Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **TUESDAY, 23 SEPTEMBER 2014**
TIME: **5:30 pm**
PLACE: **THE OAK ROOM - GROUND FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER**

Members of the Commission

Councillor Cooke (Chair)
Councillor Cutkelvin (Vice-Chair)

Councillors Bajaj, Chaplin, Glover, Grant, Sangster and Wann

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

G. J. Carey

For Monitoring Officer

Officer contacts:
Graham Carey (Democratic Support Officer):
Tel: 0116 454 6356, e-mail: Graham.Carey@leicester.gov.uk
Anita Patel (Members Support Officer):
Tel: 0116 454 6342, e-mail: Anita.Patel@leicester.gov.uk)
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Information for members of the public

Attending meetings and access to information

You have the right to attend formal meetings such as full Council, committee meetings, City Mayor & Executive Public Briefing and Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

Dates of meetings and copies of public agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk, from the Council's Customer Service Centre (91, Granby Street Leicester) or by contacting us using the details below.

Making meetings accessible to all

Wheelchair access – Public meeting rooms at the Town Hall are accessible to wheelchair users. Wheelchair access to the Town Hall is from Horsefair Street (Press the buzzer on the left hand side of the door to be let in to the building, then take the lift to the ground floor and go straight ahead to the main reception).

Braille/audio tape/translation - If you require this please contact the Democratic Support Officer (production times will depend upon equipment/facility availability).

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Filming and social media

The Council is committed to transparency and supports efforts to record and share reports of proceedings of public meetings through a variety of means, including social media.

Please feel free to use social media during this meeting.

If you wish to film proceedings at a meeting please let us know as far in advance as you can so that it can be considered by the Chair of the meeting who has the responsibility to ensure that the key principles set out below are adhered to at the meeting.

Key Principles. In recording or reporting on proceedings you are asked:

- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at the Town Hall.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

THE 6 PRINCIPLES OF EFFECTIVE SCRUTINY

In March 2014, the Health & Wellbeing Scrutiny Commission adopted 6 principles of effective scrutiny and subsequently agreed that these would be included on all agenda to enable anyone observing or attending meetings to be clear about the role of the Commission. These are:-

1. **To provide a 'critical friend' challenge to executive policy- makers and decision-makers.**

2. **To carry out scrutiny by 'independent minded governors' who lead and own the scrutiny process.**

3. **To drive improvements in services and finds efficiencies.**

4. **To enable the voice and concerns of the public and its communities to be heard.**

5. **To prevent duplication of effort and resources.**

6. **To seek assurances of quality from stakeholders and providers of services.**

TERMS OF REFERENCE OF SCRUTINY COMMISSIONS

Scrutiny Committees hold the executive and partners to account by reviewing and scrutinising policy and practices. Scrutiny Committees will have regard to the Political Conventions and the Scrutiny Operating Protocols and Handbook in fulfilling their work.

The Overview and Select Committee and each Scrutiny Commission will perform the role as set out in Article 8 of the Constitution in relation to the functions set out in its

Scrutiny Commissions may:-

i. review and scrutinise the decisions made by and performance of the City Mayor, Executive, Committees and Council officers both in relation to individual decisions and over time.

ii. develop policy, generate ideas, review and scrutinise the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas.

iii. question the City Mayor, members of the Executive, committees and Directors about their decisions and performance, whether generally in comparison with service plans and targets over a period of time, or in relation to particular decisions, initiatives or projects.

iv. make recommendations to the City Mayor, Executive, committees and the

Council arising from the outcome of the scrutiny process.

v. review and scrutinise the performance of other public bodies in the area and invite reports from them by requesting them to address the Scrutiny Committee and local people about their activities and performance; and

vi. question and gather evidence from any person (with their consent).

Annual report: The Overview Select Committee will report annually to Full Council on its work and make recommendations for future work programmes and amended working methods if appropriate. Scrutiny Commissions / committees will report from time to time as appropriate to Council.

SCRUTINY COMMISSIONS will:-

- Be aligned with the appropriate Executive portfolio.
- Normally undertake overview of Executive work, reviewing items for Executive decision where it chooses.
- Engage in policy development within its remit.
- Normally be attended by the relevant Executive Member, who will be a standing invitee.
- Have their own work programme and will make recommendations to the Executive where appropriate.
- Consider requests by the Executive to carry forward items of work and report to the Executive as appropriate.
- Report on their work to Council from time to time as required.
- Be classed as specific Scrutiny Committees in terms of legislation but will refer cross cutting work to the OSC.
- Consider the training requirements of Members who undertake Scrutiny and seek to secure such training as appropriate.

PUBLIC SESSION

AGENDA

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 6 August 2014 have been circulated and the Commission will be asked to confirm them as a correct record.

The minutes can be found on the Council's website at the following link:-

http://www.cabinet.leicester.gov.uk/ieListDocuments.aspx?CId=737&MId=6481&Ver=4

4. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

6. WORK PROGRAMME **Appendix A (Page 1)**

The Scrutiny Support Officer submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme for 2014/15. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

7. CORPORATE PLAN OF KEY DECISIONS **Appendix B (Page 7)**

The Commission is recommended to note the items that are relevant to its work in the Corporate Plan of Key Decisions that will be taken after 1 October 2014.

8. HEALTHWATCH LEICESTER

To receive a briefing from Healthwatch Leicester on the current issues of interest, including information on patients concerns and experiences.

9. CHECKING THE NATION'S HEALTH - THE VALUE OF LOCAL AUTHORITY SCRUTINY **Appendix C (Page 15)**

The Divisional Director Public Health will lead a development session on the implications for the Commission of the Checking the Nation's Health publication by the Centre for Public Scrutiny.

10. THE LEICESTER NHS HEALTH CHECK PROGRAMME **Appendix D (Page 39)**

The Divisional Director Public Health to submit a report describing the Health Checks programme in Leicester for 40 – 74 year olds. The report explains the background to the national and local NHS Health Check programme and the outcomes of the NHS Health Check programme in Leicester.

11. UPTAKE OF CHILDHOOD IMMUNISATIONS IN LEICESTER **Appendix E (Page 49)**

To receive a report from NHS England Area Team Leicestershire and Lincolnshire on the uptake of Childhood Immunisations in Leicester City. The report outlines the current uptake of immunisation programmes and existing actions which are undertaken and those planned for the future.

12. LOCAL AUTHORITIES MENTAL HEALTH CHALLENGE UPDATE **Appendix F (Page 61)**

The Commission will receive an update on the progress made in relation to the pledges promising to tackle the stigma of mental health issues and provide support and understanding that are contained within the Mental Health Challenge that was signed by the Council at its meeting on 24 January 2014.

A copy of the press release issued at the time, which sets out the background to the Challenge and the 10 pledges within the Challenge, is attached for information together with paper which summarises the progress that has been made.

13. MENTAL HEALTH SERVICES FOR YOUNG BLACK MEN IN LEICESTER SCRUTINY REVIEW

The Chair will provide a verbal update on the progress of this review.

14. IMPLEMENTATION PLAN - FIT FOR PURPOSE REVIEW **Appendix G (Page 67)**

The Chair will provide an update on the progress made to date with the

Implementation Plan relating to the recommendations which were made in the Fit for Purpose Review.

A copy of the Implementation Plan is attached.

15. CO-COMMISSIONING OF PRIMARY MEDICAL CARE BY LEICESTER CITY CCG **Appendix H (Page 79)**

To receive a report from Leicester City CCG on their submission of a formal expression of interest to NHS England to undertake co-commissioning of primary care services.

16. UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT A PREVIOUS MEETING

To receive updates on matters that were considered at previous meetings of the Commission where appropriate.

17. ITEMS FOR INFORMATION / NOTING ONLY **Appendix I (Page 87)**

a) Congenital Heart Services Review

The 30th Update report for the Review is attached and can be accessed at the following link. The link will also allow access to previous update reports.

http://www.england.nhs.uk/category/publications/blogs/john-holden/

A copy of the Consultation Events for the review is also attached for Members' information.

18. ANY OTHER URGENT BUSINESS

Health & Wellbeing Scrutiny Commission

DRAFT Work Programme 2014 to 2015 (and 2015 to 2016) – updated 11th September 2014

Meeting Date	Topic	Actions Arising	Progress
25th June 2014	*Special joint meeting with CYPS* LPT Proposed Relocation of CAMHS Inpatient Service (HSC members to join CYPS for this item)	Chairs to send a letter to LPT re: comments /outcomes	Letter sent.
1st July 2014	Introduction to Health Scrutiny and the Health Economy (Chair and Rod Moore)		
	Discussion on future Work Programme to include vcs stakeholder event outcomes, fit for purpose action plan and corporate plan of key decisions (Chair)	1) W/P to be updated 2) Visits to vcs orgs to be arranged. 3) Fit for Purpose Implementation Plan to progress to Executive (Anita to draft cover report)	
	Healthwatch Protocol (Chair and Surinder Sharma)	1) Photo of protocol signing to be inserted into the scrutiny annual report 2) To progress with legal re: co-opting healthwatch to health scrutiny	
	Review of Mental Health Services for Black/Black British Young Men in Leicester – Update (Chair)	Draft report of findings to October meeting - tbc	
	Child & Adolescent Mental Health Service (CAMHS) Review (Chair)	To be raised at Health & Wellbeing Board	
	UHL and EMAS Quality Accounts 2013/14 (Chair)	Small working group set up to look at these Quality Accounts	

Appendix A

	Topic	Actions Arising	Progress
	Items for information: a) Health & Wellbeing Board b) CQC Programme of Inspections June to Sept 2014 c) Checking the Nation's Health, CfPS health scrutiny tool. d) New Guidance for Health Scrutiny – Dept of Health	 Sept hsc meeting to allocate timeslot for members development session – led by Rod Moore Agreed to set up small working group to understand the changes and report back to hsc (Anita to arrange suitable date).	 1) Written advice received from legal officer 2) Jon has prepared draft summary for chair
8th July 2014 1st Briefing meeting	Briefing for members only re: Mental Health Services for Black British Young Men (age 18 to 25) in Leicester - *To determine the current service provision, highlighting the key issues, trends, comparable data, quality of services and good practice.*	Members information gathering session complete	
22nd July 2nd Review meeting	Review of Mental Health Services for Black British Young Men in Leicester – *to determine how service providers and commissioners address the issues/ problems*	Members evidence gathering session – partly complete	
30th September 3rd Review meeting	Review of Mental Health Services for Black British Young Men in Leicester – *to determine the processes and services provided by Police, Probation and Criminal Justice System.*		
Date tbc 4th Review meeting	Review of Mental Health Services for Black British Young Men in Leicester - *To determine how vcs community groups meet the needs of this specific group and to understand issues, concerns and gaps*	Date to be arranged	

Meeting Date	Topic	Actions Arising	Progress
6th August 2014 (Agenda meeting 29th July 2014)	EMAS – HSC agreed in Jan 2014 to receive report in 6 months, on Trusts achievements in relation to key performance indicators. Future reports to identify the Trusts performance both within the context of Leicester City specifically compared to the East Midlands as a whole (CEO)	a) Further information requested re: paramedics having to pay their own 'blue light driving' course fees to determine if this issue needs to be pursued. b) Chair to send letter to EMAS.	
	Public Health Annual Report – presentation for members on key issues (Rod Moore / Deb Watson)	a) Further information would be useful on: 1) ward data / profiles 2) age profiles of those taking up various health screening measures. b) Chair to send letter to Deputy Director of Public Health.	
	Department of Health new Guidance for Health Scrutiny – the changes and impacts (if any) to health scrutiny and the council. Liaise with legal. Feedback from chair following sub group work.	Item deferred to future meeting - To seek legal advice and to determine the changes and impacts.	
	Nhs Quality Accounts – Feedback from Chair following sub group work.	a) Agreed format for receiving future Quality Accounts in early June each year and Chair to send letters to nhs Trusts.	
	GP Service in the City – CCG briefing (Richard Morris)	Item deferred to September meeting on 'CCG Joint Commissioning with NHS England'	
	Child & Adolescent Mental Health Service Review (CAMHS) – CCG to provide a briefing paper on the proposals / application (Richard Morris)	Item deferred to next meeting	
	Glenfield Heart Unit – Update on progress. (Healthwatch, UHL, Heartlink, NHS England, Lincoln Health Scrutiny Chair & East Midlands Health Scrutiny Chairs).	a) To receive update at next meeting Re: nhs England consultation timetable. b) Chair to send letter to John Holden nhs England and to Healthwatch and UHL.	
	DOH Annual Report – For members information	noted	

Meeting Date	Topic	Actions Arising	Progress
23rd September 2014	Checking the Nation's Health, cfps guidance. members development session led by **Rod Moore** (to allocate 20 minutes approx. within hsc agenda)		
	Immunisation – **Rod Moore**		
	Nhs Health Checks – **Rod** to report on comparison data and progress so far.		
	Mental Health Challenge (Pledge) update on progress – **Rod / Mark**		
	Mental Health Services Scrutiny Review Young Black British Men in Leicester – **Chair t**o provide a verbal update on progress.		
	Healthwatch Reports – briefing on current issues, including information on patients concerns & experiences (**Karen / Surinder)**		
	Implementation Plan for Fit for Purpose – **Chair** to provide update on progress.		
	Items for information: 1) NHS England latest John Holden Blog re: consultation timetable.		
4th November 2014	City Mayor's Delivery Plan – HSC agreed in May 2013 to receive report in 6 months on progress – joint with ASC?		
	Mental Health Awareness – progress		
	Air Quality in Leicester – impact to health of residents (to invite EcDev scrutiny members)		
	Leicester City Clinical Commissioning Group Annual Report (Richard Morris)		
	Health Scrutiny new guidance from Department of Health – reporting the changes and impacts (Chair)		
	CQC – possible item for Nov or Dec tbc?		

16th Dec 2014	NHS & Leicester City Council Complaints		
27th January 15			
10th March 15			
21st April 2015	NHS trusts annual Quality Accounts during April to May- LPT, UHL, EMAS – to receive and comment.		Dates tbc

Health & Wellbeing Scrutiny Commission - Forward Planning 2014 – 2015 (and 2015 – 2016)

Topic	Detail	Proposed Date
JOINT / SHARED WORK WITH OTHER SCRUTINY COMMISSIONS		
Winter Care Plan item – invited by ASC (to include Befriending Service)	Response from the Executive and CCG to the report recommendations and evaluation of last winter's care – Lead Member: Cllr Rita Patel	25th September 2014
Better Care Fund	Joint with ASC	tbc
Better Care Together 5 yr Plan	Joint with ASC	tbc
Health & Social Care Act	Joint with ASC	August 2014
Contracts, Commissioning & Procurement	Joint with ASC	tbc
Dementia Strategy	Joint with ASC	tbc
Lack of support for carers	Joint with ASC	tbc
Care Quality Commission – to invite ASC members	Anita to contact CQC to arrange date	Nov / Dec tbc
School Nurses (service transferred over to lcc)	Joint with CYPS	tbc
Food Banks & Health – Minutes from N/hoods?	To invite Carolina Jackson & check minutes from n/hood for this item	tbc
Homelessness & Health – Joint with Housing	Initially to seek views from nhs England and Jane Grey	tbc

RESERVED LIST OF ITEMS (to be populated into work programme timetable)		
Topic	**Details**	**Proposed Date**
City Mayor's Delivery Plan	Miranda Cannon / Rod Moore	tbc
Public Health Budgets	Cllr Palmer / Rod	tbc
Capital Programme	City Mayor & Executive	
Closing the Gap and Corporate Strategies relating to health & wellbeing – to monitor	Cllr Palmer / Rod	tbc
Mental Health – needs assessment and councils pledge	Tracie Rees / Rod	tbc
Health Visitors (transferred to lcc)	Rod	tbc
MSK Pain	Initially to seek views of the LCCCG	tbc
Talking Therapies	To see views on this issue	tbc
Annual Reports e.g. Healthwatch, UHL, LPT, EMAS, Public Health)	Anita to gather further details re publish dates	tbc
To seek CCCG Views on: 1) Primary Care in the City 2) Community Services with LPT 3) G.P. Services in the City	Richard Morris	tbc

Leicester City Council

CORPORATE PLAN OF KEY DECISIONS

On or after 1 October 2014

What is the plan of key decisions?

Each month, the Council publishes a forward plan to show all the key decisions, which are currently known about, that are intended to be taken by the Council's Executive (City Mayor, Deputy City Mayor and Assistant City Mayors) over the next few months. Each plan runs from the first of each month.

What is a key decision?

A key decision is an executive decision which is likely:

- to result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or
- to be significant in terms of its effects on communities living or working in two or more wards in the City.

In addition to the key decisions, the City Mayor and the Executive also take other non-key decisions. Details of these can be found at www.cabinet.leicester.gov.uk/mgdelegateddecisions.aspx?bcr=1

What information is included in the plan?

The plan identifies how, when and who will take the decision and in addition who will be consulted before the decision is taken and who to contact for more information or to make representations.

The plan is published on the Council's website.

Prior to taking each executive decision, please note that the relevant decision notice and accompanying report will be published on the Council's website and can be found at www.cabinet.leicester.gov.uk/mgdelegateddecisions.aspx?bcr=1

Corporate Plan of Key Decisions

On or after 1 October 2014

Contents

1. A place to do business

What is the Decision to be taken?	ACQUISITION OF LAND FOR REGENERATION PURPOSES Decision to acquire land as part of the regeneration programme – to be funded as part of the Economic Action Plan.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	None.
Who can I contact for further information or to make representations	Mark.Lloyd@leicester.gov.uk

2. Getting about in Leicester

What is the Decision to be taken?	BUS LANE ENFORCEMENT - AYLESTONE QUALITY BUS CORRIDOR Decision to implement Bus Lane Enforcement on the Aylestone Road corridor bus lanes. Funding for this project is included in the approved capital programme budget allocation for the A426 project.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	Done as part of Aylestone Bus Corridor Scheme.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

3. A low carbon city

What is the Decision to be taken?	VEHICLE REPLACEMENT PROGRAMME Purchase of new vehicles under the programme, including releasing the £1.25million policy provision within the capital programme.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	None required.
Who can I contact for further information or to make representations	Nick.Morris@leicester.gov.uk

4. The built and natural environment

No key decisions are scheduled to be taken during this current period.

5. A healthy and active city

No key decisions are scheduled to be taken during this current period.

6. Providing care and support

What is the Decision to be taken?	EXTRA CARE Release of £2.4million monies from the Capital Programme (£1.2million) and Right to Buy Capital Receipts (£1.2million)
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	Not applicable.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

What is the Decision to be taken?	SPENDING REVIEW OF SUBSTANCE MISUSE SERVICES Potential savings of £1million.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	Still to be confirmed.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

What is the Decision to be taken?	SPENDING REVIEW OF INDEPENDENT LIVING Financial parameters to be determined.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	Formal consultation will take place with service users and other stakeholders.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

What is the Decision to be taken?	IMPLEMENTING THE CARE ACT 2014 (ADULT SOCIAL CARE)
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	None.
Who can I contact for further information or to make representations	Tracie.rees@leicester.gov.uk

7. Our children and young people

What is the Decision to be taken?	YOUNG PEOPLE TO PRESENT ANNUAL REVIEW OF THE WORK OF THE CHILDREN IN CARE COUNCIL Report summarising the work of the CiCC and review of the pledge.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	
Who can I contact for further information or to make representations	Julie.Jordan@leicester.gov.uk

8. Our neighbourhoods and communities

What is the Decision to be taken?	AFFORDABLE HOUSING PROGRAMME 2014-18 The programme for 15/16 could include £2.1million from estimated Right to Buy Receipts and £3million HRA funding.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	Ward Members and Local Residents Group on individual sites within the programme.
Who can I contact for further information or to make representations	Simon.Nicholls@leicester.gov.uk

What is the Decision to be taken?	HOUSING RESPONSIVE REPAIRS: IMPROVEMENT PROPOSALS Potential savings of £220k.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	Housing Scrutiny Commission Tenants and Leaseholders Forum.

Who can I contact for further information or to make representations	Christopher.Burgin@leicester.gov.uk

What is the Decision to be taken?	REVIEW OF DISTRICT HEATING CHARGES TO TENANTS Financial parameters not complete.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	Housing Scrutiny Commission, Tenants and Leaseholders Forum.
Who can I contact for further information or to make representations	Simon.Nicholls@leicester.gov.uk

What is the Decision to be taken?	PROPOSALS FOR POLICY PROVISION SCHEMES AND NEW SCHEMES IN THE HOUSING CAPITAL PROGRAMME 2014/15 Policy provisions amounting to £1.9million.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	Local Tenants and ward members have been consulted in developing the proposals.
Who can I contact for further information or to make representations	Simon.Nicholls@leicester.gov.uk

What is the Decision to be taken?	REVIEW OF THE DISTRICT HEATING CHARGES TO TENANTS
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	
Who can I contact for further information or to make representations	Peter.Coles@leicester.gov.uk

What is the Decision to be taken?	OPTIONS FOR INVESTMENT OF HRA UNDERSPEND
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	
Who can I contact for further information or to make representations	Simon.Nicholls@leicester.gov.uk

9. A strong and democratic council

What is the Decision to be taken?	REVENUE BUDGET MONITORING, PERIOD 4 Decisions consequential to the monitoring of expenditure in 2014/15 (if any).
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	Overview Select Committee, 16th October 2014.
Who can I contact for further information or to make representations	Alison.Greenhill@leicester.gov.uk

What is the Decision to be taken?	CAPITAL MONITORING, PERIOD 4 Decisions consequential to the monitoring of expenditure in 2014/15 (if any).
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2014
Who will be consulted and how?	Overview Select Committee, 16th October 2014.
Who can I contact for further information or to make representations	Alison.Greenhill@leicester.gov.uk

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Checking the Nation's Health

The Value of Council Scrutiny

cfps Centre for Public Scrutiny
accountability, transparency, involvement

Contents

The Centre for Public Scrutiny
The Centre for Public Scrutiny (CfPS), an independent charity, is the leading national organisation for ideas, thinking and the application and development of policy and practice to promote transparent, inclusive and accountable public services. We support individuals, organisations and communities to put our principles into practice in the design, delivery and monitoring of public services in ways that build knowledge, skills and trust so that effective solutions are identified together by decision-makers, practitioners and service users.

Public Health England
Public Health England's (PHE) mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

About NHS Health Check
The Global Burden of Disease 2012 Study highlighted the need to tackle the increasing trend in people dying prematurely from non-communicable disease. The UK is falling behind other countries and we need to take urgent action. The NHS Health Check programme systematically addresses the top seven causes of preventable mortality by assessing the risk factors: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption. We know that there is a huge burden of disease associated with conditions such as heart disease, stroke, type 2 diabetes and kidney disease and that many of these long term conditions can be avoided through modifications in people's behaviour and lifestyles.

Commissioning and monitoring the risk assessment element of the NHS Health Check is one of the small number of public health functions that are mandatory and detailed in the Local Authorities Public Health Functions and Entry to Premises by Local Healthwatch Representatives Regulations 2013. Supporting local authorities to implement this programme is one of Public Health England's priorities.

Acknowledgments
This publication has been written by Su Turner, Principal Consultant at the Centre, and Rachel Harris Expert Adviser for the Centre. We are very grateful to the councillors, officers, partners and their Expert Advisers from the five Scrutiny Development Areas for their hard work and commitment to the programme.

Foreword

The NHS Health Check programme is a world-leading programme and a key component of this Government's priority to reduce premature mortality. It gives us an unprecedented opportunity to tackle the UK's relatively poor record on premature mortality by focusing on the risk factors that are driving the big killers. We know that high blood pressure and cholesterol, smoking, obesity, poor diet, physical inactivity and excessive alcohol consumption increase the risk of diseases that we can – and should – do more to prevent, such as heart disease, stroke, type 2 diabetes and kidney disease.

The NHS Health Check programme is the first approach this country has taken to address these risk factors at a population level, and in a systematic, integrated way. We believe it could also be a powerful way to reduce health inequalities, because we know that the burden of chronic disease tends to fall more heavily on those who are most deprived.

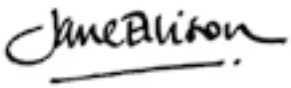
If NHS Health Check is going to realise this potential, it will require highly effective implementation. This report from the Centre for Public Scrutiny marks a valuable contribution to this effort, by providing a process for how local areas can undertake their reviews of local NHS Health Check programmes. The five case studies in this report illustrate local scrutiny in action; namely the opportunity it gives local councillors, commissioners and GPs, among others, to ask tough and practical questions: how will the NHS Health Check programme improve outcomes for those with the worst health? How will NHS Health Check be integrated with the work of health and wellbeing boards? What does best practice look like?

These challenges are the local counterpart to the national challenge set out in last year's NHS Health Check implementation review and action plan, which was led by Public Health England. This plan identified the need for greater consistency of delivery, the need for new governance structures and evaluation as well as the importance of data flows across the health and social care system.

Independent reviews can play an important role in meeting these challenges, by encouraging stakeholders to search for practical solutions that are adapted to local circumstances – how best to collect data, for instance, or how best to explain to users the aims and benefits of the programme. We need to make sure that these insights are shared, and that the questions prompted by these reviews are useful to others, who may be embarking on their own reviews of local NHS Health Check programmes.

Ultimately, though, the power of these reviews is not in coming up with a uniform set of recommendations, but in providing a forum, in which local clinicians, public health professionals and elected officials can develop a shared understanding of how to improve the health and wellbeing of their communities. The hope is that these reviews will help them to find their own way of working together. It is these relationships that will be vital to the success of NHS Health Check implementation.

I am delighted to introduce this report, which I hope will prove a valuable resource to all those who commission, deliver and support the NHS Health Check programme.



Jane Ellison MP
Parliamentary Under Secretary of State for Public Health

Introduction

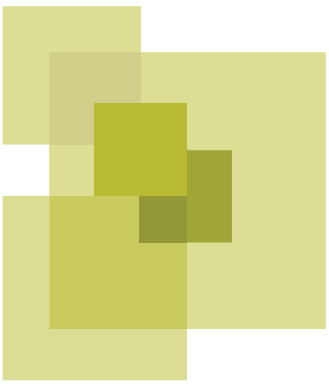
NHS Health Check is a national illness prevention programme to identify people 'at risk' of developing heart disease, stroke, diabetes, kidney disease or vascular dementia. It was introduced on a phased basis in 2009 and at that time Primary Care Trusts were expected to roll it out over five years. However, there was considerable variation across the country which meant that when local authorities took on responsibility for NHS Health Check in April 2013 they took on local programmes at different stages of implementation.

Early in 2013, a review of the lessons learned from the programme's implementation was used to develop a 10 point action plan. The implementation review and action plan set out the work that will be undertaken with key partners to support effective implementation across the country and realise the programme's potential to reduce avoidable deaths, disability and inequalities. The 10 point action plan covers:

- Leadership
- Improving take-up
- Providing the Health Check
- Information governance
- Supporting delivery
- Programme governance
- Provider competency
- Consistency
- Proving the case
- Roll-out

Councillors' scrutiny role can be a powerful lever for improving local health services, alongside other incentives in the system. Recognising this, the Centre for Public Scrutiny (CfPS) was identified as a key partner in delivering the 10 point action plan and was asked to support some local areas to undertake scrutiny reviews of their local NHS Health Check programmes to:

- Understand the benefits of the NHS Health Check programme to local areas (costed and consequential benefits).
- Understand the barriers to take up and how it can be improved.
- Promote the role of scrutiny to all councils and NHS Health Check teams.
- Increase the use of scrutiny reviews to assess NHS Health Check programmes.



CfPS worked with the following five areas to help them to carry out a scrutiny review of their local NHS Health Check Programme:

- Devon County Council
- London Boroughs of Barnet and Harrow
- Lancashire County Council and South Ribble Borough Council
- London Borough of Newham
- Tameside Metropolitan Borough Council

This publication contains the learning gathered from these areas – collectively via the outcomes of a national learning event and individually via short case studies at the end of this publication. It provides useful insight for councils and for NHS and Public Health colleagues.

Public Health England, CfPS and the five areas were aware from the outset that reviewing NHS Health Check was set against a backdrop of structural changes to the health system:

- The new health landscape created by the Health and Social Care Act 2012 was being implemented – including the creation of Public Health England.
- Public health responsibilities, including the commissioning of the NHS Health Check programme, were moving from the NHS to Local Authorities.

Using CfPS' return on investment approach (see details at appendix one) has reinforced the value of scrutiny as a way to build relationships. The case studies in this publication illustrate that there are significant opportunities for improving understanding and working relationships between councillors and primary care practitioners. Reviews of NHS Health Check programmes have led to closer working between GPs and councillors – two groups that are fundamental partners in improving the health and wellbeing of local communities.

The lessons from the five reviews chime really well with the actions that are being taken forward nationally by the NHS Health Check programme. As you will read, opportunities for improved leadership, quality, consistency and integration that are identified within the 10 point action plan have been confirmed by the CfPS support programme.

The five areas found that there were challenges and opportunities around leadership, culture and relationships; and information and communication. This publication looks at these through the lens of CfPS' principles of:

Accountable - improving leadership for whole system pathways.

Inclusive - developing relationships and cultural understanding.

Transparent – understanding information and getting communication right.

The recommendations within this publication are equally applicable to local areas as they seek to improve local population health; or to national health organisations who support and advise (including how councillors and council scrutiny have a valid role in health improvement).

The five areas also suggested questions that other councils may find useful (see appendix two).

Accompanying this publication is a series of briefings for council scrutiny:

- Improving take-up.
- Barriers and solutions to delivery of effective NHS Health Check.
- Understanding data (launched December 2013).

Accountable – Improving leadership and whole system pathways for health

Improving leadership

All five areas reported confusion about responsibility for leading local NHS Health Check arrangements. Although professionals in the system are aware of their responsibilities for delivering a NHS Health Check Programme, it is not clear to the wider health and wellbeing sector or local populations.

All areas were interested in improving take up of the NHS Health Check, however they found that variations in commissioning and the commitment of GPs were local barriers to take up.

They concluded that whilst attention is placed on inviting and carrying out NHS Health Checks, it is important for leaders of local programmes to ensure that there are effective follow-up procedures in place – either to ensure that people attend a NHS Health Check appointment or that if they are identified at risk – follow up action is taken.

Areas also reported a desire to work with NHS England as the commissioner of primary care but were unclear how to best engage local area teams.

Recommendations

- Further clarify roles and responsibilities within the health system (including the NHS Health Check programme - nationally and locally).
- Emphasise the quality of follow-up action to reap the benefits of early interventions.

Whole system pathways – embedding NHS Health Check

What became clear is that the NHS Health Check programme as a health improvement tool needs to be 'plugged in' to a wider 'improving health' pathway. Areas found that some GPs chose not to engage with the programme because the validity of the NHS Health Check as part of the whole system remained an issue of debate.

> *"GPs are geared up to deal with the unwell whereas NHS Health Checks are for people who are apparently well."*
>
> **Quote from programme participant**

Concerns also surfaced about the clarity, consistency and quality of feedback to patients following NHS Health Checks. Questions arose about how NHS Health Check can be used to encourage and support people to make lifestyle changes. Programme participants felt there were opportunities to maximise the impact of NHS Health Checks by embedding them within the work of health and wellbeing boards.

Recommendation

- The NHS Health Check programme needs to be 'plugged in' to the local health system, the preventative agenda and the work of health and wellbeing boards.

What practical steps helped?

Devon's review helped to develop the local approach to NHS Health Checks. Their approach to the review strengthened both their internal and external relationships and flagged up their intent as community leaders to embed public health improvements for their most socially isolated groups. The strong leadership focus of the review also helped to kick start relationships with local area teams.

London Borough of Newham found that whilst public health professionals understood lines of accountability there was not a shared understanding across the wider system. The transfer of public health allowed for clarity of this and the review and its recommendations have gone some way towards plugging this gap. The review took an asset based approach - supporting GPs to improve their NHS Health Check programme via their Clinical Effectiveness Group and using their expertise, adding to the clinical collaboration perspective of the review.

Inclusive – Developing relationships and cultural understanding

Developing relationships

In some areas, the reviews were pivotal to changing and enhancing the relationship between council scrutiny and local public health teams. For many, there had not been the opportunity for councillors and public health teams to work together and scrutiny provided a catalyst.

Focusing together on improving the outcomes and effectiveness of a new area of council commissioning has highlighted how closer working and sharing data and insight can move services forward. All areas reported the positive impact of outcomes and recommendations from scrutiny on commissioning of preventative interventions.

All areas agreed that the approach to identifying and hearing from stakeholders was a very effective element of the CfPS support. The approach leads scrutiny to move beyond its traditional audience and thematic workshops produced a better understanding of issues to be tackled by commissioners. Further details are included within the case studies.

Three areas recognised the need to foster relationships across tiers of local government and between councils to support health improvements. The return on investment approach was a good way to achieve closer working with robust recommendations.

Recognising the contribution of other organisations and partnerships can also help share learning about ideas for future working. The Community Hub model developed by Devon & Cornwall Probation Trust inspired a recommendation about developing a whole person 'one stop' approach for socially isolated and hard to reach groups.

Recommendations

- A commitment to develop relationships constantly and consistently can help local areas achieve better health outcomes.
- Moving beyond traditional stakeholders can strengthen the outcomes and value of scrutiny.

Understanding cultural differences

Evidence emerged in some areas that the cultural differences between the NHS 'clinical model' and councils' 'social model' need to be better understood so that a shared health and care improvement culture can be developed.

Areas found that the natural focus of clinicians and GPs is the patient and the symptoms that present to them (the clinical model); whilst the council and councillors naturally focus on what is impacting on poor health – the causes of the causes and the wider determinants of health (the social model). By blending these skills (as advocated by the Institute of Health Equity's Fair Society, Healthy Lives (Marmot) review on health inequalities) a better understanding of communities can be gained leading to better action to support health.

Scrutiny has been shown to be an effective way to build on the common ambition of GPs and local councillors to improve the health of local people. Scrutiny of the NHS Health Check programme can be a catalyst to strengthen relationships between councillors and primary care.

Recommendations

- Develop a universal language for health locally that all partners can understand.
- The knowledge and experience of councillors can enhance the work of health partners and commissioners to improve health and health services.

What practical steps helped?

Tameside Metropolitan Council's stakeholder event provided the vehicle to get everyone together to look holistically at improving a service. It allowed for open and honest dialogue between public health professionals, GPs and the commissioners – something that wouldn't have taken place without the review. Using the CfPS approach helped scrutiny to move at a pace which led to massive benefits. They will be using the model again within future reviews.

Transparent – Understanding information and getting communication right

Understanding information and data

All areas encountered challenges with the collection, consistency or analysis of data to help them explore issues and support their findings. Inconsistent data collection by different agencies, particularly at general practice level, was highlighted as a barrier to understanding the financial value of care pathways. This translated in to a lack of confidence in some areas about the validity of data.

An important lesson from the programme was that clinicians and health professionals are used to working with absolutes whereas scrutiny is more comfortable with possibilities and insight. For example, public health professionals wanted to provide detailed, statistically accurate information and data (which could take longer to produce) but councillors were happy to receive less academically robust figures, together with strong experiential evidence and public health team insight. The reviews generated considerable learning about which partners held useful information, for example:

- Clinical Commissioning Groups understand and have access to national acute care costing information as well as GP practice information. It is essential that scrutiny develops contacts with their CCGs and general practices so that they work alongside each other.
- Information about public health outcomes is often available from national organisations and charities that hold robust data banks based on specific areas of interest that can be useful for return on investment calculations.

Some areas used particular methods to test performance data. Examples included: commissioning a community researcher; direct questionnaires to GPs to establish take up levels; concentrating on gathering in depth information from a few sources.

All the areas recognised the validity of financial return on investment as a proven and important demonstrator of the effectiveness of the NHS Health Check programme. But they also found 'softer' qualitative return on investment is equally important and gave weight to the potential of the NHS Health Check programme as a key tool to improve public health. For example, the actions that can move people towards recognising their own responsibilities for improving or maintaining their personal health is an essential part of the improvements that the NHS Health Check programme is seeking to make. The drivers for changes in personal behaviour may include improving neighbourhood interactions or bringing services into one place to improve accessibility and outcomes from the NHS Health Check programme.

Recommendations

- The variation in the quality and nature of data held at GP practices needs to be reviewed at a national level alongside consideration of how population statistics could be standardised. There is a need for consistent data collection, particularly around quantifying hard to reach groups and clearer standard measurements of comparable performance and NHS Health Check take up rates. They need to be readily available and usable by local authority commissioners.
- Review and revise local data sharing protocols and consider easily accessible mechanisms to pool partners own knowledge about alternative information sources.
- Commission services from a variety of sources including 'drop-in' services for people unable to attend their GP during working hours and monitor follow-up.

Communication

Communication was a key feature that emerged at the learning event – both with the public about the NHS Health Check programme and within and across stakeholders about how to best incorporate NHS Health Check in to local actions to improve health. Improving communication across the partners in the local health system would allow for a better sharing of information leading to improved services.

Most reviews sought to gather public views on the NHS Health Check programme, and concluded that, despite national publicity, there remains a lack of public awareness about the aims, objectives and benefits of the programme. Feedback from some people indicated an awareness of the NHS Health Check programme but an anxiety that it might identify medical conditions that could not be treated.

Recommendations

- Provide clear public information about the benefits and process of a NHS Health Check and the support available to participants with health issues and consider targeted promotion.
- Consider a NHS Health Check scrutiny review to see who does what, to generate a local understanding of the breadth of the programme.

What practical steps helped?

London Boroughs of Barnet and Harrow tested public opinion about their NHS Health Check programmes by commissioning an engagement specialist and concluded that there was not a great understanding by the public on what NHS Health Check is and how to access it.

Lancashire County Council and South Ribble Borough Council created an effective “drill-down” questionnaire that generated a new set of qualitative information about GPs’ views of their experience with the NHS Health Check, and why many GP practices do not feel it worthwhile to engage with the programme. This review also demonstrated the value of district council scrutiny and the added dimension that district councillors can add to scrutiny.

The value of good scrutiny

Good scrutiny and accountability involves different people in different ways – citizens, patients and service users, elected representatives, service providers and commissioners, inspectors and regulators. Four mutually reinforcing principles, leading to improved public services, need to be embedded at every level:

- Constructive 'critical friend' challenge.
- Amplifing the voice and concerns of the public.
- Led by independent people who take responsibility for their role.
- Drive improvement in public services.

Using these principles, CfPS has again highlighted the benefit that scrutiny can bring to other partners seeking to improve health and health services.

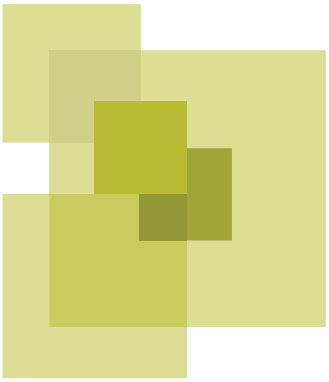
Why scrutiny - what's the added value?

- Scrutiny is independent.
- Scrutiny adds value to councils' corporate leadership and it supports health improvement by taking a proactive approach.
- Can bring the NHS / GPs and councils / councillors together by providing a neutral space to work through issues and identify solutions.
- Uses councillors' unique democratic mandate as a 'conduit between the public and their services', enables them to test whether what is provided meets community needs and aspirations.

The added value of a return on investment approach

In addition to the value described above the return on investment approach:

- Allows areas to move away from a traditional 'committee meeting' approach and explore an 'action learning' approach.
- Involves a wider group of stakeholders from across the whole system bringing more ideas and contributions to the review process.
- Uses quantitative and qualitative outcomes to provide evidence for improving joint working and the pooling of resources.
- Keeps scrutiny focused on outcomes when scoping and undertaking a review.
- Provides an opportunity to use return on investment to demonstrate the value of scrutiny, alongside internal council performance measures.



The added value of scrutiny to public health

All five reviews secured the involvement of their local public health teams, and as you have read contributed to improved understanding and working relationships. Below are quotes from public health professionals involved with the programme.

Tina Henry, Consultant in Public Health and NHS Health Check lead, Devon County Council commented:

> *The work undertaken by scrutiny on NHS Health Checks has been very timely and has raised the profile and understanding of the programme. The process allowed independent engagement with a wide range of stakeholders and providers to determine next steps in rolling out the programme. The intelligence work and feedback from the focused sessions will be used to inform the model of delivery to increase take up.*

Gideon Smith, Consultant in Public Health Medicine, Tameside MBC

> *The Tameside Health Checks Scrutiny Review has been extremely timely and supportive to the process of rethinking the local programme within the context of transition from NHS to local authority commissioning responsibility. The Stakeholder Workshop was particularly helpful in gauging the concerns, commitment and potential contributions of interested parties, and facilitating the development and delivery of a re-invigorated local programme.*

Summary and further recommendations

This programme demonstrates the diversity of good scrutiny to tackle local health inequalities in the best way suited to localities. The reviews have gone some way to overcome some scepticism regarding the validity of the NHS Health Check programme. We believe that council scrutiny has been a valuable way to independently review the roll-out of the NHS Health Check programme – with findings that can be used locally and nationally to inform commissioning decisions.

Specific recommendations have been made throughout this publication. In addition to these, below are some wider final recommendations from our observations:

- Council scrutiny can be an effective public health tool and can help areas to fully understand the health of their population and how services can improve to meet this need.
- Council scrutiny can be the bridge in developing effective working relationships – combining the knowledge of the health community and councillors in developing solutions to improving community health and wellbeing.
- The NHS Health Check programme needs to be accepted as part of a whole system review of the abiding problems of health inequalities, self-responsibility and the prevention agenda. This would enable commissioners to co-operate and to develop improved services that encompass both health and social care and continue to integrate patient pathways at all stages of their interaction with the system.
- Areas need to develop clear lines of accountability to ensure effectiveness across councils' public health role, Clinical Commissioners and general practice.
- There needs to be a continued drive towards integrated working between public health, health and wellbeing boards, council scrutiny and local Healthwatch.

Information flow is critical across all sectors of the health economy (including people who use services), with public health retaining a vital source of data and information. Partners should aspire to transparent data that can be understood by professionals and people who use services.

Appendix one – Case studies

Tipping the Scales

http://cfps.org.uk/health-inequalities

Valuing Inclusion

http://cfps.org.uk/health-inequalities

CfPS' return on investment approach to scrutiny

In 2011 CfPS developed an approach to council scrutiny that captures the potential return on investment of a review and its recommendations. This approach has been published in our previous publications.

Each area that took part in the programme was supported to use the return on investment approach to ensure that their review was outcome focused and realised 'costed and consequential' benefits.

Over the following pages you will find out more about the scrutiny reviews that each of the areas undertook.

The case studies particularly focus on:

- Why the issue was important
- Successes and challenges
- Learning points
- Qualitative benefits
- Measuring return on investment

One of the main benefits of reviewing NHS Health Check using the return on investment approach was the opportunity to involve all stakeholders in designing the review and the key lines of enquiry. Whilst stakeholder engagement is not a new concept, in a return on investment approach it focuses the review on the policy objectives of the Institute of Health Equity's health inequalities review (Marmot) – evidence based objectives to reduce inequalities.

In assessing the potential return on investment, changes in ways of working and a focus on health inequalities will no doubt realise a financial saving both in terms of joined up delivery and less money spent within the health service, however this is difficult to quantify and assign credit to the review alone. Therefore in order to determine the potential return on investment that the review could realise, a number of assumptions need to be made.

CfPS' return on investment approach it is not an exact science. The five areas did not use health economists or finance professionals, but they did use information, data and costings that were either available nationally, provided locally or collected by themselves. The calculations (summarised in the case studies) represent the potential return on investment if the recommendations are accepted and implemented.

The case studies have been provided by the areas themselves.

Case Study: London Boroughs of Barnet and Harrow

The London Boroughs of Barnet and Harrow have had a joint public health service from April 2013 which is hosted by Harrow. The review provided an ideal opportunity to transfer knowledge from the two areas and ensure that the NHS Health Check programme develops appropriately.

Successes and qualitative benefits

- Testing public views of the NHS Health Check programme within specific community groups.
- The review identified differences in how the programme has been commissioned and delivered within the two Boroughs.
- The review helped to develop relationships between scrutiny and public health services, the two scrutiny committees and their communities.

Challenges

- The review highlighted some challenges for public health and the local authorities in dealing with issues relating to a transferred shared service.
- The complexity of the issue and its role within a wider pathway could have caused the review to be unwieldy.
- The financial modelling using the ROI model was difficult with the lack of availability of data.
- Engagement with GPs was difficult.

Learning points

- ROI is an excellent tool for demonstrating the economic benefits that scrutiny can deliver.
- The opportunity to look to other boroughs and alternative delivery models brought useful insight to local discussions.
- Public health faces a new challenge operating in a political environment.
- The scrutiny review highlighted that the public are not aware of NHS health checks.
- A balanced approach needs to be taken – people need to be encouraged to make lifestyle changes.

Key Recommendations

The review has made clear recommendations to influence the future commissioning of the NHS Health Check programme:

- Accessibility, promotion and take up.
- Aligning financial incentives.
- A whole system scrutiny of care pathways.

ROI question and calculation

What would be the return on investment if we improve take up of the Health Check amongst specific groups?

Invest : Cost of additional checks	Harrow – £93,225 Barnet - £81,575 Total - £174,800
To save : Potential savings	Harrow = £1,262,105 Barnet = £2,834,882 Total = £4,096,987
Potential return on investment	**£3,922,187**

Assumptions

Average cost of a NHS Health check = £25 (local data on spend for Barnet) – using this as the basis:

Harrow (12/13) 3729 checks cost £93,225 (Of those 65 cases of those at risk of a heart attack).

Barnet (12/13) 3263 checks cost £81,575 (Of those 146 cases of those at risk of a heart attack)

The British Heart Foundation report cost of treating heart attacks as £19,417 per case.

Calculation uses a doubling of costs and cases to illustrate ROI

For more information use this link to the review report:

http://committeepapers.barnet.gov.uk/documents/s12062/NHS%20Health%20Checks%20Scrutiny%20Review.pdf

Case Study: Devon County Council

The NHS Health Check programme in Devon was in its infancy, and the committee saw the opportunity to actively contribute to policy development using the ROI model. The committee pursued their instinctive observation that the NHS Health Check programme should be of most benefit to people in groups with the poorest health outcomes and framed their review around rural and urban socially isolated groups.

Successes and qualitative benefits

- Raised awareness of the role of scrutiny and the value it can bring.
- Strengthened relationships with public health colleagues, including monthly meetings with the Director of Public Health.
- Had a high response rate to a qualitative GP survey that was developed with assistance from the two Clinical Commissioning Groups in Devon.
- Gained insight in to the take up of NHS Health Checks in rural areas via the Farming Community Network Devon.
- Heard from a range of expert witnesses including local Veterans groups, the Probation Trust, drug and alcohol service providers and outreach health services for homeless people.
- Synthesised all the information in to a template to engage with hard to reach groups across Devon.
- Structured short 'deep dive' reviews can produce locally relevant policy insights.

Challenges

- The availability of comparable local quality data and discrete service costing's to use for measurement. They endeavoured to meet this challenge by balancing and using conflicting or small sample data to widen their understanding of the evidence.

Learning points

- NHS Health Check programme is a gateway to realising the potential of health improvement and ensuring that marginalised groups are included.
- Mental Health should be integral to the consideration of health and wellbeing and included in the Health Check programme.
- There needs to be a whole person approach in considering the health and wellbeing of everyone, particularly vulnerable or hard to reach groups.
- NHS Health Checks need to be accessible - timing, location, information and trust.
- The ROI model gave a framework and a rigour that could be shared with key stakeholders and used to include them and members together from the beginning.

Recommendations:

The task group put forward nine recommendations backed by their findings covering:

- The importance of whole system approaches from all agencies to commissioning strategies.
- Improvements to the understanding and systems approach to the NHS Health Check programme for vulnerable groups.
- The County Council visibly taking up the role of health promotion and Health Check take up.

ROI question and calculation

What would be the ROI of improving the access to NHS Health Checks for our less accessible and most isolated groups?

Invest : Cost of targeting NHS Health Checks (based on 1000 smokers)	£183,000
To save : Potential savings	£323,500
Potential return on investment	**£140,500**

Assumptions and caveats

Review costs calculated 165 hours x £9.81 (Devon median wage) ; In 2013, NHS expenditure on care on smokers will be £39.7 million (122,724 smokers with av. care cost of £323.50 per person per year). **http://www.ash.org.uk/localtoolkit** ; Each NHS Health Check costs £24 ; Smoking cessation costs are £159 **http://www.smokinginengland.info/stop-smoking-services**

Therefore cost of intervention per person is £183.

Calculation based on targeting 1000 smokers with a 100% success rate.

For more information use this link to the review report:

http://www.devon.gov.uk/loadtrimdocument?url=&filename=CS/13/35.CMR&rn=13/WD1206&dg=Public

Case Study: Lancashire County Council and South Ribble Borough Council

The Review sought to identify the value of greater targeting of the NHS Health Check programme on those whose health and wellbeing could benefit most, as opposed to randomly selecting 20%. As data was discussed with the DPH and GPs, it became apparent that increasing the take-up was a factor at least as important as targeting the invitation; and that middle aged men are generally the highest risk group, being the least likely to look after their health or attend a NHS Health Check.

Successes and qualitative benefits

- High involvement of councillors.
- Developed 2-tier collaboration of county and district councils working together on a health scrutiny review - demonstrates districts can influence health.
- Engaging public health created a practical example of the kind of data that health scrutiny wants to use – a model for further projects.
- Created a way to gain engagement of GPs and general practices.
- Developed an effective "drill-down" questionnaire to seek the views of GP's.
- Generated a new set of qualitative information on GPs' views of their experience with the NHS Health Check programme, and why many GP practices do not feel it worthwhile to engage with the programme.

Learning points

- Need to "front load" information more extensively - need to think more at the start about what information is needed and the context.
- Public health teams are used to working to longer timescales and want to provide accurate data.
- This approach to generating data illuminated understanding of the choices that GPs make, and why there are the tensions in aspirations between the GP practice as a small business model versus centrally-chosen NHS policies.
- GPs have interesting and helpful views on the best ways to increase take-up.

Key recommendations

- Undertake a deeper study to generate more robust data and ROI calculation, and a transferrable model.
- Commission the NHS Health Check programme focusing on widening the range of locations for delivery (e.g. football matches) and providers commissioned to deliver.
- NHS England be asked nationally to calculate whether it would be cost-effective to pay GPs more to carry out a NHS Health Check.
- NHS England calculate the benefits of extending the age range to say 35 (perhaps particularly for men) so as to maximize the benefits of early prevention.

ROI question and calculation

What is the ROI of targeting 50% middle aged men (40-55) instead of the 20% random targeting?

Invest : Cost of targeting NHS Health Check	£552,000
To save : Potential benefits est. by QALYs & ready reckoner	£575,000
Potential return on investment	**£23,000**

Notes caveats and assumptions

NHS Health Checks cost £21 whether delivered by GP or outreach: extra costs to reach an extra 26,297 more men is therefore £552k.

Assuming take up is increased this means 26,297 more men are checked; on average x 0.09 QALYs per person (this underestimates value for particular cohorts), this generates 2331 QALYs. Each QALY costs (is worth) £247, so the value of these QALYs is £575,668 (based on average populations). QALY = Quality adjusted life year.

For more information use this link to the review report:

www.southribble.gov.uk/scrutiny.

Case Study: London Borough of Newham

Newham has a high prevalence of preventable illness such as diabetes and had been heavily involved in early stages of the NHS Health Check programme. As a result of this involvement their programme had been front loaded (invested in early), so as the NHS Health Check programme implementation progressed nationally, statistics appeared to show that they were falling behind. Research from the pilot had also identified variations within the GP clusters.

Successes and qualitative benefits

- A strong collaborative approach between scrutiny and public health resulting in excellent support to this project.
- Local Healthwatch enthusiastically engaged with the review and ran own patient forum.
- Engagement with the Clinical Commissioning Group allowed for patient feedback, which correlated the views of the patient forum.
- A short, sharp questionnaire to those who administered the NHS Health Check programme allowed front-line feedback.
- The review has prompted a more detailed cost benefit analysis of health checks to inform future commissioning of the NHS Health Check programme.
- A good example of how scrutiny can add value to health and wellbeing boards and influence commissioning decisions.
- Strengthened partnership relationships.

Challenges

- Discrepancies in how data was collected and reported by the different agencies meant that it was difficult to correlate and gain meaningful conclusions.
- Obtaining clear financial information on the cost of providing health services was a considerable challenge.

Learning points

- Clinicians work with absolutes whereas scrutiny is more comfortable with possibilities and insight. Bridging that gap so that both are comfortable with the outcomes is essential.
- The “softer” qualitative ROIs are equally as important as quantitative ROIs.

Key recommendations

At the time of writing the final conclusions and recommendations had not been determined, but emerging issues include:

- The need to complete a review of options and funding for NHS Health Check as part of the wider preventative agenda.
- The need to reduce practice variation.
- That a collaborative partnership agreement is required.
- Statin prescribing increase in line with Clinical Effectiveness Group guidelines.

ROI question and calculation

What is the ROI of supporting the GP clusters in improving NHS Health Check take up and follow through?

The review also focused on the qualitative nature of ROI which is harder to quantify. This included the benefit of developing new relationships with the commissioners and providers to create a new vision for the future commissioning and delivery of NHS Health Checks locally.

The review did notionally model a potential financial return on investment with a focus on strokes.

Invest : Cost of targeting NHS Health Check		£35,000 (1000 additional checks)
To save:	£75,000	3 people identified at risk
Potential return on investment		**£40,000**

Assumptions and caveats

Cost of treatment for a stroke = £25K (British Heart Foundation average) ; Cost of undertaking a NHS Health Check £35 (excl. admin fees) ; Research shows for every 10,000 checked 30 are identified as having risk factors for stroke (verified by the Clinical Effectiveness Group at Queen Mary University of London). Based on a crude calculation and the cost of acute medical care and rehabilitation will vary depending on the patient and other variables – including other interventions.

For more information use this link to the review report:

https://mgov.newham.gov.uk/ieListMeetings.aspx?CommitteeId=1227

Case Study: Tameside Metropolitan Borough Council

Tameside MBC had already achieved above average take up of NHS Health Check programme across the Borough but wanted to develop its community model of delivery. The public health team were undertaking a series of reviews of their services and through working closely with the Health and Wellbeing Improvement Scrutiny Panel wanted to identify and consider how best to utilise a community or GP based approach for the delivery of NHS Health checks.

Successes and qualitative benefits

- Held a stakeholder event attracting over 40 delegates from 14 organisations connected to NHS Health Checks. The event enabled participants to discuss the benefits, opportunities and challenges in the delivery of integrated GP and community based models.
- The review helped to create new and improve existing partnerships between the Council, CCG and a range of other partners and stakeholders.
- In addition to supporting the review process the stakeholder event also benefitted public health directly in allowing them to make contact and connections with the lead officers from relevant organisations in relation to the delivery in Tameside.
- The review helped to raise the profile of the NHS Health Check programme and identify areas where take-up could be improved, e.g. through publicity and marketing.

Challenges

- A significant challenge identified during the course of the review was the need for further development around communication between partner organisations linked to NHS Health Checks.

Learning Points

- The event required financial and staff resources – but this investment led to a successful outcome.
- The need for data to accurately calculate the ROI.
- The review of NHS Health Checks was undertaken following a level of transition from the Clinical Commissioning Group to the Public Health Team at Tameside Council and this caused some concerns around the sharing of information.

Key recommendations

At the time of writing the final report had not been approved but review recommendations are likely to include:

- A marketing campaign to promote the availability and benefits of NHS Health Checks.
- Utilising community centres and engagement with leaders of hard to reach communities.
- The use of electronic invites and reminders.
- A primary and community based approach to the delivery of NHS Health Checks in the borough.
- Work with local pharmacies to improve the delivery of community based Health Checks in the borough.
- Further work with Tameside Sports Trust to explore further commissioning opportunities.

ROI question and calculation

Identifying and considering how best to utilise a community or GP based approach to the delivery of NHS Health Checks and appropriate targeting?

Invest : Cost of 10% increase in NHS Health Checks	£5,708
To save : Potential savings	£28,500
Potential return on investment	**£22,792**

Assumptions

Total cost of NHS Health check programme 12/13 £567,412 including delivery in community settings

In Q1/Q2 (6 mths) of 2012/13 there were 3,976 delivered assuming therefore 7,952 over 12 mths.

Cost of a NHS Health Check £71.35

Calculation based on 10% increase 80 patients (80 x £71.35 = £5,708). Of 8000, 11.4% identified as being at risk of stroke

Cost of treatment for a stroke = £25K (British Heart Foundation average)

1.14% out of 80 would give a £28,500 saving

Reports once approved will be available at:

http://www.tameside.gov.uk/scrutiny/reports#pers

Appendix two – 10 Questions for council scrutiny about NHS Health Check

Interested in carrying out your own review of NHS Health Check? Here are 10 questions to consider before you start. You will also find additional questions in the supplementary briefings sitting alongside this publication.

1 **How has the NHS Health Check programme been commissioned so far and who measures outputs and outcomes from it?**

2 **What do we understand about the NHS Health Check programme, how and where they happen, and the intended positive benefits for our population?**

3 **How is data about outputs and outcomes collected? Are there local systems for collecting as well as national? Can we learn anything from the experience of NHS Health Checks elsewhere?**

4 **Do we understand which sections of our local population have the poorest health outcomes and how the NHS Health Check programme will improve them? If not, who can tell us about this?**

5 **How is the commissioning of the NHS Health Check programme intended to contribute to improving the content of the Joint Strategic Needs Assessment and how does it contribute to joint health and wellbeing strategic outcomes? How is this aspect monitored and by whom?**

6 **Who has actually taken up the NHS Health Check so far and what impacts have been observed? Do we have evidence to hand about the effectiveness of the current or intended programme from existing providers and clinical commissioners?**

7 **Who provides the NHS Health Check and how does this currently relate to population coverage and the Public Health Outcomes Framework?**

8 **To what extent are clinicians and service users currently involved in commissioning the NHS Health Check programme locally? How is their contribution used?**

9 **Are there any national or local organisations and charities with specific focus on health conditions that the NHS Health Check programme seeks to prevent, that might provide an external critical friend or specialist knowledge that could be useful?**

10 **How does the baseline information we have in front of us compare to other local authorities; and what ideas do they have for taking this programme forward? Have we got comparable best practice examples to consider?**

Notes

Notes

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February 2014

Appendix D

Leicester Health and Wellbeing Scrutiny Commission

23 September 2014

The Leicester NHS Health Check Programme

Summary

This briefing describes work on the Health Checks programme in Leicester in 40-74 year olds. It informs the Health and Wellbeing Scrutiny Commission of:

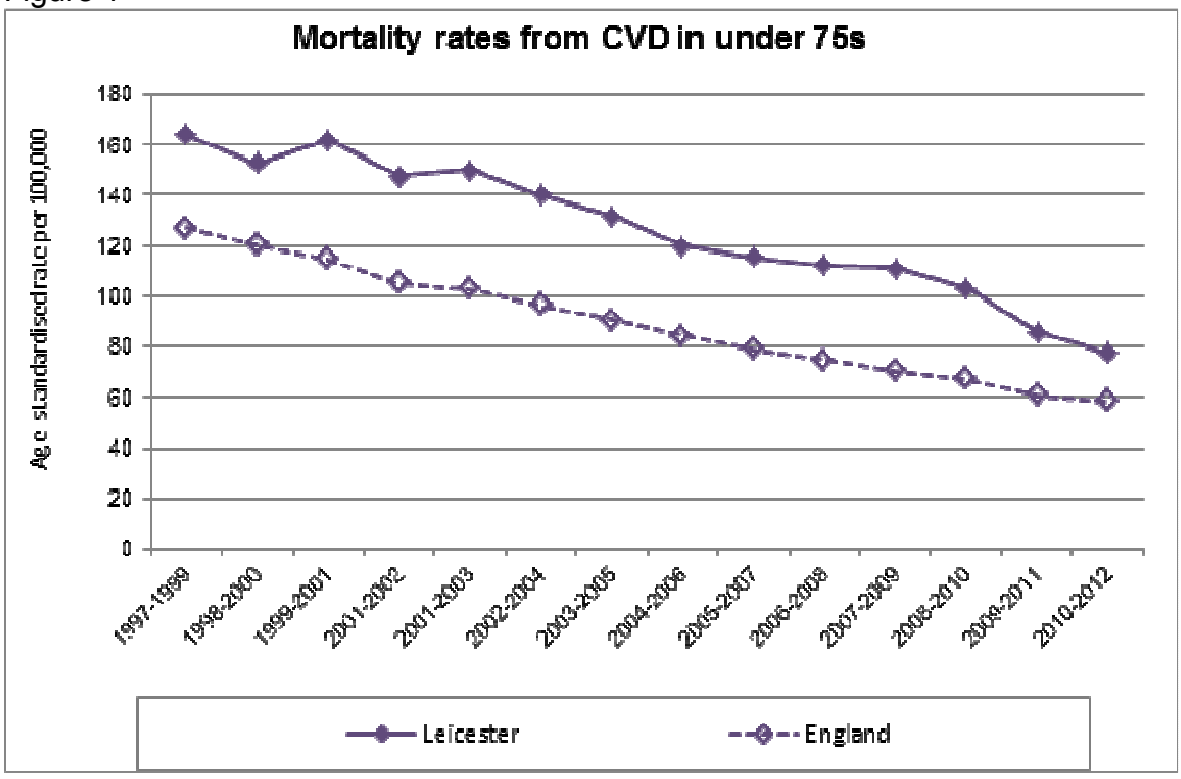
- The background to the national and local NHS Health Check programme
- The NHS Health Check programme in Leicester

Background

Burden of Cardiovascular Disease.

Cardiovascular disease, or CVD, is the second largest cause of premature mortality (mortality under aged 75) in England and Leicester.

Figure 1



In Leicester the percentage of cardiovascular deaths as a proportion of all deaths in 2009-2011 was 24.7% for people aged under 75 years and 35.6% for people aged 75 and above. This is higher than England for under 75s (23.8%) and higher than England for those aged 75 and over (34.7%). However, as Figure 1 illustrates, there has been a significant decrease in CVD mortality over time, reducing from 164.1/100,000 in 1997-1999 to 77.6/100,000 population in 2010-2012. This represents a reduction of 52.7%

over the period.

Emergency admission rates in Leicester for coronary heart disease remain significantly higher than national rates but the local rate is similar to the national rate for stroke.

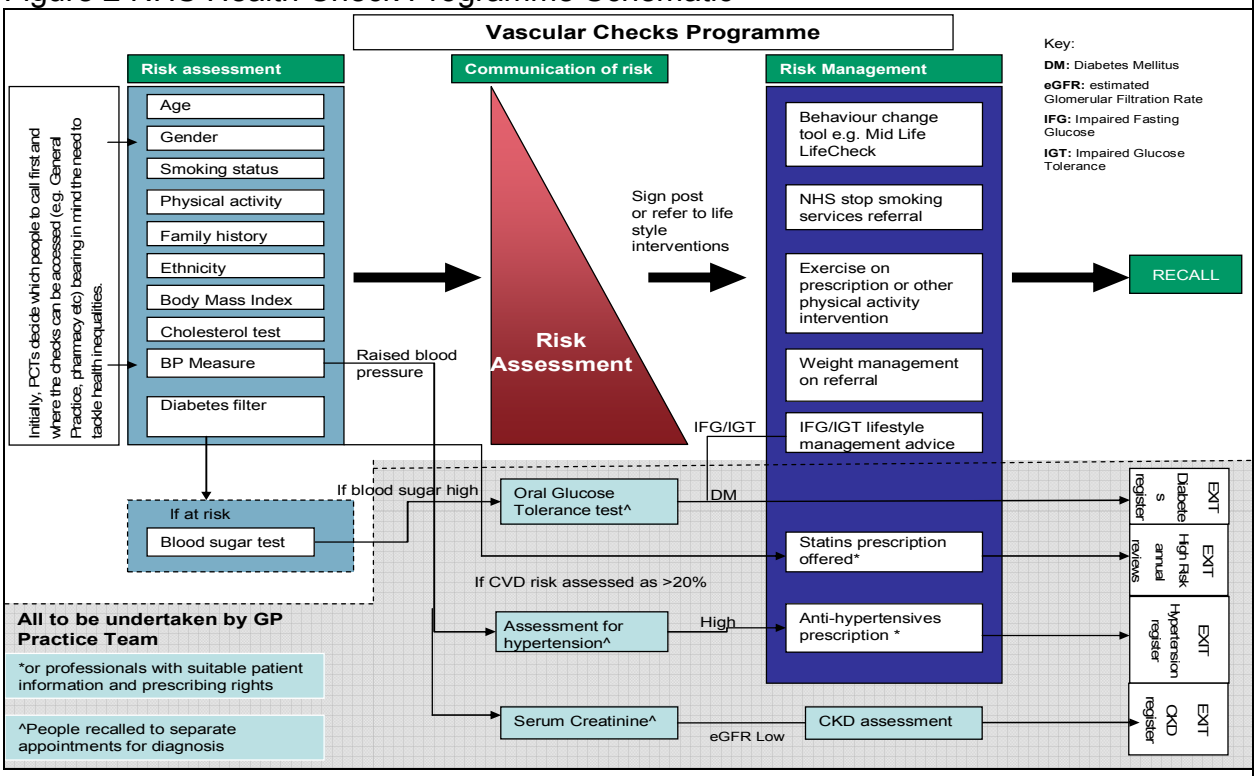
Development of Health Check Programme

If identified early, and appropriate lifestyle changes made, many CVD related illnesses such as heart disease, diabetes and kidney disease can be prevented or, if already present, their progress can be significantly slowed.

In January 2008, the Government announced its intention to shift the focus of the NHS towards empowering patients and preventing illness. As part of this approach plans to dramatically extend the availability of 'predict and prevent' checks to give people information about their health, support lifestyle changes and, in some cases, offer earlier interventions were proposed. The proposals for the programme were set out in 'Putting Prevention First', published on 1 April 2008

Later renamed the NHS Health Check Programme, national implementation of a systematic vascular screening programme began in April 2009 (see figure 2). Everyone between the ages of 40 and 74 who is not already been diagnosed with a CVD condition or certain risk factors is eligible. The programme ensures everyone in this population is invited once every five years for a NHS Health Check.

Figure 2 NHS Health Check Programme Schematic



Potential Benefits of Health Check Programme

The aim of the Health Check programme is to assess the risk an individual has of developing key vascular diseases and address identified risk factors by providing

lifestyle advice and, where appropriate, certain medication.

There is clear evidence that taking cholesterol lowering treatments, known as statins can help prevent cardiovascular disease, and NICE has produced and reviewed guidelines on their use.[1] It is also well known that making lifestyle changes, such as stopping smoking, can reduce the risk of cardiovascular disease and NICE has also produced guidelines on a range of lifestyle issues including smoking and obesity.[2]

Experts estimate that between 80% and 90% of deaths from cardiovascular disease in people under the age of 75 could be prevented by making appropriate lifestyle changes.[3]

Modelling suggests that the national NHS Health Check programme could prevent 1,600 heart attacks and strokes, over 4,000 new cases of diabetes, and at least 650 premature deaths every year. This would have a noticeably positive impact on the health and social care systems. Evidence also shows that inequality in early deaths from cardiovascular causes and the underlying risk factors persists. They are most common in people from the poorest communities, those with mental health problems and individuals in minority groups compared to people living in more wealthy areas. The NHS Health Check programme offers an opportunity to address such health inequalities.

The programme is constantly reviewed to reflect changes in the health and social care system

Evidence of the Possible Risks

As with any screening service there are risks with the NHS Health Checks programme. Research has found that one of the commonly used risk assessment tools overestimates the risk of disease in low risk groups and underestimates the risk in high risk groups.[4] This can lead to people being prescribed medication that is unnecessary or being falsely reassured about their risk and not taking appropriate action. However, locally a screening tool has been selected that reflects higher risk populations such as found in Leicester (QRISK 2).

In addition, understanding one's personal risk of disease may not necessarily motivate people to change behavior. Evidence is scarce to support the assumption that telling

[1] National Institute for Health and Clinical Excellence (2014). *Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease* (CG67). London: NICE.

[2] National Institute for Health and Clinical Excellence (2006). *Statins for the prevention of cardiovascular events in patients at increased risk of developing cardiovascular disease and those with established cardiovascular disease* (TA094). London: NICE.

[3] Capewell S, Allender S, Critchley J, Lloyd-Williams F, O'Flaherty M, Rayner M, Scarborough P (2008). *Modelling the UK Burden of Cardiovascular Disease to 2020*. London: British Heart Foundation.

[4] Brindle P, Beswick A, Fahey T, Ebrahim S. Accuracy and impact of risk assessment in the primary prevention of cardiovascular disease: a sytematic review. *Heart* 2006 92:1752-1759.
Tunstall-Pedoe H, Woodward M. By neglecting deprivation, cardiovascular risk scoring will exacerbate social gradients in disease. *Heart* 2006 92:307-310.

someone they are at high risk of disease will lead to them making significant behaviour changes. An evaluation of a health check programme in Australia found that less than half of those who took part made any changes.[5]

Studies have also found that understanding the personal health risks of smoking, for instance, is associated with intentions to quit, but the effect is short lived and does not necessarily lead to successful quit attempts.[6]

Commissioning Arrangements

Until 31 March 2013, it was the responsibility of primary care trusts (PCTs) to deliver the NHS Health Check programme, which they achieved predominantly by commissioning GPs through local enhanced services (LES). From 1 April 2013, as directed by the Health and Social Care Act (2012), the responsibility to provide many public health services, including NHS Health Checks, moved to local authorities. The NHS Health Check programme is one of only five public health programmes that local authorities are legally responsible for providing to local people.

Health Check Programme in Leicester

During initial implementation of the NHS Health Checks programme, each location was permitted to tailor the roll out of the programme to suit the local demographic and available budget. This resulted in varying approaches and levels of implementation success across the country.

Whilst there is no formal role for central performance management and targets in the development of the NHS health check, the legislation[7] does specify that:

"..the local authority shall act with a view to securing continuous improvement in the percentage of eligible persons in its area participating in the health checks."

In common with most areas of the country, initial uptake amongst the eligible local population for the health check programme in Leicester was low. Following limited progress in the first 18months, in September 2011a task group was created to both consider how to improve uptake of checks and ensure the ongoing management of those identified as being at high risk by the check. The sub-group, consisted of:

- Director of Public Health
- CCG Governing Body GP
- GP with research interests/University links
- Consultants in Public Health
- Head of Delivery

[5] Amaroso C, Harris MF, Ampt A, Laws RA, McKenzie S, Williams AM. The 45 Year Old Health Check. *Australian Family Physician* 2009, 38(5):358-362

[6] Bize R, Burnand B, Mueller Y, Cornuz J. Biomedical risk assessment as an aid for smoking cessation. *Cochrane Database Syst Rev* 2005;(4):CD004705

[7] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/351/regulation/4/made last accessed 23/10/2013

This group made the following recommendations which were subsequently implemented.

- Reduction of the levels of under or inaccurate -reporting or through the use of consistent city-wide templates for the local clinical system (SystmOne).
- Reviewed the current local contract to encourage greater uptake.
- Opened screening to all eligible patients aged 40 – 74 years olds rather than the previous age prioritised model.
- No longer funding practices for the costs of sending out postal invitations, given this method had failed to deliver high attendance.
- Enable practices to be able to offer screening opportunistically to their eligible patients.
- Provide additional funding for 2011/12 to 2013/14 provided to accelerate practice take up.
- Realignment of the payments for the screen (part 1) and management (Part 2) elements of the programme.
- The formation of a NHS Health Check sub group to support the ongoing development of the programme.

The Leicester health checks programme currently consists of 2 parts in a 'screen and treat' format. In Part 1 the patient is screened for previously undiagnosed CVD risk factors and given a 10 year risk score. In Part 2 there is a specific meeting with the GP or Nurse Practitioner for those patients identified at high risk (10 year CVD risk >20%), or with isolated risk factors, e.g. diabetes, hypertension.

Current Provision and Uptake

Leicester initiated the NHS Health Check programme in 2010 and since that time has seen a significant increase in the number of those eligible having these checks (see table 1). By the end of 2013/14 approximately 62,000 out of the estimated eligible population 88,000 had received their NHS Health Check (70%).

The national modelling associated with the NHS health Check programme suggests that from a 100% offer local commissioners should expect 70% of the population to attend for a check. Leicester is already above this figure with 2014/15 uptake to be added to the 5 year completion cycle.

Table1- NHS Health Checks completed annually

2010/11	2011/12	2012/13	2013/14
7403	8238	24048	22396

The revision to the local service resulted in a substantial increase in uptake of NHS Health Checks in Leicester since 2012/13 for the Health Checks programme in Leicester. The city is currently one of the highest performing areas in England for uptake of this programme.

Current uptake of Health Checks programme in Leicester is very good (29.1% compared to 18.5% nationally- 2012/13).

Local Outcomes

At a rate of 20,000 checks being conducted per annum, national modelling estimates suggest that we would expect to see 10 fewer heart attack events, 10 fewer stroke events and 32 cases of diabetes prevented within the local population each year.

Locally, from 32,693 checks carried out between 2010/11- 2012/13 that were recorded on the 'Systm1' clinical system, used by the majority of general practices in the city, there were almost 5,000 previously unidentified CVD related risk factors amongst patients that went on to receive routine clinical management/ monitoring for their condition. Diabetes was the most common unidentified clinical condition found in the local NHS Health Check programme (see table 2)

Table 2 – Clinical conditions identified by NHS Health Checks (2010-13)

Programme Equity

Gender	Diabetes	High Blood Pressure (Hypertension)	Heart Disease (IHD)	High Blood Cholesterol (Hyperlipidamia)	Atrial Fibrillation (AF)	High risk diabetes
Total	1125 (3.44%)	1665 (5.09%)	74 (0.23%)	1506 (4.61%)	56 (0.17%)	438 (1.34%)
Female	535 (3.2%)	706 (4.22%)	15 (0.09%)	655 (3.92%)	18 (0.11%)	254 (1.52%)
Male	590 (3.7%)	959 (6.01%)	59 (0.37%)	851 (5.33%)	38 (0.24%)	184 (1.15%)

Initial work was conducted in October 2013 to examine whether health checks were being provided in an equitable manner to the local eligible population. Using data fields collected within GP clinical records the analysis considered uptake of the health check uptake by; age, sex, ethnicity, deprivation and location of provider. The analysis didn't indicate that, within these demographic criteria, there were any particular groups that appeared to be disproportionally disadvantaged in receiving a health check by the current service provision (see appendix 1).

Whilst it appears that Leicester has good uptake for the health check programme and seems to be reaching the majority of its eligible population, it is recognised that substantial barriers may exist that prevent certain individuals from taking up their health check offer. It is for this reason that the local authority is commissioning detailed insight work to specifically identify any particular barriers the public has found to uptake and any groups who may be particularly affected by them. The findings will be used to address current programme failings and inform future programme developments focused on tackling barriers to uptake.

Programme Audit

A programme of internal audit is being established for the local NHS Health Check programme. Information governance issues associated with data sharing arrangements have delayed access to the NHS held data required to implement this task. A number of meetings have been held to try to resolve the problems identified and it is hoped that a final resolution will soon be reached.

There are currently two external audits taking place of the Leicester NHS Health Check programme. The first, being undertaken by the University of Leicester, focuses predominantly on the clinical effectiveness of the local programme, whilst the second, conducted by the specialist health care audit company 360 Assurance, places greater focus on verification of the work claimed by the providers. Draft reports for both audits have recently been produced, with final versions expected by November this year.

A member of the local authority public health division visits each of the general practices providing NHS Health Checks as part of the CCG Annual Quality Review (AQR) process. During these visits they cover the provider's performance in delivering the NHS Health Check programme and raise any particular concerns that are identified. It is anticipated that this on site visit arrangement will continue for 2014/15 and beyond.

Reprocurement

As a former NHS services that is now the responsibility of local government, following the implementation of the Health and Social Care Act 2012, the local NHS Health Check service is undergoing reprocurement. The aim is to have the have the local authority selected provider/s in place by 1st April 2015.

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September 2013

Appendix1

Figure 1. Age distribution of NHS Health Checks (2009/10-2012/13)

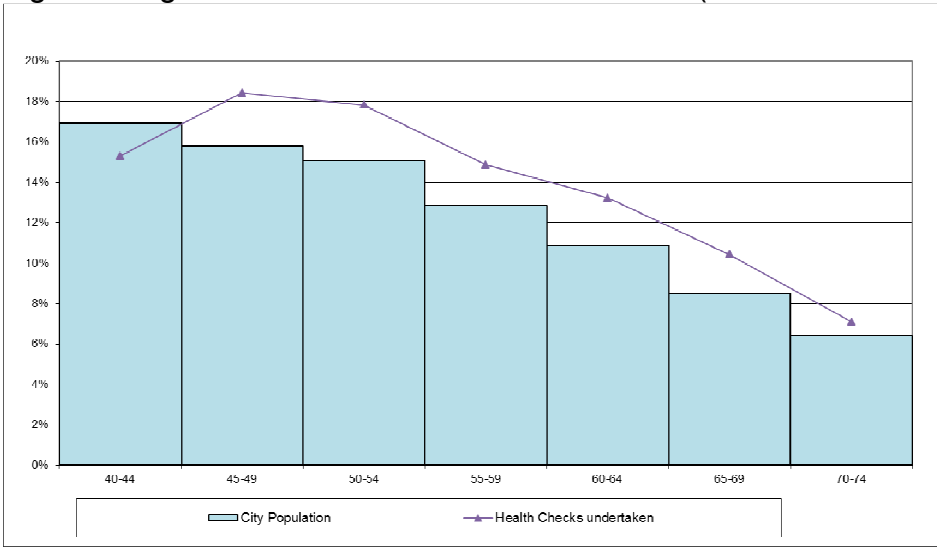
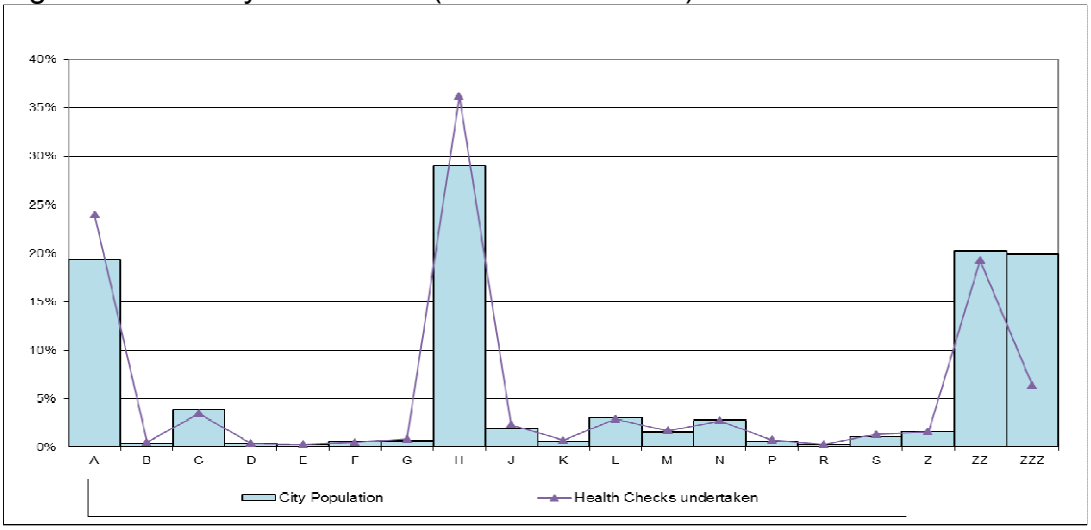


Figure 2. Ethnicity distribution (2009/10-2012/13)



A - British
B - Irish
C - Any other white back-ground
D - White and Black Caribbean
E - White and Black African
F - White and Asian
G - Any other mixed back-ground
H - Indian
J - Pakistani
K - Bangladeshi
L - Any other Asian back-ground
M - Caribbean
N - African
P - Any other black back-ground
R - Chinese
S - Any other ethnic group
Z - Not stated
ZZ - Not known
ZZZ-Unmapped Ethnicity Codes

Table 1- NHS Health Check Target Attainment and Deprivation

NHS Health Checks 2012/13 Summary - Deprivation Breakdown							
		National Target - Screens undertaken			Stretch Target - Screens undertaken		
National Quintile	Number of Practices	Lowest	Highest	Average	Lowest	Highest	Average
Q1	35	51%	641%	185%	23%	141%	76%
Q2	21	87%	411%	324%	38%	179%	98%
Q3	3	28%	173%	123%	15%	76%	56%
Q4	3	93%	179%	140%	37%	80%	60%
Q5	1	225%	225%	225%	94%	94%	94%

Appendix E

Health and Wellbeing Scrutiny Commission

23 September 2014

NHS England Area Team – Leicestershire and Lincolnshire

Screening and Immunisation Team

Uptake of Childhood Immunisations in Leicester City (September 2014)

1. Background

Prior to 1st April 2013, screening and immunisation programmes were the responsibility of public health departments in Primary Care Trusts. As a result of the Health and Social Care Act 2012 many public health functions were transferred to local authorities but the responsibility for commissioning screening and immunisation services was transferred to NHS England. Screening and immunisation programmes are now delivered under joint national arrangements between Public Health England, NHS England and the Department of Health. The section 7a agreement between the Secretary of State for Health and NHS England gives NHS England the responsibility of commissioning these services on behalf of the Secretary of State.

Each NHS England Area Team has a public health team which includes public health specialists employed by Public Health England and officers employed by NHS England. The team is led by a consultant in public health medicine. Immunisation programmes across Leicester, Leicestershire and Rutland are monitored by one whole time equivalent co-ordinator. The aim is to commission robust services and to support providers to deliver good quality services to protect the population against vaccine preventable diseases.

2. Delivery of Childhood Immunisations Programmes

Currently most childhood immunisation programmes are delivered via general practice. School based programmes include Human Papillomavirus (HPV) and seasonal flu vaccinations in special schools.

Changes to the childhood immunisation programme during 2013 included:

- reducing the number of meningococcal serogroup C (MenC) vaccines from two to one in under 1 year olds

- introduction of rotavirus vaccinations given at 2 and 3 months of age.

3. Uptake

Childhood immunisation uptake has increased over the last 5 years in Leicester City. Uptake is measured by completed courses of vaccinations at age 1, 2 and 5. The data for year-end April 13 – March 14 and Q1 2014/15 is provisional local data. The current childhood immunisation schedule for the UK is attached in Appendix A.

Performance is shown against a target of 95%. This is a WHO target and is challenging for all areas to achieve, particularly for the vaccines at age 5 years.

3.1 Childhood immunisation uptake data by percentage in Leicester City.

	2013/14 Target	Yr end Apr 09 - Mar 10	Yr end Apr 10 - Mar 11	Yr end Apr 11 - Mar 12	Yr end Apr12- Mar 13	Yr end Apr13 - Mar 14	Q1 2014/15
Age 1 DtaP/IPV/Hib	95.0%	93.2	94.1	96.3	97.3	96.5	95.8
Age 2 PCV	95.0%	91.0	91.1	93.8	95.8	96.3	95.7
Age 2 Hib/MenC	95.0%	92.9	93.2	95.2	96.0	95.7	95.7
Age 2 MMR (1 dose)	95.0%	90.1	90.4	93.0	95.7	95.9	96.0
Age 5 DTaP/IPV (4 doses)	95.0%	89.0	89.6	91.4	94.6	92.4	93.0
Age 5 MMR (2 doses)	95.0%	87.6	88.4	90.2	93.1	92.6	92.2

COVER (Cover of Vaccination Evaluated Rapidly) data from HSCIC apart from year-end 13-14 and Q1 2014/15 which are local unpublished data.

3.2 Leicester City childhood immunisation percentage uptake compared to similar organisations in 2012/13.

A useful way of assessing performance is to compare Leicester with its peer areas as defined by the Office of National Statistics (ONS). Leicester City's comparator areas according to ONS are Manchester, Birmingham, Wolverhampton, Nottingham, Barking and Dagenham and Sandwell. The table below shows Leicester City

childhood immunisation uptake during 2012/13 (most recent published data) compared to these organisations. Leicester City has an outstanding uptake in comparison to other cities, despite the movements in and out and diversity of the population.

	At age 1 year	At age 2 years			At age 5 years	
	DtaP/IPV/Hib	**PCV**	**Hib/MenC**	**MMR (1 dose)**	**DtaP/IPV**	**MMR(2 doses)**
Leicester City	97.3	95.8	96.0	95.7	94.6	93.1
Manchester	95.7	92.4	91.3	92.7	87.9	87.2
Birmingham	87.0	87.7	83.6	87.3	83.1	82.6
Wolverhampton	94.7	88.1	92.9	92.8	79.5	76.5
Nottingham	93.4	89.8	91.9	90.4	84.7	83.4
Barking and Dagenham	92.1	87.7	88.9	88.5	85.9	85.0
Sandwell	93.6	90.9	91.8	90.3	82.4	87.5
England	94.7	92.5	92.7	92.3	88.9	87.7

COVER (Cover of Vaccination Evaluated Rapidly) data from HSCIC

3.3 HPV (Human Papillomavirus) Vaccination Programme

The routine programme was introduced to protect against two of the high risk HPV types that can lead to cervical cancer. It is delivered routinely to year 8 girls aged 12-13 yrs as a 3 dose course over 6 to 12 months in school. This changes to a 2 dose course from this September 2014. Delivery of this service is through schools and is now provided by a dedicated team of immunisation nurses from Leicestershire Partnership Trust.

Percentage uptake of HPV vaccination in Leicester City

Target		2009/10	2010/11	2011/12	2012/13
Target is 90% for 3 doses since 2011/12	Dose 1	86.5	87.4	89	92.2
	Dose 2	86.5	85.7	87.5	92.2
	Dose 3	84	85	86.1	91.9

The data for 2013/14 will not be published until the end of September but we are confident that Leicester City will have achieved the 90% target for three doses.

3.4 Seasonal Influenza Uptake

The Joint Commission for Vaccinations and Immunisations (JCVI) have recommended all children between 2 to 17 will receive a flu vaccination every year in the future. The first phase was to offer the flu vaccination to all well 2 and 3 year olds in general practice. The vaccine that was used during 2013/14 is Fluenz® a nasal spray, so no injections are necessary unless a child is contraindicated to Fluenz®. The programme will increase to include all well 2, 3 and 4 year olds this year using Fluenz tetra® which is a quadrivalent nasal vaccine and offers even better protection.

Uptake of seasonal flu vaccine in the 2 and 3 year old cohorts in Leicester City

	2 Year Olds			3 Year Olds		
	Eligible	Vac'd	%	Eligible	Vac'd	%
2013/14	5555	1903	34.3	5380	1685	31.3

There is no target for the uptake of Fluenz in 2 and 3 year olds.

3.5 Flu Pilots in School

As part of the recommended roll out of flu vaccines to children by the JCVI, pilot programmes have been implemented. One such pilot took place in primary schools in Leicester City, East Leicestershire and Rutland during 2013/14 with a 52% uptake.

The same programme will be delivered as a pilot this year but it will be expanded to include schools in West Leicestershire. Children in years 7 and 8 in secondary schools will also be offered the vaccine. This means the vaccine will be offered to approximately 97,000 children in 447 schools between October and December 2014 across Leicestershire, Leicester City and Rutland. Combined with the 2, 3 and 4 year old programme mentioned above this means that all children from age 2 to 12 years of age in Leicester City will be offered the Fluenz intranasal flu vaccine in the coming autumn. Leicester City is one of only a handful of places in the country where this will be the case.

4 Action – existing and future

- All of the childhood vaccines referred to in section 3.4 are scheduled by the child health information department which is part of Leicestershire Partnership Trust. All vaccines that are given are recorded on the same system. The data that is held is used to give every practice a monthly report of performance for each of the vaccines shown in section 3.4. This data is also used to send every practice a list of children who are approaching a milestone birthday (1, 2 or 5 years) and have not had all of the vaccines that they are due. This acts as a prompt for practices to make every effort to immunise these children prior to the relevant deadline. This process has been in place for some time and has contributed to the rise in vaccination rates that we have seen over time.

- Practice clinical staff attend formal training sessions on an annual basis for immunisation and vaccination. The screening and immunisation team provide updates to non-clinical staff in line with the minimum standards for immunisation and vaccination

- Communications – the screening and immunisation team works in partnership with national and local communications teams, taking part in TV and radio interviews, assisting with articles to be put into local journals such as Leicester Link etc.

- The screening and immunisation team produces a newsletter to assist practice staff. The content is partly informed by the queries received from practices.

- The screening and immunisation team attend the Clinical Commissioning Group protected learning time for general practice staff and provide update sessions for clinical and non clinical staff.

- A new home visiting service is being commissioned for patients for whom this is deemed the only way that a child will receive a vaccination. Care is required to ensure that this service is not seen as an "easy option" either by general practice or by the population as this would become an extremely expensive way of providing a population based immunisation programme.

- A new hepatitis B vaccination pathway for infants born to mothers found to be Hep B positive via antenatal screening is being introduced. This will ensure that no child who is eligible for this course of vaccines is able to slip through the net by establishing appropriate data flows and failsafe procedures. This is being launched on 1st November 2014.

Dr Tim Davies
Consultant Lead for the Screening and Immunisation
September 2014

NHS

Vaccines for the routine immunisation schedule from summer 2014

When to immunise	Diseases protected against	Vaccine given
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)	**Pediacel** or **Infanrix IPV Hib** (DTaP/IPV/Hib)
	Pneumococcal disease	**Prevenar 13** (PCV)
	Rotavirus	**Rotarix** (Rotavirus)
Three months old	Diphtheria, tetanus, pertussis, polio and Hib	**Pediacel** or **Infanrix IPV Hib** (DTaP/IPV/Hib)
	Meningococcal group C disease (MenC)	**NeisVac-C** or **Menjugate** (Men C)
	Rotavirus	**Rotarix** (Rotavirus)
Four months old	Diphtheria, tetanus, pertussis, polio and Hib	**Pediacel** or **Infanrix IPV Hib** (DTaP/IPV/Hib)
	Pneumococcal disease	**Prevenar 13** (PCV)
Between 12 and 13 months old – within a month of the first birthday	Hib/MenC	**Menitorix** (Hib/MenC)
	Pneumococcal disease	**Prevenar 13** (PCV)
	Measles, mumps and rubella (German measles)	**Priorix** or **MMR VaxPRO** (MMR)
Two, three and four years old	Influenza	**Fluenz Tetra** (Flu nasal spray) (annual) (if Fluenz unsuitable, use inactivated flu vaccine)
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	**Infanrix IPV** (DTaP/IPV) or **Repevax**[2]
	Measles, mumps and rubella	**Priorix** or **MMR VaxPRO** (MMR) (check first dose has been given)
Girls aged 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)	**Gardasil** (HPV)
Around 14 years old	Tetanus, diphtheria and polio	**Revaxis** (Td/IPV), and check MMR status
	MenC[5]	**Meningitec**, **Menjugate** or **NeisVac-C** (MenC)[5]
From 28 weeks of pregnancy[7]	Pertussis	**Boostrix-IPV**[8]
65 years old	Pneumococcal disease	**Pneumovax II** (PPV Pneumococcal polysaccharide vaccine)
65 years of age and older	Influenza	Flu injection (annual)
70 years old	Shingles	**Zostavax** (Shingles)

Pediacel* | Infanrix IPV Hib* | Prevenar 13 | Rotarix | Menjugate*

NeisVac-C* | Menitorix | Priorix* | MMR VaxPRO* | Infanrix IPV*

Gardasil | Revaxis | Fluenz Tetra | Boostrix-IPV | Zostavax

*NB Where two or more products to protect against the same disease are available, it may, on occasion be necessary to substitute an alternative brand.

Influenza vaccine is free to all children aged two, three and four years, those aged 6 months to under 18 years in at-risk groups, and those in flu vaccination programme pilot areas. Flu vaccine for these groups only, and all the other vaccines listed above, except Pneumovax II for those aged 65, are available free of charge at **www.ImmForm.dh.gov.uk**.

immunisation

The safest way to protect children and adults

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Appendix F

Health and Wellbeing Scrutiny Commission Briefing

Progress on the local Government Mental Health Challenge 10 Actions

Lead director: Rod Moore

City Mayor

Ward(s) affected: All

Report author: Julie O'Boyle Consultant in Public Health

Mark Wheatley Public Health Principal

Author contact details: Julie.oboyle@leicester.gov.uk

Purpose of Briefing

To provide the Health and Wellbeing Scrutiny Commission with an update on local progress made with regard to meeting the Local Government Mental Health Challenge and the 10 specific actions identified within the challenge.

Background

The Mental Health Challenge was set up by Centre for Mental Health, Mental Health Foundation, Mind, Rethink Mental Illness, Royal College of Psychiatrists and Young Minds. The aim of the Challenge is to ensure that local councils use their influence to promote good mental health in their communities and to help people with mental illness to have better, more fulfilling lives. The Challenge identifies 10 actions which will enable councils to promote mental health across all of their business. These actions build upon the implementation framework for No Health without Mental Health, the national mental health strategy.

Leicester City Council is one of 28 councils that have so far taken up the mental health challenge.

Introduction

Leicester City Council has a key role to play in improving the mental health of our citizens and in developing and implementing the Joint Commissioning Strategy for mental health. This is being done, for example, through scrutinising mental health services, commissioning social care related to mental health and by tackling some of the entrenched equalities issues which impact on mental health and wellbeing.

Improving mental health is a strategic priority identified in the Joint Health and Wellbeing Strategy, *Closing the Gap*. The City Council is in a position to influence this priority through its many functions and services including, public health, adult social care, children's services, housing, homelessness services, the environment, safety and transport. It also has a crucial role in collaborating with service users and carers and other organisations across the statutory and voluntary and community sectors.

The Mental Health Challenge is a way of promoting mental health and wellbeing across all the functions of the City Council. It may help all councillors to play a positive role in championing mental health on an individual and strategic basis. It is a mechanism through which councillors can advocate for service users and carers and influence local service commissioners and providers to take a proactive approach to mental health and wellbeing.

Progress on the 10 Actions set out in the Mental Health challenge

1. **Appoint an elected member as mental health champion across the council;**

Councillor Michael Cooke is the nominated mental health champion for Leicester City Council. In this role he instigated a review, with all local partners, of the Leicester City Joint Commissioning Strategy for Mental Health. The resulting report made recommendations about increasing capacity in the voluntary sector to prevent the escalation of mental health needs. This has led to increased funding to local voluntary sector mental health providers.

However, the approach taken in Leicester is to strengthen our commitment to protecting mental wellbeing by encouraging all councillors to be champions for mental health through their work. At a full council meeting councillors were invited publicly to sign up to the Time to Change pledge and the actions set out in the Mental Health Challenge. To support councillors in this role the Deputy City Mayor intends to host some policy discussion and workshops for elected members on mental health and wellbeing in Leicester's communities later this year.

2. **Identify a lead officer for mental health to link in with colleagues across the council**

Mark Wheatley Public Health Principal is the named lead officer for mental health in the council.

Our approach in Leicester City Council is that mental health is everybody's business. To support this; a programme to ensure that staff awareness of mental health issues is raised has started. In 2014 we have:

- Delivered a mental health workshop for directors and heads of service
- Commissioned and delivered suicide awareness training for front line council staff
- Delivered a mental health and wellbeing day for council employees to raise awareness of mental health issues and the services and support mechanisms in place for both staff and the public.

Plans for the next year include mental health awareness training for council staff as part of our workplace health programme and suicide awareness training for councillors.

3. **Follow the implementation framework for the mental health strategy where it is relevant to the council's work and local needs**

The national mental health strategy is accompanied by an implementation framework which sets out actions to bring about real and measurable improvements in mental

health and wellbeing. A number of the actions identified in the implementation framework are the same as those identified in the Mental Health Challenge.

The framework consists of 4 parts:

- Part 1 suggests the changes needed to turn vision into reality;
- Part 2 sets out how progress will be measured;
- Part 3 looks at what local organisations can do to implement the strategy;
- Part 4 sets out how local action will be aided by government and other national organisations.

The specific actions identified for local authorities in Part 3 are:

To appoint an elected member as 'mental health champion.'

(See 1 above)

To assess how strategies, commissioning decisions and directly provided services support and improve mental health and wellbeing:

The local Mental Health Partnership Board oversees and influences the local strategic approach and commissioning framework for mental health. The Joint Commissioning Strategy for Mental Health in Leicester is currently under review; as part of this there is ongoing consultation with stakeholders, including service users and carers, to ensure local needs continue to be met.

Involve the local community, including those with mental health problems, their families and carers, in the co-production of service pathways and in service design. This includes providing clear and accessible communication regarding how people's views and priorities have been taken into account.

(see above and 9 below)

Consider using 'whole place' or community budgets to improve the quality and efficiency of support offered to people with multiple needs including a mental health problem.

In Leicester we have made small grants available to local grass roots organisations to develop easier access to advocacy information advice and guidance for people with mental health problems.

Use the Local Government Association's Knowledge Hub - allowing members and staff to share innovative approaches and good practice.

Sign up to the Time to Change campaign to raise the profile of mental health across the authority and address stigma among staff. Authorities can also develop local initiatives to make tackling stigma 'business as usual'.

The council has signed up to the Time to Change pledge.

4. Work to reduce inequalities in mental health in our community

The Public Health team have completed a Joint Specific Needs Assessment (JSpNA) on mental health in Leicester. This covers issues of health inequalities and diversity and how they impact on the mental wellbeing of our population. The JSpNA is a key document which will inform our ongoing commissioning intentions for health and social care. A draft version of the JSpNA is available on the council website at http:www.leicester.gov.uk/your-council-services/social-care-health/jsna/jspna-reports/

As part of the on-going work of influencing mental health and social care commissioning Public Health has collaborated with commissioners to improve access to psychological therapy to people from minority ethnic communities, lesbian, gay, bisexual and transgender (LGBT) people and probation service users.

The Health and Wellbeing Scrutiny Commission is undertaking a review of the mental health needs and mental health service experiences of young men from black African and African Caribbean ethnic backgrounds across Leicester. This process is on-going and will culminate in a report with specific recommendations to the council executive and other partners.

5. Work with the NHS to integrate health and social care support

The local authority is working in partnership with the local NHS in programmes such as the Joint Commissioning Strategy on Mental Health in Leicester and the Better Care Together Programme. The development of these on-going projects is crucial to meet local mental health needs.

This work also includes working with key stakeholders to review the current mental health care pathways in line with the national Crisis Care Concordat and the development of a local crisis house, a key priority identified by service users at the Mental Health Summits held in 2013

A proposal has been approved by the Leicester Joint Integrated Commissioning Board to commission mental health first aid awareness training in local faith groups. The aim of this programme is to increase front line capacity to recognise mental health and sign post people appropriately and to address some of the specific issues relating to stigma within different communities.

6. Promote wellbeing and initiate and support action on public mental health

The local authority has supported a series of Mental Health Summits in Leicester, raising awareness of mental illness and influencing local service commissioners to integrate health and social care. The Deputy City Mayor and the mental health champion both spoke at these summits which were attended by a wide range of stakeholders including service users and carers.

In the last year more than 200 front line workers across the community have attended

Leicester City Council commissioned suicide awareness training; this is in addition to the suicide awareness training delivered to LCC's own staff.

All Leicester City Council libraries have the national books on prescription titles. This scheme is a national reading list for England delivered by The Reading Agency and the Society of Chief Librarians with funding from Arts Council England. The scheme is supported by: The Royal College of General Practitioners, The Royal College of Nursing, The Royal College of Psychiatrists, The British Psychological Society, the Department of Health's Improving Access to Psychological Therapies Programme (IAPT), the British Association of Behavioural and Cognitive Psychotherapies, the British Association for Counselling and Psychotherapies, and Mind.

The scheme helps people to manage their own health and well-being through recommended self-help books. Books on the list have been carefully selected and are designed to cover a range of mild to moderate mental health problems including stress, anxiety, anger, phobias and depression amongst others. They are free for any registered library user to borrow and can be identified in Leicester City Council libraries by a themed display of health books, the books on prescription catalogue and an on-line booklist which includes all the books on prescription titles.

The social inclusion team is linked to the Leicester, Leicestershire and Rutland Mental Health Promotion Network, and focuses activity on raising awareness of the risks of mental illness associated with social exclusion. The team organised a mental health awareness event for the public held in the city market.

As part of our work in raising awareness of suicide prevention, Leicester City Council co-commissioned 4 films of people who had survived an attempt on their own lives and described feelings of hope and fulfilment. These were screened at a public event at Curve in September 2014 to mark World Suicide Prevention Day. The films have been widely shared on social media sites.

The local authority is seeking to protect the mental health and wellbeing of people in Leicester by raising awareness of other priority public health conditions such as obesity, alcohol misuse and smoking, and with long term conditions

7. Tackle discrimination on the grounds of mental health in our community and tackle stigma

Leicester City Council has signed up to the Time to Change pledge to tackle stigma and discrimination relating to mental ill health. There was a public signing of the pledge by councillors at a full council meeting. Mental health awareness training for staff is being undertaken which seeks to empower staff to support and deal with people experiencing mental health issues in the workplace and their local communities.

The mental health first aid initiative is also designed to tackle discrimination and stigma in our community.

In addition to the work described above, a Mental Health Partnership Board, chaired by Councillor Patel, in which individual service users and carers, local voluntary and community groups and statutory organisations such as the NHS, the Police as well as the City Council meet to work together to reduce inequalities in mental health in our community, improve mental health care and tackle the stigma associated with mental illness.

The Deputy City Mayor has been proactive in his public support to the stamp out stigma campaign, writing a column for the Leicester Mercury to coincide with World Mental Health Day; the column focussed on the need to tackle stigma and discrimination.

8. Encourage positive mental health in our schools, colleges and workplaces;

Leicester City Council encourages positive mental health in our schools and colleges, with Educational Psychologists producing anti-bullying guidance and working with commissioners to take account of the effects of mental health and mental illness across the life course.

Suicide Awareness Partnership Training has been delivered to teachers in schools and colleges and we have plans to deliver this training for relevant staff in both our universities.

9. Proactively engage and listen to people of all ages and backgrounds about what they need for better mental health

All of the work described above has included engagement with services and carers across the city. This includes the Mental Health Partnership Board, chaired by Councillor Rita Patel. Service users and carers have a key role on this board along with voluntary and community sector organisations, such as Barnardos and the Big Mouth Forum.

The review of the Mental Health Joint Commissioning Strategy includes specific consultation on engagement with local communities including LGBT people and new and emerging communities.

The JSpNA on Mental Health in Leicester was developed with partners and included wide consultation with service users, carers and their representatives, across different ages and backgrounds.

New Leicester City Council guidance, processes and information to support the use of personal budgets and direct payments, which enhance choice and control, has been developed in co-production with service users and carers

The Council is actively working to encourage and support NHS and voluntary sector providers to improve their services. The City Council wants to see excellent services across Leicester. For example, concerns were raised by both the Executive and scrutiny about Leicestershire Partnership NHS Trust's plans to temporarily relocate the CAMHS ward to Coalville Hospital. The council will now be taking an active part in discussions as part of the CAMHS review to secure the best possible outcome for young people in Leicester and Leicestershire. This will be discussed at the October meeting of the Health & Wellbeing Board.

10. Sign up to the time to change pledge

Leicester City Council formally signed the Time to Change Pledge on 23rd January 2014.

Conclusion

Leicester City Council is committed to the Local Authority Mental Health Challenge and has made significant progress against the ten actions set out in the challenge. Immediate future work includes the following:

- Linking the findings and recommendations of the JSpNA on Mental Health in Leicester to the Joint Commissioning Strategy on Mental Health
- Working with statutory sector organisations to improve real time surveillance of potential cases of death from suicide and undetermined injury
- Working with service users, carers and statutory and voluntary sector providers to develop the Strategy
- Influencing the Better Care Funding approach to the delivery of appropriate accessible mental health care
- Undertaking further work to understand the needs and tackle stigma and discrimination within the LGBT community and new and emerging communities
- Working within Leicester City Council, for instance, homelessness services, to ensure that the mental health needs of service users are considered.

Details of Scrutiny

Leicester City Council

January 2014

Local Authorities Mental Health Challenge

Leicester councillors have signed a pledge to promote mental health across Leicester recognising the key role the council can play in helping tackle this important issue. (Picture shows Councillors Cooke and Palmer signing the pledge)

Mental health problems are common with 1 in 6 people experiencing a mental health problem in any given year. People with a severe mental illness die up to 20 years younger than their peers in the UK. The pledge highlights the key role the council and councillors can play, as there is often a circular relationship between mental health and issues such as housing, employment, family problems or debt.

The council has signed up to the Local Authorities' Mental Health Challenge led by a range of mental health groups including: Centre for Mental Health; Mental Health Foundation; Mind; Rethink Mental Illness; Royal College of Psychiatrists and YoungMinds.

Improving mental health is a key priority for the city council though the health and wellbeing strategy. This pledge shows councillors have a key role in promoting good mental health and encouraging people to talk more about mental health and wellbeing.

Councillors signed a pledge committing to:

1. Appoint an elected member as “mental health champion” across the council.
2. Identify a “lead officer” for mental health to link in with colleagues across the council.
3. Follow the implementation framework for the mental health strategy where it is relevant to the council’s work and local needs.
4. Work to reduce inequalities in mental health in our community.
5. Work with the NHS to integrate health and social care support.
6. Promote wellbeing and initiate and support action on public mental health.
7. Tackle discrimination on the grounds of mental health in our community and to tackle stigma.
8. Encourage positive mental health in our schools, colleges and workplaces.
9. Proactively engage and listen to people of all ages and backgrounds about what they need for better mental health.
10. Sign up to the Time to Change pledge.

Health & Wellbeing Scrutiny Commission

IMPLEMENTATION PLAN FOR 'FIT FOR PURPOSE' REVIEW (updated 10th September 2014)

RECOMMENDATIONS (Centre for Public Scrutiny)	ACTIONS TO BE TAKEN	PROGRESS

RED – OUTSTANDING **BLACK – MAKING PROGRESS / COMPLETE**

IMPROVING PRACTICE		
1.COMMUNITY LEADERSHIP		
Recommendation 1 The commission needs to find a way to reduce the length of agenda's and maximise the time in meetings spent on scrutiny whilst still ensuring that members have adequate information.	a)To improve work programme planning in 2014/15	Ongoing / making progress
	b)To improve agenda management in 2014/15, such as: • by adding time slots for each item of business • by limiting the number of main items on each agenda, • by limiting the numbers to one person per organisation to present their report/item. • by adopting a select committee style layout of meetings e.g. horseshoe shape. • by adopting a different format to meetings e.g. avoiding long presentations and to trial Q&A only sessions*. • by providing a basket of possible questions for members for service reviews. *subject to members having had sight of reports prior to meetings	From November 2014 Completed
	c) To ensure that microphones are in correct working order and that they are used by those speaking to enable all present to hear.	Completed

Appendix G

Health & Wellbeing Scrutiny Commission

IMPLEMENTATION PLAN FOR 'FIT FOR PURPOSE' REVIEW (updated 10th September 2014)

RECOMMENDATIONS (Centre for Public Scrutiny)	ACTIONS TO BE TAKEN	PROGRESS
RED – OUTSTANDING **BLACK – MAKING PROGRESS / COMPLETE**		
Recommendation 2 Include the principles of effective scrutiny agreed by the Scrutiny Commission in the 'information for members of the public' section of agendas, to enable anyone observing or attending meetings to be clear about its role.	a) All future agendas to include 'information for members of the public' including the 6 principles of effective scrutiny, as agreed by members of the commission. *CfPS 4 principles for effective scrutiny:* • To provide a critical friend challenge to the executive policy makers and decision makers; • To enable the voice and concerns of the public and communities to be heard; • To carry out scrutiny by 'Independent minded governors' who lead and own the scrutiny process; • To drives improvements in services and finds efficiencies: *Members added in 2 further local principles for effective scrutiny:* • To prevent duplication of effort and resources; • To seek assurances of quality from stakeholders and providers of services.	Completed
Recommendation 3 Clearly inform witnesses and stakeholders invited to attend Scrutiny Commission meetings why they are being invited and who should attend.	a)To provide clear instructions when inviting witnesses or stakeholders, such as: • To inform them of the purpose and the objectives of why their item is on the agenda and what is expected of them at the meeting, • To inform them of how much time is allocated to their item, • To agree beforehand who will be attending and who will be participating in answering questions.	Completed From November 2014

IMPLEMENTATION PLAN FOR 'FIT FOR PURPOSE' REVIEW (updated 10th September 2014)

RECOMMENDATIONS (Centre for Public Scrutiny)	ACTIONS TO BE TAKEN	PROGRESS
RED – OUTSTANDING BLACK – MAKING PROGRESS / COMPLETE		
Recommendation 4 Develop and implement a consistent approach to prioritising items in the work plan and agendas.	a) Future Work programme planning to be based on: • Councils Forward Plan items impacting on health and wellbeing issues • City Mayors Delivery Plan, corporate priorities and key strategies impacting on health and wellbeing issues e.g. scrutinising health inequalities, ill health and death • 'Closing the Gap' Leicester's Joint Health and Wellbeing Strategy 2013 -16. • Councils Budget cycle process, plus Commissioning & Procurement of Public Health Services. • Monitoring the local NHS healthcare providers e.g. UHL, LPT & EMAS • Engagement with voluntary and community organisations, especially with regard to priority and agenda setting. This will be arranged at the beginning of the annual cycle, to hold an event inviting VCS to inform the work programme (see recommendation 14)	Ongoing / Considered at each meeting

IMPLEMENTATION PLAN FOR 'FIT FOR PURPOSE' REVIEW (updated 10th September 2014)

RECOMMENDATIONS (Centre for Public Scrutiny)	ACTIONS TO BE TAKEN	PROGRESS
RED – OUTSTANDING BLACK – MAKING PROGRESS / COMPLETE		
Recommendation 5 Consider using different approaches to scrutiny of different issues e.g appreciative inquiry, mini scrutiny and the CfPS Return on Investment models.	To explore different approaches when scrutinising different issues e.g. using different scrutiny models & techniques	To explore / ongoing
2. INVOLVING AND LISTENING TO LOCAL PEOPLE		
Recommendation 6 Undertake further discussions with Healthwatch and Leicester Voluntary Action representatives about building local concerns into the work of the Scrutiny Commission.	a) To discuss with Healthwatch, Leicester Voluntary Action and representatives of other voluntary community sector health related groups, how best to build local concerns into the work programme planning. b) The Chair to continue to invite Healthwatch to commission meetings, under the agreed working arrangements draft protocol (final copy of protocol to be agreed by April 2014). Healthwatch will continue the role of expert witness and to participate and contribute to the meetings. c) To explore co-opting a place for Healthwatch on the Health & Wellbeing Scrutiny Commission.	Making progress (Protocol with Healthwatch agreed)

IMPLEMENTATION PLAN FOR 'FIT FOR PURPOSE' REVIEW (updated 10th September 2014)

RECOMMENDATIONS (Centre for Public Scrutiny)	ACTIONS TO BE TAKEN	PROGRESS
RED – OUTSTANDING BLACK – MAKING PROGRESS / COMPLETE		
Recommendation 7 It is recommended that the Scrutiny Commission considers building an opportunity for members of the public to ask questions at its meeting.	a) A procedure is already in place for members of the public to ask questions at meetings.	Completed
	b) An information sheet to be available for members of the public to explain the format of meetings.	Completed
3. QUESTIONING AND LISTENING		
Recommendation 8 Make more effective use of pre-meeting by considering reports, identifying lines of inquiry and key areas for questioning, and discussing how questions may be articulated. Use de-brief meeting to reflect on what went well and what could be improved in the future.	a) To be more focussed at agenda meetings, in setting out lines of inquiry, key areas for questioning, and basket of questions.	Ongoing / to explore
	b) To be more focussed at de-brief meetings, in taking stock and improving meetings.	Completed

IMPLEMENTATION PLAN FOR 'FIT FOR PURPOSE' REVIEW (updated 10th September 2014)

RECOMMENDATIONS (Centre for Public Scrutiny)	ACTIONS TO BE TAKEN	PROGRESS
RED – OUTSTANDING BLACK – MAKING PROGRESS / COMPLETE		
Recommendation 9 Develop an approach to 'active listening' to what local people are telling individual councillors and the committee, to what anonymised complaints data shows, and to the stakeholders that present at meetings or act as witnesses.	Members to consider how this can be addressed	To develop / explore
Recommendation 10 Work more effectively as a 'team' rather than as individuals in questioning and probing witnesses.	a) Prior to main meeting, to discuss format of meeting and line of questioning for each item.	To develop / explore
	b) To prepare basket of questions relevant to topic areas / service reviews	To develop / explore
WORKING WITH OTHER STAKEHOLDERS		
Recommendation 11 The review highlighted that the Scrutiny Commission has not yet developed a working relationship	To clarify working relationships with Care Quality Commission, NHS England and Monitor.	Making progress

IMPLEMENTATION PLAN FOR 'FIT FOR PURPOSE' REVIEW (updated 10th September 2014)

RECOMMENDATIONS (Centre for Public Scrutiny)	ACTIONS TO BE TAKEN	PROGRESS
RED – OUTSTANDING BLACK – MAKING PROGRESS / COMPLETE		
with NHS England or the Care Quality Commission. This should be addressed and consideration given to the role of scrutiny in relation to Quality Surveillance Groups organised by the local area team of NHS England and to the new approaches to CQC inspection and implications locally. The Scrutiny Commission may also want to scrutinise services commissioned by NHS England such as community primary care services (including dental health) and specialised services.		Making progress
Recommendation 12 We recognise that establishing processes for joint working and joint committees can be challenging. However, some issues need to be scrutinised	a) To improve joint working with Adult Social Care Scrutiny Commission, to enable effective scrutiny of common issues/topics.	Initiated Joint Reviews & Joint Work

IMPLEMENTATION PLAN FOR 'FIT FOR PURPOSE' REVIEW (updated 10th September 2014)

RECOMMENDATIONS (Centre for Public Scrutiny)	ACTIONS TO BE TAKEN	PROGRESS
RED – OUTSTANDING BLACK – MAKING PROGRESS / COMPLETE		
jointly. It is recommended that the Scrutiny Commission reviews the experience of joint scrutiny with Leicestershire County Council and Rutland Council and establishes a joint protocol that establishes processes for stronger and more effective joint scrutiny before it is required.	b) To clarify position on joint working relationship with countywide Joint Health Scrutiny partners, Leicestershire and Rutland. c) To continue involvement with East Midlands Health Scrutiny Network Forum (Leicester City Council hosted this event on 17th Feb 2014).	To Explore Ongoing
Recommendation 13 In response to the confusion amongst stakeholders that was identified in the 360 feedback, we recommend that Leicester City Council develops a common understanding between the Health and Wellbeing Board and the Health and Wellbeing Scrutiny Commission about roles and how each adds value and influence.	a) To clarify roles and responsibilities of the Health & Wellbeing Board, Healthwatch and Health & Wellbeing Scrutiny Commission (see guidance from Centre for Public Scrutiny, appendix A).	Making progress
	b) To explore developing a protocol between Health & Wellbeing Board, Healthwatch and Health & Wellbeing Scrutiny Commission.	Making progress. Protocol with Healthwatch agreed.

IMPLEMENTATION PLAN FOR 'FIT FOR PURPOSE' REVIEW (updated 10th September 2014)

RECOMMENDATIONS (Centre for Public Scrutiny)	ACTIONS TO BE TAKEN	PROGRESS
RED – OUTSTANDING BLACK – MAKING PROGRESS / COMPLETE		
Recommendation 14 We recommend that an annual work programme event is held that involves the voluntary, community and advocacy sectors to help inform the Scrutiny Commission about the state of health and health services in Leicester. This might take the form of an inquiry day or form part of a development session for members.	a) To improve engagement with local voluntary and community organisations *(see recommendation 4a).*	Completed
	b) To develop better engagement with NHS Trusts. Members to consider outreach work to promote the work of health scrutiny at NHS Trust Boards	Ongoing programme (attended CCG Board 9/9/14)
Recommendation 15 Build the use of local public health data, such as health inequalities into priority setting and approaches to questioning.	Public Health Team (Rod Moore) to provide and interpret relevant data to enable commission members to prioritise issues and conduct effective scrutiny.	Ongoing / making progress

IMPLEMENTATION PLAN FOR 'FIT FOR PURPOSE' REVIEW (updated 10th September 2014)

RECOMMENDATIONS (Centre for Public Scrutiny)	ACTIONS TO BE TAKEN	PROGRESS

RED – OUTSTANDING **BLACK – MAKING PROGRESS / COMPLETE**

MEMBER DEVELOPMENT		
Recommendation 16 It is recommended that one or more development sessions are held, open to all councillors, to present and discuss local public health data and priorities.	Members to consider how this can be addressed	Nov / Dec meeting
Recommendation 17 Organise a development day for the existing Scrutiny Commission members to include, an overview of the NHS system, prioritisation skills, training on questioning and active listening skills and to look at how scrutiny in meetings can be outcome focussed.	Members to consider how this can be addressed	To organise
Recommendation 18 Recommend that there is mandatory training for all new	a)To develop an 'Introduction to Health Scrutiny' session for new commission members, to enable them to understand the health economy landscape. .	Developed Introduction Session for new members May 2014.

IMPLEMENTATION PLAN FOR 'FIT FOR PURPOSE' REVIEW (updated 10th September 2014)

RECOMMENDATIONS (Centre for Public Scrutiny)	ACTIONS TO BE TAKEN	PROGRESS
RED – OUTSTANDING BLACK – MAKING PROGRESS / COMPLETE		
health scrutiny councillors that includes how the system works, questioning skills, active listening, and how the Scrutiny Commission relates to other systems of accountability.		
	b) Other issues to be addressed by wider members development and training	To develop / to explore
Recommendation 19 Hold a development session for members of the Scrutiny Commission to discuss the implementation and implications of national guidance soon after it has been published.	Members to consider how this can be addressed E.g. Centre for Public Scrutiny advice /guidance and networking with other health scrutiny committees	Nov / Dec meeting
Recommendation 20 It is recommended that Leicester City Council considers reviewing progress in the implementation of these recs twelve months after the acceptance of this report.	Members to consider how this can be addressed	In hand

Expression of interest in co-commissioning of primary medical care by NHS Leicester City CCG

CCG involved

1. NHS Leicester City Clinical Commissioning Group (the CCG) has submitted a formal expression of interest to NHS England to undertake co-commissioning of primary care services. This followed an announcement by Simon Stevens, chief executive of NHS England, that CCGs would be allowed to request the ability to co-commission primary care services with NHS England to provide greater leverage over local health systems and act as enabler for delivering integrated care outside of hospitals.

2. The CCG is currently awaiting a formal response to its application, though we understand that a response is imminent.

Scope of our application

3. In its expression of interest the CCG expressed a desire to take on the full scope of primary care commissioning responsibilities. This would include:

    a. Working with patients and the public and with Health and Wellbeing Boards to assess needs and decide strategic priorities;
    b. Designing and negotiating local contracts (e.g., PMS, APMS, any enhanced services currently commissioned by NHS England);
    c. Approving 'discretionary payments', e.g., for premises reimbursement;
    d. Managing financial resources and ensuring that expenditure does not exceed the resources available;
    e. Monitoring contractual performance;
    f. Applying any contractual sanctions;
    g. Deciding in what circumstances to bring in new providers and managing associated procurements and making decisions on practice mergers.

4. In each of these areas the CCG would wish to take on full delegated commissioning arrangements, whereby the CCG carries out the functions listed on behalf of NHS England and the area team holds the CCG to account for how effectively it carries out these functions.

5. If successful, the CCG would wish to engage in further discussions with NHS England on the full implications of co-commissioning in terms of the CCG's running costs. However, in principle, the CCG would seek to ensure that arrangements take advantage of synergies with existing areas of CCG activity.

6. Should this expression of interest be successful, the CCG would also wish to work with the area team to fully work through the implications of delegation/transfer of budgets in a way which if practicable and appropriate.

Timescales

7. The CCG recognises that, if successful, transition of responsibilities from the area team to the CCG needs to be undertaken in a way which is safe and appropriate. As such, the CCG would wish to work with the area team to develop a timed phasing of delegation that is acceptable for both parties. We anticipate that is likely to be over a period of six to nine months, commencing during 2014/15 with the expectation up being fully established and operational by the first quarter of 2015/16.

Intended benefits and benefits realisation

8. The CCG believes that co-commissioning of primary medical care represents an intrinsic element in realising our long-term ambitions for health and health services in the city, supporting the delivery of a broader range of services in primary and community settings and reducing over-reliance on acute services. To do this will require radical transformation of current primary care services and the way in which they are now provided.

9. We start from a position of unacceptably low health outcomes in the city, which means that on average patients in Leicester live up to two years less than the national average and up ten years less than some areas of the county. There is also huge variation in the city, with life expectancy varying by as much as eight years depending on whereabouts an individual happens to live. In part this is a result of Leicester's huge diversity, but also the high levels of deprivation. There are particularly high death rates due to CVD and COPD and high levels of disease such as diabetes. However the recorded prevalence rates are lower than would be expected.

10. We also know that the quality of service provision in the city is patchy. While we have some exceptional GPs and high performing practices, there is too much variation and, overall, primary care quality is not as high as it should be. Current perceptions of primary medical care in the city are generally low and perform well below national averages against the majority of benchmarks.

11. Approximately 20% of our 63 GP practices are single-handed. Many struggle to deliver as full a range of services as the larger practices and this is likely to get worse as more community-based services are developed. There are large numbers of local GPs approaching retirement in the coming five to seven years. Recruitment of GPs is proving more and more difficult and retention equally so. Many practices are operating from premises that are small, cramped and not fit for the delivery of modern primary medical services. Patient experience as measured by national survey is poor, with access being

a particular challenge. Put simply, for too long primary care has been at the bottom of the pile when it has come to investment to drive change and improvement.

12. As a result, there is an over-reliance on acute services in the city. This additional pressure compounds issues for a hospital trust that already struggles to achieve satisfactorily against a number of minimum standards for patients.

13. When these health and service factors are combined we are left with a system that is fragmented, unresponsive to the needs of patients and unsustainable in the long-term. It is our belief that these challenges cannot be overcome without material reconfiguration of how local health services work. This required reconfiguration is made more difficult by current commissioning arrangements, which mean the CCG does not have the ability to influence all necessary levers for change across the system.

14. As a result, we believe that co-commissioning of primary medical care by CCGs provides the opportunity to deliver a step change in terms of whole-system integration and improvement.

15. Working on the basis that long-term sustainability for the local health economy is predicated on moving more services out of acute settings and into the community, supported by improved capacity and capability in primary care, putting the CCG in the driving seat of primary care commissioning (under delegated authority from NHS England) enables the strengths of the CCG as a GP-led organisation to be fully leveraged.

16. Peer-to-peer discussions which already take place between Governing Body GPs and member practices, supported by managerial and lay member input, primarily through our Annual Quality Review scheme, will be elevated by being able to take discussions to a contractual level when right and appropriate to do so. Combining this existing supportive peer-to-peer approach with contractual levers will, we believe, prove most likely to lead to positive long-term and sustainable improvement in the primary care sector.

17. The CCG would take the opportunity afforded by co-commissioning to explore appropriate contractual models, KPIs and outcome measures that reflect local priorities and can be implemented across integrated pathways in situations where this would bring efficiencies and improved outcomes for patients and clinicians.

18. Our Better Care Fund (BCF) programme includes investment in new community-based integrated services. These services focus upon a defined cohort of patients (60 years and above; those 18 to 59 with three or more co-morbidities; those with dementia) who are at risk of emergency admission. It is important that GP services complement and support the BCF initiatives if they are to be successful and, in the future, we may wish to explore commissioning along the whole pathway. In the short term, it will be important to explore the feasibility of common KPIs along this pathway. If the suite of BCF services

work as we envisage it will deliver a measurable improvement in the care for the identified cohort of patients, with fewer of them having emergency admissions and more of them being cared for at home or in alternative community settings. Supported by mobile working and the efficiencies that SystmOne delivers, GPs will be better informed about the care that their patients are receiving from the wider primary and community health and social care team whilst the patients, having avoided hospital admission, will experience greater continuity of care.

19. Our key focus is upon the pre-hospital stage of care: prevention of illness; early and accurate identification of conditions; and the delivery of care in a community setting for as many people as possible. This approach is also mirrored in the Better Care Together five-year strategic plans which are being designed across the local health and social care community by providers, commissioners and key stakeholders.

20. Achievement of our vision is only possible if there is a strong primary care sector in place, with sufficient capacity (both manpower and premises) and suitable skills, experience and training in place.

21. To address access, we are exploring alternative and innovative models of care. It is well recognised that the GP-centric model of care is not sustainable and in fact not all patients need to see a GP. We have several local models of care which make use of the skills and capabilities of other health professionals, including pharmacists, nurse practitioners, extended scope physiotherapists and emergency care practitioners. Evaluation has shown that the choice of model needs to be appropriate for the local population but, in some cases, up to 70% of patient contacts have been diverted away from the GP, either to self-care or to other health professionals. We are also exploring an approach used by the Hurley Group of practices in London (with a largely similar population to our own) where a range of methodologies including on-line self-triage has reduced contact with GPs but seen access to appropriate services increase with a concomitant improvement in reported patient experience.

22. Moving forward, the CCG believes that the current number of small practices is unsustainable and that, in time, there will be fewer larger practices. In the short to medium term, we are building upon our current locality groupings of member practices to encourage more formal collaborative working. In some cases this may lead to practice mergers or to formal federations. Models of collaborative working may be the result of various stimuli and one of the major areas is likely to be in the development of enhanced service delivery by some practices, covering patients from other practices which do not have the same skill-set.

23. If we can encourage the adoption of these new models of care and increase collaborative working, the result will be increased primary care capacity coupled with reduced levels of stress for GPs plus access to enhanced primary care services for more patients. We shall need to understand and formulate effective key performance

indicators that allow us to monitor and evaluate the impact that these service changes are having on the primary care system.

24. The CCG already works closely with its member practices and gathers a wealth of hard and soft data about performance and local issues affecting the practice. We want to support our clinicians in developing the capacity and capability to deliver continuously improving services and outcomes to their patients. We believe that by developing innovative models of care including enhanced service delivery by a core of practices, we can improve the overall standards. Our aim is to understand, support and develop practices wherever it is appropriate to do so. Due to our close working relationship we believe we are in a strong position to do this.

25. Such changes would, of course, require patient and public input, which we welcome. The CCG is serving a very complex, diverse population and effective commissioning requires in-depth knowledge of the local cultural sensitivities. We have a strong established network of contacts with local community leaders, public forums and patient participation groups to help shape services that are best aligned to local populations and which can be reflected in local contracts. We also already have in place a high successfully track record of engagement with patients and the public.

Governance

26. The CCG has, and already exercises, powers to commission some services from general practice and other primary care providers. In doing so the CCG has a statutory duty to manage conflicts of interest and have regard to the guidance on managing conflicts of interest published by NHS England. Through our commissioning of Locally Enhanced Services, now Community Based Services, the CCG can clearly demonstrate how the principles of conflict of interest management have been applied successfully.

27. However, as a CCG we acutely recognise the need for more detailed work in this area, particularly in addressing public perceptions of inherent conflicts of GP-led clinical commissioning groups co-commissioning primary medical care and the inevitable shift in dynamics between the CCG Governing Body, and particular board GPs, and member practices. Should the CCG be successful in its application, we propose to engage our primary legal advisors, Browne Jacobson LLP, to work with us ensuring that our systems, processes and policies are robust and appropriate for the level of responsibility delegated to us by NHS England.

Engaging member practices and local stakeholders

28. In developing our expression of interest the CCG has sought initial views from a broad range of stakeholders including member practices, local partners and patients and the public. Engagement activity was deliberately simple and straightforward, asking only a

few key questions to gain insight into the views of stakeholders on whether or not the CCG should take on additional responsibilities.

29. More than 89 responses were received to the survey from partners and patients and the public, while all 63 member practices had the opportunity to give their views through our formal locality meeting structure. Overall, feedback was positive and largely supportive of the CCG taking on delegated responsibility for additional functions.

30. For partners and other stakeholders this particularly included working with patients and the public and with Health and Wellbeing Boards to assess health needs and decide strategic priorities (72%); managing budgets and making sure expenditure does not exceed the resources available (57%); designing and negotiating local GP contracts (55%); and monitoring contractual performance and deciding in what circumstances to bring in new providers, manage procurements and make decisions on practice mergers (both 53%). Stakeholders, patients and the public wanted greater clarity on how the CCG would effectively manage conflicts of interest, particularly in approving 'discretionary' payments to practices and applying any contractual sanctions.

31. Stakeholders, patients and the public were also asked to give reasons for their answers. Typically respondents cited that they wanted to see decisions about health services in the city made locally and by CCGs that understand the local context. An example of this is below:

    "Transferring some of the NHS commissioning functions to the local Clinical Commissioning Group should enable the local healthcare provision to better reflect the needs of patients in the area. This should if administered responsibly reduce wastage of funds on duplication of services whilst ensuring that a wide range of services are available to patients in the area. It must be done in partnership with local GPs and community service providers."

32. In terms of member practices, responses were overwhelmingly positive. 95% of member practices said that the CCG should take responsibility for working with patients and the public and with Health and Wellbeing Boards to assess health needs and decide strategic priorities; 90% agreed that it should take on designing and negotiating local GP contracts; 86% monitoring contractual performance, 81% approving discretionary payments; 77% managing budgets and making sure expenditure does not exceed the available resources; 67% deciding in what circumstances to bring in new providers; and 57% applying any contract sanctions.

33. Comments from member practices particularly cited the advantages of locally developed services based on local decisions, the ability of the CCG to address grass roots problems not identified by NHS England, and avoiding duplication. Main issues of concern raised centred on the need for an effective dispute resolution process between the practice and the CCG should a conflict or disagreement present itself.

34. While a considerable amount of engagement has already taken place, the CCG is committed to undertaking more should this expression of interest prove successful. This will include building upon the findings outlined above by holding further detailed discussions with partners and patients and the public, particularly representative bodies such as Healthwatch, while a formal ballot of member practices is proposed.

Monitoring and evaluation

35. The CCG would wish to work on the basis of 'earned autonomy' as it does for the functions currently delegated to it by NHS England. The CCG is able to demonstrate a significant amount of success during its first year as a statutory body, most notably in addressing some of the wider determinants of ill health in the city. This has included taking innovative approaches to challenges, such as the response to poor uptake of NHS health Checks in the city, which as a result now sees Leicester as the highest performing area in the country.

36. The CCG has also developed a track record for ensuring good governance, and strong working relationships with the NHS England area team. We would expect to see this continue, with formal assurance of the CCG's progress taking place through the existing quarterly review meetings. We would envisage that this would be supported by the development of agreed KPIs commensurate with the responsibilities delegated to the CCG by NHS England.

The new Congenital Heart Disease review: 30th update – John Holden

3 September 2014 - 13:39

To those of you who have been on holiday – welcome back, I hope you had an enjoyable break.

In the CHD review team we have packed away our flip-flops and our attention is now focused entirely on the remaining things we have to do prior to the launch of 12 weeks' consultation on standards and service specifications. The target date for launch is Monday 15 September 2014, and although we cannot take for granted that we will get all the approvals we need, we are confident that we are ready to proceed.

Your feedback

In response to blog 29 we were asked about the distinction between paediatric and adult services, and whether this was sufficiently clear in the review. In short, what is a child?

We rely on data from different sources (for example NICOR and HES) and these data sometimes use different ages to describe children (for example "up to 16", and "up to 18"). This is evident in our work on CHD activity levels, where we put the HES and NICOR data side by side. But as far as the review is concerned, it doesn't matter what age is used, so long as we understand the different numbers in order to draw sensible conclusions about current activity, future demand etc.

What matters is that hospitals have services for children and services for adults, and we are publishing one specification for each. The children's service must comply with the children's specification, and the adults' service with the adult specification. Children will migrate to adult services – so called "transition" – and the age this happens will vary depending on the child and on the service provided at the hospital where they receive their care. Most will have undergone transition by the time they are 18, many earlier than that, but there is no fixed point, and it's not necessary for us to establish a single definition for the purpose of the review.

Patients, families and their representatives

In my last blog I told you about the joint meeting of all three of our engagement and advisory groups (Patients & Public, Clinicians' and Providers) that took place in London on 25 July 2014. A draft write up of the meeting, including a list of attendees is now available here.

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We are making plans for a series of local events during the consultation period. The enclosed timetable sets out our current thinking, though we have not finalised all the details. On the advice of our stakeholder groups these will not be “town hall meetings” with speakers delivering their message from a platform. The events will be “drop-in” style, run during the afternoon and early evening, with displays and other information available as well as one or more review team members to answer questions.

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Another date for your diary: on 9 October 2014 there will be a national engagement event in Birmingham specifically aimed at Local Government and Healthwatch organisations. We will provide more detail in due course. Just to be clear – this is in addition to the local events we are hosting during the consultation period – there will be a separate event in Birmingham on 22 October 2014 for all interested local stakeholders.

Clinicians and their organisations

The latest iterations of the draft standards are available via the links below. There have been no significant changes since we updated on the outcome of the last Clinical Advisory Panel, but the formatting has been, and will be continue to be tidied up ready for consultation.

- Paediatric standards
- Adult standards

Of course the consultation document itself (due to be published on 15 September 2014) will provide the necessary context and set out questions on which we are seeking views.

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Professor Deirdre Kelly (Chair of the review’s Clinicians’ Group) along with members of the review team made visits to Brighton on 13 August 2014, and Papworth on 15 August 2014.These were the last of three planned visits to a representative sample of units providing ACHD procedures outside the specialist congenital surgery centres.

NHS England and other partners

As the August 2014 meeting of NHS England's Directly Commissioned Services Committee (DCSC) was cancelled, this paper (and annexes) was circulated by correspondence on 15 August 2014.

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On 20 August 2014, Michael Wilson (the review's Programme Director) attended a meeting of the Women and Children's Programme of Care (PoC) Board to formally present the draft service specifications and impact assessments for a recommendation to progress to the Clinical Priorities Advisory Group (CPAG). This is a key step in the specialised commissioning governance process to gain approval for us to consult on the proposed standards and service specification. You can read the papers we submitted to the meeting here.

At this meeting, the PoC Board recommended submission to CPAG for consideration at their meeting on 2 September 2014, subject to some changes to the documents. The papers were updated and submitted to the CPAG and can be viewed here.

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NHS England's Board Task and Finish Group met on 1 September 2014 – you can read the meeting agenda and papers here. As you can imagine, the main focus of the meeting was the ongoing preparation for the launch of consultation. A draft note of the meeting will be available in due course, but in the meantime please note that the Task and Finish Group delegated authority to the review's Programme Board to approve the launch of consultation.

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The review's Programme Board is due to meet on 8 September 2014 and the agenda and papers for the meeting can be viewed here.

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Issue 3 of NHS England's Specialised Commissioning Newsletter is now available here.

Consultation Events

The new congenital heart disease review will shortly be holding consultation events around the country as part of our full consultation into the new Standards of Service that we hope will ensure a high standard of care for all congenital cardiac patients in England.

All of our events will be held in city centre locations for easy access and we hope that as many people as possible are able to attend and let us know their thoughts on the new standards that have been developed.

If you have access requirements including disabled parking please let us know in advance of the meeting so we can try to accommodate this.

Dates to remember:

- 14 October 2014 – London Event
- 16 October 2014 – Newcastle Event

- 22 October 2014 – Birmingham Event
- 24 October 2014 – Leicester Event

- 03 November 2014 – Leeds Event
- 04 November 2014 – Liverpool Event
- 05 November 2014 – Manchester Event
- 06 November 2014 – Cambridge Event

- 10 November 2014 – Oxford Event
- 11 November 2014 – Cardiff Event
- 12 November 2014 – Bristol Event
- 13 November 2014 – Southampton Event

Approximate timings of consultation events: 2pm – 8pm

(All these dates are subject to change so please do stay in touch with the team for latest information - details below)

Staying in touch: If you would like any more information or would like to register your interest for one of our consultation events please contact us at:

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Stay in touch with the review by linking to John Holden's blog published every 2 weeks:
http://www.england.nhs.uk/publications/blogs/john-holden/