Date: THURSDAY, 11 JULY 2013

Time: 10:00 am

Location: THE TEA ROOM - FIRST FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER

HEALTH AND WELLBEING BOARD

Councillors: Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Rita Patel Assistant City Mayor and Councillor Manjula Sood MBE, Assistant City Mayor

City Council Officers: Deb Watson, Strategic Director, Adult Social Care, Health and Housing

Elaine McHale, Interim Strategic Director, Children's Services

Tracie Rees, Director, Care Services and Commissioning, Adult Social Care

NHS Representatives: Professor. Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Dr Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group

David Sharp, Area Director, Leicestershire and Lincolnshire NHS Commissioning Board

Healthwatch / Other Representatives: Philip Parkinson, Interim Chair, Healthwatch Leicester

Chief Superintendent, Rob Nixon, Leicester City Basic Command Unit Commander, Leicestershire Police

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

G. J. Carey

For Monitoring Officer

City Mayor healthwatch Leicester Leicestershire Police Protecting our communities NHS Leicester City Clinical Commissioning Group NHS Commissioning Board

INFORMATION FOR MEMBERS OF THE PUBLIC

ACCESS TO INFORMATION AND MEETINGS

You have the right to attend meetings 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 Commissions, 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 Graham Carey, Democratic Support on (0116) 229 8813 or email Graham.Carey@leicester.gov.uk or call in at the Town Hall.

Press Enquiries - please phone the Communications Unit on 252 6081

1. WELCOME AND INTRODUCTIONS

2. APOLOGIES

3. DECLARATIONS OF INTEREST

Members of the Board are asked to declare any interests they may have in the business on the agenda.

4. DISCUSSION SESSION - JOINT HEALTH AND WELLBEING STRATEGY PRIORITY 3: SUPPORT INDEPENDENCE

Appendix A

The discussion session has been planned to last approximately 90 minutes and representatives of interested bodies have been invited to the meeting. The Joint Health and Wellbeing Strategy (Closing the Gap) is attached.

Deb Watson, Strategic Director Adult Social Care, Health and Housing and Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group will also give a presentation.

5. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 11 April 2013 have been circulated previously and the Board is asked to confirm them as a correct record.

The minutes can also been found on the Council's Web-site at the following link:-

http://www.cabinet.leicester.gov.uk/documents/g5616/Printed%20minutes%20Thursday%2011-Apr-2013%2010.30%20Health%20and%20Wellbeing%20Board.pdf?T=1

6. MID-STAFFORDSHIRE FOUNDATION TRUST PUBLIC INQUIRY

Appendix B

To consider the attached report from the local Clinical Collaborative Interface Group about the recommendations in the Mid Staffordshire NHS Foundation Trust Public Inquiry Report (Francis Report).

7. HEALTH PROTECTION BOARD

Appendix C

To note a report on the Health Protection Board and to note that it has met for the first time.

8. WINTERBOURNE VIEW CONCORDAT

Appendix D

To note a letter from Norman Lamb MP (Minister of State for Care and Support) about the Winterbourne View Concordat and a report summarising progress. The letter and report are attached.

9. ANNOUNCEMENTS

Members of the Board to make announcements, if appropriate, on topics of interest.

10. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

11. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will held on the following dates:-

Tuesday 8 October 2013
Thursday 30 January 2014
Thursday 3 April 2013
Thursday 3 July 2014
Thursday 9 October 2014

Meetings of the Board will be held in the Tea Room, 1st Floor Town Hall at 10.00am unless stated otherwise on the agenda for the meetings.

For further information:
www.leicester.gov.uk/ourhealthycity

Produced by Leicester City Council Marketing & Brand Management Team (RB 03.2013)

Closing the **Gap**

Leicester's Joint Health and Wellbeing Strategy **2013-16**

Appendix A

NHS Commissioning Board

NHS Leicester City Clinical Commissioning Group

Leicestershire Police

healthwatch Leicester

Leicester City Council

Our healthy city

April 2013

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Endorsements

Leicester City Clinical Commissioning Group (LC CCG)
We have worked with the Health and Wellbeing Board to jointly develop the Health and Wellbeing Strategy. It is aligned to the commissioning priorities of Leicester City Clinical Commissioning Group and we believe it fully reflects the needs of our unique local population. We are committed to working closely with the Health and Wellbeing Board to deliver the strategy for the benefit of the local population and to help people in Leicester live longer, healthier lives.
Prof Azhar Farooqi, Chair, Leicester City Clinical Commissioning Group

Healthwatch Leicester
Healthwatch Leicester fully supports the creation and implementation of the Joint Health and Wellbeing Strategy for Leicester. From 1 April 2013 Healthwatch Leicester will work with the Health and Wellbeing Board and other relevant stakeholders to achieve the aims set out in the strategy. Healthwatch Leicester considers that the development of the Joint Health and Wellbeing Strategy is a positive step for citizens of Leicester and will facilitate closer working between health and social care services, resulting in better outcomes for the most vulnerable service users in the City.
Philip Parkinson, Interim Chair, Healthwatch Leicester

Leicestershire and Lincolnshire Local Area Team of the NHS Commissioning Board.
The excellent work of the Director of Public Health, GPs and our providers of NHS services are a sign that things are improving in Health Services for the City of Leicester. What this strategy shows is how far we have yet to go in truly improving health and the outcomes of ill health for all the people in this city. The strategy does not shirk from asking some awkward questions about what we all will need to do to change the health of Leicester by using the right mixture of good planning, good partnership working and excellent delivery of public services. On behalf of the NHS Commissioning board I endorse the strategy.
David Sharp, Director of the Leicestershire and Lincolnshire Local Area Team of the NHS Commissioning Board.

Leicestershire Police.
Improving health services for the City of Leicester is key. So far the Director of Public Health, GPs and NHS services are pulling together and making excellent progress. This strategy outlines that there is much that can be done and it's not afraid to highlight that. I am confident that by working together, sharing information, ideas and good planning, great improvements can be made. I endorse this strategy and look forward to supporting it.
Rob Nixon, Chief Superintendent and City Basic Command Unit (BCU) Commander.

Foreword

I am determined that Leicester's Health and Wellbeing Board, working with our partners, will lead a renewed ambition for health in Leicester.

We need to be ambitious for health in Leicester. In our city there are very serious health challenges. Levels of obesity are too high; too many children suffer tooth decay; we do not meet targets for physical activity or healthy eating and levels of serious conditions like heart disease, respiratory conditions and diabetes are too high. Levels of infant mortality are high. In Leicester there are too many hospital stays related to alcohol.

Life expectancy for Leicester is below the national average, and the health gap between affluent and more derived areas is significant. Across the city there can be a difference of more than nine years for men and five years for women in life expectancy between the most affluent and least well off areas in Leicester.

With so many factors influencing our health, including housing, diet and the environment around us, we need to shape a new collaborative approach to health in the city. This approach must be built on strong partnerships drawing on all the expertise, experience and ideas from across the NHS community including the new Clinical Commissioning Group, the city council and many other partners. This is what the Health and Wellbeing Board will do and this strategy sets out our initial roadmap of priorities.

The Health and Wellbeing Board will work across five strategic priorities:

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

All of these priorities are important in addressing the challenges we face in Leicester and in tackling health inequalities. All five priorities are inter-linked and relate to many more priorities for the health community in the city.

To improve health we will need an approach which is outward looking and which engages Leicester's communities. This is what we will do. Whilst the role of doctors, clinicians and other health professionals is crucial we need to see people from many other sectors and organisations, working with residents and communities, with a real sense of purpose and shared effort to improve health.

I know that the organisations which make up the Health and Wellbeing Board and other partners share this determination. We want to see health improving the real progress in closing the health inequalities gap.

I would like to thank everyone who has contributed to this strategy. We now focus on working to address the priorities and towards improving health across the city, and together working to make Leicester our healthy city.

Rory Palmer
Deputy City Mayor
Chair of the Health and Wellbeing Board

2. Executive summary

Introduction (Section 4 of the strategy)

This Joint Health and Wellbeing Strategy for Leicester has been developed by the new Health and Wellbeing Board and is a key outcome of the Board. The Board brings together leaders from the health and care system to work together to improve the health and wellbeing of their local population and reduce health inequalities. The Board also includes representation from patients and the public, via the Local HealthWatch, and the police. It became a full statutory Board in April 2013.

The strategy is intended to set a direction of travel for commissioners in the city, fostering partnership working to improve health and wellbeing. It underpins other strategies including the Leicester City Clinical Commissioning Group (LC CCG) Clinical Commissioning Strategy, the Adult Social Care Transformation Plan and the Children and Young People Plan. It also takes into account the need in the current financial climate to work together to achieve appropriate economies that will enable the best outcomes.

Developing the strategy (Sections 5 and 6)

The vision of the strategy is to:

Work together with communities to improve health and reduce inequalities, enabling children, adults and families to enjoy a healthy, safe and fulfilling life.

The strategy is based on the city's Joint Strategic Needs Assessment (JSNA) and feedback from local organisations, patients and the public. The most recent JSNA for Leicester was published in 2012. The JSNA shows that Leicester is a city with a younger, diverse population, with higher levels of deprivation and significantly worse life expectancy compared to England. The strategy drills down into some of the underlying figures and priorities have been chosen accordingly.

Aim and priorities (Sections 7-12)

The overarching aim of the strategy is to **reduce health inequalities.** The five priorities are as follows:

Strategic priority 1: Improve outcomes for children and young people

- Reduce infant mortality
- Reduce teenage pregnancy
- Improve readiness for school at age five
- Promote healthy weight and lifestyles in children and young people

Strategic priority 2: Reduce premature mortality

- Reduce smoking and tobacco use
- Increase physical activity and healthy weight
- Reduce harmful alcohol consumption
- Improve the identification and management of cardiovascular disease, respiratory disease and cancer

Strategic priority 3: Support independence

- Support independence for:
  people with long term conditions
- older people
- people with dementia
- carers

Strategic priority 4: Improve mental health and emotional resilience

- Promote the emotional wellbeing of children and young people
- Address common mental health problems in adults and mitigate the risks of mental health problems in groups who are particularly vulnerable
- Support people with severe and enduring mental health needs

Strategic priority 5: focus on the wider determinants of health through effective deployment of resources, partnership and community working

- Priority five is a cross-cutting priority - to focus on tackling the wider and social determinants of health – the so called causes of the causes of poor health and health inequalities, and to do this through effective deployment of resources, partnership and community working.

Equalities (Section 13)

The strategy's overall aim is to reduce health inequalities, and throughout the development of the strategy the Board has taken account of the duty to have regard of the equality implications of their decisions.

Engagement (Section 14 and Appendix A)

The Board has carried out a programme of engagement in order to ensure appropriate input to the strategy from the voluntary sector, patients and the public, 'seldom heard' groups and partnership boards.

Measuring progress (Section 15 and Appendix B)

A set of indicators has been developed so that the progress of the strategy can be measured.

Next steps (Section 16)

Leicester City Clinical Commissioning Group and Leicester City Council, will both use the strategy to help them develop their own priorities for the next three years.

Beyond this, we want other groups working within the city, in areas such as housing, environment and the arts, among community groups and the voluntary sector, to look at how their work can help achieve these strategic aims and we will put in place a number of measures to help achieve this.

3. Introduction

This Joint Health and Wellbeing Strategy for Leicester has been developed by the new Health and Wellbeing Board, which became a full statutory Board in April 2013. The purpose of this Board is to act as a forum for key leaders from the health and care system to work together to improve the health and wellbeing of the local population and reduce health inequalities. It brings together the City Council with Leicester City Clinical Commissioning Group (LC CCG) and the NHS Commissioning Board and other local representation and has been introduced as a result of the Health and Social Care Act 2012.

The Board is chaired by the Deputy City Mayor. Members include councillors, LC CCG, representation from the NHS Commissioning Board, statutory local authority officers (director of public health, director of adult social care, director of children's services), a representative of Leicestershire police and a member of the new local HealthWatch.

The strategy has been developed on the basis of the city's Joint Strategic Needs Assessment (JSNA)[1] and feedback from local organisations, patients and the public. The JSNA was developed jointly between Leicester City Council and LC CCG as the main commissioners of health and social care services in the city. The most recent JSNA for Leicester was published in 2012.

Both the Joint Health and Wellbeing Strategy and the JSNA underpin other strategies including the LC CCG Clinical Commissioning Strategy, Adult Social Care Transformation Plan and Children and Young People Plan. The priorities set in the Joint Health and Wellbeing Strategy will be used to inform the yearly operational plans such as the CCG's Commissioning Intentions and Operational Plan. In addition the priorities will inform any joint commissioning work undertaken by Leicester City Council and LC CCG.

The Board recognise that there is a need for collaboration and active partnership between local public sector and other bodies and that this will be driven by having an effective Health and Wellbeing Board, by sharing information appropriately and by developing integrated commissioning. They also recognise the need in the current financial climate to work together to achieve appropriate economies that will enable the best outcomes.

[1]http://www.leicester.gov.uk/your-council-services/social-care-health/jsna/jsna-reports/

4. Our vision and principles

This strategy aims to improve and protect the health and wellbeing of all those who live and work in the city of Leicester. We aim to tackle the gaps caused by inequalities and achieve real and measurable improvements in the health and well-being of residents.

In order to deliver this our vision is to:

Work together with communities to improve health and reduce inequalities, enabling children, adults and families to enjoy a healthy, safe and fulfilling life.

The principles on which this strategy is based are:

- Prevention of ill health and early intervention
- A relentless focus on reducing health inequalities
- Promoting independence and self-management
- Harnessing and fostering community engagement and assets
- Creating a healthy environment for people to live and work in
- Focussing on things which can be done by organisations working together
- Meeting national standards of care and safety and working collaboratively and proactively to drive up quality standards through continuous improvement

Our approach is to concentrate on a limited number of strategic interventions which:

- Are underpinned by good national and/or international evidence of effective interventions
- Can be delivered at sufficient scale to achieve the required impact
- Are sustainable in the medium and longer term
- Benefit from partnership working with complementary inputs from a range of organisations and sectors

The strategy aims to provide a set of priorities to influence all areas of life in the city with the aim of improving health and wellbeing.

Strengthening collaboration

We recognise that we are developing this strategy at a time of financial constraint. All public bodies are looking to reduce their spend in line with reduced budgets or the need to make savings to meet rising demand. Therefore our aim is to set direction and aspiration for the city, signposting the areas where we believe we can make the biggest difference through joint working and shared focus. The challenge is to increase the efficiency of what we do, while maintaining effective and acceptable services. We want to ensure that the measures we are proposing are sustainable in the medium or longer term given our shared resources. We need to work in partnership to achieve this and to minimise the likelihood of unintended consequences from a lack of system coordination or leadership. We accept that this may require changes to historical funding patterns.

Our partnership working includes collaboration with both fellow commissioners and provider agencies such as the local NHS provider trusts, as well as voluntary, community and private sector bodies.

5. A snapshot of health and wellbeing in Leicester

Population

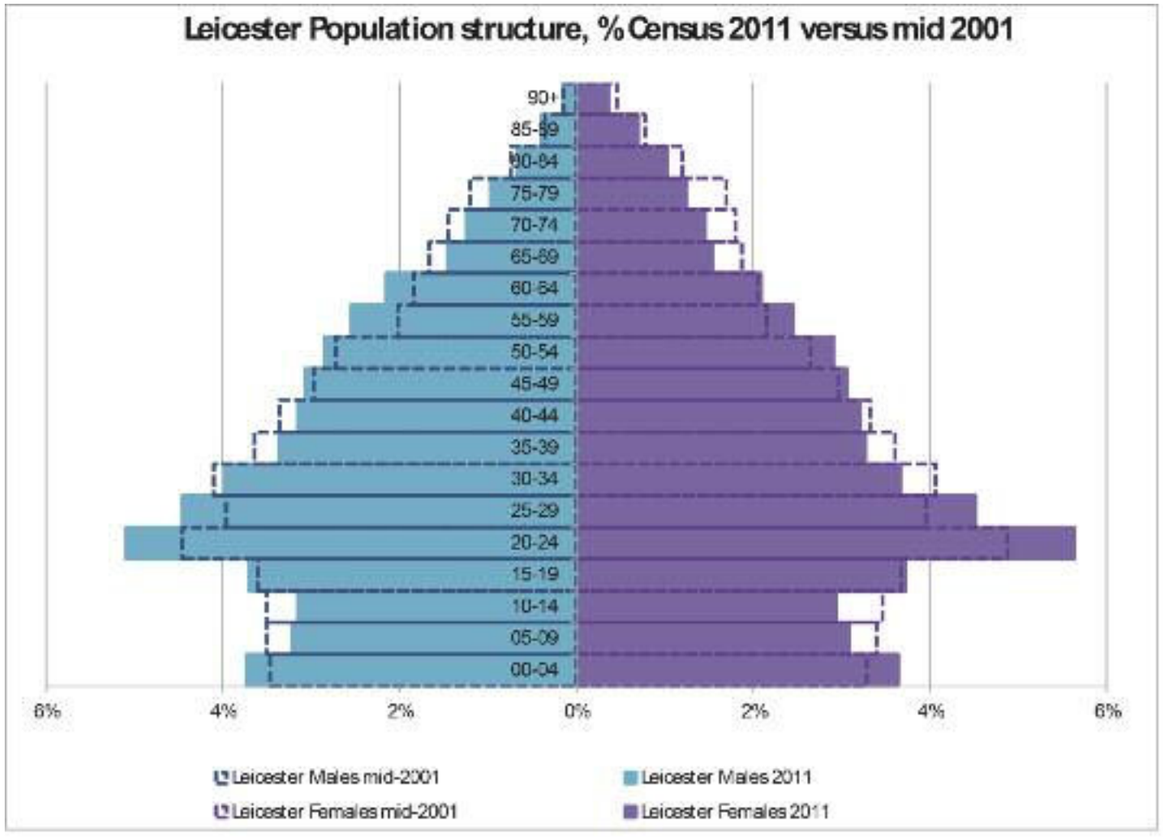
The JSNA shows that Leicester is a city with a younger, diverse population, with higher levels of deprivation and significantly worse life expectancy compared to England.

The first release of information from the Census 2011 shows that Leicester has a faster rate of growth and a larger proportion of children and young people in the population than in England and Wales generally. The figures are:

- A population of 329,900 (an increase of 16.7% since 2001)
- 37,200 (11.3%) of the population over the age of 65, a decrease of some 700 since 2001
- 24,500 (7.4%) of the population are children under 5, an increase of 5,200 (27%) since 2001
- The largest increases in the population are in people aged in their 20s (16,100) and under 5s (5,200)
- Leicester has a much younger population than England, with a large proportion under 35 years
- Although there is a decline in the number of people aged 65-79, the number of people aged over 80 has increased from 10,400 in 2001 to 11,000 in 2011
- There is a large student population

Around 50% of the population is from black and minority ethnic (BME) groups - most of these are from South Asian backgrounds. The proportion of people from BME groups will continue to increase.

Figure 1: Population pyramid



Deprivation in Leicester

Leicester is highly deprived, according to the Index of Deprivation 2010, ranking 25th most deprived of 326 local authority areas. There is a strong association between high levels of deprivation and poorer health. The impact of deprivation on health includes:

- high levels of obesity and tooth decay in children
- high levels of teenage pregnancy
- adults with worse levels of physical activity and healthy eating
- high infant mortality
- early death from heart disease, stroke and smoking
- many hospital stays for alcohol problems and self-harm
- higher than average drug misuse, diabetes, tuberculosis and broken hips in older people
- higher than average mental illness, homelessness, and cancer

In this document there are references to wards and neighbourhoods and in general, to smaller areas of the city. The purpose of this is to indicate that there is variation in deprivation within the city, as is shown in the JSNA.

It should be noted that there is also variation within wards. The map of deprivation at figure 2 which reflects deprivation on postcodes (rather than ward averages) shows the variation within wards and also shows geographical areas which are open or industrial spaces.

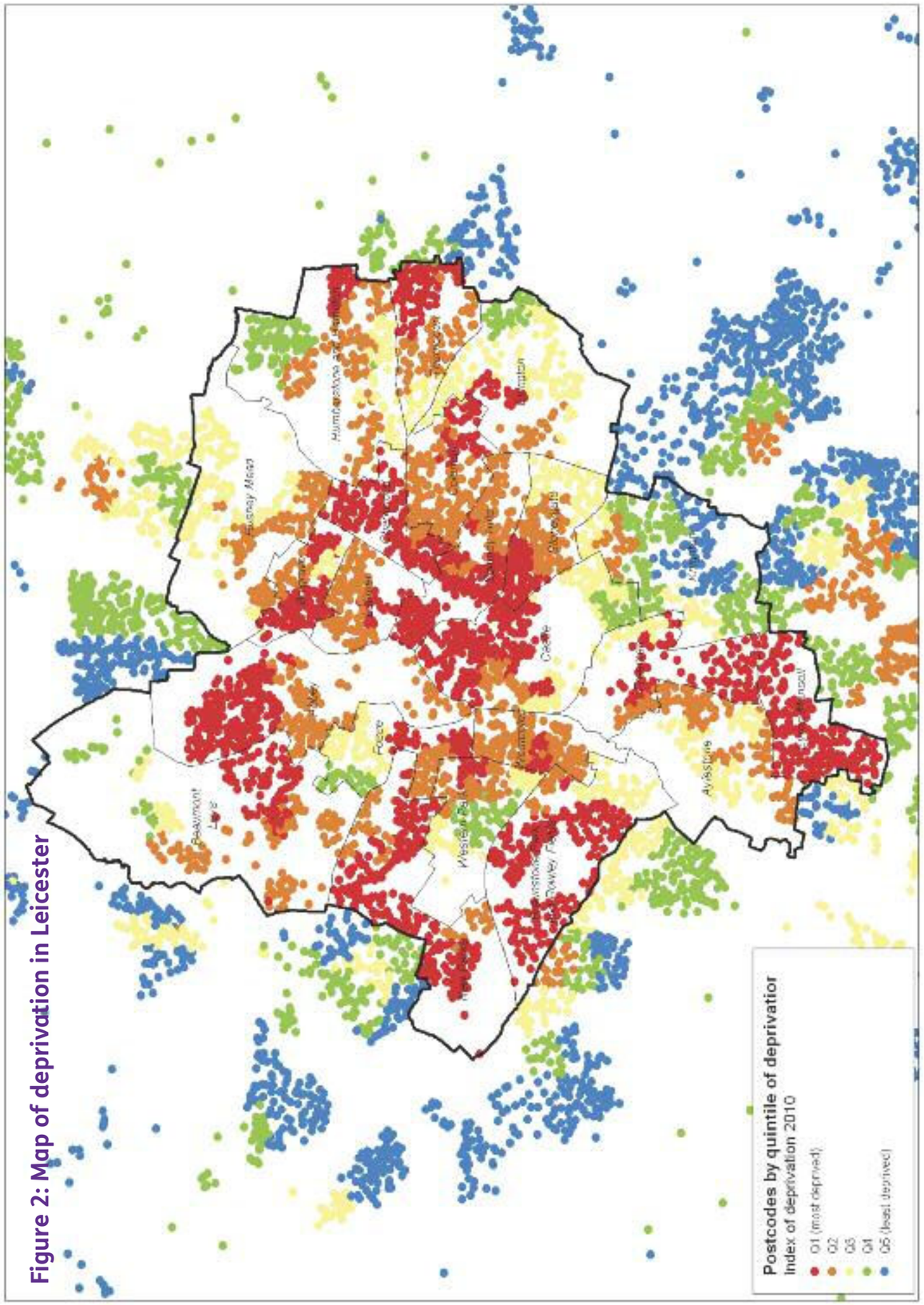


Figure 2: Map of deprivation in Leicester

Life expectancy in Leicester

Average life expectancy in Leicester is significantly lower than the national average; 3.2 years lower in males and 2.5 years lower in females. Any death below 75 is classified as premature.

- In the period 1998-10 to 2008-10 life expectancy increased from 73.3 to 75.4 for men, and 78.8 to 80.1 for women
- BUT there is variation in life expectancy across Leicester – a gap of nearly 9.5 years for men and 5 years for women between the most deprived and the least deprived areas of Leicester
- The main contributors to the gap between Leicester and the national average are deaths from:
  - Cardiovascular disease (related to the heart and circulatory system)
  - Respiratory (breathing) disease
  - Infant mortality

Diseases and long term conditions

- More than a quarter (27%) of adults are expected to suffer from high blood pressure, although only 15% have been identified by GPs
- Over 7% of adults (17+ years) are currently registered with diabetes and it is four times more common among South Asian people
- Cardiovascular disease deaths are the largest contributor to the life expectancy gap between Leicester and England
- These deaths are linked to deprivation, gender and ethnicity – there are 13 neighbourhoods significantly worse than the England average
- Deaths from cancer have been increasing in recent years.

6. Strategic Priorities

Our five strategic priorities are all based on the overall principle of this strategy – to reduce health inequalities. They have been chosen by considering:

- The key health and wellbeing issues identified through the JSNA
- Where we can make the biggest difference, taking account of evidence
- Feedback from stakeholders, including partner organisations and the public
- Local and national policy documents on health and social care

They are:

Strategic priority 1: Improve outcomes for children and young people

- Reduce infant mortality
- Reduce teenage pregnancy
- Improve readiness for school at age five
- Promote healthy weight and lifestyles in children and young people

Strategic priority 2: Reduce premature mortality

- Reduce smoking and tobacco use
- Increase physical activity and healthy weight
- Reduce harmful alcohol consumption
- Improve the identification and management of cardiovascular disease, respiratory disease and cancer

Strategic priority 3: Support independence

- Support independence for:
  - people with long term conditions
  - older people
  - people with dementia
  - carers

Strategic priority 4: Improve mental health and emotional resilience

- Promote the emotional wellbeing of children and young people
- Address common mental health problems in adults and mitigate the risks of mental health problems in groups who are particularly vulnerable
- Support people with severe and enduring mental health needs

Strategic priority 5: focus on the wider determinants of health through effective deployment of resources, partnership and community working

Priority five is a cross-cutting priority - to focus on tackling the wider and social determinants of health – the so called causes of the causes of poor health and health inequalities and to do this through effective deployment of resources, partnership and community working.

Our rationale for choice of the priorities

Within each strategic priority area, we have chosen to concentrate on a limited number of objectives. The areas we have chosen are those where we know that strategic and sustainable development is needed, where there is good evidence of effective interventions which can be further developed and built upon and where improvements depend on contributions from a range of agencies working together to empower and enable local communities.

Some objectives will require the commissioning of additional or expanded services with specific additional investment by one or more agency. Others will require us to galvanise action across organisations and communities using existing resources. In both cases we hope that the strategic priorities set out here will act as a compass to point all those who are making decisions about the wellbeing of Leicester people towards the areas where they can help to make the most difference.

The following sections explain our strategic priorities – what we know, what we would like to achieve and what we plan to do.

7. Strategic priority 1:
Improve outcomes for children and young people

- **Reduce infant mortality**
- **Reduce teenage pregnancy**
- **Improve readiness for school at age five**
- **Promote healthy weight and lifestyles in children and young people**

Why we chose this priority

The Marmot Review of Health Inequalities 'Fair Society, Healthy Lives' states:

"Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood."[2]

This presents a particular challenge in Leicester given the high levels of child and family poverty and indicates that there must be a greater investment in early prevention across the city by all partners in the early years of life and at appropriate stages of development.

To secure this we will focus upon early prevention activity from conception to age three to improve outcomes by age five. We will also aim to help all children and young people to achieve healthy weights and healthy lifestyles.

We will do this by focusing relentlessly upon our data about known need, target activity accordingly and invest in evidence based practice and our communities of interest across the city to ensure that they too become active partners in this.

In doing so the Health and Wellbeing Board will have regard to the recently established City Council 'core offer' of desired activities, interventions and services for children and their families and the growing body of evidence about the effectiveness of Sure Start Children's Centres.

[2] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review, Executive Summary, p.16

Reduce infant mortality

What we know

The infant mortality (IM) rate for Leicester City in 2009-2011 was 7.0 deaths in children under 1 per 1000 live births (95% CI: 5.8-8.4). This is significantly higher than the England and Wales average of 4.4 per 1000.

Although the actual numbers of deaths are relatively small (40 deaths in 2011) each one is clearly a tragedy. Collectively these deaths contribute significantly to the city's health inequalities gap with England. Introducing measures to reduce infant mortality also has the potential to improve infant health and wellbeing in general.

What we want to achieve

We would like to see a continual reduction in the infant mortality rate for Leicester City.

What we plan to do

We will work together to tackle the risk factors for infant mortality and work with communities by supporting a Health in Infancy Champion in each neighbourhood area of the city. We will focus on:

- Reducing smoking rates in pregnancy and promoting smoke free homes
- Reducing unsafe sleeping
- Promoting healthy weight in mothers
- Reducing teenage parenthood
- Promoting early access to maternity services
- Increasing breastfeeding rates
- Improving uptake of immunisations and screening.

Reduce teenage pregnancy

What we know

Leicester has had a higher than average under 18 conception rate for at least the past 10 years. In 2011, the conception rate showed a significant reduction with 30 conceptions per 1,000 girls aged 15-17, similar to the national rate of 30.7. This represents a 53.6% reduction in the under-18 teenage conception rate (from a 1998 baseline conception rate of 64.6 conceptions per 1,000 females aged 15-17). This has been a significant success achieved by the Leicester Teenage Pregnancy and Parenthood Partnership and needs to be maintained.

There are inequalities across Leicester where nine of the neighbourhoods have significantly higher rates than the national average. These neighbourhoods are also neighbourhoods with other risk factors that contribute to under 18 conception such as: lower educational attainment, low aspiration, White ethnicity, young people whose mothers were teenage mothers. This reinforces the approach to target services and actions areas of highest need.

What we want to achieve

A continued reduction in teenage pregnancies, reducing year on year.

What we plan to do

- Promote sex and relationship education (SRE) through the Healthy Schools programme particularly in target neighbourhoods with higher levels of pregnancy
- Target vulnerable groups more at risk: including young people not in education, employment or training (NEETs), previous pregnancy, high truanting rates, looked after children, children in need and those involved in the criminal justice system or with drug and alcohol interventions
- Ensure effective tracking and supporting of vulnerable under 19s
- Promote the Family Nurse Partnership, which provides intensive support to young first time mothers
- Involve young people in devising a communication campaign integrating teenage pregnancy, sexual health, substance misuse and domestic violence
- Raise the aspiration and academic achievement of young people in Leicester
- Ensure young women under 25 have access to contraception including free Emergency Hormonal Contraception.

Improve readiness for school at age five years (physical, behavioural, emotional and cognitive)

What we know

Frank Field's recent report (The Foundation Years: preventing poor children becoming poor adults) has 'found overwhelming evidence that children's life chances are most heavily predicated on their development in the first five years of life'. In July 2011 Nottingham MP Graham Allen published a further report that emphasised the benefits of early intervention strategies and highlighted a range of evidence-based interventions that have the potential to turn around the lives of children and their families.

We know that vocabulary at the age of five has also been found to be the best predictor of whether children who experience deprivation are able to escape poverty in later adult life. Frank Field's report identifies that gaps often develop by school age between those children from poorer backgrounds who do worse cognitively and behaviourally and those from more affluent backgrounds.

Early prevention and early intervention in early years, schools, health and education are therefore recognised as key strategies in improving health and life outcomes.

Although considerable progress has been made in the city in narrowing the gap between poorest performing children and the rest, more needs to be done. Evidence

7. Strategic priority 1 continued

shows that targeted collaborative work with Sure Start Children's Centres has resulted in measurable and tangible gains. The Health and Wellbeing Board will therefore support city Children's Centres to improve outcomes through collaborative working.

Currently, 2012 results show that at Foundation Stage 64% of pupils demonstrated that they had a good level of development (social and literacy skills) and are therefore 'Ready for School'. This is an increase of 18% over the last 3 years of children reaching this measure which shows the proportion ready for school by the age of 5.

Leicester's national ranking remains in the bottom third of authorities but has improved. We are now ranked 104 out of 152 authorities compared with 134 out of 150 in 2010, in terms of readiness for school.

The Leicester figure masks differentials across the city ranging from 76.2% (Thurnby Lodge) to 53.5% (Rushey Mead).

What we want to achieve

A continued increase in the number of children under five years who are ready for school, reducing the variance across the city and achieving the top quartile in all reporting areas/neighbourhoods.

What we plan to do

The key things that we have identified to help us to narrow this gap include:

- Improving our data systems to enable us to identify children at risk of achieving poor outcomes and who have delayed development at an early stage, enabling us to target learning support to those who need it most.
- Improving our partnership working to improve the quality, quantity and take up of family orientated preventative health and well being initiatives for children living in our most disadvantaged areas.

Promote healthy weight and lifestyles in children and young people

What we know

In reception year 23.8% of children were overweight or obese and by year 6 this increased to 35.1% (2011/12 data). Within these figures 11.1% were obese in reception, increasing to 20.5% in year 6.

What we want to achieve

We are aiming by 2020 to bring down the numbers of children that are obese or overweight to the levels that existed in 2000 and specifically halt the rising number of overweight and obese children under 11.

What we plan to do

- Continue the annual National Child Measurement Programme (NCMP).
- Review and implement Leicester's obesity strategy and the Leicester Sport Partnership Trust's implementation plan
- Support schools to maintain their Healthy Schools status and achieve an enhanced Healthy Schools status with a focus on childhood obesity
- Further promote the 'Leicester Gets Active4Life' scheme to increase levels of physical activity in those aged 14 years and over
- Ongoing support of active travel initiatives to increase levels of walking and cycling. This includes children's cycle training and improving cycle paths to encourage and support recreational cycling and commuting
- Build on the range of walking projects that promote walking to school, walking for health and structured education to reduce the risks of inactivity
- Re-commence a children's weight management programme for 4 – 14 year olds who are overweight or obese
- Explore opportunities to reduce the proliferation of fast food outlets in the city and work with existing outlets to make their food healthier.



http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review, Executive Summary, p.16

8. Strategic priority 2:
Reduce premature mortality

- **Reduce smoking and tobacco use**
- **Increase physical activity and healthy weight**
- **Reduce harmful alcohol consumption**
- **Improve the identification and management of cardiovascular disease, respiratory disease and cancer**

Why we chose this priority

The length of time that people are expected to live from birth is a key indicator of overall health of a population. In Leicester life expectancy is improving, as elsewhere, but remains significantly worse than England and East Midlands and the life expectancy gap with England is widening. Rates of premature death (under 75 years) are higher than in England, and nearly 70% of all deaths and 66% of premature deaths are caused by cardiovascular disease (heart attacks and strokes), cancers and respiratory disease (2008-2010).

The Leicester JSNA 2012, DPH Annual Reports and national work on tackling health inequalities indicate a number of key issues that lie behind the high rates of premature death in Leicester.

- **Deprivation.** Poor population health is driven by underlying levels of social and economic disadvantage and deprivation
- **Lifestyle.** Smoking, lack of physical activity, obesity and alcohol misuse feature among the leading causes of the conditions which lead to premature death in the UK and in Leicester
- **Ethnicity.** The city's sizeable South Asian populations experience consistently higher premature mortality from coronary heart disease (CHD) by 50% and much higher rates of other cardiovascular conditions, particularly of diabetes
- **Health care.** The offer, access and take up of health care services, particularly in primary care is critical but, in Leicester, variable
- **Engagement**. Improving health cannot be a matter only of 'providing interventions', no matter how evidence-based. Receptiveness and take up requires engagement and involvement and a partnership with communities to improve health together. This may be through prevention, self-management, engagement with health care providers or, more generally, greater empowerment and ownership of solutions.

One key challenge is combining cost effective public health interventions with healthcare improvements for 'at risk' groups whilst engaging and mobilising communities into an overall effective programme of the right scale to have a significant impact.

Generally services are targeted on communities and groups with the highest prevalence of risk or poorest health. Those with the worst health tend to share risk factors (e.g. those who smoke, are more likely than those who do not also to drink harmfully, report poorer health, poor diet, low physical activity, and poorer mental health) suggesting for some higher risk groups the need for more integrated 'lifestyle' approaches.

We also know that a proportion of people with serious health conditions have not had this diagnosed by their GPs. LC CCG has commissioned a piece of work to

8. Strategic priority 2 continued

identify health interventions which would have greatest impact on the greatest health inequalities in the city.

Reduce smoking and tobacco use

What we know

Smoking is the UK's biggest killer, cause of health inequalities, and drain on the NHS. Smoking significantly contributes to Leicester's overall poor health and health inequalities. Reducing smoking is a strategic priority for Leicester. The vision is for Leicester to be substantially smoke free by 2035.

Smoking causes 70% of deaths from coronary heart disease (CHD) and 84% of deaths from lung cancer and chronic obstructive pulmonary disease in England.

Nationally, smoking prevalence is estimated at 21% (Health Survey for England 2011). In Leicester, smoking prevalence in a lifestyle survey of 2010 reported 26% of all adults as current smokers, with a higher prevalence in men (29%) than women (22%).

The Leicester survey also showed:

- Smoking prevalence is highest in 25-34 year olds, reducing as people grow older
- 26% report smoking in their own home
- Among different ethnic groups, White groups have the highest prevalence of smoking (36%), Asian British 13% and Black British 11%
- The west of Leicester shows areas with the highest smoking rates, corresponding to areas of high deprivation and a mostly White population
- Of all smokers in Leicester 68% want to give up smoking, with most (84%) wanting to give up for health reasons. Of those smokers who have heard of the Leicester STOP! Smoking service, only 26% have used it

Smoking levels in pregnancy have shown a general downward improvement. In 2011-12, 12.7% of women reported smoking at time of delivery in Leicester, which is lower than nationally (13.5%). As with smoking levels generally, there is variation with higher rates of smoking in pregnancy seen in the west of the city.

What we want to achieve

To continue to reduce smoking in Leicester year on year.

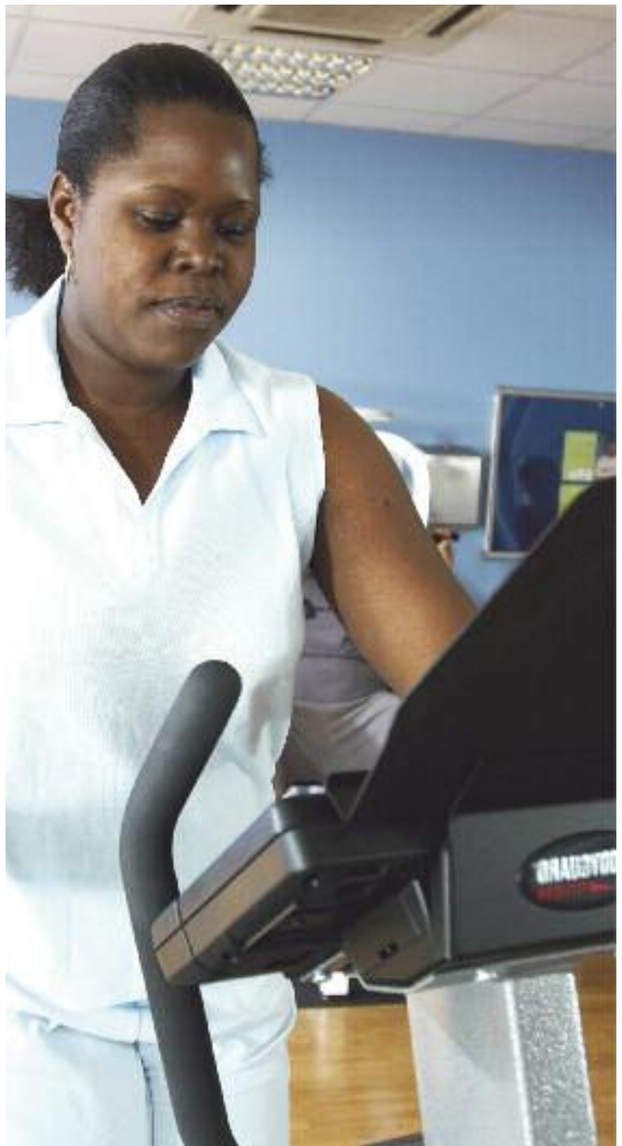
What we plan to do

- Strengthen the strategic leadership to influence decision-making
- Reduce exposure to second-hand smoke
- Motivate and help smokers and other users of tobacco to quit and stay quit
- Work to prevent young people taking up smoking
- Use media and communication effectively to inform about the dangers of smoking and motivate people to stop or not to start
- Reduce the availability and supply of illegal tobacco and under-age sales
- Evaluate and monitor our performance as we move towards our target of smoke-free Leicester

Increase physical activity and healthy weight

What we know

Nationally, the Health Survey for England 2011 shows that 25% of the adult population are obese and 62% either overweight or obese (65% of men and 58% of women). This equates to approximately 160,000 of the Leicester adult population being overweight or obese. Combining weight and waist measurement can be used to estimate risk of obesity-related long term health problems such as heart disease and type 2 diabetes.



Nationally, 56% of adults have an increased risk, a high risk or a very high risk of obesity-related problems, which equates to at least 146,000 people in Leicester; This could be an underestimate as higher levels of heart disease and diabetes are associated with specific ethnicities such as South Asians.

It is estimated that only a quarter of Leicester adults (25.8%) eat the recommended 5-a-day fruit and vegetables compared to an England average of 28.7 %.

Local area estimates for adult participation in sport and active recreation indicate only 17.7% of adults undertake the equivalent of 30 minutes on three or more days a week (Active People Survey: Oct 2010-Oct 2012). The Department of Health recommendation is 150 minutes of physical activity a week.

What we want to achieve

An increase in levels of physical activity in both adults and children and a reduction in levels of obesity and overweight.

What we plan to do

- Develop a social marketing programme to raise awareness of, promote and support healthy lifestyles
- Establish a lifestyle referral hub to improve and maximise access and referrals to healthy lifestyle services including the Active Lifestyle Scheme (GP referral), health trainers, physical activity opportunities and weight management programmes
- Ongoing support of active travel initiatives to increase levels of walking and cycling including adult cycle training for new cyclists and improving cycle paths to encourage and support recreational cycling and commuting
- Review the service model for adult weight management.

Reduce harmful alcohol consumption

What we know

Leicester has alcohol-related death and hospital admission rates that are significantly higher than the England average and this is rising.

The alcohol attributable death rate for men in Leicester is the 8th highest (out of 326 local authority areas) in England (source Local Alcohol Profiles England (LAPE) 2012)

In the year 2011-12 there were 6,283 alcohol-related hospital admissions of Leicester City residents, giving a significantly higher admission rate than nationally. Rates of alcohol-related hospital admissions vary geographically across the city. Combining the last three years data (2008-2011) shows significantly higher rates in Braunstone Park and Rowley Fields, New Parks and Castle, Eyres Monsell, Freeman, Westcotes and Charnwood neighbourhoods.

The annual cost to the NHS in Leicester of alcohol-related admissions is estimated at over £10 million.

From a lifestyle survey carried out in 2010, just over half respondents stated they drank alcohol (lower than the national level). However, over a quarter of respondents (27%) stated they drank above the recommended maximum units on a typical day when they were drinking alcohol.

What we want to achieve

- To have contained the rise in alcohol related hospital admission and deaths and subsequently reduce them.
- To halt the rise in harmful consumption of alcohol.

What we plan to do

- Raise public awareness of the health and wellbeing risks of excessive alcohol consumption
- Improve social norms with respect to alcohol consumption, increase understanding of recommended drinking levels and reduce levels of excessive alcohol consumption
- To improve access to appropriate, structured and effective alcohol treatment and support services for people affected by alcohol misuse
- To reduce under-age sales of alcohol and subsequent harm to children and young people
- Continue to work with community partners to reduce the level of alcohol related harm across our city

Improve the identification and clinical management of cardiovascular disease, respiratory disease and cancer

What we know

Across Leicester there is variation in primary care access, take up and outcome, which hampers the identification of individuals who would benefit from early identification of disease, or risk of disease and early treatment or other interventions.

Work to improve the take up of NHS Health Checks locally is underway but their take up is lower than estimates of the proportion of the population with a higher risk of cardiovascular disease. There is lower identification and treatment of coronary heart disease by GPs than is expected from estimates of need in the population. A key indicator of clinical management of people with diabetes, HbA1c, is statistically significantly worse than in comparator areas and in England as a whole. Take up of breast cancer screening is on the England average. Take up of cervical screening is lower than England. There are lower referral rates for diagnosis and treatment than in England generally which means that people may be getting into treatment later.

8. Strategic priority 2 continued

Gaps include greater ascertainment of disease, or its likelihood and improved management and support of those with identified conditions.

The National Support Team for Health Inequalities (NST HI) guidance focuses on selected evidence-based interventions to achieve improvements in life expectancy in the short term. The guidance suggests that:

Identifying disease or its likelihood at an earlier stage improves outcomes.
For example:
- identifying people with a high risk of cardiovascular disease (CVD) and diabetes.
- increasing public awareness of the signs and symptoms of early cancers and the ability of GPs to identify cancers at an early stage and refer to treatment improves outcomes

Improving the clinical management of existing conditions improves outcomes.
For example:
- further prevention for people with a previous CVD event or heart disease
- additional treatment for people with high blood pressure and no previous CVD event
- anticoagulant therapy for all patients over 65 with atrial fibrillation
- managing the health care of people with diabetes by reducing blood sugars (HbA1c) over 7.5 by one unit
- improving the management of chronic obstructive pulmonary disease (COPD)

A focus on ill-health prevention should be maintained.
For example:
- reducing smoking in pregnancy
- reducing harmful alcohol consumption
- maintaining focus on smoking cessation clinics

What we want to achieve
- Earlier identification of risks to health and the earlier provision of preventative care
- Ensure that there is an increase in the numbers of patients on relevant disease registers and the conditions of these patients are being managed appropriately.

What we plan to do
- Substantially increase the take up of the NHS Health Check Programme and subsequent management of those people identified as high risk of a CVD event or diabetes
- Ensure that all GP practices have the level of skills and competencies to more effectively manage patients with diabetes in the community and the knowledge and skills in relation to CVD, lifestyle factors and interventions
- Increase the numbers screened for cancer
- Improve the identification and referral of patients with cancers
- Work to improve awareness and implement a patient education programme
- Design and implement a patient and clinical education programme
- Improve access to COPD services and disease management, including the use of telemedicine and telehealth

9. Strategic priority 3:
Support independence

Support independence for:
- **People with long term conditions**
- **Older people**
- **People with dementia**
- **Carers**

Why we chose this priority
Supporting independence can have a positive impact on people's health and wellbeing.

Access to preventative services is essential to prevent ill health and to achieve greater independence. Preventative services can improve the quality of life. They also prevent problems from arising or worsening, thus avoiding or delaying the need for intensive and more costly interventions and services later. Preventative services can include falls checks, aids and adaptations, access to community equipment, assistive technology and appropriate good quality warm housing and screening for early detection and improved management of long term conditions.

Local neighbourhood networks are also important for providing community support. They reduce the need for statutory services, and enable people to remain within their community.

Long term conditions
What we know
Long term conditions include diabetes, respiratory disease (particularly Chronic Obstructive Pulmonary Disease (COPD) and Cardiovascular Disease (CVD)); they are more common among people from lower socio-economic groups and certain Black and Minority Ethnic (BME) groups. They are major causes of early death, contributing substantially to the life expectancy gap. There is a range of data which helps us to estimate the number of people living with long term conditions and which are outlined here.

The 2011 census shows that over a quarter (32,447) of city households in 2011 included a person with a long-term health problem or disability that limits the person's day-to-day activities and has lasted, or is expected to last, at least 12 months. This includes problems that are related to old age.

The table below shows how many people are registered with GPs in Leicester as having long term conditions, and is taken from figures submitted to the NHS Quality Outcomes Framework 2011-2012. It should be noted that there is recognition that not all people with long term conditions have had these conditions registered by their family doctor. Not all long term conditions defined in this table are limiting, but many are and others may become so.

Source: Quality Outcomes Framework 2011-2012.

Condition	Number (%) of people in Leicester estimated to have each condition
Chronic Kidney Disease (18+)	8,623 (3%)
Atrial fibrillation	3,260 (0.9%)
Heart failure	2,584 (0.7%)
Dementia	1,616 (0.4%)
Chronic obstructive pulmonary disease (COPD)	4,853 (1.3%)
High blood pressure	42,707 (11.4%)
Diabetes (17+)	21,138 (7.3%)
Coronary heart disease	10,101 (2.7%)
Cancer	3,754 (1.0%)
Stroke/Transient ischaemic attack	4,507 (1.2%)
Depression (18+)	30,831 (10.9%)
Mental Health	3,553 (1.0%)
Learning Disability	1,623 (0.6%)

9. Strategic priority 3: continued

What we want to achieve
People with long term conditions will be better managed and have earlier detection and access to services.

What we plan to do
- Develop further co-ordinated health and social care systems for patients with long term conditions across Leicester
- Continue to develop and implement the re-ablement pathway that offers intensive support after hospital discharge or prevents inappropriate hospital admissions in patients with long term conditions, particularly those who are vulnerable
- Continue to support education and training for clinicians and other staff to improve treatment and care
- Develop joint investment plans and integrated services across health and social care to ensure a co-ordinated approach to preventative services
- Review and strengthen self-management and patient education programmes to support patients in managing their own conditions
- Improve access to information for people from Black and Minority Ethnic (BME) communities
- Review and strengthen psychological support of people with physical long term conditions and the management of the physical health of those with enduring mental health problems
- Ensure a continued focus on preventing fuel poverty, particularly given the number of vulnerable residents in the city.

Older people
What we know
Data from the 2011 census show that there are about 37,200 (11.3%) people aged 65 and over in Leicester. Around 5,400 of these are aged 85 and over. The population of older people is projected to continue to increase over the next 15 years, which will mean increased demand for statutory services. Although older people are tending to stay in good health for much longer in their lives, over 85 is the age when older people are most likely to be in need of intensive health and social care services. Evidence also shows that the risk of dementia increases substantially in people over 85 years.

Falls are a common problem for older people and often result in fractures and hospital admissions. This often results in older people being placed into residential care and losing their independence. Predicting Older People Population Information (POPPI) data predicted that 10,254 people in Leicester over 65 would have a fall in 2012 (10,726 in 2016). The estimate for hospital admissions as a result of falls is 819 in 2012, rising to 836 in 2016.
There are also increased numbers of older people, mostly women, caring for others.

What we want to achieve
Older people will have improved access to services and be better able to maintain their independence. There will be fewer falls and improved community support to promote wellbeing. We will promote better end of life care including greater choice and support for older people and their families.

What we plan to do
- To develop co-ordinated health and social care preventative services and pathways that will enable older people to retain and maintain their independence for longer.
- Develop an Older Persons Strategy to support the co-ordination and delivery of culturally appropriate services across health, social care, housing and other relevant organisations, and to ensure provision of high quality services
- Increased participation of older people in their neighbourhood to increase social inclusion and general wellbeing.

People with dementia
What we know
The Joint Leicester, Leicestershire and Rutland (LLR) Dementia Commissioning Strategy (2011 to 2014) identified that there are an estimated 3,000 people with dementia in Leicester, with about 800 new cases occurring in a year. These are not always registered with GPs. Most people with dementia are aged 65 and over, but there are about 70 younger people with dementia.

Of the people aged over 65 with dementia living in Leicester we estimate that 60% live in the community and 40% live in care homes.
The LLR strategy also identified the need for early diagnosis and improved community based services and greater support for carers.

What we want to achieve
We will work to improve awareness of the needs of people with dementia and their families, promote earlier diagnosis and intervention, and provide a higher quality of care.

What we plan to do
- Support the implementation of the Joint LLR Dementia Strategy
- Develop co-ordinated services across health and social care, including establishing a memory assessment pathway and shared care protocol
- Develop respite and crisis response to prevent unnecessary hospital admissions.
- Ensure that carers receive appropriate and timely support through improved access to information and the implementation of carers' assessments
- Ensure re-ablement and intermediate care pathways are appropriate for people with dementia and facilitate early discharge back into the community.
- Ensure that people are enabled to live independently and safely within their own homes by the provision of appropriate, high quality support services and assistive technology
- Raise awareness of dementia and the availability of services within specific communities
- Ensure that the care delivered in hospitals, residential and nursing homes is of the highest quality

9. Strategic priority 3: continued

Carers

What we know

The Joint Leicester, Leicestershire and Rutland (LLR) Carers Strategy (2012 to 2015) identified that there are approximately 30,000 people in the city who are carers. However, only 1,233 Adult Social Care assessments for carers were carried out in the last year. This highlights the low level of support given to this group at this time.

The majority of carers are female – in 2001 two thirds were female but there is evidence this gap is narrowing, largely due to the rise in older male carers[3]. Of the carers, 20% care for 50 hours per week and more than 30% care for between 20 and 50 hours.

One in six carers is an older person, however the majority are of working age. There are an estimated 1,128 young carers. Projections suggest that by 2022 the number of carers in Leicester will rise to approximately 38,500. This is a 28% increase in 10 years.

What we want to achieve

We want to ensure that carers' needs are recognised and support is given to enable them to continue with their caring role and to undertake activities beyond caring to support their own well-being.

What we plan to do

- Support the implementation of the Joint LLR Carers Strategy (2012 to 2015)
- Ensure services and support for carers are co-ordinated across health and social care
- Ensure carers and their needs are identified at an early stage and action is taken to support them to retain their independence, such as respite
- Support carers to fulfil their educational and employment potential
- Ensure that carers can access personalised support to enable them to have a life beyond their caring role
- Ensure all carers have access to high quality information and advice, both early on in their caring role and throughout their time as a carer

[3]Figures are based on estimates from the proportions of people receiving carers' assessments

10. Strategic priority 4:
Improve mental health and emotional resilience

- **Promote the emotional wellbeing of children and young people**
- **Address common mental health problems in adults and mitigate the risks of mental health problems in groups who are particularly vulnerable**
- **Support people with severe and enduring mental health needs**

Why we chose this priority

Leicester has high risk factors for poorer mental health (The Community Mental Health Profile 2013) such as high rates of deprivation and unemployment, but a lower than expected proportion of people with depression. However, there is a significantly higher proportion of the Leicester population registered with a mental illness compared to the national or regional averages and the trend is worsening. By 2030 there is likely to be a 16% increase in 18-64 year olds in Leicester with a common mental illness (such as anxiety or depression) and a 7% increase in those with more than one co-existing mental illnesses.

Mental illness is the largest single source of burden of disease in the UK. Almost 23% of the total burden of disease in the UK is attributable to mental disorders, compared to 16.2% for cardiovascular disease and 15.9% for cancer (World Health Organisation). Mental illness can affect anyone of any age and many people will suffer mental illness over their lifetimes. It is associated with social exclusion, deprivation, domestic violence, low income, unemployment, poor housing, drug and alcohol misuse and low educational attainment. Mental ill health is also associated with poor physical health and high risk taking behaviour. Those who care for a relative or friend are known to suffer high rates of mental illness. National evidence suggests that more than 70 per cent of the prison population have mental health issues. BME groups are, on average, three times more likely to experience psychosis than White British ones.

The estimated number of people with anxiety and depression is about 30,000 and prescriptions for anti-depressant medications are increasing. Leicester has higher rates of emergency admission for self-harm and a high mortality rate for death from suicide and undetermined injury. It is likely that given the current economic downturn and the increase in unemployment in the city, we can expect these figures to increase. Our priority therefore has a focus on increasing emotional resilience to mitigate the psychological impact of the current economic climate.

In addition, the national mental health strategy noted that 'Mental health problems can also contribute to perpetuating cycles of inequality through generations. However, early interventions, particularly with vulnerable children and young people, can improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. Such interventions not only benefit the individual during their childhood and into adulthood, but also improve their capacity to parent, so their children in turn have a reduced risk of mental health problems and their consequences'[4].

[4] No health without mental health: A cross-government mental health outcomes strategy for people of all ages. HM Government 2011.

10. Strategic priority 4 continued

Promote the emotional wellbeing of children and young people

What we know

One in ten children aged between five and 16 years has a mental health problem, and many continue to have mental health problems into adulthood.

A good start in life and positive parenting promote good mental health, wellbeing and resilience to adversity throughout life.

Positive attachment between a young child and their primary care-giver has been consistently shown to be important for healthy early development.

Early interventions, particularly with vulnerable children and young people, or where a lifelong condition such as Autistic Spectrum Disorder is diagnosed, can improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime.

Children and young people can suffer greatly from the effects of mental health stigma.

What we want to achieve

We would like to focus on prevention and early intervention. This can help prevent emotional and behavioural difficulties, under-attainment at school, truancy and exclusion, criminal behaviour, drug and alcohol misuse, teenage pregnancy and the subsequent need for high cost statutory social care in later life.

We also want to provide intensive support for families with multiple problems and tackle discrimination and stigma.

What we plan to do

- Undertake a Specific Health Needs Assessment better to understand the needs of children and young people in relation to mental health and emotional resilience
- Improve our knowledge of barriers to early access including work to tackle the stigma and discrimination associated with mental health
- Work with communities to empower children and young people by ensuring services are centred on their needs and protect their rights
- Improve access to psychological therapies for children and young people.

Address common mental health problems in adults and mitigate the risks of mental health problems in groups who are particularly vulnerable

What we know

- Leicester has significantly worse rates of unemployment among working-age adults and is above the national average for people aged 16-18 not in employment, education or training. The availability and quality of an appropriate home has a substantial impact on mental health. These are significant risk factors for mental health problems
- Alcohol and drug misuse (dual diagnosis) are significantly worse for Leicester than the national and regional averages. People with mental health problems are more likely to have poor physical health and people with poor physical health are more likely to have mental health problems. Increased smoking is responsible for most of the excess mortality of people with severe mental health problems
- The health and social care needs of new arrivals to Leicester are different to other disadvantaged and vulnerable groups, due to language and cultural issues with the addition of specific mental and physical health issues compounded by difficulty accessing services
- National evidence suggests that more than 70% of the prison population have mental health issues

What we want to achieve

- Improve the offer, access, take-up and outcomes of health and social care services
- Reduce lifestyle risk factors for mental health
- Engage and mobilise communities to improve their own health and wellbeing.

What we plan to do

- Focus on prevention and grass roots community work, using a community assets approach which utilises and recognises the skills and knowledge within communities
- Work in partnership to improve access to debt counselling and housing advice for people in financial crisis or at risk of homelessness
- Improve the diagnosis and treatment of mental health problems for those with long term physical conditions and the identification and treatment of anxiety or depression for those with physical health problems including medically unexplained symptoms
- Improve access for people with mental health problems to public health services that aim to

increase physical activity and healthy eating, stop smoking and reduce harmful consumption of alcohol and drugs. These services also need to identify and refer people to relevant mental health services where appropriate
- Increase numbers of drug and alcohol users into treatment and increase the number of those successfully completing treatment through the commissioning of a recovery oriented treatment system.
- Ensure services are targeted and made accessible to specific groups such as substance misusers; people who experience domestic violence; newly arrived migrants; people in the criminal justice system; homeless people; people on the autistic spectrum; people with learning disabilities, and carers.
- Work in partnership with other services within the city such as cultural services, to deliver activities and environments which support good mental health

Support people with severe and enduring mental health needs

What we know

In Leicester there is a significantly higher proportion of the population registered with a mental illness than in England and the East Midlands and the trend is worsening. The estimated number of people in Leicester with serious and enduring mental illnesses, such as schizophrenia, bipolar affective disorder and other psychosis, is about 3400 people. Leicester has higher rates of emergency admission for self-harm and a high mortality rate for death from suicide and undetermined injury.

Specifically:

- Some black groups have admission rates around three times higher than average, with some research indicating that this is an illustration of need
- Migrant groups and their children are at two to eight times greater risk of psychosis
- About one in 100 people has a severe mental health problem
- People with severe mental illnesses die on average 20 years earlier than the general population

What we want to achieve

- Support commissioning of effective mental health services that are accessible to all, including the most disadvantaged and excluded.
- Ensure that all people with severe mental health problems receive high quality care and treatment in the least restrictive environment, in all settings.
- Ensure equity of access to high-quality, appropriate, comprehensive services for all groups, including the most disadvantaged and excluded

What we plan to do

- Ensure that services are designed around the needs of individuals, ensuring appropriate, effective transition between services when necessary, without discriminatory, professional, organisation or location barriers getting in the way
- Continue to work to reduce the suicide rate for Leicester city
- Work to promote the public understanding of mental health and so decrease negative attitudes and behaviours to people with mental health problems
- Improve access and uptake of mental health services among homeless people and ensure that such services are designed with the particular needs of these groups in mind and that such services take account of the very diverse range of mental health needs and dual diagnosis and include an outreach element.

11. Strategic priority 5:

Focus on the wider determinants of health through effective deployment of resources, partnership and community working

Priority five is a cross-cutting priority - to focus on tackling the wider and social determinants of health – the so called causes of the causes of poor health and health inequalities and to do this through partnership and community working.

Why we chose this priority

The wider or social determinants of health have been described as 'the causes of the causes' of poor health. They are the social, economic and environmental conditions that influence the health of individuals and populations. They include where people live, their housing and education; the jobs they do and the differences in income within and between communities; their access to healthcare, transport, healthy food, and green spaces. They are fundamental to how we live our lives. They determine the extent to which a person has the right physical, mental and social resources to achieve their goals, meet needs and deal with changes to their circumstances. Health inequalities result from social inequalities. If we are serious about reducing health inequalities we must therefore be serious about taking action across all the social determinants of health.

These factors and their interaction are represented in the diagram.

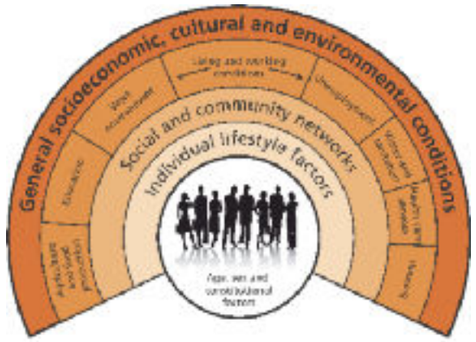


Figure 3: Dahlgren and Whitehead (1991)

The control of these key factors that affect people's health are mainly located outside of the NHS. Tackling these wider determinants therefore means we all need to work together. Central and local government, the NHS, the third sector, the education system, the private sector, individuals, families and communities all have significant roles and responsibilities for reducing health inequalities and delivering the interventions needed to make a difference. The Joint Health and Wellbeing Strategy gives us the opportunity to do just this. By having an agreed vision and approach and in determining agreed priorities we can work together to achieve real change. This is why we have chosen wider determinants and partnership and community working as a cross-cutting theme running right through the strategy. More than words though, it is fundamental to how the strategy will be implemented. We need to use all the assets of our diverse communities to drive the strategy forward. Only by working together can we begin to enable ALL the people of Leicester to live long fulfilling and healthy lives.

What we want to achieve

We want to reduce inequalities in health outcomes across the city. We recognise that in order to do this we need to engage people in improving their own health and we will promote this through real community engagement and the mobilisation of resources across all sectors of the city to work in partnership.

What we plan to do

- Understand local health inequalities and what is effective in reducing them.
- Explore with health and social care professionals and wider groupings within the city council, the NHS and the voluntary and community sector how to work in a co-ordinated and integrated way to improve health and wellbeing through effective deployment of resources, partnership working, engagement and community development
- Assess the health/health inequality implications of decisions made that will change service provision to local residents
- Encourage local professionals to explore with seldom heard and community groups how to improve two-way communication, fostering better relationships and understanding and leading to improved perceived access to health and social care services

12. Equalities

Our equality duties

The Health and Social Care Act 2012 has introduced a new duty to reduce health inequalities. This will be done through the NHS Commissioning Board and clinical commissioning groups, each being under a duty to have regard to the need to reduce inequalities in access to and the outcomes of health care.

This new duty sits on top of the existing Public Sector Equality Duty set out in the Equality Act 2010 upon which decision makers have a duty to have regard of the equality implications of their decisions and, where there are adverse impacts on any group with a shared protected characteristic, for mitigating actions to be identified that will reduce or remove identified adverse impacts.

How we meet our equality duties

The approach of the Joint Health and Wellbeing Strategy is to reduce specific health inequalities in the city of Leicester based on the evidence contained within the JSNA and engagement sessions on the proposed priorities. The health inequalities cited will address adverse health impacts experienced by local residents. The suggested actions set out the mitigating actions to address these adverse impacts. The protected characteristics of the various target groups covered by the strategy and action plans will be highlighted in order to enable decision makers to have due regard of the equality implications of their decisions.

14. Engagement

The process of engagement

A process of engagement during the development of the strategy was carried out with a range of groups. These included several attendances at Voluntary Action LeicesterShire (VAL) health and social care forum for professionals from the local voluntary sector (40 people) and two engagement events organised by Leicester Local Involvement Network (LINk) (76 people), which a wide range of stakeholders attended, including members of the LINk and representatives of a number of voluntary and public sector bodies and seldom heard groups. The draft strategy was discussed at the City Partnership Board. Representatives of the board also met with four further partnership boards and five seldom heard groups. A questionnaire was circulated electronically to the Shadow Health and Wellbeing Board electronic engagement network, MPs, Leicester City Councillors, the voluntary sector via VAL, LINk members and individuals in NHS Leicester City's membership scheme, and distributed at events. Ninety five questionnaires were completed, representing individuals and organisations. Presentations were made at the CCG's locality meetings to gather feedback from GPs.

The data collected showed broad agreement with the initial principle and priorities, but a number of people questioned what the definition of 'vulnerable' was and felt the term was too broad. As a result one of the strategic priorities was changed from 'meeting the needs of the most vulnerable in society' to 'supporting independence'.

Further engagement was carried out to gather feedback on the final draft strategy, and to understand how individuals and groups can help implement the strategy. A grid showing the engagement is at Appendix A.

Additional priorities arising out of the engagement

Besides the feedback on the suggested priorities, two issues have stood out from engagement feedback received as we have developed the strategy.

The first is the need for engagement and community development. It is clear that no matter how great the evidence for interventions, if they are not supported by a fully engaged population, then the benefits will not be as great as they otherwise would be. The Marmot Report 'Fair Society, Healthy Lives', says, 'It is vital to build social capital at a local level to ensure that policies are both owned by those most affected and are shaped by their experiences.[5]

The second is the need for better communication, both at a one-to-one level between professionals and patients/service-users and through providing clear, easy-to-understand information about the services that are available.

A number of the seldom heard groups we spoke with during the strategy development discussed their difficulties with issues such as interpretation and lack of understanding of services. There was a willingness for community groups to work with professionals to address this. This feedback is reflected in Priority 5.

[5]http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review, Executive Summary, p.24

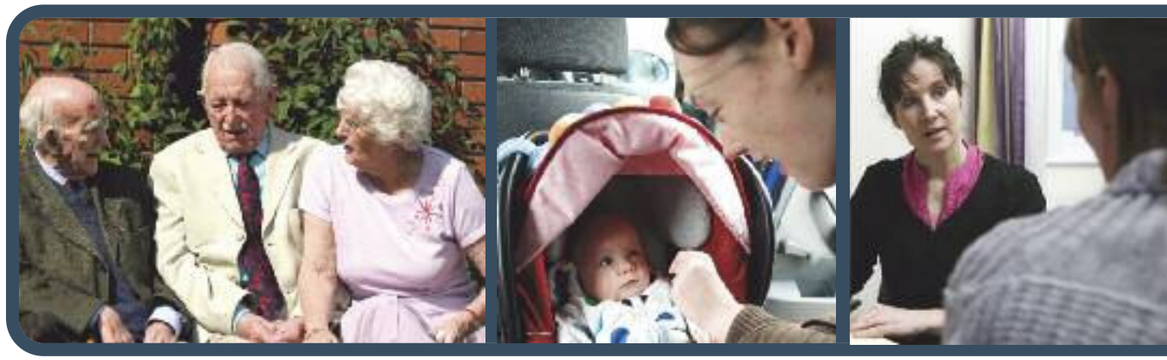
14. Measuring our progress

We have developed a set of indicators which will help us measure the progress of the strategy. In doing this, to avoid confusion we have tried wherever possible to use indicators that are already being measured by the Clinical Commissioning Group or within the City Mayor's delivery plan. We have also avoided including specific figures, but rather have shown our starting point and the progress we expect to be made – the ambition of the strategy is to improve on current positions for all our priorities.

We have chosen a relatively small number of indicators as these will be proxies for the progress of the wider strategy. We have included earlier in the strategy more detail about the issues we are addressing and the types of improvements we will expect to see. There is also information about some of the geographical areas where we would like to focus improvement because of particular need.

The indicators will be monitored annually. They will show specific progress, but our aim is that the strategy will be adopted by all parts of the system in Leicester, in order to maximise improvement in health and wellbeing across the city. The indicators are at Appendix B.

15. Next steps



This strategy is intended to focus on a set of priorities which can be adopted by all those in Leicester who can influence health and wellbeing.

The new LC CCG and Leicester City Council will both use the strategy to help them develop their own priorities for the next three years.

Beyond this, we want other groups working within the city, in areas such as housing, environment and the arts, among community groups and the voluntary sector, to look at how their work can help achieve our aims.

To help with this, we will:

- Publicise the strategy widely, meeting with key decision-making and community groups
- Work jointly to produce an implementation plan for each of the priorities
- Continue the engagement we have begun in the development of this strategy, listening to stakeholders, patients and the public to understand what is working and what is not working
- Monitor the progress of the priorities through updates to the Health and Wellbeing Board from the CCG and the City Council and other relevant bodies
- Revisit and refresh the strategy after a year.

Appendix A: summary of engagement

Leicester City Shadow Health and Wellbeing Board log of engagement about the Joint Health and Wellbeing Strategy

Date	Event	Number
29 Feb 2012	Briefing to Stronger Communities Partnership	10
20 Mar 2012	Presentation update to VAL Health and Social Care Forum	40
28 June 2012	Meet with Andrew Smith from Enterprise Partnership Board	1
3 July 2012	VAL Health & Social Care forum	40
4 July 2012	Link to questionnaire sent to 4706 members of the Leicester City NHS membership scheme (2000)	6706
4 July 2012	Link to questionnaire sent to electronic network, MPs (3), Leicester City Councillors (55), Voluntary Sector(3750), LINk members	3808 + members
5 July 2012	Presentation at the Stronger Communities Board	11
10 July 2012	Presentation at the Safer Communities Board	16
12 July 2012	LINk HealthWatch stakeholder workshop	76
16 July 2012	Somalian Response Centre (men)	12
17 July 2012	Somalian Response Centre (women)	12
26 July 2012	Presentation at the Children's Trust Board meeting	19
26 July 2012	Presentation at the Culture Partnership Board	9
30 July 2012	Meeting at Chinese Community Centre	14
1 Aug 2012	Presentation to Connexions meeting	8
20 Aug 2012	Presentation at African Caribbean Centre	26
22 Aug 2012	LPCG Locality Meeting	17
27 Sep 2012	City Central CCG Locality Meeting	25
4 Oct 2012	Presentation at the Sports Partnership Board (postponed from 19 July)	16
1 Nov 2012	City Partnership Board	27
6 Nov 2012	VAL Health & Social Care Forum	c. 40
14 Jan 2013	LINk follow-up engagement event	25
14 Jan 2013	Local Dental Committee	20
16 Jan 2013	Public Health Network	c. 50
17 Jan 2013	Follow up presentation at the Children's Trust	19

Appendix B Leicester Joint Health and Wellbeing Strategy 2013-16 Indicators

1 Improve outcomes for children and young people

Lead Indicator	Definition	Most recent position
Readiness for school at age 5	The percentage of children who are at the emerging, expected or exceeding level across the agreed key Early Learning Goals (Communication and language, Physical Development and PSE)	2012 results show that at Foundation Stage 64% of pupils demonstrated that they had a good level of development (social and literacy skills) and are therefore "Ready for School".
Supporting indicators		
Breastfeeding at 6-8 weeks	% of mothers breastfeeding at 6-8 weeks after birth	2011/12: 54.9%
Smoking in pregnancy	Rate of smoking at time of delivery per 100 maternities	2011/12: 12.7%
Conception rate in under 18 year old girls	Rate of conceptions in under 18 year old girls per 1,000 15-17 year old girls	2011: 30.0
Reduce obesity in children under 11 (bring down levels of overweight and obesity to 2000 levels, by 2020)	% of reception year children who are obese and overweight and % of year 6 children who are obese and overweight	2011/12 School year levels of obesity: Reception: 11.1%, Year 6: 20.5%

2 Reduce premature mortality

Lead Indicators	Definition	Most recent position
Number of people having NHS Checks	Number of people offered and in receipt of health checks	2011/12: Offered: 13395 Received: 8238
Smoking cessation: 4 week quit rates	Number of 4-week smoking quitters per 100,000 population	2011/12: 2806 quitters, 1153 quitters per 100,000 adult population 16+
Supporting indicators		
Reduce smoking prevalence	% of adults who currently smoke	Leicester Lifestyle survey 2010: 26%, Integrated Household Survey 2010/11: 23.4%
Adults participating in recommended levels of physical activity	The percentage of the adult (age 16 and over) population who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 3 or more days a week).	Oct 11 - Oct 12: 17.7%
Alcohol-related harm	Hospital admission rate for alcohol-related harm (DSR per 100,000)	2011/12: 6283 alcohol attributable admissions, equivalent to 1992 per 100,000 population
Uptake of bowel cancer screening in men and women	Percentage of invited population who are screened	43% uptake in 2011/12 (v. 56% in LNR)
Coverage of cervical screening in women	5 year coverage in women aged 25-64 (% of eligible population who are screened)	74.7% coverage in 2011/12 (v. 78.6% in England)
Diabetes: management of blood sugar levels	% of patients with diabetes in whom the last HbA1c is 7.5% or less in previous 15 months (DM26)	2011/12: 62%
CHD: management of blood pressure	% of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less (CHD6)	2011/12: 88.3%
COPD: Flu vaccination	% of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March (COPD8)	2011/12: Leic: 92.3%, Eng: 93.1%

3 Support independence

Lead Indicators	Definition	Most recent position
People with Long Term Conditions in control of their condition	% of people who define themselves as having one or more long term condition who are "supported by people providing health and social care services to manage their conditions"	2011/12: 81.24%
Carers receiving needs assessment or review and a specific carers service or advice and information	The number of carers receiving a 'carer's break' or other specific service following a carer's assessment or review, as a percentage of the number review, as a percentage of the number of adults receiving community-based services.	2011/12 - 18.8%
Supporting indicators		
Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement /rehabilitation services	Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) **who are at home or in extra care housing or an adult placement scheme setting** 91 days after the date of their discharge from hospital.	2011/12 outturn - 83.8%
Older people, aged 65 and over, admitted on a permanent basis in the year to residential or nursing care per 100,000 population	This measure reflects the number of admissions of older people to residential and nursing care homes relative to the population size of each group. The numerator is the number of council-supported permanent admissions of older people (aged 65 and over) to residential and nursing care during the year. The denominator is the size of older people population (aged 65 and over) in area (ONS mid year population estimates)	2011/12 - 608.9 per 100,000 pop
Dementia - Effectiveness of post-diagnosis care in sustaining independence and improving quality of life	A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	Likely to be effective from 2014/15 onwards, but awaiting further guidance from the DOH
Carer-reported quality of life	Self-reported measure - Carers Survey This is a composite measure which combines individual responses to six questions measuring different outcomes related to overall quality of life. These outcomes are mapped to six domains (occupation, control, personal care, safety, social participation and encouragement and support).	Pilot survey held in 2009-10 - 8.7 out of a possible score of 14.
The proportion of carers who report that they have been included or consulted in discussion about the person they care for	Self-report measure - Carers' Survey	Pilot survey held in 2009-10 - 70%

4 Improve mental health and emotional resilience

Lead Indicator	Definition	Most recent position
Self-reported well-being - people with a high anxiety score	The percentage of respondents scoring 4-10 to the question "Overall, how anxious did you feel yesterday?"	2011/12 41.2%
Supporting indicator		
Proportion of adults in contact with secondary mental health services living independently with or without support	The measure shows the percentage of adults receiving secondary mental health services living independently at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting.	2011/12 - provisional outturn based on Qtr. 4 data - 68.1%

Appendix B

LEICESTER CITY HEALTH AND WELLBEING BOARD
11 July 2013

Subject:	The Leicester, Leicestershire and Rutland Healthcare Community response to the Francis Report
Presented to the Health and Wellbeing Board by:	Deb Watson
Author:	Liz Rowbotham

EXECUTIVE SUMMARY:

The Clinical Collaborative Interface Group (CCIG), which brings together the clinical leaders from the clinical commissioning groups, the Leicestershire Partnership Trust , the University Hospitals of Leicester and NHS England local area team, has reviewed the Francis Report about mid-Staffordshire and produced some initial recommendations.

Six cross-cutting themes have emerged: Transparency, Listening, Walking the floors, Saving more lives, Safe Staffing levels and Targeted improvement.

A number of priorities for a first phase of joint work have been identified, and there will be an update in October making it clear how all parts of the system are responding to the Francis Report. Each organisation has also agreed organisation-specific areas for priority.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- receive assurance on the work underway to progress the recommendations from the Francis report
- support the priorities of the work as identified in this paper
- receive a further update in October 2013 on the progress achieved.

The Leicester, Leicestershire and Rutland Healthcare Community response to the Francis Report
Report on behalf of the CCIG and LLR NHS Chief Officers, June 2013

1. Introduction

1.1 On 6 February, Robert Francis QC published his report and recommendations following the public enquiry into the failings in the Mid Staffordshire NHS Foundation Trust and the failings of other organisations charged with the responsibility to regulate, monitor and assure the care provided by the Trust.

1.2 The government published its initial response at the end of March, including highlighting those areas where further work had been commissioned and expected to report by the autumn.

1.3 Within Leicester, Leicestershire and Rutland (LLR) the Clinical Collaborative Interface Group (CCIG) undertook an initial review of the report and then requested LLR chief officers to ensure that an appropriate response of the LLR healthcare community was made.

2. Key Findings of the Francis Report

2.1 The Public Inquiry report determined that the failings at the trust were primarily caused by a serious failure on the part of a provider trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.

2.2 This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking Foundation Trust status to be at the cost of delivering acceptable standards of care.

2.3 The report also concluded that the NHS system included many checks and balances and organizations which should have prevented serious systemic failure of this sort, but that this did not occur. In short, the system which ought to have picked up and dealt with a deficiency of this scale failed in its primary duty to protect patients and maintain confidence in the healthcare system.

2.4 The report concluded that the extent of the failure of the system suggests that a fundamental culture change is needed. This does not require a root and branch reorganization, the system has had many of those, but it requires changes which can largely be implemented within the system that has now been created by the new reforms.

2.5 The Inquiry Report identified numerous warning signs which could and should have alerted the system to the problems developing at the trust.

3. CCIG initial response

3.1 The CCIG, which brings together the clinical leaders from the clinical commissioning groups, the Leicestershire Partnership Trust , the University Hospitals of Leicester and NHS England local area team, discussed the Francis Report at its meeting in March. The discussions were positive and constructive in agreeing a way forward and it was agreed that there would be a number of actions:

- there should be a united public facing statement made , in addition to each organisations own specific response and agreement on a common set of actions, that could be undertaken in partnership
- sharing of those actions which would be undertaken by individual organisations, in recognition of the differing roles and purpose of each organisation in the LLR community.

3.2 The initial proposals for actions to be delivered in partnership included:

-a coherent system across LLR should be established for the collection of soft intelligence on patient care.
-there should be an emphasis on clinical leadership and coherent teamwork.
-the "right place, right care "programme should be extended to primary care
-an effective single front door to the Emergency Department at UHL NHS Trust made a high priority.

3.3 In addition there was a significant consideration to the concept of the Duty of Candour, and in particular how organisations could work to encourage staff to share their concerns.

4. The LLR commitment

4.1 The clinical and managerial leaders of the Leicester, Leicestershire and Rutland NHS community are united in the commitment that they will not allow the focus on quality and safety, which the Francis report has so effectively highlighted , to be disregarded , diluted or ignored ; and as a consequence of that commitment they will report back in public and as a local health system in October 2013 on progress on the areas identified as joint and individual priorities.

5. The common themes

5.1 Since the initial CCIG meeting to discuss the Francis report in March, each of the LLR organisations have spent time listening to staff, patients and stakeholders views. The initial proposed joint areas have been considered and expanded and as a consequence, six common themes have emerged on what the priorities should be to improve our services and to safeguard against the issues highlighted in Mid Staffordshire.

5.2 These 6 areas are:

- **Transparency** -Candour, openness and whistle blowing: a wide ranging set of actions that involve public Boards, Quality Accounts, patient and

public engagement as well as responsibilities on individuals and between organisations.

- **Listening:** all organisations have recognised and recommitted to the principles of listening to patients, staff and other stakeholders who have the critical role of "telling it as it is".
- **Walking the floors**: Providers, and commissioners, have recognised the need to spend more time in face to face observation of wards, departments and surgeries. This intelligence will play a vital role in supplementing the variety of metrics that are in place to measure quality and provide an early warning if care is or has the potential to be unsafe or of a poor standard.
- **Saving more lives**: by working together to redesign care pathways and by providing better care out of hours and at weekends we will save more lives.
- **Safe Staffing levels**: all providers are reassessing staffing levels in critical areas to ensure that they are safe.
- **Targeted improvement**: where areas are found to be struggling to sustain standards of care, support will be given, improvement plans made clear and progress monitored

5.3 These 6 areas of focus do not represent the entirety of the local NHS response to the Francis Report; they are the broad crosscutting themes that have emerged from all organisations.
5.4 In sharing the priorities identified by the CCIG it is apparent that considerable other cross LLR work is also being undertaken. The nursing leads for all organisations are coordinating specific areas of improvements related to the Compassion in Practice programme. A priority in this the role of healthcare assistants and how their standards of care can be assured.
5.5 In addition the actions related to other organisations are not reflected within this paper e.g. the role of Healthwatch locally in strengthening the influence of the patient's voice.
5.6 The October update will need to make clear how all parts of the system are responding to the Francis Report recommendations.

6. <u>The first phase of areas of joint work to be addressed</u>

6.1 The LLR NHS chief officers asked for those areas where working in partnership was a priority and the following areas were identified:

- "Duty of Candour", to establish a common definition and what it means as an LLR wide community in the way we work together.
  Proposed leads (and Forum): Chief Executives and Medical Directors (CCIG)
- In light of the above, a refresh and reaffirmation of our shared values and how these will be enacted.
  Proposed leads (and Forum): Chief Executives and Medical Directors (Better Care Together Programme Board)
- The development of models for clinical leadership across LLR
  Proposed leads (and Forum): Medical Directors (CCIG)

7. Organisation specific priorities

7.1 Each organisation has their own individual work programmes linked to the Francis recommendations and have confirmed their priorities.

- **Leicestershire Partnership Trust**:-has prioritised leadership programmes for multiple levels in the organisation; review of staffing levels for all inpatient areas with additional investment; Listening into Action programme for improving staff engagement; developing a culture for staff to report concerns i.e. transparency not "whistle blowing"; increased transparency of reporting at Board meetings; a refresh of the Quality Strategy; and external assurance on the Quality Governance Framework.
- **University Hospitals of Leicester**:-has prioritised Listening into Action programme for staff engagement; further work on the care of the elderly work programme; ongoing analysis to understand mortality information especially out of hours and weekends; special support measures to some clinical areas from corporate teams; and the introduction of supernumerary status for ward managers.
- **Leicester City CCG:-** has prioritised listening and engagement with patients and the public, with explicit feedback and response; listening to professionals involved in care delivery, with explicit feedback and response; having robust approaches to monitoring and measuring the quality of services, including visits to providers and via the contractual process.
- **East Leicestershire and Rutland CCG: -** has prioritised a refresh of the Involvement and Engagement Strategy and development of a patients forum; a GP champion to lead a work programme to raise concerns and provide feedback from primary care (a relaunch of the system currently in place but inconsistently used); review and strengthening of all provider contracts including out of county providers; review of the structure and focus of quality visits; and setting up a professional forum for practice nurses.
- **West Leicestershire CCG:-** has prioritised improved mechanism for capturing and responding to the patient voice; strengthening the mechanisms for GPs to raise concerns, receive feedback, monitor themes and provide feedback; a review of the quality schedules to include strengthening of the standards and data streams; sharing information with partners; and review of the structure and focus of quality visits.
- **NHS England local area team for Leicestershire and Lincolnshire :-** has prioritised clear mechanisms for input into Serious Incident monitoring; all clinicians to receive a communication regarding reporting of safety and quality concerns; establishment of the quality surveillance group; and a focus of the maintenance of staff moral across all organisations.

8. Timeline for Progress

8.1 Given the above identified areas, these will now be monitored through the Forums set out in Section 5 above. CCIG will oversee coordination of the publication of a further report in October, and will be meeting in September to consider progress to date on the joint and individual priorities.

9. Recommendations

9.1 The Boards of each of the Leicester Leicestershire and Rutland NHS organisations are asked to:

-receive assurance on the work underway to progress the recommendations from the Francis report

-support the priorities of the work as identified in this paper

-receive a further update in October 2013 on the progress achieved.

Appendix C

LEICESTER CITY HEALTH AND WELLBEING BOARD
11 July 2013

Subject:	LLR Health Protection Board
Presented to the Health and Wellbeing Board by:	Deb Watson
Author:	Ivan Browne

EXECUTIVE SUMMARY: Leicester, Leicestershire and Rutland's Health Protection Board has met for the first time and has made some small amendments to its Terms of Reference. It will meet quarterly.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: note the report.

Briefing note for LLR Health and Wellbeing Boards - June 2013: Changes to Terms of Reference (ToR) for the Health Protection Board

At its inaugural meeting on 5 June 2013, the Health Protection Board made a number of small changes to the ToR that had previously been ratified by the three Health and Wellbeing Boards for Leicester City, Leicestershire and Rutland. These changes are:

- The Board agreed to extend an invitation to David Sharpe, for NHS England Area Team to cover its commissioning role. It was also agreed that additional members may be invited where necessary by full agreement of the Board.

- Pandemic influenza should be out of scope, replaced by seasonal influenza.

- The paragraph covering escalation of issues should be simplified to state 'CEOs of relevant organisations' rather than listing them.

- The Board is a sub-group, rather than sub-committee of the Health and Wellbeing Boards.

The Board will meet quarterly at Leicestershire County Hall and meetings will last for a maximum of two hours. The next three meetings for this year will be booked in advance and members notified as soon as possible.

Appendix D

From Norman Lamb MP
Minister of State for Care and Support

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

To: Chairs, Health and Wellbeing Boards
Cc: Council Leaders and Chief Executives
Chairs and Chief Operating Officers, GGCs

Dear Colleague,

Delivery of the Winterbourne View Concordat and review commitments

I am writing to you at the start of your taking on your statutory functions to stress the pivotal local leadership role that Health and Wellbeing Boards can play in delivering the commitments made in the Winterbourne View Concordat[1] which represents a commitment by over 50 organisations across the sector – including the Local Government Association, NHS England, the NHS Confederation, Royal Colleges and third sector organisations – to reform how care is provided to people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. There is widespread agreement across the sector that the care of this group of vulnerable people requires fundamental change.

The abuse of people at Winterbourne View hospital was horrifying. For too long and in too many cases this group of people received poor quality and inappropriate care. We know there are examples of good practice. But we also know that too many people are ending up in hospital unnecessarily and they are staying there for too long.

NHS England, NHS Clinical Commissioners, the Local Government Association, the Association of Directors of Adult Social Services and the Association of Directors of Children's Services each committed to working collaboratively with CCGs and Local Authorities to achieve a number of objectives by 1 June 2014, including that from April 2013, health and care commissioners will set out:

> *"a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of children, young people and adults with challenging behaviour in their area.*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127312/Concordat.pdf.pdf

This could be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) process;

- *The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done.*
- *We will promote and facilitate joint and collaborative commissioning by local authorities and CCGs to support these objectives.*

Health and wellbeing boards have an opportunity through their role in agreeing the CCG and Local Authority Joint Plans to challenge the level of ambition in the plan and ensure that the right clinical and managerial leadership and infrastructure is in place to deliver the co-produced plan.

Health and wellbeing boards will, no doubt, also want to take an active interest in how far the other commitments in the Concordat, particularly those relating to care reviews having been completed by June 2013, have been achieved, as well as satisfying themselves that commissioners are working across the health and social care system to provide care and support which does not require people to live in inappropriate institutional settings.

It will only be through creative local joint commissioning and pooled budgets working with people who use services, their families, advocacy organisations and carers and other stakeholders (including providers) that we will deliver more joined-up services from the NHS and local councils in the future and see real change for this very vulnerable group.

Health and wellbeing boards are well placed to agree when a pooled budget will be established (if not already) and how it will promote the delivery of integrated care – care that is coordinated and personalised around the needs of individuals; which is closer to home and which will lead to a dramatic reduction in the number of inpatient placements and the closure of some large in-patient settings.

The Department of Health has supported the establishment of an NHS England and Local Government Association-led Winterbourne View Joint Improvement Board. This Board will be working closely with a range of partners to develop and implement a sector-led improvement programme working with local health and social care communities to deliver real and lasting change in the support and

care for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. It will shortly be in touch with you separately to take stock of progress in your area so that any appropriate level of support can be arranged.

Due to the very public nature of these failures in care, I am sure that you will want to ensure that your health and wellbeing board is able to provide transparent public information and assurance on progress locally.

Further information about the work of the improvement programme, including a recently issued framework for conducting reviews of care locally, is available on the LGA website. If you have any innovative practice to share, or views on how the programme can be designed and developed to ensure rapid progress and real and lasting change, please contact the programme chair via Chris.Bull@local.gov.uk

Yours sincerely,

NORMAN LAMB

We hope to publish progress around the country in reaching the commitments made in the Concordat in the Summer.

Thanks so much for your work on this incredibly important issue!

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Appendix D1

LEICESTER CITY HEALTH AND WELLBEING BOARD
11 July 2013

Subject:	Leicester City Winterbourne View local stocktake
Presented to the Health and Wellbeing Board by:	Deb Watson
Author:	Yasmin Surti

EXECUTIVE SUMMARY: Winterbourne View was a private hospital providing care and support to people with learning disabilities/autism who displayed challenging behaviour or serious mental health issues. As a result of poor commissioning and the lack of regular and robust reviewing of these "in patients", their complaints went unheard and they suffered horrific abuse at the hands of staff, as highlighted in a BBC Panorama expose.

The Health Minister, Norman Lamb MP, has requested that partners on Health and Wellbeing Boards provide a stocktake of local progress following the Winterbourne View Concordat. Via the Chair, they have been asked to provide assurance on local planning to deliver real and lasting positive change for this group of vulnerable people.

Local Progress to date:

- Reviews have been carried out for all individuals concerned and there is a timeline identified for moving on/discharge for each person.
- There is a shared understanding of the current care arrangements for the 17 adults and 2 children affected and the register is being updated to ensure the dataset reflects the requirements of the Winterbourne Joint Improvement Programme.
- The Joint Commissioning Strategies for Learning Disabilities and for Mental Health are being refreshed and will include the actions from the Winterbourne Joint Improvement Programme.
- The Winterbourne Working Group, formerly the "Six Lives" group, will ensure operational delivery of the programme.
- Governance arrangements have been established to ensure appropriate monitoring of the programme and to ensure people with a learning disability/autism who display challenging behaviour or serious mental health issues are appropriately supported and cared for.

RECOMMENDATIONS: The Health and Wellbeing Board is requested to: note the letter from Norman Lamb and the stocktake report which was submitted to the Winterbourne View Joint Improvement Board on 5th July 2013.

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Winterbourne View Joint Improvement Programme

Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

The sharing of good practice is also an expected outcome. Please mark on your return if you have good practice examples and attach further details.

This document follows the recent letter from Norman Lamb, Minister of State regarding the role of HWBB and the stocktake will provide a local assurance tool for your HWBB.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF). Information compiled here will support that process.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The deadline for this completed stocktake is Friday 5 July. Any queries or final responses should be sent to Sarah.Brown@local.gov.uk

An easy read version is available on the LGA website

May 2013

Appendix D2

Winterbourne View Local Stocktake June 2013			
1. Models of partnership	**Assessment of current position evidence of work and issues arising**	**Good practice example (please tick and attach)**	**Support required**
1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).	1.1 We are developing a local action plan which will be overseen by established governance structures. Additionally we are liaising with our partner authorities in Leicestershire and Rutland and the respective CCGs to develop specific joint actions and closer working arrangements.	1. Governance Structure Chart 2. HWBB Terms of Reference (TOR)	
1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers).	1.2 The Six Lives working group which includes representatives from Adult Social Care, the CCG, Leicestershire Partnership NHS Trust, University Hospitals of Leicester NHS Trust and East Midlands Ambulance Service will take an operational lead to ensure the delivery of the programme. The group will liaise with and provide reports to key stakeholders/partners supporting the programme. These include Public Health, Specialist Providers, Children's Services, Housing, Healthwatch, self-advocates and carers, all of whom are members of the Learning Disability Partnership Board (LDPB).	3. Six Lives TOR	

1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs.	1.3 A refresh of both the Learning Disability and Mental Health Joint Commissioning Strategies is currently underway. These build on the Six Lives action plan and will include future work in relation to the Winterbourne Joint Improvement Programme. The LDPB will monitor the work plan and receive regular updates and progress reports.	4. LDPB Minutes Mar.2013 (Ref 5.10)	
1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.	1.4 The LDPB, which has quarterly meetings and is co-chaired by the Assistant Mayor with the lead responsibility for Adult Social Care and a person with a learning disability, will receive regular updates and be asked to monitor our progress. The LDPB will also act in an advisory capacity to the programme, thereby ensuring meaningful inclusion of the views and challenge of experts by experience.	5. LDPB Minutes Sept.2012 (Ref. 6.4 to 6.8) TOR (see membership)	
1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.	1.5 The Health and Wellbeing Board is fully engaged and will receive updates and progress reports at each meeting from the chair of the Joint Integrated Commissioning Group (JICG), a sub-group of the Health and Wellbeing Board.	6. JICG Minutes	
1.6 Does the partnership have arrangements in place to resolve differences should they arise.	1.6 Commissioners and key Operational and Finance Senior Managers from the LA and CCG are represented at the LD and MH Joint Commissioning Board (JCB). Should differences arise that cannot be resolved in that forum they will be escalated to the JICG.	7. LD & MH JCB TOR	

1.7 Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG fora, clinical partnerships & Safeguarding Boards.	1.7 The JICG has taken the responsibility for delivering the local plan through the LD & MH JCB. Winterbourne is a standing agenda item at the JCB ensuring a robust and regular mechanism for reports, identifying of issues and solutions.		
1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this.	1.8 The issues around ordinary residence are being considered from several different perspectives: • People out of county who want to remain in that area in supported living • City funded people who want to come back to 'greater' Leicester, but not live in the city • People from other authorities who are in Leicester • Local agreement with Leicestershire on the exchange of cases • Working with neighbouring authorities in relation to ex-campus individuals		
1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	1.9 Specific support requirements will be identified as we implement the programme. However, there are several areas where we would welcome the opportunity to share learning and good practice. The three areas we have identified to date include: • the challenges of information sharing, in particular between the CCG and NHS England • the application of the CHC guidance		

	in relation to the Challenging Behaviour domain and Section 117 • Ensuring the inclusion of families at an early stage and throughout the process of planning.		
2. Understanding the money 2.1 Are the costs of current services understood across the partnership.	2.1 Work is underway to develop a comprehensive understanding of costs for each partner and establish a needs based approach to ensure individuals are safeguarded and are receiving appropriate care and support.		
2.2 Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care.	2.2 Funding streams and eligibility are currently under scrutiny. Children placed in registered hospitals under CAMHS Tier 4 have their provision commissioned and funded by NHS England.		
2.3 Do you currently use S75 arrangements that are sufficient & robust.	2.3 The section 75 agreement with the PCT is being redrafted to take on board the responsibilities and implications of the new commissioning and funding arrangements.		
2.4 Is there a pooled budget and / or clear arrangements to share financial risk.	2.4 Although all patients in secure hospitals are funded by NHS England, Pooled Budget arrangements are being considered by the JICG. However, there is already full commitment and work underway to establish the clear alignment of priorities and spend. Additionally, Leicester City Council and Leicester City Clinical Commissioning Group will be submitting an expression of interest to	8. JICG Integration Pioneer Proposal	

	become an integration pilot.		
2.5 Have you agreed individual contributions to any pool.	2.5 Currently not applicable.		
2.6 Does it include potential costs of young people in transition and of children's services.	2.6. Although there are no Pooled Budget arrangements in place, Children's Services have aligned budgets in place across Health, Social Care and Education to fund local enhanced holistic packages or external placements where appropriate, to meet the needs of children with complex needs, including those in transition. Leicester is a special educational needs and disability (SEND) Pathfinder and a decision has been taken to focus local work on young people with profound and multiple learning disabilities. The pathfinders are seeking to: • to develop a new birth to 25 assessment process and a single Education, Health and Care Plan (EHCP); • to explore how the voluntary and community sectors can introduce more independence to the process; • to ensure the full engagement of children and young people and their parents and families; • to ensure the full engagement of schools and colleges; and • to improve choice, control and outcomes for children and young people through the use of personal budgets and direct payments.	9. SEND Pathfinder Programme Report	

2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future investment and potential for savings.	2.7 Pooled budgets and joint commissioning arrangements are being considered by the JICG. However significant work is taking place in relation to benchmarking and understanding current and future costs and pressures across both partners in order to inform future investment, potential for savings and refocusing spending priorities to meet the challenges ahead.		
3. Case management for individuals 3.1 Do you have a joint, integrated community team? 3.2 Is there clarity about the role and function of the local community team? 3.3 Does it have capacity to deliver the review and re-provision programme.	3.1 No, but joint working arrangements are being established which will include regular meetings to support one another with particularly complex cases. 3.2 There is a monthly Leicester, Leicestershire and Rutland multi agency meeting, attended by Specialised Commissioning, local clinicians and LA/NHS commissioners. All adults with LD who are inpatients are discussed if they: 1) Are in secure hospital requiring a move to a different level of security 2) Require admission to secure hospital settings 3) Are ready for discharge and a local exit plan is to be agreed The process is replicated in Children's Services		

	3.3 As part of co-ordinating the review process we have recognised the need to revisit our local arrangements and pathways to ensure they are configured to provide the best service to individuals. This will identify where there may be need for revised arrangements		
3.4 Is there clarity about overall professional leadership of the review programme.	3.4 Collaborative management arrangements are supported by clinical leads for LD and a quality lead in the CCG. NHS England's Specialised Commissioning Team applies the national Access Assessment Commissioning Guidance (May 2012) procedure for determining the level of security a patient requires and the admission process into and through secure care.		
3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates.	3.5 Case managers encourage this and delivery is monitored through the contract process. Individuals are allocated to teams who provide on-going support as required. Once allocated to a worker individuals and families will have named support. We have good links with advocacy agencies and advocates will be referred as required. Within the Leicestershire Partnership Trust (Agnes Unit) the Care Programme Approach is utilised for reviews. Family carers, named workers and advocates are included where appropriate. For CHC managed cases – this requires further work to confirm that the interests of people who are being reviewed,		

	family carers and advocates are supported by named workers and/or advocates in each instance. NHS England case managers review and ensure patients are safe, that there is an appropriate and timely treatment plan and exit strategy developed. It is the responsibility of the provider to involve the patient or their representative, families, external professionals and advocates.		
4. Current Review Programme 4.1 Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.	4.1 There is clarity around the current inpatient population affected by the programme and consideration is being given to extending the cohort through identification of individuals who are at risk of admission to ensure that we can plan more effectively for their needs to be met. We will support individuals and their families through the process as we would any family where we need to review with a view to moving someone. This ensures full involvement, giving clear information as to the reasons for the move and the options available and providing advocacy and other support to enable them to make decisions. From a children's complex care perspective, there is an identified Children's Complex Care Manager who has ensured full transfer to the appropriate CCGs and maintenance of cases and records. NHS England case managers review all patients as per the NHS England Case Manager Guidance 2013. Once information sharing issues have been resolved we	10. Learning Disability In-Patient Register	

	envisage working with the NHS England case managers in the same way as the CCH team so we can plan for future discharge.			
4.2 Are arrangements for review of people funded through specialist commissioning clear.	4.2 Responsibility for reviewing is clear depending on the funding arrangements and within these the reviewing arrangements are consistent. NHS England case managers review all patients as per the NHS England Case Manager Guidance 2013.			
4.3 Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place.	4.3 The LDPB receives periodic reports from Healthwatch and the Safeguarding Unit. A QAF is in place and this is being extended to include peer reviews.	11. Safeguarding Adults: Multi-Agency Policy & Procedures January 2010		
4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.	4.4 The current LD register is being reconfigured to enable new data to be collected and collated, to meet changing requirements. This work is being undertaken by the CCGs and will be supported by Leicester, Leicestershire and Rutland local authorities and the provider trust. The inpatient register has been developed and work is underway to expand the dataset to ensure that there is adequate information to inform the development of future services.	12. Proposed Learning Disability In Patient Dataset		
4.5 Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual	4.5 A new agreement is currently being negotiated between the CCGs & Leicestershire Partnership NHS Trust for the revision of the Register to meet current			

	needs. NHS England has a database for all LD children and adult patients that are in secure hospital or CAMHS services placements funded by NHS England. The first point of contact is the NHS England case manager		
4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes	4.6 Yes, we have advocacy contracts and arrangements in place which are monitored as part of the contractual arrangements and via the quality audit.		
4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.	4.7 All reassessments are authorised by managers and complex packages of care are required to go to a Quality Assurance panel, chaired by a senior manager, to check the quality of the assessment and appropriateness of the support plan. For local providers the quality of reviews is assured via the CPA process, quality indicators in contracts and quality visits to the Assessment and Treatment Unit by commissioners.		
4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations.	4.8 The reviews do address support needs but in order to enhance the understanding of behaviour support required, pen portraits relating to individual patients are being produced by providers including the Local Provider Trust and CHC. Case managers encourage this and delivery is monitored through the contract process. This will be included in the quality assurance process that the CCG is undertaking. For NHS England Case managers and the		

	Supplier, managers monitoring a person is at the centre of the care approach through the contract process and case reviews. Evidence is collated to demonstrate providers are implementing 'My Shared Pathway' with evidence of use of easy read documentation and/or total communication systems. The 'My Shared Pathway' has been a CQINN since 2012/13.		
4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed.	4.9 All reviews for children placed out of area or receiving a local enhanced package through complex care have been completed or have a clear set date to be completed. All Adult Learning Disability/Autistic Spectrum Disorder reviews have be completed and there is a timeline identified for each patient for moving on/discharge		
5. Safeguarding 5.1 Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol.	5.1 NHS England through contact and monitoring are linked into local safeguarding issues related to patients they are responsible for. • The local authority has a process of contracting with providers when placing people, such that they would have to comply with a core contract. An expectation of the specifications is that the agency is compliant with safeguarding processes. •The process of establishing the out of area contract involves enquiry with that particular local authority to gain information to validate that we should contract with the same provider. • As a placing authority we would expect to be informed of concerns that might trigger		

	safeguarding enquiry in the local host authority. • As the placing authority we would expect to be invited to any safeguarding meetings and engaged in local processes. • If the distance of the out of area concern is great (e.g. Glasgow) we have also asked for that local authority to provide an independent annual review of the placement.		
5.2 How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments.?	5.2 • Safeguarding Adults Information Sharing Agreement in place, currently being revised to make it more staff friendly into a toolkit format with an FAQ section. • Leicester Safeguarding Adults Board (LSAB) newsletter produced quarterly which is shared with all the care providers to maintain communication channels and the LSAB provides an annual conference for all staff in Leicester working with vulnerable adults. • The care provider group EMCARE and East Midlands housing association sit at board level. • Care Providers Forum/ Care Summit/ Carers Action Group. • Care Assessment has a section regarding sharing information with third parties. • Contractually, duty to cooperate with safeguarding investigations. • QCT champion good practice examples of risk assessments and improvement plans. • In Large Scale Investigations and individual safeguarding investigations the care provider receives copies of minutes.	13. Safeguarding Adults Information Sharing Agreement (Appendix 2 p174 of Safeguarding Adults: Multi-Agency Policy & Procedures January 2010)	

5.3 Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on.	5.3 • In July 2012 the Leicester City Primary Care Trust provided a report to the LSAB Executive Group relating to assurance activity within the PCT cluster in respect of commissioning learning disability services following WBV and Castlebeck. • The CCG have planned to complete joint reviews with the local authority of private hospitals within the local area. • 'Learning Disability Group – 6 Lives' has representation from the CCG and the local authority. This group are responsible for coordinating the completion of the action plan and providing assurance to the LSAB. • The Learning Disability Partnership Board receives periodic updates on safeguarding and the outcomes of Healthwatch (LINks) enter and view reports. The LSAB's Executive Group will be requesting a 'one year on' briefing from agencies on actions taken following the previous report.		
5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme.	5.4 • October 2011 the LSAB were circulated the BBC iplayer link to the programme requesting they make note of its content. • December 2011 an update on the review progress was shared with the LSABs		

Adult Review Group, noting that Margaret Flynn was completing the Serious Case Review, an author who we have previously used locally.

- In April 2012 the Leicester Safeguarding Adults Board received a presentation from the Leicester City Primary Care Trust's Safeguarding Adults Team on the learning from Winterbourne View and the PCT's local experience.
- In July 2012 the Leicester City Primary Care Trust provided a report to the LSAB Executive Group relating to assurance activity within the PCT cluster in respect of commissioning learning disability services following WBV and Castlebeck.
- In February 2013 Browne Jacobson published their round table event on Winterbourne View which was shared with Adult Review Group members and the LSAB Chair.
- In June 2012 the PCT presented a formal report to the LSAB on providing PCT assurances for their agencies and commissioned services around learning from the national reviews into Winterbourne View and also Castlebeck.
- On 20 August 2012 the Leicester safeguarding adults board's adult review group received the Winterbourne View Serious Case Review Executive Summary by Dr Margaret Flynn and discussed its content.
- WBV was made reference to in our independent chairs introduction to the LSAB annual report 11/12 and the LSAB's October and January newsletters noting the review's publication and then the government's

		response. • LPT Safeguarding Committee gets regular updates on LD plans and these are shared with Boards. • Our Independent Chair and our CCG Board members attended a regional event on WBV run by the Care Quality Commission in March 2013 and fedback to the LSAB. • Our Independent Chair reviewed the Interim CCG assurance framework 2013/14 noting the WBV "Has the CCG self-assessed and identified any risk to progress against its Winterbourne View action plan?" requesting local assurance through the Safeguarding Effectiveness Group where the PCT provided a report. • The LSAB's Safeguarding Effectiveness Group received information that regionally the SHA had reviewed the SAAF for LPT, of which they received a positive review noting that the outcomes and recommendations from the Winterbourne Serious Case Review had been identified in reporting to the board of directors. It had identified that the trust had engaged in an effective programme to learn from the serious case review and adopt key recommendations in addressing the needs of vulnerable people coming into the service. In responding to Winterbourne View reviews and the Francis report they have piloted a panel involving people who use services and family carers and will be rolling this out across the Trust. • The Local Safeguarding Children's Board's Executive Chair attends the LSAB, and share the same Independent Safeguarding	14. Lessons learnt from Winterbourne View Hospital - LD Division Action Plan for The Agnes Unit Update April 2013		

	Board Chair for key messages to be disseminated between the two. Both Safeguarding Board Managers are members of both sets of Review Groups for the LSAB and LSCB. • The LSAB's multi-agency training programme is continuously updated to include relevant local and national case examples, and was updated to reference to WBV review.			
5.5 Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint?	5.5 • Across Leicester, Leicestershire and Rutland there is a joint DoLS partnership service. This DoLS partnership arrangement is managed by the Local Implementation Network (LIN) which monitors quality through a multi-agency quality assurance framework. • The LSAB receives a quarterly update from the DoLS Service at every meeting on the statistics and good practice examples and identified areas for improvement; providing the LSAB with assurance and the opportunity to ask questions and commission pieces of work. • The Leicestershire Social Care and Development Group provide DoLS and MCA Training to care homes free across Leicester, Leicestershire and Rutland. • Concerns and alerts about care providers are recorded on the local			

	authorities, adult social care recording system through the 'notification of concern' section and safeguarding adults recording section.			
5.6 Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings.	5.6 • The LSAB's multi-agency training programme is continuously updated to include relevant local and national case examples, and was updated to reference the WBV review. • The local authority is currently in the process of revamping its safeguarding adults professional practice forum open to adult social care and health. • The local authority has recently put on a number of 'master classes' open to social care and health, a few of which include MCA and DoLS as the focus. • The Leicestershire Social Care and Development Group have a number of training courses available for staff in all settings to look at DoLS and MCA • The local authority is in the process of inviting Mark Neary to speak at a half day training event for staff regarding proper use of DoLS and providing real case examples and family stories.			
5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments.	5.7 • The Community Safety Partnership in Leicester (The Safer Leicester Partnership) has a Safeguarding Adults			

	Delivery Group within its structure. The LSAB's Executive Group acts as a dual function for the SLP and the LSAB reporting updates to both as required delivering on priorities.		
5.8 Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.	5.8 • The Care Quality Commission (CQC) is a floating member of the LSAB and is invited annually to a meeting to present an update on its work. In 2012 the board received an update on CQC's work, including its learning from reviews such as Castlebeck and Winterbourne View with assurances as to how its is improving its systems and in 2013 CQC provided an update. • Another member of the LSAB is the Director of Care Services and Commissioning who is responsible for all local authority commissioning of care providers. Where appropriate the LSAB invites key players from Continuing Heath Care and the Service Contracting and Procurement Unit to be on task and finish groups. • The LSAB's task and finish group – 'Raising Care Home Quality' reviewed the intelligence gathering aspect of care home activity as part of their remit.		

	They found that the local authority records Notifications of Concern (NOC) raised about providers, which allows the Safeguarding Team and the Contracts Team to identify trends and patterns in these to initiate relevant action. These NoCs are recorded on the adult social care recording system within the local authority and allow social workers to review and inform them with regard to information alerted to the local authority about the home. The Large Scale Investigations information is also stored on the same system allowing social workers to see what involvement the safeguarding team currently has with a care home when seeking to place service users. To enhance the contract monitoring process, the City Council has developed a Quality Assurance Framework and a self-assessment for providers which will result in a star rating once the evidence provided has been verified following conversations with staff, service users and families. Additionally the council will carry out announced and unannounced visits and look back on complaints and notifications of concern to ensure a triangulated approach to rating providers in order to give assurance to stakeholders in		

	relation to quality and safeguarding.		
6. Commissioning arrangements			
6.1 Are you completing an initial assessment of commissioning requirements to support people's move from assessment and treatment/in-patient settings.	6.1 As well as the information contained in the inpatient register, pen portraits are being produced by providers/case managers to inform the commissioning requirement for the current inpatients. Alongside this we are working with our stakeholders as outlined in 1.3 above.		
6.2 Are these being jointly reviewed, developed and delivered.	6.2 Yes, this information will be jointly reviewed, developed and delivered by the CCG and Local Authority.		
6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services.	6.3 There is an understanding of the numbers of individuals. There are however reviews currently being undertaken which may alter the funding streams, following the change in CHC Guidance.		
6.4 Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people.	6.4 This will form part of the delivery plan and be agreed at the LD & MH JCB.		
6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	6.5 This will form part of the delivery plan and be agreed at the LD & MH JCB.		

6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.	6.6 The work is still in progress, however there is recognition of the need to review investment in this area		
6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.	6.7 Local advocacy arrangements are in place and are being further developed with the CCGs.		
6.8 Is your local delivery plan in the process of being developed, resourced and agreed?	6.8 The local delivery plan is currently being developed and will be presented to the CCG, the JICG and the Health and Wellbeing Board for sign off upon completion.		
6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment).	6.9 It is expected that the remaining individuals that will be ready for discharge will be supported to move within the given timescale. We do not envisage any significant challenges for individuals expected to be ready for discharge.		
6.10 If no, what are the obstacles, to delivery (e.g. organisational, financial, legal).	6.10 As already identified there are challenges around the interpretation of the CHC guidance and section 117 which is delaying decision making on future funding arrangements. These processes are currently under review to ensure that individual needs and support are not compromised.		CHC and section 117 process under review
7. Developing local teams and services			
7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient	7.1 The inpatient register is being analysed and enhanced to better inform this		

settings.	assessment and will be supported by joint working with our neighbouring authority.		
7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements?	7.2 Yes, advocacy contracts are monitored and reviewed regularly as part of our contract monitoring arrangements which will include quality checking with individuals and their families		
7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning?	7.3 Based on the numbers involved there will be adequate capacity in the Best Interests team.		
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies			
8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally.	8.1 This will form part of the delivery plan and joint working with our neighbouring authority as described at 7.1.		
8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.)	8.2 Part of the local work plan includes an audit of historic cases and working with individuals, their families and those who support them to understand what, if anything could have prevented their admission. This will help shape future provision and practice.		
8.3 Do commissioning intentions include a workforce and skills assessment development?	8.3 Part of the wider transformation agenda includes the development of a Workforce Strategy which will consider a skills assessment and required development of the internal and external workforce to meet changing need and priority based on enhancing choice and control for individuals		

	and their families. There is a small Outreach Team within the LD Division of LPT and as part of the SDI (Service Development Initiatives) it is planned for review in 2013 with a view to looking at increasing the flexibility and capacity to prevent admissions.		
9. Understanding the population who need/receive services 9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges?	9.1 Information from the needs assessment will inform market development and the ongoing work with the provider market to support the changing needs and priorities.	15. Market Position 2012 Statement is currently being refreshed. (Sec. 2 Supply & Sec 3 Delivery models) Joint Specific Needs Assessment currently being undertaken & will be available in autumn 2013.	
9.2 From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care services.	9.2 There is an understanding of the needs of the small number of people currently affected by the review for whom personalised solutions are being worked on. Ongoing work will include looking at the wider needs of this customer group to ensure appropriate provision is in place. In Leicestershire we have a wider register of people with learning disabilities. The register identifies those who are at risk of needing additional support with managing their behaviours. This will be used to inform our JSNA and planning for future accommodation and support needs.		

10. Children and adults – transition planning 10.1Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults.	10.1 Yes, we have a specific Transitions Partnership Board that is co-chaired by our Heads of Service from Adults and Children's Services (Removing the Barriers). The work plan feeds into and informs commissioning plans. With matched funding from the Regional Joint Improvement Programme, we piloted a family leadership programme aimed at families of young people with complex needs in order to engage them in planning for the longer term future of their loved ones and to support a change in aspiration, thinking and exploring possibilities.	16. Family Leadership Programme Report	
10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.	10.2 The Transition team redevelopment of the transitions database is taking information from education, health and social care from the age of 14 to map and plan for future need. In addition a jointly funded Transitions Project Worker is undertaking specific work with schools and colleges to understand the history, needs, aspirations, destinations, plans and outcomes for young people with complex needs, aged 14 to 25. This work involves looking retrospectively, at what has occurred over the last 5 years, as well as at future need and cohorts of individuals.		
11. Current and future market requirements and capacity 11.1 Is an assessment of local market capacity in progress?	11.1 The Independent Living and Extra Care strategy (currently being refreshed) addresses market capacity for accommodation. The ASC Market Position Statement will support the market to develop services that meet the needs of current and future communities, targeting our resources to the most vulnerable in society.	17. Choice Unlimited Flyer 18. www.choosemysupport.org.uk	

11.2 Does this include an updated gap analysis?	11.2 The JSNA is currently being refreshed and has a chapter on Learning Disability, which includes a gap analysis. Through the Right to Control local trailblazer, two large scale events were held in partnership with our User Led Organisation, for providers to talk directly with and showcase their offer to individuals, families and professionals. Part of the conversation included gathering information about gaps in the market. Additionally the Choose My Support website also has a mechanism for capturing gaps in the market based on searches for service and support by individuals, families and workers.		
11.3 Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice.	11.3 There is a Leicester, Leicestershire and Rutland NHS Autism Strategy group which has overseen the development of our local Autism Diagnostic and Support Pathway across Children and Adult services. This work and practice has been shared across the East Midlands region, and beyond. In order to address a gap identified in the development of the Autism Pathway, local commissioners in partnership with the CCG lead for Autism are developing a specification to enhance the current Learning Disability Service within the provider trust to offer a holistic diagnostic and support service to adults across the whole Autistic Spectrum.	19. Autism LLR Strategy Group TOR 20. Adult Autism Pathway Overview (Mapping skills for standards - 10)	

Please send questions, queries or completed stocktake to Sarah.brown@local.gov.uk by 5th July 2013

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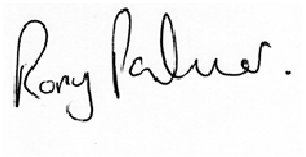
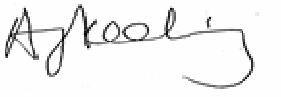
Signed by: Chair HWB  LA Chief Executive  CCG Rep 

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