care Trusts (PCTs) across the East Midlands Strategic Health Authority.

Figure 22: dmft for 5 Year Olds by PCT in the East Midlands

Source: The British Association for the Study of Community Dentistry (BASCD) Survey Report 2005/2006



The 1994 *Oral Health Strategy for England* target that on average, 5 year old children should have no more than one decayed, missing tooth due to decay, or filled primary tooth, has clearly not been met for the 5 year old children in Leicester.

Dental caries is one of the two most common oral diseases in England. It affects the structure of the tooth and in the early stages is symptom-less. If left untreated it can go on to cause pain, infection and eventually a dental abscess. Although dental decay is rarely fatal, it can impact greatly on the person affected and those close to them. Dental caries can cause pain, sleepless nights, affect eating and can lead to individuals taking time off school or work. Those 5 year old children with decay in their deciduous teeth will also suffer from decay in their permanent teeth without appropriate action.

Issues Identified

In September 2007 the Department of Health published *Delivering Better Oral Health* an evidence-based toolkit for prevention. This is a clear, simplified guide on advice and action that primary dental teams can use to help prevent dental diseases in their patients. The toolkit also gives evidence-based advice on the use of topical fluorides including toothpastes, varnishes and mouthwashes. Another way of providing fluoride is through water fluoridation. The water supply in Leicester is not fluoridated at present. This is an issue that will require further consideration.

High levels of dental decay are strongly correlated with areas of deprivation and measures of socio-economic status. There is a clear need to take action to improve the standard of oral health in children in Leicester. Many of the factors that lead to poor oral health lead to poor health in general. People living in deprivation are more likely to suffer the inequality of poorer dental health. This is often worsened by difficulty accessing and using dental services. It is important that oral health initiatives link closely with other health inequality initiatives to ensure that the common risk factors of poorer health are addressed effectively. Interventions to improve oral health need to focus on promoting long-term, sustainable change and tackle inequalities. To achieve this, action is needed to address the underlying causes of oral health disease through improving diet, reducing sugar intake, improving oral hygiene and optimising exposure to fluoride.

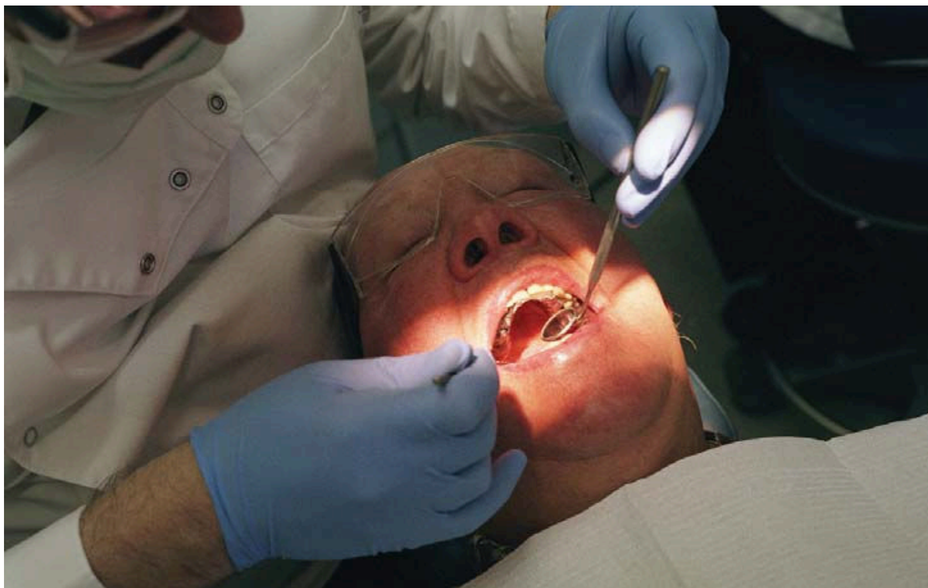
One of the major factors in the development of dental caries is the frequent intake of refined sugar, which can also contribute to the development of other health problems such as obesity. If a common risk factor approach is adopted, then dental caries should be considered to be a disease of poor diet.

Recommendations

There are many new opportunities for achieving improvements in oral health. Dental decay is preventable and dental teams are now encouraged, through an evidence-based approach, to provide more emphasis on preventative dental care and give more advice on health and lifestyle issues than previously. Placing oral health on an integrated health agenda increases the opportunity for the wider health influences affecting oral health to be addressed more effectively and ultimately promote a more sustained improvement.

It is recommended that:

- There is further development of Oral Health Promotion programmes including improvements in diet
- There is promotion of the effective use of fluoride toothpaste and other topical fluorides through widespread use of the Delivering Better Oral Health Toolkit



- There are increased initiatives to improve awareness of Oral Health among general healthcare staff
- Oral Health is recognised as an integral part of the general health agenda
- Access to dental services is increased, with a particular focus on for marginalised groups

Lead Author

Carol Mander
Consultant Dental Public Health
Tel: 0116 295 4167
Email: carol.mander@leicestercity.nhs.uk

Contributor

Semina Makhani
Specialist Registrar in Dental Public Health
Tel: 0116 295 4143
Email: semina.makhani@leicestercity.nhs.uk

References

1 Department of Health, 1994. *The Oral Health Strategy for England.* London: HMSO

Health Protection

Description of the Issue

The main challenges that faced Health Protection during 2007 were those of Healthcare Associated Infection (HCAI), maintaining control of Tuberculosis and ensuring that children are protected against infectious diseases through immunisation.

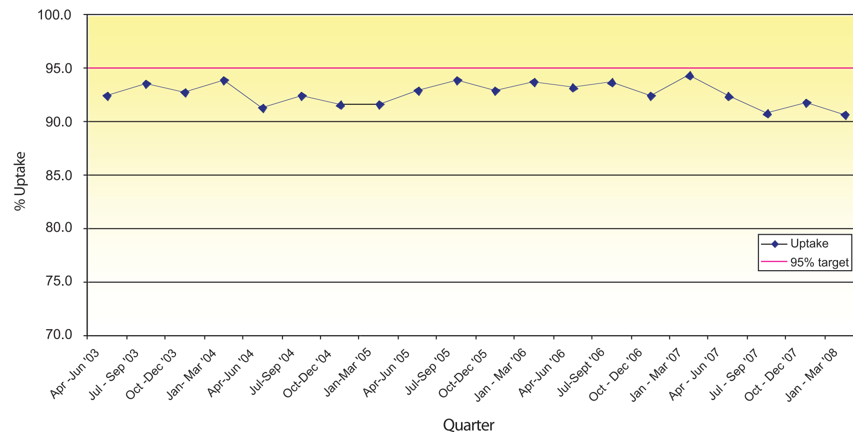
Health Protection: Epidemiology, Interventions and Issues Identified

Immunisation

It is important that we ensure that we protect children in Leicester against infections by immunising them. The World Health Organisation recommends that at least 95% of all children are immunised. There is a national target of 95% for both of the primary immunisations and pre-school boosters. Leicester started well in 2007, with 94% of children being immunised. However, the end of the year saw a fall in the number of children immunised which continued into 2008. Figure 23 (below) shows the number of children who have completed their first immunisations by the age of 1 year. These protect against diphtheria, tetanus, pertussis (whooping cough), polio and haemophilus influenza b (Hib) (DTaP/IPV/Hib).

Figure 23: Percentage Uptake of DTaP/IPV/Hib Vaccine in Children Immunised at 12 Months from April 2003 to March 2008 by Quarter

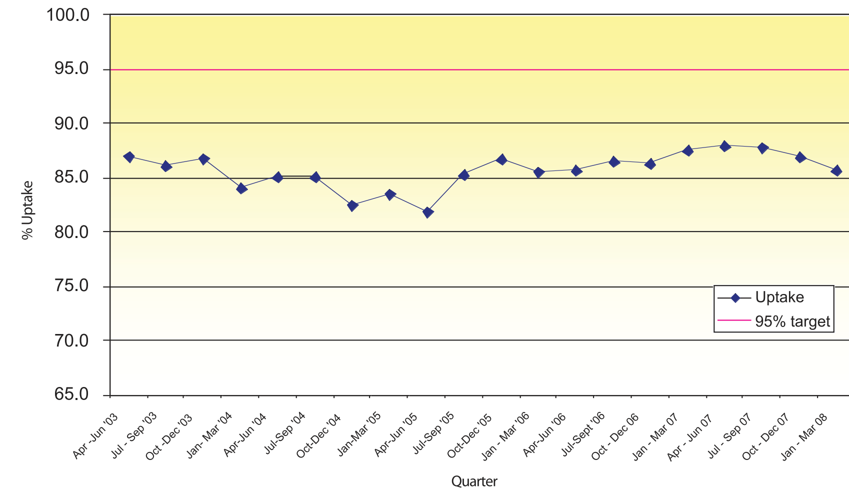
Source: Health Protection Agency



At the age of 5, fewer children receive the pre-school booster than have received the primary immunisation course. This situation is worrying as the trend is also downwards.

Figure 24: Percentage Uptake of DTaP/IPV Booster Vaccine in Children Immunised at 5 Years from April 2003 to March 2008 by Quarter

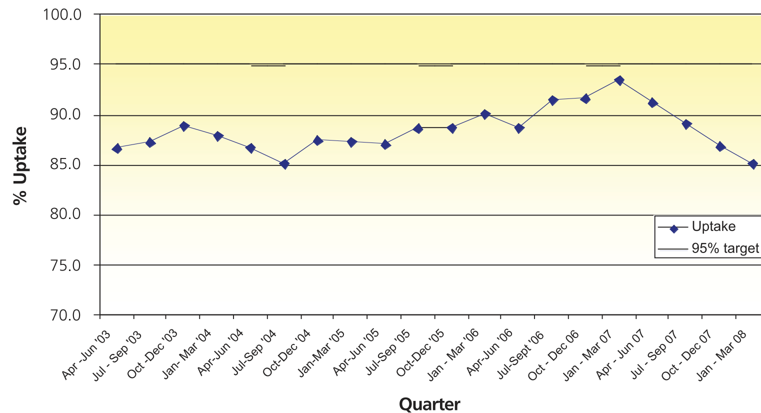
Source: Health Protection Agency



Data on Measles, Mumps and Rubella (MMR) show a similar and worrying decline in the number of children who are immunised. This is particularly worrying in the light of the current measles outbreak affecting England.

Figure 25: Percentage Uptake of MMR Vaccine in Children Immunised at 24 Months from April 2003 to March 2008 by Quarter

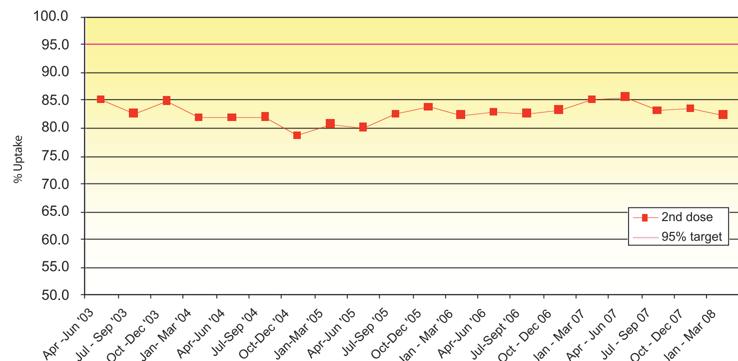
Source: Health Protection Agency



A second MMR immunisation is essential to protect children. The data show that the uptake of this immunisation is low and needs to be improved to ensure that children in the City do not catch measles.

Figure 26: Percentage Uptake of 2nd MMR Vaccine in Children Immunised at 5 Years from April 2003 to March 2008 by Quarter

Source: Health Protection Agency



Declining uptake is an indicator that the immunisation systems within the city need careful attention.

Healthcare Associated Infection (HCAI)

It is essential to ensure that people in Leicester receive the best possible healthcare. Preventing HCAIs is essential if people are to receive the very best healthcare and do not become infected in hospital and community settings, whilst being treated for other illnesses. Nationally, two organisms are monitored to ensure that infections are being controlled; these are Clostridium difficile and Methicillin Resistant Staphylococcus Aureus (MRSA).

Across the whole of Leicestershire (data are not available for Leicester alone) there were 918 people who had laboratory tests confirming Clostridium difficile in 2007. This represents a decline against the number of people infected in 2005. The main way to prevent transmission of this infection is good hand hygiene and environmental cleaning.

In the financial year April 2007 – March 2008, 43 people across Leicestershire were found to have MRSA in their blood stream. This is a serious form of infection. Whilst this seems high, in comparison with the numbers of people treated in hospital it is in fact low, with the rate being 0.68 per 10,000 bed days. When University Hospitals Leicester (UHL) rates are compared with similar hospitals in England, they are shown to be low. The main way of prevention is again good hand hygiene and monitoring patients before operations to check for MRSA. Systems for monitoring patients are being developed both locally and nationally.

Tuberculosis

In 2007 there were 143 cases of Tuberculosis (TB) reported in Leicester. This is a decrease on the number reported in 2006, which has been maintained in 2008. It is important to maintain vigilance to ensure that people are protected against TB.

Recommendations

It is recommended that:

- A comprehensive review of immunisation services and systems is undertaken and measures are strengthened to increase uptake of childhood immunisations
- Efforts are continued in relation to environmental cleaning, hand hygiene and monitoring of patients prior to operations to pick up potential HCAI
- Vigilance is maintained to ensure people are protected against TB

Lead Author

Dr Philip Monk
Consultant in Communicable Disease Control, Health Protection Agency, East Midlands South
Tel: 0116 263 1400 Email: philip.monk@hpa.org.uk

Health Facts

Health Facts 1: Mid-year 2007 estimates of resident population by age[1]

Source: National Centre for Health Outcomes Development, NHS Health and Social Care Information Centre

Area		0-4 years	5-14	15-34	35-64	65-74	75+	Total
Leicester	Total	21,771	34,967	98,744	101,505	17,951	17,663	292,601
	%	7.4%	12.0%	33.7%	34.7%	6.1%	6.0%	100.0%
East Midlands	Total	247,854	510,826	1,123,315	1,800,415	373,255	343,972	4,399,637
	%	5.6%	11.6%	25.5%	40.9%	8.5%	7.8%	100.0%
England	Total	3,038,403	5,960,790	13,481,278	20,452,216	4,192,458	3,966,887	51,092,032
	%	5.9%	11.7%	26.4%	40.0%	8.2%	7.8%	100.0%

Population projections for Leicester up to 2031 (figures in thousands)

Source: Office of National Statistics, 2006-based Population projections

	Age group (years)							
Year	0-4	5-14	15-34	35-64	65-74	75-84	85+	Total
2006	21.0	35.1	97.4	100.1	18.3	13.0	4.8	289.7
2011	24.7	35.5	103.7	104.9	18.3	12.3	5.1	304.5
2016	26.2	40.3	105.9	107.7	20.6	12.7	5.4	318.8
2021	26.5	44.3	105.3	113.3	23.1	13.3	6.0	331.8
2026	26.2	45.7	106.7	118.2	24.8	15.4	7.0	344.0
2031	26.4	45.8	110.8	121.2	26.8	17.4	8.1	356.5

* figures may not sum due to rounding

[1] Figures unchanged from *Improving Health in Leicester: Annual Report of the Director of Public Health and Health Improvement 2007*

Health Facts 2: Maternal, Child Health and Screening

Source: Office of National Statistics, National Centre for Health Outcomes Development, Health and Social Care Information Centre

Births and conceptions (2006)[1]

	Leicester	East Midlands	England
Total births	4790	51007	639166
Live births	4747	50717	635748
Still births	43	290	3418
% low birth weight (<2,500g)	11.3	8.1	7.9
% very low birth weight (<1,500g)	2.3	1.5	1.5
General fertility rate	68.3	57.4	60.3
Under 18 conception rate (per 1,000 females aged 15-17 years)	61.2	39.6	40.4

Deaths (2006)[1]

	Leicester	East Midlands	England
Stillbirth rate	9.0	5.7	5.3
Perinatal mortality rate	13.2	8.4	8.0
Infant mortality rate	7.6	5.4	5.0

Childhood Immunisations (2006-07)
Source: Health Protection Agency, COVER data

	Percentage of children immunised by their second birthday		
	Leicester	East Midlands	England
Diphtheria, Tetanus, Polio	96	95	93
Measles, Mumps, Rubella	91	88	85
Meningitis C	95	95	93
	Percentage of children immunised by their fifth birthday		
Diphtheria, Tetanus, Polio	97	96	93
Diphtheria, Tetanus, Polio Booster	86	83	79
Pertussis	96	95	93
HIB	96	95	93
Measles, Mumps, Rubella (first dose)	93	90	86
Measles, Mumps, Rubella (first and second dose)	83	77	73
Meningitis C	96	95	92

	Leicester	East Midlands	England
Breast Screening uptake	76.2	80.9	75.9
Cervical screening uptake	76.6	82.9	79.2

Live births: number of live births for all maternal ages 11+ years
Low birth weight: Percent of live and still births < 1500 and < 2500g
General fertility rate: number of live births per 1,000 female population aged 15-44 years
Under 18 conception rate: Number of conceptions in under 18 year olds per 1,000 females aged 15-17
Still birth rate: number of still births per 1,000 total births
Perinatal mortality rate: Number of stillbirths and deaths in the first week of life per 1,000 total live and still births

Infant mortality rate: Number of deaths in live born infants under 1 year of age per 1,000 live births
Breast screening uptake: Percentage of eligible women aged 53-64 screened within the last 3 years
Cervical screening uptake: Percentage of eligible women aged 25-64 with an adequate test in the last 5 years
Significantly higher than the national rate (yellow)
Significantly lower than the national rate (green)

Health Facts 3: Mortality rates[1]

Source: National Centre for Health Outcomes Development, NHS Health and Social Care Information Centre

Mortality rates in males

Cause of death	ICD 10	No. deaths in Leicester 2006	Standardised Mortality Ratio (Indirect) 2004-6 pooled, for a all ages: England SMR	East Midlands SMR	Leicester SMR	Directly age-standardised rate 2004-6, for all ages: England DSR	East Midlands DSR	Leicester DSR	Directly age-standardised rate 2004-6, for under 75 yr olds: England DSR	East Midlands DSR	Leicester DSR
Coronary heart disease	I20-I25	265	100.0	101.1	128.1	144.6	145.6	188.8	74.8	74.8	110.3
Cerebrovascular disease (stroke)	I60-I69	90	100.0	97.4	105.4	55.3	53.7	58.7	18.3	17.7	24.2
All cancers	C00-C97	282	100.0	98.4	96.3	213.7	209.5	206.5	130.4	126.6	128.4
All accidents	V01-X59	34	100.0	111.7	109.9	21.4	24.0	23.2	16.8	18.9	18.7
All accidental falls	W00-W19	7	100.0	78.2	118.6	4.6	3.6	5.4	2.6	2.0	3.2
Road traffic accidents	V01-V89	11	100.0	127.6	70.0	8.1	10.4	5.6	7.9	10.3	5.0
Suicide and undetermined death	X60-X84, Y10-Y34 exc Y33.9	19	100.0	99.1	116.0	12.5	12.3	14.4	12.4	12.1	14.2
Bronchitis, Emphysema & Chronic obstructive Pulmonary Disease	J40-J44	60	100.0	96.7	102.4	35.7	34.6	36.6	14.6	14.1	16.5
Stomach and duodenal ulcer	K25-K27	8	100.0	81.4	92.9	4.7	3.8	4.7	2.5	2.0	3.0
Diabetes	E10-E14	17	100.0	107.5	168.7	7.8	8.3	13.9	3.8	4.0	8.8
Tuberculosis	A15-A19	3	100.0	74.1	212.1	0.7	0.5	1.5	0.4	0.3	1.1
Chronic liver disease	K70, K73-K74	26	100.0	88.4	155.6	13.5	11.9	21.6	13.2	11.5	21.8
All causes	A00-Y99	1232	100.0	100.4	116.3	732.0	732.0	859.1	383.5	375.0	471.4

Mortality rates in females

Cause of death	ICD 10	No. deaths in Leicester 2006	England	East Midlands SMR	Leicester SMR	England DSR	East Midlands DSR	Leicester DSR	England DSR	East Midlands DSR	Leicester DSR
Coronary heart disease	I20-I25	189	100.0	99.8	126.9	67.5	68.5	93.6	23.8	25.7	43.3
Cerebrovascular disease (stroke)	I60-I69	129	100.0	98.6	104.3	51.3	50.9	56.2	13.7	14.2	18.8
All cancers	C00-C97	279	100.0	99.1	103.2	152.2	150.9	157.1	105.1	104.5	107.4
All accidents	V01-X59	27	100.0	117.8	93.3	10.5	11.8	10.3	5.8	5.7	6.3
All accidental falls	W00-W19	13	100.0	85.5	146.7	2.9	2.6	3.6	1.2	1.1	0.6
Road traffic accidents	V01-V89	6	100.0	106.6	69.5	2.3	2.5	1.7	2.1	2.3	1.6
Suicide and undetermined death	X60-X84, Y10-Y34 exc Y33.9	9	100.0	97.0	141.4	4.2	4.1	6.0	4.1	4.0	6.0
Bronchitis, Emphysema & Chronic obstructive Pulmonary Disease	J40-J44	47	100.0	91.7	104.8	21.5	19.8	23.2	10.2	9.6	12.3
Stomach and duodenal ulcer	K25-K27	8	100.0	95.2	123.3	3.2	3.1	4.2	1.3	1.4	2.0
Diabetes	E10-E14	18	100.0	117.5	133.7	5.6	6.4	8.3	2.5	2.5	4.6
Tuberculosis	A15-A19	3	100.0	103.4	456.2	0.4	0.4	2.0	0.3	0.3	1.7
Chronic liver disease	K70, K73-K74	5	100.0	99.4	110.2	7.0	6.9	7.4	6.7	6.6	6.7
All causes	A00-Y99	1308	100.0	102.4	118.6	512.2	522.9	622.2	240.0	243.5	305.8

Significantly better than the national rate (100)

Significantly worse than the national rate (100)

ICD 10: International Classification of Diseases: WHO's internationally accepted classification of death and disease, revision 10.

Standardised Mortality Ratio: Measure of whether someone is more or less likely to die compared to the standard population. A score greater than 100 indicates an increased probability and a score below 100 indicates a reduced probability

Standardised Years of Life Lost Rate: Potential number of years of life lost as a result of premature death (under 75 years) per 10,000 European standard population

1 Figures unchanged from Improving Health in Leicester: Annual Report of the Director of Public Health and Health Improvement 2007

Health Facts 4: Cancer rates

Source: National Centre for Health Outcomes Development, NHS Health and Social Care Information Centre

Cancer rates in males

Cause of death	ICD 10	New cases in Leicester (2002-04)	SRR Leicester (2002-04)	No. deaths in Leicester (2006)	England	Standardised Mortality Ratio (Indirect), 2004-6 pooled, all ages		Directly age-standardised mortality rate per 100,000 (2004-6), All ages			Directly age-standardised mortality rate per 100,000 (2004-6), under 75s			1 yr survival (1997-99)	5 yr survival (1997-99)
			Leic			East Midlands	Leicester	England	East Midlands	Leicester	England	East Midlands	Leicester	LNR	LNR
			SRR		SMR	SMR	SMR	DSR	DSR	DSR	DSR	DSR	DSR		
All	C00-C97	1537	94.0	282	100	98.4	96.3	213.7	209.5	206.5	130.4	126.6	128.4	-	-
Lung	C33-C34	270	107.3	74	100	95.4	100.7	51.1	48.7	51.6	33.1	31.0	32.6	20.6%	5.3%
Colorectal	C17-C21	194	86.3	27	100	97.5	79.8	23.0	22.3	18.2	13.9	13.2	10.9	64.6%	44.9%
Stomach	C16	81	129.9	14	100	100.0	138.2	8.9	8.9	12.7	5.1	5.5	9.6	33.7%	9.6%
Oesophageal	C15	53	95.8	16	100	99.0	76.7	13.0	12.8	10.3	9.0	8.6	7.4	28.5%	7.0%
Bladder	C67	77	92.2	14	100	99.6	101.3	8.2	8.1	8.5	3.7	3.4	4.1	83.4%	71.6%
Malignant Melanoma	C43	21	46.4	4	100	93.3	67.8	2.9	2.7	2.0	2.3	2.1	1.2	-	-
Prostate	C61	306	78.5	21	100	100.7	87.3	25.7	25.9	22.2	9.1	9.2	7.5	85.2%	63.6%
Leukaemia	C91-C95	-	-	6	100	100.4	101.9	6.7	6.6	6.6	4.2	4.3	4.5	-	-
Hodgkins	C81	-	-	0	100	91.4	45.3	0.5	0.5	0.2	0.4	0.4	0.2		

Cancer rates in females

Cause of death	ICD 10	New cases in Leicester (2002-04)	SRR Leicester (2002-04)	No. deaths in Leicester (2006)	England	Standardised Mortality Ratio (Indirect), 2004-6 pooled, all ages		Directly age-standardised mortality rate per 100,000 (2004-6), All ages			Directly age-standardised mortality rate per 100,000 (2004-6), under 75s			1 yr survival (1997-99)	5 yr survival (1997-99)
			Leic			East Midlands	Leicester	England	East Midlands	Leicester	England	East Midlands	Leicester	LNR	LNR
			SRR		SMR	SMR	SMR	DSR	DSR	DSR	DSR	DSR	DSR		
All	C00-C97	1674	100.8	279	100	99.0	103.2	152.2	150.9	157.1	105.1	104.5	107.4	-	-
Lung	C33-C34	207	118.3	48	100	89.9	94.2	28.9	26.0	27.3	20.5	18.7	19.4	23.3%	8.2%
Colorectal	C17-C21	188	96.8	29	100	97.6	94.0	14.4	14.3	13.3	8.6	8.8	7.3	63.6%	41.0%
Stomach	C16	41	114.7	2	100	94.0	89.3	3.8	3.6	3.9	2.1	2.1	2.9	30.8%	12.8%
Oesophageal	C15	33	103.6	18	100	107.2	129.8	4.8	5.1	6.4	2.8	3.0	4.0	28.2%	*5.7%
Bladder	C67	27	79.1	5	100	104.9	112.1	2.8	2.9	2.9	1.4	1.4	1.0	79.0%	66.2%
Malignant Melanoma	C43	33	56.5	1	100	95.7	42.1	1.9	1.9	0.8	1.5	1.6	0.8	-	-
Breast	C50	500	96.2	51	100	102.9	111.3	28.0	28.7	30.7	21.6	21.9	22.6	92.5%	77.1%
Cervical	C53	42	115.6	5	100	87.7	158.5	2.5	2.1	4.4	2.1	1.7	3.9	84.7%	61.6%
Leukaemia	C91-C95	-	-	5	100	100.1	49.5	3.8	3.7	2.0	2.4	2.3	1.2	-	-
Hodgkins	C81	-	-	1	100	108.3	120.4	0.3	0.3	0.3	0.3	0.2	0.0	-	-

*not age-standardised

Significantly worse than the national rate (100)

Significantly better than the national rate (100)

ICD 10: International Classification of Diseases: WHO's internationally accepted classification of death and disease, revision 10.

SRR Standardised Registration Ratio: Ratio of cancers registered in a population compared with the national population, standardised to adjust for differences in age and sex of the local population. A score greater than 100 indicates an increased probability and a score below 100 indicates a reduced probability.

Standardised Mortality Ratio: Ratio of number of deaths in a population compared with the national population, standardised to adjust for differences in age and sex of the local population. A score greater than 100 indicates an increased probability and a score below 100 indicates a reduced probability.

Standardised Years of Life Lost Rate: Potential number of years of life lost as a result of premature death (under 75 years) per 10,000 European standard population

Survival rate: Ratio of the survival rate actually observed among the cancer patients and the survival that would have been expected if they had only had the same overall mortality rates as the general population

Survival rate: 1 year / 5 years: Relative survival rate observed at one and five years after diagnosis, compared with general population

Health Facts 5 - Health Targets for Leicester

Source: East Midlands Strategic Health Authority, National Centre for Health Outcomes Development, Health Care Commission, Health Protection Agency

				Leicester City PCT	
	Aim	Indicator	Target Ref	Current position	Trajectory
Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy					
Life Expectancy	By 2010 increase life expectancy in England to 78.6 for men	Life Expectancy at birth in men		75.3 (2004-6)	78.6 (2010)
	By 2010 increase life expectancy in England to 82.5 for women	Life Expectancy at birth in women		79.4 (2004-6)	82.5 (2010)
	Reduce life expectancy gap between the fifth most deprived areas and the population of Leicester as a whole				
Infant Mortality	Reduction in smoking levels during pregnancy	Percentage smoking in pregnancy	PSA06a	15.4% (Mar 2008)	16.2% (Mar 2008)
	Increase breastfeeding initiation	Percentage where breast feeding is initiated	PSA06b	71.6% (Mar 2008)	66.5% (Mar 2008)
Reduce cardiovascular disease mortality rates in under 75s by at least 40%, with at least a 40% reduction in the gap between the fifth of areas with the worst health and the population as a whole					
Cardiovascular disease mortality and inequalities	Reduce cardiovascular disease mortality rates in under 75s	Mortality rate per 100,000 directly age standardised population from heart disease and stroke and related diseases in people aged under 75	PSA01a	120.0 (2004-6)	124 (2008)
	Blood pressure screening	Percentage of patients on Hypertension register whose last blood pressure reading measured within the last 15 months is 150/90 or less	PSA01c	76.2% (Mar 2008)	75.2% (Mar 2008)
	Checking cholesterol levels	Percentage of patients with CHD whose last cholesterol reading measured within the last 15 months is 5mmol or less	PSA01d	78.7 (Mar 2008)	75.2% (Mar 2008)
Reduce cancer mortality rates in under 75s by at least 20%, with at least a 6% reduction in the gap between the fifth of areas with the worst health and the population as a whole					
Cancer mortality and inequalities	Reduce cancer mortality rates in under 75s	Mortality rate per 100,000 directly age standardised population from all cancers in people aged under 75	PSA03a	117.0 (2004-6)	99 (2008)
Smoking: Reduce the adult smoking rates to 21% or less by 2010, with a reduction in prevalence among the routine manual groups to 26%					
Smoking	Smoking Quit levels	Smoking quitters at four-week follow-up stage	PSA08a	2380 (2007-8)	2,368 (2007-08)
	Smoking prevalence	No. of patients aged over 16 years on a GP register with recorded smoking status (yes or non-smoker)	PSA08b	189,690 (68%) (Mar 2008)	237,838 (90%) (2008)
Sexual health: Reduce the under-18 conception rate by 50% by 2010					
Sexual Health	Reduce teenage conceptions	Teenage conception rate per 1,000 population aged 15-17 years.	PSA11a	61.20 (2006)	42.8 (2008)
	Improve access to GUM services	Percentage seen within 48 hours	PSA11b	100% (2008)	95% (March 2008)
	Reduce the number of new diagnoses of gonorrhoea	New diagnosis of gonorrhoea per 100,000 population	PSA11c	18.81 (2006)	LNR: 26.03 (March 2008)
	Implement a Chlamydia Screening Programme	Percentage of sexually active 16-24s opportunistically screened for chlamydia	PSA11d	2%	15% (Mar 2008)
Mental Health and well-being: Substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%					
Mental Health	Mortality from suicide/injury undetermined	Mortality rate per 100,000 directly age standardised population from suicide and undetermined injury	PSA05a	Leic: 10.1 (2004-6)	7.2 (2008)
Obesity: Halt the year-on-year rise in obesity among children under 11 by 2010					
Obesity	Childhood obesity	% of Primary School children overweight or obese % of Primary School children obese	PSA10a	21.6 % Yr R, 33.2% Yr 6 (2006-7) 10.7 % Yr R, 19.6% Yr 6 (2006-7)	
	Adult obesity	Number of patients aged over 16 years on a GP register with BMI recorded in the last 15 months	PSA10b	85,942 (30.9) (Mar 2008)	198,199 (75%) (2008)

PSA: Public Service Assessment targets set by the Department of Health that will contribute towards improving the health of the population and reducing health inequalities.
LAA: Local Area Agreement

Note: The targets shown above relate to the Local Delivery Plan 2005-2008.
New targets have been set for the Vital Sign indicators within the Operational Plan 2008-2011 and these will be reported in the next annual report.

Health Facts 6: Census 2001 demographic and health indicators by electoral ward and area committee

Source: Office of National Statistics: Census 2001

			Population: Census 2001								Ethnicity				
Area Committee	Ward Code	Ward Name	Total population	00-04 years (%)	05-14 years (%)	15-24 years (%)	25-44 years (%)	45-64 years (%)	65-75 years (%)	75+ years (%)	White	Asian/British (%)	Black/British (%)	Mixed (%)	Other (%)
Area 1	00FNNY	Rushey Mead	15140	6.0	14.1	13.5	29.8	24.1	7.1	5.4	38.5%	57.7%	2.0%	1.5%	0.3%
	00FNNJ	Belgrave	10305	6.6	16.8	15.5	29.2	20.4	6.5	5.1	26.1%	69.0%	1.7%	2.6%	0.6%
	00FNNW	Latimer	11584	6.5	15.5	14.3	29.6	21.5	7.3	5.4	17.3%	79.1%	1.4%	1.7%	0.5%
Area 2	00FNNT	Humberstone and Hamilton	11885	7.5	13.3	12.0	30.5	20.3	8.6	7.7	75.3%	20.5%	1.6%	1.9%	0.7%
	00FNPB	Thurncourt	9930	6.2	14.2	11.3	24.8	22.1	11.1	10.3	83.0%	12.8%	1.9%	1.9%	0.3%
Area 3	00FNNM	Charnwood	10660	8.8	17.9	14.8	30.1	18.2	5.5	4.8	53.4%	36.4%	5.5%	3.9%	0.7%
	00FNNN	Coleman	12085	8.4	16.4	15.3	30.4	18.9	5.4	5.2	38.4%	53.6%	4.7%	2.7%	0.5%
	00FNNP	Evington	9790	4.7	11.7	11.7	23.3	23.7	11.4	13.5	58.5%	35.6%	3.0%	2.2%	0.8%
Area 4	00FNNZ	Spinney Hills	21256	9.3	17.2	17.6	30.4	17.0	5.1	3.4	17.6%	72.4%	6.9%	2.2%	0.9%
	00FNPA	Stoneygate	17068	6.7	14.3	22.3	28.7	18.8	5.2	3.8	32.8%	58.9%	5.1%	2.5%	0.8%
Area 5	00FNNU	Knighton	16260	5.6	11.4	15.4	28.1	22.4	8.0	9.1	76.1%	18.8%	1.8%	2.1%	1.2%
	00FNNL	Castle	13453	3.2	4.5	36.8	33.6	13.0	4.0	4.8	75.7%	13.3%	5.5%	2.2%	3.3%
Area 6	00FNNG	Aylestone	10804	5.5	11.8	12.3	30.1	22.6	8.3	9.4	92.6%	4.0%	1.5%	1.3%	0.6%
	00FNNQ	Eyres Monsell	11233	7.5	16.4	12.7	25.8	19.0	9.7	8.9	94.7%	1.9%	1.1%	2.0%	0.3%
	00FNNS	Freemen	9984	7.0	14.1	23.8	29.0	16.3	5.3	4.6	87.2%	4.6%	3.3%	3.1%	1.7%
Area 7	00FNNK	Braunstone Park and Rowley Fields	16609	8.0	17.2	15.2	27.3	18.5	7.0	6.9	86.1%	9.7%	1.7%	2.3%	0.3%
	00FNPC	Westcotes	8651	4.8	7.3	30.6	35.4	13.1	4.5	4.3	73.7%	18.1%	3.2%	3.2%	1.8%
	00FNPD	Western Park	9884	5.1	10.8	14.4	31.1	20.7	7.2	10.7	81.9%	13.5%	1.9%	1.8%	0.8%
Area 8	00FNNX	New Parks	16013	7.8	16.8	13.2	26.5	19.5	7.6	8.6	91.5%	3.8%	1.7%	2.6%	0.3%
	00FNNR	Fosse	10737	6.6	11.1	15.6	34.3	19.3	6.5	6.6	84.6%	10.1%	2.4%	2.2%	0.7%
Area 9	00FNNF	Abbey	12707	6.8	13.8	12.8	28.0	20.5	9.0	9.1	81.1%	14.2%	2.0%	2.1%	0.6%
	00FNNH	Beaumont Leys	13849	8.5	16.5	15.5	32.8	20.0	3.6	3.1	78.2%	12.2%	4.6%	4.0%	1.0%
	00FN	**Leicester City**	279887	**6.8**	**14.0**	**16.7**	**29.4**	**19.5**	**6.9**	**6.6**	**63.8%**	**29.9%**	**3.1%**	**2.3%**	**0.8%**
	E	**England**	49138831	**6.0**	**12.9**	**12.2**	**29.3**	**23.8**	**8.3**	**7.5**	**90.9%**	**4.6%**	**2.3%**	**1.3%**	**0.9%**

Health Facts 6a: Census 2001 demographic and health by electoral ward and area committee

Source: Office of National Statistics: Census 2001

			Health		Socio-economic			
Area Committee	Ward Code	Ward Name	Number reporting health as "Not good" (%)	People with Limiting long term illness (%)	Number unemployed (%)	Households with no car (%)	Households Rented (%)	Households overcrowded (%)
Area 1	00FNNY	Rushey Mead	10.0	18.2	6.4	22.2	15.7	12.3
	00FNNJ	Belgrave	11.9	20.0	9.3	39.1	43.8	16.7
	00FNNW	Latimer	12.7	21.2	9.9	42.4	40.3	17.9
Area 2	00FNNT	Humberstone and Hamilton	9.0	17.9	5.0	28.7	31.1	5.3
	00FNPB	Thurncourt	11.9	22.9	6.5	36.8	37.9	7.1
Area 3	00FNNM	Charnwood	11.6	19.6	12.3	49.4	56.6	13.4
	00FNNN	Coleman	10.4	17.9	9.7	41.4	42.9	14.2
	00FNNP	Evington	10.1	21.2	6.0	26.5	24.0	7.4
Area 4	00FNNZ	Spinney Hills	10.3	18.1	13.0	47.2	53.1	21.6
	00FNPA	Stoneygate	9.4	16.4	8.5	36.0	39.9	14.2
Area 5	00FNNU	Knighton	7.2	15.5	4.0	20.8	19.3	6.7
	00FNNL	Castle	8.0	14.8	7.2	47.5	60.6	18.6
Area 6	00FNNG	Aylestone	10.1	19.1	4.7	30.6	25.1	4.8
	00FNNQ	Eyres Monsell	12.2	22.8	9.1	46.1	53.7	8.1
	00FNNS	Freemen	10.1	18.6	8.2	44.5	57.9	8.4
Area 7	00FNNK	Braunstone Park and Rowley Fields	11.7	20.7	9.6	46.3	56.8	7.7
	00FNPC	Westcotes	8.7	14.9	5.7	44.3	53.4	11.1
	00FNPD	Western Park	9.0	18.4	4.6	31.0	25.7	7.5
Area 8	00FNNX	New Parks	11.8	21.9	9.8	46.8	55.8	5.9
	00FNNR	Fosse	9.0	16.4	5.6	35.7	29.8	5.2
Area 9	00FNNF	Abbey	11.9	21.2	9.8	41.5	44.9	7.7
	00FNNH	Beaumont Leys	9.0	16.8	9.4	35.8	48.4	10.1
	00FN	**Leicester City**	**10.2**	**18.8**	**7.9**	**38.3**	**42.1**	**10.6**
	E	**England**	**9.0**	**17.9**	**5.0**	**26.8**	**31.3**	**7.1**

Health Facts 6b: Local measures of Health at ward level

Data: ONS mortality data, ONS mid-2005 population estimates, ONS conception data, ONS birth data

	Life expectancy		Mortality: DSR per 100,000 (all ages)		Infant Mortality rate	Perinatal mortality rate	Still birth rate	Low birth weights (%)	Under 18 conception rate	Access to Services		Lifestyle ward estimates for 16+ year olds (2000-2002)			
Ward Name	Females (2002-6)	Males (2002-6)	Coronary Heart Disease (2004-6)	Cancers (2004-6)	(2004-6)	(2004-6)	(2004-6)	(2004-6)	(2002-4)	Elective (Apr 04-Mar 07)	Emergency (Apr 04-Mar 07)	Smoking prev-alence	Excessive drinking	Adult Obesity	Fruit & Veg consumption
Abbey	80.1	73.7	165.4	169.5	3.1	6.1	4.6	9.5%	high	136.8	148.9	35.9	12.3	26.4	17.5
Aylestone	79.3	75.6	128.2	189.7	7.3	9.7	7.3	6.8%	high	126.0	123.8	30.0	16.7	22.9	20.3
Beaumont Leys	77.7	76.3	133.1	219.0	4.3	13.9	10.7	9.4%	high	129.3	151.7	35.4	16.5	24.3	16.0
Belgrave	81.9	75.2	192.5	139.3	4.4	6.6	4.4	14.0%		121.4	145.3	23.8	5.7	26.7	30.0
Braunstone Park and Rowley Fields	77.2	73.3	137.3	242.8	3.4	7.9	5.6	10.0%	high	143.5	160.4	40.0	15.4	26.6	14.5
Castle	78.1	72.2	146.8	169.3	9.0	15.6	8.9	9.1%		110.4	158.9	31.4	30.5	16.6	29.0
Charnwood	77.6	73.5	151.1	193.8	11.9	11.8	5.9	15.0%	high	129.1	175.1	35.8	9.8	27.5	18.6
Coleman	78.0	75.2	128.4	156.7	7.1	20.8	18.0	13.5%		122.0	154.2	27.3	7.8	26.8	24.1
Evington	81.5	77.2	110.6	146.2	0.0	3.1	3.1	12.3%		123.9	121.1	18.0	7.7	21.9	28.6
Eyres Monsell	79.8	72.9	164.2	224.9	1.8	5.3	3.5	8.3%	high	141.4	158.7	42.2	14.6	28.3	13.0
Fosse	81.0	76.7	98.8	215.9	1.9	13.3	11.4	9.5%	high	118.2	118.7	37.7	19.4	22.7	20.9
Freemen	79.7	74.7	151.9	189.6	2.2	10.9	8.7	9.2%	high	135.1	150.7	43.6	23.7	23.7	14.7
Humberstone and Hamilton	80.7	76.3	130.0	163.6	9.6	20.6	14.2	10.3%		127.9	122.5	28.8	12.2	23.2	22.9
Knighton	81.5	78.3	93.5	142.1	5.8	9.6	3.8	7.5%	low	114.8	104.3	15.3	13.1	17.3	30.3
Latimer	80.9	75.6	174.6	119.5	8.6	14.8	10.6	11.9%	low	104.8	132.9	21.6	4.6	27.9	33.4
New Parks	79.0	74.0	150.3	201.3	5.8	12.6	9.1	9.3%	high	123.0	159.2	40.5	15.7	28.3	13.9
Rushey Mead	81.2	77.7	94.9	161.2	5.5	14.5	10.9	10.9%	low	120.9	119.3	22.6	7.1	24.6	28.0
Spinney Hills	80.3	74.6	167.0	160.4	10.8	11.9	7.5	15.8%		120.0	155.0	24.6	5.3	27.5	26.1
Stoneygate	81.0	76.7	147.0	130.9	9.4	14.4	9.3	12.2%		125.0	135.6	22.2	9.3	22.1	31.8
Thurncourt	80.0	73.7	117.2	192.4	2.4	7.2	7.2	11.7%	high	119.4	131.2	30.3	12.1	25.5	21.0
Westcotes	78.4	73.1	174.7	185.9	5.5	13.7	8.2	8.8%	high	101.6	135.2	36.6	30.4	18.4	26.1
Western Park	78.8	76.0	90.1	177.6	2.7	5.4	2.7	7.3%		107.3	106.2	22.2	17.8	19.5	24.5
Leicester City	**79.7**	**75.3**	**134.6**	**175.3**	**6.3**	**11.9**	**8.3**	**11.1%**	**52.5**	122.4	137.6	29.8	13.6	23.9	23.2
Leicester, Leicestershire & Rutland	**81.6**	**77.8**	**106.2**	**166.6**	**5.2**	**9.6**	**6.6**	**8.4%**	**35.3**	118.9	99.9	-	-	-	-
England			102.6	177.4	5.1	8.0	5.5	7.9%	42.1			26.0	18.2	21.8	23.8

Significantly worse than the LLR average

Significantly better than the LLR average)

Lifestyle estimates are compared to the England average for statistical significance

Life Expectancy (years) at birth for males and females

DSR Mortality: Directly age-standardised mortality rates per 100,000, for all ages, using European standard population

Infant Mortality rate: Number of deaths in live born infants under 1 year of age, per 1,000 live births

Perinatal mortality rate: Number of still births and deaths under 7 days, per 1,000 total births

Still birth rate: Number of still births per 1,000 total births

Low birth weights: Percent of live and still births less than 2500 gram

Under 18 conception rate: Number of conceptions per 1,000 females aged 15-17 years

Access to services: Directly age-standardised hospital admission rates per 100,000 population

Smoking prevalence: Estimate of adults currently smoking

Excessive drinking: Men consuming more than 8 units and women consuming more than 6 units on heaviest drinking day during the week

Obesity prevalence: Estimate of adults with a Body Mass Index (BMI) greater than 30

Fruit & Vegetable consumption: Estimate of adults consuming 5+ portions of fruit and vegetables in a day

Health Facts 7 - Disease notifications 2007

Source: East Midlands South Health Protection Unit

	Leicester 2007		Leicestershire County & Rutland 2007		Leicestershire, Northamptonshire & Rutland, 2007	
Disease notifications	**Number**	**Rate per 100,000**	**Number**	**Rate per 100,000**	**Number**	**Rate per 100,000**
Campylobacter	184	62.9	629	92.6	1611	97.6
Cryptosporidium	11	3.8	42	6.2	88	5.3
E.Coli O157	4	1.4	4	0.6	11	0.7
Food poisoning	13	4.4	47	6.9	78	4.7
Gastroenteritis	1	0.3	1	0.1	6	0.4
Giardia	39	13.3	61	9.0	109	6.6
Hepatitis A	7	2.4	1	0.1	14	0.8
Hepatitis B	27	9.2	10	1.5	75	4.5
Hepatitis C	22	7.5	20	2.9	121	7.3
Hepatitis E	3	1.0	2	0.3	5	0.3
Influenza A	1	0.3	0	0.0	13	0.8
Legionella	5	1.7	5	0.7	15	0.9
Listeria	4	1.4	2	0.3	6	0.4
Malaria	17	5.8	8	1.2	30	1.8
Measles	25	8.5	53	7.8	167	10.1
Meningococcal disease	17	5.8	43	6.3	132	8.0
Mumps	133	45.5	421	62.0	619	37.5
Norovirus	19	6.5	31	4.6	124	7.5
Para-typhoid	10	3.4	0	0.0	10	0.6
Pertussis	11	3.8	37	5.4	60	3.6
Rotavirus	3	1.0	6	0.9	69	4.2
Rubella	7	2.4	22	3.2	35	2.1
Salmonella	60	20.5	139	20.5	352	21.3
Scarlet Fever	4	1.4	29	4.3	47	2.8
Shigella	2	0.7	10	1.5	39	2.4
Tuberculosis	246	84.1	60	8.8	393	23.8
Typhoid	5	1.7	0	0.0	6	0.4

Rates calculated using ONS mid-2007 population estimates

Glossary

Directly age-standardised rate: Measure which allows direct comparison between populations with different age and gender structures. The crude rates in one or more populations are applied to a standard population to derive rates per 100,00 persons per year

Excessive drinking: Estimates of adults consuming more than double the recommended daily units on their heaviest drinking day during the week (8+ units for men, 6+ units for women)

Fruit & Vegetable consumption: Estimate of adults consuming 5+ portions of fruit and vegetables in a day

Infant mortality: Babies who die within the first 12 months of life

Index of deprivation: Measure of deprivation at a small area level. Indicators such as income, employment, health and disability, education skills and training, barriers to housing and services, crime and living environment are combined to form a single score. The lower the mean score, the more deprived the area

International classification of diseases: World Health Organisation's internationally accepted classification of death and disease. (revision 10 currently in use)

Life Expectancy: Measure of mortality at every age that allows comparisons between areas and time. Life expectancy in an area can be interpreted as the number of years a baby born in a particular period could be expected to live, if it experienced the mortality rates in that time period and area throughout its life

Local Area Agreement (LAA): A three year agreement that sets out the priorities agreed between Central Government, Local Strategic Partnerships (LSPs) and other key partners for a local area. The primary objective of an LAA is to deliver better outcomes for local people through four broad areas: children and young people; safer and stronger communities, healthier communities and older people; and economic development and enterprise

Low birth weight: Babies with a birth weight under 2500g

Obesity prevalence: Estimate of adults with a body Mass Index greater than 30

Perinatal mortality: Babies who are stillborn or who die in the first week of life

Quintile: The proportion of the distribution containing one fifth of the total sample. In the Index of Deprivation 2007 (ID2007), quintile 1 as the most deprived contains the lowest 20% of the national rankings

Resident population: Count of the population living within the geographical area of the PCT. An individual may reside in a rural area, but be registered with a City GP and would therefore be counted in the registered population but not the resident population

Screening: Identification among apparently healthy individuals, who are sufficiently at risk from a specific disorder, to benefit from a diagnostic test or procedure

Smoking prevalence: Estimate of adults currently smoking

Standardised mortality ratio (indirect): Ratio of the number of deaths in a population compared with the national, standardised to adjust for differences in age and sex of the local population. A Score greater than 100 indicates an increased probability and a score below 100 indicates a reduced probability

Standardised registration ratio (SRR) for cancer: Ratio of cancers registered in a population compared with the national population, standardised to adjust for differences in age and sex of the local population. A score greater than 100 indicates an increased probability and a score below 100 indicates a reduced probability

Super output area (SOA): Geographical areas based on size, social homogeneity and population and designed for reporting small area statistics. There are 3 levels of super output area; lower, middle and upper. The lower super output area (used for reporting ID2007) has a population of 1,000-1,500)

Survival rate (1 year/ 5 years): Ratio of the survival rate observed at one and five years after diagnosis, compared with general population

Trajectory: Predicted level of activity based on historical trends and planned actions to influence these. Trajectory may include a target measure

Years of life lost: Number of potential years of life lost in a population as a result of premature death (under 75 years)

Leicester City

To find out more about the work of the Directorate of Public Health and Health Improvement for NHS Leicester City contact:

Director of Public Health and Health Improvement
3rd Floor, St Johns House
30 East Street
Leicester LE1 6NB
Tel: Leicester (0116) 295 1400
Fax: Leicester (0116) 295 1111

Additional information and an electronic version of this report are available on our website at www.phleicester.org.uk

If you would like this document in a different format, such as larger print, Braille or on audio tape, please contact Jane Whitehouse on Leicester 0116 295 1453 or jane.whitehouse@leicestercity.nhs.uk

For more information on the contents of this document, please telephone Leicester (0116) 295 4743

આ પત્રિકામાં આવેલ મુદ્દાઓની વધુ માહિતી માટે, મહેરબાની કરીને લેસ્ટર **(0116) 295 4743** ઉપર ટેલિફોન કરો.

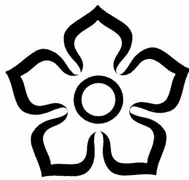
इस दस्तावेज़ के विषयों सम्बन्धी जानकारी प्राप्त करने के लिए कृप्या लेस्टर (0116) 295 4743 पर टेलीफ़ोन कीजिए।

ਇਸ ਦਸਤਾਵੇਜ਼ ਵਿਚ ਸ਼ਾਮਲ ਵਿਸ਼ਿਆਂ ਬਾਰੇ ਜਾਣਕਾਰੀ ਲਈ, ਕ੍ਰਿਪਾ ਕਰਕੇ ਲੈਸਟਰ **(0116) 295 4743** ਤੇ ਟੇਲੀਫ਼ੋਨ ਕਰੋ ।

Si aad warar faahfaahsan oo dokomentigan ku saabsan u heshid fadlan nagalasoo xiriir telefoonkan Leicester (0116) 295 4743.

এই ডকুমেন্ট-এর (প্রমাণপত্র) বিষয় সম্পর্কে তথ্যের জন্য, অনুগ্রহ করে লেষ্টার **(0116) 295 4743** নাম্বারে টেলিফোন করুন।

اس دستاویز میں جو کچھ ہے اس کی معلومات کے لئے برائے کرم (0116) 295 4743 پر ٹیلیفون کریں۔



Appendix I

PERFORMANCE & VALUE FOR MONEY SELECT COMMITTEE **6 April 2011**
CABINET **11 April 2011**

CREATION OF THE 2011/2012 PROCUREMENT PLAN

Report of the Chief Finance Officer

1 PURPOSE OF THE REPORT

1.1 This Report seeks Cabinet's approval to the Procurement Plan for 2011/2012.

1.2 The Plan serves 2 purposes:

(a) To inform the market of future procurement activity above the EU threshold, to enable them to prepare.

(b) To provide Members with an overview of significant procurement activity.

1.3 The Procurement Plan is to be reviewed on a quarterly basis for existing approved entries with an opportunity to add new planned activities .

1.4 This Report is grouped into Divisions, listing all probable procurement exercises likely to be above the EU thresholds (currently, £156,442 for supplies and services and £3,927,260 for works) and is the fourth such report.

1.5 Entry on the Plan does not necessary imply that the procurement will happen and (where procurement does happen) lower prices will be sought where possible.

2 REPORT

2.1 In consultation with divisions, the Corporate Procurement Team has produced the attached Schedule (at Appendix 1) listing all known potential procurement activity for the 2011/2012 financial year above the EU threshold.

2.2 The National Procurement Strategy, published in 2003, recommended the publication of a forward looking procurement plan – to be available for the market to have an early indication of what we may offer to the market. Once approved, the details will be published on the Council's website.

2.3 During the year, it is very likely that additional or changed procurement activities will need to be tendered. This may be, for example, if third party

funding is agreed during the year or if a strategic decision is taken which affects that particular contract delivery option. It is envisaged that the procurement plan will be a rolling document, approved three-monthly. In December, Cabinet approved the appointment of a new Strategic Partner who is due to be appointed in March 2011. The Partner will need to be involved in any new/amended activities throughout the year.

2.4 Savings, believed to range from £3.3m to £11.0m per annum, are potentially available over time, dependent upon the options pursued. The Strategic Partner will be working towards high targets and to support much needed 'immediate' value realisation. This Procurement Plan will kick-start the savings exercise in conjunction with the Partner's other targets to achieve savings.

2.5 This consolidated report is designed to provide Cabinet with an overview of currently known planned procurements above the EU thresholds; this provides corporate management with visibility of proposed EU Public Procurement requirements.

2.6 The value of the contracts contained within the 2011/2012 Plan, where a value has been declared, is in the region of £272 million. As the duration for the majority of the entries featured in this Plan are for multiple years, there is no direct link to the 2011/2012 budget alone.

2.7 Currently, the Procurement Plan consists of planned activities in the forthcoming financial year. However, the Appendix does not contain any "above EU" framework contracts that are utilised by the Council which have been tendered out by other sources eg ESPO, OGC, EMPA. In 2009/2010, this spend was in the region of £43 million. It is therefore prudent to include this spend in the evolving Procurement Planning process to provide enhanced visibility of potential spend over the coming year and ultimately a better analysis process, and this will be included in the first revision.

2.8 A separate Plan is to be created to capture potential procurement activity where value of contracts is as defined in Contract Procedure Rules and below the EU threshold. This Plan will include third party contracts eg ESPO, OGC, EMPA. This new (additional) Procurement Plan will be scrutinised by the Strategic Partner.

2.9 The Council's Contract Procedure Rules (last version approved by Cabinet in November 2008) are in the process of being amended to reflect these and other ongoing changes to best ensure that Leicester's City Council's approach to procurement generates savings which will be essential to the delivery of the Council's budget strategy.

3 RECOMMENDATIONS

Cabinet is recommended to:

3.1 Approve the forward plan of procurement activities for the market to have an early indication of potential activity and for the engagement, attached as Appendix 1.

3.2 Note that the Plan will be subject to review and refinement from time to time.

3.3 Note that actual procurement activity will be monitored against the plan by the Select Committee.

3.4 Note that on 21 April 2008, the Cabinet reserved to itself the decision to let contracts in excess of the EU thresholds.

3.5 Delegate the letting of contracts within this Plan to Divisional Directors, subject to consultation in each case with Cabinet Leads and periodic reporting to Cabinet of contracts let.

3.6 Approve that all call off/mini-competition spend which utilises external contracts above EU value eg ESPO, EMPA and OGC etc be included in future Procurement Plans.

3.7 Agree and approve that a separate Procurement Plan be created to capture potential procurement activity (which will include all third party contracts and call-offs) where value of contracts is as defined in Contract Procedure Rules but below the EU threshold. In future years, it is proposed to include this in the formal Procurement Plan.

3.8 Agree and approve the quarterly cyclical reportings of the review and additions to the Procurement Plan to Cabinet.

4 CONSULTATION

4.1 This report has been discussed at Strategic Management Board.

5 FINANCIAL, LEGAL AND OTHER IMPLICATIONS

5.1 Financial Implications

Inclusion of contracting activity on the attached Plan is a high level statement of intent and is subject to available budgetary or grant provision in each instance. The Plan will additionally be used as a basis of challenge, when the Council’s new Strategic Procurement Partners commence, with a view to securing budgetary savings. The 2011/2012 budget expects savings of £1.5m per annum from the Council’s procurement activities.

5.2 Legal Implications

As all the procurement activities are above the EU Public Procurement thresholds, as well as compliance with the Council's Contract Procedure Rules, the relevant law is contained in the Public Contracts Regulations 2006. Each procurement will need to follow due process in accordance with our internal and legislative requirements, with advice from the Corporate Procurement Team and Legal Services.
Beena Adatia
Senior Solicitor/Team Leader

Legal Services
Extn 29 6378

5.3 **Climate Change Implications**

This Report does not contain any significant climate change implications and therefore should not have a detrimental effect on the Council's climate change targets.
Helen Lansdown
Senior Environmental Consultant - Sustainable Procurement
Extn 29 6770

5.4 **Other Implications**

Other Implications	Yes/No	Paragraph References within this Report
Equal Opportunities	See comment	None specifically from this Report but the individual tendering exercises will follow the corporate standards.
Policy	See comment	
Sustainable and Environmental	See comment	
Crime and Disorder	See comment	
Human Rights Act	See comment	
Elderly Persons/People on Low Incomes	See comment	
Corporate Parenting	See comment	
Health Inequalities Impact	See comment	

6 REPORT AUTHOR

6.1 Sue Oliver
Corporate Procurement Manager
Corporate Procurement Services
Extn 29 8919

Amina Laher
Corp. Procurement Support Officer
Corporate Procurement Services
Extn 29 6304

March 2011

Key Decision	Yes
Reason	Is significant in terms of its effect on communities living or working in an area comprising more than one ward
Appeared in Forward Plan	Yes
Executive or Council Decision	Executive (Cabinet)

PROCUREMENT PLAN – FINANCIAL YEAR APRIL 2011 TO MARCH 2012

Division:	Corporate Governance
Section:	Advertising Sales
Name of Contract:	**Distribution of Leicester Link, ad-hoc leaflets and other Printed Materials**
Description of Contract:	Door to door distribution of the Leicester Link and ad-hoc leaflets to the residents of Leicester.
Expiry Date of Existing Contract:	31st March 2012
Anticipated Start of New Contract:	1st April 2012
Duration of New Contract:	2 years with an option +1 +1 years
Approximate annual value:	£60,000
Value of New Contract:	£240,000 Entire contract (including extensions)
Lead Officer:	Tess Booth

Division:	Corporate Governance
Section:	Print Procurement
Name of Contract:	**Printing of Leicester Link**
Description of Contract:	This entry was originally approved by Cabinet on 29th March 2010. However the value of the contract has now increased, hence the need for re-entry.
Expiry Date of Existing Contract:	31st August 2011
Anticipated Start of New Contract:	1st September 2011
Duration of New Contract:	2 years with an option +1 +1 +1 years
Approximate annual value:	£90,000
Value of New Contract:	£380,000 Entire contract (including extensions)
Lead Officer:	Tess Booth

Division:	Corporate Governance
Section:	Print Procurement
Name of Contract:	**Print Framework Contract**
Description of Contract:	One framework containing the lots: Lot 1 – NCR printing, stationery, envelope printing, labels, bespoke items, Lot 2 – Jobbing print, Lot 3 – Four colour printing, Lot 4 – Large format, Plan print and Lot 5 – Screen print.
Expiry Date of Existing Contract:	31st March 2012
Anticipated Start of New Contract:	1st April 2012
Duration of New Contract:	2 years with an option +1 +1 years
Approximate annual value:	£750,000
Value of New Contract:	£3,000,000 Entire contract
Lead Officer:	Chris Saville

Division:	Financial Services
Section:	Revenues and benefits
Name of Contract:	**Printing and Despatch of Revenues and Benefits Documents**
Description of Contract:	To receive documents electronically, print and dispatch those documents
Expiry Date of Existing Contract:	New Contract
Anticipated Start of New Contract:	Autumn 2011
Duration of New Contract:	5 years
Approximate annual value:	£150,000 per annum
Value of New Contract:	£750,000
Lead Officer:	Michael Lacey

Division:	Financial Services
Section:	Revenues and Benefits Service
Name of Contract:	**Credit Referencing Service**
Description of Contract:	Corporate use of external credit agency to aid in the tracing of debtors etc
Expiry Date of Existing Contract:	June 2011. This will be a new corporate contract.
Anticipated Start of New Contract:	July/August 2011
Duration of New Contract:	4 years +2 year extension option
Approximate annual value:	£50,000
Value of New Contract:	Between £250,000 and £300,000
Lead Officer:	Gita Mistry

Division:	Revenue and Benefits
Section:	Operations
Name of Contract:	**External Payment Outlets**
Description of Contract:	Ability to shops and post offices and other retail outlets to receive cash on behalf of Leicester City Council
Expiry Date of Existing Contract:	30/11/2011 – notice to be provided by 1/8/2011 that contract should continue to 1/10/12 then 1/10/13
Anticipated Start of New Contract:	1st October 2013
Duration of New Contract:	3 years +1 +1
Approximate annual value:	£100,000
Value of New Contract:	£500,000
Lead Officer:	Michael Lacey

Division:	Financial Services
Section:	Revenues and Benefits
Name of Contract:	**Revenues Management Information System**
Description of Contract:	Provision of Revenues Management Information System
Expiry Date of Existing Contract:	31/01/2012 with options to extend for a further 1 + 1 years
Anticipated Start of New Contract:	01/02/2014
Duration of New Contract:	TBC
Approximate annual value:	TBC
Value of New Contract:	TBC
Lead Officer:	Steven Barber
Comments:	Competitive Review to establish future business requirements to commence no later than August 2011

Division:	Legal Services
Section:	Practice Support
Name of Contract:	**LexisNexis Online Library**
Description of Contract:	Rolling contract under which for an annual fee access is given for Legal Services staff to access the online resource
Expiry Date of Existing Contract:	September 2011
Anticipated Start of New Contract:	October 2011 (for one year). Procurement Project underway to find vendor neutral.
Duration of New Contract:	Last contract signed and dated 23rd September 2010
Approximate annual value:	£55,000
Value of New Contract:	Apx. £220,000 over a 48 month period. The whole contract is being reviewed.
Lead Officer:	Practice Manager

Division:	Human Resources
Section:	Pay & Workforce Strategy
Name of Contract:	**Employee Assistance Programme**
Description of Contract:	Provision of professional confidential counselling via telephone and face-to-face to all LCC employees.
Expiry Date of Existing Contract:	31st January 2012 (if option to extend not progressed)
Anticipated Start of New Contract:	1st February 2012 (if option to extend not progressed)
Duration of New Contract:	The initial period of contract will be three years, +1yr +1yr option to extend
Approximate annual value:	£90,000
Value of New Contract:	£270,000 (over 3 years)
Lead Officer:	Frank Imms

Division:	
Section:	Design & Project Management (City Transport - Fleet)
Name of Contract:	**Central Vehicle Pool Replacements**
Description of Contract:	Replacement of central vehicle pool with new more fuel efficient and less polluting vehicles.
Expiry Date of Existing Contract:	Currently done on an annual programme
Anticipated Start of New Contract:	June 2011
Duration of New Contract:	Annual replacement programme procured through ESPO
Approximate annual value:	£1,400,000
Value of New Contract:	Approx £1,400,000 per annum
Lead Officer:	David Ison / Satish Shah

Division:	Regeneration Highways & Transportation
Section:	Design & Project Management (City Transport – Fleet)
Name of Contract:	**Vehicle Maintenance – Leicester City**
Description of Contract:	Vehicle/Plant items Repair and maintenance
Expiry Date of Existing Contract:	31/12/2011
Anticipated Start of New Contract:	01/01/2012
Duration of New Contract:	5/7 years
Approximate annual value:	£1,400,000
Value of New Contract:	£8,989,222
Lead Officer:	David Ison/Satish Shah

Division:	Regeneration, Highways & Transportation
Section:	City Highways
Name of Contract:	**Roadstone and Concrete Aggregates**
Description of Contract:	Supply of roadstone and highway materials
Expiry Date of Existing Contract:	30/09/2011
Anticipated Start of New Contract:	01/10/2011
Duration of New Contract:	Options to extend for a further +1 +1 year does exist and can be taken up – dependent on market analysis. However, in the event a new tendering exercise is commenced, the duration would be for 4 years.
Approximate annual value:	£150,000
Value of New Contract:	£300,000 pa approx
Lead Officer:	Martin Fletcher

Division:	Regeneration, Highways & Transportation
Section:	Traffic Management
Name of Contract:	**Parking Enforcement Services within Leicester City**
Description of Contract:	Parking Enforcement Services within Leicester City
Expiry Date of Existing Contract:	Break point 10/12/2011 but renewable for up to 24 months from this date
Anticipated Start of New Contract:	To be determined – A Report was requested by PVFM in January (Cabinet Lead: Councillor Osman) with a view to reviewing the whole service, including how this is provided.
Duration of New Contract:	To be determined
Approximate annual value:	£800,000
Value of New Contract:	Estimated £4 million over 5 years
Lead Officer:	Andrew Thomas and Nigel Clarke

Division:	Regeneration, Highways & Transportation
Section:	Traffic Strategy
Name of Contract:	**Real Time Bus Information**
Description of Contract:	Real-time Bus Information System
Expiry Date of Existing Contract:	31/12/2011 but to be determined – support contract is annual renewable
Anticipated Start of New Contract:	01/01/2012 but to be determined. This project is currently under review
Duration of New Contract:	Proposed 3 yrs +1+1
Approximate annual value:	
Value of New Contract:	Estimated £600,000 – to be confirmed
Lead Officer:	John Dowson/Mark Wills

Division:	Regeneration, Highways & Transportation
Section:	Transport Strategy
Name of Contract:	**New Bus Termini and Routing**
Description of Contract:	Architectural and Building Design Services
Expiry Date of Existing Contract:	N/A
Anticipated Start of New Contract:	To be determined
Duration of New Contract:	To be determined
Approximate annual value: Value of New Contract:	£175,000
Lead Officer:	Mark Wills and Garry Scott

Division:	Regeneration, Highways & Transportation
Section:	Design and Project Management
Name of Contract:	**Possible Successor(s) to Highways Framework Contracts 2006-2010 (extended)**
Description of Contract:	To be determined
Expiry Date of Existing Contract:	30/11/2011
Anticipated Start of New Contract:	To be determined
Duration of New Contract:	To be determined
Approximate annual value: Value of New Contract:	To be estimated
Lead Officer:	Satish Shah and Stephen Cooper

Division:	Regeneration Highways & Transportation
Section:	Highway Maintenance Section.
Name of Contract:	**Street Lighting and Festive Decorations Term Maintenance Contract**
Description of Contract:	Term Maintenance and Installation Contract
Expiry Date of Existing Contract:	31/03/2012
Anticipated Start of New Contract:	01/04/2012
Duration of New Contract:	To be Determined.
Approximate annual value: Value of New Contract:	To be Assessed
Lead Officer:	Alan Adcock, Manjeet Virdee and Rob Adamek

Division:	Regeneration, Highways & Transportation
Section:	Traffic Management
Name of Contract:	**Traffic Signals maintenance and installations using Siemens and Peek**
Description of Contract:	Traffic Signals maintenance and installations for Leicester, Leicestershire and Rutland (OGC tendered contract)
Expiry Date of Existing Contract:	Passed
Anticipated Start of New Contract:	1st August 2011
Duration of New Contract:	4 years
Approximate annual value: Value of New Contract:	£2 million - 2.25 million/year at 2010-11 prices
Lead Officer:	Steve Cooper / Andrew Thomas

Division:	Regeneration, Highways & Transportation
Section:	Traffic Management
Name of Contract:	**Term Maintenance Contract for Highway Works, 2009-14**
Description of Contract:	Civil engineering maintenance of traffic signals, etc (previously TMCHW Schedule G and separate ad-hoc "Slot-cutting and looping" commissions) in Leicester, Leicestershire and Rutland.
Expiry Date of Existing Contract:	March 2009.
Anticipated Start of New Contract:	Being redrafted and retendered as Schedule H of Term Maintenance Framework Contracts.
Duration of New Contract:	To coincide with other Schedules of Term Maintenance Contract: 31st March 2014 + 1 year + 1 year
Approximate annual value:	£350,000/year at 2010-11 rates
Value of New Contract:	£1.05 million by 31st March 2014 at 2010-11 rates
Lead Officer:	Andrew Thomas (Head of Service), Sangita Pattni (Signals Maintenance Team Leader), Stephen Cooper (Highways Contracts Engineer)

Division:	Regeneration, Highways & Transportation
Section:	Traffic Management
Name of Contract:	**City Centre Security**
Description of Contract:	Operation of City Centre Security Room based in York House (Broadland security)
Expiry Date of Existing Contract:	Contract extended
Anticipated Start of New Contract:	To be determined in association with Corporate procurement
Duration of New Contract:	3 years +1 +1
Approximate annual value:	
Value of New Contract:	Not determined – specification to be reviewed within corporate CCTV strategy
Lead Officer:	Andrew Thomas

Division:	Regeneration Highways & Transportation
Section:	City Highways, Highway Maintenance Group.
Name of Contract:	**Specialist Civil Engineering Sub-Contractors Framework (ESPO Contract)**
Description of Contract:	Proposed ESPO framework contract for specialist sub-contract services in support of highway maintenance & civil engineering construction operations carried out by City Highways (e.g. steel fixing, formwork & carpentry, groundworks, fencing, highway crafts). Wider ESPO & Leicestershire County Council use also under consideration.
Expiry Date of Existing Contract:	N/A – new contract proposal.
Anticipated Start of New Contract:	01/06/2011
Duration of New Contract:	Proposed minimum 2 years, plus option to extend.
Approximate annual value:	£300,000
Value of New Contract:	£600,000 for 2 years
Lead Officer:	Martin Fletcher

Division:	Regeneration, Highways & Transportation
Section:	Highway Maintenance Group.
Name of Contract:	**Road Surface Treatments Framework (ESPO Contract)**
Description of Contract:	Proposed ESPO framework contract for specialist road surface treatment services for highway maintenance schemes, including surface dressing, slurry micro-surfacing, retread/repave, etc. Wider ESPO & Leicestershire County Council use also under consideration.
Expiry Date of Existing Contract:	N/A – new contract proposal.
Anticipated Start of New Contract:	01/06/2011
Duration of New Contract:	Proposed minimum 2 years, plus option to extend.
Approximate annual value:	
Value of New Contract:	£300,000 per annum (approx.)
Lead Officer:	Martin Fletcher

Division:	Environmental Services
Section:	**Building Cleaning Waste Management**
Name of Contract:	Additional Building Cleaning in CLABs
Description of Contract:	Call-off contract do deep cleans
Expiry Date of Existing Contract:	31/10/2011
Anticipated Start of New Contract:	01/11/2011
Duration of New Contract:	5 years +1 +1
Approximate annual value:	£71,000
Value of New Contract:	£500,000
Lead Officer:	Bev Packwood

Division:	Environmental Services
Section:	Waste Management
Name of Contract:	**Evaluation of Mechanical Biological Treatment Stablished Soil Compost**
Description of Contract:	In conjunction with the Environment Agency, detailed analytical monthly laboratory testing of samples the bio-compost produced by the Wanlip MBT facility and to secure a contract with a local farm to use 12 months of the bio-compost output within the framework of a bespoke permit negotiated with the Environment Agenc
Expiry Date of Existing Contract:	01/11/2011
Anticipated Start of New Contract:	02/11/2011
Duration of New Contract:	2 years extension allowed within the original contract subject to progress on the bespoke permit application with the Environment Agency
Approximate annual value:	
Value of New Contract:	£125,000
Lead Officer:	Steve Weston - Head of Waste Management

Division:	Planning & Economic Development
Section:	Economic Regeneration
Name of Contract:	**Working Neighbourhoods Fund (part of Area Based Grant)**
Description of Contract:	A number of contracts as part of an overall programme in the context of government guidance and the delivery of One Leicester. This was originally in the 2008/2009 Procurement Plan
Expiry Date of Existing Contract:	31/03/2011 (Three year (out of 5) programme)
Anticipated Start of New Contract:	April 2011 (Two-year (of the remaining) 5 programme)
Duration of New Contract:	Overall programme to be extended until March 2013 as per cabinet of October 2009
Approximate annual value:	
Value of New Contract:	£25,643,416 This is a funding source and was originally in the 2008/2009 Procurement Plan and is carried forward into March 2013.
Lead Officer:	Joanne Ives

Division:	Technical Services
Section:	Building Design
Name of Contract:	**Supply and Delivery of Kitchens only 2008-2011**
Description of Contract:	Supply only of kitchens and associated items only
Expiry Date of Existing Contract:	September 2012 - Extended to Sept 12 to coincide with Supply and Delivery of Bathroom Sanitary ware
Anticipated Start of New Contract:	September 2012
Duration of New Contract:	3 yr with option to extend for further 1 year
Approximate annual value:	£1,250,000
Value of New Contract:	£5,000,000
Lead Officer:	Mahesh Parmar

Division:	Technical Services
Section:	Building Design
Name of Contract:	**Supply and Delivery of Bathroom Sanitary ware 2008-2011**
Description of Contract:	Supply only of bathroom sanitary ware to complement the Kitchens & bathroom contract
Expiry Date of Existing Contract:	September 2012
Anticipated Start of New Contract:	September 2012
Duration of New Contract:	3 yr with option to extend for further 1 year
Approximate annual value:	£750,000
Value of New Contract:	£3,000,000
Lead Officer:	Mahesh Parmar

Division:	Technical Services
Section:	Design Services
Name of Contract:	**BEMs – Building Energy Management Systems**
Description of Contract:	Install new energy management system city wide.
Expiry Date of Existing Contract:	Expired and working on small quote orders due to Esco out come
Anticipated Start of New Contract:	October 2011
Duration of New Contract:	1 year, with 3 years maintenance and upgrade facility
Approximate annual value:	
Value of New Contract:	£240,000 entire contract
Lead Officer:	Mahesh Parmar

Division:	Technical Services
Section:	Services
Name of Contract:	**City Wide – Frame work Electrical Rewires at Council Dwellings**
Description of Contract:	Rewiring of all domestic dwellings and associated properties city wide.
Expiry Date of Existing Contract:	March 2013 (please note, we have just awarded a Rewires contract for 1yr, +1 yr for two contractors)
Anticipated Start of New Contract:	March 2013
Duration of New Contract:	4 years
Approximate annual value:	£2,500,000
Value of New Contract:	£10,000,000
Lead Officer:	Mahesh Parmar

Division:	Technical Services
Section:	Design
Name of Contract:	**CCTV Installations & Maintenance City**
Description of Contract:	Maintenance and possible new installations of CCTV under the responsibility of Technical services division.
Expiry Date of Existing Contract:	11/11/2011
Anticipated Start of New Contract:	November 2011
Duration of New Contract:	3years, with a further extension of +1,+1 years
Approximate annual value:	£140,000
Value of New Contract:	£700,000
Lead Officer:	Mahesh Parmar

Division:	Technical Services
Section:	Design
Name of Contract:	**Citywide, Door Entry Maintenance & New Installations 2009-12**
Description of Contract:	To maintain and install UPVC wooden and metal doors, citywide
Expiry Date of Existing Contract:	01/02/2012
Anticipated Start of New Contract:	01/02/2012
Duration of New Contract:	3 years +1
Approximate annual value:	£750,000
Value of New Contract:	£3,000,000
Lead Officer:	Mahesh Parmar

Division:	Technical Services
Section:	Design
Name of Contract:	**Kitchen & Bathroom fit only**
Description of Contract:	To fit Kitchens & Bathrooms in dwellings city wide
Expiry Date of Existing Contract:	May 2011
Anticipated Start of New Contract:	June 2011
Duration of New Contract:	3 years, with a further extension of +1,+1 years
Approximate annual value:	£5,000,000
Value of New Contract:	£25,000,000
Lead Officer:	Mahesh Parmar

Division:	Technical Services
Section:	Design
Name of Contract:	**Asbestos removal**
Description of Contract:	To remove asbestos in housing stock city wide
Expiry Date of Existing Contract:	31/12/11 (n.b. contract now reached max EU value)
Anticipated Start of New Contract:	Jan 2012
Duration of New Contract:	3 years, with a further extension of +1,+1 years
Approximate annual value:	£300,000
Value of New Contract:	£1,500,000
Lead Officer:	Mahesh Parmar

Division:	Technical Services
Section:	Design
Name of Contract:	**Intruder Alarm, Citywide.**
Description of Contract:	To maintain and install intruder alarms citywide in the Housing Improvements and Repairs Section
Expiry Date of Existing Contract:	01/02/2012
Anticipated Start of New Contract:	01/02/2012 (extended year)
Duration of New Contract:	3 years +1
Approximate annual value:	£75,000
Value of New Contract:	£300,000
Lead Officer:	Mahesh Parmar

Division:	Technical Services
Section:	Housing Management
Name of Contract:	**Electronic Decorating Vouchers for tenants City Wide 2011-2016**
Description of Contract:	To provide electronic decorating vouchers to tenants instead of cash. The contractor is to manage the credit on the card with LCC managing the day to day handling of the card to the tenant. The tenant can only spend on decorating items. The contractor is to provide a rebate or percentage saving on volume per year. This would off set any potential resource issues.
Expiry Date of Existing Contract:	New contract
Anticipated Start of New Contract:	October/ November 2012
Duration of New Contract:	3 years with option to extend to further +1, +1 years
Approximate annual value:	£270,000
Value of New Contract:	£1,275,000 Entire contract
Lead Officer:	Mahesh Parmar/ Suki Supria

Division:	Health, Wellbeing and Community
Section:	Housing Improvements & Repairs –Technical
Name of Contract:	**Mobile Working Network Improvement**
Description of Contract:	Improving of the network to support Mobile Working
Expiry Date of Existing Contract:	NEW PROCUREMENT
Anticipated Start of New Contract:	Procurement process to commence 01/04/2011
Duration of New Contract:	5 years + 1 + 1
Approximate annual value:	£107,140
Value of New Contract:	£750,000
Lead Officer:	Steven Barber

Division:	Health, Wellbeing and Community
Section:	Housing
Name of Contract:	**Housing Management Information System**
Description of Contract:	Provision of Housing Management Information System
Expiry Date of Existing Contract:	17/08/2014
Anticipated Start of New Contract:	18/08/2014
Duration of New Contract:	TBC
Approximate annual value:	
Value of New Contract:	TBC
Lead Officer:	Steven Barber
Comments:	Competitive Review to establish future business requirements to commence no later than August 2011

Division:	HR
Section:	Pay and Workforce Strategy
Name of Contract:	**Employee Assistance Programme**
Description of Contract:	Confidential counselling and mediation services for employees. Telephone, face-to-face counselling and signposting to debt and legal advice.
Expiry Date of Existing Contract:	31/01/2012
Anticipated Start of New Contract:	01/02/2012
Duration of New Contract:	3 years +1 +1
Approximate annual value:	£90,000
Value of New Contract:	£450,000
Lead Officer:	

Division	
Section:	Partnership Executive Team
Name of Contract:	**Regional Framework for Market Research**
Description of Contract:	Framework agreement with 9 Market Research providers, to provide full public polling and market research management services. Suppliers are invited to quote via mini competition for individual projects as and when required. Framework is open for use for local authorities across the region
Expiry Date of Existing Contract:	31/08/2011 (possibility to extend for additional 1 year to 31/08/2012)
Anticipated Start of New Contract:	TBC
Duration of New Contract:	3 years +1
Approximate annual value:	£250,000
Value of New Contract:	Up to £1 million (estimated across all local authorities open to using the framework)
Lead Officer:	Julie Morley/Rachel Clark

Division:	Health, Wellbeing and Community
Section:	Supporting People
Name of Contract:	**Supporting People Local System**
Description of Contract:	Provision of software licence and maintenance for Supporting People Local System (SPLS)
Expiry Date of Existing Contract:	24/11/2011
Anticipated Start of New Contract:	25/11/2011
Duration of New Contract:	TBC
Approximate annual value:	
Value of New Contract:	TBC
Lead Officer:	Steven Barber
Comments:	Competitive Review to establish future business requirements to commence no later than November 2010

Division:	Strategy, Commissioning, Performance and Business Support
Section:	Social Care and Safeguarding
Name of Contract:	**Integrated Social Services Information System**
Description of Contract:	Ongoing provision of software licence and maintenance for Social Services Information System
Expiry Date of Existing Contract:	31/03/2011
Anticipated Start of New Contract:	01/04/2011
Duration of New Contract:	1 year
Approximate annual value: Value of New Contract:	£160,000 per year
Lead Officer:	Tony Wilkins

Division:	Strategy, Commissioning, Performance and Business Support
Section	Information Systems Unit
Name of Contract:	**Replacement of Integrated Social Services Information System**
Description of Contract:	Replacement of Social Care Case Management system for Adults and Childrens
Expiry Date of existing Contract:	31/03/2012
Anticipated start of new Contract:	01/04/12
Duration of new Contract:	7 years (+ up to 10 further years)
Approximate annual value: Value of new Contract:	Above EU Thresholds (3,000 000 to 6,000 000)
Lead Officer:	Tracie Rees/Raj Adatia

Division:	Social Care & Safeguarding
Section:	Children's Resources
Name of Contract:	**Family Action(provider) –There are three contracts with this provider; these includes Leicester Children's Support Service, Two Halves One Whole, Moving Forwards and Post Sexual Abuse**
Description of Contract:	Support Services to Children & Families
Expiry Date of Existing Contract:	31st Dec 2011
Anticipated Start of New Contract:	January 2012
Duration of New Contract:	Unknown at this time
Approximate annual value:	
Value of New Contract:	£225,969
Lead Officer:	Jasmine Nembhard/Pat Pitman

Division:	Children's
Section:	City Schools
Name of Contract:	**Broadband Connectivity Services**
Description of Contract:	Provision of Broadband services via appropriate source (to be sourced in conjunction with Corporate WAN)
Expiry Date of Existing Contract:	31/10/2012
Anticipated Start of New Contract:	01/11/2012
Duration of New Contract:	5 years + 2+ 2
Approximate annual value:	£357,150
Value of New Contract:	£2,500,000 (Initial Contract)
Lead Officer:	Helen Wright

Division:	Strategic Commissioning
Section:	ONE Team
Name of Contract:	**Management Information System for Universal Children's Data**
Description of Contract:	Maintenance Support for Management Information System
Expiry Date of Existing Contract:	31/03/2012
Anticipated Start of New Contract:	01/04/2012
Duration of New Contract:	4 year + an option period yet to be defined
Approximate annual value: Value of New Contract:	£180,000 per year
Lead Officer:	Mariam Forrester/Sue Welford

Division:	Strategic Commissioning
Section:	ONE Team
Name of Contract:	**Management Information System for Schools Data**
Description of Contract:	Maintenance Support for Management Information System
Expiry Date of Existing Contract:	31/03/2012
Anticipated Start of New Contract:	01/04/2012
Duration of New Contract:	1 year + 1
Approximate annual value: Value of New Contract:	£180,000 per year
Lead Officer:	David Harris/Sue Welford

Division:	Strategic Commissioning
Section:	ONE Team
Name of Contract:	**Replacement Management Information System for Children's and Schools Data**
Description of Contract:	Replacement Management Information System
Expiry Date of Existing Contract:	31/03/2013
Anticipated Start of New Contract:	01/04/2013
Duration of New Contract:	TBC
Approximate annual value:	
Value of New Contract:	TBC
Lead Officer:	Mariam Forrester
Comments	Competitive Review to establish future business requirements to commence no later than October 2010

Division:	Information Services
Section:	Business Services
Name of Contract:	**Multi Function Devices (MFDs)**
Description of Contract:	Call off contract – Mini-competition of suppliers listed on ESPO Framework Contract 272D
Expiry Date of Existing Contract:	31/03/2011
Anticipated Start of New Contract:	01/04/2011
Duration of New Contract:	3 years
Approximate annual value:	£346,670
Value of New Contract:	£1,040,000
Lead Officer:	Paul Masters

Division:	Information & Support
Section:	Customer Services
Name of Contract:	**ACD Maintenance**
Description of Contract:	Maintenance of Corporate ACD for Customer Services
Expiry Date of Existing Contract:	31/03/2011
Anticipated Start of New Contract:	01/04/2011
Duration of New Contract:	3 years
Approximate annual value:	
Value of New Contract:	£120,000 per year
Lead Officer	Pat Jones

Division:	Information & Support
Section:	Technology Services
Name of Contract:	**Business Continuity and Disaster Recovery Services**
Description of Contract:	Provision of Business Continuity and Disaster Recovery Services
Expiry Date of Existing Contract:	30/11/2011
Anticipated Start of New Contract:	01/12/2011
Duration of New Contract:	2 years
Approximate annual value:	£130,000
Value of New Contract:	£260,000 for initial two year contract
Lead Officer	John Doyle

Division:	Information & Support
Section:	Technology Services
Name of Contract:	**High Speed Laser Printers**
Description of Contract:	Rental of Two High Speed Laser Printers for ICT Operations
Expiry Date of Existing Contract:	15/12/2011
Anticipated Start of New Contract:	16/12/2011
Duration of New Contract:	1 year contract extension option
Approximate annual value: Value of New Contract:	£100,000
Lead Officer:	Andy Sharpe

Division:	Information & Support
Section:	Technology Services
Name of Contract:	**Review of Council Telephony Services**
Description of Contract:	Review of telephony services both fixed and mobile and call handling.
Expiry Date of Existing Contract:	31/10/2011
Anticipated Start of New Contract:	01/11/2011
Duration of New Contract:	5 years + 2 +2
Approximate annual value: Value of New Contract:	TBC
Lead Officer:	Peter Kay

Division:	Information & Support
Section:	Technology Services
Name of Contract:	**Appointment of CRM Implementation Support**
Description of Contract:	CRM Implementation Support for corporate Microsoft implementation project.
Expiry Date of Existing Contract:	Not Applicable
Anticipated Start of New Contract:	01/06/2011
Duration of New Contract:	1 year
Approximate annual value: Value of New Contract:	£140,000
Lead Officer:	Marlo Valente

Division:	Information & Support
Section:	Technology Services
Name of Contract:	**Sharepoint Installation Support**
Description of Contract:	Sharepoint Installation Support for corporate Microsoft implementation project.
Expiry Date of Existing Contract:	Not Applicable
Anticipated Start of New Contract:	01/06/2011
Duration of New Contract:	1 Year
Approximate annual value: Value of New Contract:	£140,000
Lead Officer:	Marlo Valente

Division:	Information & Support
Section:	Technology Services
Name of Contract:	**Corporate-wide Area Network Maintenance Contract**
Description of Contract:	Corporate Wide Area Network to include Leicester City schools
Expiry Date of Existing Contract:	31/10/2012
Anticipated Start of New Contract:	01/11/2012
Duration of New Contract:	5 years +2+2
Approximate annual value: Value of New Contract:	£5,300,000 - Initial Contract
Lead Officer:	Peter Kay

Division:	Information & Support
Section:	Financial Services
Name of Contract:	**Payment Card Software and Maintenance**
Description of Contract:	Provision of Payment Card software and maintenance
Expiry Date of Existing Contract:	30/09/2011
Anticipated Start of New Contract:	01/10/2011
Duration of New Contract:	3 years
Approximate annual value: Value of New Contract:	
Lead Officer:	Stephen Charlesworth

Division:	Culture
Section:	Libraries
Name of Contract:	**Library Management System**
Description of Contract:	Supply and Maintenance for the Library Management System
Expiry Date of Existing Contract:	31/12/2012
Anticipated Start of New Contract:	01/01/2013
Duration of New Contract:	TBC
Approximate annual value:	
Value of New Contract:	TBC
Lead Officer:	Lee Warner
Comments	Competitive Review of future business requirements to commence January 2011

Division:	Property
Section:	Project Management
Name of Contract:	**Corporate Property database (not Project Mgt)**
Description of Contract:	Replacement for PAMIS – Corporate Property Database to also incorporate the Schools properties
Expiry Date of Existing Contract:	Ongoing until new Contract can be sourced
Anticipated Start of New Contract:	01/12/2011
Duration of New Contract:	6 years + 1 + 1 + 1 years
Approximate annual value:	£25,000
Value of New Contract:	£200,000
Lead Officer:	Brian Garrity

Division:	Planning & Policy
Section:	Policy
Name of Contract:	**Concession for the sale of ice cream**
Description of Contract:	
Expiry Date of Existing Contract:	31/08/2011
Anticipated Start of New Contract:	
Duration of New Contract:	
Approximate annual value:	
Value of New Contract:	Concessions benefits unknown
Lead Officer:	

Division:	Strategic Asset Management
Section:	Corporate Premises
Name of Contract:	**Window Cleaning - Leicester City**
Description of Contract:	Window Cleaning at all City Council buildings
Expiry Date of Existing Contract:	01/04/2012
Anticipated Start of New Contract:	02/04/2012
Duration of New Contract:	5 Years (i.e. 3 Years +1 +1)
Approximate annual value:	£60,000
Value of New Contract:	£300,000
Lead Officer:	Wyndham Price

Division:	Strategy, Commissioning, Performance and Business Support/Personalisation & Business Support Division
Section:	Service Contracting and Procurement Unit
Name of Contract:	**Provision of supported living services, residential/nursing care services, extra care schemes and retender of health homes contracts for adults with severe, complex and general learning disabilities**
Description of Contract:	This contract was previously agreed by Cabinet in December 2010 however has been placed back on plan as the approach has changed to a joint Leicester Leicestershire and Rutland one across the PCTs and LAs .
Expiry Date of Existing Contract:	From December 2011 to April 2012
Anticipated Start of New Contract:	From December 2011 to April 2012
Duration of New Contract:	3 + 1 + 1 years
Approximate annual value:	£2,040,000
Value of New Contract:	£102,000,000 value 5 years for Leicester City Only, the five partner contract value will be significantly higher.
Lead Officer:	Sarah Morris / Yasmin Surti / LLR

Division:	Strategy, Commissioning, Performance and Business Support
Section:	Service Contracting and Procurement Unit
Name of Contract:	**Welfare Advice Services**
Description of Contract:	Provision of welfare advice services (Contract subject to review 2011, future commissioning activity to be agreed after review)
Expiry Date of Existing Contract:	31/03/2011
Anticipated Start of New Contract:	01/04/2011
Duration of New Contract:	3 +1 +1 years
Approximate annual value:	
Value of New Contract:	Approximately £480,000 per annum
Lead Officer:	Ashraf Osman / Nicola Hobbs

Division:	Strategy, Commissioning, Performance and Business Support/Personalisation & Business Support Division
Section:	Planning and Commissioning (Housing Related)
Name of Contract:	**Housing Related Support for a range of long term housing related services including, sheltered, alarm provision, supported housing and floating support**
Description of Contract:	As above
Expiry Date of Existing Contract:	31/03/2011
Anticipated Start of New Contract:	01/04/2011
Duration of New Contract:	(future procurement activity to be determined)
Approximate annual value: Value of New Contract:	£4,732,000
Lead Officer:	Jo Clinton/Caroline Ryan

Division:	Strategy, Commissioning, Performance and Business Support/Personalisation & Business Support Division
Section:	Planning and Commissioning (Housing Related)
Name of Contract:	**Domestic Violence Framework Contracts for Housing Related Support**
Description of Contract:	As above
Expiry Date of Existing Contract:	31/03/2012
Anticipated Start of New Contract:	01/04/2012
Duration of New Contract:	(future procurement activity to be determined)
Approximate annual value: Value of New Contract:	£965,639
Lead Officer:	Jo Clinton/Caroline Ryan

Division:	Strategy, Commissioning, Performance and Business Support/Personalisation & Business Support Division
Section:	Planning and Commissioning (Housing Related)
Name of Contract:	**Domestic Violence Contract for Housing Related Support**
Description of Contract:	As above
Expiry Date of Existing Contract:	31/03/2012
Anticipated Start of New Contract:	01/04/2012
Duration of New Contract:	(future procurement activity to be determined)
Approximate annual value: Value of New Contract:	**£132,699**
Lead Officer:	Jo Clinton/Caroline Ryan

Division:	Strategy, Commissioning, Performance and Business Support/Personalisation & Business Support Division
Section:	Planning and Commissioning (Housing Related)
Name of Contract:	**Long-term housing related support contracts including sheltered, supported housing, handy person service, floating support and alarm provision**
Description of Contract:	As above
Expiry Date of Existing Contract:	31/03/2012
Anticipated Start of New Contract:	01/04/2012
Duration of New Contract:	(future procurement activity to be determined)
Approximate annual value: Value of New Contract:	£2,876,292
Lead Officer:	Jo Clinton/Caroline Ryan

Division:	Strategy, Commissioning, Performance and Business Support/Personalisation & Business Support Division
Section:	Planning and Commissioning (Housing Related)
Name of Contract:	**Floating Support Framework Contracts for Housing Related Support**
Description of Contract:	As above
Expiry Date of Existing Contract:	31/03/2012
Anticipated Start of New Contract:	01/04/2012
Duration of New Contract:	(future procurement activity to be determined)
Approximate annual value: Value of New Contract:	£168,772
Lead Officer:	Jo Clinton/Caroline Ryan

Division:	Strategy, Commissioning, Performance and Business Support/Personalisation & Business Support Division
Section:	Planning and Commissioning (Housing Related)
Name of Contract:	**Miscellaneous Floating contracts for Housing Related Support**
Description of Contract:	As above
Expiry Date of Existing Contract:	31/03/2012
Anticipated Start of New Contract:	01/04/2012
Duration of New Contract:	(future procurement activity to be determined)
Approximate annual value: Value of New Contract:	£218,576
Lead Officer:	Jo Clinton/Caroline Ryan

Division:	Safer and Stronger Communities
Section:	Leicester Drug & Alcohol Action Team
Name of Contract:	**Provision of Open Access, Harm Reduction, Substitute Prescribing, Psycho Social Interventions, Inpatient Detoxification and Other Structured Interventions to Individuals with Drug and Alcohol Problems**
Description of Contract:	Service Lot 1: Adult community based drug and alcohol services including open access provision, pharmacy and community syringe distribution stimulant services and specialist prescribing services operating in Leicester.
Expiry Date of existing Contract:	30/06/2011
Anticipated start of new Contract:	01/07/2011
Duration of new Contract:	2 years + 1 year
Approximate annual value:	£1,800,000
Value of new Contract:	(£5.4m 3 years). Please note that 80% of funding for this contract comes from Central government grants and partner contributions which have not yet been confirmed for 2011-12.
Lead Officer:	Ashok Chotalia

Division:	Safer and Stronger Communities
Section:	Leicester Drug & Alcohol Action Team
Name of Contract:	**Provision of Substitute Prescribing, Harm Reduction, Psycho Social Interventions, Inpatient Detoxification and Other Structured Interventions to Individuals with Drug and Alcohol Problems within community and primary care settings**
Description of Contract:	Service Lot 2: Primary Care Services for drugs that will support the development of GP led services in Leicester and includes meeting the needs of offenders accessing the criminal justice pathway across Leicester, Leicestershire and Rutland.
Expiry Date of existing Contract:	30/06/2011
Anticipated start of new Contract:	01/07/2011
Duration of new Contract:	2 years + 1 year
Approximate annual value:	£1,850,000
Value of new Contract:	(£5.55m. 3 years) Please note that 100% of funding for this contract comes from Central government grants and partner contributions which have not yet been confirmed for 2011-12.
Lead Officer:	Ashok Chotalia

Division:	Safer and Stronger Communities
Section:	Leicester Drug & Alcohol Action Team
Name of Contract:	**Provision of Substitute Prescribing, Harm Reduction and Other Structured Interventions to Individuals with Drug and Alcohol Problems within Criminal Justice settings.**
Description of Contract:	Service Lot 4: Criminal Justice Drug and Alcohol services (on behalf of Leicester, Leicestershire and Rutland County Councils) that provide a fully integrated criminal justice service including Prison treatment at HMP Leicester developed out of the Systems Change Programme and will include an end to end alcohol treatment pathway for those whose alcohol use brings them into contact with the Criminal Justice System.
Expiry Date of existing Contract:	30/06/2011
Anticipated start of new Contract:	01/07/2011
Duration of new Contract:	2 years + 1 year
Approximate annual value:	£2,730,000
Value of new Contract:	(£8.19 m 3 years) Please note that 100% of funding for this contract comes from Central government grants and partner contributions which have not yet been confirmed for 2011-12.
Lead Officer:	Bernadette Wharton

Division:	Safer Stronger Communities
Section:	DAAT
Name of Contract:	**Quality of Life Team**
Description of Contract:	Quality of Life Services that will support users into recovery and community integration within Leicester and Leicestershire.
Expiry Date of existing Contract:	New Contract
Anticipated start of new Contract:	01/07/2011
Duration of new Contract:	2 years + 1 year
Approximate annual value:	£461,000
Value of new Contract:	(£1.383 m 3 years) Please note that 100% of funding for this contract comes from Central government grants which have not yet been confirmed for 2011-12.
Lead Officer:	Ashok Chotalia/Alyson Taylor

Division:	Adults and Community/ Safer & Stronger Communities
Section:	DAAT
Name of Contract:	**Young Person's Specialist Substance Misuse Treatment Services**
Description of Contract:	Provision of specialist treatment and professional consultancy relating to young people's Substance misuse.
Expiry Date of existing Contract:	30th June 2011
Anticipated start of new Contract:	1st July 2011
Duration of new Contract:	3 years
Approximate annual value:	£312,000
Value of new Contract:	£936,000 Please note that 80% of funding for this contract comes from Central government grants which have not yet been confirmed for 2011-12.
Lead Officer:	Mark Aspey

Division:	Strategy, Commissioning, Performance and Business Support
Section:	Promoting Independence Unit
Name of Contract:	**687LC Small Works and Minor Adaptations**
Description of Contract:	Supply and fit of minor adaptations in the homes of disabled people.
Expiry Date of Existing Contract:	August 2011
Anticipated Start of New Contract:	September/October 2011
Duration of New Contract:	2 + 2 years
Approximate annual value:	£190,000
Value of New Contract:	£760,000 (based on 09/10 expenditure)
Lead Officer:	ESPO/Andrew Bolstridge/Nilesh Shukla

Division:	Strategy, Commissioning, Performance and Business Support
Section:	Promoting Independence Unit
Name of Contract:	**ESPO Framework Agreement**
Description of Contract:	Supply and installation of stair lifts, vertical lifts, step lifts and ceiling track hoists in the homes of disabled people.
Expiry Date of Existing Contract:	No current contract
Anticipated Start of New Contract:	Unknown
Duration of New Contract:	2 + 2 years
Approximate annual value:	£400,000
Value of New Contract:	£1,600,000 (based on 09/10 expenditure – does not include income received for lift installations)
Lead Officer:	ESPO/Andrew Bolstridge/Nilesh Shukla

Division:	Strategy, Commissioning, Performance and Business Support
Section:	Promoting Independence Unit
Name of Contract:	**364 – Servicing and Maintenance of stair lifts, vertical lifts, step lifts and ceiling track hoists**
Description of Contract:	Servicing and Maintenance of stair lifts, vertical lifts, step lifts and ceiling track hoists installed in the homes of disabled people.
Expiry Date of Existing Contract:	30/04/2012 with a two year options (up to 2014)
Anticipated Start of New Contract:	
Duration of New Contract:	2 + 2 years
Approximate annual value:	£208,000
Value of New Contract:	£832,000 (based on 09/10 expenditure)
Lead Officer:	ESPO/Andrew Bolstridge/Nilesh Shukla

Division:	Strategy, Commissioning, Performance and Business Support
Section:	Service Contracting and Procurement Unit
Name of Contract:	**British Red Cross – Community Assessment Team (CAT)**
Description of Contract:	This supports independent living for adults requiring community equipment services this is a joint LLR contract and will need procuring during 2011.
Expiry Date of Existing Contract:	31/03/2011
Anticipated Start of New Contract:	2011/2012 (future procurement activity to be determined)
Duration of New Contract:	To be determined subject to Personalisation and Business Support review
Approximate annual value:	£96,370 approx per annum Leicester City contribution only
Value of New Contract:	£481,850 approx Leicester City contribution only Full contract value to be determined, involves other partner organisations.
Lead Officer:	Julie Morley/Nilesh Shukla

Division:	Strategy, Commissioning, Performance and Business Support
Section:	Service Contracting and Procurement Unit
Name of Contract:	**British Red Cross – Disabled Living Centre (DLC)**
Description of Contract:	As above (Contract subject to review 2011, future commissioning activity to be agreed after review)
Expiry Date of Existing Contract:	31 March 2012
Anticipated Start of New Contract:	1 April 2012
Duration of New Contract:	3 years + 1 +1
Approximate annual value:	£21,318 approx per annum Leicester City contribution only
Value of New Contract:	£106,690 Leicester City contribution only Full contract value to be determined, involves other partner organisations.
Lead Officer:	Julie Morley/Nilesh Shukla

Division:	Access Inclusion and Participation
Section:	Secondary Behaviour Support Service
Name of Contract:	**Commissioning of Alternative Education Vocational learning Placements with Training Providers**
Description of Contract:	To avoid permanent exclusion of young persons from school, this alternative scheme is readily accessible, high quality, continuum of provision which is initially with the Secondary Behaviour Support Service at one of its Specialist learning Centres (PRUs). Part of exit strategy it often involves these young persons going on a full-time vocational placement (often the case where a return to mainstream school is not deemed either viable or appropriate to the needs of the young person).
Expiry Date of Existing Contract:	New
Anticipated Start of New Contract:	01/09/2011
Duration of New Contract:	2 years +1 +1
Approximate annual value:	
Value of New Contract:	£400,000 per annum
Lead Officer:	John Broadhead

Division:	Learning Services
Section:	ICT Team
Name of Contract:	**VLE (Virtual Leaning Environment) Contract**
Description of Contract:	Provision of VLE services to schools.
Expiry Date of Existing Contract:	31/10/2011
Anticipated Start of New Contract:	07/11/2011
Duration of New Contract:	3 years with an option to extend for 2 years
Approximate annual value:	£250,000
Value of New Contract:	£1,250,000 (maximum)
Lead Officer:	Christine Springett

Division:	Learning Services CYPS
Section:	Removing Barriers
Name of Contract:	**Special Needs Family Support Centre/Carers Support & Toy Library**
Description of Contract:	As above (Contract subject to review 2011, future commissioning activity to be agreed after review)
Expiry Date of Existing Contract:	31/12/2011
Anticipated Start of New Contract:	01/01/2012 (future procurement activity to be determined)
Duration of New Contract:	To be determined subject to Personalisation and Business Support review (approx 3 years)
Approximate annual value:	£15,912 per annum
Value of New Contract:	£45,000 approx. Per Annum (Life of contracts: To be determined subject to Voluntary Sector Contracts review) (Transformation of ASC)
Lead Officer:	Margaret Libreri /Sandra Holyoake

Division:	Strategic Asset Management
Section:	Building Maintenance
Name of Contract:	**Framework for Consultancy Services – Building Surveying**
Description of Contract:	For procurement of building surveyors as required
Expiry Date of Existing Contract:	14 September 2011
Anticipated Start of New Contract:	October 2011
Duration of New Contract:	1 year extension
Approximate annual value:	
Value of New Contract:	£200,000
Lead Officer:	Robin Matthewman

Division:	Property Services
Section:	Building Maintenance
Name of Contract:	**National Schedule of Rates (NSR) – All schedules Minor Improvements Contract (for works > £5k up to £35k in Value of New Contract)**
Description of Contract:	All schedules Minor Improvements Contract. EMPA contract to be utilised.
Expiry Date of Existing Contract:	30/04/11
Anticipated Start of New Contract:	01/05/11
Duration of New Contract:	3 year+ 1 Year
Approximate annual value: Value of New Contract:	£900,000 per annum
Lead Officer:	Robin Matthewman

Division:	Strategic Asset Management
Section:	Projects
Name of Contract:	**EMPA Framework for Professional Consultancy Services only for CONSTRUCTION**
Description of Contract:	For the procurement of construction consultancy services
Expiry Date of Existing Contract:	N/A
Anticipated Start of New Contract:	mid May 2011
Duration of New Contract:	4 Years
Approximate annual value: Value of New Contract:	Call off contract
Lead Officer:	N/A

Division:	Strategic Asset Management
Section:	Projects – Project Management
Name of Contract:	**Provision of Type 2 Asbestos Surveys + Analytical Works**
Description of Contract:	Asbestos Consultants/ Surveyors
Expiry Date of Existing Contract:	25 Aug 2011
Anticipated Start of New Contract:	26 Aug 2011
Duration of New Contract:	3 years
Approximate annual value:	£435,000
Value of New Contract:	£1.3m
Lead Officer:	Cameron Price

Division:	Strategic Asset Management
Section:	Projects - Structures
Name of Contract:	**Demolition Term Contract**
Description of Contract:	Framework for demolition of structures – rate based on volume/materials
Expiry Date of Existing Contract:	28/9/11
Anticipated Start of New Contract:	1 October 2011
Duration of New Contract:	3 Years
Approximate annual value:	£400,000
Value of New Contract:	£1,200,000
Lead Officer:	Hamid Ahmed

Division:	Strategic Asset Management
Section:	Projects - Structures
Name of Contract:	**Soil Investigation Term Contract**
Description of Contract:	Standard Rates depending on level of investigations required
Expiry Date of Existing Contract:	15/10/11
Anticipated Start of New Contract:	16/10/11
Duration of New Contract:	3 Years
Approximate annual value:	£54,000
Value of New Contract:	£160,000
Lead Officer:	Hamid Ahmed

Division:	Strategic Asset Management
Section:	Projects – Building Maintenance
Name of Contract:	**Reactive Maintenance and Minor Building Improvement Contract 2010-12 - Drainage**
Description of Contract:	Maintenance of drainage systems
Expiry Date of Existing Contract:	27/9/10
Anticipated Start of New Contract:	27/9/10
Duration of New Contract:	1 year + 1 year
Approximate annual value:	£150,000
Value of New Contract:	£300,000
Lead Officer:	Robin Matthewman

Division:	Strategic Asset Management
Section:	Projects – Building Maintenance
Name of Contract:	**Reactive Maintenance and Minor Building Improvement Contract 2010-12 - Finishings**
Description of Contract:	Maintenance of all types of floor, ceilings and wall finishes
Expiry Date of Existing Contract:	27/9/10
Anticipated Start of New Contract:	27/9/10
Duration of New Contract:	1 year + 1 year
Approximate annual value:	£375,000
Value of New Contract:	£750,000
Lead Officer:	Robin Matthewman

Division:	Strategic Asset Management
Section:	Projects – Building Maintenance
Name of Contract:	**Reactive Maintenance and Minor Building Improvement Contract 2010-12 - Roofing**
Description of Contract:	Maintenance of all types of Roofing systems
Expiry Date of Existing Contract:	27/9/10
Anticipated Start of New Contract:	27/9/10
Duration of New Contract:	1 year + 1 year
Approximate annual value:	£500,000
Value of New Contract:	£1,000,000
Lead Officer:	Robin Matthewman

Division:	Strategic Asset Management
Section:	Projects – Building Maintenance
Name of Contract:	**Reactive Maintenance and Minor Building Improvement Contract 2010-12 - Glazing**
Description of Contract:	Maintenance of all type of glazing systems
Expiry Date of Existing Contract:	27/9/10
Anticipated Start of New Contract:	27/9/10
Duration of New Contract:	1 year + 1 year
Approximate annual value:	£250,000
Value of New Contract:	£500,000
Lead Officer:	Ro/bin Matthewman

Division:	Strategic Asset Management
Section:	Projects – Engineering Services
Name of Contract:	**Reactive Maintenance and Minor Building Improvement Contract 2010-12 - Electrical**
Description of Contract:	Maintenance of fixed electrical installations to buildings
Expiry Date of Existing Contract:	27/9/10
Anticipated Start of New Contract:	27/9/10
Duration of New Contract:	1 year + 1 year
Approximate annual value:	£600,000
Value of New Contract:	£1,200,000
Lead Officer:	Frank Ellis / Paul Sarson

Division:	Strategic Asset Management
Section:	Projects – Engineering Services
Name of Contract:	**Reactive Maintenance and Minor Building Improvement Contract 2010-12 - Mechanical**
Description of Contract:	Maintenance of fixed mechanical plant & equipment to buildings
Expiry Date of Existing Contract:	27/9/10
Anticipated Start of New Contract:	27/9/10
Duration of New Contract:	1 year + 1 year
Approximate annual value:	£650,000
Value of New Contract:	£1,300,000
Lead Officer:	Frank Ellis/ Paul Sarson

Division:	Strategic Asset Management
Section:	Projects – Engineering Services
Name of Contract:	**Intruder Alarms including Door Entry Systems and Disabled Toilet Arms**
Description of Contract:	Monitoring and servicing of intruder equipment and controls to buildings including Door Entry Systems and Disabled Toilet Arms
Expiry Date of Existing Contract:	Existing contractor is in receivership
Anticipated Start of New Contract:	1st April 2012
Duration of New Contract:	3 years plus option to extend for one year
Approximate annual value:	£288,300
Value of New Contract:	£865,000
Lead Officer:	Frank Ellis/ Paul Sarson

Division:	Strategic Asset Management
Section:	Projects – Engineering Services
Name of Contract:	**Lift monitoring and servicing**
Description of Contract:	Monitoring and servicing of lift equipment and controls to buildings
Expiry Date of Existing Contract:	31st Mar 2012
Anticipated Start of New Contract:	1st Apr 2012
Duration of New Contract:	3 years plus option to extend for one year
Approximate annual value:	£100,000
Value of New Contract:	£400,000
Lead Officer:	Engineering Services Manager/ Frank Ellis

Division:	Strategic Asset Management
Section:	Projects – Engineering Services
Name of Contract:	**Gas boiler servicing and maintenance**
Description of Contract:	Servicing of gas boiler equipment and controls to LCC buildings
Expiry Date of Existing Contract:	30th Nov 2011
Anticipated Start of New Contract:	1st Dec 2011
Duration of New Contract:	3 years plus option to extend for one year
Approximate annual value:	£65,000
Value of New Contract:	£260,000
Lead Officer:	Engineering Services Manager – Frank Ellis/Paul Sarson

---

Division:	Strategic Asset Management
Section:	Projects – Engineering Services
Name of Contract:	**Servicing, maintenance and refurbishment of Air Conditioning, Ventilation Units and Fan Assisted Heating**
Description of Contract:	Servicing, maintenance and refurbishment of Air Conditioning, Ventilation Units and Fan Assisted heating to buildings
Expiry Date of Existing Contract:	31st Mar 2011 (existing contract permits work to be undertaken up to September 2011)
Anticipated Start of New Contract:	September 2011
Duration of New Contract:	3 years plus option to extend for one year
Approximate annual value:	£164,000
Value of New Contract:	£656,000
Lead Officer:	Engineering Services Manager - Frank Ellis

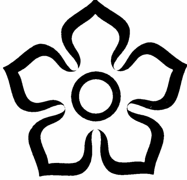
Division:	Strategic Asset Management
Section:	Projects – Engineering Services
Name of Contract:	**Servicing and maintenance of Emergency Lighting**
Description of Contract:	Servicing of emergency lighting equipment and controls to LCC buildings
Expiry Date of Existing Contract:	
Anticipated Start of New Contract:	September 2011
Duration of New Contract:	3 years plus option to extend for one year
Approximate annual value:	£72,000
Value of New Contract:	£288,000
Lead Officer:	Engineering Services Manager – Frank Ellis/ Paul Sarson

---

Division:	Strategic Asset Management
Section:	Projects – Engineering Services
Name of Contract:	**Portable Appliance Testing – ESPO Framework Contract**
Description of Contract:	Testing of Portable Appliances used in LCC buildings
Expiry Date of Existing Contract:	1 Jan 2012
Anticipated Start of New Contract:	2 Jan 2012
Duration of New Contract:	Period to be determined by ESPO – anticipated 4 years
Approximate annual value:	£160,000
Value of New Contract:	£640,000
Lead Officer:	Engineering Services Manager - Frank Ellis

Division:	Strategic Asset Management
Section:	Projects – Engineering Services
Name of Contract:	**Servicing and maintenance of blending and mixing valves**
Description of Contract:	Servicing of blending and mixing valves to hot water and shower installations in LCC buildings
Expiry Date of Existing Contract:	30th June 2010 (existing contract permits work to be undertaken up to September 2011)
Anticipated Start of New Contract:	September 2011
Duration of New Contract:	3 years plus option to extend for one year
Approximate annual value:	£57,500
Value of New Contract:	£230,000
Lead Officer:	Engineering Services Manager/ Paul Sarson

Appendix J



WARDS AFFECTED ALL

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:

Cabinet **11 April 2011**

Reducing the Cost and Use of Agency Staff
(Vacancy Management Service)

Report of the Director of Human Resources

1. Purpose of the Report

1.1 The purpose of this report is to provide Cabinet members with an update on the drive to reduce the cost and use of agency staff throughout the authority during 2010/2011.

1.2 To inform Cabinet members that the same approach has been adopted to manage the cost and use of consultants.

2. Recommendation

2.1 It is recommended that Cabinet note the content of this report and acknowledge the work of the Vacancy Management Service within Human Resources in leading on reducing the reliance on agency workers and the associated costs over the past 12 months

2.2 To inform Cabinet members that a reduced spend of £3.8 million has been achieved in the financial year 2010/2011 compared to the previous year

3. Background Information

3.1 The cost and reliance on using agency staff has been high over the past 3 years and last year(financial year 2009/10) the cost of hiring agency workers was £18 million. In March, 2010, a Vacancy Management Service (VMS) was created in Human Resources. The VMS is now a gateway for the procurement of all temporary staff, ensuring robust governance and monitoring arrangements are in place and adhered to when managers require temporary workers. It seeks to challenge, control and reduce agency workers costs by exploring alternative options to agency procurement.

3.2 The VMS has brought together the procurement of all temporary staffing resource across the authority and resides in the Employment Service Centre along side the Recruitment service. This now includes the agency vender neutral contract client management function (Beeline), the internal temporary staffing agency (TSA) and from November 2010 the control and procurement of consultants. This ensures these services continue to make the necessary improvements, including adherence to the new agency staff governance arrangements.

3.3 With the introduction of a VMS a spend reduction of £1m was set for 2010/11 and 2011/12. This has already been significantly exceeded with a reduction in agency spending of £3.8 million achieved through these governance arrangements. Not all of this money results in cash savings: it is an indication of reduced agency spend only.

3.4 In September 2009, the Council undertook a review of its agency worker procurement process. The review revealed a number of areas for improvement, in particular the need for tighter control and governance arrangements in relation to the procurement of agency workers. The vacancy management process is linked to the new governance arrangements for agency staff under which there is a challenge process before managers are allowed to engage agency staff and the duration of approval is limited and subject to review.

3.5 To address and deliver the above areas for improvement, the new VMS has established effective and efficient control measures. The service has brought together, in one location, the management of all vacancies – temporary, permanent, agency and the TSA (Temporary Staffing Agency) and latterly consultants into a single function, overseen by the Vacancy Management Officer

4. Governance Arrangements

4.1 The Vacancy Management Service (VMS) has introduced new governance arrangements which have brought clarity, consistency, challenge and control to the procurement of temporary staff. These arrangements were critical to the success of the new service and include:

- Tight control of temporary staffing costs to ensure value for money and to achieve reduction in spend.

- Establishing clear lines of responsibility and accountability by developing and implementing a tight approval procedure for staffing requests, which will include the need for a business case to justify requests for non 24/7? statutory staff cover.

- Established a regular reporting pattern to the ODI board and the provision of monthly management information to divisional directors to aid management decisions.

- Developing cost-effective alternative recruitment and staffing options to fill vacancies eg.
    - Use of graduates on the Council's Graduate Trainee Scheme and the Graduate Talent Pool
    - Establishing casual staff pools for various services within the authority, eg operational transport, craft operatives, care workers.
    - Sharing resources
    - Offering short, time limited temporary contracts to existing staff, particularly staff who are currently on redeployment

- Prompt escalation of concerns to Divisional Director level and/or the ODI board where necessary.

4.2 The current internal Temporary Staffing Agency (TSA) provision has been incorporated into the new VMS and this service will be reviewed to assess its effectiveness with a view to restructuring it to ensure a more streamlined service.

4.3 It is important to note that although the remit of the VMS is primarily to control temporary worker procurement it is also the intention to deliver a flexible non-bureaucratic service to meet the varying needs of the divisions e.g. 24/7 and frontline statutory services to ensure staffing levels are maintained at an appropriate level.

5. The Benefits of the Vacancy Management Service (VMS)

5.1 The controls and governance arrangements put in place by the VMS has now been adopted across the authority for procuring consultants.

5.2 Details of the success of the VMS over the last 12 months can be found on the following appendices
- **Appendix 1** - Agency worker spend for financial years 2009/10, 2010/11 and a projected spend for 2011/2012
- **Appendix 2** - Agency worker headcount for financial years 2009/10, 2010/11 and the projected numbers for 2011/12

5.3 Managers now have one central point of contact for advice and guidance on temporary resources. Hiring managers and divisional directors are accountable and where necessary challenged where necessary.

5.4 The VMS works with some service manager to ensure the governance arrangement put in place do not impact on statutory services to ensure service delivery is not put at risk.

5.5 The reduction in the use of agency workers has been acknowledge by Trade Unions, especially by creating opportunities for redeployees' and offering temporary contracts where ever possible .In some circumstances this also reduces and or delays the need for redundancy payments and helps to create a more flexible workforce.

6. Financial Implication

6.1 The cost of establishing the Vacancy Management Service is £42k per annum. This covers the salary cost of the post of Vacancy Management Officer. This post holder oversees the service outlined in the report.

6.2 In the first year the VMS has achieve, with the co-operation of managers and directors a reduction in spend of £3.8 million.

7. Legal Implication

Legal Services have been involved in advising the VMS on individual agency workers claims that due to employment practise they could have accrued employment rights with the authority. This has meant assessing each claim separately and due to the complex nature has taken time to complete, but this has resulted in no agency workers been given a automatic right to a job.

9. Author

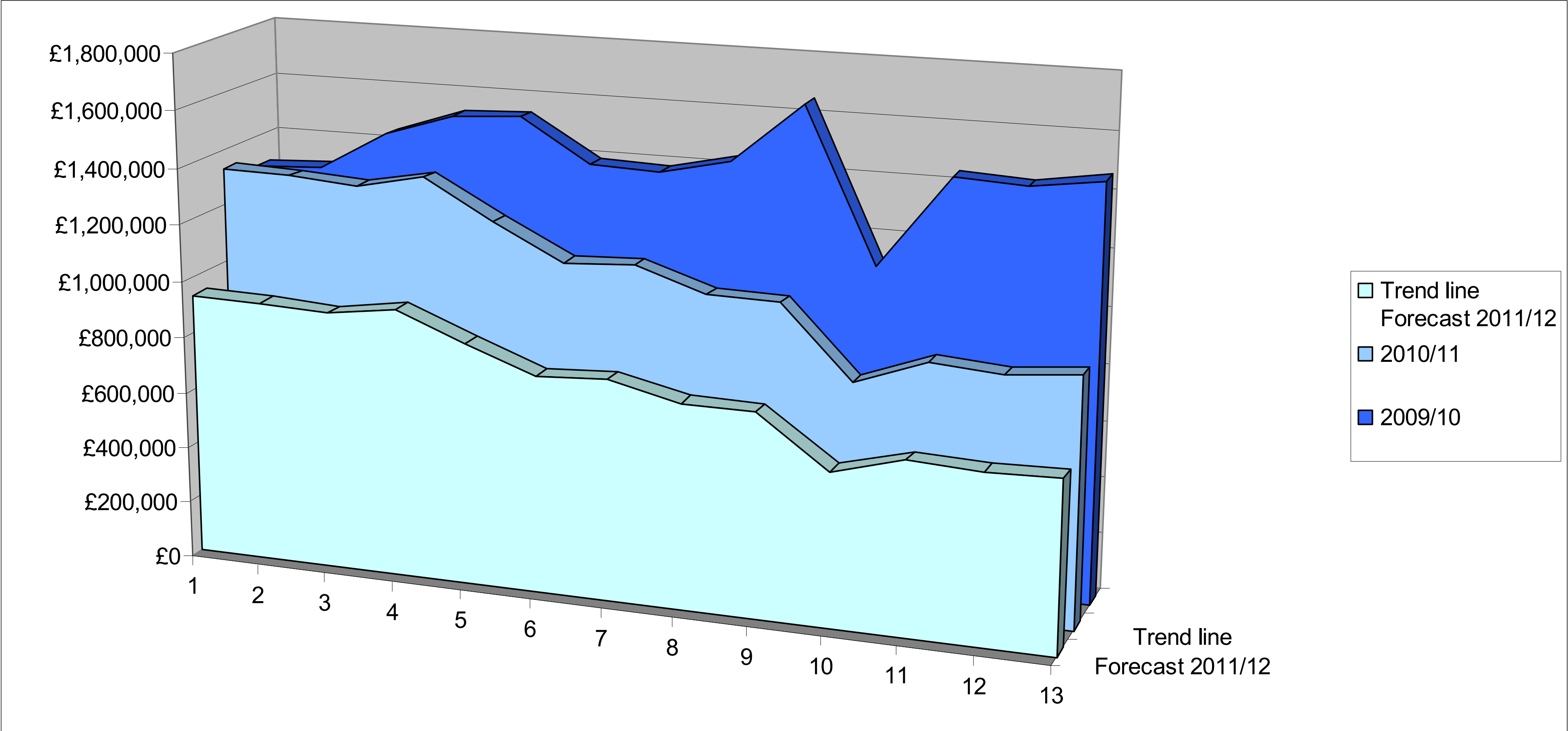
Enid Grant
Head of Employment Services
HR Division

Ext no 39 5000 (Internal) 2995000 (External)

Key Decision	No
Reason	N/A
Appeared in Forward Plan	N/A
Executive or Council Decision	Executive (Cabinet)

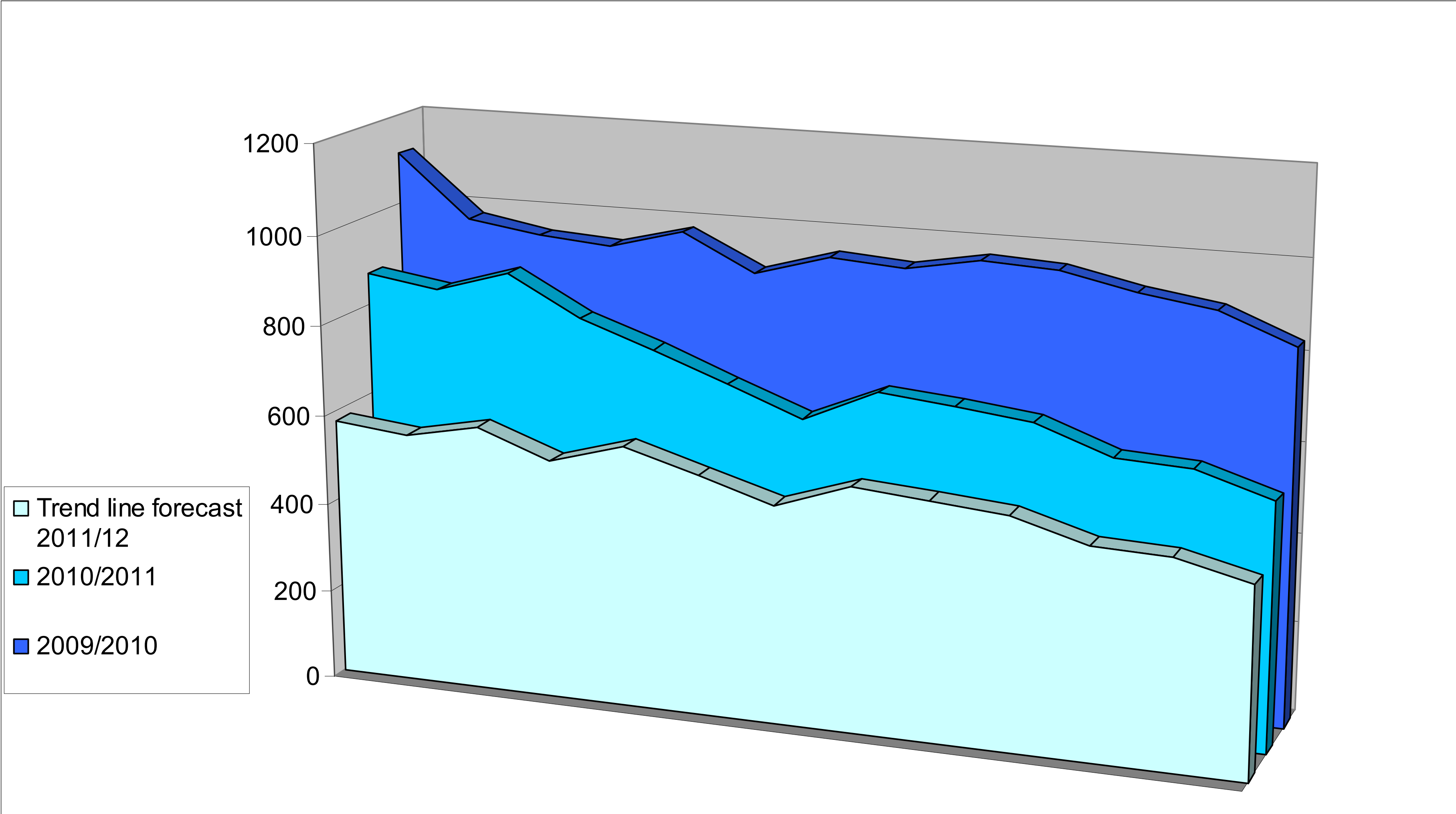
Appendix 1

Agency Spend per year, included estimated spend for 2011/2012



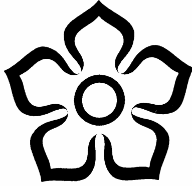
Appendix 2

Agency workers – Headcount, including estimate for 2011/2012



This page is left blank intentionally.

Appendix K



WARDS AFFECTED
All

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:
CABINET **11 April 2011**

BME Workforce Task Group: Improving BME Senior Management Representation

---

Report of the Director of Human Resources

1. Purpose of Report

1.1 The report sets out the investigation and findings of the cross party BME Workforce Task Group into the issue of low BME Senior Management representation within the Council.

1.2 The report presents the Task Group's recommendations for action to be taken by the Council in seeking to improve BME Senior Management representation.

2. Recommendations

2.1 Cabinet is asked to support the following recommendations for action proposed by the BME Workforce Task Group:

(a) That the Director of Human Resources amend the Recruitment Procedure in regard to panel members for appointments to managerial and professional posts: from a minimum of 2 members to a minimum of 3 members, and that there should be balanced panels (in terms of representativeness of its members).
(b) That the Director of Human Resources revises the process for Member appointment panels to ensure that Members are involved at an early stage and receive the appropriate training.
(c) That the Black Workers Group conducts a follow up survey to their 2009 BME staff survey and that they receive organisational support in its delivery and analysis.
(d) That a Strategic Director be identified as a corporate equalities champion.
(e) That a new Standing Equalities Task Group be established to enable Members to have an inclusive overview of equalities practice across the Council's business processes.

3. Report

3.1 Background

3.1.1 The cross party Task Group was established to look into the issue of Black Minority Ethnic (BME) under-representation in senior management positions (non-schools), raised as an issue of concern at the 25 November 2011 Council meeting during discussion of the Corporate Equality Strategy.

3.1.2 The Chair of the Task Group is the Cabinet Lead for Community Cohesion and Human Resources, and the Task Group consists of six Members and four community representatives. Two representatives from the Black Workers Group were invited to join part way through its cycle of meetings. The Task Group has met since 10 January 2011 and has been supported by officers from Strategic Human Resources, the Employment Service Centre and Corporate Equalities.

3.2 Evidence considered

3.2.1 The Task Group received briefings and documentation on the Council's current recruitment policy and practice. This included the new Recruitment Policy and Procedure, a presentation on the new Recruitment website, the 2010 Employment Monitoring Report, and data on recent secondments and acting up opportunities. It also received briefings on Employment Service Centre support in the recruitment of senior management positions and practice followed in the most recent senior management appointments.

3.2.2 Briefings on proposals for the Workforce Plan and its talent management strategy were also provided.

3.2.3 Representatives from the Black Workers Group presented the findings of their 2009 BME Staff Survey in order to provide a staff perspective to the issue of senior management under-representation.

3.3 Discussion and findings

3.3.1 The Task Group considered the composition of recruitment panels as recommended in the Recruitment Procedure. They recommended that changes be made to recruitment panel representation to remove potential barriers for BME candidates and have a more robust process by increasing minimum panel numbers from 2 to 3 members for management and professional appointments, and that there be a balanced panel (in terms of representativeness of its members).

3.3.2 The Task Group also discussed Members' experience of their involvement in senior management recruitment panels. They agreed that improvements could be made to strengthen the role of Members in the recruitment process. This included involving Members in the recruitment process from the very beginning, enabling them to scope the recruitment search, as well as providing training for Members so that they knew their responsibilities throughout the process. The Task Group acknowledged the need to raise Member profile and importance of recruitment panels as compared to appeals panels.

3.3.3 The Task Group acknowledged that for now, the Council will have to search for external BME candidates to improve senior management representation. However,

their recommended longer term approach was to develop a BME talent pool for promotion as part of the Council's talent management strategy.

3.3.4 Members of the Task Group considered the evidence presented regarding recruitment trends and the data on secondments and acting up opportunities. Their view was that the evidence indicated a definite difference between the outcomes for BME and non-BME candidates, and that further analysis was required to unpack and better understand the reason for this difference. Suggestions for the Employment Monitoring Report to contain more detailed analysis of recruitment outcomes by gender as well as ethnicity were made to enable the Council to better track and understand the outcomes being achieved.

3.3.5 The Task Group supported the survey work undertaken by the Black Workers Group and recommended that the survey be carried out again as soon as possible for the Council to be able to continue to track and respond to BME staff perceptions over time. They agreed that the next survey should include BME staff working in schools. The Task Group discussed resourcing the next survey, and supported the Black Workers Group's request for organisational support in the delivery and analysis of the survey.

3.3.6 All members of the Task Group felt that the profile of equalities needed to be raised within the Council. They recommended that a Strategic Director be given responsibility as a corporate equalities champion. They also recommended that a new Standing Equality Task Group be established, responsible for taking an inclusive overview of equalities practice across the Council's business processes, taking on board equality issues that Members would wish to raise for their consideration. The membership of the new Task Group would need to be considered by Members in liaison with the Chief Executive and refreshed after the elections in May.

3.3.7 Cabinet are asked to support the following recommendations of the BME Workforce Task Group:

(a) That the Director of Human Resources amend the Recruitment Procedure in regard to panel members for appointments to managerial and professional posts: from a minimum of 2 members to a minimum of 3 members, and that there should be balanced panels.
(b) That the Director of Human Resources revises the process for Member appointment panels to ensure that Members are involved at an earlier stage and receive the appropriate training.
(c) That the Black Workers Group conducts a follow up survey to their 2009 BME staff survey and that they receive organisational support in its delivery and analysis.
(d) That a Strategic Director be identified as a corporate equalities champion.
(e) That a Standing Equalities Task Group be established to enable Members to have an inclusive overview of equalities practice across the Council's business processes.

4. FINANCIAL, LEGAL AND OTHER IMPLICATIONS

4.1. Financial Implications

There are no direct financial implications arising from this report.

Alison Greenhill, Interim Chief Accountant

4.2. Legal Implications

The Council must ensure that it acts within the parameters of the Equality Act 2010. This is particularly important in relation to the proposal to have a BME talent pool for promotion. The Council is legally required to appoint on merit.

There is no legal necessity for recruitment panels to be balanced in terms of representativeness.

Kate James, Solicitor

4.3 Climate Change Implications

This report does not contain any significant climate change implications and therefore should not have a detrimental effect on the Council's climate change targets.

Helen Lansdown, Senior Environmental Consultant - Sustainable Procurement

5. Other Implications

OTHER IMPLICATIONS	YES/ NO	Paragraph/References within the report
Equal Opportunities	Yes	Throughout
Policy	No	
Sustainable and Environmental	No	
Crime and Disorder	No	
Human Rights Act	No	
Elderly/People on Low Income	No	
Corporate Parenting	No	
Health Inequalities Impact	No	

6. Background Papers – Local Government Act 1972

Recruitment Policy and Procedure
2010 Employment Monitoring Report

Resourcelink data
15 February 2010 Cabinet Report: Black Workers Group Report 2009

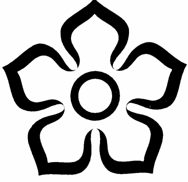
7. Report Author

Irene Kszyk
Head of Equalities
Ext. 391624
Irene.Kszyk@leicester.gov.uk

Key Decision	No
Reason	N/A
Appeared in Forward Plan	N/A
Executive or Council Decision	Executive (Cabinet)

This page is left blank intentionally.

Appendix L



WARDS AFFECTED
All Wards

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:

OSMB	**7th April 2011**
Cabinet	**11th April 2011**

New Affordable Housing for Leicester 2011-2015

Report of the Director Housing Strategy and Options

1. Purpose of Report

1.1 To seek decisions on how the Council wishes to respond to the Government's new approach to enabling new affordable housing as set out in its "2011-15 Affordable Homes Programme Framework". **The Homes and Communities Agency deadline for receipt of "offers" to deliver affordable housing for the next 4 years is May 3rd.** These offers will need to specify the level of HCA subsidy required.

1.2 This framework provides the only opportunity to seek subsidy to develop affordable housing for the next four years. Although some details and issues are still not clear, it is crucial that Housing Associations and the Council meet this deadline or opportunities will be closed off. The Council will not be asked to enter into a binding contract until the final HRA settlement is confirmed, which is likely to be around January 2012.

2. Recommendations

2.1 That Cabinet confirms the affordable housing needs of the City for the period 2011-15 (Appendix 1).

Recommendations for Guidance to Housing Associations

2.2 That Cabinet confirms previous decisions on the principle of discounted sale of land at Saffron Velodrome and Whittier Road to appropriate Housing Associations (Appendix 2), subject to further reports being brought to Cabinet outlining the detailed terms of any proposed disposal.

2.3 That Cabinet agrees, in principle, to the discounted sale of the site at Conduit Street to an appropriate Housing Association, subject to a further report being brought to Cabinet outlining the detailed terms of any proposed disposal (Appendix 2).

2.4 That Cabinet agrees the principle of disposal of appropriate HRA sites at a nominal sum to assist in facilitating affordable housing development by HAs, subject to further reports being brought to Cabinet for approval outlining the detailed terms of any proposed disposal. (Appendix 3)

2.5 That Cabinet agrees the principle of the proposed disposal of the affordable housing elements of larger corporate sites as identified in appendix 3 for a nominal sum to assist in facilitating affordable housing development by HAs, subject to further reports being brought to Cabinet for approval outlining the detailed terms of any proposed disposal. (Appendix 3)

2.6 Should the Council decide not to make an offer to build new Council homes or if the Council's offer is not accepted, Cabinet agree, in principle, to the discounted sale at £1 of the sites at Hamelin Road and Saffron Depot to appropriate Housing Associations, subject to further reports being brought to the Cabinet outlining the detailed terms of any proposed disposal. (Appendix 3)

2.7 That Cabinet considers the principle of a discounted sale of further land at Mundella, Laburnum Avenue, Manor Farm and Benbow Rise or its use for Council building. This would form a second phase of affordable housing at those locations effectively extending the provision beyond planning requirements being sales at less than best consideration and providing a loss of opportunity to achieve capital receipts to the Council from the alternative of sale for private housing. (Appendix 3 and Paragraph 7.10). Officers shall explore the opportunity for netting off this cost against other sites.

3.0 Summary

3.1 The Government has introduced a new approach to providing subsidy for new Affordable Housing, set out in "2011-15 Affordable Homes Programme Framework" (Department of Communities and Local Government and Homes and Communities Agency). The system will be administered, as now, by the Homes and Communities Agency (HCA).

3.2 Developers, including Councils and Housing Associations must submit "offers to develop" to the HCA by May 3rd. Offers which the HCA consider to be value for money and which Councils confirm meet their identified needs will be awarded a 4 year framework contract.

3.3 If we are to continue to enable even a small amount of new affordable housing in Leicester, the Council will need to accept that Housing Associations will charge Affordable Rents on their new build and some of their relets.

3.4 The Council needs to decide if it wants to submit an offer to deliver more new Council houses and/or to fund conversions and extensions which will help reduce overcrowding. The implications of this are set out in a separate confidential report on this agenda.

3.5 The Council needs to indicate its likely attitude to disposing of land at a nominal sum to Housing Associations for the development of affordable housing over the next 4 years.

3.6 With the housing market continuing to be slow, it is unlikely that there will be a significant amount of S106 affordable housing completions over the next four years. That means that Leicester's likely volume of affordable housing opportunities/outcomes will largely reflect the schemes/sites put forward by Housing Associations and the Council. If funding is secured for the sites already owned by the HAs and the Council owned sites listed in appendix 3, Leicester could see at least 300 new affordable housing completions between April 2011 and March 2015 (the final figure depends on both the amount of HCA subsidy/outputs that successful partners expect to deliver in

Leicester and the success of the Council in bringing forward the sites/opportunities listed in appendix 3 early enough). This would be less than half the amount delivered in the last four years, and is by no means certain.

3.7 This report proposes that the Council indicates to Housing Associations that in principle some discounted land will be made available over the next four years. The HAs need this indication now in order to develop their Business Plans and make offers to develop.

4. Background

4.1 Except where a private developer under a S106 Agreement provides sufficient cross subsidy, affordable housing will require public subsidy. This is usually provided by grant aid from the Homes and Communities Agency (HCA), and often through sale of land at a nominal sum. The balance of the development costs is met by the Housing Association (or by the Council for our own new homes) through borrowing. Repayment of the loan can then be made from rents. Sometimes a Housing Association will also put in capital resources from their reserves, etc.

4.2 The HCA's national 'pot' for grant aid will be 50% less than over the previous 4 years, and 50% of that is already committed. Ministers want to make it go further by reducing the amount of grant for each scheme. There will be no local, sub-regional or regional allocation of grant. Allocations will be made for a 4 year broad programme of affordable housing outputs to Developers, Housing Associations and Councils who "offer" the best value for money. There will be no consideration of individual scheme/site bids outside of these offers of broad programmes.

4.3 In the years April 2008 – March 2011, the Council enabled the completion of 670 new affordable homes. Funding has been secured for a further 242 to be completed in 2011/12. (The completion of the 146 new Council homes is included within these figures) Only 2 new affordable homes are secured so far for 2012/13.

5.0 The New Framework

5.1 The elements of the new system, which is broadly the same for both Housing Associations and Councils who wish to build, are as follows:

Affordable Rent

5.2

- An affordable rent will be greater than a social rent and *up to* 80% of the gross market rent (ie including any service changes).
- The HCA would wish to 'explore' reasons why it should be less than 80%.
- Market rent will be determined *for each property type on each site* individually using RICS valuation methods. The difference between an affordable rent and a social rent will therefore vary across the City.
- Housing Benefit payments for Affordable Rent will be based on the actual rent charged (ie not subject to Local Housing Allowance rules). Where tenants are eligible for Housing Benefit it will continue to be paid in full subject to the means test, in the same way as for social rented properties at present.

- Affordable Rent rises will not be part of rent restructuring, but will rise at RPI + 0.5%.
- The Government propose that Affordable Rent is a form of social housing for planning purposes.
- The Affordable Rent properties will be nominated to or allocated using the Council's Housing Allocation Policy and advertised on HomeChoice. Prospective tenants will therefore know the rent charged when they express an interest (bid).
- The element of increased income from Affordable Rent must be used to fund that scheme or further new Affordable Rent units (or conversions, extensions or other agreed developments).
- Only partners (HAs and LAs) which are successful at securing contracts with the HCA to provide new affordable housing will be able to charge Affordable Rent. HAs and Councils which do not submit offers to the HCA or do not have their offer accepted by the HCA cannot charge Affordable Rent on any of their housing stock.
- Councils who convert to Affordable Rents will still retain the option of offering lifetime tenancies (ie do not have to use new powers to offer "flexible" short term tenancies).

5.3 **Affordable Rents on New Build**

In order to reduce the amount of grant needed on each scheme the HCA **expects** that the new properties will be let at the new "Affordable Rent" (social rents will only be possible in limited circumstances, eg where existing tenants are returning to a regenerated estate).

Affordable Rents on Relets

5.4 The HCA also expects Housing Associations and Councils who wish to develop to "convert" a proportion of existing social rented properties to Affordable Rent when they become vacant and available for reletting. The Council or RSL will need to use the additional rent to finance the new supply.

5.5 It seems most unlikely that any schemes will be funded via the HCA in the City without using the new Affordable Rent for both new build and relets.

5.6 Under this new approach, there is no guarantee of new HCA funded affordable housing within any particular local authority area. Therefore, successful HA partners may need to charge affordable rent on an agreed proportion of their relets in Leicester, but their new supply might be outside of Leicester. The City Council has no power to prevent HAs from doing this.

Making an "Offer" to deliver new affordable homes.

5.7 Any provider (Council or Housing Association) submitting an offer to the HCA must clarify which geographical area(s) their offer covers. The HCA has identified the level at which such geographic areas should be identified. Leicester City is within the area defined as the Leicester, Leicestershire and Rutland Housing Market Area. Offers only need to identify the local authority area and site where firm schemes are included. Otherwise, the offers to be made to the HCA by May 3rd can be to deliver a stated

number of affordable homes over the whole of the next 4 years across Leicester, Leicestershire and Rutland.

5.8 There is £2.2bn available nationally. The bulk (£1.8bn) of the available money is for new affordable homes (including supported housing). There is also money for Mortgage Rescue (£0.22bn), Empty Homes (£0.1bn), Homelessness Change Programme (£0.03bn) and Traveller Pitch funding (£0.06bn). "Offers" will need to set out the number and type of homes that the provider can deliver and how value for money will be achieved by using affordable rents, land and any other resources available to the provider and what funds are required from HCA. The HCA will then enter into a framework contract in a standard form required by the HCA for the delivery of that supply. At the time of writing a copy of the contract has not been issued.

5.9 If the Council wants to continue building or bid for subsidy for conversions, extensions or travellers pitches it must submit its offer by May 3rd. However, the HCA does not expect the Council to enter into a framework contract until after the final HRA settlement and borrowing headroom is confirmed later in 2011/12. For a Council contract, start on site would begin after April 2012 and 'converted' Affordable Rents would start on the number of relets which were agreed in the contract.

6.0 Affordable housing needs for 2011-15

6.1 The Council must let the HCA and potential developers know the City's needs for the next four years and the types of development the Council will support. This can be fairly specific for the first two years and more general for the last two years. The broad needs have already been agreed by the Leicester and Leicestershire Leadership Board and set out in the Leicester and Leicestershire Investment Plan (although this is not binding). Appendix 1 summarises the needs.

6.2 Provision of affordable housing for vulnerable groups underpins many of the Council's other policies and aspirations for the City.

7.0 Council Guidance to Housing Associations

7.1 More detailed information is needed by Housing Associations who propose to submit offers to develop where their business plan envisages some of that development being in Leicester.

7.2 Housing Associations need to describe numbers and types of affordable rent homes that they propose to develop and what subsidy they require. In order to prepare their business plans they need some indication of the resources they can expect from Councils.

7.3 Housing Associations have asked what the City Council's stance will be towards seeking developer contributions from Housing Associations' future new affordable housing schemes. Officers have informed them that at Leicester, the Planning Authority makes its decision on required developer contributions (eg for infrastructure, open space, education, etc) when considering each individual planning application against the Council's approved policies including, where relevant, its impact on the viability of the scheme. Housing Association schemes are treated this way.

Identified Housing Association Schemes

7.4 Housing Associations already own 64 plots in the City which we expect them to include in their offers and which they would hope to build out in the first two years. To build more they will need to acquire land from the Council and/or acquire land or buildings on the private market (eg within the Leicester Regeneration Area). The HCA own some land in Waterside Area, however, it is not expected to be developed within this plan period. Officers are asking HCA how they will deal with their land.

7.5 The Council has already agreed in principle to dispose of areas of land for a nominal consideration by way of Council contribution to enable provision of Affordable Housing. RSLs have invested resources in developing schemes in response to this. (See Appendix 2)

The Council has been asked if it will, in principle, be prepared to continue to make this land available in the event that they submit offers under the new framework which will rely on Affordable Rents.

Future Discounted Land and release of parts of larger sites

7.6 For a number of years, the Council has sold HRA land at a discount (usually, but not always, for £1) to enable affordable housing. In response to the previous Government's additional investment known as the Housing Pledge the Council built on 146 plots of its own land and also disposed of discounted land on parts of larger sites to 2 Housing Associations providing a further 63 plots. It is recommended that these principles be used on other suitable HRA and corporate sites subject to further reports to Cabinet for approval when terms for individual sales agreed.

This approach maximised HCA and RSL investment in the City.

7.7 The contribution of the Council by way of the provision of land for the development of affordable housing would be likely to make an HAs overall offer more competitive, making it more likely they would be successful in obtaining a contract. Further, the guidance to authorities as set out in the Government's Framework, envisages that the Council will be receptive to using land identified as suitable for the development of affordable housing, when entering into dialogue with HAs in formulating their bids. However, there are many other variables that would need to be taken into consideration in respect of the formulation of bids, including which existing stock they choose to "convert" to affordable rents and where they choose to invest the proceeds.

7.8 Cabinet will recall the recent examples at Manor Farm and Benbow Rise where corporate land has been sold at a discount to HAs to enable development of affordable housing. These examples are where the Council owns a larger housing site and the release of the affordable element, in accordance with planning policy, has allowed early start on site, has opened up the sites with infrastructure and enables the Council to sell the balance of the site for private housing without detriment to the overall receipt expected for the site in the future. These sales have resulted in 63 new affordable homes being commenced.

7.9 To enable HAs to make as successful a bid as possible, it is now recommended that the principles involved in previous disposals of the affordable housing elements of larger development sites are agreed for other suitable sites (as identified in Appendix 3). Disposals could be for a nominal sum where the affordable housing provided is in accordance with planning policy and the sale is not detrimental to the total receipt

anticipated across the whole site, and the land would constitute the Council's contribution to the development of affordable housing. The detailed terms of proposed disposals on each site will be brought to Cabinet for decision. Cabinet will also be able to take into account, for each site, the capital implications of sharing of infrastructure costs (to be paid on sale of the balance of land or a long stop date) and other relevant issues.

7.10 The progress of the affordable housing schemes at Manor Farm and Benbow Rise and the Council houses at Mundella and Laburnum Avenue has opened up the remainder of the sites for private housing for which outline planning consent exists. It is intended that this land be marketed when the market improves and receipts in the region of £750,000 per acre could be anticipated. However there is the potential that the Council could allow HAs to bid for an extension of the affordable housing in these locations which the infrastructure that has been provided would make practically quite straight forward to achieve. Sale of this land at a discounted rate would be at actual financial loss to the Council and would result in the overall sites having a total of affordable housing in excess of planning requirements. This imbalance could then also impact on receipts for the sale of the remainder. Cabinet are therefore asked to consider the principle of including these sites into the bidding process in the light of the financial implications. Should the principle be accepted then the terms of any sales would be subject to a further Cabinet report. Officers will explore opportunities for netting off this cost against other sites.

7.11 Appendix 3 sets out identified Council land that is allocated for residential use that would be developable over the next 4 years and recommends how we use that land.

8.0 HCA subsidy on S106 sites

The HCA has confirmed its expectation that S106 schemes can be delivered with no HCA subsidy for affordable housing. The amount of affordable housing on private developments will therefore depend on the viability on each site, which will be determined when individual planning applications are made.

If HCA funding is requested on S106 sites, the HCA would expect to see evidence that its funding would result in the provision of additional affordable housing which would not otherwise be delivered, including evidence from the local Planning Authority's viability assessment.

9. <u>FINANCIAL, LEGAL AND OTHER IMPLICATIONS</u>

9.1 **Financial Implications** Rod Pearson, Head Finance (Health & Wellbeing) Ext 29 8800, Graham Troup, Principal Accountant Ext 29 7425 and for para 9.1.5 Nick Booth, Principal Accountant Ext 29 7460

9.1.1 The report gives details of the Government's new approach to facilitating new affordable housing over the period 2011-2015.

9.1.2 Capital receipts from the sale of housing land are 100% reusable to finance the City Council's capital expenditure, and are currently used towards the financing of the Housing General Fund Capital Programme. This includes Disabled Facilities Grants where there is currently a substantial backlog. Therefore, in agreeing any proposals to

offer land to Housing Associations at a discounted or zero cost, Members should be aware that there will generally be an "opportunity cost" in depriving the Housing General Fund Capital Programme of the foregone value of the land, particularly since the Government is no longer providing any grant-support for the private sector decent homes programme after 2010/11. The alternatives should be considered before any decision is taken to discount land for affordable housing purposes.

9.1.3 A separate report gives details of the support that may be available from the Homes & Communities Agency (HCA) towards local authority new builds (or conversions) under the new arrangements. In general, the level of capital grant will be substantially less than that received on the current new build schemes, although viability will be improved by the HCA requirement for "affordable" rents (ie 80% of market rents on comparable properties) to be charged on the new properties. Also, subject to HCA agreement, local authorities will be able to charge "affordable" rents (or some other level of rent above standard HRA rents) on properties in the general HRA stock when they are relet, in order to further improve the viability of new build projects.

9.1.4 A number of illustrations of possible new build or conversion schemes are given in a separate report, along with details of the impact on HRA rents of various options. It should be noted that full details of the new "self-financing" system for the HRA (effective from 2012/13) are still awaited, and no commitments on the HRA should be made until these have been fully evaluated.

9.1.5 The capital receipt from the Queensmead site has been earmarked towards the CYPS capital programme which has already been committed.

9.2 **Legal Implications** John McIvor, Team Leader, ext 297035 (Property & Development), Legal Services

9.2.1 As explained in the body of the Report, the Affordable Housing Programme makes significant changes to the procedure for making applications for funding, and in respect of the levels of rent that may be charged. In particular, the Council will need to have regard to the requirements of Section 5 (Programme Requirements), and 6 (Programme Management) in considering any proposals for funding bids. Although a copy of the standard contract has not been received, careful consideration will need to be given to the terms of the contract once it is available, and the potential implications for the Council, especially in respect of any potential clawback provisions.

9.2.2 The Report sets out the approach that local authorities may wish to adopt when considering supporting bids by HAs. The Council should consider this in the light of its general strategy and programme of asset management and disposals, and in particular the Framework for the Disposal of Property adopted by the Council in 2003. The Council will also have to have regard to its general fiduciary duty to its taxpayers, and any relevant procurement rules. With regard to the proposed disposals referred to in Recommendation 2.7, Members will have to consider whether or not the potential loss of the capital receipt as outlined in paragraph 7.10 is in the interests of the Council, having regard to all the circumstances of the matter at the time that any formal report is presented, and with regard to the advice contained in any future report. The Council will also need to be satisfied that the site is suitable for use as affordable housing in planning terms.

9.2.3 In considering a proposed disposal of land for a nominal consideration as outlined in the Report, The Council will need to have regard to the relevant powers of disposal. Under the terms of s.123 of the Local Government Act 1972, the Council is required to obtain the best consideration reasonably obtainable. The Government has however issued the following General Consents:-

(a) The 2003 General Consent permits the sale of land at less that best consideration, where the authority thinks that the proposed disposal will contribute to the social, economic and environmental well-being of the authority's area.

(b) The 2005 Housing General Consents permit the disposal of HRA land, for which the prior consent of the Secretary of State is not required for disposal.

Officers will need to consider and to identify whether these Consents will apply to proposed disposals.

9.2.4 Officers will need to ensure that the terms of any land transactions contain appropriate provisions for the protection of the Council's retained land, particularly in respect of the disposal of the affordable housing elements of larger development sites.

9.2.5 Officers in Legal Services will continue to work with and to provide advice to officers in respect of the legal issues arising from the Programme, and in respect of the proposed land disposals outlined in the Report.

9.2.6 Of particular relevance to land and property disposals are Sections 5.12 and 13. These state that providers should work in partnership with public sector landowners to deliver affordable housing. In particular, providers may wish to look for opportunities to enter into long-term arrangements with public sector landowners to build out their land banks. Providers carrying out developments on land owned by the public sector should aim to minimise other forms of subsidy such as HCA funding. Where a public body is unwilling or unable to transfer the land for free or for a nominal capital receipt, then it should be willing to share in the risks of development, with the deferred value to be realised over the lifetime of a project. However it should be stated that these proposals will need to be considered in the light of the authority's own strategy for asset management and disposal.

9.3 **Climate Change Implications**

Increasing the number of homes in Leicester will inevitably lead to an increase in city-wide carbon emissions. However, if the decision is taken to develop new housing measures can be taken to try and minimise the carbon emissions generated by these homes. Previous projects completed with HCA subsidy have been required to meet level 4 of the Code for Sustainable Homes (assessing the sustainability of a home against 9 areas including energy/CO2) which goes some way towards ensuring that carbon emissions are kept to a minimum.

Helen Lansdown, Senior Environmental Consultant - Sustainable Procurement

9.4 **Other Implications**

OTHER IMPLICATIONS	YES/ NO	Paragraph/References Within the Report
Equal Opportunities	NO	
Policy	YES	Throughout
Sustainable and Environmental	YES	10.3
Crime and Disorder	NO	
Human Rights Act	NO	
Elderly/People on Low Income	YES	Appendix 1. (Extra Care) and throughout. Affordable Housing is provided for those who find it difficult to access market housing
Corporate Parenting	NO	
Health Inequalities Impact	YES	Appendix 2. The reduction of severe overcrowding is an action within the Health Inequalities Plan

10. Background Papers – Local Government Act 1972

10.1 Report to Cabinet meeting on 9th November 2009, entitled ‘Disposals of Residential Land to Housing Associations’.

11. Consultations

11.1 The Affordable Housing Programme Board has discussed the Government’s Framework and Housing Associations identified where they needed guidance and decisions from the Council in order to include proposals to deliver affordable housing in Leicester within their offers to the HCA.

12. Report Authors

Ann Branson, Director Housing Strategy and Options, ext 29 6802
Janet Callan, Head of Housing Development, ext 29 8713
Julia Keeling, Head of Housing Development, ext 29 8713
Neil Gamble, Head of Estates Management, ext 29 8002

Key Decision	Yes
Reason	Is significant in terms of its effect on communities living or working in an area comprising more than one ward
Appeared in Forward Plan	Yes
Executive or Council Decision	Executive (Cabinet)

Appendix 1

Affordable Housing Needs in Leicester 2011-15

Earlier this year the Leicester and Leicestershire Leadership Board agreed the draft Leicester and Leicestershire Local Investment Plan (LIP) which sets out the focus for investment to support housing growth and infrastructure investment to support growth in jobs.

Housing Associations and others are encouraged to seek to address these needs when they submit their offers to the HCA.

Leicester City identified the following themes and schemes that would need HCA funds for affordable housing:

1. **New sustainable communities**

   Ashton Green

   East Hamilton

2. **Strategic Regeneration Area**

   Abbey Meadows

   Donisthorpe

   Waterside (Northgate) (HCA own land here)

3. **Existing Neighbourhoods**

   Braunstone

   New Parks

   Saffron

   Eyres Monsell

   Beaumont Leys

   Inner Area Neighbourhoods

   Neighbourhoods in East Leicester

4. **Themed Priorities**

   Affordable housing throughout the City

   Gypsy and Travellers provision

   Improvement to existing stock

   Supported Housing including Extra Care (see below)

Empty Homes (private sector)

Non decent homes (private sector)

The framework does not cover non-decent homes in the private sector, and a separate announcement will be made later on bringing private empty homes back into use.

General needs Housing: mix and type

The Affordable Housing SPD and the Strategic Housing Market Assessment 2008 sets out the type of general needs housing required.

SHMA's affordable housing annual type/size profile for the next 7 years for Leicester:

Social Rent			
1 bed	12	2%	General needs
2 bed	295	37%	4 (1%) upsizing general needs flats 67 (9%) downsizing flats/bungalows 145 (18%) general needs houses 79 (10%) older households
3 bed	222	28%	23 (3%) general needs flats 199 (25%) general needs houses
4+ bed	32	4%	General needs
*Sheltered/Supported**	30	4%	Sheltered/supported
Total	591	75%	
Intermediate			
1 bed 2 bed 3 bed 4+ bed	4 97 77 21	1% 12% 10% 3%	General needs General needs General needs General needs
Total	199	25%	
Overall total	**790**	**100%**	

* This figure is not used by the Council as ASC have more detailed evidence base available

Gypsy and Traveller Pitches

Leicester City Council's Core Strategy for Development refers to the 2007 assessment of Gypsy and Travellers needs which identified that the City should provide 24 residential pitches, 10 transient pitches for gypsies and travellers and 3 plots for travelling show people by 2012.

Extra Care/Supported Housing

Housing Associations will be given more detailed guidance on the supported housing requirements for 2011-2015 to support Adults and Social Care proposals/budget. These are 4 x 30 self contained units in an Extra Care setting and 200 self contained flats with support in mixed communities. Experience with Wolsey Building in Belgrave will inform the balance between 1 and 2 bedroom flats required and the proportion that are fully wheelchair adapted. Analysis is also being done about which potential locations might best address demand.

Hostels

The Council will consider whether any proposals from Voluntary Sector or Community Groups for improvements to hostels are in support of the Council's Homeless Pathway Model.

Mortgage Rescue

The Council wishes to see a Mortgage Rescue Scheme continue in the City.

Empty Homes

The Council has a pro-active strategy for bringing private empty homes back into use and would welcome schemes that make some available for social letting at affordable rent.

Conversions/Extensions

The Council has a pro-active strategy in seeking to address overcrowding and would welcome any schemes that seek to address this via extensions/conversions.

Appendix 2

Existing Cabinet decisions on principle of land sales at a nominal sum where a Housing Association has began preparatory work

a) Conduit Street (Extra Care)

A Housing Association has been in discussions with the Council to bring forward a supported housing scheme at this site. There have been pre-planning meetings, but apart from staff time, the Association has not yet incurred costs in pursuing this proposal.

b) Former Whittier Road Allotments (36 Houses)

In November 2009, Cabinet approved the principle of selling land within four potential residential development sites, including the Whittier Road site, to appropriate Housing Associations for a nominal sum and that the land to be subject of the disposal would comprise of up to the amount of the affordable housing requirement sought under planning policies. The reason for seeking this approval in November 2009 was to enable Housing Associations to bid for new schemes in Leicester from the "Housing Pledge". Both the bidding and delivery timetables for this extra funding were extremely tight. Under this approval, a Housing Association was selected to prepare a scheme for 36 homes on the former Whittier Road allotments site. Once early pre-planning discussions were held, it quickly became clear that this site required a longer lead-in time than the funding opportunity could then allow. The Housing Association are still very interested to continue with their proposals for this site and would wish to reflect this site within their 'offer' to the HCA for new affordable housing supply 2011-15 on the basis of charging affordable rents.

c) Former Velodrome site, Saffron Lane (20 Houses)

In November 2009, Cabinet approved the principle of selling land within four potential residential development sites, including the Saffron Velodrome site, to appropriate Housing Associations for a nominal sum and that the land to be subject to the disposal would comprise of up to the amount of the affordable housing requirement sought under planning policies. A Housing Association was selected to prepare a scheme for this site and completed detailed pre-planning application discussions and submitted its bid for HCA funds within the required timetable. The H.A. was unsuccessful at securing funds from the enhanced 2009/10 HCA programme and submitted a more competitive bid to the HCA for 2010/11. Unfortunately, the cuts made to the HCA programme last year have meant that no new schemes have been approved for HCA funds in Leicester in 2010/11.

The Housing Association is very interested in pursuing its scheme at this site and would wish to reflect this site within its 'offer' to the HCA for new affordable housing supply, 2011-15.

Its scheme would take up 20% of the available development site and would consist of a total of 20 affordable housing homes (16, 2 bedroom and 4, 3 bedroom).

The H.A. advises that it intends to bid, on the basis of charging the Affordable Rent because the scheme would require too much HCA subsidy if the former social rent levels are assumed.

In progressing this scheme the Housing Association has, in good faith, already incurred costs. If the scheme is aborted, the H.A. will also have to be responsible for the cost of ground investigation works carried out by its contractor.

The Affordable Rent will be fully eligible for Housing Benefit.

Appendix 3

Summary of Council owned residential land that could be made available for housing completions 2011-2015, via disposals to RSLs, grouped by the relevant recommendation to Cabinet

<table>
<tr><th>Site</th><th>Potential for affordable homes completions 2011-15</th><th>HRA/GF</th><th>Comment</th></tr>
<tr><td colspan="4">1. Recommendation 2.2: That Cabinet confirms previous decisions on the principle of discounted sale of land at Saffron Velodrome and Whittier Road to appropriate HAs (Appendix 2), subject to further reports being brought to Cabinet outlining the detailed terms of any proposed disposal.</td></tr>
<tr><td>Saffron Velodrome</td><td>20 homes</td><td>GF/Culture</td><td>See Appendix 3</td></tr>
<tr><td>Whittier Road</td><td>36</td><td>GF/Corporate</td><td>See Appendix 3</td></tr>
<tr><td colspan="4">2. Recommendation 2.3: That Cabinet agrees, in principle, to the discounted sale at £1 of the site at Conduit Street to an appropriate Housing Association, subject to a further report being brought to Cabinet outlining the detailed terms of any proposed disposal (Appendix 3).</td></tr>
<tr><td>Conduit Street</td><td><40 units Extra Care Scheme</td><td>Housing General Fund</td><td>See Appendix 3</td></tr>
<tr><td colspan="4">3.Recommendation 2.4: That Cabinet agrees the principle of selling appropriate HRA land, a nominal sum to facilitate affordable housing developments by HAs, subject to further reports being brought to Cabinet outlining the detailed terms of any proposed disposal. (HA’s will be informed that only some of these sites will be available)</td></tr>
<tr><td>Braunstone Backlands</td><td>26</td><td>HRA</td><td>Initial site assessments completed. Further investigations now required to bring forward scheme proposals.</td></tr>
<tr><td>Other HRA potential development sites.</td><td>25</td><td>HRA</td><td>e.g. ex-housing depot sites, further backland sites, etc.</td></tr>
<tr><td colspan="4">4. Recommendation 2.5: That Cabinet agrees the principle of selling the affordable element of larger corporate sites as identified in appendix 4 at a nominal sum to facilitate affordable housing development by HAs, subject to further reports being brought to Cabinet outlining the detailed terms of any proposed disposal. (HAs will be informed that only some of these sites will be made available. Some may be used by the Council if an offer is successful).</td></tr>
<tr><td>Queensmead School</td><td>13</td><td>GF/CYPS</td><td>Has previously been marketed, but in this housing market, response has been poor</td></tr>
<tr><td>Humberstone Road (road scheme clearance area)</td><td>5</td><td>GF/Highways & Housing General fund</td><td>Most viable development option would require acquisition of adjoining plots</td></tr>
</table>

Site	Potential for affordable homes completions 2011-15	HRA/GF	Comment
Ashton Green Phase 1	75	GF/Corporate	Site has outline planning approval and Project Board and management in place
Other LCC sites including redevelopment/conversions	25 or more	Housing and Corporate	Buildings surplus to requirement Other sites may well be identified during the next 4 years.

5. Recommendation 2.6: Should the Council decide not to make an 'offer' to build new Council homes or if the Council's offer is not accepted, Cabinet agree, in principle, to the discounted sale at £1 of the sites at Hamelin Road and Saffron Depot to appropriate Housing Associations, subject to further reports being brought to the Cabinet outlining the detailed terms of any proposed disposal.

Hamelin Road	10 homes	HRA	Full Planning approval
Saffron Depot	9 homes	HRA	Full Planning approval

6. Recommendation 2.7: That Cabinet considers the principle of a discounted sale of further land at Mundella, Laburnum Avenue, Manor Farm and Benbow Rise or its use for Council building. This would form a second phase of affordable housing at those locations effectively extending the provision beyond planning requirements being sales at less than best consideration and providing a loss of opportunity to achieve capital receipts to the Council from the alternative of sale for private housing. (Appendix 3 and Paragraph 7.10). Officers shall explore the opportunity for netting off this cost against other sites.

Further phases at sites where new Council house building has formed phase one on a larger site eg Mundella ex school site, Laburnham Road, Manor Farm and Bendbow Rise	To be explored (See 7.10)	Corporate	These sites have outline planning approval for entire site

This page is left blank intentionally.