Date: TUESDAY, 2 FEBRUARY 2016

Time: 2:00 pm

Location: MEETING ROOM G.01, GROUND FLOOR, CITY HALL, 115 CHARLES STREET, LEICESTER, LE1 1FZ

HEALTH AND WELLBEING BOARD

Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Adam Clarke, Assistant City Mayor

Councillor Abdul Osman, Assistant City Mayor

Councillor Sarah Russell, Assistant City Mayor

City Council Officers:

Frances Craven, Strategic Director Children's Services

Andy Keeling, Chief Operating Officer

Ruth Tennant, Director Public Health

Steven Forbes, Strategic Director of Adult Social Care

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

Trish Thompson, Director of Operations and Delivery, NHS England Local

Healthwatch / Other Representatives:

Karen Chouhan, Healthwatch Leicester

Chief Superintendent, Sally Healy, Head of Local Policing Directorate, Leicestershire Police

Professor Martin Tobin, Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester.

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

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

G. J. Carey

For Monitoring Officer

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

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PUBLIC SESSION

AGENDA

NOTE:

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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 27 October 2015 are attached and the Board is asked to confirm them as a correct record.

4. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

5. UNIVERSITY HOSPITALS LEICESTER NHS TRUST - STRATEGIC PRIORITIES **Appendix B Page 17**

To receive a presentation from Kate Shields, Director of Strategy, University Hospitals of Leicester NHS Trust (UHL) on the Trust's strategic priorities and current challenges.

6. BETTER CARE FUND

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Page 31

To receive a report on the Better Care Fund (BCF) from Sue Lock, Managing Director, Leicester City Clinical Commissioning Group.

The Board are requested to approve the draft BCF 16/17 template for submission on February 8th 2016 and to delegate approval of draft narrative plans to the Chair of the Joint Integrated Commissioning Board (Sue Lock) and the Strategic Director for Adult Social Care for submission on February 8th 2016.

7. NHS PLANNING GUIDANCE - IMPLICATIONS FOR LEICESTER

Appendix D
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To receive and note the NHS publication 'Delivering the Forward View: NHS planning guidance 2016/17 – 20120/21 that will have implications for the work of the Board. Sue Lock, Managing Director, Leicester City Clinical Commissioning Group will introduce the guidance.

8. MENTAL HEALTH JOINT COMMISSIONING STRATEGY

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To receive a report from the Lead Commissioner – Mental Health & Learning Disabilities on a Mental Health Joint Commissioning Strategy developed by Leicester City Council and the Leicester City Clinical Commissioning Group; which outlines the commissioning intentions for the period 2015-2019.

The strategy has been developed in full consultation with stakeholders, including people with mental health problems and carers of people experiencing poor mental health.

The Board is requested to endorse the Mental Health Joint Commissioning Strategy as part of the sign off process prior to publication.

9. PRIMARY CARE WORKFORCE PLANNING

To receive a verbal update.

10. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: TUESDAY, 27 OCTOBER 2015 at 2.00pm

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
Ivan Browne	–	Deputy Director of Public Health
Richard Clark	–	Chief Executive, The Mighty Creatives.
Frances Craven	–	Strategic Director, Children's Services, Leicester City Council.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group.
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
Chief Superintendent Sally Healy	–	Head of Local Policing Directorate, Leicestershire Police.
Sue Lock	–	Managing Director Leicester City Clinical Commissioning Group.
Councillor Abdul Osman	–	Assistant City Mayor, Public Health, Leicester City Council.
Balhu Patel	–	Vice Chair, Healthwatch Leicester.
Councillor Sarah Russell	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council.
Sarah Theaker	–	Head of Operations and Delivery NHS England (Central Midlands)

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

Sue Cavill – Head of Customer Communications and Engagement NHS Arden and Greater East Midlands Commissioning Support Unit.

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13. APOLOGIES FOR ABSENCE

Apologies for absence were received from Karen Chouhan (Chair Healthwatch Leicester) Andy Keeling (Chief Operating Officer), Dr Avi Prasad (Co-Chair, Leicester City Clinical Commissioning Group), Ruth Tennant (Director of Public Health), Trish Thompson (Director of Operations and Delivery, NHS England Local) and Professor Martin Tobin (professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester).

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. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

16. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the Minutes of the previous meeting of the Board held on 9 September 2015 be confirmed as a correct record, subject to the Resolution in Minute 9 – Public Health Budget being amended to read:-

"1. That the update be noted and the Board unanimously oppose the proposed reduction in Council's ring fenced public health budgets and that all health partners make strong representations to the Government to this effect.

2. That the Board be kept aware of future developments."

17. LEICESTERSHIRE PARTNERSHIP NHS TRUST - STRATEGIC PRIORITIES

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust (LPT) gave a presentation on the Trust's strategic priorities and current challenges. A copy of the presentation had been published with the agenda for the meeting.

During the presentation the following comments were noted:-

a) The Trust had four strategic objectives:-

- Deliver safe, effective, patient-centred care in the top 20% of the Trust's peers.
- Partner with others to deliver the right care, in the right place, at the right time.
- Ensure sustainability.
- Staff will be proud to work here, and we will attract and retain the best people.

b) The current income was £2.31m with a planned surplus of £2.2m

c) The Trust is working to provide the continued integration of clinical services to provide:-

- Improved access to services, enhancing the service user experience and allowing earlier integration.
- Reduced duplication of contracts and activities within and across agencies.
- Earlier intervention with reduced escalation of health conditions, improved health of patient and reduced specialist service contracts.
- Better health and social care system integration reducing administration and management costs across statutory agencies.

d) The Trust's services could be broadly divided into:-

- Adult Mental Health and Learning Disability Services
- Community Health Services
- Families Young People and Children

e) <u>Adult Mental Health and Learning Disability Services</u>

i) Developing the Adult Mental Health Care Pathway, involving promoting care in crisis, reducing the time spent in hospital, reducing delays in discharge, keeping patients at home longer, and promoting alternatives to hospital admissions and remodelling the crisis services.

ii) Enhancing integration of services working closely with the primary care and voluntary sector, focussing on recovery, increasing resilience and reducing escalation of health conditions.

iii) Supporting people with learning difficulties to remain in the community by improving access to services, treating in the home wherever possible and improving crisis management services. The number of inpatients with learning difficulties was now a relatively small number compared to previous decades.

f) <u>Community Health Services</u>

i) Improving prevention and early intervention by working with

communities to enable people to stay healthy and help prevention of health conditions to avoid the early need for acute care services. The Trust was also working with patients with long term conditions to manage their conditions and to make an early identification of patients with dementia.

ii) Improving access to care and reducing waiting times. There had been good partnership working with the primary care sector and early referrals to memory cafes.

iii) Developing out of hospital care which was important for the Better Care Together Programme. The Trust was growing the Intensive Support Services with the commissioners and an additional 130 virtual beds were being provided in the current year.

iv) Integration of whole system provision of care by aligning the care pathways with both the County, Rutland and City areas and implementing Phase 2 of a programme to develop partnership working with the voluntary and third sectors and carers to access services.

v) Numerous measures were being introduced and developed for Out of Hospital Care including:-

- Developing the capability and capacity to provide sub-acute care in community hospitals.
- Providing integrated community based specialist services for patients recovering from the acute phase of a stroke or neurological illness.
- Establish an In-Reach team to expedite the prompt and smooth transfer of patients into community based sub-acute care and Intensive Community Support Service beds.
- Providing enhanced health in care homes for people diagnosed with dementia and mental health care in order to reduce their need for a hospital admission.

vi) Funds have been secured through the Nursing Technology Fund to implement technology advances in nursing practices to connect nurses across the community hospitals and acute trusts.

vii) The Trust will be pioneering a Robotic Telepresence Solution to enable a clinician to be virtually present in another location.

viii) Bed use will be optimised to provide the same or increased volume of activity with fewer beds.

g) <u>Families Young People and Children</u>

i) Develop Asset Based Community Development (ABCD) to

strengthen, support, co-ordinate and build capacity within families and communities for self-help and to support each other.

ii) Increase knowledge and skills across the workforce through introducing new roles and integrating practice across teams. This will increase practitioners' capacity for service users, reduce referrals to specialised services and reduce the number of practitioners involved in the care of a child or a family. It would also lead to an increased quality of intervention at an earlier stage improving the service user's health and reduced workforce costs through the safe delivery of interventions by lower banded qualified and trained staff.

iii) Use of alternative technologies to change the way the Trust communicates with younger people through social media apps and virtual appointments to allow earlier intervention and reduce face to face contacts and improve service user experience. Mobile working technology increases workforce agility and reduces estate usage and travel costs as well as improves productivity.

iv) The Trust has recruited 7,000 people to research projects which will provide better quality improvement outcomes.

h) The Trust faced the following Challenges and risks:-

i) Financial stability of the health economy – the Trust Development Agency had given an extended target for the deficit recovery. Currently approximately 80% of Trusts nationally were in financial deficit.

ii) Workforce capacity, capability and engagement – the Trust was still heavily dependent upon agency and bank staff which had on going implications for staff skills and costs.

iii) Demand continued to rise and the capacity was not always available within the health system to respond to it at times.

Following questions from Members of the Board the following responses were noted:-

a) The Trust was working with commissioners to implement quality improvements to care for the physical needs of patients that had mental health illnesses.

b) Waiting times for the CAMHS service were improving and currently the average waiting time was 7 weeks and, although many users were seen early, there were still a number who may have to wait for up to 40 weeks for behavioural or non-urgent related health conditions.

c) Work was progressing with CAMHS Teams to have manageable workloads and it was hoped that in the forthcoming months everyone would be seen with 13 weeks. Currently Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder support was not provided from the Adult Mental Health services and arrangements were being put in place for this to be provided for children moving into young adulthood.

d) Dr Miller was leading on the Workforce Group in Leicester, Leicestershire and Rutland. He fully recognised that that there was a challenge to ensure that staff resources moved with patients as the left shift in patient care took effect and fewer patients were treated in the acute sector and more in the community and primary care sectors. He envisaged that staffing levels within the health sector would remain at current levels for a number of years and this would require some staff to receive additional training and acquire different skills to enable them to move from the acute sector and provide community based care. Whilst this was fully recognised as a potential risk, he felt that all appropriate steps were being taken at the present to address the issues. It also needed to be recognised that new entrants embarking on nursing training schemes would take three years to complete their qualification.

The Managing Director, Leicester City Clinical Commissioning Group (CCG) stated that the CCG had recently taken over the strategic lead for children's services and had met with the Director of Children's Services to discuss the delivery of more integrated services. As the CCG was also the lead commissioner for the UHL contract this would also assist this process.

Following questions from Board members, Dr Miller stated:-

a) Although there was evidence to show that promoting resilience in an individual's treatment and recovery programme had beneficial and long term effects, it was more difficult to measure resilience in a whole community. However, this would need to be developed and be better quantified in the future as it would be one of the indicators that would affect the setting of strategic priorities of the wider health economy in the future.

b) An indication of progress in the next 12 months would be to be lower A&E admissions than present levels, that the new community capacity was fully utilised and that waiting times, especially in the CAMHS services, were achieving their waiting time targets.

c) The LPT priorities outlined in the presentation were aligned with the direction of travel of other partners in the health economy but there were some challenges to the delivery of the integration agenda by the simple virtue that partners were individual and separate statutory organisations which could present inherent challenges from time to time.

In relation to community resilience, it was noted that as the Council moved towards ensuring services became more focused and targeted at those people

who needed them it could lead to striping away parts of the universal offer. This would affect the development of community resilience such as providing networks and the ability to support one another one and this had the potential to store up future problems and issues by trying to address current issues. For example, the Play and Stay Sessions such as Toddlers Time in Libraries, where individuals develop friendships, relationships and networks to provide cross-peer support, can reassure young parents about child development matters and minor ailments and ultimately reduce the number of "worried-well" parents consulting GP and School services.

The Chair thanked Dr Miller for his very useful presentation and for the openness to responses. Whilst he acknowledged that LPT faced challenges, he wished to recognise that the organisation had improved and developed from its previous position 2 years before and he recognised Dr Miller's leadership role in that process.

18. GENERAL DENTAL CARE SERVICES - URGENT CARE CONSULTATION AND SPECIAL CARE DENTISTRY PRE-ENGAGEMENT PROCESS

Jane Green, Assistant Contract Manager, Dental and Optometry, NHS England – Midlands and East (Central Midlands) and Semina Makhani, Consultant in Dental Public Health, Public Health England attended the meeting to present a briefing paper on the consulting the public on two options to improve access to urgent dental care services.

The consultation started on 3 August and would finish on 1 November 2015. A pre-engagement process had taken place in March and the responses had been used to shape the proposals.

The two options were:-

Option 1 Merge the existing Dental Access Centre and the dental out-of-hours services with revised opening times. The service would be delivered from the Dental Access Centre in Nelson Street (off London Road) Leicester.

Option 2 To establish two new dental practices providing urgent and routine dental care to patients from 8am to 8pm, seven days a week, 365 days a year including all Bank Holidays. When local practices are closed, the sites will provide urgent care services. The creation of the new practices is based on the oral health needs assessment and the review of existing contracting arrangements.

The report also contained details of the Specialist Care Dentistry for Leicestershire and Lincolnshire Pre-Engagement which had been extended in Leicestershire for six weeks from the original closing date of 25 September 2015.

NHS England would be considering both issues in late November with a view

to the two procurement programmes commencing in January 2016. It was intended to award new contracting arrangements in June 2016 to enable new providers to have an extensive mobilisation period to establish the new service arrangements.

Members of the Board made the following comments:-

a) It was difficult to state a preference between the two options as they were not readily comparable. The parameters of services in Option 2 were far in excess of Option 1 but at unknown locations; whereas Option 1 was located in the City where 80% of users of the urgent care services lived.

b) If there was capacity within the existing dental services, the need to promote and offer 'routine' dental services at the urgent care service was questioned. It may be better to signpost patients to dentists with capacity and encourage registration with them so that on-going care can be provided.

c) Healthwatch received a number of calls daily from people wishing to go to an NHS dentist and there was a difficulty recommending a dentist that was known to have spare capacity. It would appear there was a mismatch of dental services availability and it would be helpful if NHS England supplied a list of dental practices that had spare capacity.

d) There was evidence that in LE2 and LE5 post code areas there was no capacity as people were waiting 6-8 months to apply to see a local dentist.

e) As 80% of the users of the urgent dental care services were currently living in the City, it was queried whether there would be a guarantee that their needs would be catered for in whichever option was adopted. It was important to have a service where City patients did not have less access to the service that the current need clearly demonstrated exists within the City.

f) It needs to be recognised that car ownership in parts of Leicester with low levels of NHS registration is less than 50% and this has a major effect upon people's ability to travel, whereas car ownership in the county is higher. A city centre location is accessible by public transport, but travel is more difficult across the City and into county areas.

In response to comments made by Members of the Board it was stated that:-

a) Not every patient contacting the services requires treatment as advice may be given.

b) There were parts of the population that don't engage regularly with dental services until they have an urgent care need.

c) Part of the rationale for offering 'routine' dental care services was to address the pockets around the County where there was a need to improve access to dental services particularly in relation to children. Currently only 20% of 0-2 years olds had been seen by a dentist and NHS England were working with local dental practices to encourage increased levels of attendance so that preventative advice could be given.

d) Dental practices have not been required to register patients since 2006, they were however required to see patients until a particular course of treatment had been completed. Dental practices now maintained 'lists of patients' that they saw over a regular period.

e) A list of dental practices was supplied to Healthwatch on a monthly basis, but it was recognised that there were pockets of demand where people were reluctant to travel to see a dentist.

f) There could be more than one provider for the service and the provider would have to guarantee the service was available during the contracted hours of operation.

RESOLVED:

1) That the Board does not feel able to indicate a preference for either Option 1 or Option 2 on the information currently provided. However, the Board would expect that whichever model of care was eventually chosen that it would provide as a minimum level of service:-

   i) The current urgent dental care capacity provided in the City would be sustained.

   ii) The opening hours of access to the service would be a minimum of 9 am to 7 pm Monday to Friday and 6 am to 6 pm at weekends and Bank Holidays.

   iii) That the service would be delivered from a city centre location which was both central located and easily accessible.

2) That the Board receive a further report in the future focussing on the strategic provision of dental services and strategies for achieving higher levels of dental registration.

19. PROPOSAL FOR A NEW PRIMARY HEALTH SERVICE FOR LEICESTER CITY CARE HOME RESIDENTS

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group (CCG) submitted a report on a proposal to establish a new multi-disciplinary

primary care service for care home patients.

The CCG was currently undertaking work to determine the optimum model of care for residents of care homes within the city boundary. Patients in care homes were often the most medically complex and frail within the community. They represented a complex interface between many different agencies such as primary care, acute care, community care, mental health, palliative care and statutory services. This often resulted in unnecessary admissions to hospital, lack of co-ordinated care and gaps in service provision. In all there were twenty five external services that have an input into care homes but currently these were not well integrated with primary care services. The CCG was working on a proposal to establish a new multi-disciplinary primary care service to provide targeted and specialist input into the care of this cohort of patients.

It was noted that there were approximately 2,260 people living in 107 care homes in the City. Whilst this represented approximately 1.2% of the city's population they accounted for 8% of acute admission to hospitals. Some GP practices had no patients in care homes and others had in excess of 200. This could lead to disproportionate effect upon a GP practice where residents in care homes could account for 2% of the patient list but account for 50% of patient visits.

The current care model had a tendency to provide reactive care and the multi-disciplinary approach was aimed at ensuring:-

- care for the patient was better co-ordinated
- there was a continuity of care for the patient
- more specialist support leading to enhancements in care
- more end of life patients being able to die in their normal place of residence
- the need to be admitted to hospital unnecessarily was minimised

The new model would need to maintain patient choice and it would need to enhance the current primary care services and not destabilise them.

Engagement had taken place with care home patients and care home managers and both were very supportive of developing more joined up services for this cohort of patients. The exact form of the new service was currently under consideration and would be subject to a Business Case approval by Leicester City Clinical Commissioning Group's Governing Body either late 2015 or within the first quarter of 2016.

Members of the Board made the following comments:-

a) Extra care provision should also be taken into account as people often preferred to take this option in preference to living in a care home.

b) It should be recognised that people's health can deteriorate whilst living in their own homes and there should not be a two tier system of care when people were not living in care.

c) The new model should not be solely based around GPs providing care

as models elsewhere in the country had shown that some patients felt more comfortable talking to nurses rather than GPs about their care.

In response to Members' questions it was noted that:-

a) The new model of care should be able to be extended to incorporate the extra care provision and this would be considered when the options for the new care model were discussed.

b) It was recognised that patients preferred to retain their own GP but some GPs were unable to provide sufficient dedicated time for all care patients in view of their other patient commitments. The best solution was a formula where the patient received the best care package from various sources and was also able to retain a relationship with their own GP.

RESOLVED:

1) That the report on the Care Homes Primary Care Service Project be received, progress be noted and that the Board's comments be considered as the care model is developed.

2) That the Council's Adult Care Scrutiny Commission should also be apprised of the options and asked to provide a view on the preferred model of care.

20. 0-19 HEALTHY CHILD PROGRAMME UPDATE

Ivan Browne, Deputy Director of Public Health presented a report requesting the Board to note plans for the recommissioning of the 0-19 Healthy Child Programme (HCP) and to develop further integration of this programme with the Council's Early Help Offer.

It was noted that the HCP was a universal public health programme for improving the health and wellbeing of children and young people. It was currently delivered by two separate programmes:

- HCP 0-5 years delivered by the Health Visiting and Family Nurse Partnership services, and
- HCP 5-19 years delivered by the School Nursing service

Both these elements were provided by Leicestershire Partnership NHS Trust and the Council now had the opportunity to integrate elements of the HCP programmes to ensure better service provision. Integration would enable the provision of a strong comprehensive offer to children and young people, while ensuring value for money and making commissioning decisions based on the best available evidence.

The impact of an effective 0 – 19 HCP would be measured through outcomes and indicators including; life expectancy, school readiness, domestic abuse,

breastfeeding, smoking prevalence at age 15, excess weight in 4-5, 10 –11 year olds and adults, tooth decay in children aged 5 and self-reported wellbeing.

In preparation for recommissioning the integrated HCP 0-19 years, a full review of the current HCP programmes had been carried out. The review findings will inform the development of the specification for the new 0 – 19 integrated healthy child programme for Leicester.

The Strategic Director of Children's Services commented that this proposal presented a real opportunity to realign services and avoid duplication of existing children's services.

RESOLVED:

That the plans for recommissioning the 0-19 Healthy Child Programme and to develop further alignment of this programme with the Council's Early Help Offer be noted and welcomed.

21. THE DEVELOPMENT OF THE JOINT HEALTH AND WELLBEING STRATEGY

Ivan Browne, Deputy Director of Public Health presented a report on the emerging themes for developing the strategy in preparation for it to be renewed/refreshed in 2016. Since the publication of the strategy in 2013, there had been considerable changes in the health and social care landscape. There was a clear need to for a strong and sustained focus and local leadership around prevention. This was needed to reduce the health gap in the city, meet the challenge set out in the NHS 5 Year Forward Review and to reduce pressure on social care and children's services.

The Board had held a number of development sessions and the following key principles had been identified to drive the strategy's development:-

- The strategy should set out a long term vision for 20-25 years, which would act as a blueprint for how to deal with inequalities, enabling investment in prevention and reducing the gap in health outcomes between different parts of the city. The strategy should recognise that changes in life expectancy require short-term action but the impact on key outcomes such as life expectancy, will take longer to demonstrate and will need sustained focus. However, there is also a clear need to take rapid action to accelerate the pace of change in some 'high impact' areas which could lead to more rapid change in the next 3-5years.

- The strategy should focus on different stages of people's lives, looking at what would lead to sustained improvements in children's health and well-being, in adult life and in older age. It should also look at the wide range of assets and resources locally that could drive improvements in health and well-being. The strategy needed to clearly reflect and help

drive work already going on locally to improve health outcomes.

- There needed to be clear buy-in and support from the public for the 'high impact' areas that the strategy will focus on.

- The strategy needed to be supported by good data, including the Joint Strategic Needs Assessment and local MORI Health and Well-being Strategy and be measured against key short, medium and long-term outcome measures.

- The strategy needed to be innovative and developed and delivered in a way which uses new techniques to support behaviour change, for example using social media or local health challenges to encourage people to think differently and to encourage people across the city to get involved.

- There needed to be effective engagement of different groups from across the city to mobilise resources to deliver the strategy, including the voluntary sector, community groups, schools and local businesses.

- It should draw on external expertise, such as the Institute of Health Equity, to support the development of a clear and evidence-based framework for systematically tackling health inequalities

The strategy will be developed and delivered by a working group which would develop a draft strategy and engagement plan. The group will include:

- Key thematic leads from public health /public health data analyst
- A representative from the CCG's strategy team
- Representatives from Adult Social Care and Children's Services
- The council's equalities lead
- A representative from Healthwatch
- Key HWB members

It was proposed to submit a draft strategy document to the February Board meeting and then undertake a programme of engagement with patients, the public and stakeholders to elicit feedback on the draft, including ideas about the best measures to put in place to achieve the strategy's objectives.

RESOLVED:

That the proposals for the development of the strategy and the subsequent engagement programme be noted and supported.

22. LIVE/WORK LEICESTER CAMPAIGN

Ivan Browne, Deputy Director of Public Health presented a report on a proposed approach to developing a joint city-wide campaign to address critical gaps in areas of the local workforce and what can be done to address these.

Leicester City Council was leading on place-based marketing for the City and

work was underway to develop a consistent brand for the city and to highlight the key features of Leicester, promoting the city as a tourist destination and attracting in inward investment. This included plans to develop a clear brand and identity to be used for place marketing. This brand would be used as an over-arching identity for the campaign.

Initial discussions with key partners including the City Council, Leicester City Clinical Commissioning Group, University Hospitals Leicester and Leicester and Leicestershire Partnership Trust had indicated that there was a willingness for partners to develop and potentially contribute to a joint local campaign, with the aim of recruiting staff to key shortage areas as well as promoting the city.

It was noted that initial expressions of interest had been sought from local partners and initial scoping work had been carried out to map the feasibility of a joint local campaign and to identify potential target staff groups. This work, which would be led by the City Council, now needed to be further developed with a view to identifying and agreeing target staff groups, developing a costed proposal and seeking financial commitments from all partners, likely to be in the region of £20k per partner. Sponsorship may also be sought from major businesses in the city.

The Chair commented that the working title of Live/Work Leicester Campaign would be changed as the work was developed.

RESOLVED:

1) That Board endorse the proposed approach to developing a joint city-wide campaign and that it oversees its development and implementation.

2) That the offer of Sue Lock and Professor Farooqi to be involved in the work be welcomed and that contact be made with the Chief Operating Officer of West Leicestershire Clinical Commissioning Group to avoid duplication of effort.

23. DATES OF FUTURE MEETINGS

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

Tuesday 8 December 2015
Tuesday 2 February 2016
Tuesday 5 April 2016

Meetings of the Board were scheduled to be held in City Hall, at 2.00pm unless stated otherwise on the agenda for the meeting.

24. ANY OTHER URGENT BUSINESS

There were no items to be considered.

25. CLOSE OF MEETING

The Chair declared the meeting closed at 3.35 pm.

15

University Hospitals of Leicester NHS Trust

Delivering

Caring at its best

Our 5 Year Plan

July 2015

Appendix B

Our vision

Our plan outlines our thinking about the future shape of our clinical services.
It reflects the ambitions of our staff to provide quality acute care and contribute to the wider healthcare system for the people of Leicester, Leicestershire and Rutland... within an increasingly tight budget.

How do we behave on this journey?

We treat people how we would like to be treated

We do what we say we are going to do

We focus on what matters most

We are passionate and creative in our work

We are one team and we are best when we work together

Safe, high quality, patient centred healthcare

Quality Commitment

	Clinical Effectiveness Improve Outcomes	Patient Safety Reduce Harm	Patient Experience Care and Compassion
Aim	To reduce preventable mortality	To reduce the risk of error and adverse incidents	To improve patients' and their carers' experience of care
2015/2016 Priorities	**Improve pathways of care:** • Review of all in-hospital deaths • Use of clinical benchmarking tools • Identify actions and work-streams where greatest potential for preventable mortality **Improve Consistency of 7 Day Services** • In line with Keogh 10 Clinical Standards **Learning and Development** Implementation of Trust M&M Database for shared learning across all areas	**Earlier Recognition & Rescue of the Deteriorating Patient** • Sepsis • Handover • Early Warning Scores • Acting on results **Consistencies in Core Practices** • Medication Safety • Infection Prevention **Learning and Development** Implementation of Safety Briefings in wards and departments	**Further expand end of life care processes** • Early identification of patients requiring supportive and palliative care (SPICT) • Strengthen bereavement support **Improve the experience of care for older people across the Trust** • 'Fixing the Basics' • Improve the Environment **Learning and Development** Triangulation and review of feedback from all sources and all key characteristic groups

An excellent, integrated emergency care system

- Improved primary care to anticipate and prevent admissions
- Improved hospital processes that design out delays
- Improved discharge processes which get the patient home safely and quickly

Services which consistently meet national access standards

- Redesigning services to cope with growing volumes and moving some into other settings
- Separating planned care from emergency care to reduce cancellations
- Building a Planned Care Treatment Centre
- To create the 'lowest wait teaching Trust in the country' by 2016/17

Integrated care in partnership with others

- Gaps in the system
- Joining up expert generalists (GPs) with specialists in hospital
- Partnerships and alliances with other hospitals to help them maintain services and protect our own
- For the first time a 5 year plan not just for UHL but the whole health and social care system... "Better Care Together"

Better care **together**

A partnership of Leicester, Leicestershire & Rutland Health and Social Care

An enhanced reputation in research, innovation education

- Research and education sets us apart
- Income, talent and new treatments for our patients
- 100,000 Genomes, Life Study, Breathonomics, Institute for Older People's Health
- Closer links with Universities

Clinically sustainable services, operating from excellent facilities

- Under investment for years... now £320m over next five
- Three big acutes for the size of population and duplication / triplication of services.

Major Building Projects - High Level Indicative Programme

	Project Title	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	Emergency Floor						
ICU schemes	Interim Enablers at Leicester Royal Infirmary						
	Interim Enablers & Vascular Support to Glenfield						
	Interim beds at Leicester Royal Infirmary & Glenfield						
	Additional permanent ICU capacity						
Vascular	Vascular Hybrid Theatre						
Beds	Wards Glenfield						
	Wards Leicester Royal Infirmary						
Children's	Interim East Midlands Congenital Heart Centre						
	Children's Hospital Leicester Royal Infirmary						
	Treatment Centre						
	Women's Services						

Business case
Construction
Rolling refurbishment

Financially sustainable organisation

- Last year's deficit was £40m savings of £48m
- Currently most services spend more than they earn
- Running 3 acute sites is wasteful
- Spending too much on agency and locums
- 'Delivering Caring at its Best' will return us to balance

Enabled by excellent IM&T

- Some of the smartest clinical tech on the planet vs notes in shopping trolleys!
- The Electronic Patient Record will be a game changer.
- Full patient history at the touch of a hand to enable faster decision making and better care.

Caring, professional, passionate and engaged workforce

- Without you we are nothing... 1 in every 100 people in City, Leicestershire and Rutland work for us.
- If you think the hospitals do a good job and are a good place to work people listen, if you don't they still listen.
- Only half of staff would recommend us as a place to work
- A third of staff wouldn't recommend their hospitals as a place to be treated.
- ... We need to talk!

The two minute vision

- Safe, quality, patient centred care
- Delivered from 2 rather than 3, acute hospitals as simpler care moves to the community
- Hospitals and processes quicker and easier to navigate
- With more investment in buildings
- Less DGH care, but specialist services grow through partnerships and networks
- Research and talent combine to make Trust attractive to new staff, whilst staff engagement improves
- Restoring pride, returning to balance and 'Delivering Caring at its Best'.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Better Care Fund 2016/17: Templates for approval
Presented to the Health and Wellbeing Board by:	Sue Lock, Managing Director, LC CCG
Author:	Rachna Vyas, Deputy Director of Strategy, LC CCG

EXECUTIVE SUMMARY:

In preparation for 2016/17, the Leicester City Better Care Fund Programme is required to submit 2 documents by February 8th 2016:

1. A draft template outlining expenditure and trajectories for improvement against the 5 national metrics;
2. A draft narrative plan, outlining how our plans for 16/17 will enable achievement of the trajectories in the template.

This paper presents the draft BCF template for 16/17, completed as required by NHS E for February 8th 2016. This template was approved by the Joint Integrated Commissioning Board (JICB) on January 21st 2016.

The template for the narrative plan has not yet been released and therefore cannot be presented to the HWB at this time for approval. Further guidance on the requirements for this narrative plan is expected imminently but is currently held up due to ongoing policy discussions at national level. It is therefore requested that the HWB delegates the approval of the draft narrative template to the Chair of the JICB (Sue Lock, MD, LCCCG) and the Strategic Director for Adult Social Care (Steven Forbes, DASS).

The final version of both plans will be presented to the HWB for approval prior to March 31st 2016.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

APPROVE the draft BCF 16/17 template for submission on February 8th 2016.

DELGATE approval of draft narrative plans to the Chair of the JICB and the Strategic Director for Adult Social Care for submission on February 8th 2016.

Better Care Fund 2016-17 Planning Template DRAFT v5

Overview

The purpose of this template is to collect finance and activity information from CCGs, local authorities, and HWBs in relation to Better Care Fund plans for 2016-17. The template represents the minimum collection required to provide assurance that plans meet the requirements of the Better Care Fund policy framework set out by the Department of Health and the Department of Communities and Local Government [INSERT LINK]. This informtation will be used during the regionally lead assurance process in order to ensure that BCF plans being recommended for sign-off meet technical requirements of the fund.

The information collected within this template is therefore not intended to function as a 'plan' but rather as a submission of data relating to a plan. A narrative plan will also need to be provided seperately to regional teams, but this will not be conducted via a centrally submitted template for 2016-17. CCGs, local authorities, and HWBs will want to consider additional finance and activity information that they may wish to include within their own BCF plans that is not captured here.

This tab provides an overview of the information that needs to be completed in each of the other tabs of the template. This should be read in conjunction with Annex J of the NHS Shared Planning Guidance for 2016-17; Better Care Fund Planning Requirements for 2016-17', which is published here: [INSERT LINK].

The full submission timeline is set out as follows:

[INSERT TIMELINE]

Introduction

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre populated cell

The details of each sheet within the template are outlined below.

Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.

Once all tick-boxes have been selected the 'sheet completed' cell will change to green and contain the word "Yes".
The checker column (E) has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word "No" - once completed the cell will change to Green and contain the word "Yes".
Once the checker column contains all cells marked "Yes" the 'Incomplete Template' cell (B6) will change to 'Complete Template'.

Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

On the cover sheet please **enter the following information:**
- The Health and Well Being Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 5, and allows for confirmation of the amount of funding idetnfied for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please **enter the following information:**
- In cell D29 ,please confirm the amount allocated for ongoing support adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from infromation provided in the 'HWB Expenditure Plan' tab. If this is the case then cell E29 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F39 please indicate the total value of funding held as a contingency as part of local risk share, if appropriate. For guidance on instances when this may be appropriate please consukt the full BCF Planning Requirements document. Cell F36 shows the HWB share of the national £1bn that is to be used as set out in national condition 6. Cell F37 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F39 will show any potential shortfall in meeting the financial requirements of the condition.

The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary.

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. [INSERT LINK] These cannot be changed.

On this tab please **enter the following information:**
- Please use rows 15-24 to detail Local Authority funding contributions by selecting the relevant authority from the drop down in column B and then entering the values of the contirbutions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box provided to detail how contributions are made up.
- Please use cell C41 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 44 to 53 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C.

Cell C56 then calaculates the total funding for the Health and Wellbeing Board.

4. HWB Expenditure plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instrances when several lines need to be complated in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please **enter the following information:**
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B68 - C76); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.

This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 national metrics and 2 local metrics. The non-elective admissions metric does not currently require any input of data during the first submission - once CCG plans have been collected this data will be populated into this template by the national team and sent back in time for the second submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

On this tab please **enter the following information:**
- In cell F48 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column G to provide any useful information in relation to how you have agreed this figure.
- Please use cell F57-59 to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell F59 (the planned total number of older people (65 and over) discharged from hospital into reablement/ rehabiliation services) and the numerator figure in cell F58 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell F57. Please add a commentary in column G to provide any useful information in relation to how you have agreed this figure.
- Please use rows 74-76 to update information relating to your locally selected performance metric. The local performance metric set out in cell B74 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.
- You may also use rows 82-84 to update information relating to your locally selected patient experience metric, although this is no longer a national requirement. The local patient experience metric set out in cell B82 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return.

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework [INSERT LINK] and further guidance is provided in the BCF Planning Requirements document [INSERT LINK]. Please answer as at the time of completion.

On this tab please **enter the following information:**
- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - plan in place' should be used when a condition is not currently being met but a plan is agreed to meet this through the delivery of your BF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition.
- Please use column C to indicate when it is expected that the condition will be met if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

CCG - HWB Mapping

The final tab provides details of the CCG to HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity plans.

Better Care Fund 16/17 Planning Template

Data collection checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
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1. Cover

	Cell Reference	Complete?	Checker
Health and Well Being Board	C9	☐	Yes
completed by:	C12	☐	Yes
e-mail:	C14	☐	Yes
contact number:	C16	☐	Yes
Who has signed off the report on behalf of the Health and Well Being Board:	C18	☐	Yes

Tab Completed:	No

2. Summary and confirmations

	Cell Reference	Complete?	Checker
Summary of BCF Expenditure : Please confirm the amount allocated for the protection of adult social care : Expenditure (£000's)	D29	☐	Yes
Summary of BCF Expenditure : If the figure in cell D29 differs to the figure in cell C29, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services	E29	☐	Yes
Total value of funding held as contingency as part of lcoal risk share to ensure value to the NHS	F39	☐	No

Tab Completed:	No

3. HWB Funding Sources

	Cell Reference	Complete?	Checker
Local authority Social Services: <Please Select Local Authority>	B16 : B25	☐	
Gross Contribution: £000's	C16 : C25	☐	
Are any additional CCG Contributions being made? If yes please detail below;	C42	☐	
Additional CCG Contribution: <Please Select CCG>	B45 : B54	☐	
Gross Contribution: £000's	C45 : C54	☐	
Comments (if required)	E16	☐	N/A

Tab Completed:	No

4. HWB Expenditure Plan

	Cell Reference	Complete?	Checker
Scheme Name	B17 : B66	☐	Yes
Scheme Type (see table below for descriptions)	C17 : C66	☐	Yes
Please specify if 'Scheme Type' is 'other'	D17 : D66	☐	Yes
Area of Spend	E17 : E66	☐	Yes
Please specify if 'Area of Spend' is 'other'	F17 : F66	☐	Yes
Commissioner	G17 : G66	☐	Yes
if Joint % NHS	H17 : H66	☐	Yes
if Joint % LA	I17 : I66	☐	Yes
Provider	J17 : J66	☐	Yes
Source of Funding	K17 : K66	☐	Yes
2016/17 (£000's)	L17 : L66	☐	Yes
New or Existing Scheme	M17 : M66	☐	Yes

Tab Completed:	No

5. HWB Metrics

	Cell Reference	Complete?	Checker
Residential Admissions : Numerator : Planned 16/17	F48	☐	Yes
Comments (if required)	G47	☐	N/A
Reablement : Numerator : Planned 16/17	F58	☐	Yes
Reablement : Denominator : Planned 16/17	F59	☐	Yes
Comments (if required)	G57	☐	N/A
Delayed Transfers of Care : 16/17 Plans : Q1	L67	☐	Yes
Delayed Transfers of Care : 16/17 Plans : Q2	M67	☐	Yes
Delayed Transfers of Care : 16/17 Plans : Q3	N67	☐	Yes
Delayed Transfers of Care : 16/17 Plans : Q4	O67	☐	Yes
Comments (if required)	P66	☐	N/A
Local Performance Metric	B74	☐	Yes
Local Performance Metric : Planned 15/16 : Metric Value	D74	☐	Yes
Local Performance Metric : Planned 15/16 : Numerator	D75	☐	Yes
Local Performance Metric : Planned 15/16 : Denominator	D76	☐	Yes
Local Performance Metric : Planned 16/17 : Metric Value	E74	☐	Yes
Local Performance Metric : Planned 16/17 : Numerator	E75	☐	Yes
Local Performance Metric : Planned 16/17 : Denominator	E76	☐	Yes
Comments (if required)	F74	☐	N/A
Local defined patient experience metric	B82	☐	Yes
Local defined patient experience metric : Planned 15/16 : Metric Value	D82	☐	Yes
Local defined patient experience metric : Planned 15/16 : Numerator	D83	☐	Yes
Local defined patient experience metric : Planned 15/16 : Denominator	D84	☐	Yes
Local defined patient experience metric : Planned 16/17 : Metric Value	E82	☐	Yes
Local defined patient experience metric : Planned 16/17 : Numerator	E83	☐	Yes
Local defined patient experience metric : Planned 16/17 : Denominator	E84	☐	Yes
Comments (if required)	F82	☐	N/A

Tab Completed:	No

6. National Conditions

	Cell Reference	Complete?	Checker
1) Plans to be jointly agreed	C14	☐	Yes
2) Maintain provision of social care services (not spending)	C15	☐	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	C16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number	C17	☐	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	C18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	C19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	C20	☐	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	C21	☐	Yes
1) Plans to be jointly agreed, Comments	D14	☐	Yes
2) Maintain provision of social care services (not spending), Comments	D15	☐	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate, Comments	D16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number, Comments	D17	☐	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional, Comments	D18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans, Comments	D19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services, Comments	D20		Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan, Comments	D21	☐	Yes

Tab Completed:	No

Cover and Basic Details - Better Care Fund Planning Template
2016/17

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

On the cover sheet please enter the following information:
- The Health and Well Being Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the Health and Well Being Board. Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

Health and Well Being Board	**Leicester**
completed by:	David Lewis
E-Mail:	David.Lewis@LeicesterCityCCG.nhs.uk
Contact Number:	0116 295 1481
Who has signed off the report on behalf of the Health and Well Being Board:	Councillor Rory Palmer, Chair of Leicester City Health and Well

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. HWB Funding Sources	#REF!
3. HWB Expenditure Plan	11
4. HWB P4P Metric	21
5. HWB Metrics	16
Summary	2

Summary of Health and Well-Being Board 2016/17 Planning Template

Selected Health and Well Being Board:

Leicester

Data Submission Period:

2016/17

This sheet summarises information provided on sheets 2 to 5, and allows for confirmation of the amount of funding idetnfied for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please enter the following information:
- In cell D29 ,please confirm the amount allocated for ongoing support adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from infromation provided in the 'HWB Expenditure Plan' tab. If this is the case then cell E29 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F39 please indicate the total value of funding held as a contingency as part of local risk share, if appropriate. For guidance on instances when this may be appropriate please consukt the full BCF Planning Requirements document. Cell F36 shows the HWB share of the national £1bn that is to be used as set out in national condition 6. Cell F37 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F39 will show any potential shortfall in meeting the financial requirements of the condition. The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary.

3. HWB Funding Sources

	Gross Contribution
Total Local Authority Contribution	£0
Total Minimum CCG Contribution	£21,861,000
Total Additional CCG Contribution	£0
Total Contribution	**£21,861,000**

4. HWB Expenditure Plan

Summary of BCF Expenditure

	Expenditure	Please confirm the amount allocated for the protection of adult social care Expenditure	If the figure in cell D29 differs to the figure in cell C29, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
Acute	£1,926,540		
Mental Health	£314,927		
Community Health	£2,581,195		
Continuing Care	£0		
Primary Care	£2,600,292		
Social Care	£14,075,289	£14,075,289	
Other	£362,757		
Total	**£21,861,000**		

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

	Expenditure
Mental Health	£0
Community Health	£0
Continuing Care	£0
Primary Care	£0
Social Care	£0
Other	£0
Total	**£0**

Summary of use of local share of £1 billion previously linked to performance fund

	Fund
Local share of £1 billion	£6,180,000
Total value of NHS commissioned out of hospital services spend from	£0
Total value of funding held as contingency as part of local risk share	
Balance (+/-)	**-£6,180,000**

5. HWB Metrics

HWB NEA Activity plan

	Q1	Q2	Q3	Total
Total HWB Planned Non-Elective Activity	0	0	0	0

Residential Admissions

		Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	634.3848857

Reablement

		Planned 16/17
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Annual %	90%

Delayed Transfers of Care

Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
		566.8	532.1	497.4	460.2

Local performance metric (as described in your approved BCF plan / Q1 return)

	Metric Value
	Planned 16/17
Number of patients on dementia registers as % of the estimated dementia prevalence (national indicator)	0.700030239

Local defined patient experience metric (as described in your approved BCF plan / Q1 return)

	Metric Value
	Planned 16/17
Taken from GP Survey (For respondents with a long-standing health condition)	8.8

6. National Conditions

Condition	**Please Select (Yes, No or No - plan in place)**
1) Plans to be jointly agreed	Yes
2) Maintain provision of social care services (not spending)	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes
4) Better data sharing between health and social care, based on the NHS number	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	No - in development
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes

Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Leicester

Data Submission Period:
2016/17

Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instrances when several lines need to be complated in order to fully describe a single scheme. In this case please use the scheme name column to indicate this. On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B68 - C76); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

	Expenditure										
Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme
Risk Stratification	Other	Enabler	Other	John Hopkins ACG	CCG			Private Sector	CCG Minimum Contribution	£64,000	Existing
Lifestyle Hub	Other	Prevention	Other	Public health	Local Authority			Private Sector	CCG Minimum Contribution	£100,000	Existing
IT	Other	Enabler	Other	Health informatics services	CCG			NHS Community Provider	CCG Minimum Contribution	£4,000	Existing
Clinical Response Team	Integrated care teams		Primary Care		CCG			Charity/Voluntary Sector	CCG Minimum Contribution	£1,380,015	Existing
Assistive Technology	Assistive Technologies		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£213,321	Existing
LPT Unscheduled care team	Integrated care teams		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£469,216	Existing
ICRS	Integrated care teams		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£835,000	Existing
Night Nursing team	Integrated care teams		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£90,990	Existing
Services for complex patients	Personalised support/ care at home		Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	£1,220,277	Existing
Mental Health Planned Care Team	Integrated care teams		Mental Health		CCG			NHS Community Provider	CCG Minimum Contribution	£232,025	Existing
MH Housing team	Integrated care teams		Mental Health		CCG			NHS Mental Health Provider	CCG Minimum Contribution	£40,440	New
MH Discharge team	Integrated care teams		Mental Health		CCG			NHS Mental Health Provider	CCG Minimum Contribution	£42,462	Existing
ICS (+)	Intermediate care services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£883,614	Existing
Reablement - LPT	Reablement services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£1,137,375	Existing
Existing ASC Transfer	Other	Adult social care	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£5,901,968	Existing
Carers Funding	Support for carers		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£650,000	Existing
Reablement funds - LA	Reablement services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£825,000	Existing
2016/17 ASC Increased Transfer	Other	Adult social care	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£5,650,000	Existing
Performance Fund	Other	Performance fund	Acute		CCG			NHS Acute Provider	CCG Minimum Contribution	£1,926,540	Existing
Uncommitted	Other	Uncommitted	Other	Unknown	CCG			CCG	CCG Minimum Contribution	£194,757	New

Scheme Type	Description
Reablement services	The development of support networks to maintain the patient at home independently or through appropriate interventions delivered in the community setting. Improved independence, avoids admissions, reduces need for home care packages.
Personalised support/ care at home	Schemes specifically designed to ensure that the patient can be supported at home instead of admission to hospital or to a care home. May promote self management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term. Admission avoidance, re-admission avoidance.
Intermediate care services	Community based services 24x7. Step-up and step-down. Requirement for more advanced nursing care. Admissions avoidance, early discharge.
Integrated care teams	Improving outcomes for patients by developing multi-disciplinary health and social care teams based in the community. Co-ordinated and proactive management of individual cases. Improved independence, reduction in hospital admissions.
Improving healthcare services to care homes	Improve the quality of primary and community health services delivered to care home residents. To improve the consistency and quality of healthcare outcomes for care home residents. Support Care Home workers to improve the delivery of non essential healthcare skills. Admission avoidance, re-admission avoidance.
Support for carers	Supporting people so they can continue in their roles as carers and avoiding hospital admissions. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. Admission avoidance
7 day working	Seven day working across health and/or social care settings. Reablement and avoids admissions
Assistive Technologies	Supportive technologies for self management and telehealth. Admission avoidance and improves quality of care

Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Leicester

Data Submission Period:
2016/17

Better Care Fund Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 national metrics and 2 local metrics. The non-elective admissions metric does not currently require any input of data during the first submission - once CCG plans have been collected this data will be populated into this template by the national team and sent back in time for the second submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet. On this tab please enter the following information:
- In cell F48 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column G to provide any useful information in relation to how you have agreed this figure.
- Please use cell F57-59 to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell F59 (the planned total number of older people (65 and over) discharged from hospital into reablement/ rehabiliation services) and the numerator figure in cell F58 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell F57. Please add a commentary in column G to provide any useful information in relation to how you have agreed this figure.
- Please use rows 74-76 to update information relating to your locally selected performance metric. The local performance metric set out in cell B74 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.
- You may also use rows 82-84 to update information relating to your locally selected patient experience metric, although this is no longer a national requirement. The local patient experience metric set out in cell B82 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return.

HWB NEA Activity plan

Contributing CCGs	% CCG registered population that has resident population in	% Leicester resident population that is in CCG registered population	Quarter 1		Quarter 2		Quarter 3		Total (Q1 - Q3)	
			CCG Total Non-Elective Activity Plan*	HWB Non-Elective Activity Plan**	CCG Total Non-Elective Activity Plan*	HWB Non-Elective Activity Plan**	CCG Total Non-Elective Activity Plan*	HWB Non-Elective Activity Plan**	CCG Total Non-Elective Activity Plan*	HWB Non-Elective Activity Plan**
NHS East Leicestershire and Rutland CCG	2.5%	2.2%		0		0		0	0	0
NHS Leicester City CCG	92.5%	95.2%		0		0		0	0	0
NHS West Leicestershire CCG	2.6%	2.6%		0		0		0	0	0
Totals		**100%**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

* This should match CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level
** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see tab CCG - HWB Mapping)

Residential Admissions

		Actual 14/15***	Planned 15/16***	Planned 16/17	Comments
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	727.7	671.4	634.4	Please add comments, if required
	Numerator	287	270	260	
	Denominator	39,438	40,216	40,985	

***Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'

Reablement

		Actual 14/15	Planned 15/16	Planned 16/17	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	85.1%	90.0%	90%	Please add comments, if required
	Numerator	200	252	198	
	Denominator	235	280	220	

Delayed Transfers of Care

		15-16 actuals				15-16 plans				16-17 plans			
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	541.1	364.2			1167.6	1314.9	1054.5	1208.1	566.8	532.1	497.4	460.2
	Numerator	1,395	939			3,010	3,390	2,718	3,133	1470	1380	1290	1200
	Denominator	257,793	257,793			257,793	257,793	257,793	259,335	259,335	259,335	259,335	260,752

Local performance metric (as described in your approved BCF plan / Q1 return)

		Planned 15/16	Planned 16/17	Comments
Number of patients on dementia registers as % of the estimated dementia prevalence (national indicator)	Metric Value	0.7	0.7	2016-17 Proposed figures based on 2014-15 QOF results
	Numerator	2285	2315	
	Denominator	3410	3307	

Local defined patient experience metric (as described in your approved BCF plan / Q1 return)

		Planned 15/16	Planned 16/17	Comments
Taken from GP Survey (For respondents with a long-standing health condition)	Metric Value	8.8	8.8	2016-17 Figures based on CQC Inpatient Survey at University Hospitals of Leicester (publised on 21 May 2015)
	Numerator	Not available	Not available	
	Denominator	Not available	Not available	

National Conditions

Selected Health and Well Being Board:

Leicester

Data Submission Period:

2016/17

National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework [INSERT LINK] and further guidance is provided in the BCF Planning Requirements document [INSERT LINK]. Please answer as at the time of completion. On this tab please enter the following information:
- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - plan in place' should be used when a condition is not currently being met but a plan is agreed to meet this through the delivery of your BF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition.
- Please use column C to indicate when it is expected that the condition will be met if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

National Conditions For The Better Care Fund 2016-17	Does your BCF plan for 2016-17 set out a clear plan to meet this condition?	Comments
1) Plans to be jointly agreed	Yes	
2) Maintain provision of social care services (not spending)	Yes	
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	
4) Better data sharing between health and social care, based on the NHS number	Yes	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	No - in development	To be aligned with CCG planning assumptions
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	

Appendix D

LEICESTER CITY HEALTH AND WELLBEING BOARD
2 February 2016

Subject:	Delivering the Forward View – NHS Planning Guidance 2016/17 – 2020/21
Presented to the Health and Wellbeing Board by:	Sue Lock
Author:	NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

EXECUTIVE SUMMARY:

This guidance informs NHS Planning for the next four years.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: note the guidance

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

December 2015

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

Version number: 1

First published: 22 December 2015

Prepared by: NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

This document is for: Commissioners, NHS trusts and NHS foundation trusts.

Publications Gateway Reference: 04437

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.

2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new Mandate to NHS England (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.

4. We are requiring the NHS to produce two separate but connected plans:

   - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
   - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016[1] and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.

8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement[2] will need to help secure remedies through more joined-up and effective system oversight.

9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

[1] For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.

[2] NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.

13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:

    (i) the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;

    (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;

    (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and

    (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of 'national challenges' to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.

15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing 'transformation footprints'

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.

17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.

18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the 'six principles' created to support the delivery of the Five Year Forward View. By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.

20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title 'STP feedback'. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National 'must dos' for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.

22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

(i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;

(ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and

(iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine 'must dos' for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:
    - secondary mental health providers managing care budgets for tertiary mental health services; and
    - the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.

26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:

    - how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
    - their planned contribution to the efficiency savings;
    - their plans to deliver the key must-dos;
    - how quality and safety will be maintained and improved for patients;
    - how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
    - how they link with and support with local emerging STPs.

    The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

    - greater equity of access through pace of change, both for CCG allocations and on a place-based basis;

    - closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and

    - faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

    NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.

33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.

34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.

35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top- ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.

38. As notified in Commissioning Intentions 2016/2017 for Prescribed Specialised Services, NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.

39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.

40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.

42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.

43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.

44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?

    - How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?

    - What action will you take to address obesity, including childhood obesity?

    - How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, accountable consultants?

3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1 What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?

3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?

4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?

5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?

6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?

8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?

9. What steps will your local area take to improve dementia services?

10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support

11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?

12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?

13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?

14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?

15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?

16. How will you put your Children and Young People Mental Health Plan into practice?

17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?

19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?

20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?

2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?

3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?

5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full Mandate to NHS England

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	**Overall 2020 goals:** • Consistent improvement in performance of CCGs against new CCG assessment framework.
	2016-17 deliverables: • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.	
2.1 Avoidable deaths and seven-day services	**Overall 2020 goals:** • Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. • Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures. • Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020. • Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients. • Measurable improvement in antimicrobial prescribing and resistance rates.
	2016-17 deliverables: • Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline. • Rollout of four clinical priority standards in all relevant specialties to 25 percent of population. • Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety. • Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

2.2 Patient experience	**Overall 2020 goals**: • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
	2016-17 deliverables: • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
2.3 Cancer	**Overall 2020 goals:** • Deliver recommendations of the Independent Cancer Taskforce, including: o significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and o patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
	2016-17 deliverables: • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

3. To balance the NHS budget and improve efficiency and productivity	
3.1 Balancing the NHS budget	**Overall 2020 goals**: • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.
	2016-17 deliverables: • With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in: o securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending; o delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and o reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament. • Roll-out of second cohort of RightCare methodology to a further 60 CCGs. • Measurable improvement in primary care productivity, including through supporting community pharmacy reform. • Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients. • Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.	
4.1 Obesity and diabetes	**Overall 2020 goals:** • Measurable reduction in child obesity as part of the Government's childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes.
	2016-17 deliverables: • Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. • 10,000 people referred to the Diabetes Prevention Programme.
4.2 Dementia	**Overall 2020 goals:** • Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: o maintain a diagnosis rate of at least two thirds; o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and o improve quality of post-diagnosis treatment and support for people with dementia and their carers.
	2016-17 deliverables: • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Work with National Institute for Health Research on location of Dementia Institute. • Agree an affordable implementation plan for the Prime Minister's challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.

5. To maintain and improve performance against core standards	
5.1 A&E, ambulances and Referral to Treatment (RTT)	**Overall 2020 goals:** • 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population. • 75 percent of Category A ambulance calls responded to within 8 minutes. • 92 percent receive first treatment within 18 weeks of referral; no-one waits more than 52 weeks.
	2016-17 deliverables: • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E. • Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact. • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out. • With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.
6. To improve out-of-hospital care.	
6.1 New models of care and general practice	**Overall 2020 goals:** • 100 percent of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.

	2016-17 deliverables: • New models of care covering the 20 percent of the population designated as being in a transformation area to: o provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and o make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing. • Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists. • Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
6.2 Health and social care integration	**Overall 2020 goals:** • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.
	2016-17 deliverables: • Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17. • Every area to have an agreed plan by March 2017 for better integrating health and social care. • Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals. • Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	2016-17 requirements: • NHS England is required to: o ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care; o consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and o consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
6.3 Mental health, learning disabilities and autism	**Overall 2020 goal:** • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: o 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and o 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	2016-17 deliverables: • 50 percent of people experiencing first episode of psychosis to access treatment within two weeks. • 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. • Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care. • Agree and implement a plan to improve crisis care for all ages, including investing in places of safety. • Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018. • Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.	
7.1 Research and growth	**Overall 2020 goals:** • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
	2016-17 deliverables: • Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.
7.2 Technology	**Overall 2020 goals:** • Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations.
	2016-17 deliverables: • Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020. • Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016. • Robust data security standards in place and being enforced for patient confidential data. • Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care. • Significant increase in patient access to and use of the electronic health record.

7.3 Health and work	**Overall 2020 goal:** • Contribute to reducing the disability employment gap. • Contribute to the Government's goal of increasing the use of Fit for Work.
	2016-17 deliverables: • Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce. • Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment.

#FutureNHS

LEICESTER CITY HEALTH AND WELLBEING BOARD
2 February 2016

Subject:	Mental Health Joint Commissioning Strategy
Presented to the Health and Wellbeing Board by:	Yasmin Surti, Lead Commissioner - Mental Health & Learning Disabilities
Author:	Yasmin Surti, Lead Commissioner - Mental Health & Learning Disabilities

EXECUTIVE SUMMARY:

This strategy has been recently developed by Leicester City Council and the Leicester City Clinical Commissioning Group and outlines our commissioning intentions for the period 2015-2019.

The strategy has been developed in full consultation with stakeholders, including people with mental health problems and carers of people experiencing poor mental health.

It takes in to account the priorities set out in the Health and Well Being Strategy: "Closing the Gap", the Better Care Together Programme and needs identified in "Mental Health in the Leicester: A Joint Specific Needs Assessment" and the outcomes identified in a recent Health and Well Being Mental Health Mini Summit.

The Strategy is set out in 11 sections and is presented with an accompanying delivery action plan summarising the current and planned activity to support the achievement of the following priorities:

1. Building Well - being and Resilience
2. Personalisation
3. Accommodation
4. Healthcare
5. Employment, Education and training
6. Preparing for Adulthood
7. Carers

It is a live document that will be reviewed annually to ensure we continue to address local needs and changes priorities. The impact of the strategy on individuals and carers will be measured using a dashboard that has been designed in consultation with Public Health.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to endorse the Mental Health Joint Commissioning Strategy as part of the sign off process prior to publication.

Joint Mental Health Commissioning Strategy Delivery Action Plan for Leicester

April 2015 – March 2019

2 year priority work plan:

Area	Action	Timescales	How will we achieve this	Lead
Building Well-being and Resilience	Building resilience within children and young people	Sept. 2015	Establish online counselling pilot scheme for children and young people	CAMHS Commissioning Manager LLR CCG's
		Ongoing	A range of Schools based programmes - Initiatives aimed at improving emotional wellbeing and resilience and schools responses including- Optimistic Kids. Thinkwise. Anti-bullying /stigma/ Anti-discriminatory	Public Health LCC
	Increasing mental health awareness and	Oct. 2015	Mental Health First Aid Training Cascade across the Faith Communities and 'train the trainers' (resilience)	Public Health LCC
		Dec. 2015	Develop a general awareness campaign to promote the Five ways of mental health wellbeing (Connect, be active, take notice, keep learning and give) and 'Time for Change' to reduce stigma	Public Health LCC
	Improving access to counselling (IAPT) service to support people with mild to moderate depression/ anxiety	Sept. 2015	Improve access to IAPT therapy services through developing patient self-referral	Leicester City CCG

		April 2016	Implement a revised Open Mind IAPT service with improved choice of treatment options and delivery in both GP and community settings	Leicester City CCG
		Sept. 2016	Introduce extended hours provision and flexible web based therapy provision.	Leicester City CCG
	Developing Healthy workplaces	April 2016	Engage with local employers to encourage mindful employment and better understanding of mental health in the workplace	Public Health LCC
Personalisation	Develop structure to implement Personal Health Budgets and Integrated Personal Budgets	April 2016	Develop Integrated Personal Budgets to extend offer to those who are joint health and social care funded	LLR CCG's/ Adult Social care LCC
		April 2017	Support individuals to experience greater choice and control by increasing the number of people in receipt of a Personal Budget Direct payment by 30%	Leicester City CCG/ Adult Social care LCC
		April 2017	Develop a local policy and practice guidance for Personal Health Budgets and Mental Health	LLR CCG's

	Increasing Choice and Control	April 2016	Work with providers to develop the market and increase choice, opportunity and quality	Leicester City CCG/ Adult Social care LCC/ Voluntary and Community sector Partnerships
		April 2016	Improved access and experience of diverse communities by involving service users in: • training, • developing services • contract monitoring	Leicester City CCG/ Adult Social care LCC/ Voluntary and Community sector
		April 2017	Explore the potential to integrate health and social care mental health services thereby eliminating duplication such as repeat visits and assessments	Leicester City CCG/ Adult Social care LCC
Accommodation	1. Ensure that housing needs are considered and met in both planning and provision, so reducing the use of residential care, & increasing the take up of supported living	2015/16 Sept 2015	Review & learn from the Bradgate Unit Housing Support pilot	NHS Leicestershire Partnership Trust / LLR CCG's
		Ongoing	Address the needs of people experiencing mental health problems, including homelessness and hospital discharge	Housing Options Leicester City Council

	2. Ensure annual review is robust in assessing current needs & considers supported living as an alternative to residential care ASCOF 1H: Proportion of adults in contact with secondary mental health services who live independently, with or without support. — 40%	2015/16	Support up to 40 people a year to move on from residential care settings into independent living.	LCC Adult Social care Supported living team
Health	**Improve crisis response services**	Sept. 2015	Work with NHS Leicestershire Partnership Trust to review and improve response times from crisis support and home treatment services	LLR CCG's
		Oct 2015	Work with NHS Leicestershire Partnership Trust to remodel Community Mental Health Teams to improve access for patients known to the service at times of crisis	LLR CCG's
		Ongoi ng	Work with local partners to implement the wide ranging actions within the LLR Mental Health Crisis care concordat.	Leicester City CCG/ Adult Social care LCC
		April 2017	Improved access and experience of patients needing support by involving people in co- production of crisis response services, taking into account Due Regard and in particular experience of BME communities.	NHS Leicestershire Partnership Trust / LLR CCG's

	Strengthen primary care and community based recovery support services	Dec 2015	Jointly review Third Sector provision to strengthen and integrate provision at local level in line with the Leicester, Leicestershire and Rutland Better Care Together Strategy	LLR CCG's
		April 2016	Implement plans to strengthen and integrate role of VSC to support resilience and recovery at a local level	LLR CCG's
		June 2015	Increase the number of primary care Mental Health facilitators to provide greater support for people with severe and enduring mental health needs within community settings	Leicester City CCG
	Improve inpatients care services	April 2016	Work with NHS Leicestershire Partnership Trust to improve the acute care pathway in line with CQC and independent review recommendations	LLR CCG's
		April 2017	Improved access and experience of patients needing support by involving people in co- production of inpatient services, taking into account Due Regard and in particular experience of BME communities.	NHS Leicestershire Partnership Trust / Leicester City CCG
	Develop alternatives to hospital admission	April 2016	Work with partners to evaluate the effectiveness of a LLR Crisis House established in early 2015	LLR CCG's

		Sept. 2015	Work with LPT to review pilot and develop effective step down services from inpatients beds	NHS Leicestershire Partnership Trust / LLR CCG's
		April 2016	Accelerate return of patients in rehabilitation placements away from home and improve community rehabilitation services	NHS Leicestershire Partnership Trust / LLR CCG's
Employment, education and training	1. Support the development of a Recovery Network that promotes employment, education and training.	2015/16	Work with mainstream providers e.g. Job Centre Plus to enable better support back into employment. Promote apprenticeships and internments for young people. Work with employers to raise awareness and to be ' Mindful' employers.	Leicester City CCG/ Adult Social care LCC/ Voluntary and Community sector Partnerships
	2. ASCOF 1F: Proportion of adults in contact with secondary mental health services in paid employment. – 2.5%		Improve data collection of people in contact with secondary care services supported into employment.	NHS Leicestershire Partnership Trust / Adult Social care LCC
Preparing for Adulthood	1. Continue to work together to fulfil our responsibilities under the Children and Families Act 2014	April 2016	Improve Children and Adolescent Mental Health Services (CAMHS) pathways and interfaces with adult & non-specialist services	CAMHS Commissioning Manager LLR CCG's
	2. Improve the pathway from child to adult mental health services	April 2016	Develop clear pathways for transition from children's services to adult services & offer early interventions to help people with mental health needs	NHS Leicestershire Partnership Trust / Leicester City CCG/ Adult Social care and

			to function more independently when they reach adulthood.	Children's services LCC
		April 2016	Ensure the review of Child Mental Health services links with the Autism Pathway Improve understanding	CAMHS Commissioning Manager CCG's
Carers	1. Family carers have expectations and experiences which are comparable to the general population	April 2016	Provide information, advice, guidance, services and support in a timely way responding to the Care Act. To better understand and respond to the needs of Carers of all ages, anticipating future needs as well as addressing immediate needs in the most appropriate setting.	LA
	2. Ensure carers are identified and supported appropriately with preventative services. ASCOF data	April 2016	Identification and flagging of carers in primary and secondary care. Enhance information and advice, advocacy, training and peer support to ensure carers receive the support they need. Raise awareness of caring role particularly with BME carers.	Leicester City CCG/ Adult Social care LCC/ Voluntary and Community sector Partnerships

Leicester City Council

NHS
Leicester City
Clinical Commissioning Group

Joint Mental Health Commissioning Strategy for Leicester

2015 – 2019

Acknowledgements:
This Mental Health Strategy has been truly co-produced, and grateful thanks are expressed to all who have been involved and agreed to sign up to it.
MH Strategy Group with Users, Carers and Professionals.

Signed for and on behalf of:	**Signature**	**Organisation Logo**
Leicester City Council **Adult Social Care Services**		Leicester City Council
Leicester City CCG		NHS Leicester City Clinical Commissioning Group
The Health and Wellbeing Board has approved and signed up to the strategy giving a collective responsibility. The board comprises of the following partner members: Elected members including the deputy City Mayor NHS representatives for the Leicester Clinical Commissioning Group & Leicestershire & Lincolnshire NHS England City Council officers for Public Health, Adult Social Care and Children's Services Healthwatch Leicestershire Constabulary		

Contents

Foreword

Mental Illness is the largest single cause of disability in the UK with 1 in 4 people experiencing poor mental health at any given time. In Leicester the risk factors associated with mental ill health are significantly worse than the values for England. Therefore at a time of increasing pressures on funding it is important that we focus our resources on those who need the most support, whilst continuing to enable those with lower needs to improve or maintain their health, wellbeing and independence. Our Joint Mental Health Commissioning Strategy shows we are committed to both:

- improving the mental health and wellbeing of the population and keeping people well,
- improving outcomes for people with mental health problems through high-quality services that are accessible to all

Our approach to keeping people well and maintaining their independence is also reflected in the Leicester, Leicestershire and Rutland Better Care Together Programme and the Health and Wellbeing Board Action Plan on Mental Health and the commitments in the recent Labour manifesto, *Building a strong future for our city*[1].

Further we recognise that it is important to use strategic opportunities to bring together mental health and wellbeing initiatives across health and social care and build improvements in collaboration between the statutory, voluntary and community and private sectors, promoting rights and recovery, addressing stigma and improving service outcomes. Such an approach will support the Leicester, Leicestershire and Rutland Mental Health Charter pledges:

Mental Health Charter- Every person has the right to Mental Health Services that:

1. **Work together with respect, dignity and compassion.**
2. **Make a positive difference to each person's recovery and quality of life.**
3. **Are guided by the individuals views about what they need and what helps them**
4. **Treat everyone as a capable citizen who can make choices and take control of their own life.**
5. **Give people the appropriate information they need to make their own decisions and choices about their recovery.**
6. **Recognise that mental health services are only part of a person's recovery; it can involve a wide range of different options.**
7. **Communicate with each person in a way that is right for them.**
8. **Understand that each person has a unique culture, life experiences and values.**
9. **Recognise, respect and support the role of carers.**
10. **Support their workers to do their jobs well.**
11. **Challenge stigma, fear and discrimination both within mental health services and the wider society.**
12. **Put mental health on a par with physical health.**
13. **Are culturally competent and can meet the diverse needs of local people.**

We know that things will change in the next few years, as our plans are implemented, so our aim is to monitor progress. In that sense, we regard this strategy as a live document, setting out our current ambitions, but flexible enough to tackle new challenges as they emerge.

Introduction

This Joint Mental Health Commissioning Strategy for Leicester supports Health and Wellbeing Strategy *Closing the Gap*[2] and reflects key legislative and practice changes which have implications for people with a mental health need and run through the whole strategy:

- **The Care Act 2014**[3] This draws together all previous social care legislation. It confirms the equal right to an assessment for users and carers, and the right to advocacy if a person has a substantial difficulty.

- **Better Care Together Strategy**[4] (*LLR Five Year Strategy, 2014-2019.)*

- **The Children and Families Act 2014**:[5] This legislation will change the transition process for young people from September 2014, with what is called the Local Offer. Implementation will vary across local authorities, but the principles are the same

- **Future in Mind**[6] 2015 sets out NHS England's transformational strategy to improve the mental health and wellbeing of children and young people

- **Achieving Better Access to Mental Health Services by 2020** (DH 2014)[7]

It takes into account related strategies which can have a positive impact on mental health, such as:

- Leicester *City Mayor's Delivery Plan*[8],
- Local Autism Strategy.[9]
- NHS England Business Plan 2015-2016[10]

The strategy aims to improve services and people's experience of them by focussing on the wider determinants of health and wellbeing, developing prevention and early intervention services and appropriate care, while at the same time addressing major financial challenges.

The Strategy builds on the findings and recommendations suggested in the JSpNA on mental health in Leicester. This shows that Leicester has high rates of risk factors associated with mental ill health and improving rates of diagnosed mental health need. The rate of emergency care use for mental ill health is high, but recovery is poor. The rate of death from suicide and undetermined injury is stable, but higher than the England average.

Of vital importance is the requirement to support mental health in our diverse population, ensuring in particular that preventative, crisis response and recovery services are able to meet the needs of the diverse communities of the city and other groups with protected characteristics such as Lesbian, Gay and Transgender communities.

According to national evidence relative mental health need, access to services and outcome of care is different for people from Black and Minority Ethnic (BME)

backgrounds compared to their White/White British counterparts[11]. This highlights that cultural and social factors can play a key role in how and when BME communities access Mental Health crisis support services. Further a local Health and Wellbeing Scrutiny Commission review identified Black British young men had poorer experience of mental health services.[12]

It is therefore important to understand these barriers and to improve access. One of the principles underpinning this Strategy is that we aim to ensure that commissioning and provider organisations reach the diverse communities in Leicester, provide culturally appropriate services and support delivered by culturally competent staff and improve the ways in which people from BME communities access mental health services. Further it requires programmes that specifically focus on increasing mental health awareness for all hard to reach groups.

We know that we have a long way to go. We have identified where we are now, what we want to change and where we need to be in 5 years' time:

Where we are now	**What are we going to do**	**Where we want to be in 5 years**
• Wellbeing inequalities and low life expectancy: we need to support parity of esteem • Crisis and home treatment services can be difficult to access: we need to make more responsive • Lack of primary and community outreach services including drug and alcohol: we need to expand the support available within local areas • Waits for some services are too long: we need to ensure people receive timely care • Focus on treatment: we need to increase focus on person centred recovery and prevention services	• Increasing general mental health well-being and resilience through targeted prevention initiatives • Redefining the meaning of recovery with stakeholders to develop person centred approaches • Reviewing the role of the Third sector to strengthen and integrate their role in supporting both recovery and resilience • Increasing the capability and capacity of primary care to manage people with severe and enduring illness in the community. • Increase life opportunities through the use of personal budgets and direct	• Reduced stigma related to mental health and greater awareness within population of promoting good mental health • Improved health Increased life expectancy for people with severe and enduring mental health needs • Reduce incidence of mental health conditions • Reduced crisis escalation episodes, with quicker response times when required which is responsive to individual need • Reduced delays in discharge and length of stay • Reduced reliance on acute services and

• Difficulties in finding long term accommodation for people discharged from mental health inpatients and rehabilitation units • Limited collection of patient experience feedback and co-production with user and carers to improve mainstream services.	payments • Promote mental health and resilience and develop early help services for children's, young people and those that care for them • Ensure that housing needs are considered and met in both planning and provision, so reducing the use of residential care • Ensure that carers get the right level of support and breaks	increased capability and capacity within primary and community settings. • Increased level of community accommodation to support mental health rehabilitation and discharge from hospital

Overall progress in delivering the strategy will be measured at least on an annual basis using a number of indicators covering service delivery and outcomes, measurements of the wider determinants and risk factors associated with mental ill health. By these measurements we will articulate a picture in Leicester of the factors which give rise to poor mental health and the effectiveness of our response.

Table: Priority indicators in the Joint Commissioning Strategy for mental health

Priority category	Indicators to be measured	Chapter
Wider Determinant	• Poverty • Educational Attainment • Employment • Homelessness • Reducing Alcohol Harm • Poverty	Accommodation Education Employment Preparing for adulthood
Risk Factor	Parity of esteem	Health
Population health	Prevalence of Depression	Health
Early intervention	Access to IAPT	Health
Effective treatment	• Effective crisis response at home • Acute admissions • Access to IAPT • Stable accommodation	Health Accommodation Preparing for adulthood

	• Diagnosis of dementia • Re-attendance at A&E • Enhancing quality of life for people with mental ill health	Carers
Outcomes	• Suicide rate per 100,000 • Rate of recovery for IAPT • Under 75 mortality rate for people with mental ill health	Health

This strategy is a "live" document. A two year Delivery Action Plan will be over seen by an implementation group, and the local health and social care commissioners will review its content regularly to measure progress in delivering the identified priorities and determine whether or not these need to change in light of changing circumstances.

Building Wellbeing and Resilience

Where are we now?

Good mental health is the foundation for good physical health and for important life skills and is fundamental to public health and health improvement. Public mental health is a critical element of the City's overall mental health strategy and can support the primary prevention of mental health problems and the development of a recovery focussed agenda. Elements from public health include training in mental health issues for frontline staff, training in managing mental health and improving the physical health of people with mental health problems as part of a recovery strategy.

The Joint Specific Needs Assessment on Mental Health in Leicester[1], and this Joint Commissioning Strategy on Mental Health is founded on the ethos that mental health is everyone's business. As the title of the Government mental health strategy declares, there is "no health without mental health."[2]

Health promotion interventions focus on health and mental wellbeing rather than illness. They can take place at an individual, community or population level. The aim is to improve individual wellbeing, enable healthier and more sustainable communities, facilitate environments which support improved health, and achieve structural changes in policy and law which benefit health and reduce health inequalities. Health promotion can occur at three levels:

- Primary: promoting the health and wellbeing of the whole population
- Secondary: targeted approaches to groups at higher risk of poor health and wellbeing
- Tertiary: target groups with established health problems to help promote their recovery and prevent recurrence.

Commissioning intentions

We will to work in partnership with key stakeholders, including public, private and voluntary sector organisations and with communities and individuals to improve the health of the population through preventing disease by building resilience, promoting recovery, prolonging life by supporting people to stay well and promoting good health. This will include:

- Raising awareness and training for local people in developing skills to manage their mental health and develop emotional resilience e.g. the '5 ways to wellbeing'
- Improve the availability of evidence based self-help information and resources in the City
- Improve access to physiological therapies for people with mild to moderate depression & anxiety by introducing self-referral, introducing extended hours provision and flexible web based therapy programmes.

[1] See http://www.leicester.gov.uk/media/178811/mental-health-jspna.pdf
[2] See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

- Deliver large scale training programmes to develop the skills of key frontline staff in addressing mental health issues, e.g. Mental Health First Aid
- Explore the feasibility of a city wide Recovery Network.
- Enhance the availability and status of peer support services with statutory services
- Further develop of social prescribing in the city in order to sign post individuals to community services able to offer support.
- Improve access and advice to employers on best practice approaches to workplace mental health and wellbeing
- Improve and expand the access to condition management and vocational rehabilitation to reduce loss of employment and improve pathways back into work

What will this mean to me?

Health and social care will work with people with lived experience of mental health, carers and other partners across the public, private and voluntary sector to ensure people have the tools to maintain their mental health and wellbeing:

- I will understand what I need to do to keep well - 5 ways to wellbeing
  - Give.
  - Connect
  - Keep learning
  - Be active
  - Take notice

- Organisations or people I come into contact with will have more awareness about mental health
- I will be able to access information and advice easily, for example housing or debt advice
- My employer will have a better understanding of how to support me
- I will feel more included in my community
- I will feel safer in my community

Personalisation

Where are we now?

Personalisation is an approach that has been in at the forefront of social care for the last decade in which every person in receipt of support will have choice and control over how, where and by whom their needs are met.

Personalised services are associated with direct payments and personal budgets, under which service users can exercise greater choice and control. However the scope of personalisation is wider than giving personal budgets to people eligible for health or social care funding. It includes ensuring that people are mobile and that they have access to leisure, education, housing, health, employment and other opportunities regardless of age or disability.

People with mental ill health may have the most to gain from increased choice and control over their support arrangements. However, support and provision available to date has often not been adequate. For personalisation to make a real difference for people with mental ill health it requires improved information and advice on care and support for individuals and and families, investment in preventive services to reduce or delay people's need for formal care, better management of the market and the promotion of independence and self-reliance.

Currently about two thirds of all people supported by Adult Social Care are in receipt of a Personal Budget. Of those more than half have chosen to take a Direct (cash) Payment. In 2013/14 the total number of Direct Payments in Adult Social Care for people aged 18 to 64 years was 965; almost a quarter of all support packages (195, 24.4%) were for people with mental health needs.

What do users and carers say?

- People are concerned about the eligibility criteria, some feel it is too limited and there is also a worry about what happens to those people not deemed eligible. There is also a concern about the lack of understanding in relation to the "ups and downs" that people with poor mental health can have.
- Transparency is required, this should include both pricing options and the services provided, which should include recovery focussed options, in order to enable informed decision making.
- Service users and carers should be more involved in key decisions.
- We need to monitor the quality of services; there are a lot of dubious quality services with poorly trained staff and a high staff turnover.
- There should be more emphasis on early intervention and prevention thus preventing people from reaching crisis point.

Commissioning intentions

The Commissioning organisations will focus on the following areas to improve personalisation for people with mental health needs:

- Extending the right to Personal Budgets, Integrated Person Budgets and Personal health Budgets - People with 100% Continuing Healthcare funding have had a right to Personal Health Budgets since October 2014.
- Develop models of Enablement- Work with providers to develop a model of support which looks at what a person can do now and how best to support them to enhance or maintain their wellbeing and independence without the need for formal, and institutionalised, support.
- Work with providers to offer clearly priced support options available to self-funders and all eligible people using their allocated personal health and social care budget.
- Work with communities and the voluntary sector to support the expansion and enhancement of self-care and preventative and early intervention support for people with mental health needs and their carers.
- Consider the impact of universal credit in relation to clientele and the support actions that can be developed to encourage greater engagement in training, volunteering and employment.

What will this mean to me?

- I will have a self-assessment and person centred support plan.
- I will be supported with a personal budget if eligible.
- I will have a real say in how my care and support needs are met
- I will have a range of accessible support options available to me including access to universal services, personal support needs, accommodation, employment, leisure, day activities, transport, and flexible short breaks.

Accommodation

Where are we now?

A settled home is crucial for good mental health. People with mental ill health are less likely to be homeowners and more likely to live in unstable accommodation; 41% of Leicester residents live in the 20% most deprived areas of England and 0.46% are homeless.[13]

The home is sometimes the setting for packages of care where informal family and community support can play a big part in maintaining people's wellbeing. Some housing providers have experience in designing and delivering services that enable positive outcomes that can improve the health of individuals, reduce overall demand for health and social care and aid recovery from poor mental health. In some cases the integration of housing with discharge planning is critical if delayed discharges and inappropriate settings of care are to be avoided.

Even though there is suitable affordable housing in Leicester, too many people with poor mental health are living in residential care and out-of-area placements. Therefore there is a need to work with providers of social housing and private landlords to ensure the availability of more properties in areas where people feel safe and where they will have access to the support they require.

Providers can offer a range of independent living options across the city with different facilities available to meet individual needs. As accommodation and support needs vary so there are different styles of delivery, for example, Manor Farm is a scheme which opened in 2012, with the aim of supporting working age adults with mental health support needs. Some people have already felt confident enough to move on to greater independence.

The outcomes delivered for those with a mental health condition shows that 77.7% are living independently, however we need to improve the performance against this year's target of 40 people to move from residential care into independent living. [3] Our approach is to ensure people have better life outcomes, and increased opportunities to live independently or in supported accommodation schemes across the city.

A review of local residential and nursing placements shows that there are 611 people with mental health needs living in residential care. Most are older people, with 461 aged over 65 years. However, 150 are aged between 18 and 64 years, 45 of whom have been admitted in the last 2 years.

The total number of people requiring residential or nursing care has decreased recently, although the proportion of those with mental ill health has increased. In October 2014 there were 1,328 individuals in residential care including nursing placements, of which

[3] Adult Social Care Independent Living and Extra Care Commissioning Strategy 2013 to 2016

46% (611 people) had poor mental health. Most of the 611 people resident care or nursing homes were aged over 65 years (75%; 458 people).

The net spend for residential and joint funded cases is set out below;[14]

Mental Health – residential and nursing (18 – 64)	£4,449,600
Mental health – residential and nursing (65 & over)	£4,694,100

The national Adult Social Care Outcomes Framework records data across the country under the title – Adults in contact with mental health services who are in stable accommodation. The data indicates Leicester City outcomes are below the national average and there is much work to be done to enhance the experience of local people in secondary mental health services. This suggests that there is an opportunity for collaboration between commissioners, mental health providers and housing associations to provide better pathways and outcomes for service users. There is also an imperative to ensure that the needs of people with poor mental health are explicit in relevant housing strategies.

What do users and carers say?

- Specific housing support is essential, including support for carers, this needs to be a priority, and should include support at the right times including outside normal working hours.
- Problems occur when people are placed in inappropriate housing and issues may exacerbate existing conditions. Commissioners should ensure that housing is appropriate for the service users' needs.
- There should be more community support and work should be done to understand the stigma suffered by people with mental ill health.
- Housing staff should be trained in mental health so that they know how to communicate with people; perhaps have a member of staff in each department that is trained and responsible for ensuring best practice.
- More work is required with private landlords; they should be monitored and reviewed to ensure that they provide an equitable service for people with mental health needs.
- There should be support and funding for friends and family of people who are placed out of area for their care.
- There needs to be good communication between services.

Commissioning intentions

The Commissioning organisations will focus on wherever possible supporting people to live in mainstream housing by:

- Work to inform and shape the Housing Strategies to reflect the importance of poor mental health as both a cause and consequence of homelessness.

- Explore and develop options to support people locally who are currently in out-of-area placements.
- Work with housing providers to increase the availability of supported housing for people with mental health support needs.
- Continue to develop mental and physical health care support services for people who do not have secure accommodation.
- Promote anti-stigma and discrimination messages by working with key partners to raise awareness of the risks to emotional health and wellbeing associated with homelessness (such as the Police, Probation Service, housing, health and social care).
- Continue to develop Leicester City Councils Independent Living Support and Extra Care accommodation which is available for people aged 18+ and who are eligible for Adult Social Care.

What does this mean to me?

- I will have greater choice from a range of housing options to live where I choose.
- I will be involved in the running of my home, and choose who supports me.
- I will not be fitted into a service where there is a vacancy that doesn't suit me.
- The support I receive at home will help me to stay well

Healthcare

Where are we now?

Mental health is everyone's business. Individuals, families, and communities all have a part to play. Good mental health and resilience are fundamental to physical health, relationships, education and employment. Mental health services need to be effective to ensure that people are supported and have timely access to effective care.

Mental Health services need to be more responsive to needs of local communities; particularly black and minority ethnic and newly emerging communities and they need to meet the financial challenge on the NHS.

In addition to poor outcomes from mental health care, services in Leicester are characterised by the following:

- A large single mental health provider covering Leicester, Leicestershire and Rutland – NHS Leicestershire Partnership Trust.
- An inpatients' service which has been under significant pressure in recent years.
- Lack of community based alternatives to support people in mental health crisis.
- Historic health funding for voluntary and community sector mental health provision which may not target those who need most support.
- Recently developed and NHS funded Improving Access to Physiological Therapies (IAPT) services.
- Services where access needs improving for example specialist counselling, early intervention in psychosis and better crisis care.

Leicester City Clinical Commissioning Group spends:

- £42m on MH services from Leicestershire Partnership Trust.
- £2m on Improving Access to Psychological services.
- £650k on Voluntary and Community Sector.

What do users and carers say?

- More mental health promotion work is needed to increase awareness of mental ill health and how to access support.
- More needs to be done to address the stigma associated with poor mental health.
- There is a need to improve crisis support including better response times.
- The referral route to the Crisis House should not only be through the crisis resolution team.
- There is a need for self-referral and flexible provision of IAPT services which will enable users to have a choice and control of counselling support.
- Peer support groups for people of all ages can support recovery and resilience.
- There should be more recognition of the role that the Voluntary and Community Sector can play in supporting people with mental ill health.
- There needs to be closer working between mental and physical health services.

- It is important to build resilience to mental ill health in younger people.
- Mental health first aid training is required for faith and community groups.
- There is a need to ensure carers' registers are held in Primary Care and carers' needs are monitored and evaluated by GPs.
- More work should be done in the community, to increase the community based services, ensuring there are more venues which are safe places. Look to engage with faith groups, sports clubs etc.
- More recovery focused treatment is needed, with innovative ways to enable self-care.
- There should be more meaningful involvement of users to improve services, with more peer support on wards.

Commissioning Intentions

Locally Better Care Together (BCT) is based on a partnership between NHS organisations and local authorities across Leicester, Leicestershire and Rutland (LLR). The BCT strategy 2014-19 prioritises mental health.

The overall aim of the BCT strategy is to refocus priorities from traditional centralised services to primary and community based services, supported by a greater emphasis on building mental health resilience within the population. Leicester City Council and Leicester City Clinical Commissioning Group will work with BCT partners to implement this strategy.

We will ensure the needs of the city, including minority communities, are reflected in future service planning and commissioning. Taken together the BCT and this joint strategy will:

Strengthen mental health resilience

- Educate people about mental health and the importance of early support.
- Wider education on understanding mental health to reduce stigma.
- Raise awareness by offering Mental Health First Aid training for professionals, employers, communities and faith groups.
- Develop social prescribing through GP practices to address underlying causes; debt, employment, isolation, housing.
- Ensure that mental health services take a lead in dual diagnosis of mental ill health and substance misuse.

Improve crisis response services

- Work with partners in LLR to implement the local Mental Health Crisis Concordat action plan.
- Work with NHS Leicestershire Partnership Trust to remodel and improve response times from crisis response and home treatment services.
- Work with NHS Leicestershire Partnership Trust to improve patient experience of crisis response services, particularly for patients from BME communities.
- Explore opportunities for Third sector support services to support people whilst in crisis.

Improve inpatient care services

- Work with NHS Leicestershire Partnership Trust to ensure ongoing and sustainable improvement in inpatient care services and limit the need for out of county placements and delayed transfers of care.
- Continue to explore alternatives to hospital, including potential Third sector provision.
- Work with NHS Leicestershire Partnership Trust to improve patient experience outcome monitoring, particularly for patients from BME communities.

Strengthen primary and community based recovery services

- Improving access to psychological therapies (IAPT) services will include specific services for targeted groups, self-referral and extended provision of clinics in community venues.
- Increase the number of primary care Mental Health Facilitators in order to provide support to vulnerable people in general practices.
- Review the role and existing funding to Third sector (including VCS) providers to ensure services are locally targeted and support the objectives of the BCT Mental Health Strategy.
- Develop locality based recovery support services including peer support and social networks.
- Review the role of the Third sector (including local Voluntary and community funded services) to support and develop local recovery support networks.

What will this mean to me?

- ❖ I will be able to manage my mild or moderate depression through psychological support services.
- ❖ I will be provided with mental health rehabilitation services in the community.
- ❖ I will have quicker crisis response times.
- ❖ I will have improved access to mental health acute/crisis care and better overall experience.

Employment, Education and Training

Where are we now?

Education, employment and training are wider determinants of health and wellbeing which have an impact on mental health needs. A life course approach to mental wellbeing will protect children's mental health in school. The approach to adult mental health care will be to work with children and young people's services to protect mental health.

The Royal College of Psychiatrists view, which is supported more recently by direction in The Care Act, places great emphasis on employment and the important role it plays in helping people maintain their health and wellbeing, as well as feeling part of and contributing to society. Assessments and support need to take account of peoples employment aspirations, and in the case of young carers, there needs to be an assumption that they may want to go to university or enter paid employment.

Education has a bearing on employment and social inclusion, both of which have can affect mental health. As a city with two universities, there will be a focus on the development of student mental health provision to ensure that young people have appropriate access to the services they require, whilst undertaking higher education. Certain groups are at risk of common mental health problems, such as those with low level qualifications. Individuals with psychotic disorders are most likely to have left school before age 16. Measures show that the risks for children in Leicester are high. In Leicester 7% of 16-18 year olds are not in employment, education or training, compared to 6.2% for England.[15] In addition 54.8% of Leicester children achieve 5 GCSEs at grades A to C, compared with 60.8% for England.[16]

Unemployment is associated with social exclusion, which has a number of adverse effects, including reduced psychological wellbeing, greater incidence of self-harm, depression and anxiety. It is recognised that employment can have a beneficial effect on mental health, boosting a person's confidence and self-esteem.[4] Unemployment is a cause and consequence of mental ill health. This is also a risk factor for Leicester; 79.5 per 1,000 working age adults in Leicester are unemployed compared to 59.4 for England.[17] Of working age adults receiving secondary mental health services on the Care Programme Approach only 2.2% are employed.

Open Mind IAPT works in partnership with the Fit for Work Service to provide clinical and non-clinical support to help workers experiencing a period of ill-health to keep attending work or to resume work after a period of absence.

NHS Leicestershire Partnership Trust also works with ASPIRO (Social enterprise) to offer employment support to individual using secondary care mental health services.

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212266/hwwb-mental-health-and-work.pdf

We have a local Recovery College which provides a range of recovery focused courses, seminars and workshops for people accessing adult mental health services and for their friends and family.

What do users and carers say?

- There is a need for services outside normal working hours for workers to access.
- Volunteering opportunities should be more flexible, with easier access (e.g. employment checks (Disclosure and barring Services – DBS) that can be used by different organisations).
- There is a need to increase the Recovery network bases and courses.
- Education and employment organisations need to understand that people with mental ill health have ups and downs.
- There is a need for job coaching opportunities where people learn the job together, with support.
- There is a need for shared success stories about work with positive messages being enforced that people with mental ill health can, and do work in paid jobs, leading to more aspirational goals with a belief that people can find and sustain paid employment.
- DWP/Job Centre need to be more aware about mental ill health.
- Raise people aspirations in increasing their skills or moving into volunteering, employment or training
- There is a need for more employment support to enhance the confidence of service users.
- There needs to be a focus on recovery with people able to set goals, attend voluntary work and training without sanctions.
- There needs to be greater understanding on what constitutes appropriate activities for each individual.

Commissioning intentions

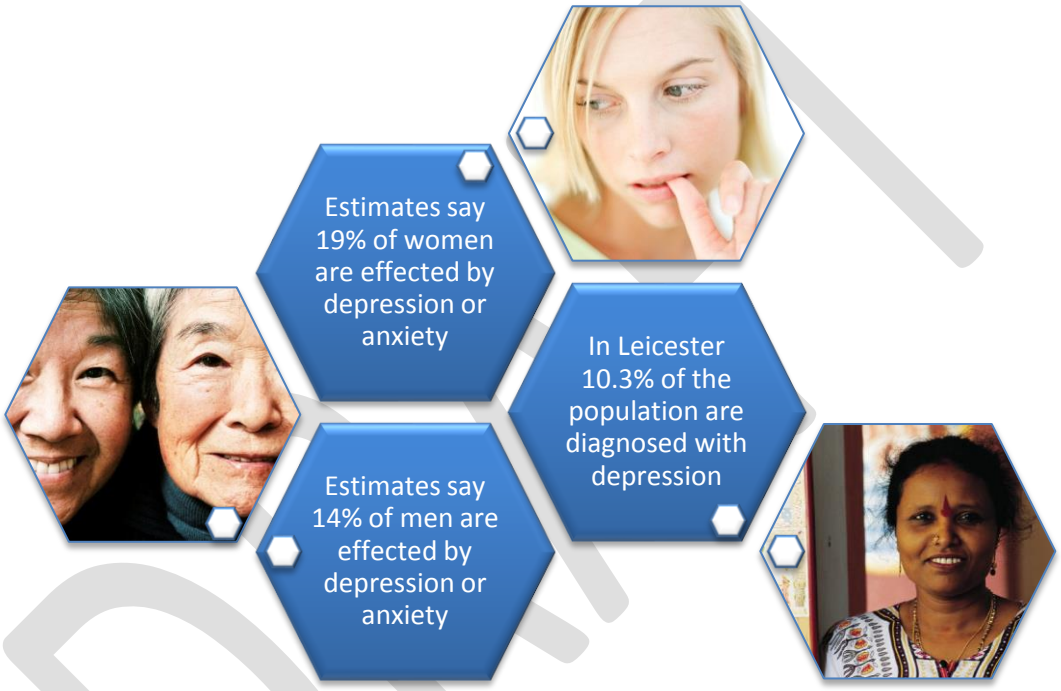
Leicester City Council and Leicester City CCG will:

- Work to raise awareness of the impact of education, employment and training on mental health and wellbeing and are seen a key to recovery.
- Support public mental health programmes aimed at reducing the risk of social exclusion and discrimination associated with mental ill health.
- Ensure personalisation work includes people accessing employment, education, training and social inclusion.
- Ensure that agencies and employers understand the reasonable adjustments they must make to support people with a range of mental health needs, including high functioning Autism.
- Support and promote Mindful employers across all sectors including local employers.
- To promote real case studies of individuals that has progressed either through increased learning or through active employment etc. These individuals could act as mentors or ambassadors for other individuals.
- To actively engage and seek external funding to meet the gaps in provision in addressing employment related support

- Continue to work with local student bodies, universities and colleges to promote opportunities for employment.

What will this mean to me?

- I will have a self-assessment and person centred support plan.
- I will be supported to have a fulfilled life which includes opportunities to work, study, and enjoy leisure and social activities.
- I will have access to employment, education, training and social support.



Preparing for adulthood

Where are we now?

Most lifelong mental ill health is acquired before the age of 14. Common mental health needs 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.

These factors are linked to poor adult outcomes, including links to crime. In Leicester 30% of children live in poverty[18] and 1,422 young people aged 10-17 years were first time entrants into the criminal justice system;[19] both of these measures are worse than the England average.

Leicester is also city with 2 universities and an estimated student population of 35,000 people. Education can be an important part of a person's recovery from mental ill health but it can also precipitate distress and relapse. The effects of student mental ill health can be felt not only by the students themselves but by their peers, family and friends, and of course it has an impact on their education. In some areas academic and pastoral support may be difficult to obtain, so both the University of Leicester and DMU have developed services to sustain student wellbeing. Further work needs to be undertaken with the higher education student population, with specific action planning for mental health support and discharge from hospital back to halls of residence.

Therefore in common with young people with long-term physical health conditions, the transition from adolescence to young adulthood for those with mental health problems requires individualised health, education and social care planning. This should recognise the wider health, social, psychological, educational and vocational impact of a young person's medical condition(s) within a developmental framework and appropriate culture of care.

The Annual Report of the Chief Medical Officer (CMO) 2012, *Our Children deserve better: Prevention Pays*[20] uses the United Nations definition of young people, which includes all those aged under 25 years. This is because key areas of human development, including emotional development, continue until a person's early 20s.

In recognition of this, the Children and Families Act 2014 included reforms to Special Educational Needs Disability (SEND) extending the age up to 25 years with the introduction of Education, Health and Care Plans, the expectation that plans are reviewed annually while the young person is in education or training and new planning for Preparing For Adulthood that replaces the 'Transition' phase.

Further 'Future in Mind'[21] 2015 sets out NHS England's transformational strategy to improve the mental health and wellbeing of children and young people

The Care Act became law in 2014, and gives young people a legal right to request an Adult Social Care assessment before they turn 18 years. This is to help them plan for the types of support services they may be eligible for in the future.

What do users and carers say?

- Help young people to be heard and have their say.
- Help parents to 'let go'
- Help young people to have a dream and vision for their future.
- Support young people's choices.
- Give information and advice to parents about choices.

Commissioning Intentions

Leicester City Council and Leicester City CCG will:

- Support implementation of the Leicester, Leicestershire and Rutland Transformational plan for mental health and wellbeing services for children and young people 2015-2020[22]
- Ensure the changes with the Education, Health and Care Plan include mental health needs, including the Preparing for Adulthood (Transition) pathway for young people.
- Ensure the review of Child Mental Health services links with the adult mental health and autism pathways
- Improve access team to Child & Adolescent Mental health services (CAMHS) and other specialist support
- Commission services that have robust processes and practice in supporting young people leaving children's services.
- Commission a range of low intensity early help, advice and information services specifically for young people
- Work with children, young people and their families, schools, colleges and universities to identify individuals earlier and understand their needs, and to promote mental health and well-being.
- Develop the work force so that all services caring for children and young people can identify mental health risk factors and signpost to timely and appropriate services.
- Develop a family approach to mental health care, which focuses on protecting the emotional health and wellbeing of children and young people.

What will this means for me?

- I will be able to find information on options available to me as I plan for my future.
- I will have my needs better understood as I go through life changes.
- I will have flexible support available to meet my needs.
- I will be able to access appropriate care pathways.

Carers

Where are we now?

Providing support for and reducing the risks to, the health and wellbeing of carers are significant challenges for health and social care services. Evidence indicates that carers have higher levels of stress and anxiety and poorer physical health than the population generally.

Services need to be arranged in a way that ensures people's needs are met in the communities where they live and that their carers feel confident about the carer their loved one is receiving.

The Care Act 2014 made the following changes to support for carers:

- Putting carers on an equal legal footing to the people they care for
- Giving all carers the right to receive an assessment for support from their local authority
- Placing an emphasis on carers' wellbeing: ensuring that services are in place to protect their dignity, promote their physical and mental health, and ensure they are able to lead a fulfilling life
- Placing a duty on local authorities to prevent or delay a carer's need for support by investing in preventative support services

In Leicester there are currently an estimated 30,000 carers. While not all carers need formal support, there is evidence of a large potential gap between need and service provision. For instance there are 7,000 recipients of adult social care but there were only 1,972 completed carers' assessments in 2013/14. There is inconsistent recording of carers on General Practice registers. There are 249 young carers known to social care services, when census results indicate that there may be four to five times as many young carers in the city.

The ethnic background of known carers in Leicester is changing. Based on the proportion of carers' assessments by social care services, carers from Asian/Asian British ethnic backgrounds have increased since 2007/08, from 33.3% to 37.5%. Those from White/White British ethnic backgrounds have decreased from 61.8% to 54.7%.

There are key times within life when issues arise and needs change as people mature and age:

- Leaving home for the first time
- Leaving your home locality for education or work
- Marriage or relationship breakdown
- Birth of a child
- Retirement
- Bereavement.

The significance of these must not be underestimated.

There are a range of services available within the voluntary and community sector which support carers with things such as information and advice, advocacy, training and peer support. These are being enhanced to ensure carers receive the support they need.
Not all carers will require or want help, but there is a significant number, estimated to be 16,000 people who could require some degree of support. Following the introduction of the Care Act, early estimates and demand modelling suggest that Adult Social care could see a significant increase in the number of carer assessments, the figure for 2015/16 is estimated to be almost 4,000 completed assessments almost double last year's figure.

What do users and carers say?

- Better recognition for carers of all ages, including informal carers and multiple carers.
- Carers' assessment of their needs, commensurate with the caring role.
- Better access to advice and support where the cared for person is not eligible for ASC provision.
- More respite care, more culturally specific services.
- A range of services which are flexible.
- Better information at an earlier stage in different languages, accessible communication and signposting to helpful services and networks.
- Advocacy for carers, including support to remain in employment.
- Better peer support.
- Training for carers.
- Help to manage direct payments, including Carers' Direct Payments.

Commissioning Intentions

Leicester City Council and Leicester City CCG will:

- Improve identification of carers on GP and social care registers.
- Ensure health and social care providers collaborate to improve the assessment and advice offered to carers; learning from and involving carers at every stage of planning and designing services and changing ways in which services are provided.
- Involve carers in local planning and service development
- Ensure that there is consistent formal assessment of individual carer's needs by health and social care staff.
- Increase the range and provision of short break services for carers.
- Improve monitoring and data collection from services which support carers.
- Further work to encourage young carers to register as carers and offer appropriate support.
-

What this means to me?

- I will know that the people who support me will have their own support needs met
- I know my carer's voice will be heard
- I know information, advice and guidance is available for my carer


There are 6.5 million carers in the UK today
61% of carers have faced depression because of their caring role
Every day 6,000 people become carers

Measuring Local progress:

OBJECTIVE / PRIORITY	Outcome being measured	INDICATOR	SOURCE / FREQUENCY	Rationale for indicator
Wider Determinant	Poverty	Proportion of children in poverty	Annual DfE	Neurotic disorders are more frequent in lower socio-economic groups. ONS has showed higher prevalence of mental health needs in children from lower socio-economic groups. As children and adults from disadvantaged backgrounds are more likely to suffer mental ill health, measures of deprivation may help to target services
Wider Determinant	Educational attainment	GCSE achieved (5 A*-C including English & Maths)	Annual DfE	Education has a bearing on employment and social inclusion, both of which have a bearing on mental health. Certain groups are at risk of common mental health problems, such as those with no, or low level qualifications and the unemployed. Individuals with psychotic disorder are most likely to have left school before age 16
Wider Determinant	Employment	% of the population of working age (16-64) who are economically active	Annual NOMIS	Unemployment is associated with social exclusion, which has a number of adverse effects, including reduced psychological wellbeing, greater incidence of self-harm, depression and anxiety. Employment can have a beneficial effect on mental health, boosting a person's confidence and self-esteem. Unemployment is a cause and consequence of mental ill health.

Wider Determinant	Homelessness	Rate of statutory homelessness	ONS	Mental ill health is both a cause and a consequence of homelessness. Existing disorder is made worse by homelessness. Compliance with treatment is difficult for homeless people.
Risk factor	Reducing alcohol and/or drug harm	Rate of hospital admissions for alcohol and/or drug related harm	NHSOF/PHOF	There is an association between increased alcohol / drug consumption and mental ill health. Alcohol / drug consumption is a cause and consequence of mental ill health.
Risk factor	Parity of esteem for MH	*New national measure being developed*		Parity of esteem is the principle by which mental health must be given equal priority to physical health. Mental ill health is associated with increased physical morbidity. Poor physical health increases the risk of mental ill health. Parity of esteem will become the norm for people with severe mental ill health to get regular physical health checks and for people with chronic physical health care problems to get regular mental health checks.
Population Health		Prevalence of mixed anxiety and depression - persons aged 16-64	PHE	Depression and anxiety are among the greatest contributors to mental ill health. Predominantly treated in primary care.
Early Intervention	Access to IAPT	Ratio of the number of people entering talking therapies to the estimated number of people with depression and/or anxiety	CQC mental health crisis data	Specialised early intervention can benefit people with mental ill health.

Crisis Response	Effective crisis response at home	Home treatment episodes as a % of crisis team referrals	CQC mental health crisis data	Crisis care at home is intensive short term support for people who can safely be cared for in the community.
Crisis Response	Acute admissions	Ratio of observed to expected number of emergency acute admissions for**:** Self-harm	CQC	Following an episode of self-harm there is a risk of suicide.
Effective Treatment	Prescriptions of antidepressants	Number of items prescribed per 1000 population	HSCIC PCA data	People with persistent subthreshold depressive symptoms or mild depression are prescribed antidepressants.
Effective Treatment	Access to IAPT	Percentage of referrals entering treatment from IAPT		IAPT routinely measures the performance of mental health services to highlight those areas where improvement is needed. This indicator describes the percentage of people who are referred for psychological therapies who received psychological therapies.
Effective Treatment	Stable accommodation	Psychological Therapies, 2011/12	Annual ASCOF	Ensuring that people with mental ill health have a safe and stable home is a crucial part of recovery and rehabilitation. A stable home provides a sense of identity and belonging, giving people a base from which they can recover.
Effective Treatment	Enhancing quality of life for people with mental health needs	Proportion of adults in contact with secondary mental health services in employment	Annual ASCOF 1f	The measure shows the percentage of adults receiving secondary mental health services in paid employment at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting.

Effective Treatment	Diagnosis of dementia	Ratio of recorded to expected prevalence of dementia	Community Mental Health profile	Known cases of dementia as a proportion of estimated prevalence
Effective treatment	Re-attendance at A&E	% of emergency admissions via A&E for a MH condition (for patients with a history of previous MH contact) that returned to A&E within 30 days (for any reason)	CQC mental health crisis data	Emergency admissions should be avoided through the use of community based services and early intervention.
Effective treatment	Care for those with severe mental health problems	% of people with a severe mental health disorder with a comprehensive care plan in place	CQC mental health crisis data	Care planning is a way of co-ordinating mental health services for people with severe mental ill health.
Effective Treatment		Suicide rate (per 100,000)	Community mental health profile	A person may be more likely to take their own life if they have mental health ill health
Outcomes		Rate of recovery for IAPT (%)	LCC PH data	IAPT is care for people with depression and/or anxiety disorders, as determined by scores on the Patient Health Questionnaire.
Outcomes		Under 75 mortality rate in people with a serious mental ill health	NHSOF	People with a serious mental ill health are defined as those who have been in contact with specialist secondary mental health services at any time over the previous three years; including out-patients, people in contact with community services and in-patients.

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