Date: THURSDAY, 11 DECEMBER 2014

Time: 10:00 am

Location: THE COUNCIL CHAMBER - FIRST FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER

HEALTH AND WELLBEING BOARD

Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Vi Dempster, Assistant City Mayor

Councillor Rita Patel, Assistant City Mayor

Councillor Manjula Sood MBE, Assistant City Mayor

City Council Officers:

Frances Craven, Strategic Director Children's Services

Andy Keeling, Chief Operating Officer

Elaine McHale, Interim Director Adult Social Care

Rod Moore, Acting Director Public Health

NHS Representatives:

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

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

David Sharp, Director, (Leicestershire and Lincolnshire Area) NHS England

Healthwatch / Other Representatives:

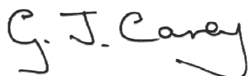
Karen Chouhan, Chair, Healthwatch Leicester

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

2 Vacancies

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

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



For Monitoring Officer

City Mayor

healthwatch Leicester

Leicestershire Police
Protecting our communities

NHS
Leicester City
Clinical Commissioning Group

NHS
Commissioning Board

Information for members of the public

Attending meetings and access to information

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- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ 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 City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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

PUBLIC SESSION

AGENDA

NOTE:

This meeting will be webcast live at the following link:-

http://www.leicester.public-i.tv

An archive copy of the webcast will normally be available on the Council's website within 48 hours of the meeting taking place at the following link:-

http://www.leicester.public-i.tv/core/portal/webcasts

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed at the meeting.

3. MINUTES OF THE PREVIOUS MEETING

Appendix A
PAGE 1

The Minutes of the previous meeting of the Board held on 9 October 2014 are attached and the Board is asked to confirm them as a correct record.

4. ANNOUNCEMENTS

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

5. JOINT HEALTH AND WELLBEING STRATEGY

Appendix B
PAGES 23-40

A) To receive verbal updates (5 minutes) on each of the five priorities:-

i) Improve outcomes for children and young people

ii) Reduce premature mortality

iii) Support independence

iv) Improve mental health and resilience

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

B) Update on recovery plans for the four areas of concern discussed at the last Board meeting.

i) Improve outcomes for children and young people Readiness for school age 5.
Appendix B1 – PAGE 23

ii) Diabetes: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol in the preceding 15 months.
(Presentation)

iii) Adults in contact with secondary mental health services living independently.
Appendix B2 PAGE 29

iv) Cervical Screening Coverage – NHS England to be followed up separately.
Appendix B3 PAGE 35

C) Presentation from the Housing Department on how they are working towards the Joint Health and Wellbeing Strategy Ann Branson, Director of Housing.

6. BETTER CARE TOGETHER **Appendix C PAGE 41**

To receive an update report on the Better Care Together Joint Leicester, Leicestershire and Rutland Five Year Strategy and to agree proposals with regard to comments on the drafts and a programme of wider engagement.

Geoff Rowbotham, Interim Programme Director and Michael Cawley, Finance Director will attend the meeting to present the report.

7. FUNDING TRANSFER FROM NHS ENGLAND TO SOCIAL CARE 2014/15 **Appendix D PAGE 91**

To receive a report from the Interim Director for Adult Social Care and the Managing Director, Leicester City Clinical Commissioning Group on the funding transfer from NHS England to Social Care 2014/15 and to approve the plan.

8. JOINT SPECIFIC NEEDS ASSESSMENT ON MENTAL HEALTH **Appendix E PAGE 103**

To receive a report from the Acting Director of Public Health on the Joint Specific Needs Assessment for Mental Health.

9. BETTER CARE FUND UPDATE

Appendix F
PAGE 121

To receive an update on the progress of the Better Care Fund from the Interim Director for Adult Social Care and the Managing Director, Leicester City Clinical Commissioning Group.

10. HEALTH AND WELLBEING SCRUTINY COMMISSION - OVERSIGHT OF IMMUNISATIONS AND VACCINATIONS

Appendix G
PAGE 133

To receive a report from the Acting Director of Public Health on the outcome of the Leicester Health and Wellbeing Scrutiny Commission consideration of a report from NHS England on childhood immunisations in 2013/14 and Q1 2014/15.

11. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

12. DATES OF FUTURE MEETINGS

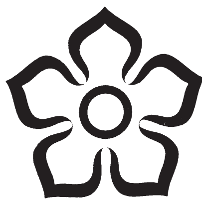
To note that future meetings of the Board will be held on the following dates:-

Thursday 5 February 2015
Thursday 26 March 2015
Thursday 25 June 2015
Thursday 3 September 2015
Thursday 29 October 2015
Thursday 10 December 2015
Thursday 4 February 2016
Thursday 7 April 2016

Meetings of the Board are scheduled to be held in City Hall, at 10.00am unless stated that otherwise on the agenda for the meeting.

13. ANY OTHER URGENT BUSINESS

Appendix A



Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 9 OCTOBER 2014 at 10.00am

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council
Karen Chouhan	–	Chair Healthwatch Leicester
Frances Craven		Strategic Director, Children's Services, Leicester City Council
Councillor Vi Dempster	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council
Dr Simon Freeman	–	Managing Director Leicester City Clinical Commissioning Group
Andy Keeling	–	Chief Operating Officer, Leicester City Council
Chief Superintendent Rob Nixon	–	Leicester City Basic Command Unit Commander, Leicestershire Police
Councillor Rita Patel	–	Assistant City Mayor, Adult Social Care
Dr Avi Prasad	–	Co-Chair, Leicester City Clinical Commissioning Group
David Sharp		Director, (Leicestershire and Lincolnshire Area) NHS England
Deb Watson	–	Strategic Director Adult Social Care and Health, Leicester City Council

In attendance

Graham Carey	–	Democratic Services, Leicester City Council
Sue Cavill	–	Head of Customer Communications and Engagement - Greater East Midlands Commissioning Support Unit

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13. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Sood, Andy Keeling Chief Operating Officer, Leicester City Council, Tracie Rees, Director Care Services and Commissioning, Adult Social Care, Leicester City Council and Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group.

Councillor Cooke, Chair of the Council's Health and Wellbeing Scrutiny Commission was also unable to attend as an invited observer to the Board

Meeting.

14. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting. No such declarations were made.

15. CHAIR'S INTRODUCTIONS AND ANNOUNCEMENTS

The Chair welcomed everyone to the meeting.

He announced that the Council had signed the NHS Statement of Support for Tobacco Control prior to the meeting. This was a part of a national initiative to actively support work to reduce smoking prevalence and health inequalities in conjunction with local health partners.

It was also announced that the Leicester Stop Smoking Service and Wellness Service, inherited with the transfer of Public Health Services to the Council in April 2013, would be moving to be an in-house Council service from April 2015. If was felt that the Service would be better placed to work in partnership with wider Council as well as partner services which would strengthen the public health work of the Council as a result.

The Chair welcomed Frances Craven to her first Board meeting as the Council's newly appointed Strategic Director of Children's Services, Leicester City Council. He thanked Elaine McHale, Interim Strategic Director of Children's Services for her service and contribution to the Board whilst in her current post.

This would also be the last Board meeting for both Dr Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group and Deb Watson, Strategic Director of Adult Social Care and Health, Leicester City Council.

Dr Freeman was leaving the CCG to become the Chief Operating Officer of the Greater East Midlands Commissioning Support Unit. The Chair thanked Dr Freeman for his services to the Board and his wider contribution to health services in Leicester particularly in working to achieve the early formal recognition of the Leicester City CCG in 2013.

The Chair thanked Deb Watson for her immense contribution to health and wellbeing in the city since taking up her post. He paid tribute to her professional expertise and integrity and her passion and enthusiasm for taking forward initiatives to improve health in the City.

Members of the Board joined the Chair in wishing both Simon Freeman and Deb Watson their very best wishes for the future.

16. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

> That the Minutes of the previous meeting of the Board held on 3 July 2014 be confirmed as a correct record.

17. THE CHALLENGES FACING PRIMARY CARE IN LEICESTER CITY

Leicester City Clinical Commissioning Group (CCG) submitted a report on the challenges in primary care in the City and what was being done to respond to these challenges. Dr Simon Freeman, Managing Director, Leicester City CCG, Sue Lock, Chief Operating Officer, Leicester City CCG and David Sharp, Director, Leicestershire and Lincolnshire Area, NHS England presented the report to the meeting.

It was noted that national and local policies required efficiency savings and improved quality of services to be delivered by expanding out-of-hospital services through creating sufficient capacity and capability in the primary medical care services.

The report identified the major challenges facing primary care, from both a patient and a practice perspective and gave a summary of the planned solutions to address them.

Tackling GP recruitment was the highest short-term priority as an effective and efficient GP service was vital to looking after patients and reducing the number of hospital admissions. There was a local aging population and a backdrop of global financial pressures which required local solutions to meet the needs and deliver quality care within the resources available.

The CCG had undertaken an analysis of the local health economy and of the 62 GP practices in the City, 13% were single GP practices compared to a national average of 9%. In addition, approximately 50% of the principal GPs were aged over 50 years old. There was a changing GP workforce profile in Leicester from one which was predominately comprised of principal GPs to one that was now approximately a third principal GPs, a third salaried GPs and a third locum GPs. Given the changing emphasis of health care to focus on prevention and reducing hospital admissions, it was considered essential to address the GP recruitment issue, particularly in view of the large proportion of the population living in deprivation, which was a key driver of health needs.

The diversity of the population, particularly where English was not spoken as a first language presented further challenges to conducting effective consultation on services. A number of engagement activities had been undertaken with the public, patient groups, member practices and wider stakeholders since November 2013 to understand the perceived issues and challenges. The results demonstrated that the challenges facing practices were causing the issues and concerns raised by patients. This supported the view that addressing the GP issues was a key factor in delivering the Better Care

Together programme.

NHS England were proposing a pilot project to address GP recruitment and retention issues in order to underpin the overall strategy for developing a growing range of primary care services and to develop the 7 day per week market for providing services. Attracting GPs to enter and stay in the local workforce required incentives in order to compete with the competitive market for GP services.

Following the outline of the pilot proposals and questions from Members, it was noted that:-

a) The pilot scheme would involve a fund of £250k to recruit and retain GPs in the City by providing an incentive to work in surgeries within deprived areas, with the aim of encouraging new GPs to progress in practices to become 'principal' GPs.

b) NHS England was meeting the Local Medical Council later that day to discuss whether the pilot would address the concerns expressed by both GPs and patients in consultation and summit exercises.

c) The scheme would be administered through the Joint Integrated Commissioning Board and, after the initial payment of incentives for recruitment and retention; there would be an evaluation of the pilot in approximately a year's time.

d) The proposal would benefit from being included in the Better Care Fund programme as this would remove the pressure to spend the allocation of funds within a single financial year.

e) The CCG were continually testing service provision to ensure that services were fully accessible by everyone. For example, although the number of NHS health checks carried out in the City was one of the highest in the Country, it was still important to check that all parts of the community had equal access to the programme. The University of Leicester were currently undertaking research to check that older members of the BME community had been able to access dementia services as one element of the programme.

The Strategic Director of Adult Social Care and Public Health commented that the majority of the public's interaction with the NHS was through primary care services. The current emphasis on preventative measures for health relied heavily on the capacity and quality of the primary care services to deliver the services. NHS England's decision for funds to follow need was welcomed as a positive step to address health in the City.

The Chair commented that whilst it was important to address the

strategic needs he was keen that the everyday issues that were of concern to the public; such as phone systems, appointment systems and on-line access to services, were not overlooked. These everyday concerns framed the perceptions, experiences and views of health care by the public and this was equally important in achieving the desired outcomes under Better Care Together.

RESOLVED:

1. That the report analysing the challenges facing primary medical care in the City be noted.

2. That tackling GP recruitment be agreed as a short-term priority.

3. That the principle of the proposed pilot GP recruitment scheme be welcomed and supported and that the funding be added to the Better Care Fund to be administered through the Joint Integrated Commissioning Board.

4. That a further reports be submitted to a future Board meeting on how and where the funds are being used and whether this is achieving the aims of recruiting and retaining GPs in the City.

5. That Healthwatch be asked for a view on whether some of the existing public sector funded premises around the City, which have excess capacity, could have the potential to be used as surgeries by GPs who are currently operating in inadequate premises.

18. BETTER CARE TOGETHER JOINT LEICESTER, LEICESTERSHIRE AND RUTLAND FIVE YEAR STRATEGY - UPDATE

Geoff Rowbotham, Interim Programme Director Better Care Together, submitted a report providing an update on the progress of the Better Care Together Strategy.

The report noted that the Better Care Together (BCT) Programme Board was responsible for the production of the 5 year strategic plan for the Leicester, Leicestershire and Rutland (LLR) health and social care system. The Programme Board included local social care, health commissioners and providers, public and patient representatives. It was supported by a structure of clinical, patient, public, and political reference groups, and by enabling groups e.g. Estates, Workforce, Information Technology.

The BCT Programme Board had taken a phased approach to the production of the 5 year strategic plan: development (to June 2014); discussion and review (June to Sept 2014); and, implementation and formal consultation where required (Oct onwards). A draft plan had been made available to the public as part of the 'discussion and review stage'. It had also been received by Health and Wellbeing Boards and Healthwatch groups across Leicester,

Leicestershire and Rutland. Comments received were being incorporated within the draft plan through a 'You said, we did' section prior to it being proposed for formal approval alongside the supporting Programme Initiation Document (PID) and Strategic Outline Case (SOC)

During July –August 2014 the BCT programme has been focused on:-

i. LLR draft 5 year plan- 'discussion and review' phase.

ii. Leadership and governance of the BCT programme.

iii. Developing, resourcing and commencing service reconfiguration.

Considerable progress had been made during the past 8 weeks resulting in the programme being on schedule; despite the challenging timescales it had set itself. The report intended to provide a high level update on progress during this time and highlighted the key programme priorities for the next 3 months.

The Interim Programme Director made the following observations and comments on the progress that had been made:-

- There had been extensive consultation in the discussion and review phase with public and patient groups, voluntary and community sectors groups and Healthwatch which had produced a number of comments around the plan.

- The responses to the 'You said – we did' section of the plan would be taken back to the public and patient groups etc for comment and approval before being formally being submitted to the Board in November.

- There were now Public and Patient Involvement representatives on all programme streams.

- Kaye Burnett had now been recruited as a permanent Chair of the BCT Partnership Board and would take up the duties later in October. Thanks were extended to Philip Parkinson for his work as Interim Chair of the Board.

- The BCT Board had agreed that it would meet in public from the New Year and this would strengthen the engagement and transparency aspects within the governance arrangements.

- All of the 8 work streams were due to be completed by the end of October.

- The Plan had been extensively reviewed by all key stakeholders in the local health economy.

- Two key supporting documents to the Plan were also being developed.

A Programme Initiation Document (PID) setting out how the Plan will be initiated, governed and delivered; and a Strategic Outline Case (SOC) to ensure the proposed way forward of all the individual organisations' business cases represents value for money. The Plan together with these two documents would be submitted to the Board and other bodies in for approval in December.

Following questions for the Members of the Board, it was noted that:-

- It was important to recognise the scale and complexity of the programme within the national context. The programme had a strong management approach with designated accountable actions and targets.

- The Plan's assurance programme would be made public in January 2015 and it would then be clear what progress had been made and whether the Plan's delivery was on target.

- The Board's Assurance Framework identified the key risks and how those risks would be managed.

- The programme was already open to public scrutiny by a range of public bodies such as the Board and by individual participants in the programme who played a vital role in holding the programme to account.

- The Office of Government Commerce were commencing an external gateway best practice review to ensure that the programme was on track.

- If the programme was successful the public should not see any difference in their health care if it succeeded in them not going into hospital, as they would not necessarily realise that they were receiving the appropriate level care in the primary care sector instead of being admitted into hospital.

- There were already clear indications that UHL and LPT were working closely to discuss arrangements for transferring patient support to the community rather than UHL embarking on a course of action independently which subsequently would impact upon LPT requiring them to take reactive measures.

- There was also closer working with the social care sector at an earlier stage to see how the social care budgets could be integrated to achieve the aims of the programme.

The Chair reported that he had received three questions from a member of the public who was unable to attend the meeting and proposed that the Interim Programme Director would respond to them after the meeting and the response be included with the minutes of the meeting.

RESOLVED:-

1. That the considerable progress that had been made since the last update report and the next key steps to be taken be noted.

2. That the Interim Programme Director be thanked for the update.

3. That the responses to the questions asked by the member of the public be circulated with the minutes of the meeting. (Note: The responses are attached to these minutes)

19. JOINT HEALTH AND WELLBEING STRATEGY - UPDATE

Dr Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group submitted the six monthly update report on the progress of the Joint Health and Wellbeing Strategy on behalf of the Joint Integrated Commissioning Board (JICB).

It was noted that:-

- No areas of activity had been ‘red flagged’, but there were fewer areas rated ‘green’ and more ‘amber’ than in the previous report; indicating a modest increase in risk to delivery.

- In relation to the Key Performance Indicators where data was available, 45% showed improvement from the baseline, 32% showed no significant change and 23% showed a worsening of the position.

- There were four areas of concern:-

    - Readiness for school at age 5 years old.
    - The coverage for cervical screening in women.
    - Diabetes – the management of blood sugar levels.
    - Proportion of adults in contact with secondary mental health services living independently with or without support.

- Measures showing particular improvement to the baseline were:-

    - The number of NHS Health Checks carried out was amongst the best outputs in the country. 25,886 health checks had been carried out and 3,535 patients were subsequently having a health management plan put in place.

    - The trend for carers receiving needs assessments was continuing to improve and they were currently at 28.4%.

    - Reablement continued to be a great success with 91.2% of older people, who had received support to live at home following discharge from hospital, still living at home 91 days after their discharge.

Following Members' questions on the four areas of concern, the following responses were noted:-

- Readiness for school at age 5 years old.

    - The assessment for this indicator was a complex assessment and to achieve a good level of development it expected 12 of the 17 early learning goals to be achieved. These goals involved personal development, independence, ability to communicate, language and physical activity etc.

    - The indicator was useful to see how a young child was developing and to benchmark against other areas.

    - The indicator changed in 2013 so comparisons cannot be made directly with 2012. However, although there has been some improvement this year the performance in Leicester still lags behind the national levels and more work needs to be done to improve this as it translates into outcomes for youngsters achievement at Key Stages 1 and 2 and GCSE. There was evidence to suggest that children who do not do well in early years do not do well later on in school.

    - Steps were being taken to improve data systems and collection to improve the early identification of vulnerable children. Appropriate information was being shared with staff in health services, children centres and those in early years' settings to identify where resources need to be placed.

    - There was good partnership working so that vulnerable children and families take up the services that were on offer to them.

    - Increasing the participation of 3 and 4 year olds in education and ensuring that all the available free education place were taken up was a priority, as this contributes to children being ready for school.

    - More work was needed to communicate the expectations to staff to improve the current rate of 41%.

    - Measures were in place for the early identification of children who were vulnerable with additional needs (such as a disability) so that arrangements could be put in place to support the child in school.

    - Good attendance at school was encouraged and maintained. The Council was working with the Leicester Education Strategic Partnership around reading literacy and numeracy to ensure

there was a link between school and home settings to ensure that youngsters were ready for school. Parents were also supported in helping children to have the numeracy and literacy skills through early leaning activity in children centres and other partnership working.

- The Early Years Pupil premium was coming on stream in April 2015 and this was being targeted to gain maximum impact from it.

- Cervical Screening in Women

  - There was a small fall in the national and a similar fall in local levels of screening.

  - NHS England proposed to look at the individual primary care provision to find out the uptake rate, work on a higher quality set of materials, more engagement and development programmes with primary care and patient reference groups to highlight this as being an important part of the primary care offer. This also fitted in with the Early Diagnosis and Intervention Programme which is aimed at improving outcomes by improving early diagnosis and treatment.

  - The take up rate had declined faster in Leicester than nationally and an assessment had been carried to looking at attitudinal and cultural aspects of the take up and there was no obvious explanation for the decline in the local take up rate.

  - There was a successful model in Lincolnshire that had seen a significant uptake in rates and NHS England were intending to roll this model out in Leicester as the practical response to the concern.

- Management of Blood Sugar Levels

  - This was a key measure of the effective management of diabetes.

  - There was a small fall in national levels, mirrored by a small fall in Leicester levels, but the Leicester position does need to be viewed against the significant increase in detection and prevalence within the City.

  - The 1% decrease in the indicator should be seen against the 10% increase in prevalence over the last two years. There had been an increase in diagnosis of 3% in the last year so there were far more people who were in the early stages of being controlled. Improvements would require the support of patients and public engagement in the process.

- The CCG had also invested in upskilling diabetic education amongst GPs through the Eden Model to allow GPs to deliver more complex diabetes care to patients in the community and this will also have a beneficial impact in the future.

- <u>Proportion of adults in contact with secondary mental health services living independently with or without support.</u>

    - The position showed a fall in relation England.

    - There were some local issues in changes of data which may not necessarily accurately reflect the actual current position.

    - The data and the performance measures were collected by Leicestershire Partnership Trust (LPT) and there were changes in both the ways that the data was recorded and reported at the end of 2011/12 which is when the dip in the performance measure was observed.

    - LPT were in discussion with Adult Social Care to improve the working of this measure. LPT would know who was being seen in secondary care but not all these would be eligible for statutory adult social care services and, therefore, the join up of these two issues in data terms was complicated.

    - The practical difficulties of this mis-match in comparing the local data to national data were recognised. Locally a task and finish group had been established to actively explore and understand the reason for the apparent halving of the performance on the indicator, whilst there had not been any diminishing of the services and arrangements in place to support and help people to live independently.

    - There had been additional services such as an adult care worker on the Bradgate Unit supporting patients with their exit planning for discharge from hospital including their accommodation needs. Extra care streams had also been introduced which would have been expected to improve the performance measure rather than seeing a decline in the measure.

The next steps to be taken were that the agencies concerned would be asked to report back to the JICB with an assessment and understanding of the recovery plans for these areas on concern and these would subsequently be brought back to the Board.

Councillor Dempster referred to the critical need for the co-ordination of effort between the work of schools, school nurses, children centre's staff and health visitors to avoid duplication of effort and to ensure that everyone was working at the right level at the appropriate time to maximise the support to children. She suggested that a further report on this work be submitted to a future

meeting of the Board as early years was critical to the long term welfare of children and families. It was noted that Leicester had made a submission to the Big Lottery Scheme for 'Fulfilling Lives – A Better Start' and, as part of the bid preparation process, there was a great deal of work done on differentiating the data on early years for social and emotional development and language and communication skills. Teasing out the aspects of early years and readiness for school that Leicester was particularly challenged about and also looking at the spread of those issues across the City by wards, would provide a good platform for the report.

RESOLVED:

1) That the progress on the delivery on the Joint Health and Wellbeing Strategy be noted.

2) That a further report on the recovery plans for the areas of the Strategy that were causing concern be submitted to a future meeting.

3) That a report be submitted to the Board early in 2015 on the progress made with improving the readiness of children for school at age 5 years old.

20. JOINT HEALTH AND WELLBEING STRATEGY - PRESENTATION BY DIRECTOR OF PLANNING, TRANSPORT AND ECONOMIC DEVELOPMENT

Andrew L Smith, Director Planning, Transportation & Economic Development, Leicester City Council gave a presentation on how the Directorate were working to support the Joint Health and Wellbeing Strategy. A copy of the presentation is attached to these minutes.

The Director commented that the department was working closely together as a set of disciplines and professions in delivering programme and projects which contributed to the holistic approach towards improving health and wellbeing through addressing the wider determinants of the physical, mental and social wellbeing of people and communities. There were linkages to the Closing The Gap Strategy in numerous plans and strategies such as the Local Plan, Local Transport Plan, Economic Action Plan and Cycle City etc.

The preparation of the new local plan for the City was an opportunity to embed health and wellbeing issues within the document that will shape the built and green environment in the future. It was also an opportunity to link in a health impact assessment with the sustainability appraisal which was required to be carried out and this was possibly the first time it had been done in the country. The Issues and Options document (the first stage of the local plan process) would be issued shortly and had a chapter on health. It was proposed to establish a themed workshop to focus on health and wellbeing issues and Members of the Board were invited to take part and help develop and improve the plan and the put forward the key issues that need to be included in the new

plan document.

The new 10 year cycling strategy aims to substantially increase the number of people cycling in the City. There were currently approximately 13,000 cyclists a day across the City and there was an ambitious target to double these numbers by 2018. There were proposals to improve the infrastructure, training, promotion of cycling as an alternative mode of transport and work with a number of cycling bodies to help to achieve the targets. The Action Plan was likely to be launched in November.

The Local Sustainable Transport Fund worked closely with health partners to achieve health and wellbeing outcomes. Details of these initiatives were shown on the presentation. Many of these initiatives were targeted at areas of high unemployment and deprivation, targeting those likely to have health issues. There were schemes to promote walking and to develop personalised travel planning encouraging people to change their travel behaviour. The Sky Bike Ride was one of the most successful in the country and this year it included the new areas of access in the city. There was also an additional Special Needs Ride around a shorter route involving specially adapted cycles and wheelchairs which was extremely well used.

There were a number of schemes improving the infrastructure for cycling and walking around the city and approximately 11km of pedestrian routes had been completed. Major transport infrastructure improvement schemes were included and detailed walking and cycling audits were undertaken so the opportunity for people to travel by these means were embedded into the scheme from the start.

Work was nearing completion on an Air Quality Action Plan which would be available for consultation later in the year. It was being developed in conjunction with health colleagues to understand the areas of concern and to include measures to address these, particularly around the arterial routes, where traffic pollution was highest. There had been some success in retro-fitting buses to make bus engines cleaner and more efficient and buses would continue to be a key measure in the initiative to bring about behavioural change in transport and travel.

Wellbeing initiatives included getting people into employment with a particular focus on promoting life chances and opportunities for young people.

The Chair commented that there was a great deal happening across the City through Council activities that contributed to health and wellbeing that were not always quantified and promoted as such.

During discussion the following comments and observations were made:-

- The cycle training and cycling initiatives should be communicated to GPs as a practical gateway into improving health, particularly as a referral into physical activity programmes.

- Scheme such as the 'Bike It Scheme' could be taken to the Secondary Head Teachers Meetings to promote and encourage take up.

- Where large developments were proposed in the future with a health impact assessment, there should be a mechanism for the Board to comment upon them and feed comments into the planning process. This need not necessarily be through a formal meeting process. The Director felt that this could be incorporated within the existing consultation process for such developments.

- The link between air pollution and respiratory disease such as COPD, which was a major contributor to premature death in the City, was an area of interest and it would be helpful to know if there was a correlation between the incidents of respiratory disease along the arterial routes within the City and if any measures could be introduced alleviate the incidence of respiratory disease.

The Director commented that research was currently being undertaken to see if there were any patterns arising from traffic congestion on major routes, especially at peak hours when there was standing traffic. Creating a shift in people's travel options towards cleaner buses could bring benefits. Cycling and walking were key elements but would not in themselves bring about a step change in improving air quality. This would be brought about by reducing traffic and having cleaner engines and emissions.

RESOLVED:

1) That the Director be thanked for an informative and useful presentation.

2) That the Chair discuss with the Chair of the Planning and Development Committee a mechanism for Board members to comment on large development proposals involving a health impact assessment.

3) That the Air Quality Action Plan be submitted to the Board together with any research into links between the air quality and its impact upon health issues.

4) That the next presentation to the Board be on the topic of the housing economy, both private and public, covering issues such as health, good homes and warmth etc.

21. CAMHS REVIEW

Leon Charikar, CAMHS Commissioning Manager, Leicester, Leicestershire and Rutland attended the meeting to present the report providing an update on the Children and Adolescent Mental Health Service Review (CAMHS). It was noted that the Commissioning Manager worked as part of the team that was funded by all three CCGs operating in Leicester, Leicestershire and Rutland.

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This report addressed the work that had been taken across Leicester City, Leicestershire County and Rutland County to produce a joint multi-agency strategic approach to improving the emotional and mental health of children and young people. This strategy was based on four strands:

- Promotion of good emotional health through universal services.
- Co-ordinated and integrated early and targeted support services.
- Clear care pathways to and from specialist clinical services for children with mental health or developmental disorders.
- Joint strategic direction and leadership to ensure strong co-ordination and joint working across organisations.

The report also provided an update on the review of the Child and Adolescent Outpatient Mental Health Services provided by Leicestershire Partnership Trust.

It was noted that:-

- The CAMHS service saw 1,800 children per year which was a small proportion of the children across Leicester, Leicestershire and Rutland.

- The review had been instigated by health commissioners following concerns raised by referring agencies, families and partner agencies that there were difficulties in accessing the service and it was not communicating very well with referrers or families.

- The initial findings of the independent review were referred back initially to the CAMHS service on 22 September and then to a wider group of stakeholders.

- Some of the key issues were around waiting times for routine referrals for which the target of 13 weeks from being referred to assessment was regularly being breeched, and there were concerns that the target itself was not appropriate. An urgent referral was seen within 4 weeks and work was needed to review that process.

- The assessment was carried out with a multi-disciplinary team with the families and the review was looking to streamline the process so that a single practitioner undertook the assessment.

- Referral rates were different for different GPS practices and referral rates are lower in the City than in the County area. This was being investigated to see if there were other services available in the City, young people do not know about CAMHS, whether local services do not understand how to access CAMHS, or whether there were cultural difference in the prevalence rates of identification of mental health conditions.

- The CAMHS service was also an outlier service as it appeared to hold

onto to cases longer than the national average, and this also impacts upon waiting times.

- Improvements were also needed for family engagement and support arrangements and outcome measures needed to be used systematically across the service.

- It was recognised that CAMHS services were underfunded nationally and this had been raised both by the Department of Health and a Government Inquiry looking at a lack of beds in the in-patient provision.

- Approximately 6% of the mental health service budget in the local health economy goes towards CAMHS and increased investment could have an impact on the service and on adult mental health services in the long term.

- The service compared well to other CAMHS services with the exception of discharge times.

- There was a commitment to changing the service and partnership working and commissioners wanted to see a high quality service that was responsive to the needs of children.

Board Members:-

- Recognised this was difficult process for the CAMHS staff and welcomed their strong energy and enthusiasm to take the issue forward.

- Commented on the staff's feelings that the perception of not accepting referrals was unjust when 34% of referrals were returned without seeing CAMHS.

- Recognised that some issues were outside the control of the CAMHS service and it was important that staff were supported as the review moved forward as the service was totally dependent upon the staff to make it successful.

- Felt it was important to have an holistic approach so that there was integration between Tier 1 and 2 services which had consequences for Tier 3 and 4 services, so it was important to have clear working arrangements.

- Asked whether there was an understanding of the consequences of delay, as often people accessed mental health provision at a point of crisis or life changing situation leading to crisis. Often other organisations, such as the Police, were then involved in picking up the consequences of these events. The delay of 13 weeks in referral times could have consequences for the CAMHS service in terms of being

involved longer in the service provision and also for the resources of a number of other organisations that could subsequently be involved as a direct result of that period of the delay.

- Felt that GPs needed a better system, similar to the SPAR model so that when the right information was given then a referral could be made to the right skill set to achieve a more appropriate dispersal of cases within the system. GPs also need access to a more cohesive system than is currently provided by the educational psychologists, CAMHS, nurses and voluntary sector. If the signposting was right it may be that the capacity already exists within the system to cope with the demand.

Following questions form the Board the Commissioning Manager stated:-

- That the formal report would be published in November and CAMHS would then be asked to produce an Implementation Plan for immediate auctioning.

- Reviews of the Implementation Plan would be required at 3 monthly intervals to oversee the Plan and see if the actions are making any difference and improving the service and partnership agencies.

- The key theme of the Board's comments and concerns was around the risk assessment of the young person's needs and it was, therefore, important to involve and provide skills to primary care and social care and education, so that CAMHS can provide support and guidance to others to avert a crisis or to determine that the risk is too high and CAMHS intervention is required.

RESOLVED:-

That the report and the progress of the review be noted, and that some issues raised in the discussions be pursued after the meeting.

22. LEICESTER PHARMACEUTICAL NEEDS ASSESSMENT

Rod Moore, Divisional Director Public Health, Leicester City Council provided a verbal update on the progress of the development of Leicester's Pharmaceutical Needs Assessment (PNA). A copy of the consultation document on the Draft PNA which started on 29 September 2014 and ended on 28 November 2014 had previously been circulated to Members.

The consultation document was available on the Council website and had been circulated to a number of interested parties, as well as the statutory consultees, and was also available upon on request. Comments in response to the consultation could be submitted in writing or orally at public meetings that had been publicised.

In response to questions from Board Members it was noted that:-

- The pharmacies in Leicester were not evenly distributed throughout the City as many had been established before the current regulations had come into force.

- There were sufficient pharmacies in relation to the population within the City, even though they were not evenly distributed.

- The pharmacies open for 100 hours or more were situated in Westcotes, Eyres Monsell, Spinney Hills, Stoneygate and Latimer wards resulting in the west of the City being poorly served.

RESOLVED:

1) That the consultation document and the update on the consultation process be noted.

2) That a further report on the responses to the consultation be submitted to a future meeting of the Board.

23. BETTER CARE FUND

The Board at its meeting on 3 April 2014 considered the draft submission and gave delegated authority to Councillor Palmer, Chair of the Board, Dr Simon Freeman, Managing Director Leicester City Clinical Commissioning Group, and Andy Keeling, Chief Operating Officer, Leicester City Council to approve the final submission. (Minute 63 refers)

An update report was received which outlined the process that had been followed to achieve the national deadline for the resubmission of the Better Care Fund Plan to NHS England and the Local Government Association by the deadline on September 19th 2014. The paper outlined the key sections of guidance which had impacted upon the resubmission and the actions taken locally to address these. The paper also outlined the assurance process which was currently being undertaken.

The Strategic Director of Adult Social Care and Health stated that the plan had been based upon the previous draft that had been considered by the Board. The initial feedback required more work to be undertaken around the assurance process, and the considerable work undertaken by the CCG and the Council on this was acknowledged. Since the final Plan was submitted it was currently going through the assurance process, details for which were contained in the report. KPMG were undertaking an external assurance assessment and the initial feedback had been positive, and few changes had been requested. The changes made were mainly of additional narrative.

It was noted that the Plan was likely to be rated as ‘Assured with Support’ which would be the highest rating that it could be given because of the current classification of the CCG as a ‘distressed health economy’.

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It was further noted that:-

- Schemes already implemented under the Plan were generally working well, although the number of people going through these schemes would need to continue to rise.

- It was encouraging that a member of the Social Care Intervention Crisis Response Team had worked with the emergency department on the previous Sunday and had prevented 5 people from being admitted to hospital and enabled them to stay at home. It was hoped to eventually roll this provision out as a mainstream service.

- There was clear evidence of increased social care services bringing benefit to the health service and to people that were using the services.

- The fund was a powerful example of the strength of joint working between the Council and CCG which will develop into bringing considerable benefits to the City.

RESOLVED:

That the Better Care Fund Plan submitted to NHS England and the Local Government Association by the deadline on September 19th 2014 be received and noted and that everyone contributing to its production be thanked.

24. QUESTIONS FROM MEMBERS OF THE PUBLIC

A member of the public commented that he was surprised that arts had not been mentioned in the presentation given earlier in the meeting.

The Chair stated that the arts were recognised as having a positive influence on people's health and wellbeing. These services were not provided by the Directorate that gave the presentation but would be covered in the appropriate Directorate's presentation to a future Board meeting.

25. DATES OF FUTURE MEETINGS

It was noted that future meetings of the Board would be held on the following dates:-

Thursday 11 December 2014
Thursday 5 February 2015
Thursday 26 March 2015
Thursday 25 June 2015
Thursday 3 September 2015
Thursday 29 October 2015
Thursday 10 December 2015
Thursday 4 February 2016
Thursday 7 April 2016

(Note: - Meetings of the Board are likely to be held in City Hall from January onwards.)

26. CLOSE OF MEETING

The Chair declared the meeting closed at 12.05 pm.

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BETTER CARE TOGETHER JOINT LEICESTER, LEICESTERSHIRE AND RUTLAND FIVE YEAR STRATEGY - UPDATE

QUESTIONS SUBMITTED TO THE BOARD BY A MEMBER OF THE PUBLIC

QUESTION 1.

When will the directional plan go to the Health Overview Scrutiny Commission as indicated by Geoff Rowbotham at the Health and Wellbeing Board meeting of July 2014?

RESPONSE

In discussion with the Chairs of the Health and Wellbeing Scrutiny Commission and Health and Wellbeing Board, Leicester Health and Wellbeing Board have and continue to support us in the shaping and development of the Better Care Together directional strategy. We are presently still working on the wider implementation proposals. It is anticipated therefore that we will be in a position to propose to the both a proposed strategy and implementation plan in spring 2015.

QUESTION 2

What further plans are there for involving the public especially given the limited attendance at the Healthwatch organised meeting in August?

RESPONSE

We have to date in partnership with Healthwatch carried out a number of ongoing engagement and media led events to communicate and get feedback on the 5 Year Strategic Plan. We are presently developing with Healthwatch and the voluntary sector a further program of engagement and communication events for spring 2015 as well as our proposals for the formal consultation program post May 2015.

QUESTION 3

When is the risk register going to be made available to the public and how can proper scrutiny of the plan take place in the absence of the risk register?

RESPONSE

In line with Office of Government Commerce (OGC) good practice the first step of the program has been to develop the key strategic risks and agree a process for managing them within the Better Care Together program and partner organisations. These are completed and are now being developed through the program committees into a more detailed risk register from which a Board Assurance framework will then be made available to the Better Care Together Partnership Board and partner organisation boards and committees.

The Board Assurance Framework is scheduled to go the January 2015 Partnership Board which is held in public.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Early Years Strategy – Readiness for School
Presented to the Health and Wellbeing Board by:	Frances Craven
Author:	Frances Craven

EXECUTIVE SUMMARY:

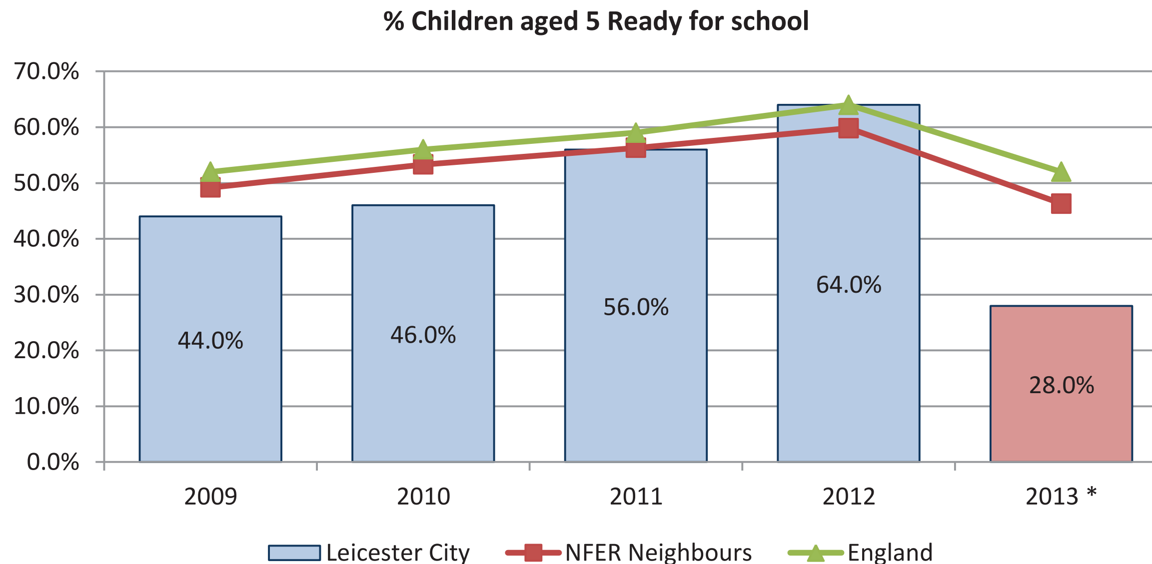
Support for Early Years development is provided across a range of services and providers, including the private and voluntary sector. One of the key tasks is to map this range of services to ensure we engage well with all providers to achieve consistency of message and quality. A strategic group is being formed to pull this work together to ensure that a multi-agency approach is taken.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to note this report.

Early Years Strategy – Readiness for School

- Support for Early Years development is provided across a range of services and providers, including the private and voluntary sector. One of the key tasks is to map this range of services to ensure we engage well with all providers to achieve consistency of message and quality. A strategic group is being formed to pull this work together to ensure that a multi-agency approach is taken.



* N.B. trend graph shows historical trend for the old measure of "Achieving a good level of development at Early Years Foundation Stage for 2009-2012, 2013 was the first year of results for the new Foundation Stage Profile.

Improving the quality of early years provision

- Nearly all primary schools received good Ofsted comments on quality of early years provision. Recent Ofsted inspection of Northfields - West Humberstone cluster highlighted good practice being made in evidencing positive progress made with children accessing Children's Centre teachers compared with those not. Two additional recent (past 3 weeks) Ofsted inspections of 2 local authority pre-school settings have been graded good

- A report is in progress mapping and analysing the role of the Children's Centre teacher role and the impact the role is having. Recommendations will refocus the role on working with pre-school

- There is dedicated funding for training and development of pre-school settings to enable them to deliver good quality provision with highly skilled and qualified staff. There is a need for more joint training across schools and different settings/providers

- **Support for improving teaching and learning particularly in the areas of Literacy and Maths** These are two areas where our children do less well and this has an adverse effect the city's overall scores for Good Level of Development. These are two key workstreams in the Leicester Education Strategic Partnership improvement plan. Knowledge Transfer Centres focussed on the teaching of reading (with particular emphasis on foundation stage) have been established in four schools and approximately a quarter of schools will participate in this programme over the next year. A recent Reading Summit gained endorsement for a roll-out of the teaching methodology to all city schools and this will be supported through funding from Schools Forum.

- **Increasing the participation of 3 and 4 year olds in education provision -** Although attendance at an education setting is not statutory our services have identified 3 and 4 year olds not attending any setting. Early Help services will work with families to target these children, develop families' awareness of the entitlement to free early education and support them in finding and taking up a place and knowing the importance of regular attendance. A key focus is currently on encouraging parents to take up their entitlement for early years placements to support school readiness. The percentage of 2yr old take up has doubled from 30 - 60% in the last quarter.

- **Support for parenting** (and practitioners working in partnership with parents) is a priority in relation to building attachments, developing communication and language and creating a home learning environment. The Healthy Tots programme is being developed within public health and will be delivered through Children's Centres and the Quality Improvement Team, which will focus on physical activity and development, as well as social and emotional development of young children.

- **Improving attendance in the foundation stage -** the attendance of Leicester reception children is the lowest nationally so we are developing a communication strategy to disseminate to parents through the children's workforce (e.g. in Children's Centres, early years settings) the importance of regular attendance right from the beginning of school.

- **Support for the early identification of, and input for, children with additional needs/SEND -** linking with health to support early identification, and effective commissioning of services to address developmental delays, e.g. Speech and Language support. This is in within the remit of the Integrated Commissioning Board.

- **Other activity includes:** providing Family Learning in every Children's Centre cluster, through our Adult Skills and Learning service; developing guidance on the effective use of Early Years Pupil Premium (this funding will be available from April 2015).

- **Emerging issue**: An issue being identified by both early years settings and schools is the growing number of children with English as an additional language, and particularly the range of languages spoken. We are reviewing our EAL advice and support for schools and will need to extend this to early years settings.

Appendix B2

LEICESTER CITY HEALTH AND WELLBEING BOARD
18th November 2014

Subject:	Proportion of Adults in Contact with Secondary Mental Health Services Living Independently (with or without support)
Presented to the Health and Wellbeing Board by:	Elaine McHale
Author:	Yasmin Surti

EXECUTIVE SUMMARY:

Poor mental health is the largest cause of disability in the UK and can be influenced by things like having good relationships, meaningful work, housing and feeling part of a community.

The Adult Social Care Outcomes Framework Indicator 1H and the Public Health Outcomes Framework Indicator 1.6a are a step to creating a set of outcome measures that gauge how well health and social services together support people to recover the lives they want for themselves.

The above measure relates specifically to adults on the Care Programme Approach who are receiving secondary mental health services recorded as living independently, with or without support.

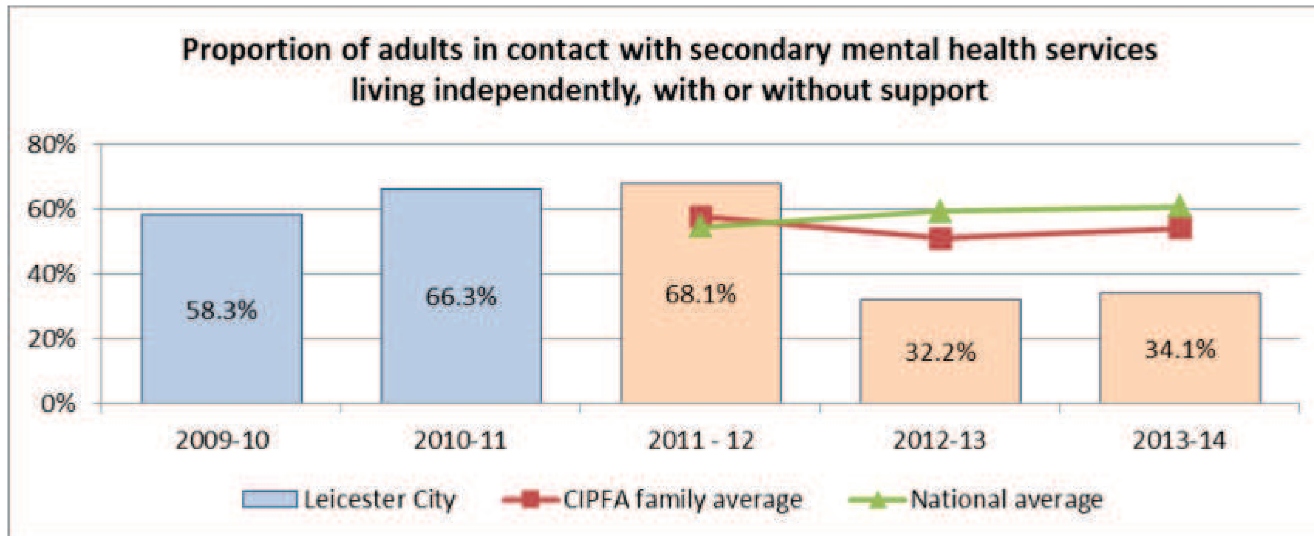
Data and performance measures for this indicator are currently collected by Leicestershire Partnership NHS Trust (LPT) as the main provider for Secondary Mental Health Services in the City. As such Adult Social Care (ASC) may not always be aware of adults in contact with secondary mental health services who are living independently and are therefore reliant on LPT collecting and recording the data as well as making appropriate referrals to ASC where an individual may need support with this aspect of their lives.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to note:

1. The remedial actions being undertaken in order to ensure the data is up to date
2. The significant ongoing work to secure suitable accommodation schemes that support people with mental health problems to live independently;
3. The work being undertaken as part of the Better Care Together Programme to improve data collection and information sharing across agencies.

Proportion of Adults in Contact with Secondary Mental Health Services Living Independently (with or without support)



- Relates only to those on the Care Programme Approach (18 to 69), approx. 370 individuals - may exclude those detained under the Mental Health Act for a significant part of the year;

- The data shows a marked decline in performance, however, we are confident that the data is not accurate;
  - Recent changes mean current status for each individual has to be updated <u>and</u> dated on the system each year or it cannot be reported
  - Using local, historical data demonstrates performance at 77% against this indicator
  - Most care plans reflect accommodation status but the information is historical and not dated
  - 29% of patients currently do not have any information on accommodation recorded on their care plan (Q2), this is an improvement from 37% (Q1)

- Understanding and identifying any actions relating to commissioning or frontline practice to improve this outcome measure is reliant on accurate data.

Recovery Plan

Action	Owner	Review Date	Comment
CPA Records to be updated with current status on Accommodation and employment	Mark Griffith - LPT	January 2015	Although captured the sections on accommodation and employment require dating or cannot be included
Patients who have not had a recent review to be contacted to ascertain current status	Mark Griffith - LPT	January 2015	
Reiterate Employment and Accommodation must be discussed at every Multi-Disciplinary Team meeting	Mark Griffith - LPT Sharif Haider - ASC	January 2015	
New residential care placements will be reviewed regularly and supported to move on as soon as it is appropriate.	Sarah Morris - ASC	Ongoing	Commissioning Board receives regular updates on movement in and out of residential care
Agreement from JICB to continue funding ASC staff on the Bradgate Unit	Sarah Morris - ASC	March 2015	1.5 ASC staff based on the Bradgate Unit to support patients and clinical staff with exit planning, including accommodation needs
Review progress on Delayed Transfers of Care and Out of area Placements	John Singh -- CCG	March 2015	Housing colleagues are present on the wards and have simplified and revised information for patients and staff
Ensure outcomes are being monitored through the contractual process	Yasmin Surti - ASC	December 2014	Monthly MH/LD Clinical Sub discusses LPT contract and performance ASC Data analysts will track monthly progress from National Minimum Data Set Reports
Continued strategic discussions and planning continues with commissioners and providers to explore options and ensure the availability and development of suitable accommodation, including for forensic cases which are harder to place	Caroline Ryan - ASC	Ongoing	A number of schemes are in place and new schemes are planned
ASC will begin to use NHS numbers which should provide verification that people are not being double counted and mitigate the risk of people slipping through the net	Sarah Morris - ASC	April 2015	The Better Care Together Programme enabling work stream for Information Management and Technology exploring integrated working including the ability to share data, support plans and information.
Identify and allocate further actions following data cleansing	Yasmin Surti – ASC Sarah Morris – ASC Carline Ryan - ASC Mark Griffith - LPT	January 2015	Quarterly meetings to monitor progress, issues and actions

Accommodation and Support

- ASC commissions and provides a range of independent living options tailored to meet the needs of people with mental health problems, including:
  - statutory support for people which is commissioned from the Supported Living Framework for people who have had a Community Care Assessment;
  - Support commissioned via the Independent Living Support Framework for people who may not be eligible for statutory support from ASC;
  - The opportunity for individuals to commission their own support to live independently using a direct payment.

- ASC works closely with Housing to ensure there is appropriate and adequate accommodation for people with mental health problems.

- Current schemes:
  - Wolsey Extra Care age designated scheme;
  - Manor Farm flats;
  - Orchard House referrals managed by LPT Service Manager;
  - Glenfield Road and Hinckley Road self contained flats with on site support;
  - Abbey Mills;
  - Norton House, Glengarry Court and Eversley House = Independent Living Support.

- Planned schemes:
  - Manor Farm phase 2;
  - Wycombe Rd;
  - Tilling Road and Queensmead –Extra Care all ages;
  - Upper Tichbourne Street;
  - Lower Hastings Street;
  - Thurnby Lodge cluster of bungalows;
  - Internal refurbishments.

Appendix B3

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Cervical screening uptake in Leicester City
Presented to the Health and Wellbeing Board by:	Dr David Sharp
Author:	Dr Tim Davies

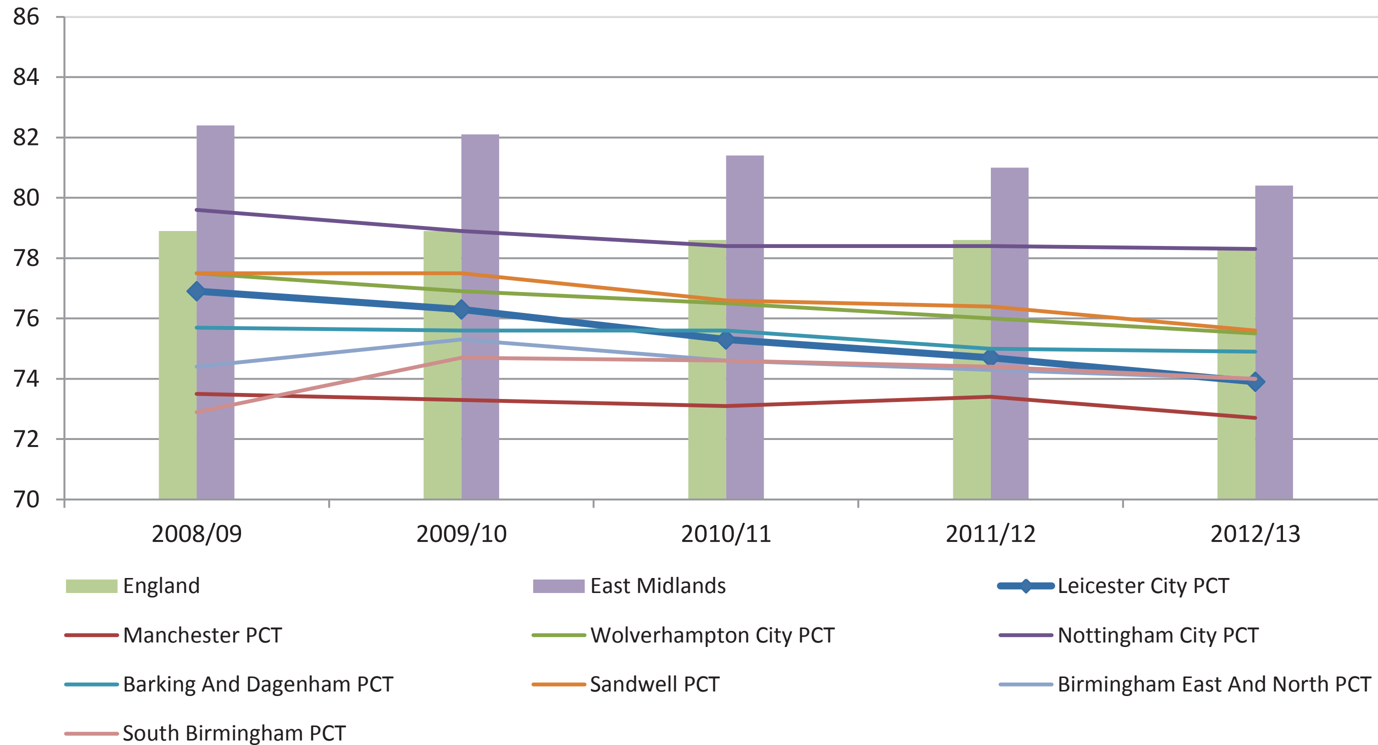
EXECUTIVE SUMMARY:

Uptake for cervical screening in Leicester City has been declining for a number of years. This pattern is reflected in much of the country. There is no single explanation for this.
The Area Team has established a local multiagency health promotion group to focus on uptake of all national screening programmes. A number of actions aimed initially at professional have been agreed.

RECOMMENDATIONS:

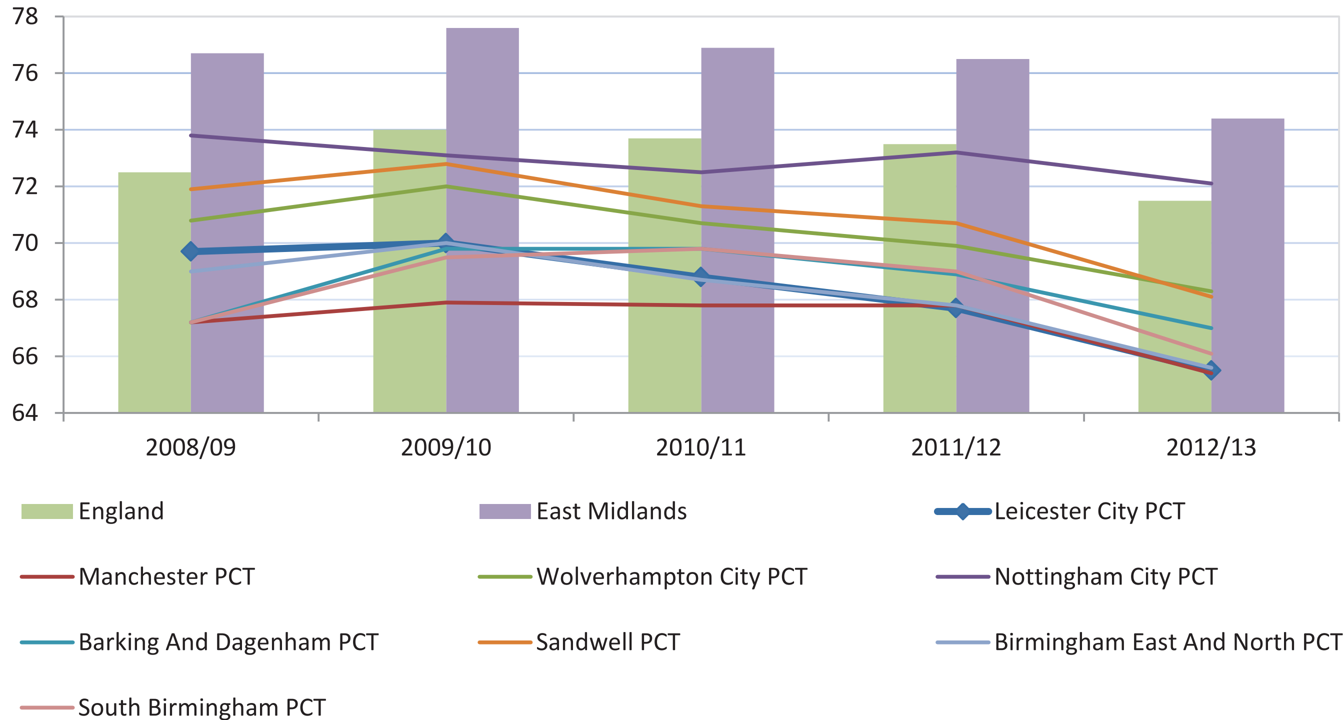
The Health and Wellbeing Board is requested to note this report.

Uptake for cervical screening, 25-64 yrs, for Leicester City, England, East Midlands and peer areas



Most areas have seen a decline in uptake over time, Leicester City experience is similar to its peers.

Uptake for cervical screening, 25-49 yrs, for Leicester City, England, East Midlands and peer areas



Similar pattern when looking at younger age group except Leicester City is now near the bottom of its peer group

Explanation and actions

- There is no single reason for this, it is not as simple as saying it is the result of low uptake in BME groups for example.
- The introduction of the HPV immunisation in teenage girls is believed to have had an effect on people’s thinking about cervical screening but it may also be a reflection of the general attitude to sexual health which is seeing a rise in STDs.
- A multiagency LLR Health Promotion Steering Group has been established by the Area Team’s screening and immunisation team – the following actions have been agreed.
  - Resource packs to be sent out to all GP practices, containing information on all adult screening programmes
  - Screening & Immunisation Team will be sharing quarterly practice data with the CCGs , to enable low uptake monitoring
  - Developing an anticipatory calendar linked to national campaigns, and working to formalise links with communication teams across the health community
  - Reviewing all adult screening programme content / patient information available on the following websites – CCGs, UHL, Leicester City and County Councils
  - Explore how the Screening & Immunisation Team link into the Quality, Engagement & Development Programme that is being rolled out by the City CCG

- The local authorities commission sexual health services, it is critical that cervical screening continues to be available through sexual health and family planning services

Leicester City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD
11 DECEMBER 2014

Subject:	Leicester, Leicestershire and Rutland Better Care Together – Programme Update
Presented to the Health and Wellbeing Board by:	Geoff Rowbotham, Interim Programme Director and Michael Cawley, Finance Director
Author:	Geoff Rowbotham, Interim Programme Director and Michael Cawley, Finance Director

EXECUTIVE SUMMARY:

Following the completion of the LLR 5 Year Plan in July 2014 the BCT Partnership Board requested the completion of a Strategic Outline Case (SOC) and Program Initiation Document (PID). It was agreed to commission Ernst and Young (EY) external consultancy to support the LLR partnership organisations in developing the SOC.

The PID and SOC have been derived from the analysis, planning and decisions reflected in the Five Year Strategic Plan. While the purpose of the SOC is to appraise whether the BCT Programme is the best way of addressing the local case for change and recommend any supporting resource requirements, the aim of the PID is to provide the authoritative definition of the BCT Programme that sets out the basis on which it is to be initiated, governed and delivered.

The SOC sets out the case for the BCT Programme as being the preferred way forward to deliver the plans set out in the five year strategic plan. The SOC is designed to be a 'wrapper' for all the future transformation business cases which will be required for the system to realize its vision. It has been developed and reviewed by EY through the BCT partnership Chief Officers, Delivery Group and Finance officers groups.

The PID sets out the policy of the Partnership Board for the management of the BCT Programme. Over its development, comment and input has been received from Ernst & Young, the BCT Clinical Reference Group, Public and Patient Group, Implementation Group, senior Finance staff and Chief Officers covering both Health and Social care .

Following approval by the Partnership Board at its November meeting it proposed a two step approach is adopted in reviewing the drafts.

A summary presentation of the 5 Year Plan, SOC and PID are presented at the partnership Board meetings, Health and Well being Boards, BCT Clinical Reference and PPI groups for information and initial comment prior to draft versions of the complete documents being made publicly available w/c 22nd December 2014

A wider review and discussion programme is then proposed for early 2015. Recognising that these documents are written to meet an internal requirement a public version of each is proposed that would then be utilized for approval at Health and Well being Boards and for wider public and staff engagement.

Following the review of the wider key draft documents and development of the proposed formal engagement plan it is proposed to agree a date early in 2015 to review the proposals with the Health and Wellbeing Scrutiny Commission.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

Note the progress made, outline information within the enclosed draft Strategic Outline Case and Program Initiation Document presentation and proposal to make the draft documents available for comment w/c 22nd December 2014

Agree the proposal to provide initial comment on the drafts and the proposal to carry out a wider engagement of the 5 Year Plan, Strategic Outline Case and Program Initiation Document during January-March 2015

NHS
Leicester, Leicestershire and Rutland

Better Care Together Summary of the Five Year Strategic Plan, Strategic Outline Case and PID

November 2014

20/11/2014

Version 1.5

Better care **together**

NHS
Leicester, Leicestershire and Rutland

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1
Introduction

Introduction

Better Care Together vision

'…to maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings'.

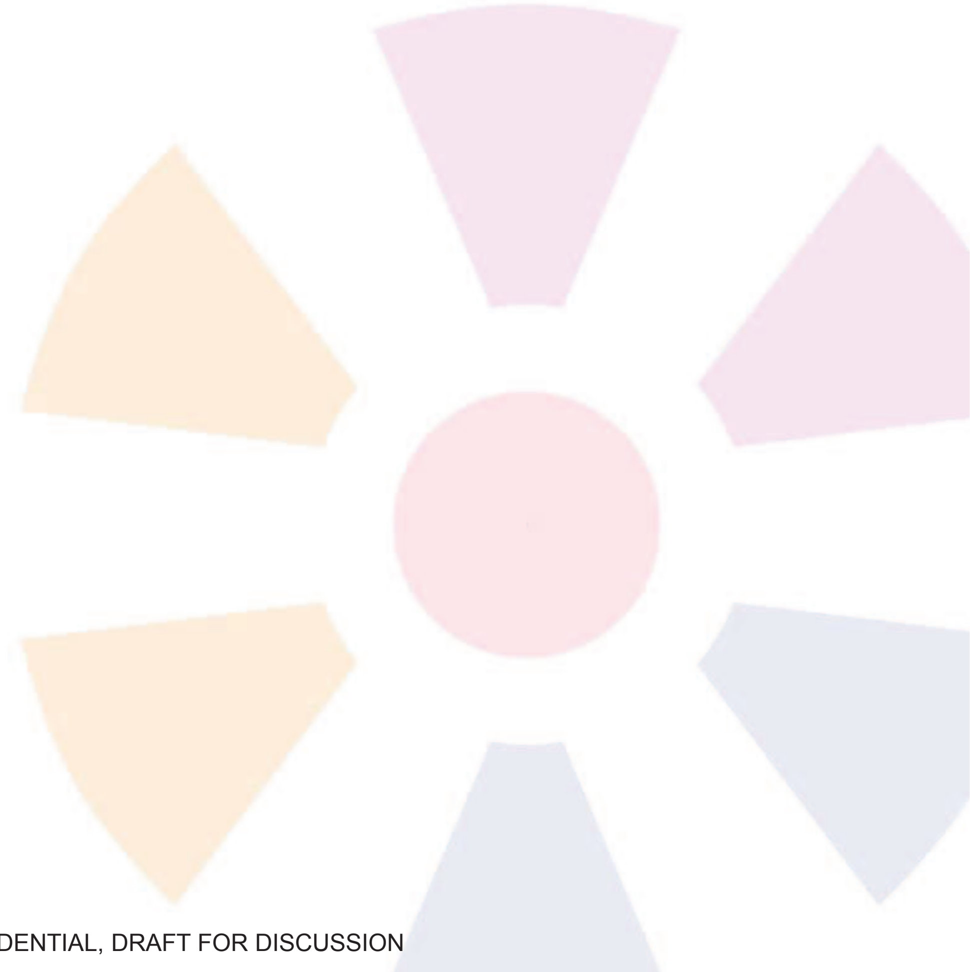
What have we produced so far

(1) The BCT five year strategic plan, updated in September 2014, which describes our plans to reform health and social care services across LLR;

(2) The strategic outline case (SOC), published in October 2014, which sets out the case for the BCT programme as being the preferred way forward to deliver the plans set out in the five year strategic plan. The SOC is designed to be a "wrapper" for all the future transformation business cases which will be required for the system to realise its vision;

(3) The programme initiation document (PID), from November 2014, which defines the BCT programme and sets out the basis on which the programme is to be initiated, governed and delivered.

2
The case for change

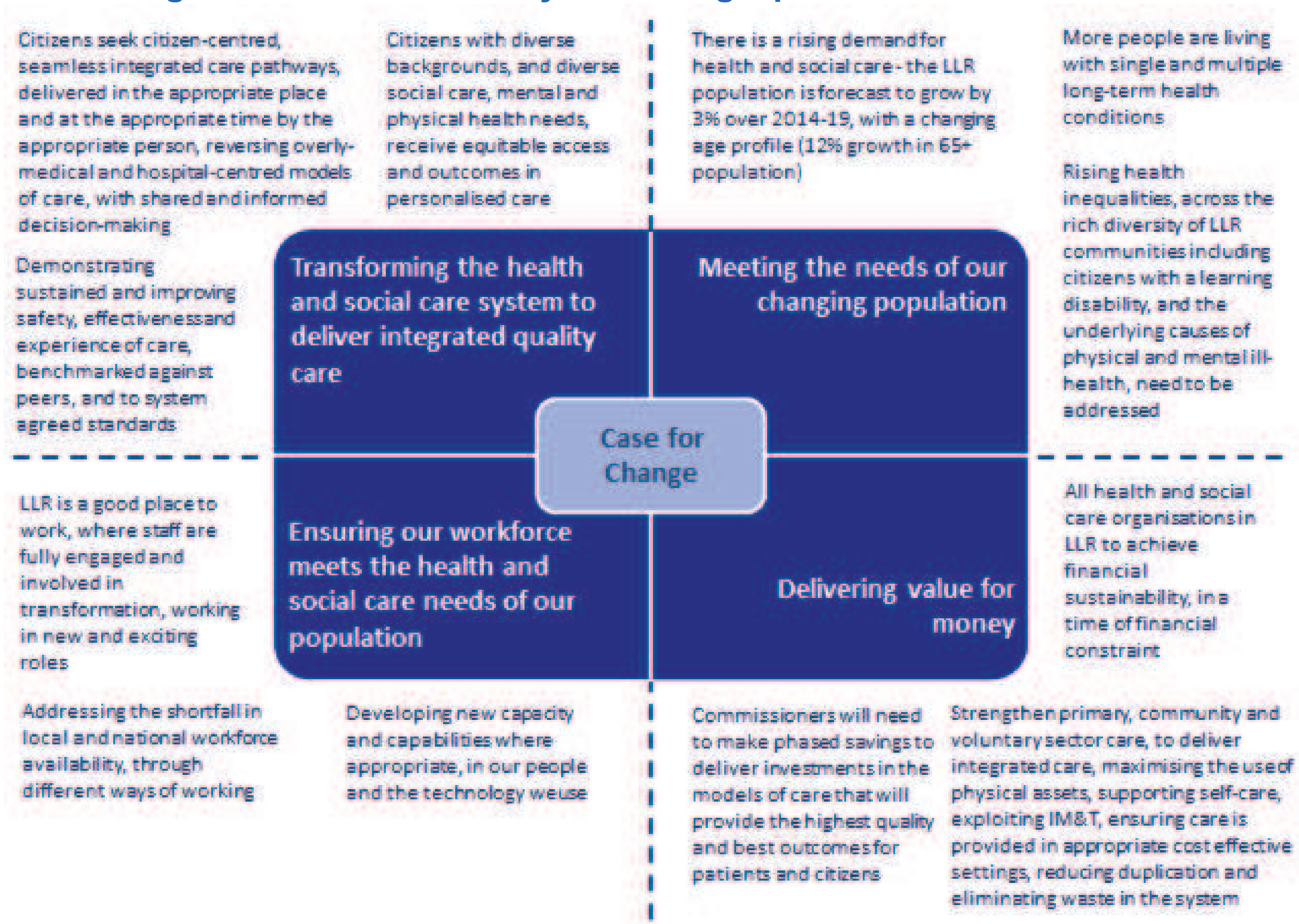


Better care **together**

CONFIDENTIAL, DRAFT FOR DISCUSSION

Case for change across Leicester, Leicestershire and Rutland

The case for change was set out in the 5 year strategic plan



Case for change across Leicester, Leicestershire and Rutland

NHS savings continue to be under significant financial pressure

In 2011 the “Nicholson Challenge” set out the need to make £20bn of savings against a budget of £110bn. The NHS is on track to deliver against the challenge by March 2015 but is now faced with the need to make further savings.

In NHS England's recently released *Five Year Forward View* , it is stated that "a combination of a) growing demand, b) no further annual efficiencies, and c) flat terms real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30bn a year".

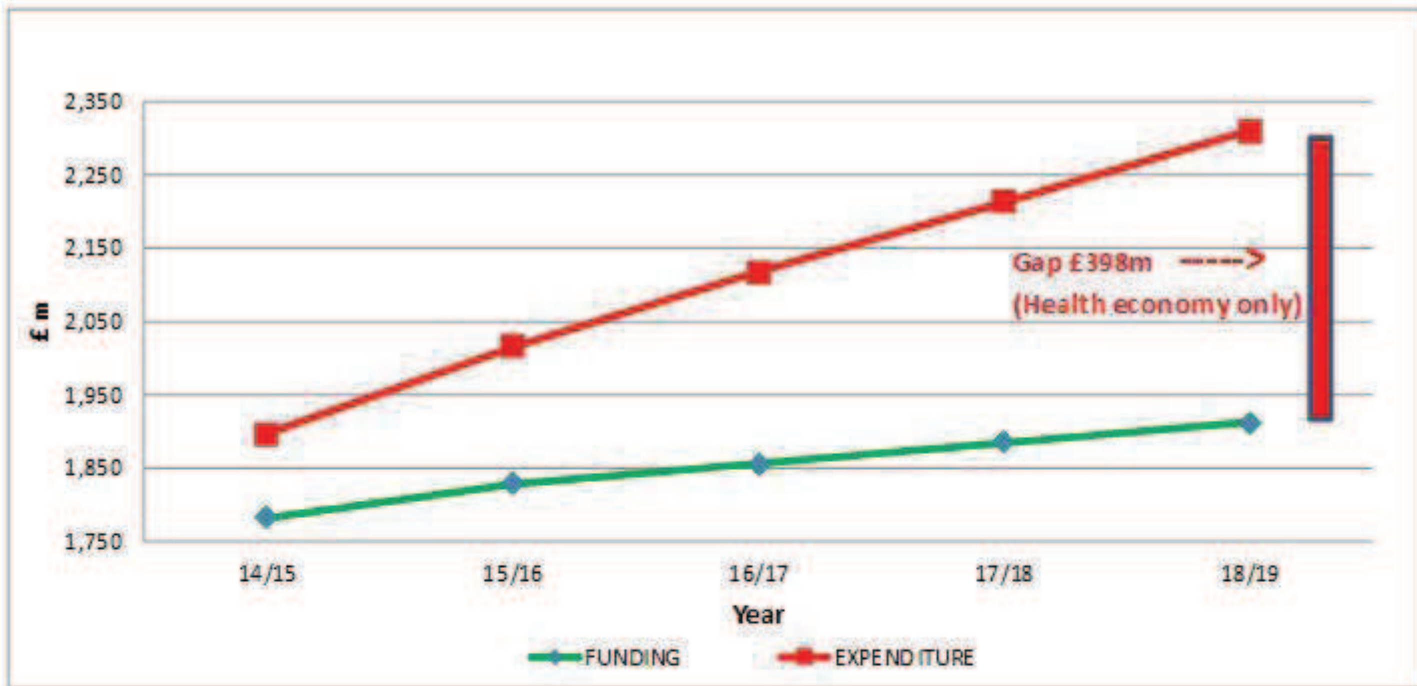
This requires organisations to find different ways of working to address these growing pressures and sets out a call for action on demand, efficiency and funding.

Cuts to local government budgets are affecting adult social care

The government’s deficit reduction plan involves significant cuts in public spending. The 2010 Government Spending Review set out plans to reduce government funding for councils by 26% by 2014/15, whilst the 2013 Spending Round resulted in council resources being cut by a further 10% in 2015/16. Adult social care accounts for a significant proportion (33-45%) of local authority spending, meaning that the pressure to reduce costs will inevitably impact on social care.

These financial pressures translate into significant funding gaps

The local NHS faces a shortfall of £398m by 2018/19

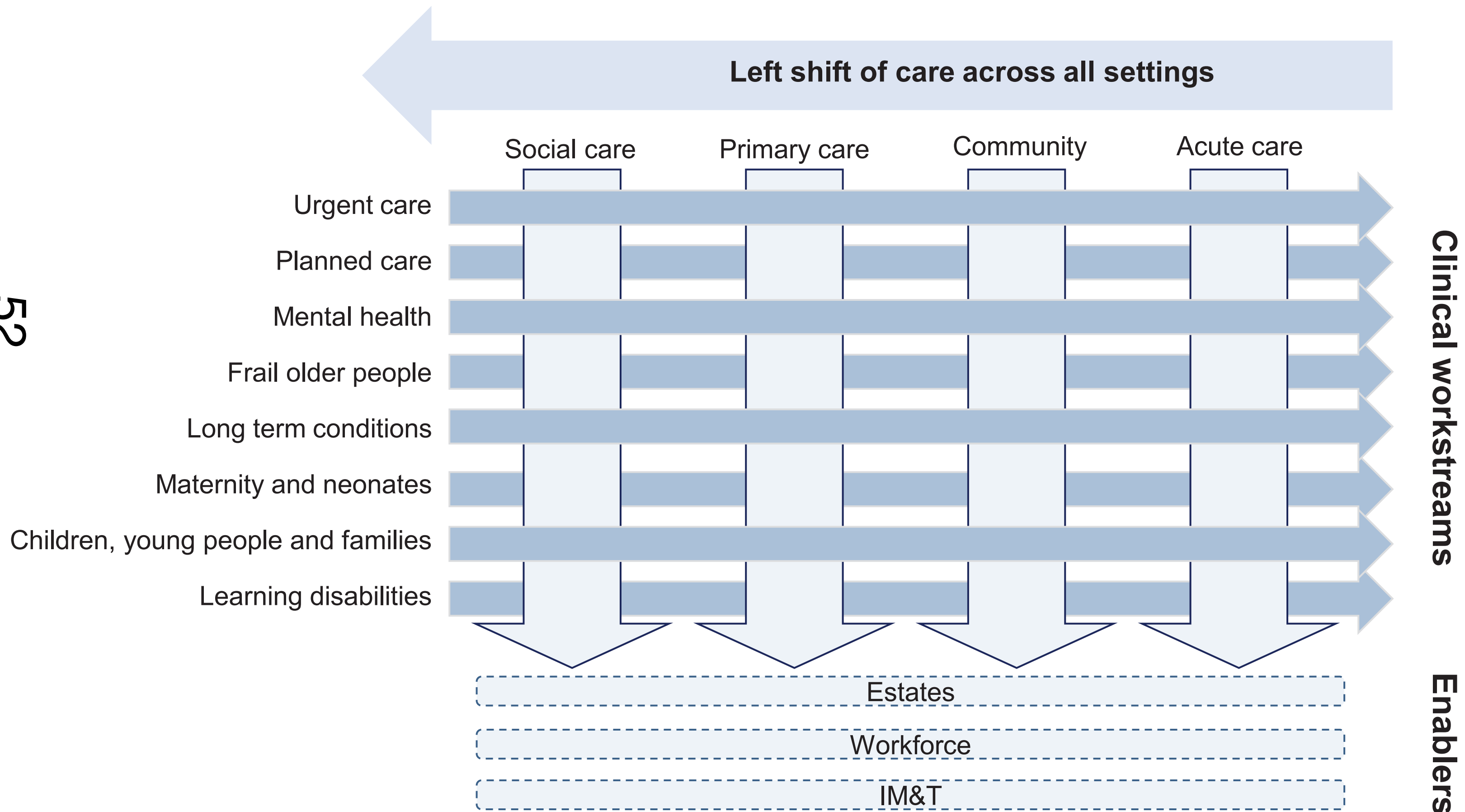


Local authorities will require even more significant savings and the details of these are still being worked through. A collective savings requirement across the three local authorities of £177m is predicted.

3
Our response to the case for change

Better Care Together

The Better Care Together Programme sets out plans for eight clinical workstreams, and within four different care settings



Clinical pathway workstreams

Each of eight clinical pathway workstreams has worked to the same format of describing our existing service, the interventions we intend to make and the resulting outcomes.

Urgent care example…

The ten components of care

The urgent care, frail older people and long-term conditions workstreams used the Kings Funds' Ten Components of Care to frame service transformation

Urgent care example…

1 Age well and stay well	2 Live well with one or more long term conditions	3 Support for complex co-morbidities / frailty	4 Accessible, effective support in crisis	5 High quality, person centred acute care
FOP LTC	FOP LTC	FOP	FOP LTC UC	UC
6 Good discharge planning and post discharge support	**7 Effective rehabilitation and reablement**	**8 Person centred, dignified, long term care**	**9 Support, control and choice at end of life**	**10 Integrated services to provide person centre care**
FOP	FOP LTC	FOP	FOP LTC	FOP LTC UC

Clinical workstreams

The clinical workstreams have drawn on existing plans and newly developed interventions to set out a strategic direction

Learning disabilities

- Review team to benchmark and analyse the cost and content of high cost packages of care
- Reconfiguration of short break services for LD patients / service users
- Implementation of an Outreach Team that will work between the community and the Agnes Unit for challenging individuals LLR approach to enable carers to be involved in service development and planning
- Flexible LLR wide provision of short term intensive crisis support
- Pooled personal budgets and personal health budgets

Urgent care

- New emergency floor at LRI to ensure there is sufficient space to support the flow of "majors" and to offer dignified care and create a positive working environment.
- Improving system navigation by boosting NHS111, out of hours medical cover and local single point of access
- Increasing the availability of ambulatory care options
- Boosting the urgent out of hospital options for at risk patients;
- A "Choose Well" public campaign to help people to make the right urgent care choices.

Long term conditions

- Based around principles of "Education", "Prediction", "Care planning", "Ambulatory pathways", "Innovation", "Services available when required", and "Choices and plans at the end of life"
- Specific interventions include: integrated COPD team cover primary, community and acute care avoiding hospital admissions, including ambulatory care wherever possible.
- Exercise medicine to improving levels of activity, giving people access to integrated reablement services
- Workplace wellness proof of concept in UHL

Frail older people

- Primarily based on existing BCF plans
- Age well and Stay well: Introduce Unified Prevention Offer
- Risk stratification, Early diagnosis and referral, and the increase in the number of quality care plans
- Care Navigators, Local Area co-ordinators and the development of integrated pathways for Dementia.
- Clinical Response team, the Falls service, Integrated Crisis response
- Assistive technology.
- Good discharge planning and post discharge support

Note: End of life will be taken forward by a new workstream from November 2014

Clinical workstreams

The clinical workstreams have drawn on existing plans and newly developed interventions to set out a strategic direction

Planned care	Mental health	Maternity and neonates	Children and young people
• Implementation of PRISM system to improve referral quality • 40% left shift of acute activity into community • 10% of outpatient activity attendances will be decommissioned • 50% of out of county OP/DC repatriated to LLR (excluding City CCG). • Reviewing pathways for 18 specialties • Introduce non-face to face where appropriate • Full compliance with BADS • UHL OP and daycase elective care hub	• Strengthen prevention and self-help services to improve resilience • Implement Crisis House, step down beds, discharge team and changes to inpatient pathway to reduce out of county placements • Increased access to alternative services, for example through IAPT; • Reduce alternative health placements by 40%, • Providing more step-down support post-discharge, for example step down beds and crisis house facilities.	• Development of single obstetric unit at UHL • Maximise the uptake of midwifery led care options by promoting home births and midwife-led provision – the key system intervention is redesigning how community based midwife led services are delivered to ensure that there is a sustainable model for community based midwife care • Continue with the multi-agency programme to improve perinatal outcomes in Leicester. • Develop an integrated maternal mental health pathway	• Merger of Children's ED and CAU to become a single Ambulatory care unit and deliver Children's acute care provision from a single site • Increasing the provision of counselling and emotional health and wellbeing services to reduce the number of children escalating to tier 3 CAMHS • Reduce out of area placements • Redesigning the hepatitis B pathway to shift 100% of activity from to primary care • Develop options to deliver integrated provision

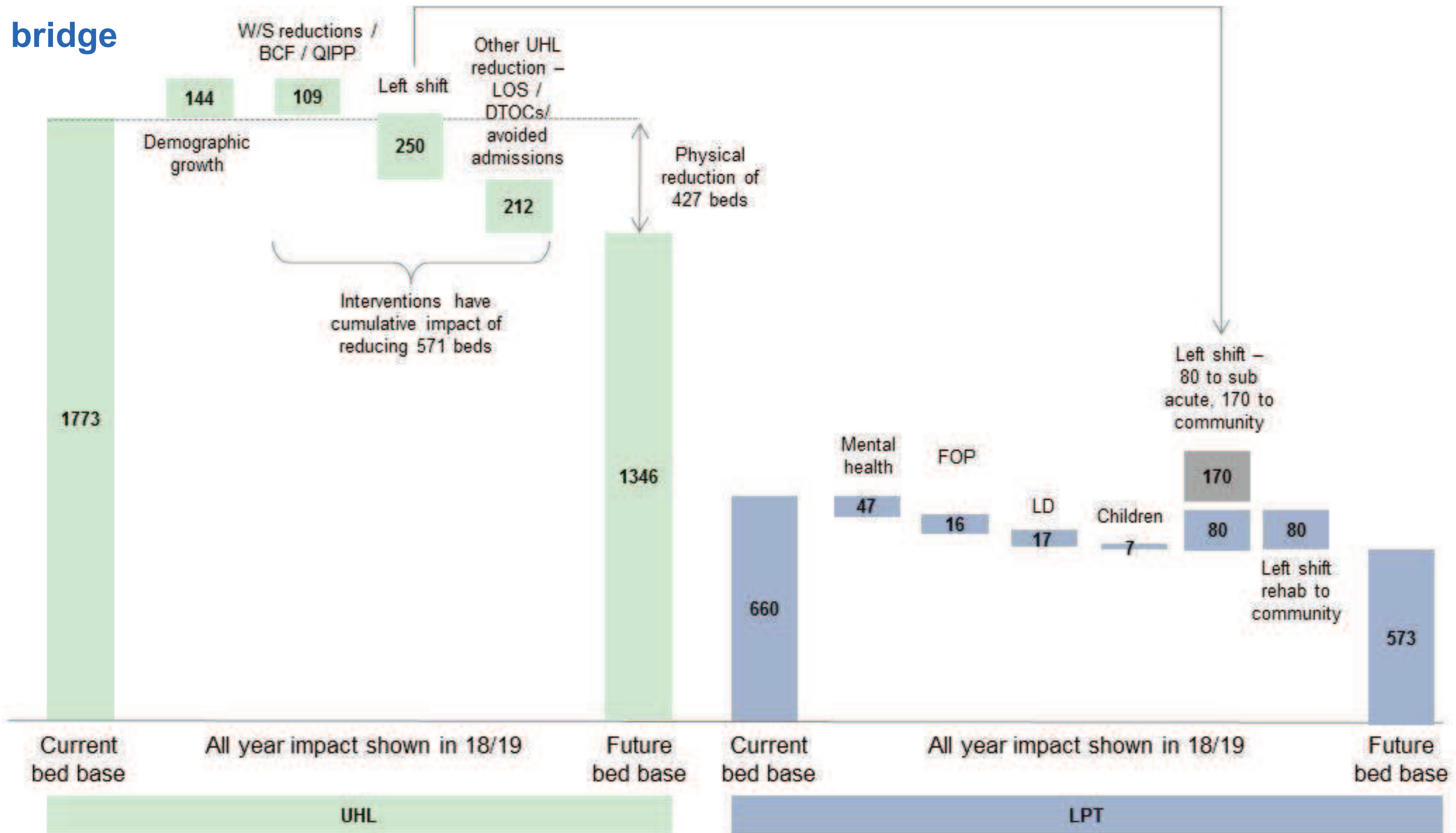
4
The impact on our providers

CONFIDENTIAL, DRAFT FOR DISCUSSION

The beds programme and left shift

Acuity reviews carried out by UHL and LPT have identified a significant number of patients who do not require treatment in an inpatient setting, and the workstreams are developing further interventions to provide better quality care in a community setting including home.

Beds bridge



UHL plans

Vision

"Overall Leicester's hospitals will become smaller and more specialised and more able to support the drive to deliver non-urgent care in the community. As a result of centralising and specialising services we will improve quality and safety… this will be done in partnership with other local health organisations and social care though the Better Care Together programme. We will save money by no longer supporting an old expensive and under used estate and we will become more productive."

Major service changes over the five years

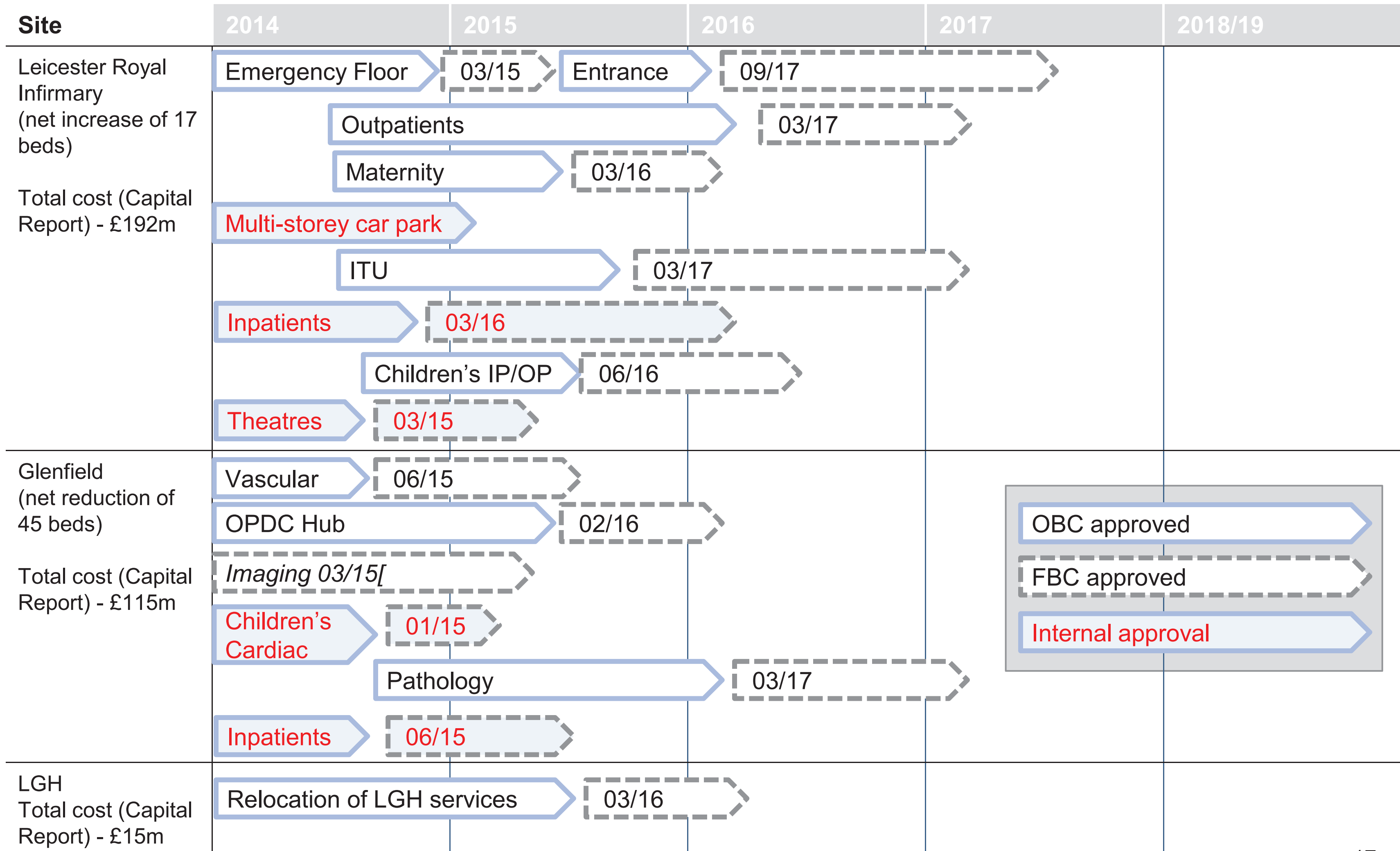
- New emergency floor
- Obstetric hub at the LRI
- OP/DC hub created
- Shift 40% of OP/DC to a non-acute setting

Beds programme

- The shift of activity to community settings involves the health economy taking actions that will reduce the need for 571 beds at UHL
- Once the additional growth expected in the system is taken into account this will require a physical reduction of beds at UHL of 427 beds

UHL plans – capital programme

UHL's financial recovery plan requires moving from 3 to 2 acute sites by 2019. The key business cases planned for UHL are laid out below:



LPT plans

Vision

"To improve the health and wellbeing of the people of Leicester, Leicestershire and Rutland by providing high quality, integrated physical and mental health care pathways".

Three major service programmes over 5 years

- Co-ordinated community health services - creating effective, more integrated pathways for frail older people and adults suffering from chronic conditions;
- Creating effective, more integrated pathways for children and young people; and
- Creating effective, more integrated pathways for adults with acute and enduring mental health conditions and those with complex learning disabilities.

Beds programme

- UHL and LPT have agreed that 250 beds worth of patients can be cared for outside of an acute setting. The **250** beds are broken down as follows:
  - **170** where patients can be treated by expanded community teams
  - **80** "sub-acute" beds, where patients need to be treated in an existing community hospital bed, with enhanced home care support.

LPT beds reconfiguration

The beds reconfiguration will take place over three phases

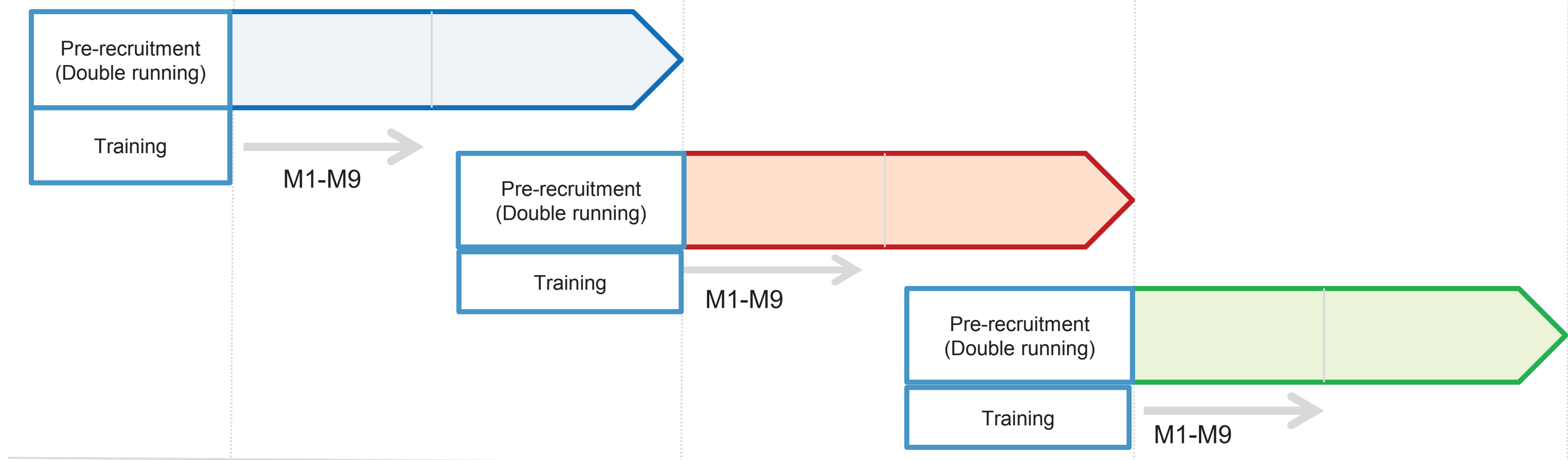
LPT have identified three separate phases:

The left shift will entail shifts as follows:

Phase 1:
24 Beds shift from LPT beds to LPT community;
36 Beds shift from UHL to LPT community
24 Beds shift from UHL to LPT Hospitals

Phase 2:
24 Beds shift from LPT beds to LPT community;
36 Beds shift from UHL to LPT community
24 Beds shift from UHL to LPT Hospitals

Phase 3:
34 Beds shift from LPT beds to LPT community;
96 Beds shift from UHL to LPT community
34 Beds shift from UHL to LPT Hospitals



Primary care plans

Key themes emerging for strategies across LLR

- Each CCG has developed a primary care strategy following wide engagement with GPs across LLR
- While each CCG is different – i.e. different geography, different populations, and different history – there is a common theme of collaboration across primary care to overcome workload pressures, offer accessible local alternatives to acute care, and to prevent illness or exacerbation.
- The core role of primary care will remain but there will be a range of additional services available to patients with the most complex needs

How the primary care model could change

- Any new model will require a broader range of clinical skills both within general practice and in the ancillary services.
- There will need to be more highly trained nurses and GPs with broader skills for both planned and complex care
- A significantly greater number of patients could be empowered to self-care
- Changes to the model of care will enable simplification and scale, reducing duplication and the need for as many non-clinical staff.
- This will create an opportunity for re-investment into new or differently skilled clinical staff to support the practices /hubs
- It may be possible to stop up to 10% of GP contacts by organising better and improving access to other health professionals, allowing GPs to focus their time on those patients who need them the most

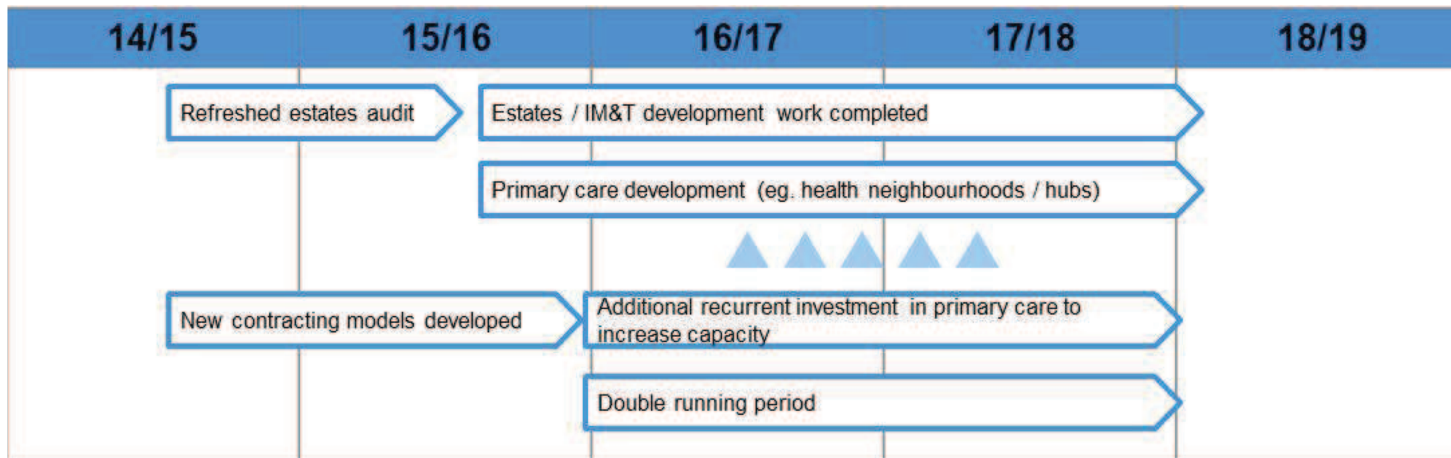
Primary care plans

Transformation plan

- The transformation plans set out for all three CCGs will require significant planning in order to significantly increase capacity. The below timeline sets out the expectations for how this development will be phased over the next 4 years:

Provisional timeline

64



External funding requirements

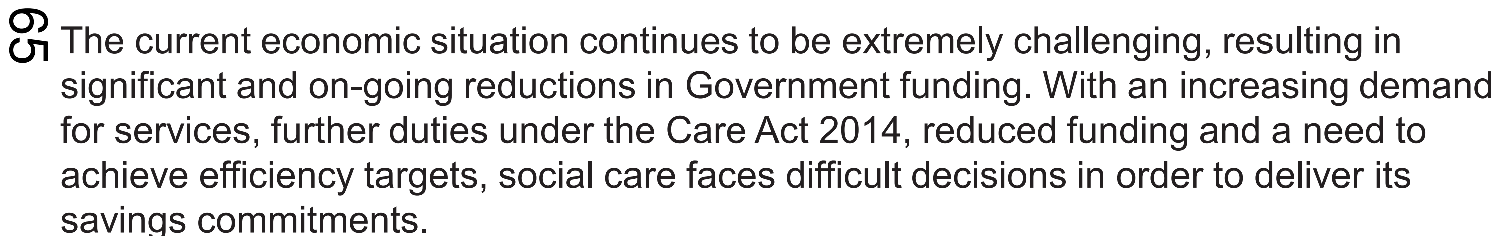
- CCGs have requested up to £46m for new capital projects to support the development of estate to make it fit for purpose in the future
- In addition to this it is expected that the development of new capacity will require a transition period where £15m of non-recurrent revenue funding will be required

Social care plans

Development of a social care strategy

Social Care is a critical element to the successful delivery of the Better Care Together programme. Working together, health and social care partners across LLR aim to provide integrated, high quality services, delivered in local community settings where appropriate, whilst improving emergency and acute care.
A social care strategy has been produced setting out a broad direction of travel, but highlights significant financial risk associated with delivery

Financial pressure



The current economic situation continues to be extremely challenging, resulting in significant and on-going reductions in Government funding. With an increasing demand for services, further duties under the Care Act 2014, reduced funding and a need to achieve efficiency targets, social care faces difficult decisions in order to deliver its savings commitments.

The Better Care Fund

Adult social care is contributing to the reduction in need for care through a clear integration agenda, and this is primarily being driven by the Better Care Fund. BCF services supporting this work are varied across the authorities and include:

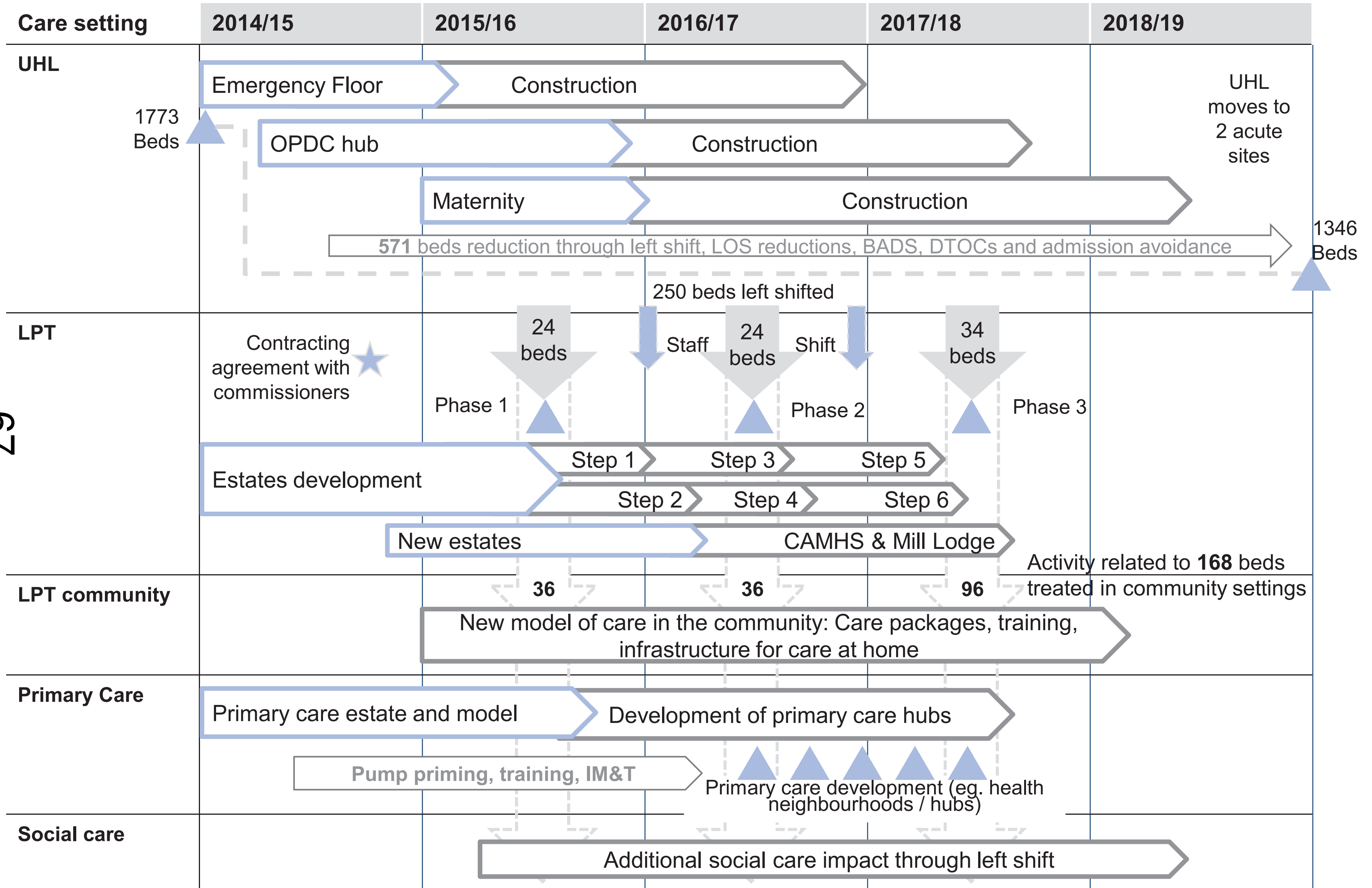
- Enhanced crisis services to avoid hospital admissions
- Support for assistive technology and equipment to reduce and delay need
- Proactive care management in aligned planned care teams
- Carer Support
- Care Navigators to focus on over 75s
- Early support for those diagnosed with dementia

Social care plans – interdependencies between health and social care

Financial impact of changes to health and social care services

- There is significant uncertainty related to the delivery of the BCT plan in respect of its impact on adult social care, particularly given the current funding environment.
- Over the next 5 years both health and social care organisations are facing significant financial pressures which will mean services need to be provided in different ways.
- Any changes made across health and social care will inevitably have an impact on each others' ability to provide corresponding services safely and in a sustainable way.
- Work has begun to make estimates to quantify this impact, and this has begun by reviewing the current beds programme. Provisional work has suggested that the financial cost to social care of treating these patients in the community could be around £5m, based on a weighted average of the current cost of care packages. This will only be one element of the joint impact of the changes taking place however this highlights the need for careful planning and coordination between the different services.
- Given the large amount of uncertainty surrounding the impact of the cuts to both services a joint programme of work is required to collectively ensure that potential disruption and risk is minimised.

Critical path for programme



5
Enabling change

Enablers – our plans for workforce and the estate

Workforce – ensuring LLR:

- Employs the right workforce with the right skills, in the right place, at the right time and with the right numbers;
- Employs a workforce with the appropriate values and behaviours;
- Collaborates to reduce vacancies and agency usage to deliver high quality, safe and patient focussed outcomes with appropriately skilled workforce;
- Develops an appropriate primary and community workforce to support the "left shift";
- Maintains and develops the acute and sub-acute workforce;
- Supports and develops appropriate education, training and workforce development to support social care (e.g. support local authority policies around carers, offering appropriate support, development and valuing the contribution).
- Is supported around improving Organisational Development – an additional £200k has been set aside in the funding requirements for the LHSCE

The estate – delivering:

- A smaller but more specialised acute estate, with consolidation of services onto two sites;
- An adapted community bed base reflecting the transfer of “sub-acute” patients from UHL to LPT;
- A hub and spoke model for the community estate;
- An adapted primary care estate which may include the development of hubs as well as the refurbishment of existing premises;
- A more efficient and better utilised estate;
- A smaller health care estate footprint.

Enablers – our plans for IM&T

IM&T – using technology to transform health and social care delivery:

- Transforming how care is delivered – IM&T is a powerful tool for automation and standardisation of processes;
- Transforming where care is delivered – IM&T can be used to reduce reliance on physical healthcare locations and minimise unproductive travel time for patients and practitioners;
- Transforming who delivers care – IM&T allows specialists to be present in multiple locations either directly through remote consultation facilities, or indirectly through protocol driven logic designed by experts or analytics-driven clinical decision support systems using the latest best practice guidance and research to give real-time advice;
- Transforming when care is delivered - e-mail and social network-type sites allow asynchronous communication removing the need for both parties to be available at the same time.

6
Delivery options

Delivery options appraisal

The economic appraisal

The economic appraisal conducts a qualitative and quantitative appraisal of the options to deliver the required transformation.

After discussion with stakeholders across LLR three initial listed options were developed:

1. Delivery through the BCT strategy
2. Delivery of financial balance through organisational efficiency alone (Do Minimum option)
3. Ceasing delivery of non-agreed services to regain financial balance

Each option was appraised against six investment objects and six critical success factors

Investment objectives	Critical success factors
Quality of Care out of Acute Hospitals	Business Needs
Reduction in Inequalities	Strategic fit
Improved Patient Experience	Affordability
Efficient delivery of Care	Achievability
Financial Sustainability	Impact on clinical quality
Developed workforce	Impact on access

Qualitative Appraisal of three Delivery options - results

Ref	Criteria	Option 1 – Better Care Together	Option 2 – organisational efficiency alone	Option 2 – ceasing delivery of non-essential services
IO1	Quality of Care out of Acute Hospitals			
IO2	Reduction in Inequalities			
IO3	Improved Patient Experience			
IO4	Efficient delivery of Care			
IO5	Financial Sustainability			
IO6	Developed workforce			
CSF1	Business Needs			
CSF2	Strategic Fit			
CSF3	Affordability			
CSF4	Achievability			
CSF5	Impact on clinical quality			
CSF6	Impact on access			
Assessment				

Delivery options appraisal continued

The BCT option was deemed to be the only viable way to achieve financial balance based on a qualitative discussion:

- Delivery of financial balance through organisational efficiency alone without working as part of system would require internal organisational savings programmes well above the level deemed sustainable
- In addition this would pose significant risks to the integrated working which has underpinned the programme so far
- Ceasing delivery of non-agreed services was also considered, however the impact on patient safety and the risks posed by an uncertain legal process were considered to be too great for the health and social care economy to take on.

Economic assessment on shortlisted options

- Given this qualitative discussion the **BCT programme** was economically assessed against the **"do minimum" option**.
- The do minimum option assumed that organisations attempted to make savings until such point as they were deemed to be unsustainable, at which point it was probable that an external party would place one or both local providers into an administration process
- This process adding further cost and delay to the decision to find a sustainable solution. The anticipated impact of this delay and additional uncertainty has been calculated in the economic case and the net present cost was compared against the BCT option, as below:

Costs/(Benefits)	RANK	14/15 (£m)	15/16 (£m)	16/17 (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)	Total (£m)
BCT Option	1	(31,566)	74,778	93,994	103,734	19,166	(78,422)	(66,711)	114,139
Do Minimum Option	2	(29,864)	84,072	101,811	106,875	16,677	(62,014)	(84,946)	132,610

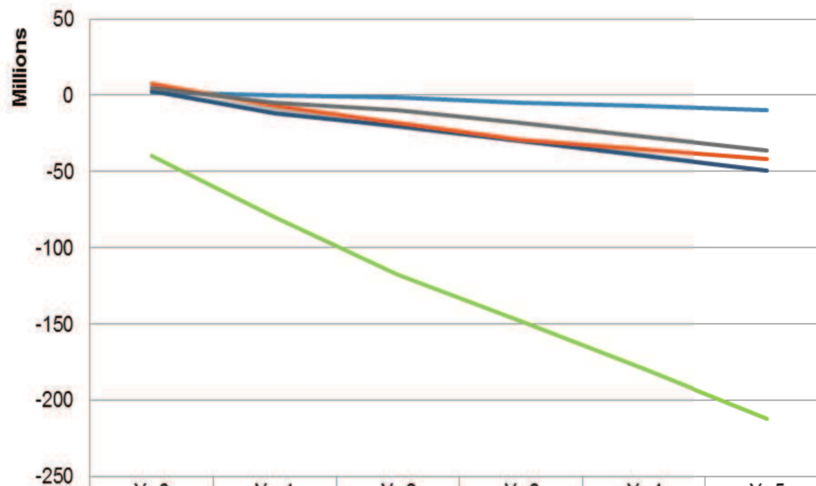
The economic case therefore concluded that the BCT programme had a lower net present cost than the next best alternative option and that this should be the preferred way forward for the health and social care economy. This remained the case after applying sensitivities.

7
Financial impact

The BCT Programme will address a £398m funding shortfall for LLR

Whole health economy modelling work undertaken alongside the 5 year strategy demonstrated the total gap between LLR income and expenditure in 2018/19 is £398m before any CIP/QIPP/ BCT interventions are modelled.

The gap cannot be closed by ‘general’ organisational savings of 3-4% p.a. alone.



	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Leicestershire Partnership NHS Trust - RT5	2,911,000	-9,636,734	-20,530,145	-30,043,441	-39,242,889	-49,231,090
University Hospitals Of Leicester NHS Trust - RWE	-39,794,000	-79,961,955	-117,137,721	-148,294,360	-179,203,169	-212,295,747
Leicestershire & Lincolnshire AT	1,937,000	164,556	-1,497,553	-5,147,624	-7,296,649	-9,482,978
NHS East Leicestershire and Rutland	3,045,862	-11,743,514	-20,273,471	-29,698,708	-39,297,623	-49,529,196
NHS Leicester City CCG	7,627,648	-7,198,785	-18,218,003	-29,323,088	-35,577,569	-41,615,324
NHS West Leicestershire CCG	4,929,504	-4,869,834	-9,687,867	-18,065,276	-26,867,994	-35,959,579

If BCT cross system initiatives, aligned and linked to organisation savings initiatives, deliver according to the initial plans, then the economy as a whole would deliver a **£1.9m surplus** in year five before the UHL reconfiguration benefits of £30.8m in year 6.

The programme requires **transitional** capital, revenue and cash support to deliver all required benefits

How the £398m gap will be delivered by 2018/19

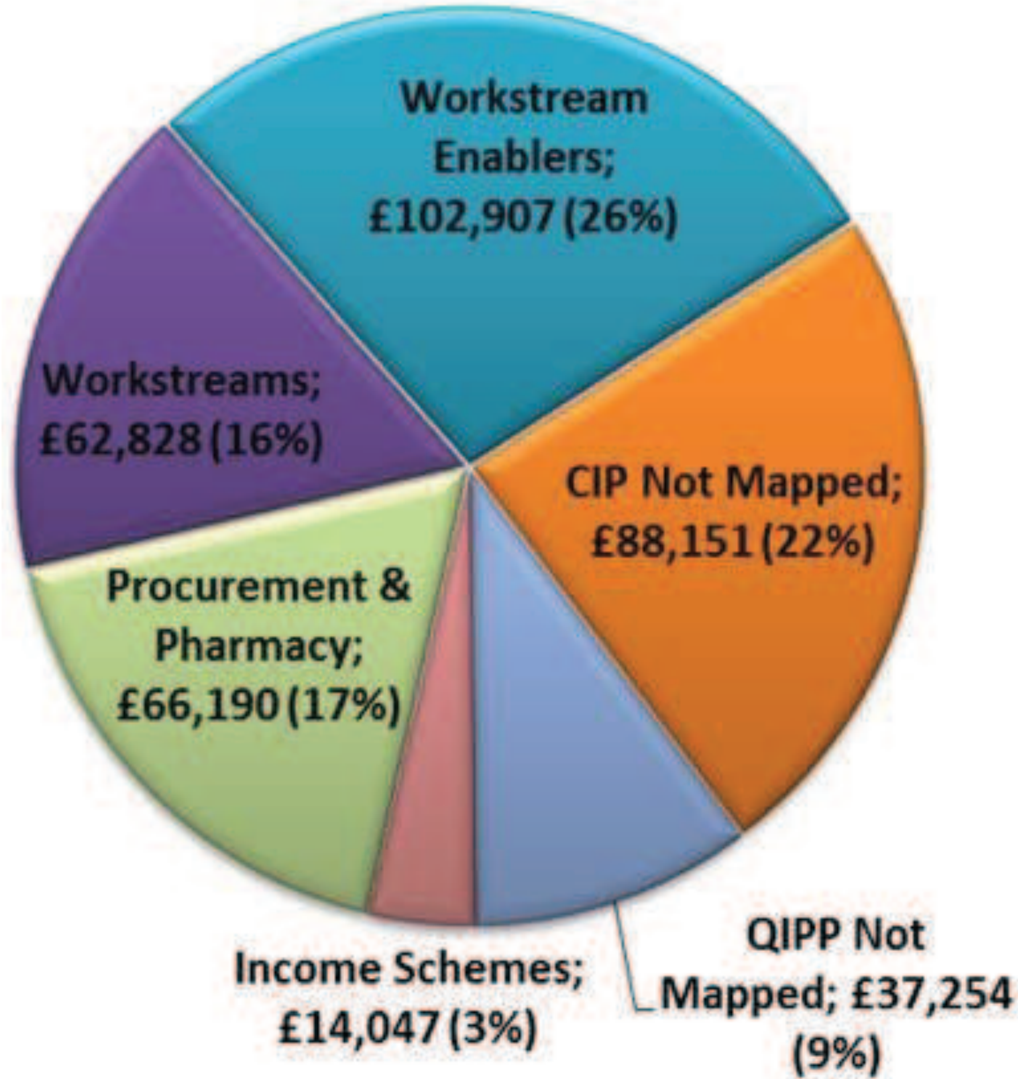
The following table sets out savings information provided by LLR organisations combined with the BCT workstream savings. Together these components describe 94% of the total 5 year opportunities. The balance is bridged by (a) additional workstream opportunities, identified but not yet developed into detailed initiatives; (b) CCG allocation growth believed to be higher than that modelled based upon NHS England's Five Year Forward View.

Further work is required to ensure that robust pan-health economy plans are developed to ensure all interdependencies and risks are mapped through and testing as to whether some of the proposals could be accelerated.

	Reported Savings @ Oct 14 (Cumlative)				
	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)
LD Pathways	0	316	1,225	1,609	1,859
MH Pathways	2,625	8,605	12,383	15,562	18,201
LTC Pathways	1,293	3,183	5,084	6,980	8,574
FOP Pathways	6,023	12,784	12,784	12,784	12,784
Urgent Care Pathways	1,852	2,407	5,014	6,512	7,362
Planned Care Pathways	3,105	6,443	8,571	10,700	11,731
Maternity Pathways	0	0	378	378	378
Children's Pathways	300	355	600	600	600
End of Life Pathways	892	1,338	1,338	1,338	1,338
Workstream Total	**16,090**	**35,431**	**47,377**	**56,463**	**62,828**
UHL-LPT Bed Reconfiguration	1,102	9,840	17,423	25,441	29,114
Estates	6,929	8,904	10,962	12,565	19,476
Workforce	12,886	24,358	36,386	46,158	54,317
Workstream Enablers Total	**20,917**	**43,103**	**64,771**	**84,164**	**102,907**
Clinical Income(Non-LLR)	250	650	729	807	884
Clinical Income (Non-NHS)	0	250	417	582	745
Other Income	2,178	4,738	7,298	9,858	12,418
Income Schemes Total	**2,428**	**5,638**	**8,444**	**11,247**	**14,047**
Procurement	4,904	10,222	15,836	21,432	27,019
Pharmacy	7,946	14,874	22,988	30,957	39,171
Procurement & Pharmacy Total	**12,850**	**25,096**	**38,824**	**52,389**	**66,190**
Total	**52,284**	**109,268**	**159,417**	**204,263**	**245,972**
CIP Not Mapped	**30,101**	**47,795**	**61,525**	**76,951**	**88,151**
QIPP Not Mapped	**7,273**	**14,052**	**17,240**	**20,480**	**23,617**
Disclosure Adjustment relating to model	**0**	**0**	**0**	**0**	**13,637**
Total	**37,374**	**61,847**	**78,765**	**97,430**	**125,405**
(Cumlative) Grand Total	**89,658**	**171,115**	**238,181**	**301,693**	**371,377**

This financial analysis set out above is shown separately as a pie chart overleaf.

Analysis of £371m reported savings



The programme requires transitional capital, revenue and cash support to deliver all of the required benefits

Capital Requirements: In addition to existing capital funds available, an extra £430.3m of capital investment is required to support existing and new capital developments.

The table below shows each organisation's projected capital spend and the external funding required where this is in excess of existing Capital Resource limits (CRLs)

The capital spend will predominantly drive the following major service changes in the system:

- UHL's complex capital programme to move from three acute sites to two
- LPT's Community Hospital Strategy to develop modern fit for purpose community hubs to support the changing model of care
- Primary Care development of existing and new estate in support of the transformation
- These estimates will require further testing

Org	Project	14/15 (£'000)	15/16 ('000)	16/17 ('000)	17/18 ('000)	18/19 ('000)	Total (£'000)
UHL	Total Requirement	46,530	120,221	125,672	117,834	72,121	482,378
	Use of capital resource limit	34,507	33,300	33,300	33,300	33,300	167,707
	External Capital Requirement (Gross)	12,023	86,921	92,372	84,534	38,821	314,671
	Receipts	-	-	-	-	28,350	28,350
	External Capital Requirement (Net)	12,023	86,921	92,372	84,534	10,471	286,321
LPT	Total Requirement	14,636	14,652	23,000	48,944	52,332	153,564
	Use of capital resource limit	14,636	10,908	12,608	10,108	10,108	58,368
	External Capital Requirement (Gross)	-	3,744	10,392	38,836	42,224	95,196
	Receipts	-	-	-	-	-	-
	External Capital Requirement (Net)	-	3,744	10,392	38,836	42,224	95,196
Primary Care	Total Requirement	-	4,625	13,875	13,875	13,875	46,250
Planned Care	Total Requirement	-	-	250	-	-	250
Urgent Care	Total Requirement	-	-	2,070	-	-	2,070
Long Term Conditions	Total Requirement	-	200	-	-	-	200
	External Capital Requirement (Net)	-	4,825	16,195	13,875	13,875	48,770
OVERALL	Total Requirement	61,166	139,698	164,867	180,653	138,328	684,712
	Use of capital resource limit	49,143	44,208	45,908	43,408	43,408	226,075
	External Capital Requirement (Gross)	12,023	95,490	118,959	137,245	94,920	458,637
	Receipts	-	-	-	-	28,350	28,350
	External Capital Requirement (Net)	12,023	95,490	118,959	137,245	66,570	430,287

The programme requires transitional capital, revenue and cash support to deliver all of the required benefits (continued)

Revenue/ Cash Requirements: In addition to existing revenue funds available, an extra £255.9m of non recurrent cash/ revenue investment is required to support the transition period during which services are changing.

Support Type	14/15 (£'000)	15/16 (£'000)	16/17 (£'000)	17/18 (£'000)	18/19 (£'000)	Total (£'000)
UHL Deficit funding	40,700	36,100	34,300	33,300	30,800	**175,200**
LPT revenue support	131	3,614	4,558	5,218	2,920	**16,441**
UHL revenue support	1,200	19,707	21,880	22,836	22,920	**88,543**
Work streams	376	5,045	2,176	438	272	**8,307**
Central PMO	1,539	997	997	997	997	**5,527**
Consultation Costs	0	200	200	100	100	**600**
Primary Care	0	4,500	6,000	3,000	1,500	**15,000**
Enablers	366	254	224	224	224	**1,292**
TOTAL REVENUE/(CASH) REQUIREMENT	**44,312**	**70,417**	**70,335**	**66,113**	**59,733**	**310,910**
Funded by						
Uncommitted CCG Transformation funds	0	3,280	3,484	3,684	3,885	**14,333**
Independent Trust Financing Facility (deficit support already applied for by UHL in 14/15)	40,700					**40,700**
Remaining External Funding Requirment	**3,612**	**67,137**	**66,851**	**62,429**	**55,848**	**255,877**
	44,312	70,417	70,335	66,113	59,733	**310,910**

The overall requirement of **£255.9m** shown above is net of £14.3m of local CCG transformation funds.

The revenue funding required by the programme will be used to support;

- UHL's remaining deficit funding (**£134.5m**) which would be required anyway
- Programme revenue costs (**£121.4m**)

8 Engagement

CONFIDENTIAL, DRAFT FOR DISCUSSION

Continuous engagement to ensure we meet needs and expectations

Our approach to engagement

Our stakeholders are well defined:
- patients, service users, carers and the Voluntary and Community Sector
- staff, practitioners and clinicians
- the public and communities
- political representatives, local government and regional administration
- LLR partner organisations

We have established formal links with the key stakeholder groups:
- Health and Wellbeing Boards
- Healthwatch
- the Patient and Public Involvement (PPI) Reference Group
- the Clinical Reference Group (CRG)
- Voluntary Sector

Equality and Diversity (including Equality, Inclusion and Human Rights)
This is built in to our plans for delivery and will be ongoing.

Formal consultation is being planned for commencement post-May 2015.

9
Governing and delivering the programme

CONFIDENTIAL, DRAFT FOR DISCUSSION

Approach to managing the programme

Our approach is based on:

- The Five Year Strategic Plan
- Direction from the LLR Partnership Board
- The Office of Government Commerce (OGC)'s guidance on best practice

The Five Year Strategic Plan has led to the SOC and the PID.

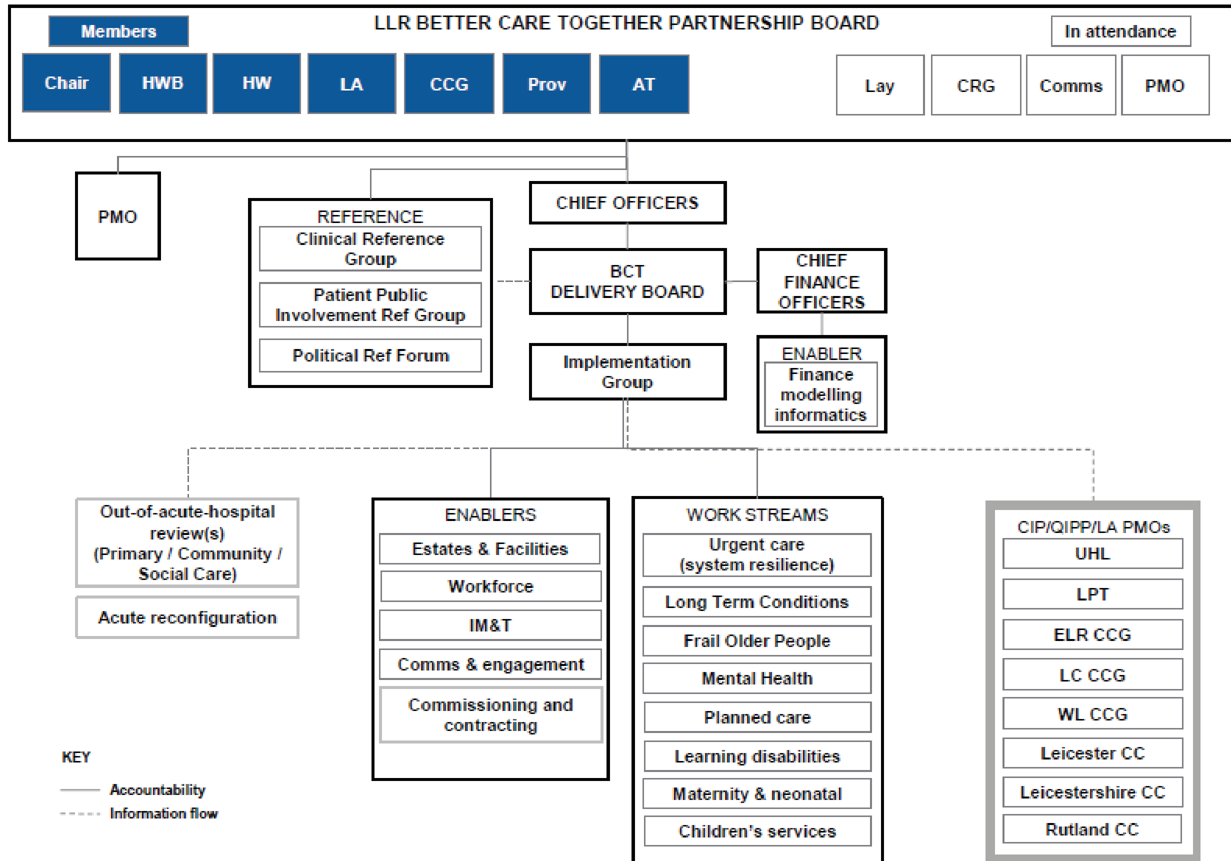
Ultimate accountability for the success of the Programme lies with the LLR Partnership Board. The Partnership Board will meet in public from January 2015.

The BCT Delivery Board, under the joint SROs, will oversee delivery of the Programme on behalf of the Partnership Board.

The Programme Director will manage the Programme, day-to-day, on behalf of the joint SROs.

The Programme will be coordinated and synchronised by the Programme Director, supported by a LLR Programme Management Office (PMO).

Programme governance structure



Overall OBC/FBC approval timeline
(re major schemes subject to public consultation)

August – October 2014	Nov – Dec 2014	Jan – June 2015	July-Oct 2015	Nov-Dec 2015	Jan-June 2016	2016-20

Programme

1. Programme Strategic Outline Case (SOC)

Sets out the:
- Clinical / Strategic case
- Financial case
- Management case
- Economic case
- Commercial case

2. Agreement in principle

High level funding agreed:
- Acute provider
- Community provider
- Primary care

3. Development of pre-consultation business case (PCBC)

Outline the options associated with each area of proposed service change, with a preferred option indicated by the LHE

4. Public Consultation

Consultation for *Better Care Together* initiatives– multi-organisational, covering all acute and out of hospital proposed changes

5. Decision making business case (DMBC)

Pulls together outcomes of consultation process

Sets out the case for individual investments:
- *CCGs / UHL / LPT*
- *LAT*

Plans put into place

Commissioners

6. OBC / FBC development

Providers

6. OBC / FBC development

7. OBC/ FBC Implementation

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10
Next Steps

Next steps

- Agreement of PID and SOC at each local Governing Body
- Submission of SOC to NHSE/TDA
- Workstreams to be fully mobilised and commence implementation
- Detail work up of primary and social care to commence
- Joint Programme SROs to:
  - establish timescales and approval requirements for external support and evaluate the consequences of not securing this support
  - clarify decision making authority and a scheme of delegation
  - ensure the further development of clinical leadership and engagement
  - review workforce plans to mitigate risks and prioritise actions
  - consider current contractual arrangements
  - determine the scope and strategy for consultation
  - review the risk management process work and ensure it is embedded into day to day programme activity

Appendix D

LEICESTER CITY HEALTH AND WELLBEING BOARD
11th DECEMBER 2014

Subject:	Funding Transfer from NHS England to Social Care 2014/15
Presented to the H&WB by:	Elaine McHale/Sue Lock
Author:	Michelle Iliffe / Rod Pearson

EXECUTIVE SUMMARY:

In previous years the Department of Health has provided funding via Primary Care Trusts for 'Joint Working' between the NHS and Social Care. Prior to April 2013, the use of this funding in Leicester was subject to agreement between Leicester City Primary Care Trust and Leicester City Council. Since the implementation of the NHS Reforms and the abolition of Primary Care Trusts in April 2013, this funding will now be provided to Leicester City Council directly from NHS England. However, the use of the funding is still subject to local agreement between each local authority and their respective Clinical Commissioning Group.

In Leicester, the plans for the use of funding for 'Joint Working' were originally agreed in September 2011 and the original plans have continued to inform the use of this funding in subsequent years. The attached plan for 2014/15 has been agreed by Leicester City Council and Leicester City Clinical Commissioning Group.

In order to release the funding in Leicester, the following governance rules need to be adhered to:

- A joint, NHS Leicester City CCG and Leicester City Council Adult Social Care, plan on the use of the funding and the agreed monitoring arrangements to be presented at the Health & Wellbeing Board. This is attached.
- Memorandum of agreement Section 256 is appended to this plan (see Appendix 1) which will be signed by respective authorities once the H&WB approves the plan.
- Once we have gathered all the above documents, this will then be sent to NHS England Finance Allocations Team and the transfer of the funding will be made.

RECOMMENDATIONS:

The H&WB is requested to:

- Approve the attached joint plan.

Joint NHS Leicester City Clinical Commissioning Group and Leicester City Council Plan to support the Funding Transfer from NHS England to Social Care – 2014/2015

Proposal Title	Support for Joint Working		
Organisation	Leicester City Council	Sponsor	Deb Watson
Contact for queries	Ruth Lake Tracie Rees	Tel no	0116 - 4544551 0116 - 4542301
Amount requested	2014/2015: £5.902m		
State transformation fund category Redundancy costs Pump priming Capital expenditure Double running costs		Quality and Equality impact assessments **must** be attached.	

1. Objectives of the proposal - outline why you wish to undertake the work and what you think it will achieve in terms of benefits. How does it align with organisational (your own or the wider health economy's) cost improvement plans?
The following proposals support the direction of travel for Adult Social Care, in terms of ensuring the authority does not have to reduce its Fair Access to Services (FAC's) criteria from substantial and critical to critical only. If this did happen then it would create significant additional pressure on health services, both acute and community. The money would also be used to support the prevention and early intervention agenda, in terms of funding more Assistive Technology and Telecare initiatives. As dementia is also a key priority for the Council, the money would also be used to support the delivery of the LLR wide Joint Dementia Strategy, which also benefits the wider health economy.

2. Detail the proposal specifically including application of requested funds. Is this proposal capable of being scaled down if the total funds are not available?
Proposal One: £2,719k to help maintain eligibility criteria *Leicester City Council operates within national eligibility criteria, with thresholds set at substantial and critical. This is consistent with the majority of local authorities. Authorities are required by law to set their thresholds according to their available resources. Once set, all people with eligible needs are legally entitled to support, regardless of whether resources are in fact available.* *Adult social care (ASC) is shifting its assessment processes deliver a systematic Resource Allocation System (RAS), in line with national transformation requirements. ASC has a contingency budget for meeting the needs of people where support costs exceed the RAS allocation. Due to reductions in base budgets the available resources through both RAS and contingency will not be sufficient to meet all assessed need. Reducing eligible need (i.e. reducing the numbers of people who receive support) can be achieved via a tightening of eligibility. A number of Councils have / are considering raising the threshold. For Leicester, this would mean restricting eligibility to critical only. This would create significant additional pressure on health services, both acute and community. For example, many individuals that are currently supported out of hospital with care packages would be reassessed at the point of discharge and deemed ineligible. This would impact on acute care costs and efficiency. A number of people in receipt of community care packages receive support with delegated health tasks that are provided within a health*

and social care protocol - such as medication management – by social care services. Were these people to become ineligible for social care support due to a rise in thresholds, this support would cease, creating significant additional demand for community health services. There is the additional cost of crisis as a result of the lost social care support at the substantial level of eligibility.
In order to mitigate pressure to change thresholds to live within the available resources, transferred funding will be used to maintain people with substantial and critical needs, whilst ASC undertake its wider transformation programme, intended to reduce costs of care for the longer term.

Proposal Two: £100k for Dementia Care Advisors
Nationally and locally the prevalence of Dementia is increasing (the number is estimated to increase by 48% across LLR by 2025). It has been recognised that early diagnosis, and appropriate services and support to carers can reduce the impact on health and Adult Social Care services, including the acute sector. For example people with a dementia over 65 years are currently using up to one quarter of hospital beds at any one time (Alzheimer's Society 2009). Therefore, the use of community facing Dementia Advisors (4 posts) can support people to seek appropriate diagnosis, including memory assessment clinics to reduce the impact of the condition at potentially an earlier stage to reduce the long term implications for both health and social care services. This would include people not eligible for Adult Social Care support and their carer's, by reducing the likelihood of crisis situations occurring if support and information relating to preventative services and respites was readily available. It is proposed that the Single Point of Access and each of the three locality teams across the city will have a Dementia Care Advisor to support local need. This will be a key preventative initiative and long term, if needed staff within ASC will be re-organised to ensure that this service will continue.

Proposal Three: £300k for Prevention
Investment in preventative services underpins ASC strategy to longer term financial balance and to greater choice and control for individuals. However this is difficult to achieve without pump priming to enable development particularly within the voluntary and community sector (VCS). Often opportunities can be seen to develop services that support and divert away from statutory care provision, but small providers cannot bear the up-front risk or investment. This proposal is to invest up front resources in a range of small initiatives, that support market development, subsidise services that promote self-care and wellbeing and to fund services that deliver reductions in demand for formal care.

Proposal Four: £300k for Community Equipment
The use of community equipment enables people eligible for ASC services to remain independent with relevant aids and minor adaptations. Choice and control underpins the direction of travel for ASC, and the provision of community equipment supports this approach. For 2011/12 the City Council allocated £400k to fund community equipment across all client groups; however the estimated outturn for this financial year is over £700k. With increased demand, which has been stimulated by greater awareness of its use as a preventative measure, it is likely that demand will continue to increase, however it provides a benefit to ASC and health with less people needing higher cost care. Therefore, the extra monies will cover the shortfall to the ASC budget for the next 2 years, beyond this date resources will be moved to enable this service to continue to support the prevention and early intervention agenda across health and ASC.

Proposal Five: £306k for additional capacity for re-assessments
ASC supports approximately 8000 individuals. Their individual support plans need to change, both to deliver personalisation and in order to reduce the cost of care and therefore achieve financial viability into the future. ASC has a transformation vision, premised upon maximising independence, creating financial efficiency through greater choice and control and through direct payments which give greater purchasing flexibility. To do this, ASC must reassess individuals and redesign their existing support plans. Although ASC undertakes regular reviews of individuals, the capacity and time required to complete in-depth reassessments and to work with individuals to access new types of services is considerably greater than completing a routine review. This funding proposal will support some of the additional resources required to complete this work expediently. A targeted team of staff will focus solely on this task, to ensure that its focus is not reprioritised in the context of other demand such as safeguarding or emergency assessments. This will allow ASC to release resources tied up with individual care plans and to recycle those into the RAS pot, thereby reducing the risk of having insufficient resources in the future and pressuring eligibility thresholds (please reference proposal 1)

Proposal Six: £250k Dementia in Care Homes

One of the key priorities of the LLR Joint Dementia Strategy relates to the need to improve the quality of service provision of residential and nursing care across the independent sector providers. The monies will be used to develop a Quality Assurance Framework (QAF) that reflects the quality requirements for people suffering from a dementia for both adult social care and health to ensure a consistency of approach. There, is also a need to provide training for staff (including contract monitoring officers) to ensure they are able to implement the QAF, which in turn will reduce safeguarding incidents. It is also important to give support to providers to ensure they are equipped to recognise the needs of people in their care with a dementia, and the extra resources will support the development of a provider improvement programme. It is also the intention to invest in a temporary resources for 6 months (co funded with Leicestershire Council) to map out the care pathway for people with a dementia and carer's, in order to re-align spend against the priorities of the Joint Dementia Strategy.

Proposal Seven: £200k Assistive Technology

Please see proposal eight, which explains the benefits of Assistive Technology (AT) and Telecare. For the purposes of this document Telecare covers Assistive Technology and Telecare. Assistive Technology is stand-alone equipment that is not connected to an alarm/sensor system. For example, this type of AT could be medication dispensers, calendar clocks, picture phones, night lights etc. These items cost on average between £20 and £60 and as one off items can prevent the need for domiciliary support and residential care.

Proposal Eight: £200k Telecare

Uniquely among care and support interventions, telecare can prevent or delay both the need for care, and the financial and personal costs of care provision:
Telecare can prevent or delay the need for more complex interventions or deterioration in a person's condition;
Telecare can be a more cost effective option for meeting care needs, potentially reducing the need for formal care;
Telecare can also reduce the burden on informal carers.
Telecare and Telehealth has also been shown to improve the quality of life of users, providing reassurance, peace of mind and a monitoring system for health conditions. An example of Telehealth would be a monitoring system for heart conditions, where the individual will measure their heart rate on a daily basis and the result are then be fed into a health IT system for the clinician to monitor.

Telecare/Telehealth is the remote monitoring of emergencies and lifestyle changes over time in order to manage the potential risks associated for individuals with care and support needs living independently in their own home.
Telecare enables earlier interventions in the event of complications for users, whilst also assisting them in their re-ablement following an incident. Telecare consists of various sensors placed around the home linked to a system that allows the user to be supported by an external monitoring centre 24 hours a day, 365 days a year. Telecare devices typically cost between £100 and £500, and remote monitoring services may cost as little as £5 per week per person.

An national evaluation in 2008, identifying what a traditional, non-telecare package of care would have cost if telecare were not being used found that 46% of the traditional packages would have been in residential or nursing care, and 64% of the traditional packages would have been at home. The evaluation found that among those who would have received more than 10 hours home care, there was a reduction in the number of hours needed. It was calculated that the net average annual efficiency per telecare user was between £12,246 and £1,756, averaging at around £3,600 across the county, which represented a 38% reduction in typical care package costs. This is a substantial saving for social care but equally for health whilst the development of Telehealth is in its early stages, there is evidence to prove equipment prevents the need for, visits by clinicians and, admissions to hospitals.

Proposal 9: £1,527k Intermediate Care Services

Leicester City Council will provide a comprehensive intermediate care service to people who are otherwise at risk of admission to hospital or to facilitate their discharge. This service provides direct care (personal and domestic support), therapy support and equipment provision and care management (assessment) activity to ensure people are provided with suitable services both during and after a period of intermediate care. This service directly contributes to the priorities for the NHS, in reducing emergency admissions, reducing delayed transfers and avoiding readmissions.

3. Describe the scope and scale of the impact of the proposal in terms of numbers of patients/staff/resources affected, what is included and what is not. Note the key stakeholders whose support is required. Is any public or staff consultation required?
These proposals are wide reaching, impacting on all people who use ASC (approx. 8000) and by association their carers. Key stakeholders in the delivery of these proposals are people using services, staff, VCS, local health services, elected members. The direction of travel that underpins these proposals has been consulted on at a national level and in local consultations for example with the VCS; no further local consultation is required for delivery.

4. Give a clear timetable for proposed actions and for delivery of results and outline how the proposal will be managed and monitored within the organisation

No.	***Project Name***	***Implementation timescale***	***Lead Officer***	***Monitoring Arrangements***
1	*Maintain Eligibility Criteria*	*Immediately – will form part of the RAS*	*Ruth Lake*	*Monthly reports, which are presented to the Senior Management Team, including the DASS (Deb Watson) to give assurance that only packages of care are being approved that support people who are either substantial or critical. This in turns forms part of the quarterly budget monitoring process, which is presented to the Councils Cabinet for approval.*
2	*Dementia Co-ordinators*	*Immediately*	*Ruth Lake*	*Performance will be monitored by the LLR Commissioning Board, which in turn will be reported to the various Cabinets and CCG's*
3	*Prevention*	*Immediately*	*Tracie Rees*	*Spend with be monitored on a monthly basis, including the reduction of care packages to demonstrate that preventative services reduce costs long term.*
4	*Community Equipment*	*Immediately – the money will be used to cover the shortfall in the budget for 2011/12*	*Tracie Rees*	*Spend is already monitored as part of the Community Equipment Contract with NRS, to ensure that only relevant cases receive assistance in line with the policy criteria.*
5	*Assessment Resources*	*Immediately*	*Ruth Lake*	*Numbers are monitored on a weekly basis and outcomes reported to the Senior Management Team on a monthly basis. The financial performance is also monitored on a monthly basis.*
6	*Dementia in care homes*	*Immediately*	*Tracie Rees*	*Performance will be monitored by the LLR Commissioning Board, which in turn will be reported to the various Cabinets and CCG's*
7	*Assistive Technology*	*Immediately*	*Tracie Rees*	*Spend with be monitored on a*

				monthly basis, including the reduction of care packages to demonstrate that preventative services reduce costs long term
8	*Telecare*	*Immediately*	*Tracie Rees*	*Spend with be monitored on a monthly basis, including the reduction of care packages to demonstrate that preventative services reduce costs long term*
9	*Intermediate Care*	*Immediately*	*Ruth Lake*	*Spend and activity outcomes will be monitored on a monthly basis. This service directly contributes to the priorities for the NHS, in reducing emergency admissions, reducing delayed transfers and avoiding readmissions.*

5. Detail how the proposal will contribute to recurrent increased productivity, cost efficiency and quality. In particular detail any effect on recurrent costs in 2012/13.

The proposal is a mixture of new investment and offset funding against pressures in social care. Failing to provide services to people with substantial needs would bring about deterioration in their wellbeing and independence, with consequences for both health and social care services. Additional investment in preventative services, AT etc. will help to mitigate the increasing demand for health services and social care. It will reduce longer term costs by developing an infrastructure that supports people with lower levels of need quickly and effectively.

6. Detail the risks to the proposal and how they will be addressed; in particular what assumptions have you made and are there any dependencies on other work?

The key risks will be to ensure there are robust governance arrangements are in place to manage relationships and achieve key milestones between respective partners from different disciplines. For Adult Social Care this will comprise of working closely with UHL, GPs and Leicester Community Health Services.

7. List the key success criteria, and for each one provide suggested indicators (KPIs) which can be used to assess delivery and state how and when they would be measured.

Proposal One
Eligibility threshold is maintained with sufficient resources in 11/12 and 12/13 to meet eligible need.
KPI – No. of people in receipt of Council-funded services / Personal Budget

Proposal Two
Individuals with dementia and their carer's have access to advice and information
KPI (Previous National Indicator 135 still used by the local authority) No. Carers receiving needs assessment or review and a specific carers service or advice and information

Proposal Three
Individuals and carers having greater choice and control
KPI (Previous National Indicator 130 still being used by the local authority) Proportion of people (including carers) using social care who receive self-directed support, and those receiving direct payments

Proposal Four
People are supported to live in their own homes with appropriate provision of equipment to aid their independence

KPI – No. of people enabled to live in the community through the provision of community equipment

Proposal Five
Individuals requiring a reassessment in order to change service patterns receive one during the period
KPI – No. of people in target groups who are reassessed
PAF D40 – Clients receiving a review in the year

Proposal Six
Safeguarding training provided to ASC staff and to Providers
KPI – No. of Adult social care staff trained in the year
Number of Non-council staff trained in the year

Proposal Seven & Eight
Individuals are supported in cost effective ways with the provision of AT / telecare, reducing care costs and crises.
KPI – No. of people in receipt of AT / telecare

Proposal Nine
This investment will lead to reduced hospital admissions, delayed transfers of care and hospital readmissions.

The above key performance indicators form part of the monthly monitoring for adult social care services, which are discussed on a monthly basis with the DASS. This in turn forms part of the Councils quarterly monitoring information that is presented to Cabinet.

8. Exit strategy

The future funding of the schemes will be integral to the work that will be undertaken to form local plans for the use of monies that will come from the Better Care Fund (former Integration Transformation Fund).

Appendix 1

Memorandum of Agreement
Section 256 or 257 transfer

Reference number: 2014/15 Social Care Allocation

Title of Scheme: Funding Transfer from NHS England to Social Care – 2014/15

1. How will the section 256 or 257 transfer secure more health gain than an equivalent expenditure of money on the National Health Service?

2. Description of scheme (in the case of revenue transfers, please specify the services for which money is being transferred).

Financial details (and timescales)

3. Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed).

Year(s)	Amount	Capital	Revenue
2014/15	£5.902m	N/A	£5.902m

In the case of the capital payments, should a change of use outlined in direction 4(1)(b) of the National Health Service (Conditions Relating to Payments by NHS bodies to Local Authorities) Directions 2013 occur, both parties agree that the original sum shall be recoverable by way of a legal charge on the Land Register as outlined in direction 4(4) of those Directions.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 and 2 have been secured.

Signed: ……………………………………for the NHS England

……………………………………………… Position

……………………………………………… Date

Signed: ……………………………………for the Local Authority

……………………………………………… Position

……………………………………………………………… Date

Section 256 or 257 Annual Voucher
Leicester City Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2015
(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Expenditure Project	Revenue Expenditure	Capital Expenditure	Total
	£5.902m	£0	£5.902m

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme approved by the ……………………………………… Clinical Commissioning Group in accordance with these Directions.

Signed: ……………………………………………………

Date: ………………………………………………………

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions).

Certificate of independent auditor

I/We have:

- examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ………. and

- carried out such tests and obtained such evidence and explanations as I/we consider necessary.

(Except for the matters raised in the attached qualification letter dated)* I/we have concluded that

- the entries are fairly stated: and
- the expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature ………………………………………………. .

Name (block capitals) ………………………………… .

Company/Firm ………………………………………….

Date …………………………………………………..

* Delete as necessary

Leicester City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD

DATE 11 December 2014

Subject:	**Joint Specific Needs Assessment on Mental Health in Leicester**
Presented to the Health and Wellbeing Board by:	**Rod Moore, Acting Director of Public Health**
Author:	**Mark Wheatley**

EXECUTIVE SUMMARY:

1. Summary

This Joint Specific Needs Asssessment (JSpNA) is based on information gathered from a wide range of evidence and key stakeholders and overseen by a Mental Health JSpNA Steering Group. The contributors are listed on the acknowledgement pages 27 and 28.

The first draft of the needs assessment was put on the JSNA webpage for comment in May 2014 and a consultation event, attended by local voluntary and community sector organisations was held on June 18th 2014. Specific views were gathered at separate meetings with stakeholder groups, including those concerned with children and adolescents, transgender people, students, asylum seekers and refugees and homeless people.

Attention is drawn to the attached two summaries, which form the beginning of the Needs Assessment. The full needs assessment is available at www.leicester.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=511401

2. Structure

The JSpNA takes a life course approach to mental illness, beginning with perinatal mental health, followed by children, adolescents, students, adults of working age and older people. There are chapters on special topics of interest, mental health promotion, suicide and dual diagnosis. A chapter on equalities looks at the mental health of black and minority ethnic groups, asylum seekers and refugees, carers, lesbian, gay, bisexual and transgender people, homelessness, and people with learning disabilities. Veterans are also considered.

The document has a one page executive summary (p.3) and a summary of findings and recommendations (pp.5-18).

3. Findings and recommendations

The JSpNA shows that Leicester has high rates of risk factors for poor mental health. Access to services is often poor, and recovery is often worse than the local or national averages.

The Assessment sets ways in which health and social care may work together to address these issues.

Commissioners should find opportunities to deliver a joint health and social care approach to mental health and wellbeing across all areas of health care. Future commissioning should focus on:

- protecting the mental health of children and young people
- prevention of mental illness and promoting wellbeing
- population mental health
- early intervention
- personalisation and social care

The aims of a joint approach to commissioning health and social care should be to develop system wide thinking, multi-agency provision of mental ill health services and ensure that mental wellbeing underpins traditional universal services.

Most health care commissioning focuses on services at specialist level mental health services, whist most people with mental illness are treated in primary care. It is vital, therefore to ensure that commissioners of mental health and social care in Leicester improve the capacity and capability of community and primary care services to meet mental health care needs, as well as improving more specialist services.

4. Use

The needs assessment has already informed the Better Care Together Mental Health workstream. It is currently being used as the basis for the development of the Joint Health and Social Care Commissioning Strategy for Mental Health.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Receive the Joint Specific Needs Assessment on Mental Health in Leicester;
- Promote its use in shaping strategic intentions and defining specific commissioning activities to improve mental health in the city.

Appendix

Executive Summary

Mental illness is the largest single cause of disability in the UK. Leicester has high rates of risk factors associated with mental illness, improving rates of diagnosed mental health problems. The rate of emergency care use for mental illness is high, but recovery is poor. The rate of death from suicide and undetermined injury is stable, but higher than the England average. Whilst most mental illness is treated in primary care, most commissioning focuses on secondary care. In addition to improving secondary care commissioners should meet mental health need, and establish parity of esteem with physical health, by developing the capacity and capability of non-specialist resources.

Mental health promotion	Mental health is everyone's business. Policies to improve the economy, education, environment and transport, as well as health and social care, can contribute to mental wellbeing. 5 Ways to Wellbeing is an important initiative. More investment is needed for mental health promotion.
Perinatal maternal mental health	Moderate to severe depressive perinatal maternal mental illness affects 150-250 women in Leicester each year. Resources available to help women include universal and specialist outreach services. The closest in-patient mother and baby unit for perinatal mental illness is in Nottingham. Better use of universal services will help women and families.
Children and adolescents	Most mental illness results from childhood experience. 3,500-5,000 children have mental illness in Leicester each year. Statutory and voluntary providers work with specialist CAMHS. Protecting childhood mental health now will sustain future mental wellbeing. Commissioners should to develop joint frameworks to ensure better use of non-specialist resources. Services should target the vulnerable; those in deprived areas and looked after children.
Students	There are 35,000 students in Leicester. Mental illness can negatively impact on study and have long term effects. Universities offer specialist mental health support and counselling. Local GPs, IAPT, PIER team and the voluntary sector offer support. Strategic support is required to develop student mental health services.
Working age adults	A GP with 2,000 patients would expect to treat 50 people with depression, 10 people with a serious mental illness, 180 people with anxiety disorders and a further 180 or so with milder degrees of depression and anxiety. Adult mental health care is based on a stepped care model and includes Open Mind IAPT, Community Mental Health, Access and Complex Care Services. Voluntary and Community Sector organisations provide essential support. Commissioners should develop services in primary care and the community to sustain mental wellbeing and to support people with mental illness. Commissioners should work with service providers and other partners, such as the Police and voluntary sector to develop crisis care provision.
Older People	As people live longer so mental illness in old age is becoming more of a problem. Depression is the most common mental disorder in later life, affecting 3,000-4,500 older people in Leicester; Schizophrenia affects about 1% of the older population. Dementia, delirium and substance misuse are also linked with poor mental health in older people. Mental illness in old age is affected by deprivation, bereavement, isolation and physical illness.
Equalities	Mental illness disproportionately affects minorities, but these groups have difficulty accessing appropriate care. Although services, such as Assist, Inclusion Healthcare and Open Mind IAPT have improved treatment for minorities, more services are needed to sustain mental wellbeing, improve access to specialist therapy and reduce Mental Health Act detentions. Commissioning must also meet the needs of those with learning disability, veterans and carers.

Suicide	In Leicester about 32 people take their own lives each year; the second highest rate in England. Most deaths are from hanging or overdose. Most at risk are males aged 35-54. There is a need for real time surveillance of information to enable better review and response to suicide.
Offenders	Prisoners and offenders have high rates of mental illness compared with the general population. IAPT and the Probation Trust work together to provide better access to mental health care. Local and specialist commissioners should learn from this model, to work together to improve mental healthcare for prisoners and offenders.
Dual Diagnosis	There is an association between mental illness and substance misuse. Mental health services should take the lead in treating people with dual diagnosis.

Key Findings and Recommendations

The aim of this section is to present the key findings and recommendations from each chapter in the Joint Specific Needs Assessment (JSpNA). The JSpNA on mental health in Leicester is an evidence based resource for local policy makers, providers and commissioners. It identifies key issues and, rather than providing an action plan, it sets the agenda for improving local mental health and wellbeing.

The findings and recommendations suggested in the JSpNA aim to increase individual and community resilience to protect against mental illness and to increase individuals' control over their own lives. They offer suggestions which may help to integrate mental health and social care, driving forward improvements across Leicester. In addition to information about health and social care, the report touches on employment, accommodation, education, and transport for the purpose of sustaining population mental health. The recommendations emphasise the importance of mental health service users and carers in the development of high quality mental health services.

Key Findings

Mental health in Leicester

Although a range of national and local health and social care policies have a bearing on mental health and wellbeing, some other policies will have a positive impact too, such as the Leicester City Mayor's Delivery Plan. It is important therefore that commissioners use every strategic opportunity to link mental health and wellbeing to cross-cutting initiatives **(Recommendation 1.1; 1.2)**.

When people experience mental illness they should have timely access to the right treatment, be treated with respect, have their views and preferences valued. In 2008 local commissioning and provider organisations signed a commitment to the Charter for Mental Health, a clear set of statements for service users and carers about what they can expect from local mental health services in Leicester, Leicestershire and Rutland (LLR). Organisations in the new commissioning and provider landscape should confirm their commitment to renew and endorse the spirit of the original Charter **(Recommendation 1.3)**.

There is a stepped care approach to mental health, in which services should be accessed appropriately for the greatest health gain. Most people with mental health problems are self-caring; they attend schools, colleges, university or work, sometimes they may receive social care or primary health care. However, most commissioning focuses on more specialist level services, which are needed by fewer service users. Therefore, there is a need to ensure that mental health and social care improves the capacity and capability of universal services to address less complex mental health needs, as well as improving specialist services **(Recommendation 1.4)**.

Mental health commissioning cuts across different organisations, including the Clinical Commissioning Group, Local Authority, NHS England and the Police and Crime Commissioner. Commissioners should work to ensure that provision for mental health across the life course is contiguous, that the different organisations do not commission work in isolation **(Recommendation 1.5)**.

Poor mental health is linked to poor lifestyle choices and increased risk taking behaviour, such as smoking, drinking and drug taking, higher risk sexual behaviour, lack of exercise, poor diet and obesity. These are associated with excess early mortality for people with mental illness, emphasising the need of parity of esteem between mental and physical health care **(Recommendation 1.6)**.

Risk factors for poor mental health are high in Leicester. Most ward areas experience deprivation. Mental illness is higher in the most deprived areas, with recorded depression being significantly higher in Aylestone, Braunstone Park and Rowley fields, Eyres Monsell, Freemen and Humberstone and Hamilton. However, recorded depression is lower in Belgrave, Castle, Coleman, Latimer, Rushey Mead, Spinney Hills, and Stoneygate ward areas. These areas have similar rates of deprivation, but are characterised by a higher proportion of residents from black and minority ethnic (BME) communities **(Recommendation1.7)**.

Deprivation may be worsened by the impact of the economic recession. Welfare benefits changes are likely to have a negative impact on service users and providers. Many claimants, who are service users, may lose their entitlement to benefit and service providers may no longer have adequate resources to meet increased need **(Recommendation 1.8)**.

Local strategies from the Health and Wellbeing Board and the Clinical Commissioning Group emphasise the importance of improved mental health and mental health care. Just as *No health without Mental Health* is a cross-cutting strategy, linked to other policies, local commissioners should consider that improved mental health and wellbeing relies on a broad strategic approach and a range of resources not just restricted to mental health service provision **(Recommendation 1.1)**.
The commissioning landscape is still evolving, for instance there are important changes in the criminal justice system, with commissioning to prisons and for offenders in the community linked to transformed probation services, NHS England and the Police and Crime Commissioner **(Recommendation 1.5)**.

Better Care Together and the LLR 5-year strategy both call attention to the links between mental health and the health and social care economy. 5-year strategy workshops suggested at least 6 problems related to mental health. These are low levels of screening and prevention; lack of systematic detection and risk assessment in primary care; poor information sharing and communication; misinformation regarding care pathways; lack of enhanced recovery pathways/early discharge and anticipatory care; and lack of stratified risk pathways for patient-led post treatment care. Better Care Together focuses on 3 key priorities for improving mental health care; prevention and early intervention, an integrated approach to primary and secondary care, better crisis care. The strategy accepts the need to use the JSNA process to underpin these improvements **(Recommendation 1.9)**.

Mental Health Promotion

Promoting mental health carries significant social, economic and health benefits, including preventing mental ill health and improving mental and physical health and wellbeing. Although resources are available in adjacent systems which have an impact on health, there is a need for specific funding for mental health promotion **(Recommendation 1.17)**.

Mental wellbeing is integral to health; it is connected to physical health and behaviour. Obesity disproportionately affects people with mental illness, learning and physical

disability. Antipsychotic medication can cause significant weight gain, dyslipidaemia and diabetes. People with serious mental illness are less likely to exercise. Regular physical activity is associated with improved mental wellbeing and lower rates of depression and anxiety. Public Health Guidance makes recommendations for community engagement with the most vulnerable as a way of improving health and wellbeing and tackling health inequalities **(Recommendation 1.11)**.

The World Health Organisation, the Foresight Report and the Report of the Chief Medical Officer 2013 each consider the challenges to mental health and wellbeing. They highlight a number of signposts for action, including improved diagnosis and treatment, addressing stigma and discrimination, targeting risk factors and strengthening protective factors **(Recommendation 1.13; 1.14)**.

One way in which commissioners and providers may help to improve population mental health is through the Five Ways to Wellbeing. These are a set of actions which individuals can do in their everyday lives, namely: Connect, Be Active, Take Notice, Keep Learning and Give. Culture and creativity can protect mental wellbeing, and there are many resources available to communities, such as libraries and neighbourhood centres which can act as hubs for this work. Arts in mental health projects may help individuals and populations at risk to sustain their mental wellbeing **(Recommendation 1.14; 1.15)**.

Paid work is important for wellbeing and financial security. Many people who require some support to get into work, especially those with mental health problems, have difficulties getting employment support. Employment and mental wellbeing have a reciprocal connection. People with mental health problems are less likely to be in paid employment, and people who are unemployed are more likely to develop depression or other mental disorders **(Recommendation 1.10; 1.12; 1.16)**.

Perinatal Maternal Mental Health

Perinatal maternal mental health has an impact on the health and wellbeing of women, children and families. The incidence of some conditions, such as anxiety, may not be significantly different in the perinatal period to that of the general population. However, perinatal obsessive compulsive disorder and puerperal psychosis are specifically associated with pregnancy and childbirth. Women with no history of mental illness may experience it for the first time during the perinatal period. Others may have a pre-existing condition which recurs or persists, or may have experience of previous trauma which hampers their wellbeing. The severe impact of such conditions emphasises the need to protect women and families against them **(Recommendation 2.2)**.

Many women with postnatal depression had experienced depressive symptoms during pregnancy, and could have been identified earlier. Better antenatal detection of depression offers an opportunity for earlier intervention. Primary care has a role to play in facilitating better detection of depression. Adult mental health services should counsel women with serious affective disorders about the reciprocal effects of pregnancy, mental illness and medication **(Recommendation 2.6)**.

Healthcare professionals (midwives, obstetricians, health visitors and GPs) should screen women for experience of past or present severe mental illness, previous treatment by a psychiatrist/specialist mental health team. They should use assessment tools such as the Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression Scale (HADS)

or Patient Health Questionnaire 9 (PHQ9). Public health is well placed to ensure that the development of the Health visitor service can have a positive impact on the mental health of women and families (**Recommendation 2.10)**.

Although perinatal mental illness can affect all women, having a first-degree relative affected by mental illness is an added risk factor. Socio-economic factors can increase the risk of mental illness or exacerbate its effects. Rates of perinatal depression are higher amongst women experiencing poverty or social exclusion, and the risk of depression is twice as high amongst teenage mothers. The stress caused by issues such as poor housing, domestic violence and poverty can exacerbate symptoms of anxiety and depression.

If there are 5,000 births in Leicester in a year, then commissioners should expect at least 10 cases of post-partum psychosis; 10 cases of chronic serious mental illness; 150 cases of severe depressive mental illness; 500-750 cases mild-moderate depressive illness/anxiety; 150-250 cases of post-traumatic stress disorder and 750-1,500 cases of adjustment disorders and distress. Given the wider context of mental wellbeing, commissioners should develop a broad strategic response which ensures capacity for high quality perinatal mental health care in Leicester **(Recommendation 2.1)**.

Research shows that training community midwives and health visitors in psychological approaches can have a protective effect on women in the antenatal and postnatal periods. Better use of all available resources may help to improve collaboration between primary care, obstetricians, midwives and health visitors and specialist mental health services **(Recommendation 2.7)**.

The Leicestershire Perinatal Psychiatry inpatient service did not meet Royal College of Psychiatry and NICE guidelines, and has recently closed. Women who require inpatient care should be treated in a mother and baby unit which is accredited by the Royal College of Psychiatrists' quality network for perinatal services, possibly in Nottingham **(Recommendation 2.2; 2.3; 2.4)**, to ensure that they are not admitted on to a general adult mental health admission ward **(Recommendation 2.5)**.

Community care for women with perinatal mental illness in Leicester should be integrated to cover all levels of severity of mental illness, possibly with the development of a perinatal care outreach team and more capacity in primary care **(Recommendation 2.8; 2.9)**. This integrated practice should include regular links with the regional clinical network for perinatal maternal mental health.

Child and adolescent mental health

Most lifelong mental illness is acquired before the age of 14. Treatment of mental illness and resilience to future mental illness in Leicester largely depends on commissioners and policy makers planning to protect the health and wellbeing of children and families. This requires a system wide approach, with frameworks for integrated care. A coherent integrated service will only be achieved through effective joint commissioning, and a better understanding of the factors which impact on childhood mental illness.

Available resources include services for children and young people, families, Clinical Commissioning Groups, local authorities, health care professionals, voluntary sector organisations, schools and educational psychology **(Recommendation 3.1; 3.5)**.

The Annual Report of the Chief Medical Officer 2012 defined children and young people as those who are aged up to 25 years. The rationale for this primarily concerns the continuation of emotional development of young people into their early 20s. However, it also relates to the difficulty adolescents have in accessing adult services. Commissioners should therefore work together to ensure that service provision fits with emerging national initiatives around the care of young people to age 25 **(Recommendation 3.2)**. Learning about how to develop such services may be gained from the PIER team, which provides service for people aged 14-35 years.

Mental health disorders and difficulties encountered during childhood and the teenage years include: Attention deficit hyperactivity disorder (ADHD); anxiety disorders ranging from simple phobias to social anxiety; Post-traumatic stress disorder (PTSD); autism and Asperger syndrome (the Autism Spectrum Disorders, or ASD); behavioural problems; bullying; depression; eating disorders (including anorexia nervosa and bulimia); obsessive compulsive disorder (OCD); psychotic disorders, in particular schizophrenia; and substance abuse.

Good childhood mental health depends on many factors, such as having good physical health, eating a balanced diet and regular exercise. Children need time to play indoors and outdoors, they need to be part of a family that gets along well most of the time, to attend a school concerned with pupil wellbeing and to take part in activities for young people.

Mental health problems are higher among children who experience poverty, low educational attainment, domestic violence and bullying. Childhood poverty is higher in ward areas such as Spinney Hills, New Parks, Braunstone Park and Rowley fields, Stoneygate and Charnwood.

Mental health problems are also higher among children who do not engage in activities which protect mental health, such as exercise and eating a balanced diet. Public health is well placed to work with schools and relevant services to build on efforts to increase child participation in physical activity and to promote healthy lifestyles **(Recommendation (3.4)**. This may be done, for instance, by increasing health visitor and school nurse numbers and developing them to be better equipped to meet mental health needs. It may also be done by using initiatives, such as the Early Help and Prevention Offer and THINK family, as leverage to co-ordinate services for children and families who are at risk of poor emotional health and wellbeing.

One way of organising prevention services to meet the needs of children is to use the principle of proportionate universalism, with greater resources targeted at the ward areas with greater disadvantage **(Recommendation 3.6)**.

In Leicester between 3,500 and 5,250 children have a mental health problem. There are higher risks of poor mental health in Looked after Children, there are about 520 such children in Leicester. 9-10% women and 5-6% of men will be parents with a mental health problem, equivalent to 9,700 women and 6,400 men in Leicester and 25% of children aged 5-16 years have mothers at risk of common mental health problems, equivalent to 12,000 children in Leicester.

Child and Adolescent Mental Health Services (CAMHS) in Leicester are organised in tiers. Universal health care services and services adjacent to health care, such as schools, all have a part to play in protecting mental health. Health visitors and school nurses are well placed to prevent escalation of mental illness and to ensure that children and young people join

mental health pathways at the appropriate tier, when necessary **(Recommendation 3.3)**. Specialist services care for children with severe and enduring mental illness. They improve access to psychological therapy for children, support victims of abuse and those who have been bereaved, and can improve parenting skills.

Student Mental Health

There are 2 universities in Leicester which contribute to the economic and cultural life of the city. There are 20,000 students at DMU, 10.5% from outside the EU and 15,000 from University of Leicester, 27% are non-EU residents.

Whilst education is generally protective against mental illness the stresses associated with attending university can precipitate mental distress and may cause a relapse into poor mental health. This occurs at a time of challenge as young people progress from adolescence into adulthood, when there is a high risk of developing serious mental illness.

Young adults entering Higher Education have additional challenges as a consequence of moving away from home, having autonomy and responsibility, living communally in halls of residence or shared housing, developing new social relationships, financial pressures and balancing academic work and part-time paid work.

Often health care is not a high priority for students. They are less likely, for example, to register with a general practice and may use the emergency department for non-emergency care. Students may be reluctant to admit a mental health problem, because it may impact on their academic work. Underachievement or failure at this stage can have long-term effects on self-esteem, employment, debt and progression through life. Tutors may not feel equipped to deal with the mental health problems of their students **(Recommendation 4.2)**.

A student may feel that referral to secondary mental health care may have a negative impact on their ability to study, reach their full potential and graduate. Furthermore, as students are a transient population, with the academic year being 35 weeks, actually accessing secondary care may be a problem **(Recommendation 4.3)**.

Universities in Leicester offer specialist mental health support. There are counselling services to support students with their academic studies. Local general practices at Victoria Park Health Centre and De Montfort Surgery are central to student health care **(Recommendation 4.4)**. The Open Mind IAPT service provides regular support to students in Leicester. As some students experience severe mental ill-health, often because they have not accessed timely support, the Crisis Team and the Emergency Department are important points of care. There is a need therefore to develop strategies to understand the role of specialist student mental health services, to enable students to gain appropriate access to mental health services and to investigate how University counselling services fit in the stepped care model **(Recommendation 4.1; 4.5)**.

Mental health of working age adults

Prevalence rates from national surveys show 16-18% of working age adults may experience a common mental health problem at any time. Applied to the 2011 Census population of Leicester aged 18-64 years, this equates to somewhere between 34,000 and 38,000 people. Half of adults with mental health problems have symptoms severe enough to require treatment. Common mental health problems are more frequent among females than males

(19.7% and 12.5% respectively). The estimated number of people in Leicester with serious and enduring mental illnesses, such as schizophrenia, bipolar affective disorder and other psychosis, is about 3,400 people.

In Leicester rates of diagnosed depression are improving, there are higher than average rates of hospital admission for mental illness and worse than average outcomes. Commissioners should continue to work to improve diagnosis of mental health problems, tackling issues such as stigma and assigning parity of esteem to mental and physical health **(Recommendation 5.5; 5.6)**.

Adult mental health services are organised according to a stepped care model. More than 90% of people with mental health problems are managed entirely in primary care. General practice is also the main point of referral to other parts of the pathway, which includes the Improving Access to Psychological Therapies Service (IAPT), Mental Health Facilitators, and Community Mental Health Teams, Liaison Psychiatry and Access and Complex Care services.

Commissioners should focus on preventing mental illness from worsening and enabling earlier access to appropriate care. This means improving the capacity and capability of resources in primary care. There is an opportunity to do this, using the proximity of Clinical Commissioning Groups (CCGs) to local problems to develop an integrated approach to mental illness, inclusive of statutory and voluntary sector organisations **(Recommendation 5.4)**. CCG commissioners should work with service providers, users and carers to develop the recovery model of care, for instance through the Recovery College **(recommendation 5.3)**.

Some people with a mental health crisis are treated out of area. Commissioners should work with service users **(Recommendation 5.1)** and providers from all sectors to improve crisis response to mental illness. This should include models of care to meet acute mental health need, such as the crisis house **(Recommendation 5.2)**.

Mental health of older people

As people live longer so protecting the mental health and wellbeing of older people will become more of a problem. Depression is the most common mental disorder in later life, affecting 3,000-4,500 older people in Leicester. Schizophrenia affects about 1% of the older population; equating to about 400 people aged over 65 years in Leicester. Dementia, delirium and substance misuse are also linked with poor mental health in older people. Mental illness in old age is affected by deprivation, bereavement, isolation and physical illness. There is a need to meet the combination of mental and physical health problems where they co-exist in older people **(Recommendation 6.3**

Mental health services for older people in Leicester should be commissioned on the basis of need **(Recommendation 6.1)** rather than focusing specifically on age or disease. Although there is an integrated approach between health, social care and voluntary and community sector services this needs to be improved to ensure that mental health needs of older people are addressed as early and effectively as possible, including access to crisis services, psychiatric liaison in the Emergency Department and routes for safe discharge into the community **(Recommendation 6.2; 6.4; 6.5; 6.6)**.

Equalities and mental health

Mental illness disproportionately impacts on people from minority groups, whilst these groups have difficulty accessing appropriate services.

Leicester has a diverse population compared with England as a whole; 50% of Leicester residents are from BME backgrounds compared with only 13% in England overall. 37.1% of people in Leicester are of South Asian ethnic backgrounds, 6.2% are Black/British, 3.5% mixed and 2.6% from other ethnic origins. The age profile of Leicester's BME population is relatively younger than the White/White British population.

There are cultural differences in how mental illness is perceived across different communities; this may impact on access to, and experience of, statutory services. The issues vary widely between and within BME groups by factors like age and gender. This means that there is no single 'BME mental health problem'. Those affected may range from a person whose first language has no word to describe depression through to a person who has no trust of statutory services.

Recent data shows that there has been some progress in meeting mental health needs of people from BME communities, but inequalities still persist. For instance, evidence has consistently shown an over representation of people from Black/Black British and White/White British ethnic backgrounds among those Leicester residents who were detained under provision of the Mental Health Act.

With regard to access to specialist cognitive behavioural therapy in 2013/14 there was an over representation of people from White/White British backgrounds, an under representation of people from Asian/Asian British ethnic and people from Black/Black British ethnic backgrounds. IAPT services showed in 2013/14 a slight under representation of people from Asian/Asian British ethnic backgrounds, but no difference for those from White/White British or Black/Black British ethnic backgrounds.

Leicester is the dispersal centre for 800 asylum seekers. Mental illness is more prevalent among asylum seekers and refugees than the population generally. A number of factors have a detrimental impact on the mental health of asylum seekers and refugees, for instance experiences in their country of origin, the journey to the UK and the process of claiming asylum have an impact on the mental health of this group. Commissioners need to establish effective multiagency working through the local New Arrivals Strategy Group **(Recommendation 7.8; 7.9)**.

It is likely that the LGBT community comprises 2-2.5% of the general population, somewhere between 6,000-7,500 people. Compared to the population generally LGBT people have greater detrimental exposure to the wider determinants of health, poorer experiences of hospital and residential care, poorer access to health and social care provision and are particularly subject to stigmatisation, discrimination and insensitivity. LGBT people have higher rates of poor mental health. There is a need to develop specialist care for transgender people **(Recommendation 7.3)**. Commissioners should work with statutory and voluntary sector providers to address issues of access and outcome for people from minority communities **(Recommendation 7.1; 7.2)**.

The carers' needs assessment showed that in Leicester there are an estimated 30,000 carers. While not all need formal support, there is a large gap between need and service provision. For instance there are more recipients of adult social care than those with recorded carers' assessments. There is inconsistent recording of carers on general practice registers. There are 249 young carers known to social care services, but the census indicates that there are 4 to 5 times as many young carers in Leicester. There is a need for commissioners of mental

health and social care to work with colleagues and key stakeholders to improve the mental health care of carers **(Recommendation 7.4)**.

When servicemen and women leave the armed forces, their healthcare is the responsibility of the NHS. The duty of care owed to service personnel can be found in the armed forces covenant.
All veterans are entitled to priority access to NHS hospital care for any condition as long as it's related to their service, regardless of whether or not they receive a war pension. Veterans are encouraged to tell their GP about their veteran status in order to benefit from priority treatment. A minority of people leaving the armed forces need access to mental health services, while others might require it later in civilian life. Post-traumatic stress disorder, stress and anxiety are problems commonly experienced by veterans. Commissioners should ensure that the mental health care of veterans is commensurate with the obligations under the armed forces covenant **(Recommendation 7.5)**.

Mental illness is more common among homeless people. Serious mental illness is present in 25-30% of those people who are sleeping rough or in hostels. There is a need for commissioners to work in partnership with the Homelessness Strategy Group to develop specialist homelessness services and to ensure that the health and social care needs of homeless people are a considered holistically **(Recommendation 7.10)**.

People with learning disabilities are amongst the most vulnerable members of society. They have a wide range of social and health care needs, and they may have coexisting conditions which contribute to need, such as physical or developmental disabilities, mental and physical ill-health and a range of behavioural problems. It is often the presence of these conditions that defines need for services. They also have needs which occur as a result of social exclusion, such as poverty, unemployment and lack of adequate accommodation. Health and social care commissioners should work together to consider the mental health of people with learning disabilities, when developing frameworks and care pathways. In addition, they need to work together to implement the findings of the Winterbourne View Concordat which resulted from the report into the emotional and physical abuse of people at Winterbourne View Hospital **(Recommendation 7.6; 7.7)**.

Suicide

The rate of death from suicide includes deaths from self-inflicted injury and deaths for which the cause was undetermined. Cases are decided by the coroner. From a medical and mental health perspective some verdicts, including open and misadventure, may have been viewed as suicide. Coroners' verdicts are often 18 months after a death has occurred, there is a need therefore for real time surveillance to ensure that key learning from incidents are shared in a timely fashion **(Recommendation 8.1)**.

Evidence suggests that the act of a person taking their own life is often impulsive and dependent on different factors, in addition to mental illness, such as the presence of a physically disabling or painful illness; alcohol and drug misuse; deprivation and the level of support that a person receives. Stressful life events such as the loss of a job, imprisonment, a death or divorce may also play a significant part. For many of those who take their own life it is the combination of factors which may be important. There is a need therefore to raise awareness of the issue of suicide and to audit and learn from cases where people have taken their own lives **(Recommendation 8.2: 8.6)**.

Each case is a tragedy for individuals, their families, friends and colleagues. There is a need to support those who are bereaved by a case of suicide **(Recommendation 8.5)**.

In Leicester, on average, approximately 32 people take their own lives each year. The rate for suicides is calculated on a 3 year rolling average. In the period 2010-2012 there were 96 deaths from suicide and undetermined injury in Leicester, giving a rate of 10 per 100,000. As there are a small number of suicides each year in Leicester, an increase or reduction in the numbers can result in a large change in the rate. Furthermore, as deaths from suicide and undetermined injury disproportionately affect younger people, it is a cause for a high proportion of years of life lost. Most deaths occur as a result of hanging or overdose; most occur in a person's own home. The rate is higher among males.

The incidence of self-harm is different, in that it occurs equally among males and females and the population affected is generally younger. Commissioners should ensure that the current guidance on self-harm is being implemented by key stakeholders **(Recommendation 8.3; 8.4)**.

Offenders

The commissioning architecture for the mental health of prisoners and offenders is complex, and includes local health and social care bodies, NHS England and the Police and Crime Commissioner. This requires greater monitoring and collaboration when developing the mental health care pathway for prisoners and offenders **(Recommendation 9.2; 9.3)**.

Approximately 90% of prisoners have a psychotic, a neurotic or a personality disorder or suffer with a substance misuse problem which impacts on their mental health. Prisoners are also likely to have with more than one concurrent mental health problem, with remand prisoners more likely to suffer with multiple problems. As a Category B Local Prison for male prisoners, HMP Leicester has a large throughput of prisoners, including those on remand; this makes mental healthcare in the prison a major challenge.

Studies show a higher level of need for mental health services, and worse outcomes, for offenders in the community than in the general population. There is a need to develop improved care pathways for offenders in the community and on release from prison, with particular focus upon health and social care services **(Recommendation 9.1).**

Initiatives to improve mental healthcare for prisoners and offenders include the development of mental health in-reach teams and the transfer of prison healthcare to the NHS. There has also been guidance on improving mental health provision for offenders in general and in particular to improve access to mental health services for 16 and 17 year olds, as people in this age group are responsible for the majority of youth crimes and for the more serious crimes. However, more work is needed to ensure that frameworks and accessible pathways are developed for prisoners and offenders **(Recommendation 9.4)**.

Dual Diagnosis

The co-existing problems of mental ill health and substance misuse represent a difficult challenge for mental health services. Elements of care, such as diagnosis and treatment are difficult and service users represent high risk of relapse, readmission to hospital, self-harm and suicide. Substance misuse among people with mental health problems is usual rather than exceptional; treatment for substance misuse problems often improves mental health;

and the healthcare costs of untreated people with dual diagnosis are likely to be higher than for those receiving treatment.

People with co-existing mental illness and substance misuse disorders have high rates of physical ill health. The provision of integrated care for people with a combination of mental health problems and substance misuse requires an effective links across health, social care, and the voluntary sector and criminal justice services.

People with dual diagnosis often receive sub-optimal care because of concerns about the need to treat either mental health or substance misuse. Whilst commissioners should ensure that all staff in mental health and substance misuse teams are trained and equipped to work with co-morbidly issues **(Recommendation 10.2),** governance frameworks should be developed to ensure that mental health teams take the lead in cases of dual diagnosis **(Recommendation 10.1; 10.3).**

Number	Commissioners are recommended to:	CCG	Local Authority	Other
	Promoting Mental Health and Wellbeing			
1.1	**Ensure that mental health and wellbeing is everybody's business**	**√**	**√**	**√**
1.2	**Link mental health promotion activity to all health and leisure activities**	**√**	**√**	
1.3	**Confirm commitment to renew, and endorse the spirit of, the Mental Health Charter**	**√**	**√**	
1.4	**Improve the capacity of education, workplaces and universal services to support people with mental health problems**	**√**	**√**	
1.5	**Recognise that services should be contiguous and ensure that they are not developed in isolation**	√	√	√
1.6	**Ensure that there is parity of esteem between mental and physical health care**	√	√	√
1.7	**Ensure equity of access to mental health care across all Leicester ward areas**	√	√	√
1.8	**Recognise the link between deprivation and mental illness, which has worsened with the recession and austerity**	√	√	√
1.9	**Note the similar themes in the 5 year strategy and the JSpNA on mental health in Leicester**	**√**	**√**	
1.10	**Make a commitment to mindful commissioning of services to protect mental health and challenge the stigma of mental illness in the workplace**	√	√	√
1.11	**Use mental health promotion impact assessment tools to ensure strategies and initiatives do not produce unintended negative outcomes for mental health**	√	√	√
1.12	**Influence employers in Leicester to develop robust mental health in the workplace programmes and implement strategies to promote employment of people with mental health problems**	√	√	
1.13	**Promote anti stigma messages and support action to reduce discrimination**	√	√	√
1.14	**Ensure that mental health and wellbeing cuts across all local strategies, such as economic development, transport, arts and culture and the environment**	√	√	
1.15	**Support 5 Ways to Wellbeing**	√	√	√
1.16	**Support human interventions and case management as a way of helping people back to employment**	√	√	√

1.17	**Fund specific mental health promotion projects**	√	√	
	Perinatal Maternal Mental Health			
2.1	**Develop a strategic response to perinatal maternal mental health across Leicester, Leicestershire and Rutland which ensures capacity for perinatal maternal mental health need in Leicester**	√	√	√
2.2	**Ensure that there is an integrated pathway for perinatal mental health in Leicester which covers all levels of service provision and severities of disorder and the mental health of other family members**	√		√
2.3	**Ensure that local perinatal maternal mental health service offers timely access to services compliant with NICE Guidance**	√		√
2.4	**Ensure mother and baby units for Leicester are accredited by the Royal College of Psychiatrists' quality network for perinatal services**	√		√
2.5	**Ensure all women requiring admission in late pregnancy or after delivery are admitted with their infant to a mother and baby unit not an adult mental health admission ward**	√		√
2.6	**Ensure adult mental health services counsel women with serious affective disorder about the effects of pregnancy on their condition and the possible effects of their medication on pregnancy**	√		
2.7	**Support additional training in perinatal mental health and the detection of at-risk patients for providers such as health visitors and midwives**	√		
2.8	**Create capacity in primary care to ensure that mental health promotion can be delivered effectively**	√		
2.9	**Develop a Perinatal Mental Health Outreach Team, including obstetricians, midwives, community, primary care staff, and the voluntary sector, to work across primary and secondary care to allow early identification and prevention of serious problems; plan care for antenatal period, labour, birth and the postnatal period.**	√		
2.10	**Support health visiting to identify women at risk of perinatal depressive illness**		√	
	Child and Adolescent Mental Health			
3.1	**Adopt system wide thinking to ensure that key resources are identified and properly used to improve the health and wellbeing of children (including schools and voluntary sector organisations)**	√	√	√
3.2	**Recognise that support for young people extends beyond teenage years, and should include people up to age 25**	√	√	√
3.3	**Commission a range of services to meet the needs of children, young people and parents, including more integrated work at Tier 1 and improved timely access to specialised services.**	√	√	
3.4	**Ensure all professionals involved in the identification of mental and emotional health receive training to improve the mental health care of children and young people.**	√	√	
3.5	**Work with schools and relevant services to build on efforts to increase child participation in physical activity and to promote healthy lifestyles**			
3.6	**Target prevention resources at ward areas with greater disadvantage**	√	√	
	Student Mental Health			
4.1	**Develop strategic level contact with student welfare services to develop an integrated approach to student mental health in Leicester**		√	
4.2	**Recognise and develop the role of primary care mental health for**		√	

	students in Leicester, focusing on interested clinicians, social support and good liaison with secondary care services.			
4.3	Develop strategies to enable students to gain appropriate access to mental health services		√	
4.4	Investigate whether student mental health support and counselling services have any role to play in the stepped model of care for mental health		√	
4.5	Gain an understanding of how the specialist mental health teams in the universities work, and commission services which work in partnership with these services	√		
	Working Age Adults			
5.1	Facilitate increased support for the involvement of service users and carers in the planning, development and delivery of mental health services	√	√	
5.2	Develop the crisis response, including a crisis house, to reduce the number of people with acute mental illness who are treated out of area	√	√	
5.3	Improve commitment to the recovery model; for instance by better support of the Recovery College	√	√	
5.4	Improve the capacity and capability of primary care teams to manage mental health problems as early as possible	√	√	
5.5	Improve timely diagnosis of mental illness	√	√	
5.6	Ensure that services offer non-stigmatising support for people with mental illness	√	√	√
5.7	Work towards delivering parity of esteem between mental and physical health	√	√	√
	Mental Health of Older People			
6.1	Ensure mental health services are commissioned on the basis of need; recognise that the needs of older people with functional mental illness (for example depression) and/or organic disease such as dementia and their associated physical and social issues are often distinct from younger people	√	√	√
6.2	Develop an integrated approach between health, social care and voluntary and community sector services to ensure co-ordination between secondary and primary care and community services	√	√	
6.3	Meet the combination of mental and physical health problems which often co-exist in older people	√	√	
6.4	Develop a multi-disciplinary approach to older people's mental health; including integrated input from nurses, psychologists, physiotherapists, occupational therapists and speech and language therapists when necessary	√	√	
6.5	Ensure older people have access to crisis services, with extended hours of working and intensive crisis management, home treatment workers help to reduce the need for admission, facilitate early discharge and reduce transfer to residential care	√	√	
6.6	Develop older person's psychiatric liaison expertise in University Hospitals Leicester	√	√	
	Equalities and Mental Health			
7.1	Work with key stakeholders to address the needs of people in minority communities, and ensure that they have access to the appropriate level of care and better outcomes	√	√	
7.2	Integrate VCS organisations which represent minority communities into the care pathways	√	√	√
7.3	Develop specialist care for transgender people	√	√	√
7.4	Work with key stakeholders to improve the mental health and	√	√	

	wellbeing of carers			
7.5	Ensure that the mental health care of veterans is commensurate with the obligations under the Armed Forces Covenant	√	√	√
7.6	Work together to consider the mental health of people with learning disabilities, when developing frameworks and care pathways	√	√	√
7.7	Work together for local implementation of the Winterbourne View Concordat	√	√	√
7.8	Establish effective multiagency partnership working, in particular integrating statutory mental health service providers with the local VCS groups involved in the care of asylum seekers	√	√	
7.9	Work with the New Arrivals Strategy Group to ensure that the health and social care needs of asylum seekers are included in local development plans and to promote understanding of the needs of asylum seekers	√	√	
7.10	Work in partnership with the Homelessness Strategy Group to develop specialist homelessness services and ensure that health and social care needs of homeless people are a considered holistically	√	√	
	Suicide			
8.1	Work with key stakeholders to develop real time surveillance of information to enable better review and response to deaths from suicide	√	√	
8.2	Raise awareness about suicide and self-harm amongst the general public and professionals	√	√	
8.3	Support those who self-harm or who are affected by acts of self-harm	√	√	
8.4	Implement NICE guidelines on self-harm should be followed so that individuals who self-harm receive an assessment of need and access to relevant support	√	√	
8.5	Support people who are bereaved by suicide	√	√	
8.6	Audit local trends in order to inform local delivery and actions	√	√	
	Offenders			
9.1	Develop improved care pathways for offenders in the community and on release from prison, with particular focus upon health and social care services which relate to mental health. This should include improved access and co-ordination with Probation Services and successor organisations	√	√	√
9.2	Initiate greater monitoring of services and arrangements for offenders with mental ill-health	√	√	√
9.3	Ensure that the mental health needs of offenders are considered and addressed by the main commissioning bodies	√	√	√
9.4	Develop accessible pathways into alcohol and drug treatment for offenders in the community, building on treatment which has been undertaken in prison	√	√	√
	Dual Diagnosis			
10.1	Ensure that mental health teams take the lead in cases of dual diagnosis	√	√	√
10.2	Ensure that all staff in mental health and substance misuse teams are trained and equipped to work with dual diagnosis with appropriate support and supervision	√	√	√
10.3	Develop integrated governance, roles and responsibilities of the different agencies involved are defined by clear local protocols	√	√	√

Appendix F

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Leicester City Better Care Fund: Next steps following resubmission
Presented to the Health and Wellbeing Board by:	Sue Lock, Managing Director, Leicester City CCG
Author:	Rachna Vyas, Head of Strategy and Planning, Leicester City CCG

EXECUTIVE SUMMARY:

1. The Leicester City Better Care Fund achieved a rating of 'Approved with support' from the National Consistent Assurance Review process, the highest available to Leicester City as a challenged health economy.
2. Guidance released in early November indicates that all plans in this category are expected to be fully approved by the end of December 2014.
3. All changes required to BCF plans in this category will be managed by a Relationship Manager from NHS England
4. The attached presentation outlines the following timeline for this process. In summary, the final submission of the Leicester City BCF is expected by November 28th 2014, with key milestones as follows:
    a. 14 November – area to agree with Relationship Manager what evidence and information will be submitted to mitigate risk areas and when this will be submitted
    b. By 28th November - Agree timetable for when areas to have submitted their further information/evidence for review and sign-off with Relationship Manager
    c. Recommend to Taskforce that they seek Programme Board approval to move area(s) to fully approved category
5. Final letters for approved plans will be issued on December 8th 2014.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

NOTE the timetable and expectations for the final submission of the Leicester City BCF.

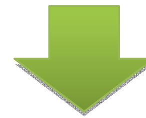
Better Care Fund Leads

East Midlands

7, November 2014

Plan Improvement Process

HWBs receive letter notifying them of assurance category outcome with NCAR outcome report appended – 29 October
NCAR results announced – 30 October



NCAR outcome report to be developed into an agreed Action Plan – 14 November

Assurance Category	Action	Who will manage process?	Complete by
Approved	Approval to go ahead and take full responsibility for the BCF budget	NHS England	Complete by 30th October
Approved with Support	Approval to go ahead and take full responsibility for the BCF budget, but will be required to submit further information or evidence to mitigate risk areas highlighted by the NCAR	NHS England	Aim to complete by end November
Approved Subject to Conditions	Approved to continue improving plan but will not receive full responsibility for BCF budget until they meet conditions set, and will be limited in proceeding implementation activities, including contractual and procurement negotiations – Action Plan required	BCF Taskforce and ICDAs	Aim to complete by end December
Not Approved	Plan not approved at this stage, and they will not have responsibility for the BCF budget, and will be limited in proceeding implementation activities, including contractual and procurement negotiations – Action Plan required	BCF Taskforce and ICDAs	Aim to complete by end January

Next steps for HWBs ‘Approved with Support’

Approved with Support
AIM FOR COMPLETION BY END NOV 2014

NHS England

<u>NCAR outcome</u>: This local area has approval to go ahead and take full responsibility for the BCF budget, however, they will be required to submit further information or evidence to mitigate any risk areas highlighted by the NCAR

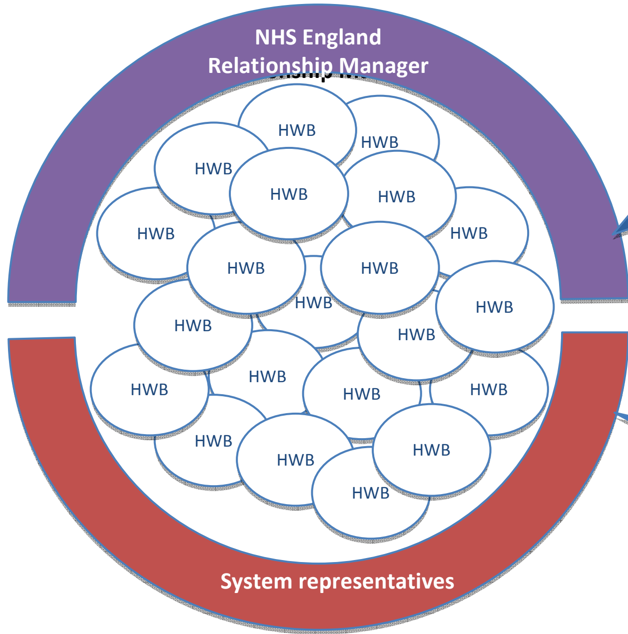
<u>Next Steps</u>

Areas in this category will be assigned a relationship manager from NHS England Regional/Area Teams to agree a plan to provide the further information required identified through the NCAR process – this will be a straightforward and light-touch process and we would aim for all HWBs in this category to be **fully approved before December**.

<u>Key Milestones</u>:

- **29 October** – receive letter notifying assurance category and named point of contact (NHS England Relationship Manager)
- **14 November** – area to agree with Relationship Manager what evidence and information will be submitted to mitigate risk areas and when this will be submitted
- Agree timetable for when areas to have submitted their further information/evidence for review and sign-off with Relationship Manager
- Recommend to Taskforce that they seek Programme Board approval to move area(s) to fully approved category

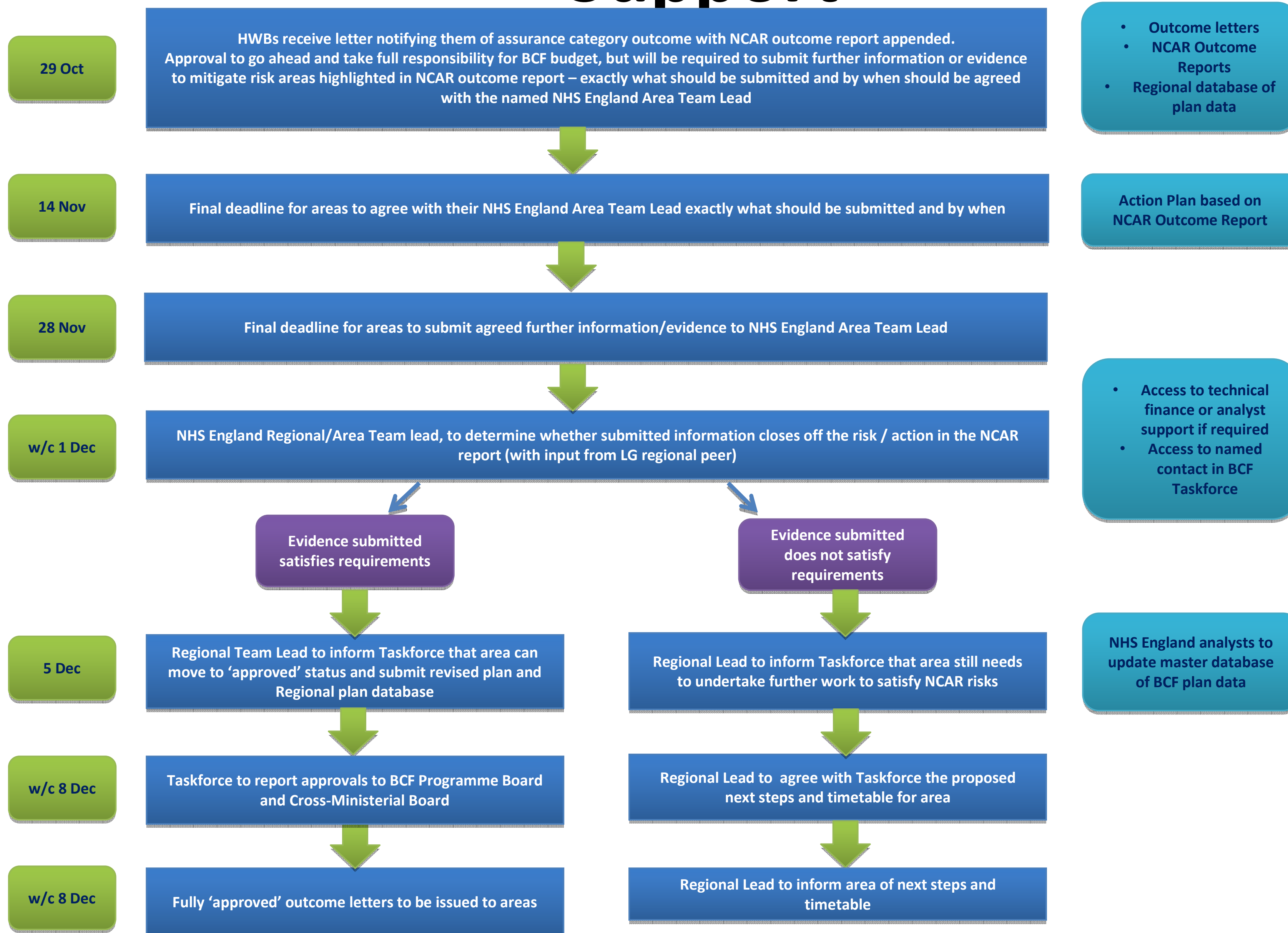
Each NHS England Region will have a named Taskforce Lead to follow up any queries with



NHS England Relationship Manager
- Agree timetable to receive additional evidence in line with NCAR requirements
- Light touch support, on request
- Coordinate any technical support /review from NHS England
- Sign-off submitted evidence and move plans to fully approved status

System representatives
- Supported by LG regional peer support

Process Chart for 'Approved with Support'



Next steps for areas ‘Approved subject to Conditions’ or ‘Not Approved’

Approved subject to Conditions
AIM FOR COMPLETION BY END DEC 2014

Taskforce

NCAR outcome: This local area will be approved to continue improving plan but will not receive full responsibility for BCF budget until they meet conditions set, and will be limited in proceeding implementation activities, including contractual and procurement negotiations

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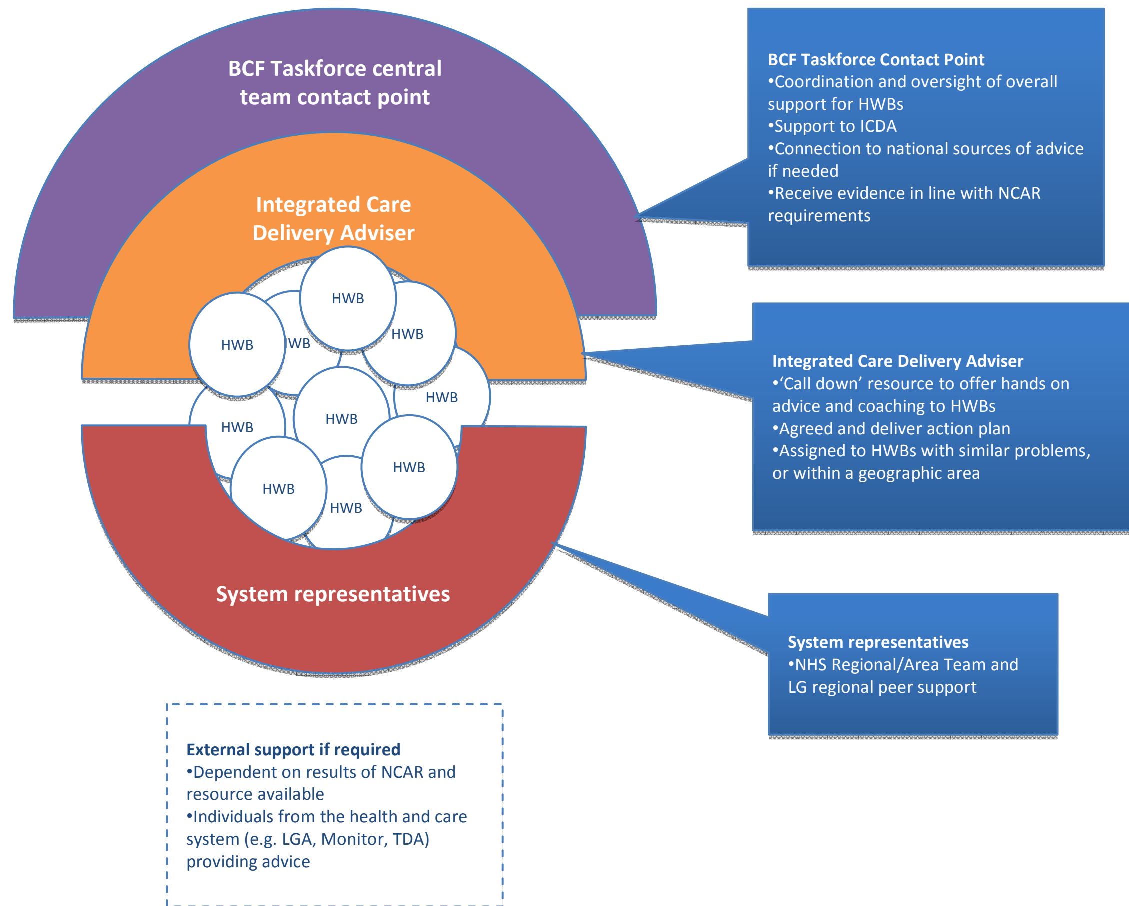
Next Steps
Areas in this category will be assigned an Integrated Care Delivery Advisor as their relationship manager who will work with the local team to agree an action plan to address areas of weakness identified through NCAR, access available support and agree the level of resubmission required to secure removal of conditions. The aim is to have these **areas fully approved before January**.

Key Milestones:
- **29 October** – receive letter notifying assurance category and named point of contact (Integrated Care Delivery Advisor)
- **14 November** – area to have Action Plan agreed with Integrated Care Delivery Advisor which addresses how and by when they will address the risk areas from the NCAR assessment, what support is required, and what level of resubmission and assessment is required to remove conditions
- Areas to re-submit parts or all of their plan for NCAR or NCAR compliant process (by timescale agreed with Integrated Care Delivery Advisor)
- Areas to receive result of NCAR/NCAR compliant assessment and move to fully approved



Not Approved
AIM FOR COMPLETION BY END JAN 2014

Taskforce

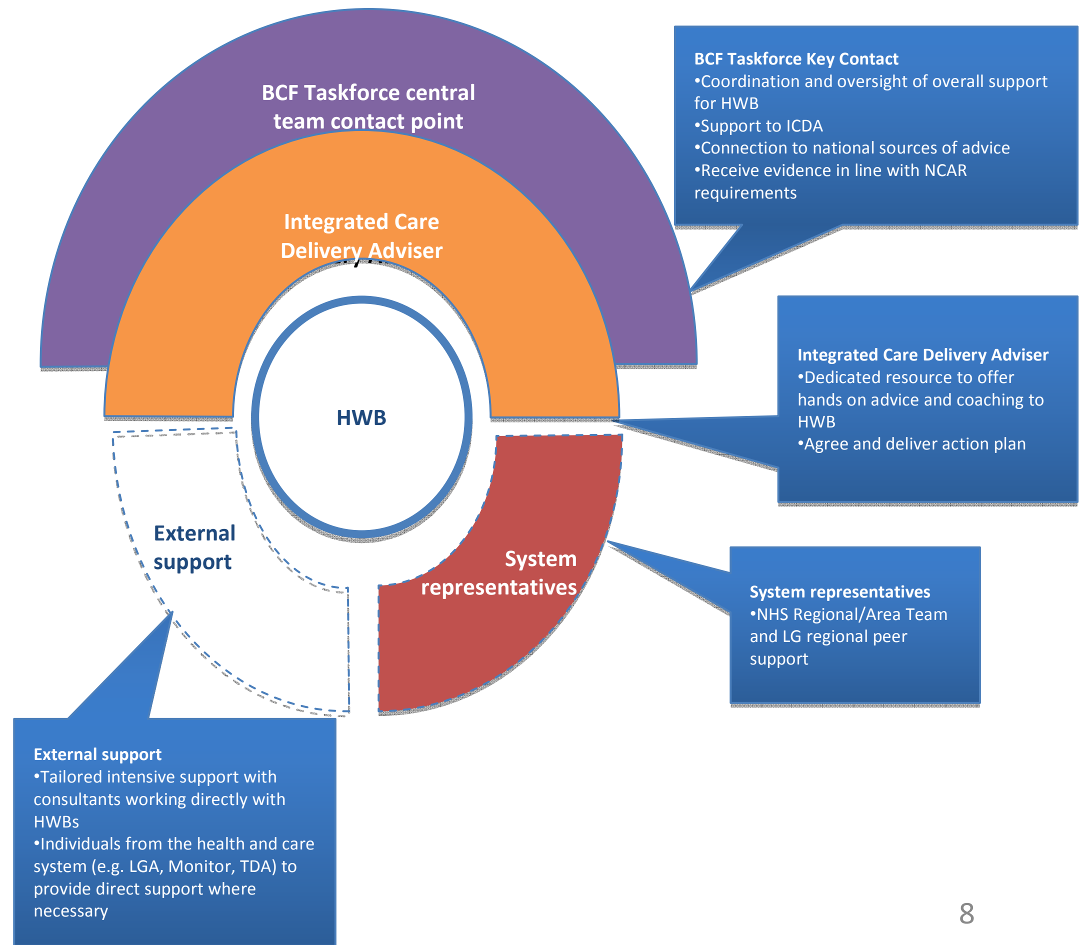
NCAR outcome: This local area will not be given approval of their plan, nor will they be given responsibility for the whole BCF budget, and will be limited in proceeding implementation activities, including contractual and procurement negotiations

Next Steps

Areas in this category will be will be assigned an Integrated Care Delivery Advisor and will be required to work closely with them to agree an action plan that will ensure they submit a fully revised plan in January so they are approved in time to begin implementation. Areas in this category will receive intensive support to improve their plan. These areas will be required to resubmit a **full plan for a further NCAR assessment process on 2 January.**

Key Milestones:

- **29 October** – receive letter notifying assurance category and named point of contact (Integrated Care Delivery Advisor)
- **14 November** – area to have Action Plan agreed with Integrated Care Delivery Advisor which addresses how and by when they will address the risk areas from the NCAR assessment, what support will be in place to help them improve their plan, and by when they will submit a revised plan
- **2 January** – latest deadline for areas to have re-submitted their revised plan for a full NCAR assessment process
- Areas to receive result of NCAR and move to an approved category



Resources already available from Phase 1

All existing resources can be found on the NHS England BCF webpage:

http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

The main resources are:

1. The 'How to' Guide: The BCF Technical Toolkit which covers Population segmentation and stratification, Evidence based plans, Outcomes and impact measurement, Financial analysis
2. Fast track plans and case studies
3. Making it Better – A guide to resources for improving Better Care Fund plans
4. Risk sharing guidance and sample S.75 template
5. The BCF Frequently Asked Questions document
6. Archived recordings of webinars
7. The Better Care Atlas

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Appendix G

Leicester City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD

DATE 11 December 2014

Subject:	**Health and Wellbeing Scrutiny Commission – oversight of immunisations and vaccinations**
Presented to the Health and Wellbeing Board by:	Rod Moore, Acting Director of Public Health
Author:	Rod Moore, Acting Director of Public Health

EXECUTIVE SUMMARY:

The Board will recall that the Leicester Health and Wellbeing Scrutiny Commission was asked to receive a quarterly report on the progress of Childhood Immunisation in Leicester to ensure that progress made in recent years is maintained.

The Health and Wellbeing Scrutiny Commission, meeting on Tuesday 23 September 2014, considered a report from NHS England on childhood immunisations in 2013/14 and Q1 2014/15 and found that despite a slight reduction in the boosters in 5 year olds in 2013/14 progress is satisfactory.

Comments from members of the Commission have been reported to NHS England regarding improving performance for the age 5 boosters, the poor experience of the administration of Fluenz in a school, the challenge of getting teens to attend appointments and the problems they and parents have in keeping track of the immunisation they have had.

The report from NHS England is available in the Health and Wellbeing Commission agenda papers for 7 October at weblink URL
http://www.cabinet.leicester.gov.uk:8071/documents/s65843/Report%20-%20childhood%20imms%20-%20Leicester%20City%20v3%2008%2009%2014.pdf

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the above report;
- Receive further reports on a quarterly basis.