# LEICESTER CITY
# HEALTH AND WELLBEING BOARD

Date: THURSDAY, 17 AUGUST 2017

Time: 4:00 pm

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

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

**NOTE:**

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

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

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## MEMBERS OF THE BOARD

### Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Adam Clarke, Assistant City Mayor, Energy and Sustainability

Councillor Piara Singh Clair, Assistant City Mayor, Culture, Leisure and Sport

Councillor Abdul Osman, Assistant City Mayor, Public Health

Councillor Sarah Russell, Assistant City Mayor, Children, Young People and Schools

### City Council Officers:

Frances Craven, Strategic Director Education and Children's Services

Steven Forbes, Strategic Director of Adult Social Care

Andy Keeling, Chief Operating Officer

Ruth Tennant, Director Public Health

### NHS Representatives:

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

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

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

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

Roz Lindridge, Locality Director Central NHS England – Midlands & East (Central England)

### Healthwatch / Other Representatives:

Karen Chouhan, Chair, Healthwatch Leicester

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Chief Superintendent, Andy Lee, Head of Local Policing Directorate, Leicestershire Police

Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service

## STANDING INVITEES: (Not Board Members)

Toby Sanders, Senior Responsible Officer, Better Care Together Programme
Will Legge, Divisional Director, East Midlands Ambulance Service NHS Trust

# Information for members of the public

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- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

**Further information**

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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

# PUBLIC SESSION

# AGENDA

## FIRE/EMERGENCY EVACUATION

**If the emergency alarm sounds, you must evacuate the building immediately by the nearest available fire exit and proceed to area outside the Ramada Encore Hotel on Charles Street as directed by Democratic Services staff. Further instructions will then be given.**

**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 (Pages 1 - 10)**

The Minutes of the previous meeting of the Board held on 19 June 2017 are attached and the Board is asked to confirm them as a correct record.

**4. PRIMARY CARE STRATEGY AND GENERAL PRACTICE FORWARD VIEW** **Appendix B (Pages 11 - 18)**

Leicester City Clinical Commissioning Group to submit a report detailing the approach to delivering the General Practice Forward View (GPFV) in Leicester City and how delivering this national work links to the development of the Sustainability and Transformation Plan delivery across Leicester, Leicestershire and Rutland.

**5. HEALTH AND WELLBEING WORKSHOPS OVERVIEW** **Appendix C (Pages 19 - 24)**

The Director of Public Health submits a report that explains the purpose of the workshops, the key findings and how these will be applied to the draft strategy and future work. The report will be supported by a presentation at the meeting.

## 6. LEICESTER CHILDREN AND YOUNG PEOPLE'S HEALTH AND WELLBEING SURVEY 2016

**Appendix D (Pages 25 - 100)**

The Director of Public Health to submit a report on the Leicester Children and Young People's Health and Wellbeing Survey 2016 that provides a cross-sectional snapshot of health and wellbeing issues for children and young people in the city. A presentation will be made at the meeting.

## 7. BETTER CARE FUND

**Appendix E (Pages 101 - 140)**

Leicester City Clinical Commissioning Group to submit a report on the Leicester City Better Care Fund 2017-19.

## 8. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

## 9. DATES OF FUTURE MEETINGS

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

Monday 9th October 2017 – 3.00pm
Thursday 7th December 2017 – 10.30am
Monday 5th February 2018 – 3.00pm
Monday 9th April 2018 – 2.00pm

Meetings of the Board are scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

## 10. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: MONDAY, 19 JUNE 2017 at 2:00 pm

P R E S E N T :

**Present:**

| | | |
|---|---|---|
| Councillor Sarah Russell Chair for the Meeting in the Deputy City Mayor's absence. | – | Assistant City Mayor, Children's Young People and Schools, Leicester City Council. |
| Andrew Brodie | – | Assistant Chief Fie Officer, Leicestershire Fire and Rescue Service |
| Karen Chouhan | – | Chair, Healthwatch Leicester. |
| Councillor Piara Singh Clair | – | Assistant City Mayor, Culture, Leisure and Sport, Leicester City Council. |
| Frances Craven | – | Strategic Director, Education and Children's Services, Leicester City Council. |
| Chief Inspector Jed Keen | – | Local Policing Directorate, Leicestershire Police. |
| Dr Peter Miller | – | Chief Executive, Leicestershire Partnership NHS Trust. |
| Liz McDermott | – | Commissioning Manager, Office of the Police and Crime Commissioner. |
| Richard Morris | – | Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group |
| Councillor Abdul Osman | – | Assistant City Mayor, Public Health, Leicester City Council. |
| Jill Smith | – | Chief Nurse, University Hospitals of Leicester NHS Trust. |

Ruth Tennant – Director of Public Health, Leicester City Council.

**In attendance**
Graham Carey – Democratic Services, Leicester City Council.

## 72. APOLOGIES FOR ABSENCE

| | |
|---|---|
| John Adler | Chief Executive, University Hospitals of Leicester NHS Trust |
| Lord Willy Bach | Leicester, Leicestershire and Rutland Police and Crime Commissioner |
| Councillor Adam Clarke | Assistant City Mayor Energy and Sustainability, Leicester City Council |
| Steven Forbes | Strategic Director Adult Social Services, Leicester City Council |
| Prof. Azah Farooqi | Co-Chair, Leicester City Clinical Commissioning Group |
| Mark Gregory | Leicestershire General Manager, East Midlands Ambulance Service |
| Andy Keeling | Chief Operating Officer, Leicester City Council |
| Chief Supt Andy Lee | Head of Local Policing Directorate, Leicestershire Police |
| Will Legge | Divisional Director, East Midlands Ambulance Service |
| Roz Lindridge | Locality Director Central NHS England, Midlands and East (Central England) |
| Sue Locke | Chief Executive, Leicester City Clinical Commissioning Group |
| Councillor Rory Palmer | Deputy City Mayor, Leicester City Council |
| Dr Avi Prasad | Co-Chair, Leicester City Clinical Commissioning Group |
| Toby Sanders | Senior Responsible Officer, Better Care Together Programme |

## 73. 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.

## 74. MEMBERSHIP OF THE BOARD

Members noted the membership of the Board for 2017/18 approved by the Council on 11 May 2017 as follows:-

**City Councillors**

Councillor Rory Palmer, Deputy City Mayor – Chair

Councillor Adam Clarke, Assistant City Mayor – Energy and Sustainability

Councillor Piara Singh Clair, Assistant City Mayor - Culture, Leisure and Sport

Councillor Abdul Osman, Assistant City Mayor - Strategic Partnerships and Change

Councillor Sarah Russell, Assistant City Mayor – Children, Young People and Schools

**NHS Representatives**

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

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

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

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

Roz Lindridge, Locality Director Central NHS England – Midlands & East (Central England)

**City Council Officers**

Andy Keeling - Chief Operating Officer

Frances Craven - Strategic Director – Education and Children's Services

Stephen Forbes - Strategic Director - Adult Social Care.

Ruth Tennant - Director of Public Health

**Local Healthwatch and Other Representatives**

Karen Chouhan, Chair, Healthwatch Leicester

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Chief Superintendent, Andy Lee, Head of Local Policing Directorate, Leicestershire Police

Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service

**Standing Invitees: (Not Board Members)**

Toby Sanders, Senior Responsible Officer, Better Care Together Programme
Richard Henderson, Acting Chief Executive, East Midlands Ambulance Service NHS Trust

## 75. TERMS OF REFERENCE

The Board's Terms of Reference approved by the Council on 11 May 2017 were noted.

## 76. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the Minutes of the previous meeting of the Board held on 3 April 2017 be confirmed as a correct record.

## 77. LEICESTER CITY CHILDREN'S IMPROVEMENT PLAN 2016-18

The Strategic Director Education and Children's Services submitted a report on the Leicester City Children's Improvement Plan 2016-18. This iteration of the Improvement Plan was approved in draft form by the Leicester City Children's Improvement Board (LCCIB) in January 2017 and was last updated in March 2017. The Board were asked to consider the contents of the plan and any implications it had for Board members' organisation and to make any comments on aspects of the Plan.

The Strategic Director Education and Children's Services stated that the LCCIB had embarked upon a vigorous programme in response to the inspection findings in March 2015. Following a moderate start there had been a significant strengthening of the performance monitoring framework and improved delivery of data by partner agencies. The partnership had been essential to the vast improvements that had been made and had led to a number of new developments including the neglect strategy, refreshed guidance on injuries to non-mobile babies and engagement with young people

and front line staff.

The issues identified by the LCCIB were highlighted in the report and these 9 areas continued to be the focus for the next stage of development. The LCCIB had recently met and had signed off on all the recommendations from the previous Ofsted Report but there was still work to be done in relation to consistency and quality of practice. Whilst improvements had been made as a result of having robust plans in place for undertaking early health assessments for local children in care who were living in other areas of the country and for mental health care provision for children in care generally, further improvements were still required. As the role of LCCIB reduced around these areas and was replaced by an increasing role for the Leicester City Safeguarding Board's, it was important to ensure the governance roles between the two bodies were understood.

The Chair commented that it had been a long journey and she wished to echo the thanks to those involved in the partnership who have worked openly through some difficult circumstances. It was also important that when the authority moved out of 'Inadequate' it was important for these partnership relationships to be maintained because there would still be work to be done to achieve a 'Requires Improvement' rating which would still require a significant journey to deliver the consistency and quality of service to young people. The ultimate aim should be to work towards achieving a rating of 'Outstanding'.

AGREED:

1) That the report be received and partners in the LCCIB be thanked for working together to achieve the improvements to date.

2) That the acronyms used in Children's Services be appended to this and other reports in the future.

**78. TIME TO CHANGE LEICESTER: CAMPAIGN 2017/18**

The Director of Public Health submitted a report on the Time to Change Leicester: Campaign 2017/18. Time to Change was a national charity that worked to combat the stigma and discrimination faced by those who spoke about their experience of mental health problems. Officers had been working in conjunction with Time to Change to develop a programme specifically for Leicester based upon the national campaign; using their national resources and support.

It was noted that:-

a) Although there was co-ordinating and steering group for the programme, the real driver for the initiative would need to come from the partnership of Board members.

b) In effect, the Council would become a hub to enable the Time to Change resources to be channelled across the city in ways which were best suited

to local circumstances.

c) A proposed local campaign had been produced to run from August 2017 to 2018 with the aims of:-
    - Changing the behaviour and attitude of the local population towards people with mental health problems.
    - Reduce the levels of reported mental health stigma and discrimination in the local area.
    - Empower people with experience of mental health problems to be at the heart of all agreed local activity.

d) The first phase would be a Stop the Stigma campaign, working in partnership with the Council's communications unit to target different groups throughout the year with appropriate material for the particular group. These groups would be:-
    - Men and be would be launched in July.
    - Children and Young People (July-August) focusing in the Summer reading Challenge.
    - Schools and places of education including mothers through the September back to school period.
    - Working age adults with a focus on workplace stress, this would be an ongoing focus.
    - Higher education and student mental health in February to coincide with the university mental health awareness dates.

e) The second part of the campaign would be the proposed community grants fund. This was intended to mirror the Time for Change national grant fund to support groups working to tackle stigma and attitudes in their communities. £50,000 had been allocated locally to this fund. Guidance was still being developed for applicants but there was no specific project types being stipulated. However, any projects must be able to demonstrate that they are able to work towards combating stigma and discrimination around speaking about mental health in their own areas of the community.

f) The Steering Group comprised stakeholders, voluntary sector, local businesses, schools, Time to Change East Midlands and mental health partners, including champions' representatives. The Governance arrangements were fully outlined in the report.

g) 7 businesses and organisations had already signed up to the programme and more were encouraged to take part. These businesses and organisations would be supported by the Steering Group and had representation upon it. The Resilience Service would also be involved.

In response to Members questions it was stated that:-

a) The pledge from partners was an important way forward as it was hoped that the partners would then encourage and influence other organisations they were involved with to become involved as well.

b) The existing links with the Children's Trust and the Leicester Education Strategic Partnership would be used to engage with those groups who had already looked at mental health issues and would be able to provide immediate support.

c) The £50,000 for the Community Grant Fund was funded through the current ring fenced public health budget.

d) The Council was the first in the Country to enter into a partnership with Time to Change and, although it would not bring any additional funding, it would attract considerable resources, campaign materials and expertise in working with schools and businesses in the area of mental health.

e) The criteria for the grant application currently being developed could be brought back to the Board if required. The timescales were short as it would be important to have projects completed and evaluated by the end of 2018.

f) There was already a large amount of information available through Time for Change and it was important locally that the projects focused on stigma and were not simply a re-badging of existing projects. Significant progress was envisaged in the next few weeks.

g) UHL's offer to become involved was welcomed and officers would contact UHL after the meeting to discuss the details of how the engagement could be taken forward. There was a general invitation being issued to communication units across all organisations to be involved in the launch in July and then to take it forward in their respective organisations.

h) The launch would be in a variety of venues encompassing faith groups, health café type venues as well as pubs to reach as wide an audience as possible.

i) A number of resources were being used to understand a baseline for current levels of stigma and attitudes to mental health. The resources of Time to Change would also be helpful in establishing the baseline.

k) Whilst measuring outcomes were important, it was recognised that the emphasis for this programme should be primarily focused on bringing about change.

Healthwatch Leicester indicated that the Leicester Aging Together Partnership comprising 17 organisations, although working mainly with the over 50s, did undertake much work around mental health which could be useful to utilise in addition to their experience of engaging with men experiencing mental health issues.

The Fire and Rescue Service reported that they had a wide programme of

events with their workforce in relation to mental health issues. The Service would be happy to provide venues and role models to support the programme if this was helpful. There were also similar support arrangements for Police and Ambulance staff.

AGREED:

1) That the report be received and the initiative be supported.

2) It would be useful for the Board to some insight and be able to give a steer on the timescales and the criteria given the short lead in for projects to be implemented and completed by August 2018.

3) That partner organisations encourage their communications representatives to attend the launch in July.

4) That partner organisations who were not already represented upon the Steering Group be encouraged to send an appropriate representative to future Steering Group meetings.

**79. HEALTH AND WELLBEING STRATEGY ENGAGEMENT SESSIONS**

The Director of Public Health reminded members of the numerous events that were being organised to refine the Health and Wellbeing Strategy. There were four events in the next month and there had been a good response to attend them from Board Members and their organisations. The first one later in the week was looking at the Healthy Lives strand in the strategy and would be challenging how we invest in diet, obesity, smoking and diabetes to bring about lifestyle changes. The events would be attended by voluntary sector and community groups and key stakeholders in the City to get a broad view of opinions. Other sessions would be held on Healthy Children, Healthy Places and Healthy Minds. Feedback on these sessions would be brought back to the next Board meeting.

**80. QUESTIONS FROM MEMBERS OF THE PUBLIC**

There were no questions from Members of the public.

**81. DATES OF FUTURE MEETINGS**

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

Thursday 17th August 2017 – 4.00pm
Monday 9th October 2017 – 3.00pm
Thursday 7th December 2017 – 10.30am
Monday 5th February 2018 – 3.00pm
Monday 9th April 2018 – 2.00pm

Meetings of the Board were scheduled to be held in Meeting Room G01 at City

Hall unless stated otherwise on the agenda for the meeting.

**82. ANY OTHER URGENT BUSINESS**

There we no items of Any Other Urgent Business.

**83. CLOSE OF MEETING**

The Chair declared the meeting closed at 2.47 pm.

**LEICESTER CITY HEALTH AND WELLBEING BOARD**
17th August 2017

| | |
|---|---|
| **Subject:** | Update on delivery of Leicester City CCG Primary Care Strategy and General Practice Forward View |
| **Presented to the Health and Wellbeing Board by:** | Richard Morris, Director of Operations and Corporate Affairs, Leicester City CCG |
| **Author:** | Julia Cory, Head of Primary Care Commissioning. Leicester City CCG |

**EXECUTIVE SUMMARY:**

The attached paper details the approach to delivering the General Practice Forward View (GPFV) in Leicester City and how delivering this national work links to development of the Sustainability and Transformation Plan delivery across Leicester, Leicestershire and Rutland. The Blueprint for General Practice is the key strategy document for delivery across LLR, with an underpinning implementation plan to drive delivery of key milestones.

The paper focuses on delivery of investment, workforce support, new models of care and extended access in Q1 and Q2 of 2017 linked to the key milestones.

**RECOMMENDATIONS:**

The Health and Wellbeing Board is requested to:

**NOTE:** progress on delivery of key milestones against the Blueprint for General Practice in Q1 and Q2 2017.

**LEICESTER CITY CLINICAL COMMISSIONING GROUP**

**An update on delivering the Leicester City CCG Primary Care Strategy**

**Introduction**

1. The purpose of this paper is to provide an update on the development and delivery of the Leicester City CCG Primary Care Strategy and how it links with the General Practice Forward View (GPFV) delivery across the Sustainability and Transformation Planning (STP) footprint of Leicester, Leicestershire and Rutland (LLR). The paper will focus on reporting against delivery of key milestones for Q1 and Q2, and describe some of the links between national and local approaches to supporting and sustaining primary care in Leicester City.

**Context**

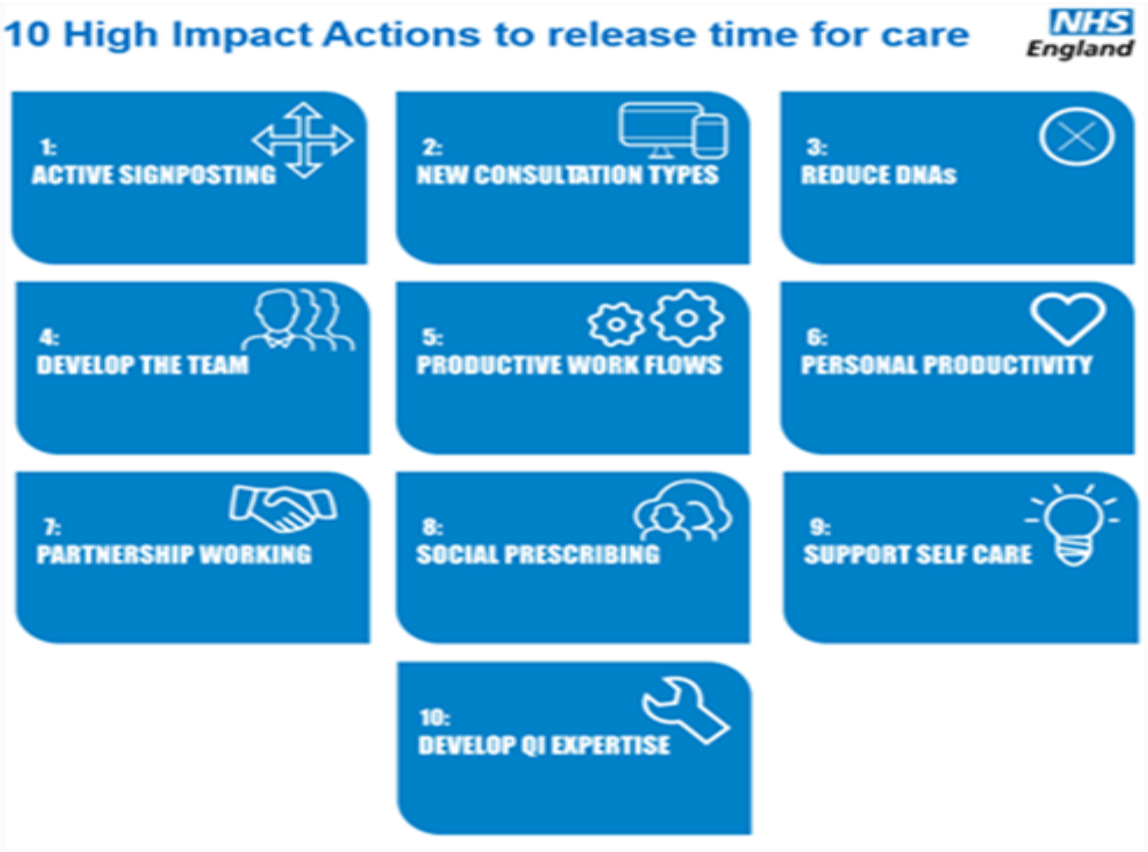
2. For background the GPFV was launched in April 2016 by NHS England with the aim to stabilise and transform General Practice, and included practical and funded actions against five key areas;

    - Investment
    - Workforce
    - Workload
    - Infrastructure
    - Care redesign.

3. One of the key elements of the GPFV is the 'Releasing Time for Patients' programme, which included support for practices to accelerate change either within individual practices or across groups or federations of practices. The main components of this programme are:

    - Innovation spread – to support introducing the 10 High Impact Actions
    - Service redesign – to support practices to release capacity and improve patient care
    - Capability building- investment and support to build leadership capability in practices.

4. The diagram below shows the 10 high impact actions. Through work with their local CCGs, practices are asked to decide which of the 10 high impact actions will have the most benefit for them, and to consider how to implement their choice. In some cases practices have grouped together to explore implementing one or more of the actions. Some of the 10 high impact actions are linked to other areas of work detailed in Table one below.




**Sustainability and Transformation Planning and local delivery of the GPFV**

5. At the same time as publication of the GPFV, the CCG had started to develop its own Primary Care Strategy. It became obvious during the development of the CCG strategy that there were some links with this strategy and the wider piece of work across Leicester, Leicestershire and Rutland to deliver the GPFV through the STP. As part of this work the STP produced a plan called a Blueprint for General Practice. City and countywide aspirations were aligned in this document. The ambitions contained in the document have been formed into an implementation plan. The detail contained within the GPFV plan for Leicester, Leicestershire and Rutland were presented to the Health and Wellbeing Board at the beginning of the summer.

6. Table one describes the areas of the plan which have been delivered or are in scope to be delivered during Q1 and Q2 of 2017.

**Details of Q1 and Q2 delivery milestones**

7. The delivery of key workstreams for the first 6 months are detailed below:

Table one

| Deliverable (National) | Action | Milestone | Comment |
|---|---|---|---|
| 50% of the public have access to weekend and evening GP appointments by March 2018 and 100% by March 2019 | Integrated primary care service that offers up to 45 minutes/1000 patients of GP services | Met | Primary care access hubs running across 3 sites in the city (Saffron Health, Westcotes Surgery and Brandon St) offer this to 100% of patients, a fourth hub at Merlyn Vaz offering an enhanced urgent care service commences 1st October 2017 following a recent reprocurement. Currently utilisation of hub appointments remains at around 90-95%, with some under utilisation at saffron and across all sites on Sunday afetrnoons. |
| | Clinical Triage HUB to enhance NHS 111 service | Met | The clinical navigation hub is operational. During Q1 the hub triaged 8,992 cases in April, 8,574 in May and 7,590 in June. Of those approximately 13% were signposted to a GP or hub, 8.5% to ED and 7.5% to ambulance or 999. |
| | An integrated home visiting service available 24/7 for patients with urgent or complex needs | Met | Home visiting service available across LLR. In April 3,102 home visits were undertaken across LLR, 3,013 in May and 2,847 in June (942, 1087, and 1181 in-hours respectively). Of these approximately 40% were city |

| | | | |
|---|---|---|---|
| | | | patients – with around 11.5% of all cases requiring onward referral to an acute setting. |
| Increase the number of clinical pharmacists working in GP practices to over 900 (nationally) by March 2018 and over 1300 by March 2019 | Complete bids for funding as part of wave 1 and 2 national pilots | Met | LCCCG have wave 1 pilots sites within 9 practices in the city to deliver clinical pharmacist services (6.5 wte in wave 1) and a further 1 wte linked to wave 1, but part of wave 2 pilots |
| Estates and Technology Transformation Fund | Business case completion for GP premises investment (3 practices in total across LCCCG) and 1 bid for LLR wide technology investment | Partially met | 2 bids are undergoing a due diligence process leading to final sign off of funds, 1 bid is undergoing business case approval, and the 4th bid relates to technology funding |
| Use of funding incentives – including for extra staff and premises- to support the process of practices working together | This is delivered through Health Needs Neighbourhoods in LCCCG. | Met | Funding provided to practices to support at scale working across federations or groups of practices, to support resilience of general practice |
| **Deliverable (National)** | **Action** | **Milestone** | **Comment** |
| Workforce support for active signposting and correspondence management to support 10 high impact changes | To support and upskill practice staff and release GP time | Met | GP practices have been invited to submit expressions of interest to be involved in training to meet this aim |
| Transferring care safely | Clinical integration group in place across LLR<br>Development of new common reporting pathways for operational and quality concerns | In scope to be delivered during Q2 | Transferring Care Safely Guidebook co-designed with stakeholders across LLR - Transferring Care Safely Task & Finish Group - addresses key areas such as - medication, investigations, referrals at final draft stage. GP concerns |

| | | | |
|---|---|---|---|
| | | | pathways being re-designed across UHL and LPT. Engagement plan being co-developed for communication of re-designed pathways and guidebook. |
| 10 High impact actions | Support launch event and rollout of supported cohorts (reducing workload and improving productivity) | In scope to be delivered during Q2 | Focus on reducing workload as detailed above, and delivering the 2nd wave of productive general practice programme as part of 10 high impact actions. Events for active signposting delivered in February and July '17. |
| Linking three clinical workstreams for complex, non-complex and planned care within the STP GP programme board to assess, analyse and model joint working, new models of care | Develop toolkit for general practice to support delivering sustainable models of care | In scope to be delivered during Q2 | Toolkit describes a range of options for GP practices to consider when deciding whether to work at scale, and models examples for practices to explore and implement |

| **Deliverable (National)** | **Action** | **Milestone** | **Comment** |
|---|---|---|---|
| Communication and engagement plan and vision | To formulate and agree a single vision and stakeholder communication and engagement plan | In scope to be delivered in Q2 | To include plans to communicate with internal and external stakeholders |
| Transformation and models of funding | Agree, align and distribute funding to support further transformation in General Practice | Met | £1.50/ head (£582k) distributes to GP practices to support working at scales models and develop GP federations to become at scale provider |

**Details of Q3 and Q4 delivery milestones**

8. Whilst this paper has dealt with key milestones for the first two quarters of this financial year, there are key deliverables which extend into Q3 and Q4. These are detailed below, and give the Board details of the focus for the latter half of this financial year and into 2018/19.

Table two

| Deliverable (National) | Action | Milestone | Comment |
|---|---|---|---|
| 800 mental health therapists in place in primary care by March 2018 and 1500 by March 2019 (nationally) | Increase number of trainee places for psychological therapists, including developing recruitment and retention plans | For delivery through Q3 and Q1 and Q3 2018/19 | Links to workforce and resilience capability workstreams |
| Modelling delivery of complex/non-complex patient pathways | Testing pathways to support patient receiving the best care in right place | For delivery/completion in Q4 | Link to new models of care workstream |
| On-line consultations and single platform linked computer systems | Development of online consultation systems | For delivery/completion during Q3 and Q4 | Links to infrastructure and making best use of clinicians time |
| Increase and support use locally of clinical pharmacists | Ensure bids are placed when national pilots are announced | For delivery completion during Q4 | Links to making best use of clinicians time and workforce workstreams |
| Estates and Technology Funding | Support business case development for scheme cohorts (premises) | For delivery and completion during Q3 and Q2 (2018/19) | Links to infrastructure workstream |

**Recommendation**

The Health and Wellbeing Board is requested to:

**NOTE** progress on delivery of key milestones against the Blueprint for General Practice in Q1 and Q2 2017.

**LEICESTER CITY HEALTH AND WELLBEING BOARD**
**17th August 2017**

| | |
|---|---|
| **Subject:** | Health and Wellbeing Strategy. An overview of key findings from the workshops. |
| **Presented to the Health and Wellbeing Board by:** | Ivan Browne |
| **Author:** | Ivan Browne and Kate Huszar |

**EXECUTIVE SUMMARY:**

This paper supports a presentation to the Health and Wellbeing Board explaining the purpose of the workshops, the key findings and how these will be applied to the draft strategy and future work.

**RECOMMENDATIONS:**

The Health and Wellbeing Board is requested to:

Note and discuss the content and key findings from the workshop.

**Health and Wellbeing Strategy: An overview of Key themes from interactive workshops: Healthy Lives, Healthy Places and Healthy Minds**

## 1. Introduction

Leicester's 2017 Health and Wellbeing Strategy emphasises the importance of good mental health as well as physical health. Early work on the strategy includes a series of interactive workshops to allow key stakeholders and partners to contribute to the shape and direction of the next draft of the document.

This overview of key themes across from the three workshops draws together insights of stakeholders and partners and provides suggestions for how limited resources can be utilised to maximum advantage in order to improve mental and physical health.

## 2. Themes

Several themes were consistent across the workshops, these are presented below alongside suggestions of ways to action the points raised.

a) **Early action**. It was strongly proposed that attention and resources needed to focus heavily on maternity as well as children and young people in order to have the most impact. The importance of promoting good physical health as well as mental resilience was noted. Factors such as encouraging healthy habits in formative years such as eating healthily, engaging in exercise, learning how to manage stress and talk about mental health were acknowledged.

**ACTIONS:** Making spaces and places accessible and attractive to children. Simple ideas such as putting small walls and different textures surfaces on key walking routes, having child friendly exercise equipment in parks and incentives to encourage walking or cycling were mentioned. It was also suggested that health checks for young people may encourage some to adopt healthier behaviours.

b) **Inclusiveness.** A key consideration was *how* to encourage people to engage with a healthier lifestyle. Although focusing on formative years was strongly suggested it was noted that the whole family would have to adopt healthier behaviours to facilitate success. Rather than focusing attention on specific societal groups it was suggested that community based approaches would be more successful for improving health in the longer term. This approach was favourable as it is perceived as less divisive whilst avoiding the labelling and stigmatising of individuals.

**ACTIONS:** Encouraging communities to take up collective direct challenges such as walking 1 million steps, promoting a culture change in terms of walking or cycling to school or work and promoting the use of open or green spaces for community events and meetings. Having mentors within communities such as mental health survivors and healthy eating champions was considered to be beneficial. Schools were regarded as key to these activities

c) **Technology.** In some respects technology was regarded as counterintuitive as some could promote sedentary behaviours, however it was also noted that there were also considerable benefits. For example 'fitbits' and applications monitoring health and exercise were being increasingly utilised. Geocaching and augmented reality games such as PokemonGo were noted to have been effective in terms of encouraging exercise and increased use of outside spaces. In addition social media platforms were recognised as being useful for promoting health messages, arranging physical activity sessions and reducing loneliness and isolation in the short term.

**ACTIONS:** Develop apps that can be used to support specific areas such as mental health by providing advice, linking with mental health professionals or mentors. Utilise information from fitbits or other applications to encourage collective action in reaching a common goal and to inform LA's of use of equipment, places and spaces and possible impact on health. Ensure widespread use of reality games to engage children and young people in activity. Use social media as a platform for health campaigns and advice using consistent but subtle messaging.

d) **Communication and Language.** Good communication at all levels was raised as an important issue across the workshops. In terms of signposting it was noted that messages and advice needs to be consistent across services and organisations. Good health messaging should be subtle and focus on 'nudging' or encouraging people into behaviour change. Using appropriate language, particularly in terms of mental health was considered to be extremely important to avoid demonising, stigmatising or labelling people

**ACTIONS:** Signage in public places, workplaces and schools could incentivise people, such signs could promote walking or cycling, taking stairs, food swaps, community actions, promote mental health awareness and where to go for help. Communication should be inclusive and effective across multi - media platforms.

e) **Existing resources –** Achieving solutions in the current financial climate was noted to be a challenge, yet a number of schemes, programmes and incentives were currently operating, these included STOP, MECC, change 4 life, however there was a general agreement that existing resources could be managed more effectively and utilised better. Resources mentioned included services, people and physical resource, all of which were regarded as assets that could be enhanced. Parks and open spaces were considered to be underutilised.

**ACTIONS**: In terms of services it was felt that services such as Make Every contact Count could be made more effective with better buy in, it was also suggested that the 'join-up' between services could be improved to reduce duplication and promote better health. People and more specifically their knowledge and expertise of communities, health issues, exercise programs etc. was regarded as a very underutilised resource and promoting local champions to encourage people into positive behaviour change was considered to be worthwhile. Further, it was established that open and green spaces have the potential to used to better advantage. Ideas such as improving lighting for winter use, holding community events and community exercise programs were mentioned.

f) **The role of the public sector.** This question caused some confusion because the term 'public sector' was considered to be unclear. It was mentioned that legislation banning smoking in

public places had played a significant part in reducing the number of people smoking and suggest that passing more legislation to promote healthy behaviour may be beneficial.

**ACTIONS:** It was suggested that working collaboratively with the universities, particularly in terms of conducting research and sharing data but also in terms using students as a resource for health promotion would be beneficial. Greater join-up between public and other sectors and businesses would also be effective. Some suggested that the LA in particular could play a more direct role by lobbying Government over issues such as marketing of 'healthy' food, tighter legislation around fast food outlets. The introduction of a sugar tax was mentioned with profits being directed back into schools. Overall the role of the public sector was to direct consistent, subtle positive health related messaging to inspire and encourage community members.

## 3. Conclusion

This paper highlighted key themes consistently occurring across the workshops alongside some pragmatic ways to encourage wider engagement with the Health and wellbeing strategy and enhance its effectiveness.

## 4. Next Steps

Findings from individual workshops will be analysed in detail. The key themes will be explored and included in the redrafted strategy where it is appropriate and possible. A further workshop, healthy Start will take place in September and will also inform the strategy. It is anticipated that a revised draft of the strategy will be available following this. A consultation period will follow the final draft of the strategy.

**LEICESTER CITY HEALTH AND WELLBEING BOARD**
**Thursday 17 August 2017**

| | |
|---|---|
| **Subject:** | **Leicester Children and Young People's Health and Wellbeing Survey 2016** |
| **Presented to the Health and Wellbeing Board by:** | Ivan Browne, Consultant in Public Health |
| **Author:** | Gurjeet Rajania, Public Health Analyst<br>Rod Moore, Consultant in Public Health |

**EXECUTIVE SUMMARY:**

**Background**
The attached Leicester Children and Young People's Health and Wellbeing Survey 2016 provides a cross-sectional snapshot of health and wellbeing issues for children and young people in the city. This will be made available on the City Council web-site.

A key purpose of the survey is to inform strategic and specific need assessments, which are essential to the council and partners' commissioning and policy making for improved health and wellbeing. Importantly, the survey also aims to provide starting points for further insight activity on health and wellbeing issues in the city to help shape communications, service delivery and opportunities for children and young people. The survey is also complementary to the adult Leicester Health and Wellbeing Survey 2015.

It is expected that use of the findings of the attached survey will inform and be included in appropriate reports and proposals prepared by partners and viewed as an important contemporary adjunct to the Leicester Children and Young People's JSNA.

The survey was undertaken by the Schools Health Education Unit (SHEU), based in Exeter, working closely with staff from the Division of Public Health. SHEU collected information from just under 3,000 10-15 year olds in the city. This data was analysed by the SHEU and shaped for presentation by staff of the public health division in the council. Brief details of methodology of the survey are included in the report.

**Results**
Overall the survey paints a picture of children and young people who are positive about life and their prospects. Most, for example, like where they live and are positive about their school. They feel safe in their neighbourhood, school and home. Two-thirds say they have a trusted adult they can talk to when worried about something and, faced with disappointment, some two-thirds say they learn from it for next time.

The survey also identifies challenges involving some children and young people which call for new or continued attention. Analysis by demographic group, deprivation and geography has highlighted White British, most deprived, and those living in the North West, South and West of the city as more likely to report 'risk factors' than other groupings of children and young people in the city. For example these groups

are more likely to suggest; their area is not a good place to live, they hardly enjoy any of their lessons, they have a parent/carer who smokes, and they have been bullied in the last 12 months. By comparison those of Asian background are less likely to report issues highlighted by their White British counterparts. Black and Mixed Heritage respondents are also less likely to raise these issues and are similar to Leicester overall.

**Contents**
The early sections on "The Survey at a glance" and "Who's at risk?" provide an overview of the results, followed by sections on:

- Where you live?
- Schools
- Leisure activities
- Relationships and sexual health
- Emotional wellbeing and resilience
- Bullying
- Diet
- Physical activity
- Oral health
- Smoking
- Alcohol and drug use
- Who are our sample?
- What we mean by risk?
- Technical notes

**Further reports**
The Division of Public Health have received the full data set from SHEU and further analysis of the data can be undertaken around particular questions.

A shorter infographic presentation of key findings aimed at young people will be produced with the support of Council's Specialist City Wide/ Youth Involvement Lead and partners.

Schools facilitating input to the survey will receive a separate report based on the results from respondents attending their schools. This will be unique to the school and any comparisons will be made with the overall Leicester results. The reports will be prepared by Schools Health Education Unit (SHEU) and be available for the autumn term.

**Further insight – focus groups**
The contract with the Schools Health Education Unit (SHEU) includes undertaking five focus groups on areas of the survey which would benefit from closer, qualitative investigation. We will therefore identify topics where a focus group would add value to the survey. These focus groups will take place in September/October 2017.

**Dissemination Plan**

The working draft report of the survey has been considered and revised following feedback from:

- Public Health DMT, 12 June 2017.
- Lead Member Briefing Public Health 21 June 2017.
- Education and Children's Services DMT 28 June.
- Children's Lead Member Briefing, 4 July 2017.

Next steps for sharing the survey results include:

- Publication of the summary report on Leicester City Council website (August).
- Workshops at Children's Trust Board (to include discussion of possible focus groups, September).
- Circulation of school based reports (September/October).

- Presentation to Young People's Council and Youth Involvement Team (October)
- Young person's debate as part of Democracy week, (October).

It is proposed that in addition to these actions, a short presentation and guidelines to promote discussion of findings is developed, with the intention that this supports cascading the results to a range of organisations and functions, for example commissioners, practice and delivery leadership and their teams, and those concerned with promoting a clearer understanding of issues for children and young people.

This process will start with the Children's Trust Board workshop in September. It is intended that those participating will be able to cascade the survey to others within their organisations or networks. Relevant materials will be made available on the web, and available to stakeholders in the Health and Wellbeing Board, voluntary sector and young people's groups.

**RECOMMENDATIONS:**

The Health and Wellbeing Board is requested to:

- Receive and provide comment on the attached report
- Support dissemination, consideration and use of the survey results

**Attachment:** Leicester Children and Young People's Health and Wellbeing Survey 2016.

# Leicester Children and Young People's Health and Wellbeing Survey 2016

## Report of Findings

Leicester City Council and Schools Health Education Unit

*Version 1.0*

Leicester City Council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# Contents

- The Schools Health Education Unit was commissioned by Leicester City Council to undertake a survey of children and young people in Leicester.
- The survey was conducted between October 2015 and April 2017.
- The majority of questionnaires were completed on-line in schools. A small proportion of respondents completed paper questionnaires, and a number completed surveys outside of schools.
- 2,997 responses were included in the final sample. This represents 28% of the target group of children and young people in years 6, 8 and 10 in Leicester schools.



# Introduction

# Survey at a glance...

**The sample...** 2,997 10-15 year olds (year groups 6, 8 and 10) drawn mainly from 30 primary schools and 8 secondary schools in Leicester. *Page 62.*

**What we mean by risk?...**
Survey analysis highlights specific demographic groups as particularly vulnerable. *Page 66.*

**Technical notes...**
Including statistical reliability and lower geographies. *Page 69*

**Where they live...**
Nine out of ten children and young people think their area is a 'good' or 'ok' place to live. Most feel safe where they live and around a quarter want to live in the same area after leaving school. *Page 9*

**Schools...**
Many 10-15 year olds are positive about their school. It's the main source of information for many health and wellbeing topics. Some feel they are asked about their opinions but few think their opinion makes a difference. *Page 15*

**Leisure...**
The most common leisure activities are watching TV, playing electronic games, listening to music, and communicating by phone, text or messages on line. Nearly half belong to a group, such as a sports team or youth organisation outside of school. *Page 19*

**Relationships...**
Just less than half of 12-15 year olds say they are 'going out' or 'seeing someone', some of whom report at least some jealous, aggressive or controlling behaviour. Less than one in ten of all 14-15 year olds say they have had sex. Two-thirds of whom reported using contraception. *Page 24*

**Emotional wellbeing and resilience...**
Many children worry 'quite a lot' about at least one issue. Two-thirds say they have a trusted adult they can talk to when worried about something. When things go wrong two thirds say they learn from it for next time but, under a quarter say they get upset and feel bad for ages. *Page 29*

**Diet...**
Three quarters said they eat fewer than the recommended five portions of fruit and vegetables a day. Close to one in ten report they have a take-away meal on most days. *Page 40*

**Physical activity...**
Few children and young people report exercising at currently recommended levels for them. Seven in ten use active travel for at least some part of their journey to school. A quarter belong to a sports team outside of school. *Page 46*

**Bullying...**
Half say they have been bullied ever, a quarter in the last 12 months. This was mostly in or near school, with bullying on-line or by text also reported. Not all think schools deal well with bullying. *Page 36*

**Oral Health...**
More than four-fifths clean their teeth at least twice a day. A similar proportion visit the dentist for a check-up. One in six say they do so only when they have trouble with their teeth. *Page 51*

**Smoking...**
Smoking at age 15 in Leicester is significantly lower than in England. This survey shows that a third of children and young people have a parent/carer who smokes and that these children are more likely to have tried smoking or be a smoker. *Page 54*

**Alcohol and drug use...**
Reported alcohol and drug use at this age is lower than in England. Exposure to drugs appears to increase with age. One in five 14-15 year olds say they have been offered drugs. One in ten say that they have ever tried drugs. *Page 57*

# Who's at risk?



**The use of the term 'risk factor' in this report...**
is to highlight selected associations found in the survey. The factors below can be viewed as risks, undesirable experiences or as indicators of potential issues with engagement in school or community. Judgement as to the extent to which these factors, either alone or in combination, are a risk to longer term wellbeing should be considered when reflecting on the survey results.

**The factors considered...**
whether respondents say they view their area as 'not a good place to live', 'hardly enjoy lessons', experience 'abusive or aggressive behaviour in a relationship', indicate 'poor resilience', 'have been bullied in the last 12 months', have 'not had something to eat for breakfast', 'do not enjoy physical activity', 'have a parent/carer who smokes', 'drink more than a sip of alcohol' and having 'ever been offered drugs'. Page 65.

**Overall...**
analysis by demographic group, deprivation and geography has highlighted White British, most deprived, and those living in the North West, South and West of the city as more likely to report 'risk factors' (as described above) than other groupings of children and young people in the city.

**Boys and young men...**
are more likely to report that they hardly enjoy any of their lessons, but less likely to say they do not enjoy physical activity or to respond in a way that shows poor resilience.

**Girls and young women...**
are more likely to show poor resilience or not to enjoy physical activity, but are less likely to say that they 'hardly enjoy any of their lessons' or that they have ever been offered drugs.

**Experience of these factors increases with age...**
14-15 year olds were more likely to say they do not live in a good place, or enjoy any of their lessons, that they have experienced abusive behaviour in a relationship, drink more than a sip of alcohol and have been offered drugs.

**By geography and deprivation...**
there is a higher likelihood that those living in the North West, South and West of the city, and also those living in the most deprived areas, will report a risk factor.

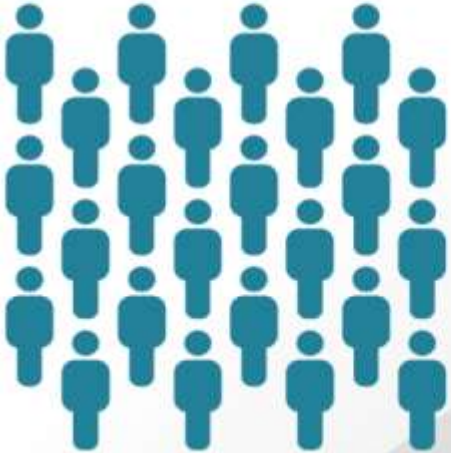
**White British respondents...**
are more likely to report that they do not think they live in a good place, hardly enjoy any of their lessons, have been bullied in the last 12 months, have a parent/carer who smokes, have drunk more than a sip of alcohol, and have ever been offered drugs. They are more likely to not enjoy physical activity. These respondents also show a greater likelihood of Free School Meals takeup, having a disability or illness, and reporting a Poor Wellbeing score.

**Asian ethnicity...**
are less likely to report the issues highlighted by their White British counterparts. They are more likely to report where they live to be a good place, to enjoy lessons, to demonstrate resilience, and to enjoy physical activity. They are less likely to have been bullied in the last 12 months, to have a parent/carer who smokes and to have drunk more than a sip of alcohol. Asian respondents are also less likely to report having Free School Meals or a Poor Wellbeing score.

**Black respondents...**
are less likely to report the issues highlighted by White British respondents. Responses are similar to Leicester overall, however they are more likely to not have had something to eat for breakfast. This group is more likely to report having Free School Meals and being a young carer. They report a lower likelihood of disability or illness and poor wellbeing.

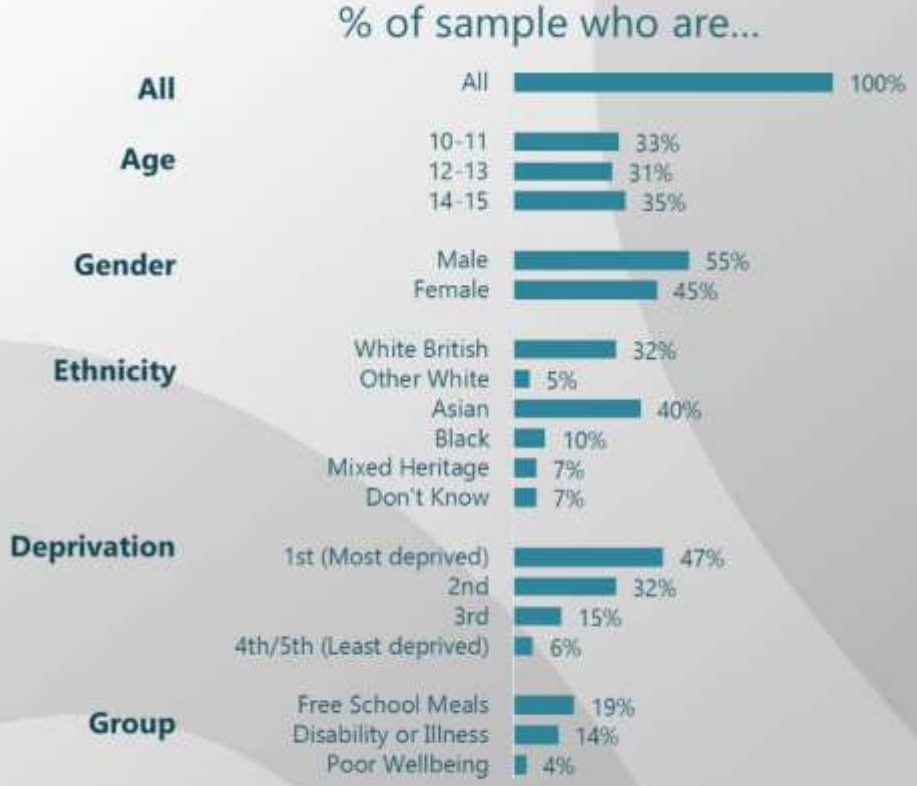
**Mixed heritage...**
most responses are not significantly different from the overall sample, but are more likely to report having a parent or carer who smokes and that they have been offered drugs.

**Analysis of the sample* focuses on age, gender, ethnicity and deprivation. As well as groups such as those in receipt of Free School Meals (FSM), those with a disability or illness (DOI), and those with a poor emotional wellbeing score (PWB).**



Final Sample: 2,997 responses

Percentage breakdown by groups can be seen in the spine chart (on the right).




*Further sample information can be found on page 62

**Spine charts are used in the survey for group analysis.

- Over half of 10-15 year olds think their area is a good place to live and a further third think it's OK.
- 6% of 10-15 year olds did not think their area is good.
- The most common suggestions for improving their area were better parks, more things for young people to do, and cleaner streets.
- One in four children want to stay in their neighbourhood after leaving school.

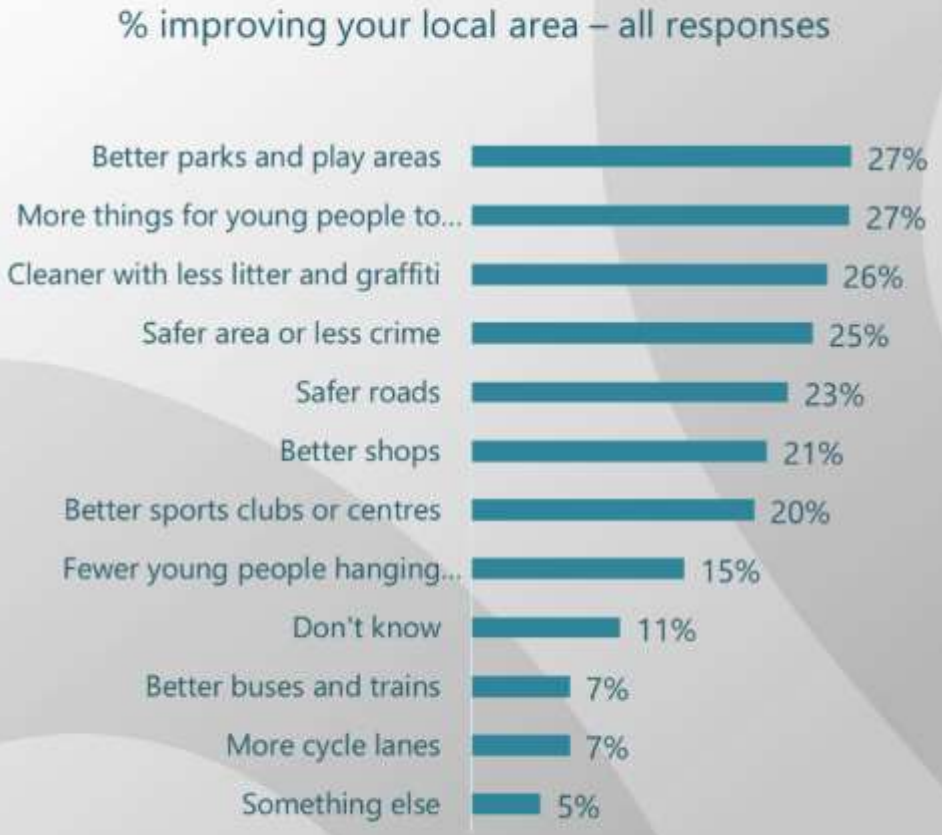
# How do you feel about where you live?

# Most children and young people report that their area is either a good (58%) or OK (36%) place to live.

A range of issues were raised to help improve their local area.

Young people would like to see better parks, more things to do, and cleaner areas.

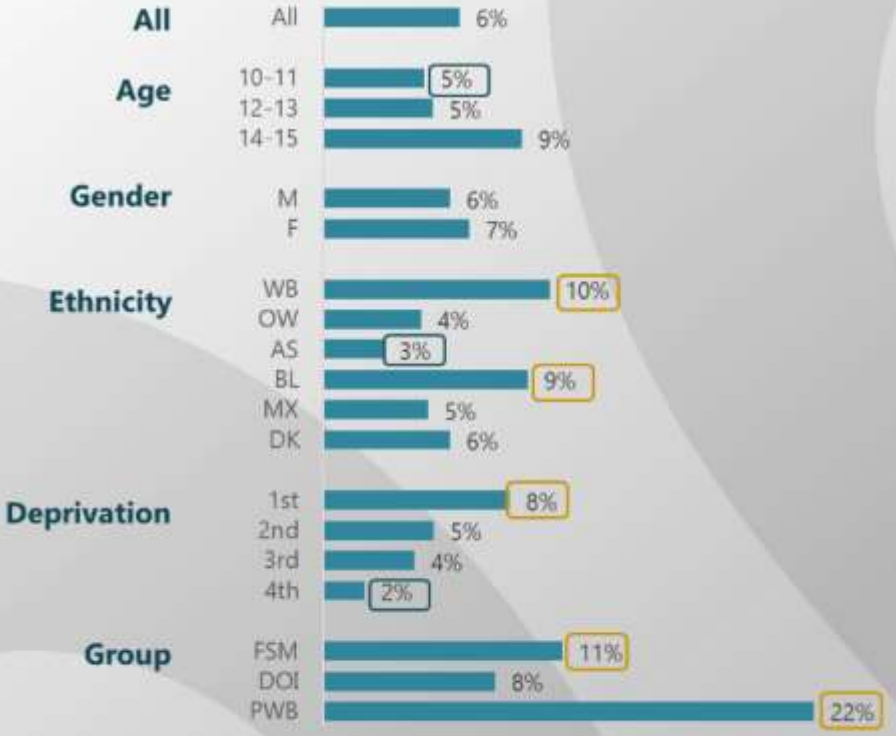
Safer areas/roads and better shops/sports clubs are also areas for improvement for one in five 10-15 year olds.



**Few (6%) 10-15 year olds report that their area is 'not a good place to live'. They highlight issues such as safer roads, fewer young people hanging around, and more things to do for young people as areas for improvement.**

% improving your local area – respondents 'not a good place to live'


% area is not a good place to live




White British and Black ethnicity, most deprived, free school meals and poor wellbeing are significantly more likely to report their area as not a good place to live.

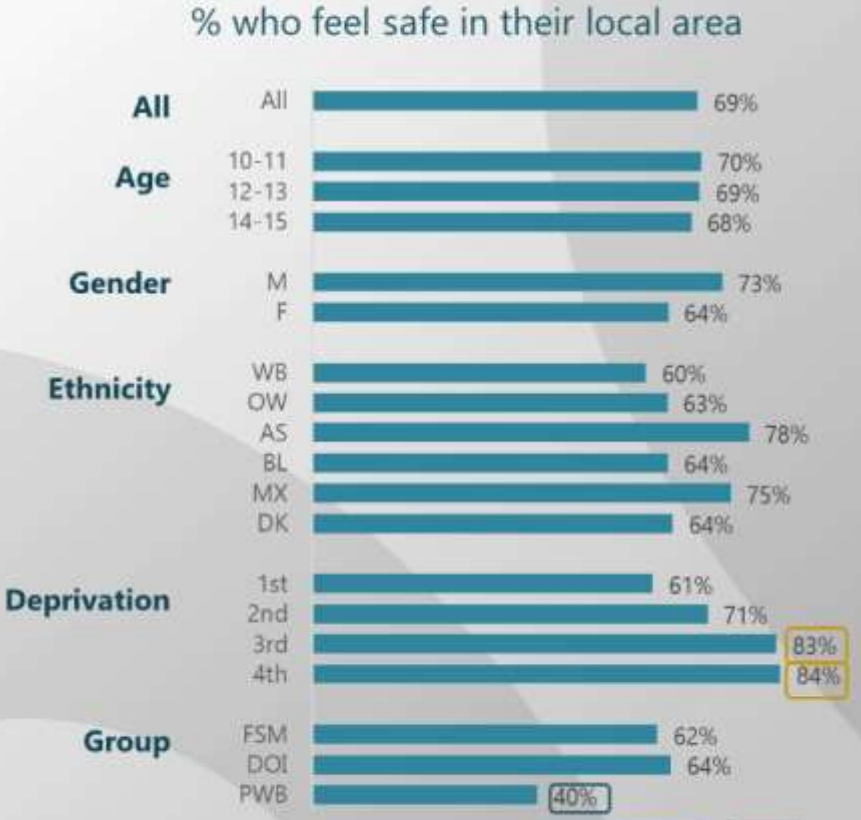
*Significantly higher or lower*

**Nine out of ten (92%) 10-15 year olds feel safe in their home, eight out of ten (79%) feel safe in school and seven in ten (69%) feel safe in their local area.**

71% report they feel safe on their journey to and from school.

Children and young people are significantly more likely to report feeling safe in their local area if they reside in less deprived areas.

Those with a poor wellbeing were significantly less likely to say they feel safe in their local area.

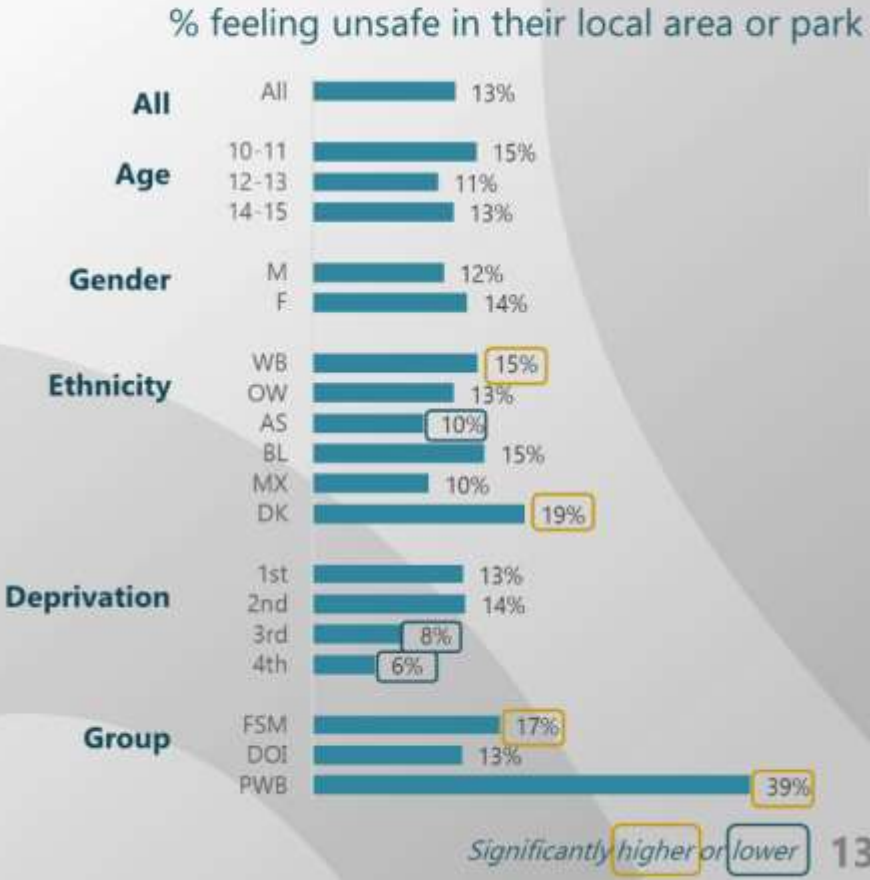


# While few 10-15 year olds feel unsafe in their home (2%) or at school (6%). 13% feel unsafe in a public space (local area or park).

One in five 10-15 year olds reported feeling unsafe at either home, school, local area or their nearest park.

Those living in the least deprived areas are less likely to feel unsafe in public spaces.

White British, poor wellbeing and free school meals children and young people were significantly more likely to say they feel unsafe in their local area or park.



# About a third (35%) of 10-15 year olds experienced an accident requiring medical attention in the last year. Most accidents took place in the home or at school.

Males were significantly more likely to have had an accident in the last year.

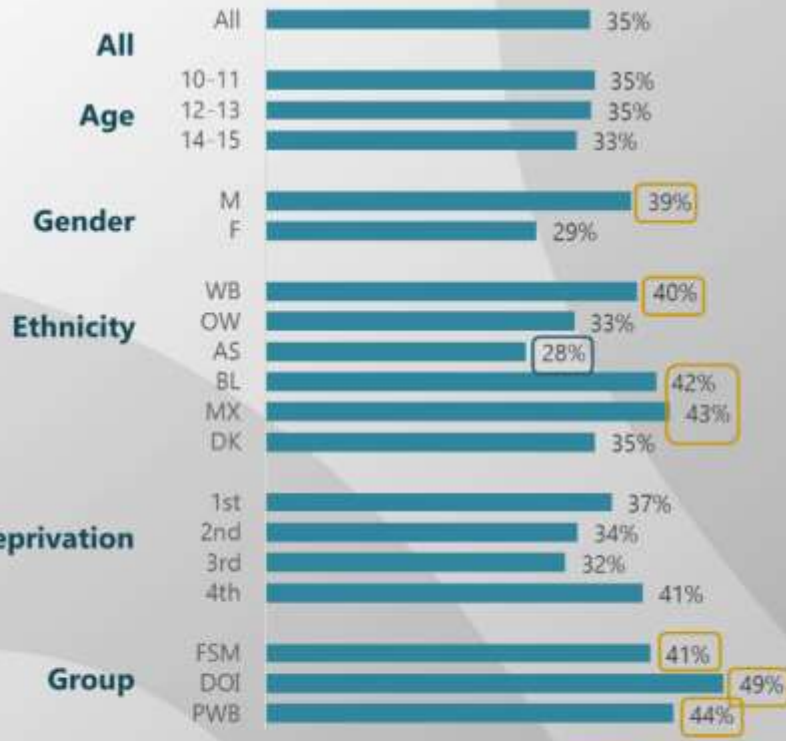
White British, Black and Mixed Heritage reported significantly higher rates of accidents.

Free school meals and poor wellbeing children were more likely to have had an accident in the last year.



% where accident took place


% who have had an accident in the last year




*Significantly higher or lower*

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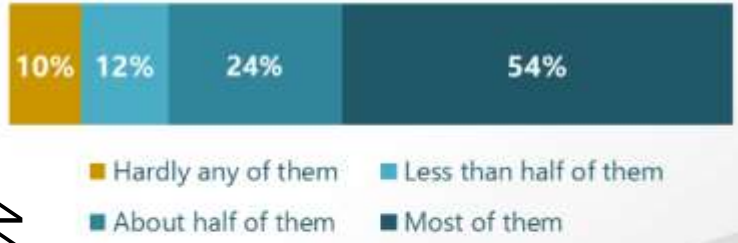
- Three-quarters of 10-15 year olds enjoy at least half their lessons.
- Six in every ten 12-15 year olds want to go to university.
- Six in every ten 12-15 year olds say their ideas and opinions are asked for at home, school or in the community.
- Half of 12-15 year olds think their opinions make a difference.

# School

**Over half (54%) of respondents enjoy most of their lessons. One in ten say they 'hardly enjoy any of their lessons'. Many 10-15 year olds agree with positive statements about their school.**

% enjoying school lessons

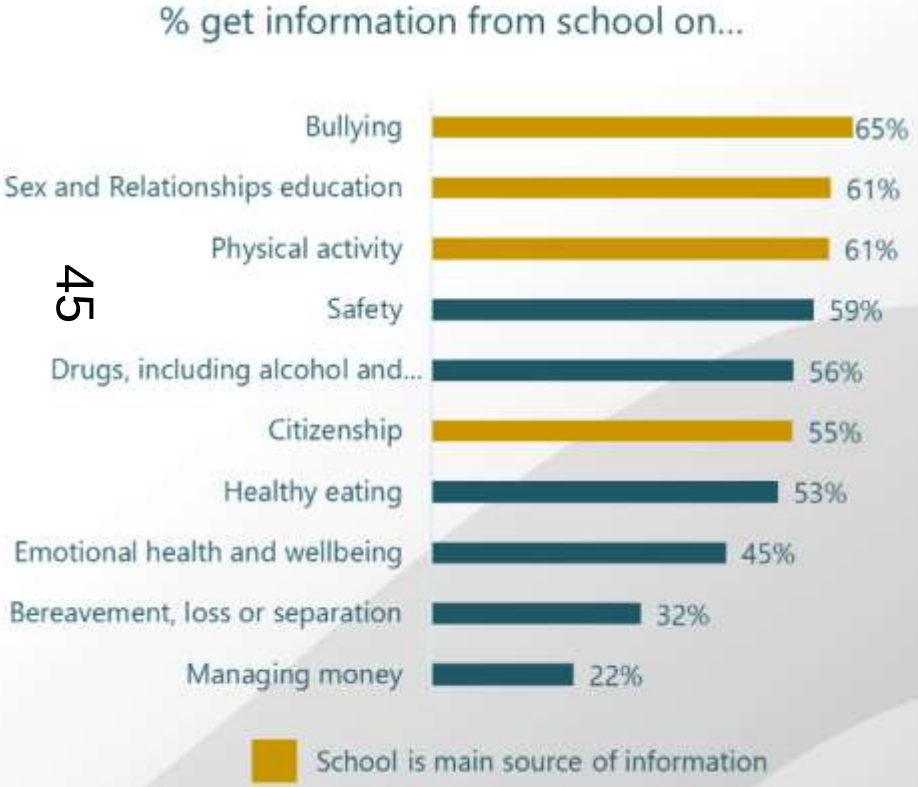


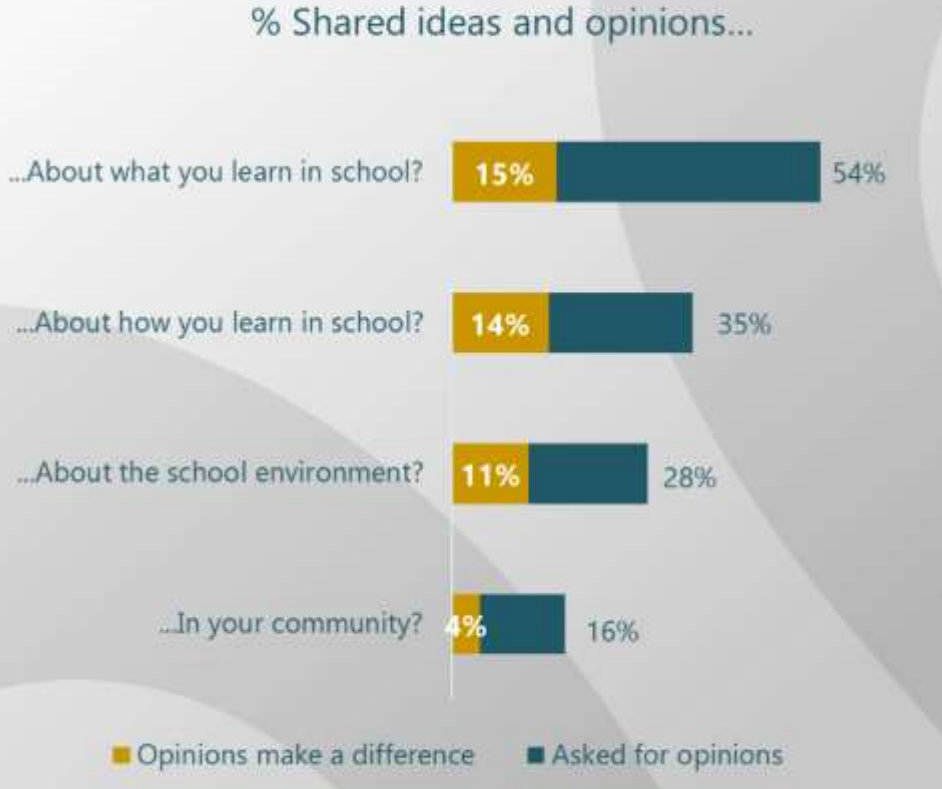

% agreeing with statements about their school


Younger respondents are more likely to agree with these statements compared to older respondents.

Seven out of ten 14 to 15 year olds say their work is marked and over half know their own targets.

# School is the main source of information on a range of health & wellbeing topics. Children and young people are more likely to report they are asked for their ideas in school compared to in the community. Fewer feel their opinions make a difference.



# Children and young people in Leicester have a range of aspirations.

Six out of ten 10-15 year olds aspire to further education and university.

About half would like a job as soon as they can, while a third are seeking an apprenticeship or training.

One in five are seeking a long term partner as soon as possible and one in ten would like to start a family as soon as they can.

- The most common leisure activities were watching TV, playing electronic games, listening to music, and communicating by 'phone, text or messages online.
- Two-thirds of children spent at least two hours looking at some sort of screen on the day before the survey.
- Nearly half of 10-15 year olds are part of a group such as a sports team out of school.
- Over a quarter of children say they do voluntary activities at least once a month.

# Leisure Activities

# The most common forms of activity in the evening before the survey were watching live or recorded TV or films, playing games, and listening to music.

Screen based activities such as watching TV, playing computer games and texting all feature highly on the list.

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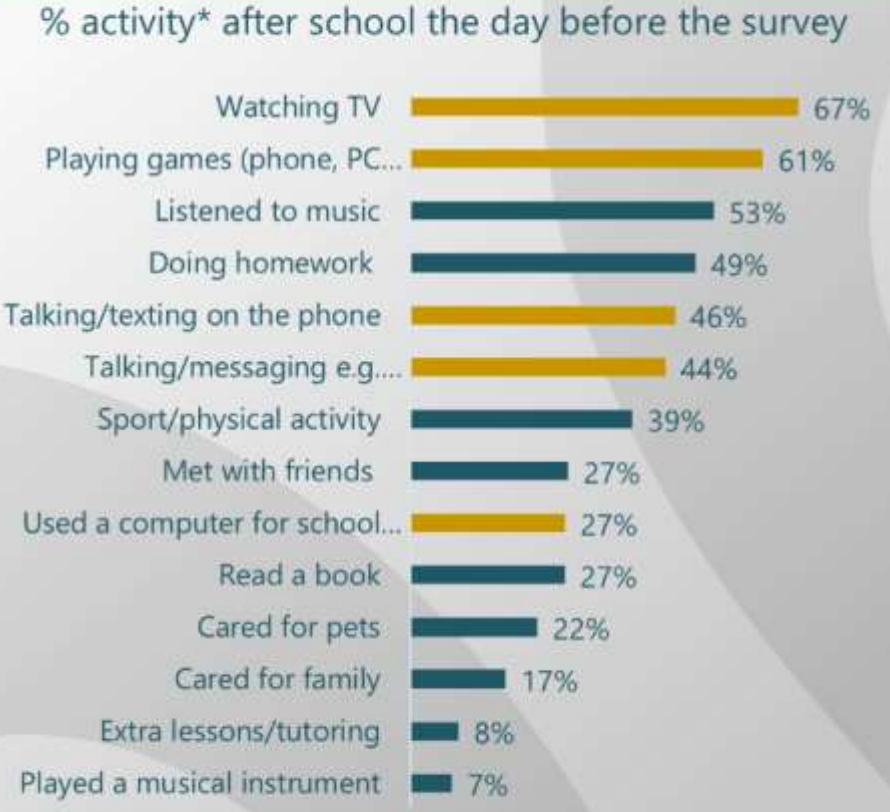
Leicester children enjoy a variety of leisure activities.

Over a quarter of children read a book for pleasure. Less than one in ten played a musical instrument.



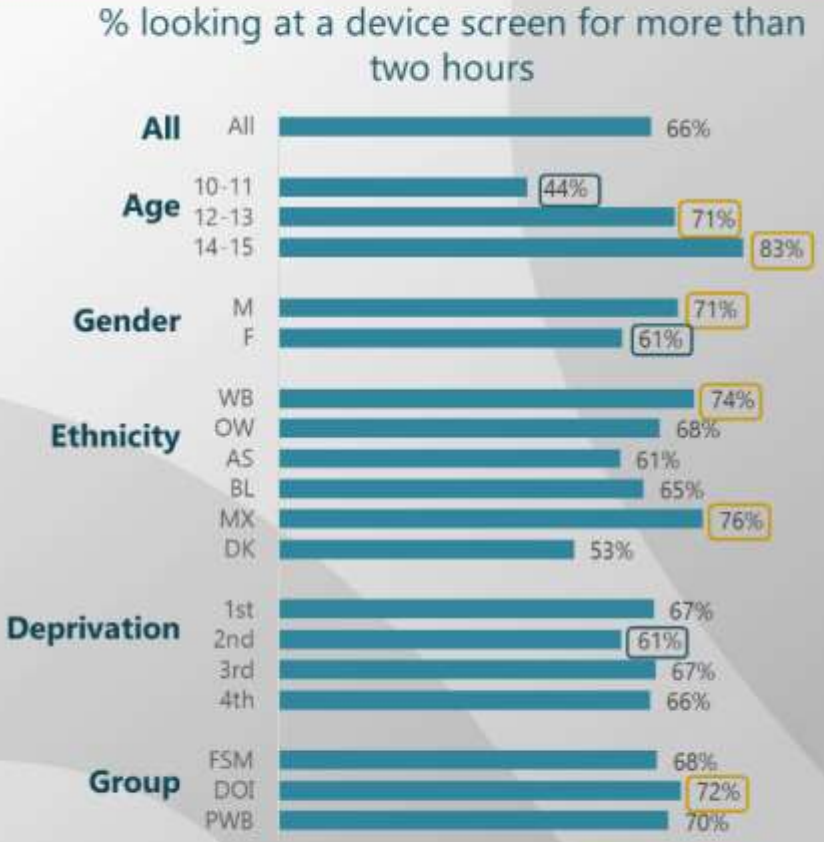

** Children could select more than one leisure activity*

**Most children (66%) reported looking at a device screen for two hours or more on the day before the survey. One in five children reported looking at a screen for five hours or more.**

Increased screen time is linked to having a negative effect on children's wellbeing including anxiety, depression and low self-esteem.*

Older age groups are significantly more likely to look at a screen for two hours or more.

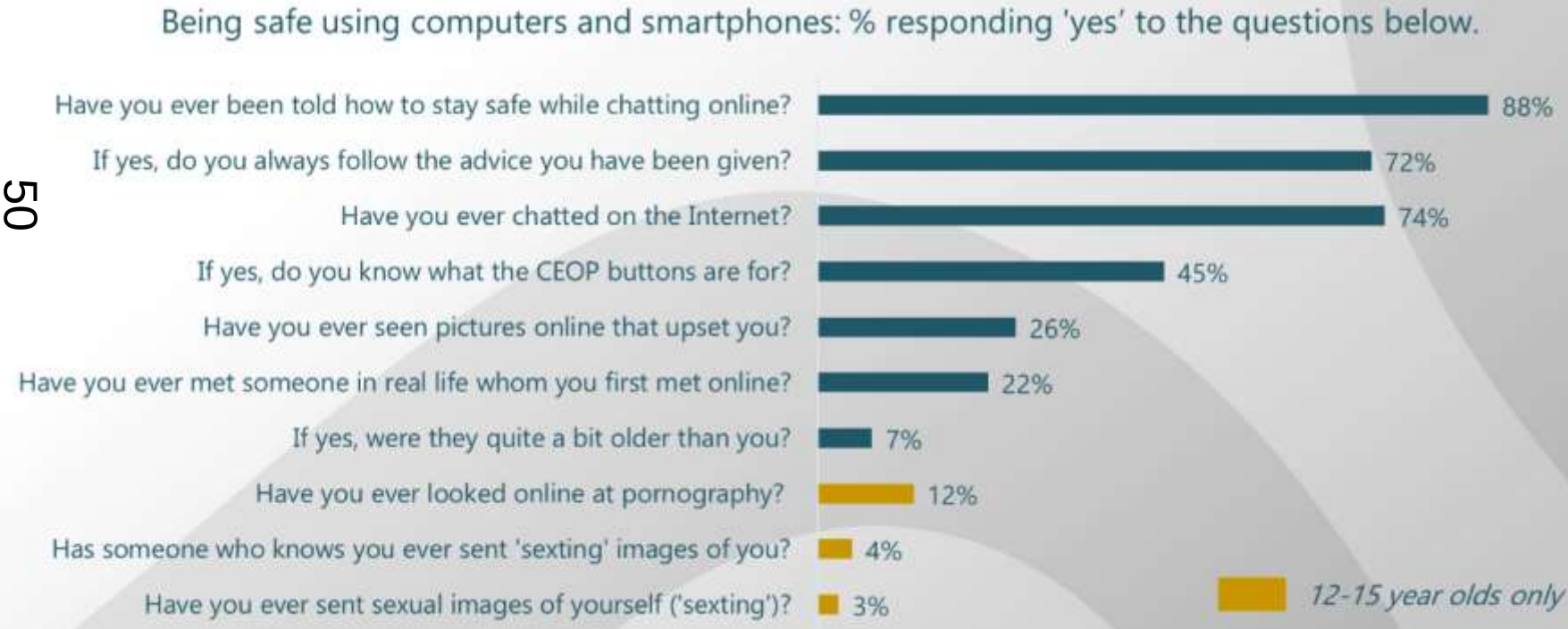
30% of 14-15 year olds looked at a screen for five hours or more the day before the survey.




*Public Health England, How healthy behaviour supports children's wellbeing, 2013.*

*Significantly higher or lower*

**Nine out of ten 10-15 year olds said they had been told how to stay safe while chatting online and seven out of ten say they always follow internet safety advice. Significant minorities report seeing pictures that upset them, say they have met someone in real life first met on-line, or have looked on-line at pornography.**



**Close to half (45%) of 12-15 year olds say they volunteer outside of school (e.g. at a local organisation, raising funds, supporting a local or national issue, or other action to support the local community).**

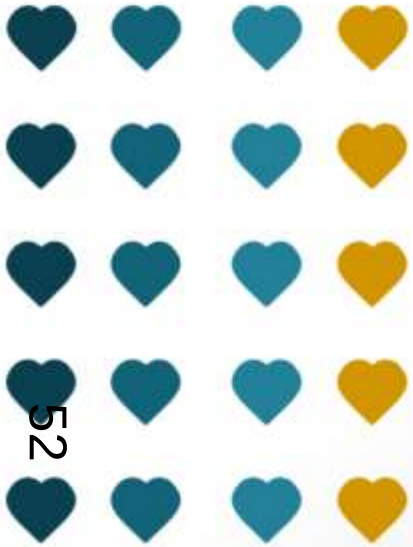
Older children were significantly more likely to volunteer at least once a month.

Half of children and young people do no voluntary activity.

% reporting voluntary activity


% undertaking voluntary activity at least once a month


*Significantly higher or lower*



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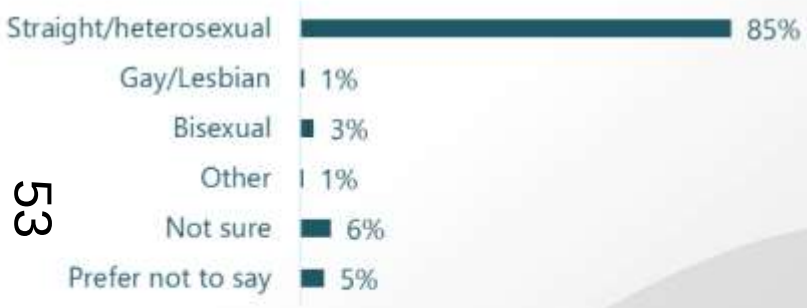
- Adolescence entails emotional, social and physical changes, including the exploration of closer relationships, and the development of gender and sexual identity.
- Just over half of 12-15 year olds say they have ever been in love and just less than half say they have ever been in a relationship.
- Four in ten who have ever been in a relationship report at least some jealous, aggressive or controlling behaviours.
- Less than one in ten 14-15 year olds report experience of sexual intercourse.

# Relationships

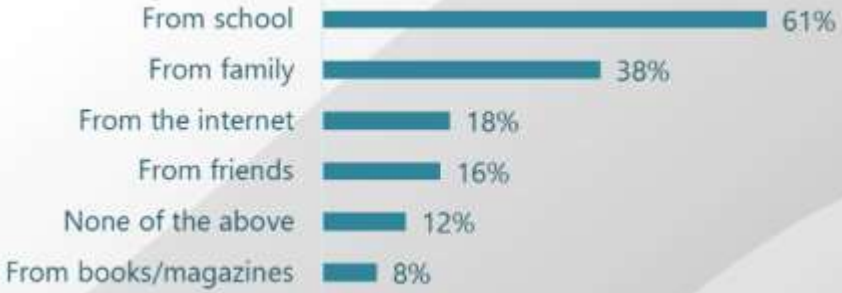
**Children and young people reported a variety of sexualities. The main source of information for sex and relationships is school. Just over half of all 12-15 year olds said they had been in love, and just under half that they had been or are in a relationship.**



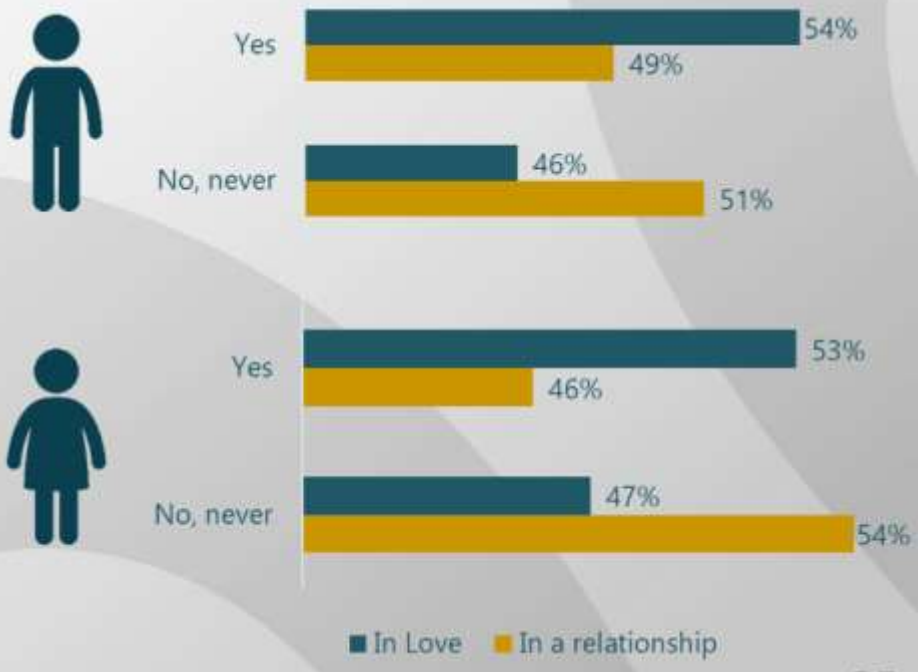
## % reported sexuality of 12-15 year olds




## % sex and relationship advice of 12-15 year olds




## % of males/females 'in love' and in a relationship

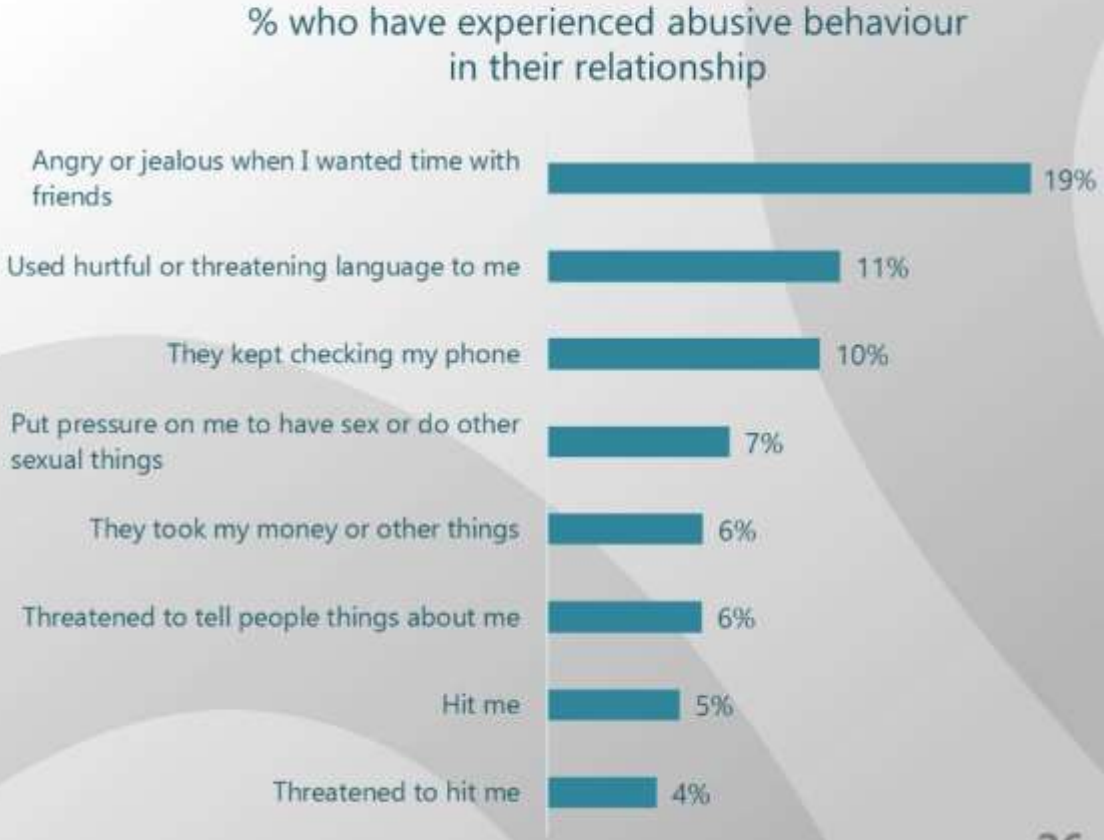


# Some young people also said they had experience of abuse or aggressive behaviour. Most, but not all said they knew where to get help.

One in five 12-15 year olds reported experience of aggressive or abusive behaviour in their relationship.

The most frequently reported was anger or jealously about spending time with friends.

Four out of five 12-15 year olds in a relationship stated they knew where to go for help if they needed it.

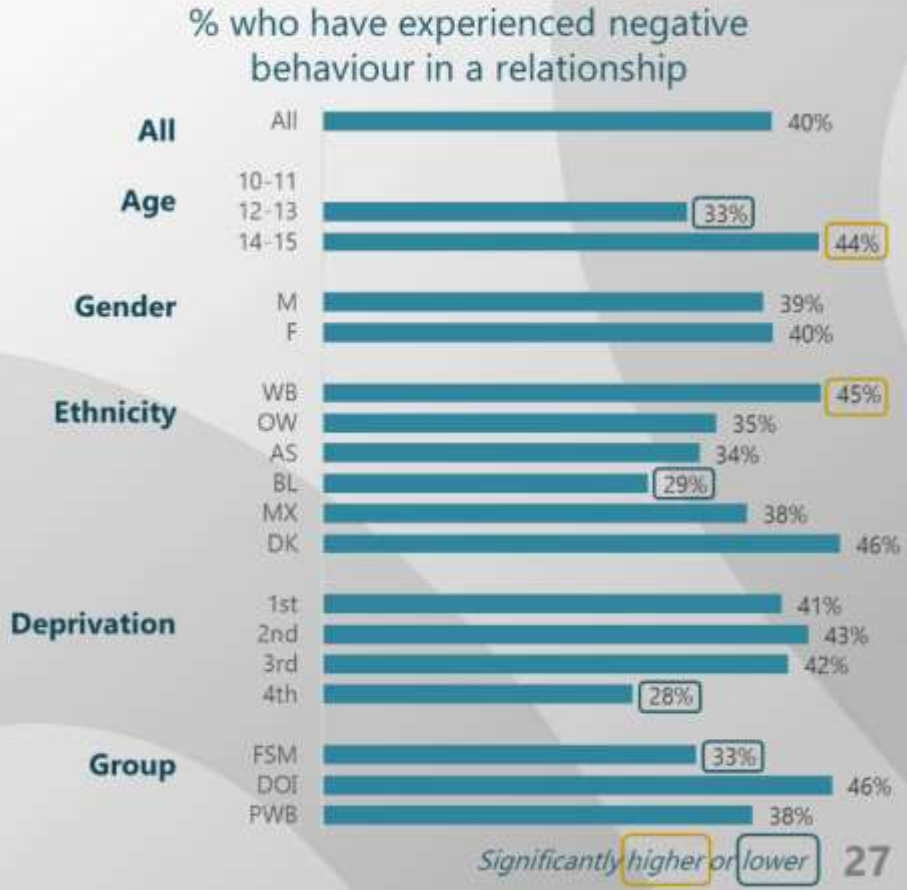


**Overall, 40% of 12-15 year olds who had been in a relationship said that they have experienced at least one of the undesirable behaviours listed (on page 26).**

There is no significant overall difference in experiences of abusive behaviour by gender.

Those aged 14-15 were significantly more likely to experience abusive behaviour in their relationship.

White British 12-15 year olds were more likely to say they have experienced abusive behaviour.



**Less than one in ten 14 to 15 year olds (8%) reported ever having had sexual intercourse*, 5% stated they used some form of contraception.**

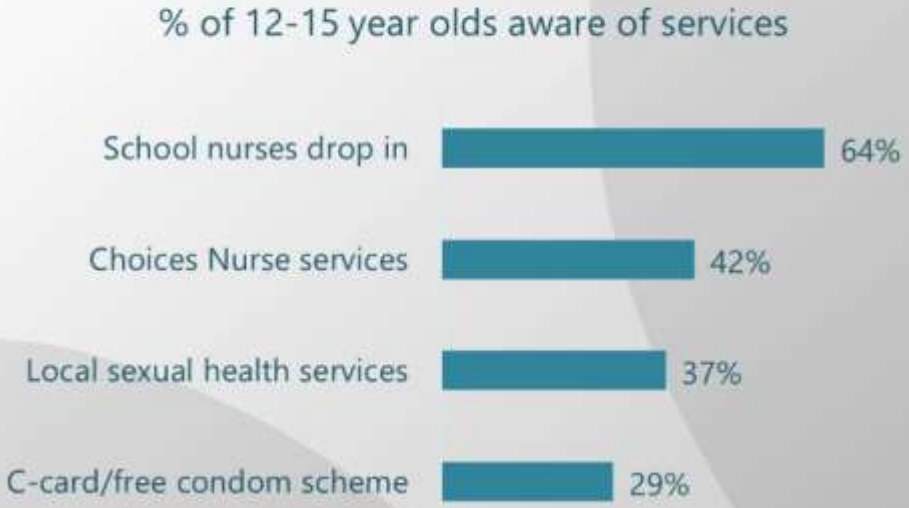
Groups more likely to report sexual intercourse include:

- Males
- White British or Mixed Heritage
- Living in the South

56

The mismatch in males may be due to over reporting.

Survey data indicates that of those who have had sexual intercourse 63% have used contraception.



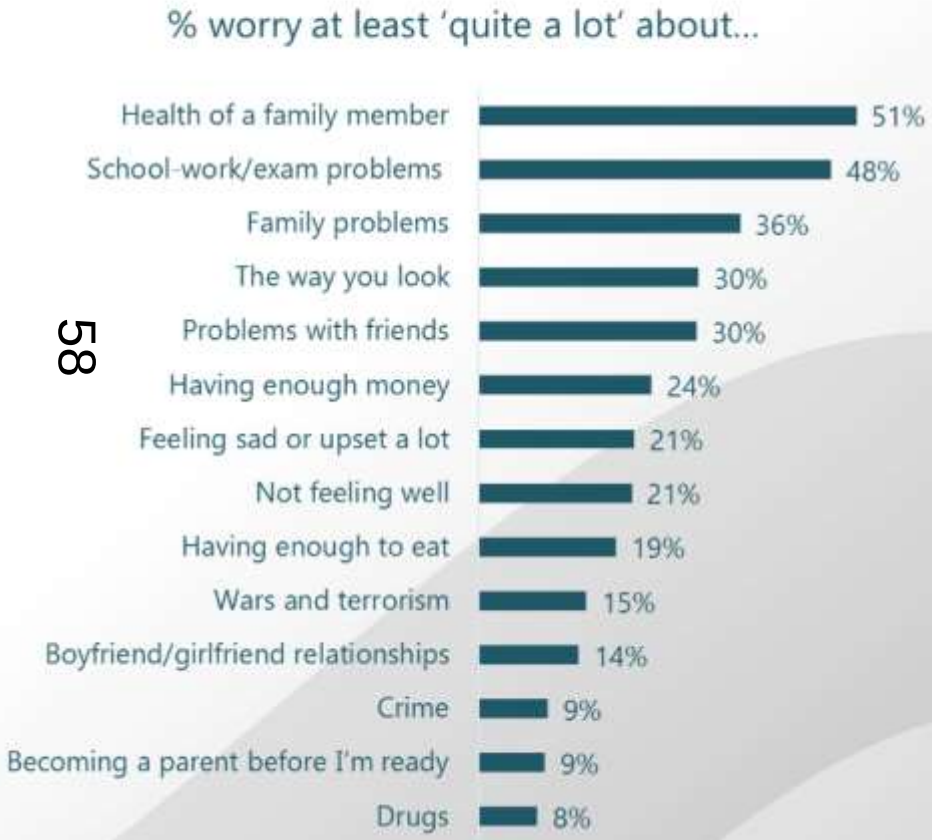

Knowledge and awareness of health and sexual health services is varied, fewer are aware of sexual health services.

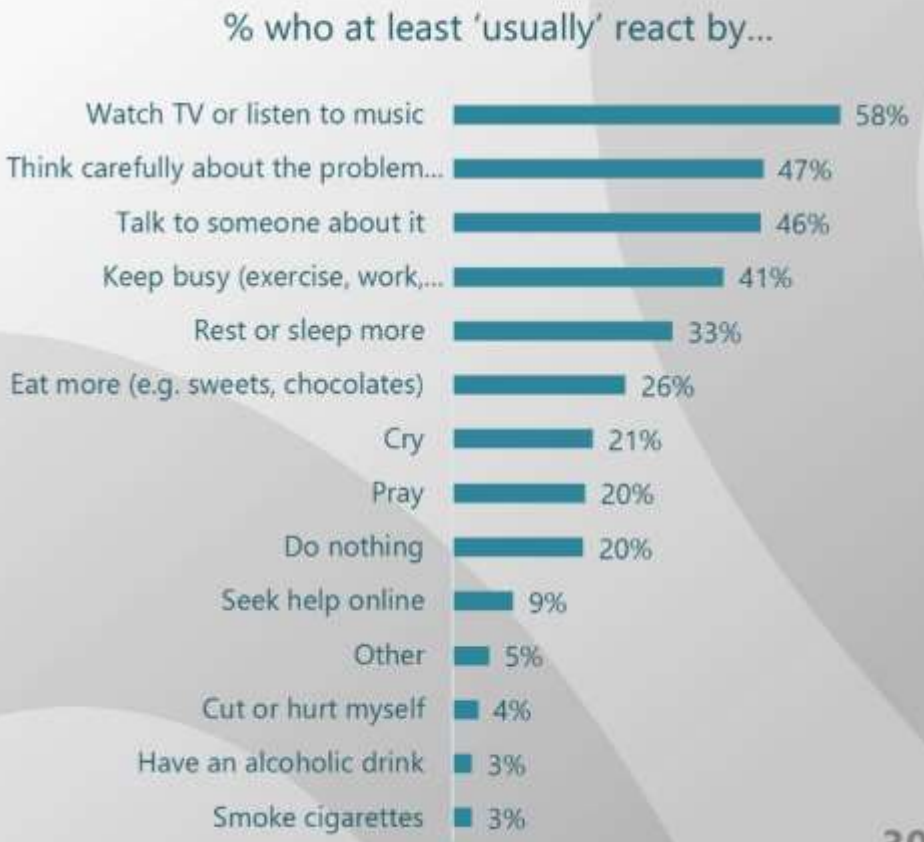
*labelled 'making love' or 'having sex' in the survey

- More than four of every five children worry about at least one issue at least 'quite a lot'.
- Two thirds of children say they have a trusted adult they can talk to if worried about something.
- Three in every 10 children say they usually or always find it hard to trust people.
- 4% of 12-15 year olds say they usually or always cut or hurt themselves when stressed or worried.

# Emotional wellbeing and resilience

**Four of every five children (83%) worry about at least one issue at least 'quite a lot'. Children and young people react to these problems differently. Two out of every three (68%) children have an adult confidant, while one in ten (10%) state they know no adult they can trust.**



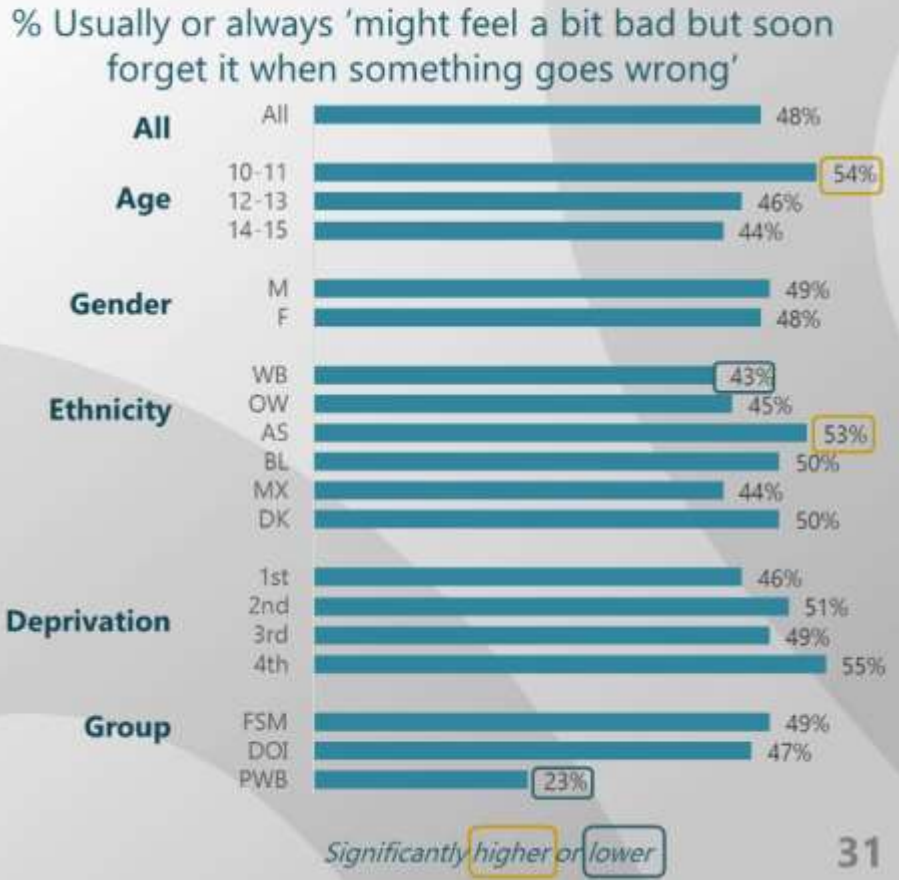



**When asked about their reactions 'If something goes wrong…' a quarter of 10-15 year olds said that they usually or always 'get upset and feel bad for ages' while just under half said ' I might feel bad for a bit but soon forget it'. Two-thirds said they 'learn from it'.**

Children were significantly more likely to soon forget a setback if they were younger compared to older children.

White British and Poor Wellbeing children were less likely to say they usually forget about something that goes wrong .

One in four children said they have become a 'peer supporter, buddy or mentor'.

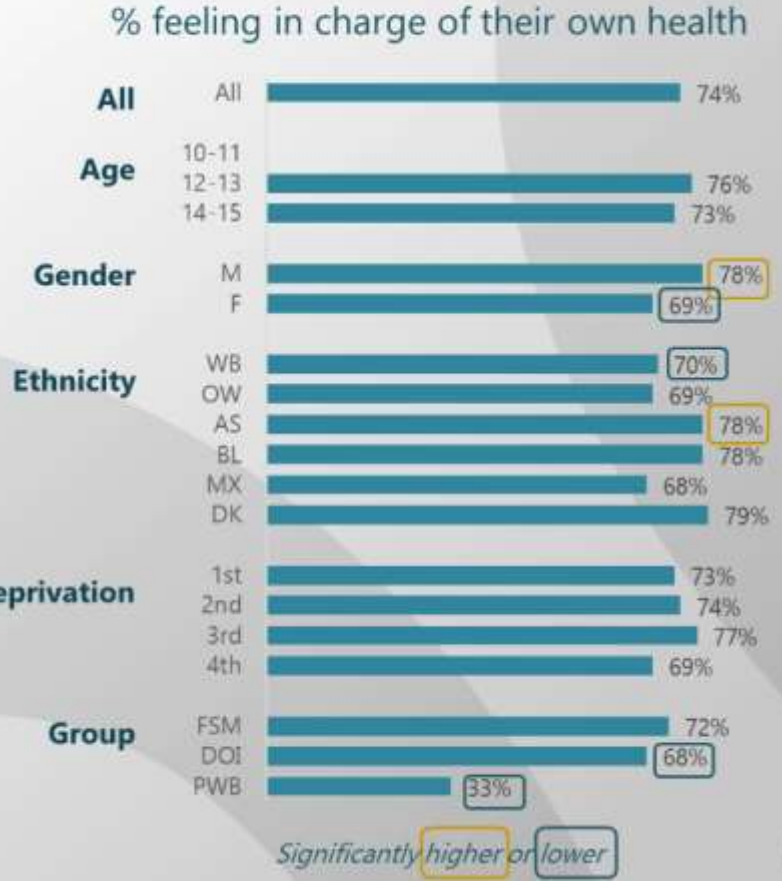


# Three out of four (74%) 12-15 year olds agreed that *I am in charge of my health.*

Males are significantly more likely to agree that they are in charge of their health compared to females.

Asian children and young people are significantly more likely to agree they are in charge of their health whereas White British children are significantly less likely.

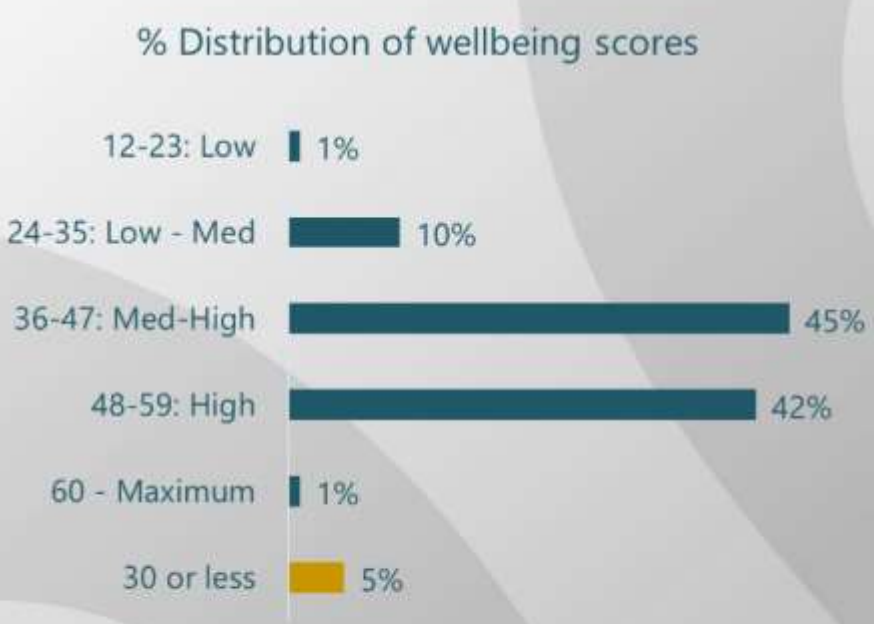
Those who disagree that they are in charge of their own health are more likely to have demonstrated risky behaviours such as having tried smoking.



# The responses of 5% of 10-11 year olds indicated a lack of positive mental health and potentially poor mental health - those who scored 30 or less on the Stirling Children's Wellbeing Scale (SCWBS).

| Children were asked to respond to the following statements |
|---|
| I think good things will happen in my life |
| I have always told the truth* |
| I've been able to make choices easily |
| I can find lots of fun things to do |
| I feel that I am good at some things |
| I think lots of people care about me |
| I like everyone I have met* |
| I think there are many things I can be proud of |
| I've been feeling calm |
| I've been in a good mood |
| I enjoy what each new day brings |
| I've been getting on well with people |
| I always share my sweets* |
| I've been cheerful about things |
| I've been feeling relaxed |

Answers to these items were combined to form an overall score where higher = better wellbeing



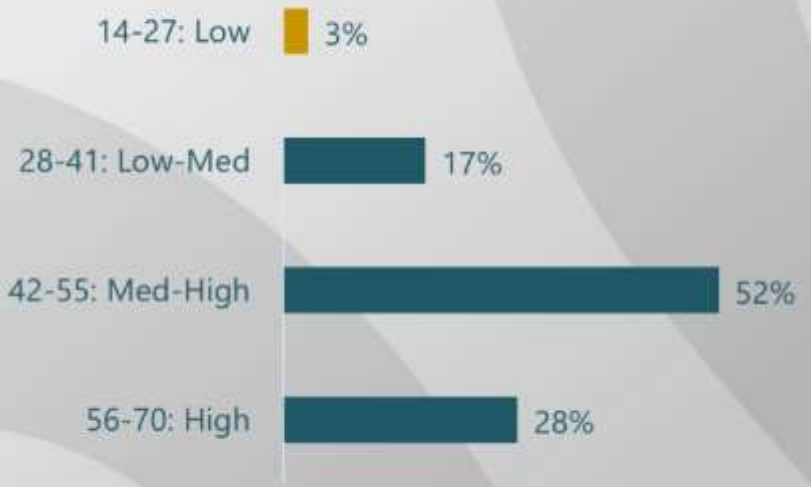

** Social Desirability items*

# 3% of 12-15 year olds scored at or below 27/70 on the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

| Children were asked to respond to the following statements |
|---|
| I've been feeling optimistic about the future |
| I've been feeling useful |
| I've been feeling relaxed |
| I've been feeling interested in other people |
| I've had energy to spare |
| I've been dealing with problems well |
| I've been thinking clearly |
| I've been feeling good about myself |
| I've been feeling close to other people |
| I've been feeling confident |
| I've been able to make up my own mind about things |
| I've been feeling loved |
| I've been interested in new things |
| I've been feeling cheerful |

Answers to these items were combined to form an overall score, where higher = better wellbeing

% Distribution of wellbeing scores

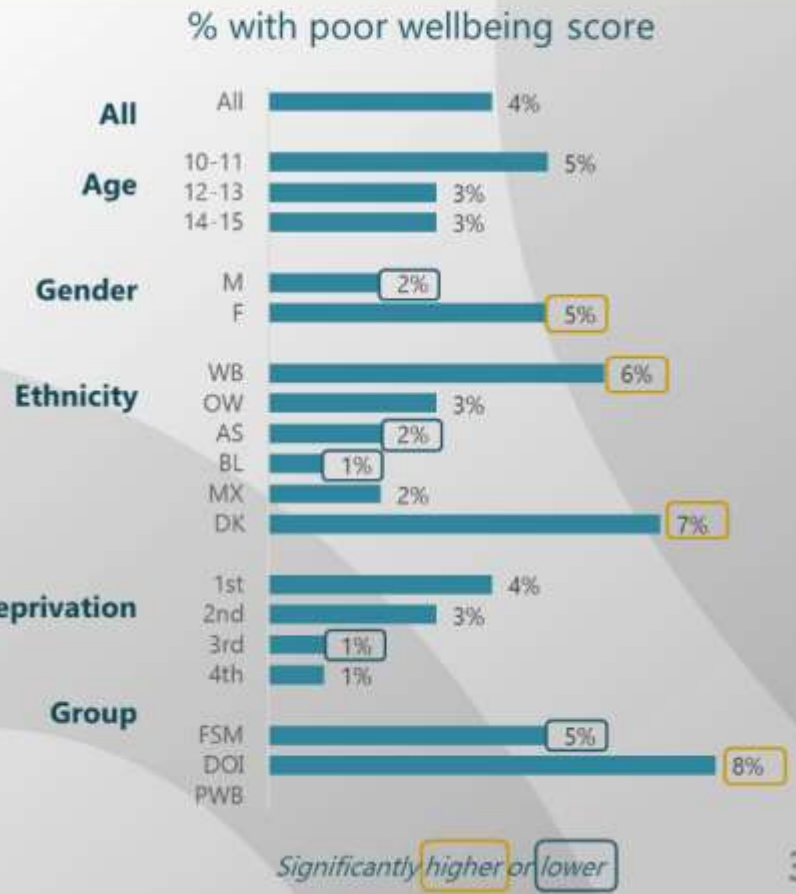


# 4% of children and young people had a poor score for wellbeing, but this was not even across the groups. *Poor wellbeing was defined as having a score either 30 or less on SCWBS or 27 or less on WEMWBS*

Females were more likely than males to report a poor wellbeing score.

Poor wellbeing scores were found significantly more often amongst White British children and those in the west area.

Those with a disability or illness were significantly more likely to report a poor wellbeing



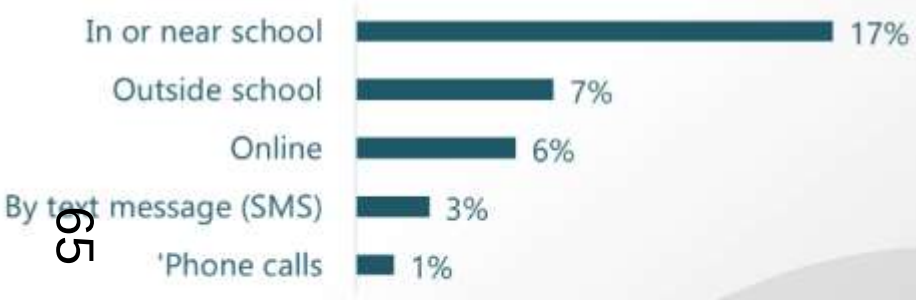
64

- Nearly half of children say they have been bullied, nearly a quarter in the last 12 months.
- Bullying was mostly in or near school, with online bullying or bullying by text also reported.
- Bullying was mostly being made fun of or being called names but pushing/hitting was also reported by one in ten.
- Nearly half of children say their school deals well with bullying, however a third said it dealt 'not very well' or 'badly'.

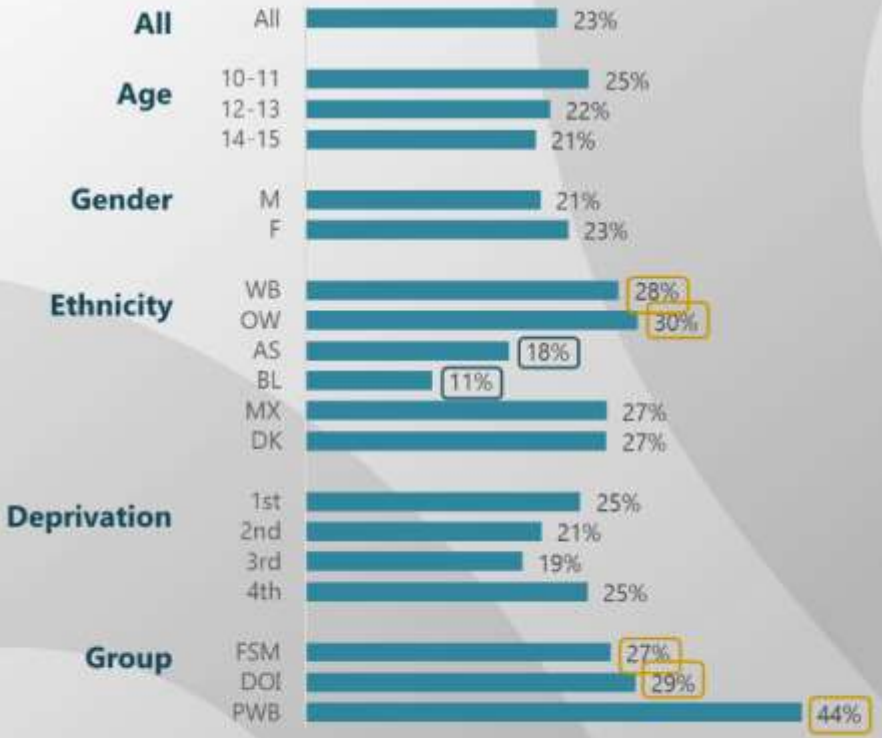
# Bullying

# About half (46%) of 10-15 year olds reported ever having been bullied, about a quarter (23%) reported bullying in the last year. Most bullying was face-to-face in or near school.

## % where bullying took place in the last year



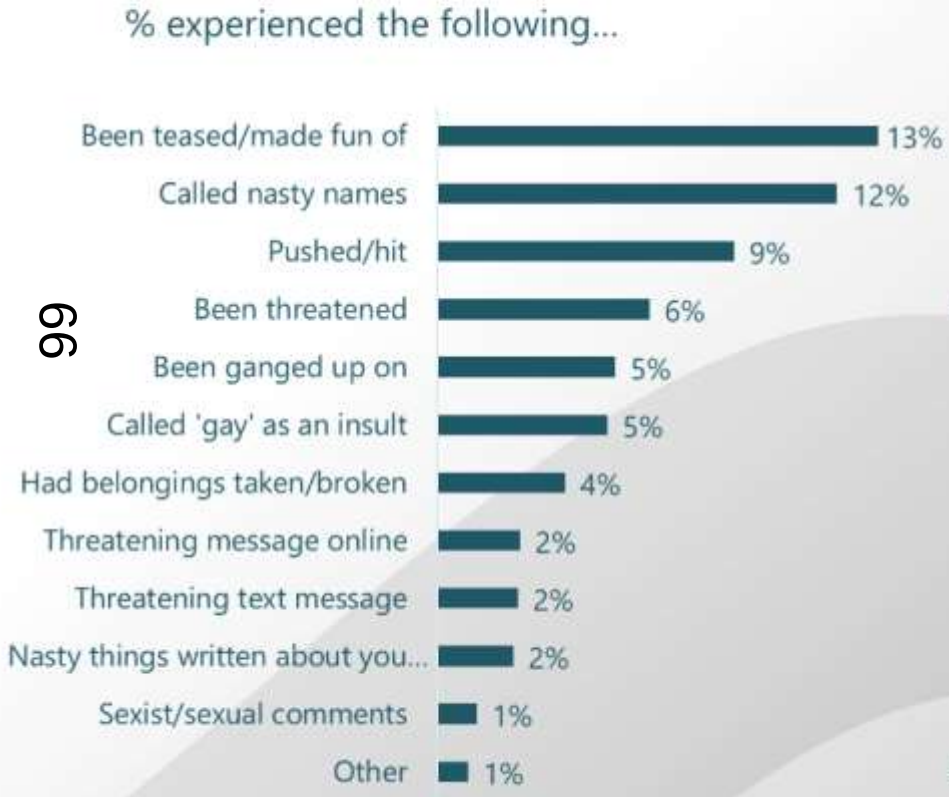

## % ever bullied over the last 12 months

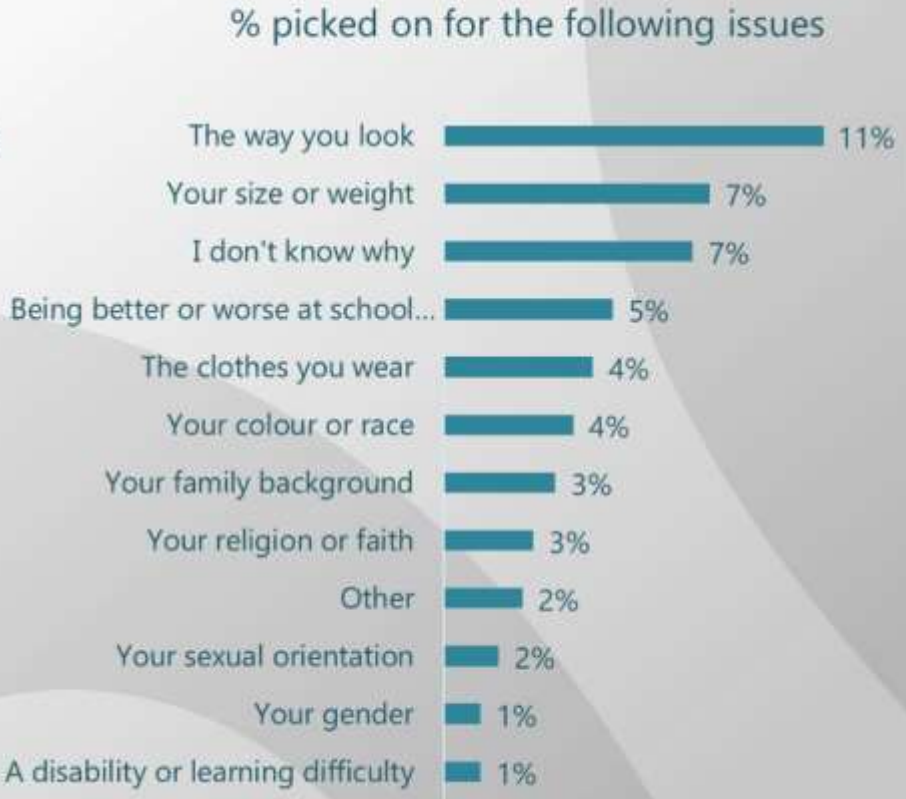



Those most likely to report being bullied in the last year were White British or Other White ethnicity, Asian and Black ethnicity were significantly less likely to report being bullied.

Those receiving Free School Meals, with a Long-term illness or disability, or Poor Wellbeing are more likely to report being bullied.

**The most common types of bullying recorded were verbal, but nearly one in ten children reported pushing/hitting. The most common reason for bullying was 'the way you look', some reported bullying because of their race, religion or sexuality.**



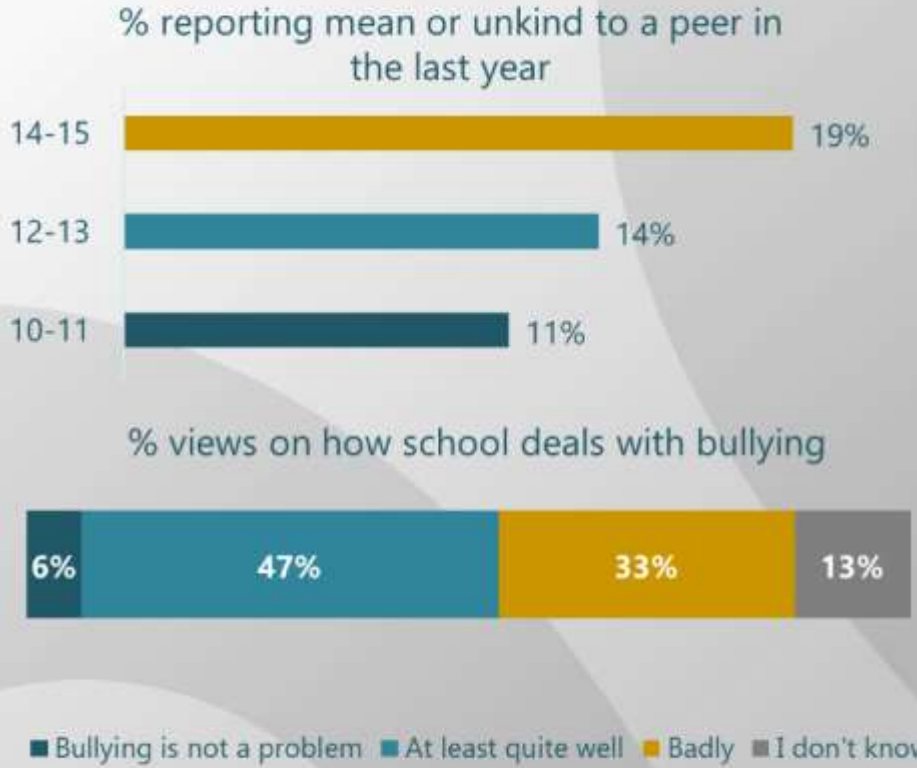

99

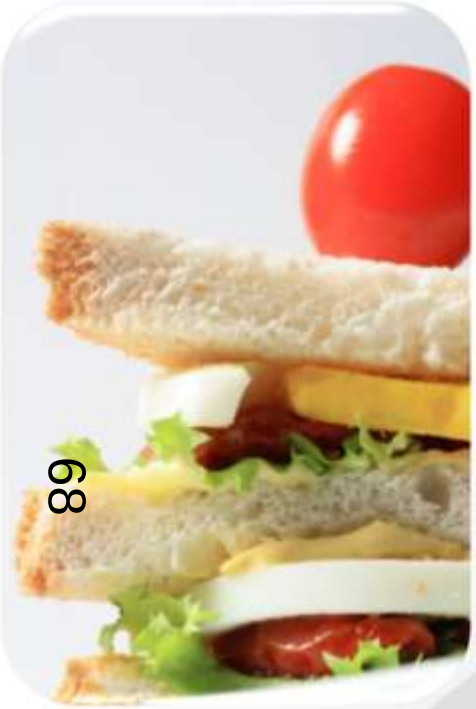
**One in six (15%) 10-15 year olds said they had been mean or unkind to someone in the last 12 months because they wanted to upset them, a quarter (26%) were unsure if they had. There were a range of views about how schools responded to bullying.**

Older children were more likely to say they have been mean or unkind to one of their peers.

Over half of 10-15 year olds said their school dealt with bullying at least quite well. However, a third said that bullying was dealt with 'badly'.

Three out of ten 10-15 year olds have given their views on the anti-bullying policy and contribute to anti-bullying activities.





- One in six children had nothing to eat or drink before lessons.
- Nearly a quarter of children reported having five or more portions of fruit/vegetables on the day before the survey.
- 4 out of 5 children have a home cooked meal on most days. Close to one in ten have a take-away on most days.
- Foods eaten on most days included fruit/ vegetables, high-carbohydrate items like bread, dairy products, and sweet items like cakes and chocolate.
- One in five worry 'quite a lot' about having enough to eat.

# Diet

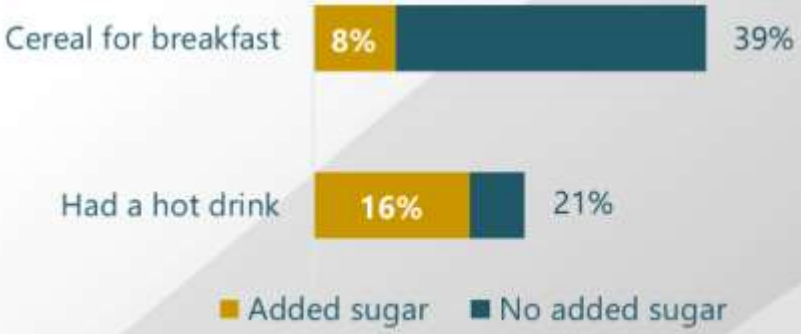
**Most children and young people (84%) had something to eat or drink before lessons on the morning of the survey. 16% had nothing at all, while 77% had something to eat.**

Most children (71%) had a conventional breakfast – that is, some non-snack food plus a drink.

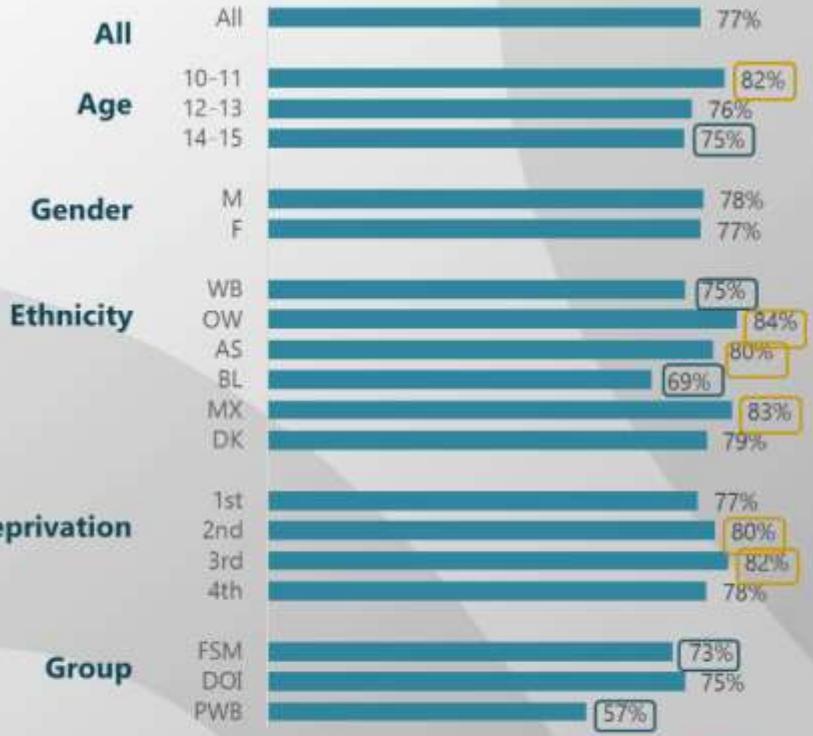
2 out of 5 children had cereal for breakfast and 1 out of 5 had a hot drink, some children added sugar.



% adding sugar to cereal and hot drinks




% having something to eat for breakfast



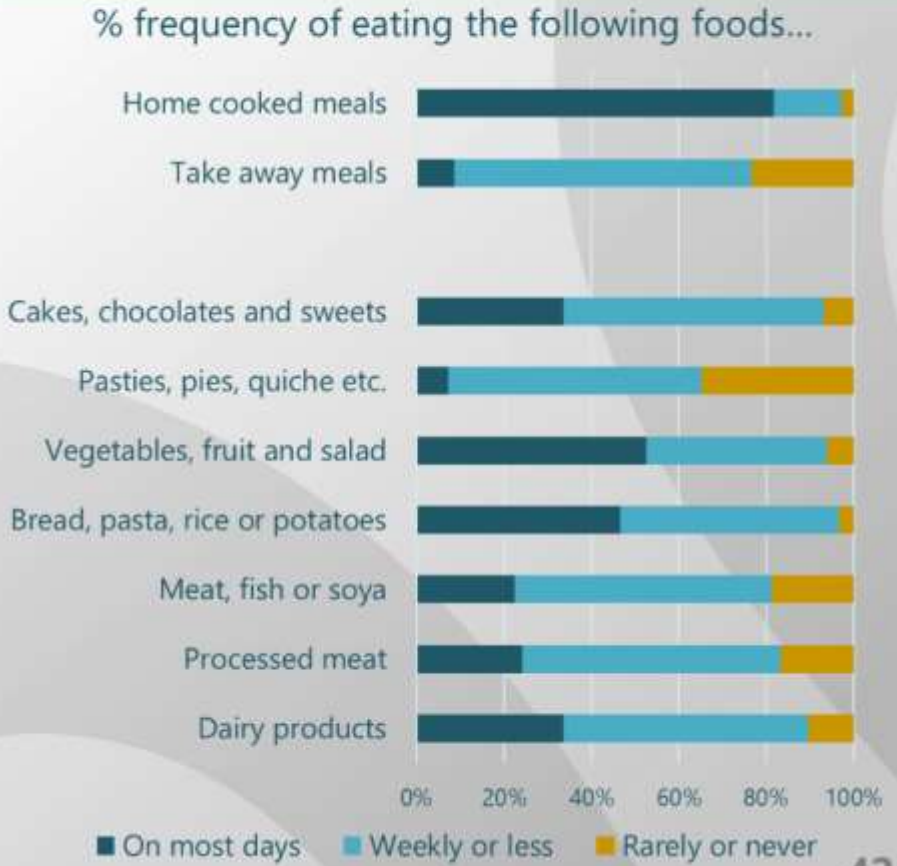

*Significantly higher or lower*

**Most children and young people have a home cooked meal on most days. One in ten (8%) have a take away on most days. 6% of children rarely or never have vegetables, fruit or salad.**

The diet of children in Leicester includes many different types of food.

Half of children eat vegetables, fruit and salad on most days.

93% of children have cakes, chocolates and sweets weekly.

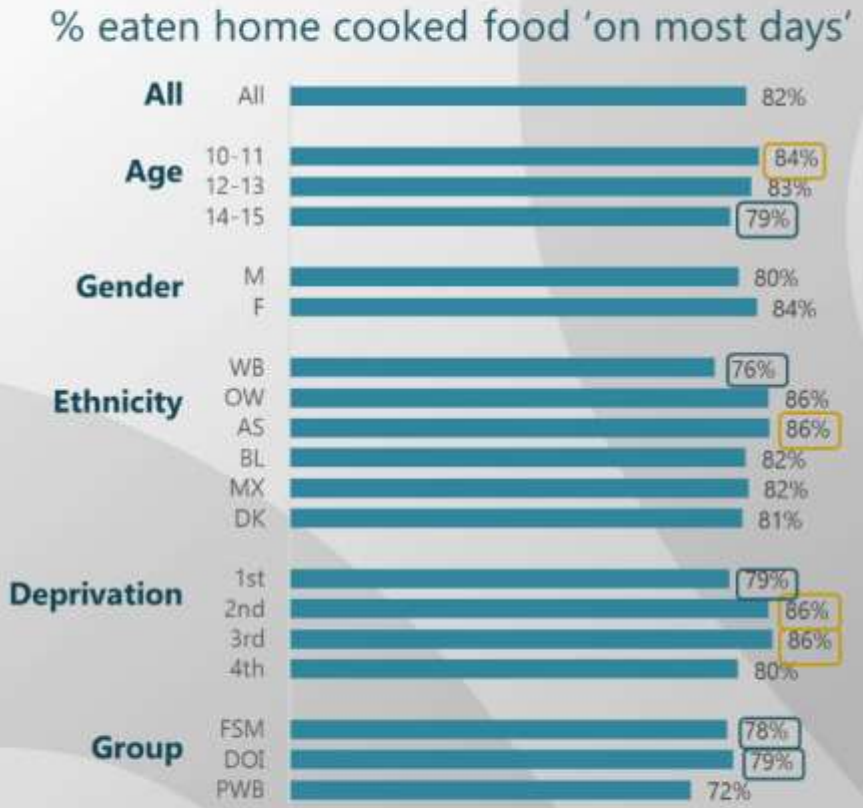


# Four out of five (82%) 10-15 year olds eat home cooked food 'on most days'. 14-15 year olds are less likely to eat home cooked food 'on most days'.

Those residing in the Central or North areas are significantly more likely to eat home cooked food 'on most days', and those in the North west are significantly less likely.

Asian children and young people are significantly more likely to say they have a home cooked meal, whereas White British are significantly less likely.

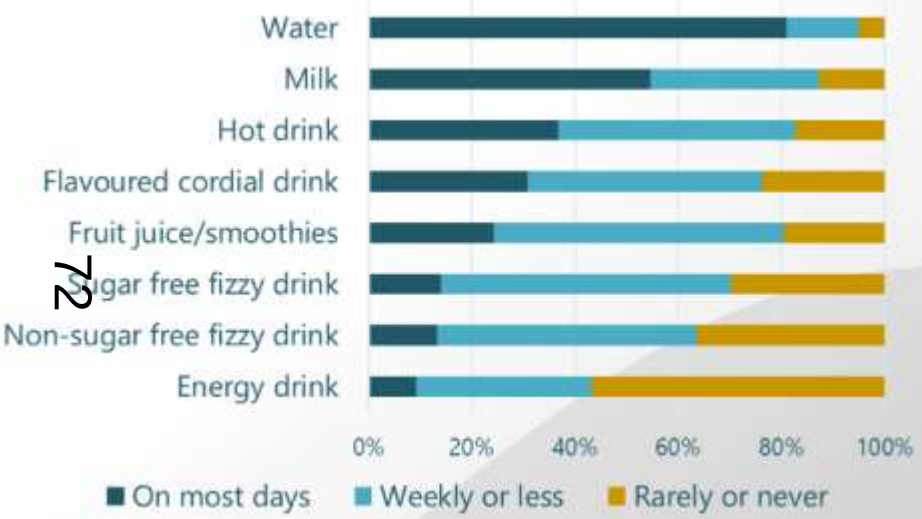
Children were significantly less likely to have home-cooked food 'on most days' if they were in the most deprived quintile, or in the Free School Meals or Poor Wellbeing groups.



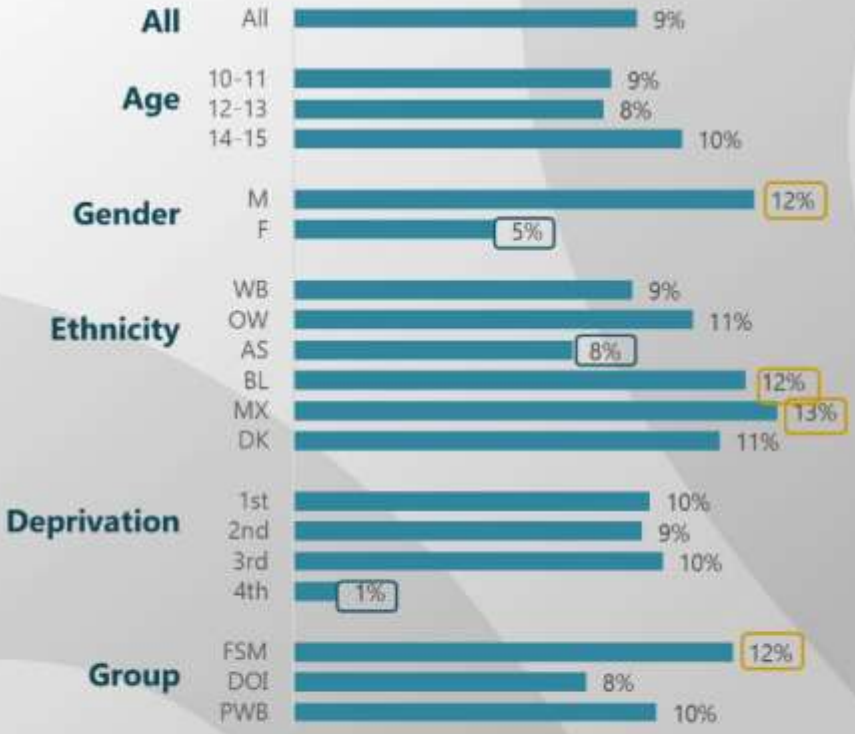

*Significantly higher or lower*

# Most 10-15 year olds drink water on most days. Other popular drinks include milk, hot drinks, fruit juice and cordials. About one in ten drink energy drinks on most days.

% frequency of drinking the following...




% drinking energy drinks on most days




Groups more likely to have energy drinks 'on most days' include males, Mixed Heritage or Black, and Free School Meals children and young people.

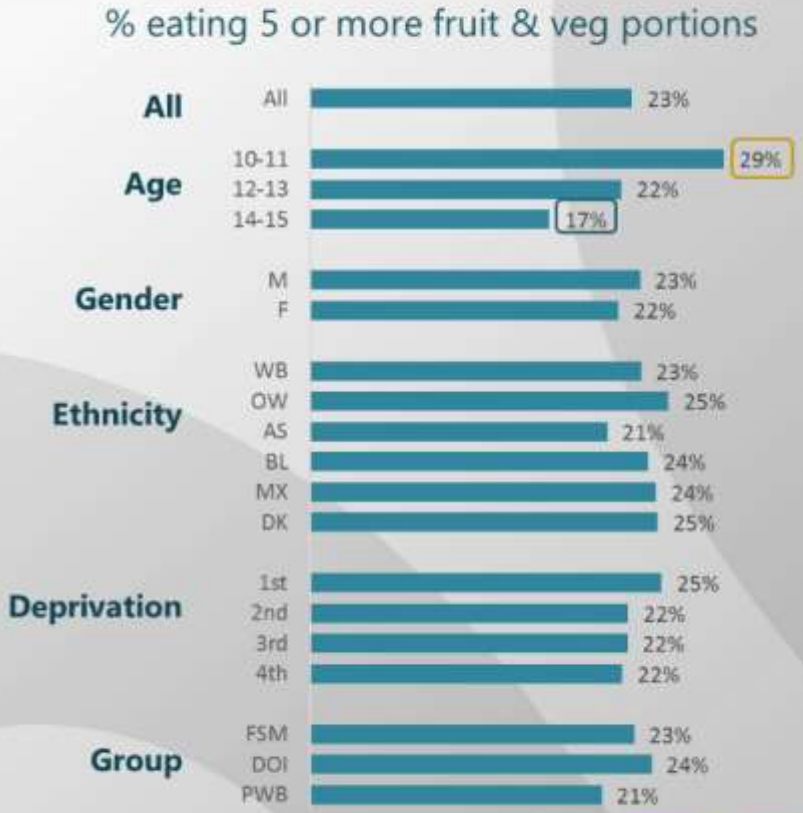
*Significantly higher or lower*

**About a quarter of all children and young people (23%) reported that they ate at least five portions of fruit and/or vegetables yesterday, while 11% said they had none at all.**

Younger children are more likely to eat 5-a-day compared to older groups.

Those from the South area are most likely to eat 5-a-day (36%).

Groups significantly more likely to say they had no portions of fruit & veg at all include males (12%), White British (12%), Black (17%), and those with a poor wellbeing (16%).




*Significantly higher or lower*

74

- Four out of five Leicester children enjoy physical education at school: boys more so than girls.
- However, only close to one in five participated in physical activity on all seven days of the week.
- 5% of children did no exercise at all, 35% did no vigorous exercise and 49% did no vigorous exercise that lasted more than an hour in the seven days before the survey.
- Seven in ten children used some form of active travel for at least part of the journey to school on the day of the survey.

# Physical activity

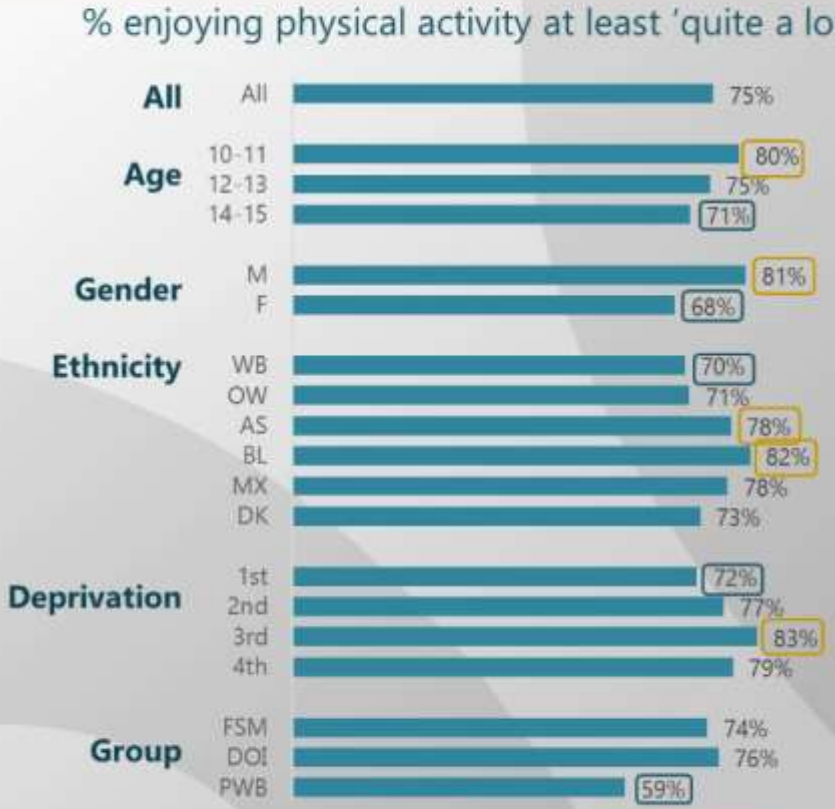
**Most 10-15 year olds (81%) reported that they enjoy PE and games at school at least 'quite a lot'. Three quarters reported that they enjoy other physical activities. A quarter are a member of a sports team outside of school.**

Males are significantly more likely than females to enjoy PE at school and other physical activities.

75

Those living in the most deprived areas are significantly less likely to say they enjoy physical activities.

Those recording a poor mental wellbeing score are significantly less likely to enjoy physical activities.



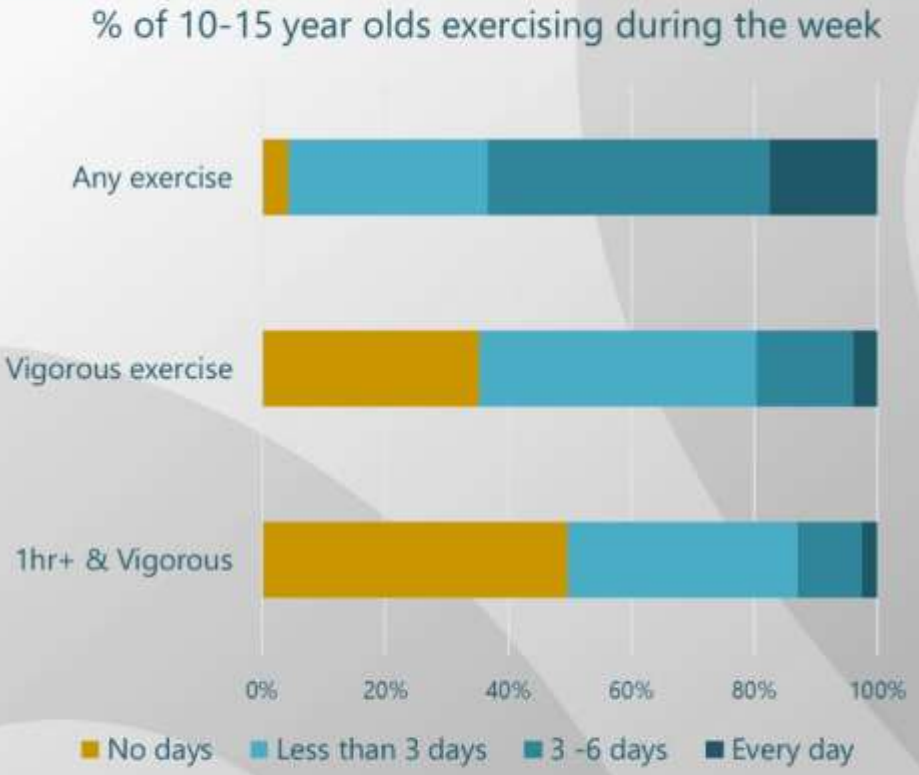
**While games and physical activity appear to be enjoyed by 10-15 year olds, the extent of physical activity varied. 4% did no exercise at all in the 7 days before the survey, 35% did no vigorous exercise and 49% did no vigorous exercise that lasted more than an hour.**



18% of 10-15 year olds exercised every day.

20% exercised vigorously and got out of breath and/or sweaty on at least three days in the week before the survey.

14% exercised vigorously and did so for at least an hour on at least three days in the week before the survey.



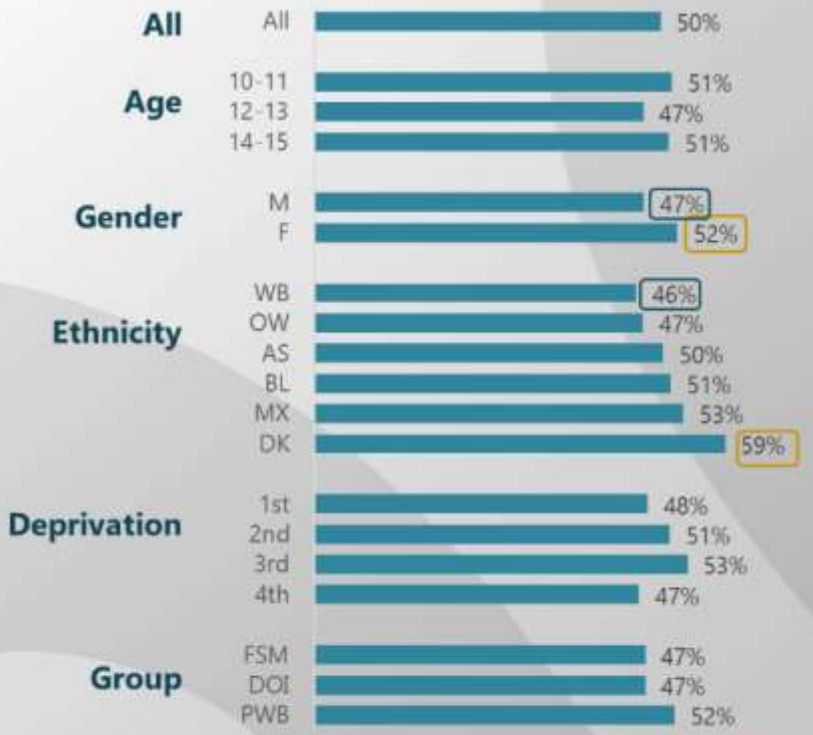
# 50% of 10-15 year olds did no vigorous exercise that lasted more than an hour all week. Most young people gain their advice about physical activity from school or their family.

Females are significantly more likely to do no vigorous exercise that lasts an hour or more all week.

For all groups we are seeing that about half are not completing 1 hour or more of vigorous exercise.

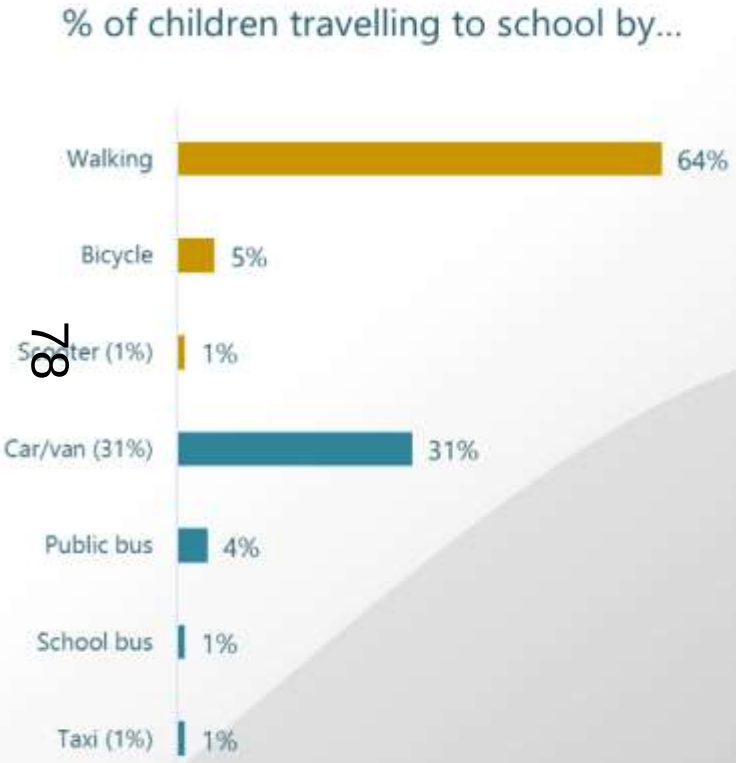
% physical activity advice for 12-15 year olds


% who did no vigorous exercise that lasted 1 hour +




*Significantly higher or lower*

**Seven in ten (70%) children used some form of active travel for at least part of the journey to school on the day of the survey.**




Children were more likely to have walked to school if they were from the most deprived quintiles, or were White British, and less likely if from the East area.

Children were more likely to have travelled by bicycle if Male, from the North area, or from the Other White or FSM groups.

Children were more likely to have travelled by car/van if from the East area or the least deprived quintiles, or were Asian.


79

- Leicester children at age 5 have poor oral health, just under half have dental decay.
- More than four-fifths of children and young people in this survey say they clean their teeth at least twice a day.
- Nearly four-fifths say they usually visit the dentist for a check up.
- However a small number say they have never been to the dentist, and one in six say they usually go only when they have trouble with their teeth.

# Oral Health

**More than four-fifths (85%) of children and young people in this survey say they clean their teeth at least twice a day. Nearly four-fifths (79%) say they usually visit the dentist for a check up.**

Those in the North area are more likely to clean their teeth just once a day.

Children and young people are more likely to say they have never been to the dentist if from the North or Asian.

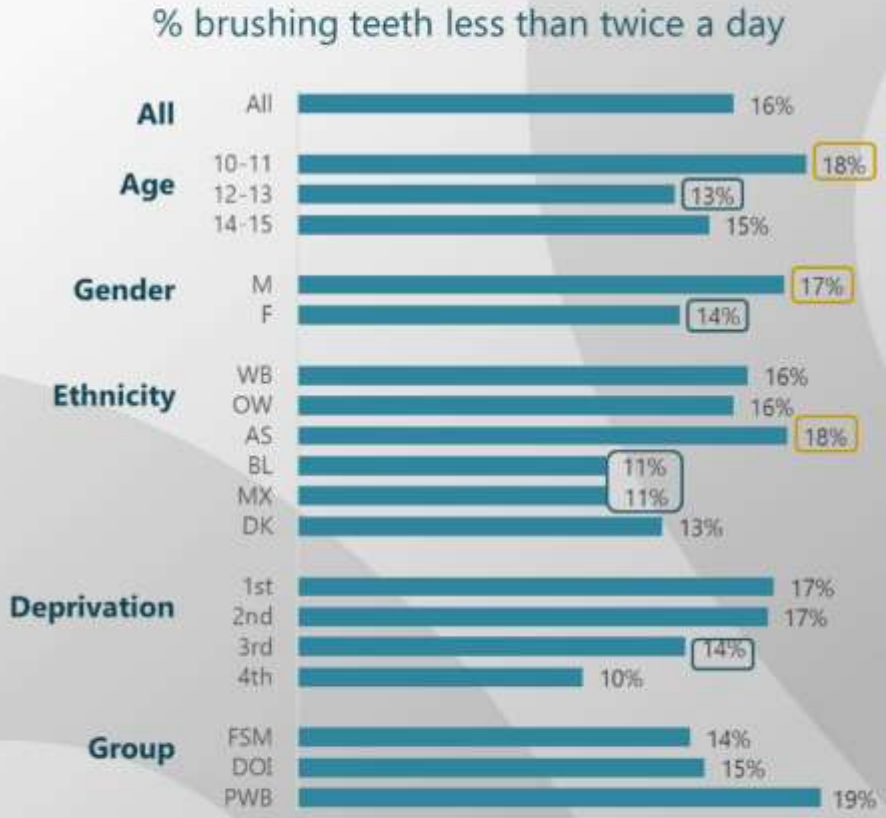
The local context is that Leicester children at age 5 have poor oral health, with just under half (45%) showing signs of dental decay*.


*Public Health England, Oral health survey of five year old children (2015).

# About one in seven (15%) of 10 to 15 year olds clean their teeth less frequently than the recommended twice a day.

Children and young people significantly more likely to brush their teeth less than twice a day include 10-11 year olds, Males and Asians.

Survey data shows that females, 12-13 year olds, Black and Mixed Heritage ethnicities are less likely to brush their teeth less than twice a day.




*Significantly higher or lower*

- Most 12-15 year olds in Leicester (73%) have not tried smoking cigarettes, using shisha or vaping e-cigarettes.
- A significant minority of children and young people live in an environment where smoking is common.
- The parents/carers of a third of children and young people smoke.
- Over a quarter of 12-15 year olds in Leicester say they have tried tobacco cigarettes, shisha or e-cigarettes. 4% of these are current users (using at least weekly).
- The national WAY survey shows that at age 15 smoking in Leicester is significantly lower than in England.

# Smoking

**A key determinant of young people smoking is having a parent or carer who smokes. One in three children have a parent/carer who smokes. A significant minority of children and young people live in an environment where smoking is common.**

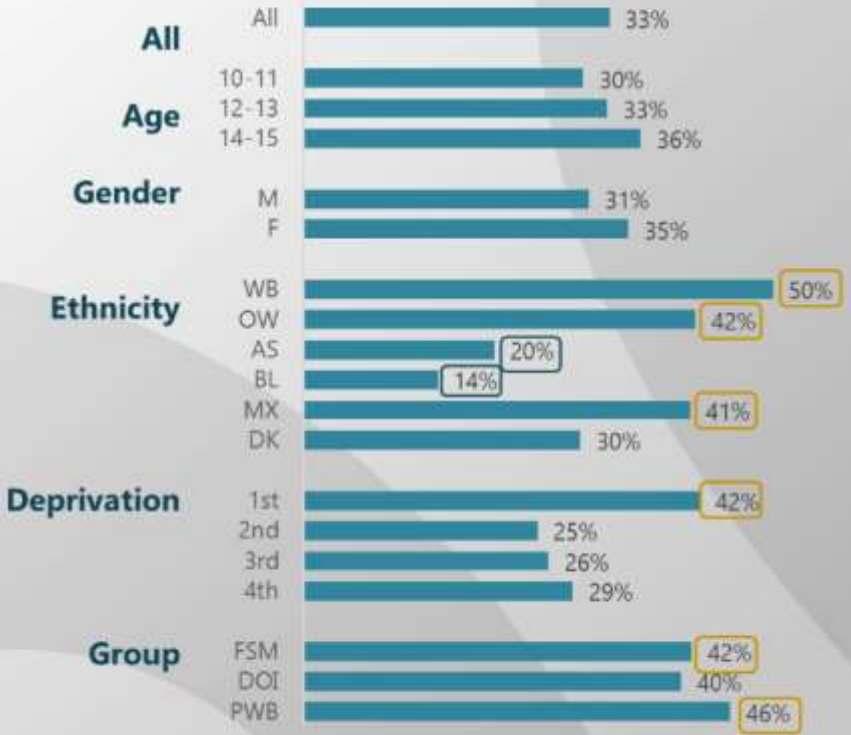
A significant proportion of children and young people in Leicester are exposed to smoking, and to unhealthy cigarette smoke.



% of children who experience...


White British, Other White and Mixed Heritage, those in our most deprived areas are significantly more likely to have a parent/carer who smokes.

% with parent/carer who smokes



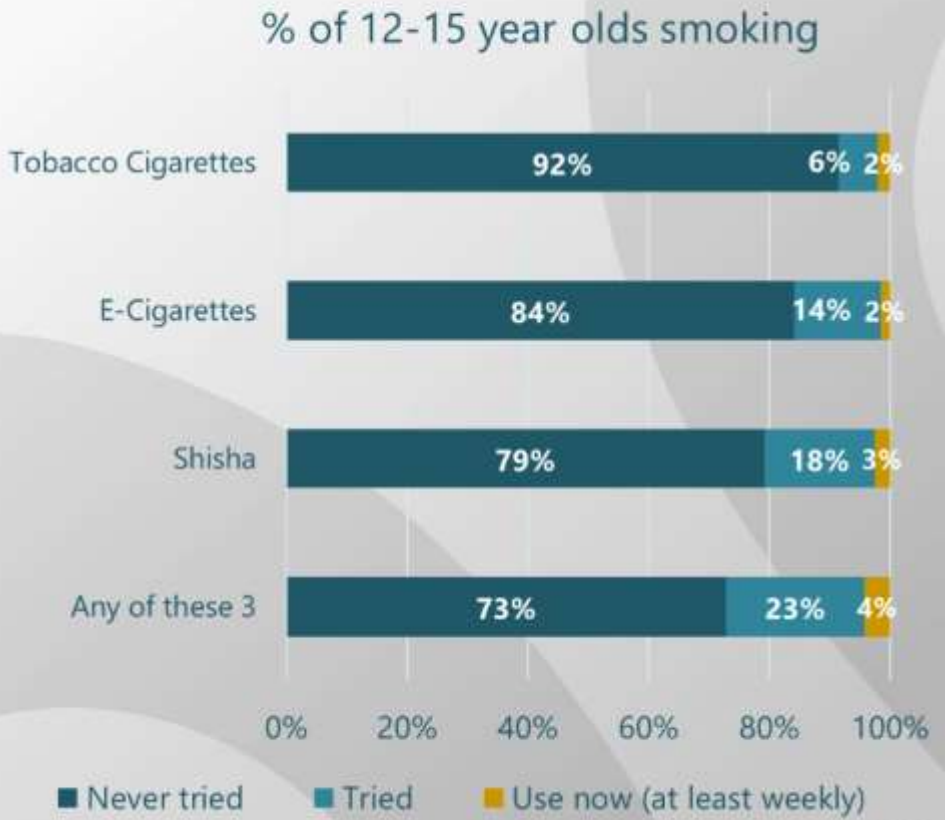

*Significantly higher or lower*

**Over a quarter (27%) of 12-15 year olds in Leicester say they have tried tobacco cigarettes, shisha or e-cigarettes. 4% of these are current users (using at least weekly).**

Most (73%) 12-15 year olds in Leicester have not tried any of these products.

12-15 year olds are more likely to have tried shisha or e – cigarettes rather than tobacco cigarettes.

16% of 12-15 year olds with a parent/carer who smokes have tried tobacco cigarettes and 4% currently smoke. This is twice the rate found in that age group overall.



- Reported drinking at this age is lower in Leicester than in England as a whole.
- About a third of Leicester 14-15 year olds said that they have ever drunk alcohol, and less than 5% did so in the week before the survey.
- Just under a fifth of 10-15 year olds say they are 'certain' or 'fairly sure' they know a drug user.
- About one in ten say they have been offered a drug.

# Alcohol and drug use

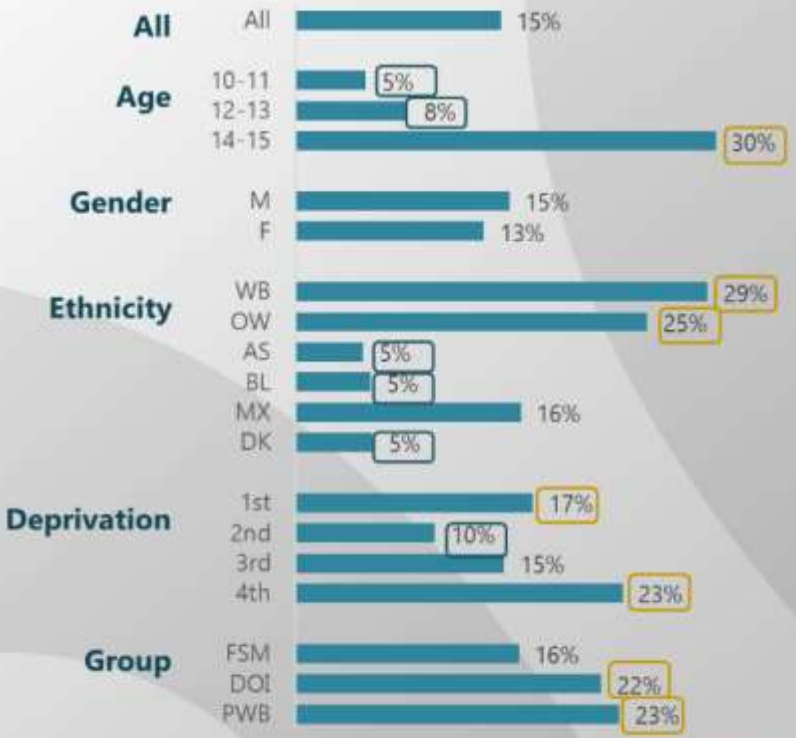
**A significant minority of children (15%) reported drinking more than a sip of an alcoholic drink. This figure rises to 30% for 14-15 year olds.**

Consumption and experimentation with alcohol at earlier ages is rare.

White British and Other White were more likely than Asian or Black children and young people to have tried alcohol.

The most deprived and least deprived communities were more likely to have drank alcohol.

% having drunk more than a sip of alcohol



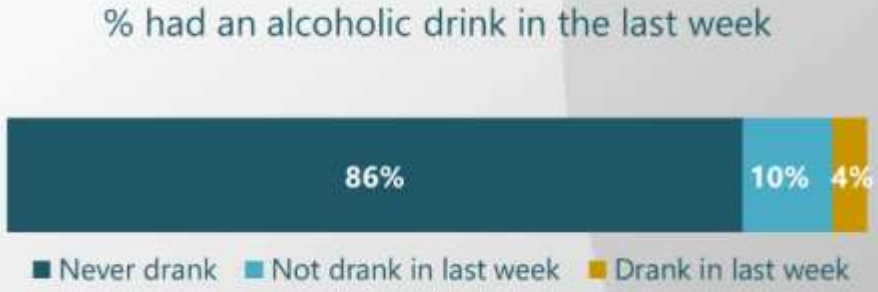

*Significantly higher or lower*

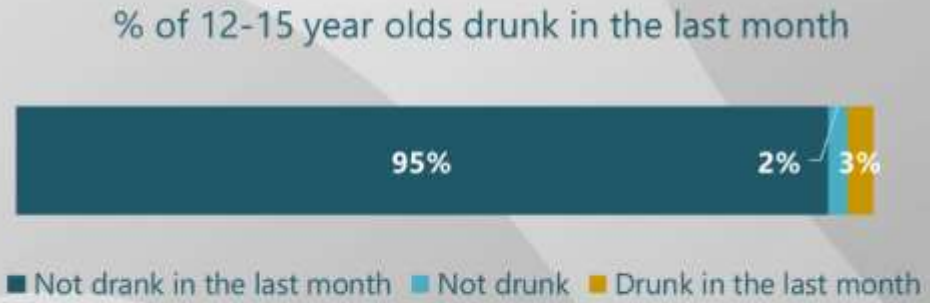
# A small minority of children (4%) had an alcoholic drink in the last week. 3% of 12-15 year olds reported getting drunk in the last month, this figure rises to 5% for 14-15 year olds.

The WAY survey* reported that 6% of 15 year olds in Leicester drank once a week.

This local survey reports a similar percentage for those who drank in the last week.

The most common source of alcohol was to be given it by family members.



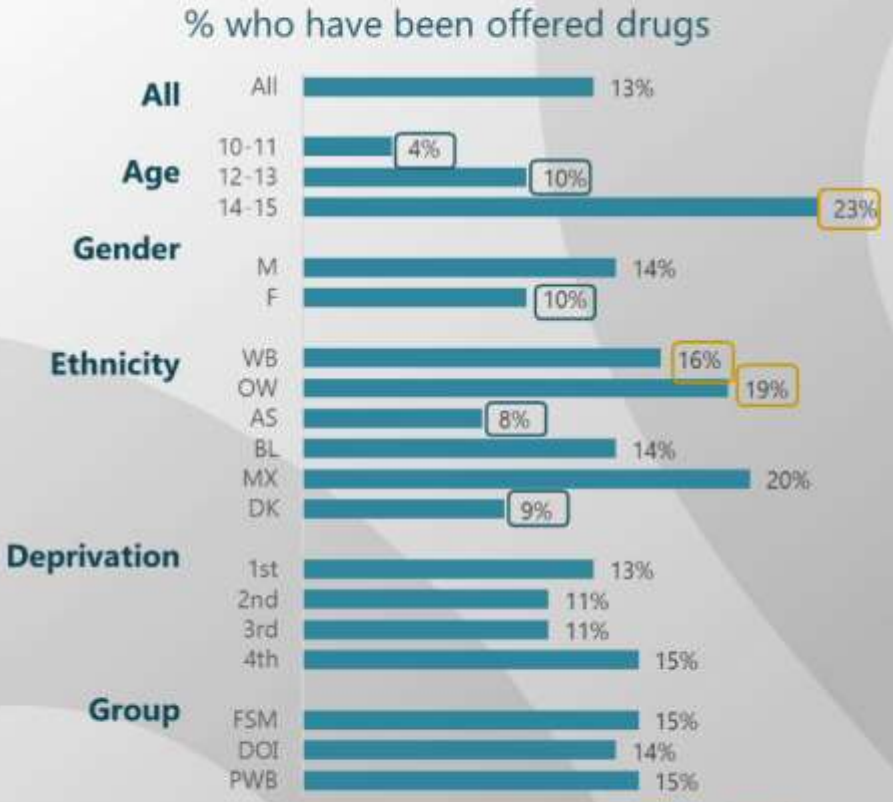

*What About Youth survey of 15 year olds (2014/15).

**Just under a fifth (19%) of 10-15 year olds say they are 'certain' or 'fairly sure' they know a drug user. About one in ten say they have been offered a drug.**

The most common drug to have been offered is cannabis (10%), but new psychoactive substances (incorrectly known as 'legal highs') (9%) and other drugs (7%) have also been offered.

A fifth of 14-15 year olds have been offered drugs, significantly higher than younger groups.

White British and Other White are significantly more likely to say they have been offered drugs compared to Asian children and young people.



**5% of 12-15 year olds say they have taken drugs (not tobacco, alcohol or medicine prescribed by doctor) to change the way they feel (e.g. to get high/chill or to increase energy/motivation).**

The WAY survey* reports that 7% of Leicester children have tried cannabis compared to 11% in England.

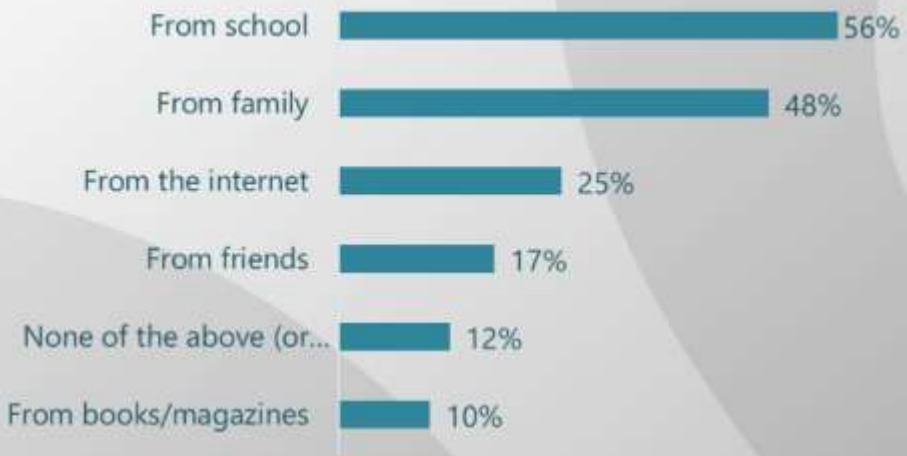
This survey reports that 8% of 14-15 year olds have tried drugs.

Groups more likely to have tried drugs include:

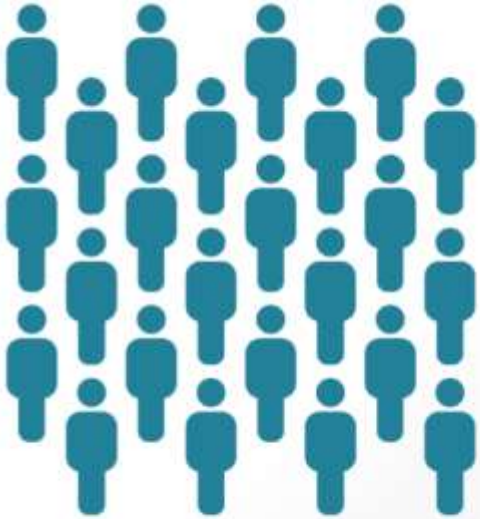
- White British and Mixed Heritage
- Disability or illness and Poor Wellbeing
- Least deprived quintile

*What About Youth survey of 15 year olds (2014/15).

% alcohol, drug and smoking advice for 12-15 year olds




Most 12-15 year olds get their advice about alcohol, drugs and smoking from school or family, with less using the internet or friends.

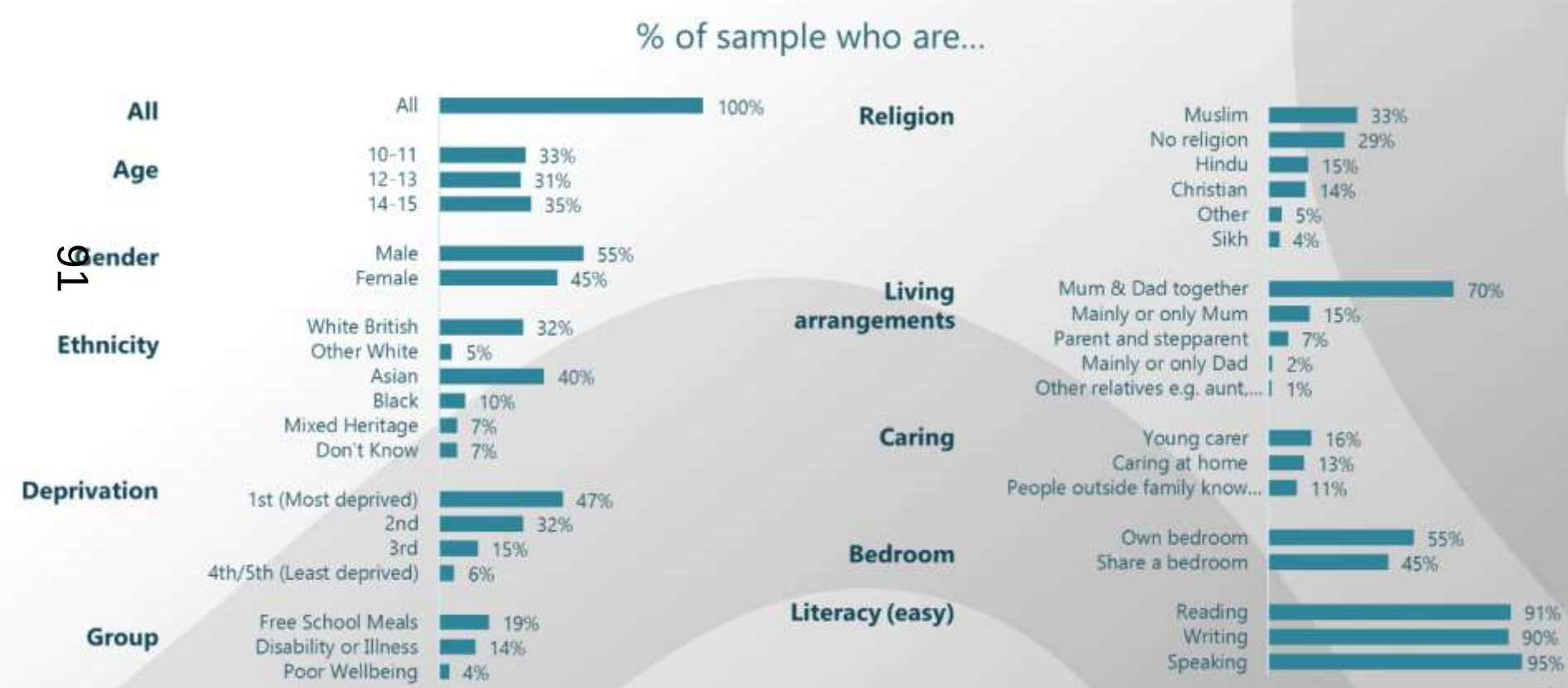


| | |
|---|---|
| Final Sample: | 2,997 responses |
| 10-11 year olds: | 1,399 responses |
| 12-15 year olds: | 1,598 responses |

- The target group includes children and young people in years 6, 8 and 10 attending Leicester schools.
- 28% of the target group were included in the final sample.
- The sample was weighted to match the ethnicity and deprivation profile of the city, and remove age bias.
- Central, North and North West areas are well represented while the East, South and West have lower response rates.

# Who are our sample?

**There are slightly more males than females and a mix of different ages from 10 -15 years old. Many (71%) identify with a religion and over two thirds (68%) are from a BME background. One in six identify as a young carer.**



**76% of the sample provided a valid postcode allowing for some geographic and deprivation analysis. More responses came from those in the Central, North and North West areas.**

For the purposes of analysing the findings, the city has been split into six geographical areas*.


*These areas have no significance other than showing how the findings vary across the city.


**2260 respondents are included in the deprivation analysis (76% of the entire sample). The above percentages are the % in each quintile of those who gave a valid postcode. The Indices of Multiple Deprivation 2015 has been used to assign the postcode of the child to a deprivation quintile (where quintile 1 is the 20% most deprived nationally and quintile 5 is the 20% least deprived nationally). The sample has few children in quintile 5 and for analysis these have been combined with quintile 4.

The use of the term 'risk factor' here is to highlight selected associations found in the survey as shown in table 1. These factors can be viewed:

- as risks (e.g., children whose parents/carers smoke have twice the rate of current smoking than the sample overall) and/or
- as undesirable experiences (e.g., not having something to eat for breakfast) and/or
- as indicators of potential issues with engagement in school or community (e.g. hardly enjoying any of their lessons).



Table 2 shows the association between groups used in the analysis of the survey and demographics.

Survey data shows the experience of a risk factor may be associated with a range of other issues as shown in table 3.

Judgement as to the extent to which these factors are a risk to longer term wellbeing should be considered by those working with children and young people when reflecting on the survey results.

# What we mean by risk?

# Table 1: Risk factors by demographic group.

| | Not a good Place to live | Hardly enjoy any of their lessons | Experienced abusive behaviour in relationship (12-15 year olds) | Poor resilience | Been bullied in the last 12 months | Not having something to eat for breakfast | Do not enjoy physical activity | Parent/ carer smokes | Drinking more than a sip of alcohol | Ever been offered drugs |
|---|---|---|---|---|---|---|---|---|---|---|
| Male | | | | | | | | | | |
| Female | | | | | | | | | | |
| 10-11 year olds | | | | | | | | | | |
| 12-13 year olds | | | | | | | | | | |
| 14-15 year olds | | | | | | | | | | |
| White British | | | | | | | | | | |
| Other White | | | | | | | | | | |
| Asian | | | | | | | | | | |
| Black | | | | | | | | | | |
| Mixed Heritage | | | | | | | | | | |
| Most deprived* | | | | | | | | | | |
| Central | | | | | | | | | | |
| East | | | | | | | | | | |
| North | | | | | | | | | | |
| North West | | | | | | | | | | |
| South | | | | | | | | | | |
| West | | | | | | | | | | |

| | |
|---|---|
| *Significantly higher likelihood* | |
| *Significantly lower likelihood* | |
| *No significant difference* | |

*Living in most deprived 20% areas nationally (Index of Multiple Deprivation 2015)

# Table 2: Highlighting 'vulnerable' demographic groups based on specified factors.

| | Free School Meals | Disability or illness | Poor Wellbeing | Young carer | Find it 'OK'/'Hard' to write, read or speak English |
|---|---|---|---|---|---|
| Male | | | | | |
| Female | | | | | |
| 10-11 year olds | | | | | |
| 12-13 year olds | | | | | |
| 14-15 year olds | | | | | |
| White British | | | | | |
| Other White | | | | | |
| Asian | | | | | |
| Black | | | | | |
| Mixed Heritage | | | | | |
| Most deprived* | | | | | |
| Central | | | | | |
| East | | | | | |
| North | | | | | |
| North West | | | | | |
| South | | | | | |
| West | | | | | |

| | |
|---|---|
| *Significantly higher likelihood* | |
| *Significantly lower likelihood* | |
| *No significant difference* | |

*Living in most deprived 20% areas nationally (Index of Multiple Deprivation 2015)

# Table 3: Correlations between risk factor groups.

| | Not a good Place to live | Hardly enjoy any of their lessons | Experienced abusive behaviour in relationship (12-15 year olds) | Poor resilience | Been bullied in the last 12 months | Not having something to eat for breakfast | Do not enjoy physical activity | Parent/ carer smokes | Drinking more than a sip of alcohol | Ever been offered drugs |
|---|---|---|---|---|---|---|---|---|---|---|
| Parent/carer smokes | | | | | | | | | | |
| Do no vigorous exercise | | | | | | | | | | |
| Not having something to eat for breakfast | | | | | | | | | | |
| Drinking more than a sip of alcohol | | | | | | | | | | |
| Ever been offered drugs | | | | | | | | | | |
| Been bullied in the last 12 months | | | | | | | | | | |

| | |
|---|---|
| *Significantly higher likelihood* | |
| *Significantly lower likelihood* | |
| *No significant difference* | |

- Where results do not sum to 100, this may be due to multiple responses, computer rounding or the exclusion of don't knows/not stated.
- A number of questions were only asked of children 12 -15, where this is the case the text will highlight that these figures apply to the older sample.
- Significant differences are highlighted, this denotes a significant difference to the Leicester overall figure.
- Charts show percentage for all and by the following analysis groups; age, sex, geographical area, deprivation quintile (where 1 is the most deprived 20% nationally), ethnicity, free school meals, disability or illness, and poor well-being.

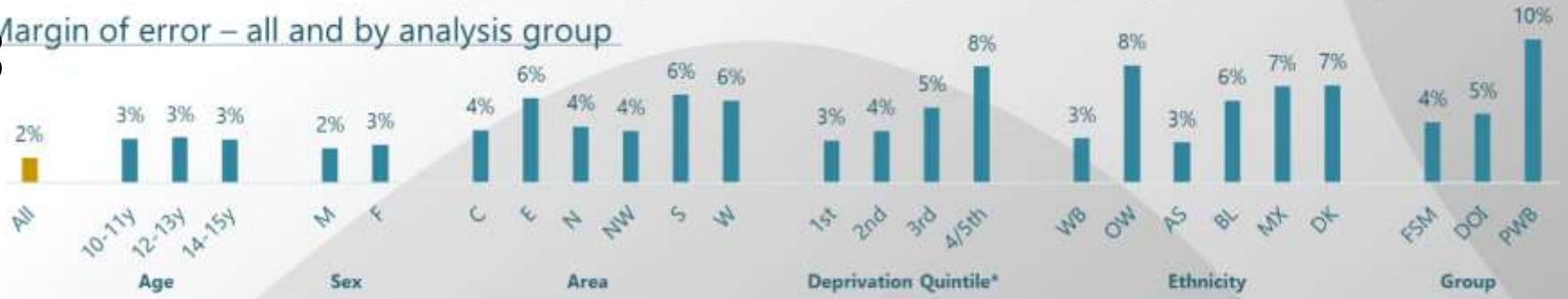


# Technical note

- The sample has been broken down to look at differences between groups.
- To determine whether these differences are due to random variation or a real underlying issue a margin of error has been calculated at the 95% confidence level.
- A margin of error must be exceeded to determine a statistically significant difference. Figures (chart below) for the overall sample are at most ±2% of the 'true' value, while for the smaller poor wellbeing (PWB) group we can expect ±10%.



Margin of error – all and by analysis group




*There were few respondents from the least deprived quintile 5 therefore these were combined with quintile 4 (and labelled 4th)

# Guide to statistical reliability

*Respondents to the survey are not evenly distributed across the city.*

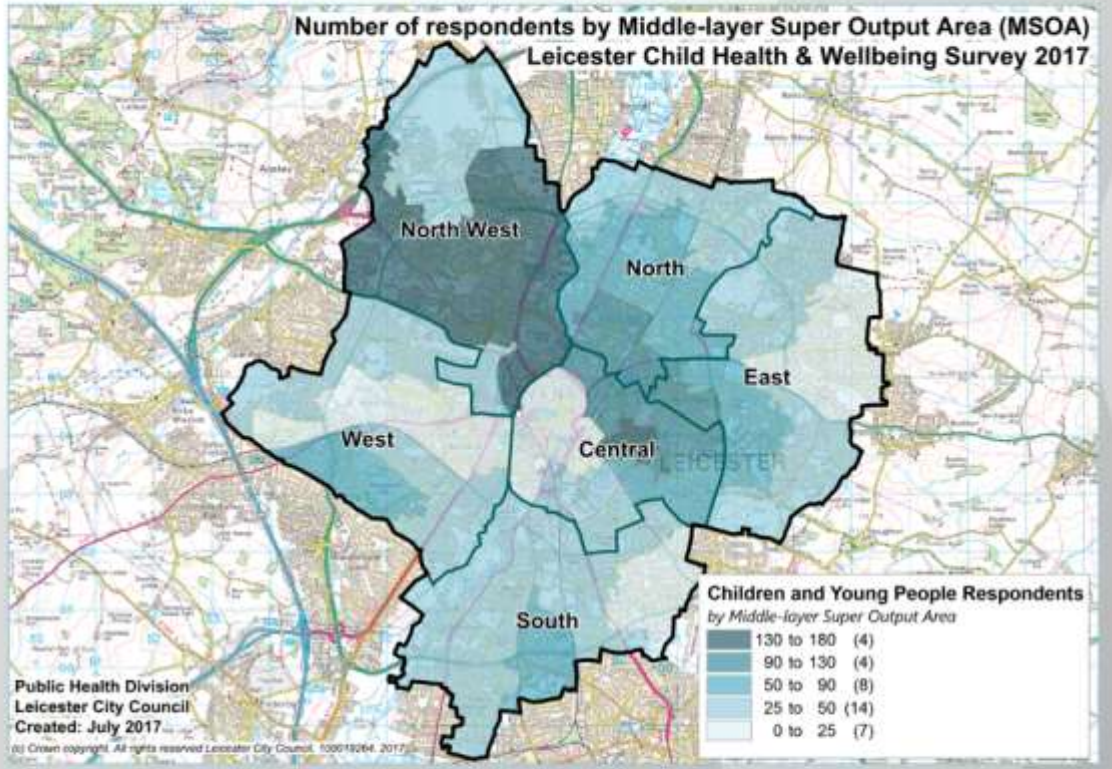
Overall findings can be provided at a broad area geography.

There are fewer responses (particularly at a secondary level) in the East, West and South.

Lower geography analysis is difficult and representation is uneven.

Some wards/Middle Super Output Areas have a very high sample while others are too low to report.

Few in the sample reside out of the city.




# Lower geography analysis

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Exeter, Devon EX2 8PF

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# Contacts

**LEICESTER CITY HEALTH AND WELLBEING BOARD**
**17th August 2017**

| | |
|---|---|
| **Subject:** | Leicester City Better Care Fund 2017-2019 |
| **Presented to the Health and Wellbeing Board by:** | Sue Lock, Managing Director, Leicester City CCG |
| **Author:** | Rachna Vyas, Deputy Director of Strategy & Implementation, Leicester City CCG |

**EXECUTIVE SUMMARY:**

1. The 2017-19 Better Care Fund approval process required each area to submit a 2 part plan on September 11th 2017 – the first requirement is a planning template detailing activity, finance & metrics and the second is a narrative plan providing a detailed description of plans for 2017-19.
2. Both components were co-produced between the CCG and the LA, with approval sought from members of the Joint Integrated Commissioning Board (JICB) between meetings prior to this submission.
3. The draft narrative plan is presented as Appendix 1. Final 'Key Lines of Enquiry' have not yet been received from NHS England and therefore the plan may change to reflect any additional information requested before the formal submission date. A final planning template is also awaited from NHS England
4. It is therefore recommended that both documents should be taken to the Joint Integrated Commissioning Board for approval on behalf of the HWB, once final documents are received.
5. Plan assurance will include moderation at NHS regional level, led by Better Care Fund leads for each region, with appropriate representation from regional NHS and local governance.
6. The plan meets all national conditions except achievement of a Delayed Transfer of Care rate of 3.5% of all occupied beds by September 2017. A realistic assessment of issues has led the LLR health and social care economy to present a trajectory which allows the target to be met by March 2018. This has been agreed at the LLR A&E Delivery Board.
7. The final plan will be reviewed by the JICB in August 2017. Before submission it will be authorised and signed off by the Chair of the Health and Wellbeing Board, The Chief Operating Officer of Leicester City Council and the Managing Director of Leicester CCG.

**RECOMMENDATIONS:**

The Health and Wellbeing Board is requested to:

**APPROVE** the draft narrative of the Leicester City Better Care Fund plan 2017-19
**DELEGATE** approval of the final narrative plan and the final planning template to the Chair of the Health and Wellbeing Board for submission on September 11th 2017.

Leicester City Council

NHS
Leicester City
Clinical Commissioning Group

# The Leicester City Better Care Fund 2017-19

August 2017

| | |
|---|---|
| Local Authority: | **Leicester City Council** |
| Clinical Commissioning Group: | **Leicester City Clinical Commissioning Group** |
| Boundary Differences: | **None** |
| Date agreed at Health and Wellbeing Board: | **August 17th 2017** |
| Date submitted to DCO team: | **September 11th 2017** |
| Minimum required value of BCF pooled budget 2017-18: | **£33,242,254** |
| Total agreed value of pooled budget 2017-18: | **£33,242,254** |

## a) Authorisation and signoff

| | |
|---|---|
| **Signed on behalf of NHS Leicester City CCG** | |
| **By** | Sue Lock |
| **Position** | Managing Director |
| **Date** | |
| **Signed on behalf of Leicester City Council** | |
| **By** | Andy Keeling |
| **Position** | Chief Operating Officer |
| **Date** | |
| **Signed on behalf of the Leicester City Health and Wellbeing Board** | |
| **By Chair of Health and Wellbeing Board** | Cllr Rory Palmer |
| **Position** | Deputy City Mayor and Chair of Leicester City Health & Wellbeing Board |
| **Date** | |

## Contents

## Chapter 1: Our core vision and approach for health and social care integration in Leicester City

Our core vision for this programme, as set out in Leicester's Health and Wellbeing Strategy, '*Closing the Gap'*, continues to be:

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



Our vision for a healthier population goes much further than just ensuring people get the right care from individual services. We want to create a holistic service delivery mechanism so that every Leicester citizen benefits from a positive experience and better quality of care.

At the core of our vision remains a thorough understanding of our population (with a focus on the demographic and socio-economic breakdown across the City) and the health inequalities faced and what we need to do to achieve better outcomes in the short and medium term in line with our JSNA and Joint HWB strategy. A full contextual breakdown of these issues is provided in Appendix 1.



### Using integration as a vehicle to delivering the Five Year Forward View

The NHS Five Year Forward View enables a far greater focus to be put onto ambitious and transformative change across the totality of the health and social care economy, through new models of care, driving change through relationships with communities and truly achieving parity of esteem for mental health services. Translating national policy into the practical reality on the ground is a complex task, which is being undertaken in the context of ongoing austerity. Partner organisations are facing unprecedented levels of demand with correspondingly large saving requirements.

To truly achieve change at both a system level and a place-based local level, we have fully aligned our Better Care Fund plans for 17/18 to enable delivery of the aims outlined in our LLR Sustainability and Transformation Plan, our CCG Operational Plan and our Adult Social Care Operating Plan – this will take us closer to fully integrated health and social care services by 2020 as mandated in the 2015 Comprehensive Spending Review.

### The LLR Sustainability and Transformation Plan

The vision for the Leicester, Leicestershire and Rutland (LLR) health and care system is create a high quality, integrated health and care system, which is affordable and meets the needs of local people in the medium term. The Better Care Fund is a core component in the delivery of this vision,

enabling people to be cared for at home or in their own community, whenever possible, and for as long as possible. This plan was formed during 2016 and has recently been rated as one of the more advanced STP's. The plan is available at http://www.bettercareleicester.nhs.uk/Easysiteweb/getresource.axd?AssetID=47665.

The preparation of the STP has led to improved collaboration on financial and activity modelling across partners in the health and care system. Partners have jointly considered the demand and resource flowing through the health and care system, the interdependencies of activity assumptions, financial assumptions, reconfiguration & transformation plans and savings requirements over the five year period.

The development of the STP signals a move away from an annual planning process that has delivered incremental, organisational-specific improvement to a longer-term view that delivers transformational change across organisational boundaries. The STP therefore represents a combined LLR strategy supported by joint planning assumptions and delivery arrangements for the partners across the health and care economy.

Our entire model of care is being transformed across LLR so that "home first" becomes a reality. This means tackling the over reliance on acute care, and ensuring our community based services are integrated, consistent, reliable and resilient.

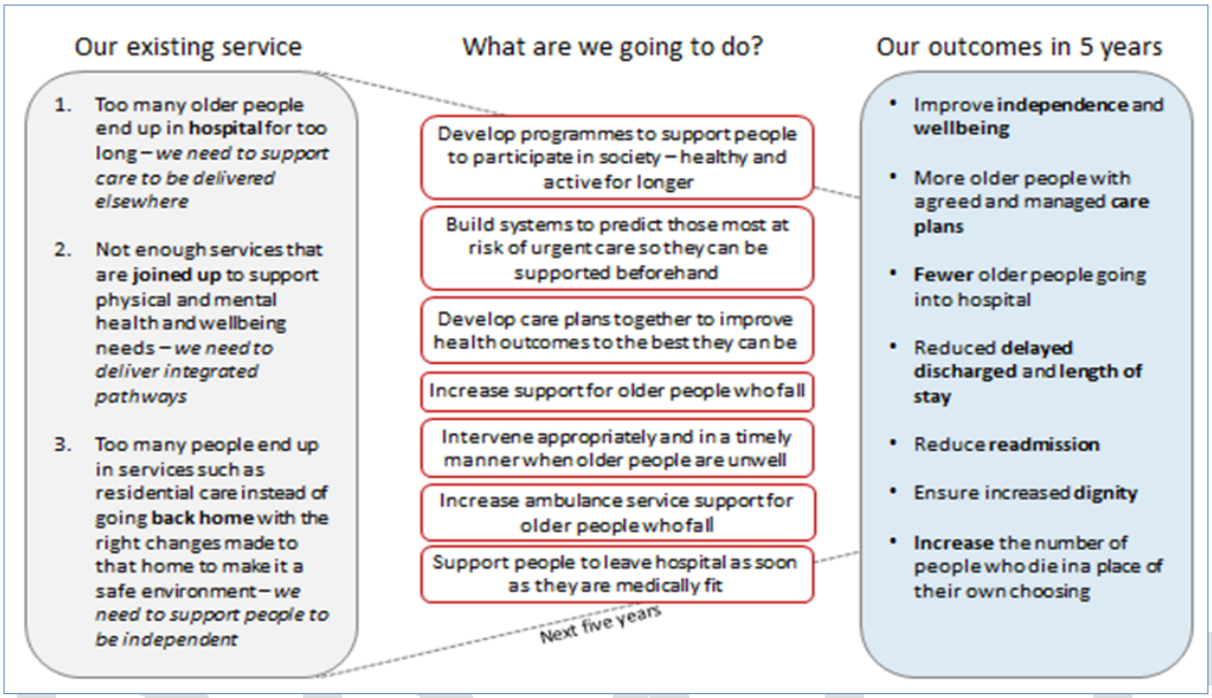
For home first to operate successfully, rapid, easy access to the appropriate level of care and support outside of hospital on a 24/7 basis is required, with person centred care coordinated effectively across organisational boundaries and professions. If an emergency admission to hospital does occur, then the 'home first' principle also applies, so that, if someone is admitted to hospital and after necessary interventions and treatment, the system's primary aim will be to return that person to the home address from which they came as soon as possible.

Over the past two years some core components of the home first model have been developing in LLR, through the Better Care Fund Plan in Leicester City, and other transformational programmes of work such as the LLR Urgent Care Vanguard. These cross-cutting workstreams have included for example providing 2 hour health and social care responses for admission avoidance and consolidating hospital discharge routes into five streamlined pathways across LLR.

Some elements of integration have started to take shape over the past two years but we are now entering a further phase of redesign within the STP, where remaining variations in care pathways and delivery across the LLR area can be fully addressed and where medium term solutions will be implemented across the system. The development of the STP has led partners to achieve consensus on the top priorities across the system, and renew their collective commitment to achieve a much greater level of integration across care pathways and organisations over the next few years.

### Our steps towards a fully integrated system of care by 2020 – Background and context to the plan

The services within the Leicester City Better Care Fund were launched in 15/16 and embedded through 16/17, following the roadmap outlined below:




In 16/17, the BCF delivered a series of interwoven interventions including new model of care coordination, integrated crisis response services and enhanced care planning; these were all co-designed to reduce the time spent avoidably in hospital through provision of integrated community services (whether to prevent an admission or to facilitate a holistic discharge back into the community).

Due to the success of these interventions, these services remain the key building blocks upon which our 17/18 BCF has been co-constructed and we will use the BCF to accelerate our progression towards our joint optimal delivery model, fully operational by 2020, in line with the intent set out in the 2015 spending review.

Our delivery model is based on 3 key priority areas, which have been designed to deliver one integrated, place-based model of care:

Priority 1: **Prevention, early detection and improvement of health-related quality of life**

**We will achieve this by implementing:**

- Services for complex patients:
  - **Increasing the number of people identified as 'at risk' and ensuring they are better able to manage their conditions, including out of hours, thereby reducing demand on statutory social care and health services. This will include both physical and mental health.**
- The Leicester City Lifestyle hub (enhanced self-care):
  - **Delivering 'great' experience and improving the quality of life of patients with long term conditions by expanding our use of available technology, patient education programmes and GP-led care planning, reducing avoidable hospital stays.**

Priority 2: **Reducing the time spent in hospital avoidably**

**We will achieve this by implementing:**

- The Clinical Response team (integrated into a 24/7 home visiting service):
  - **Providing an ECP-led 2 hour response to patients at risk of hospital admission from GP's, care homes, 999 and 111.**
  - **Proving a proactive care home service to ensure our care home population receive high quality care in their usual place of residence**
- Our joint Integrated Locality Teams:
  - **Four integrated physical and mental health teams, ranging from health and social care to housing and financial services, which respond in a coordinated way to ensure care is delivered in the community and around the individual, geographically aligning services from our Adult Social Care, GP practices and Community services for the first time .**
- Interoperable IT systems & governance:
  - **Enabling the use of the NHS number as a primary identifier for all patients, linked to high-quality care plans for our frail elderly patients or those with complex health needs.**
- Our Intensive Community Support Service:
  - **Increasing community capacity to look after people in their own homes rather than in a hospital bed.**

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Priority 3: **Enabling independence following hospital care**

**We will achieve this by implementing:**

- Our nationally commended ICRS service:
  - **Ensuring timely hospital discharge via the provision of in-reach (pull) teams to swiftly repatriate people to community-based services and maintain independence across physical and mental health services. This service also has an admission avoidance function through partnership working with our GP's. Access to assistive technologies is also provided through ICRS.**
- **Our Hospital based Health Transfers Team**
  - Ensuring optimal discharge pathways for our patients requiring Adult social care – this team is based on-site at the acute trust preventing delays to discharge
- Our holistic enablement & reablement services:
  - **Increasing the number of patients able to live independently following a hospital stay by helping them back to independence**
- Our Joint community mental health teams:
  - **Mobilising community-based capacity specifically targeting the discharge of patients in mental health care settings.**

The vast majority of these services are linked into one community pathway, ensuring that referral into any service listed above produces a holistic health and social care assessment which addresses the patient's wider needs, rather than just the requirement that they were referred for.

The delivery model described will move us towards a fully integrated system by 2020 and takes into account other areas of development across our system, such as implementation of our primary care strategy and the ambitions of our STP:

**As at 2012/13:**

Fragmented pathways across health and social care, not mapped to general practice

Unsustainable demand on all services, creating a significant financial gap by 2018/19

Significant variation in outcomes from care as a result of health inequalities

Sub-optimal provider performance as a result of demand on services and processes between sectors

Insufficiant workforce, both in terms of capacity and capability to deliver new models of care

Sub-optimal use of assets & resources across LLR

**Delivered in 2016/17**

Preventative services co-located into one **Lifestyle Hub**, with a single referal process

**4 Integrated Locality Teams**, geographically aligning General Practice, social care and community services

Increased p**lanned care** community capacity, including in g**eneral practice capacity** to provide care in the community, focussing on acute demand reduction

**Co-located access teams**, making the best use of assets across the health and social care system, with **joined up IT systems**

**By 2020:**

Preventative models of care embedded into every pathway of care, with a city-wide **Lifestyle Hub**

A new **model of primary care** launched across the city, ensuring timely access, care planning and management, with **one simple integrated pathway into community support**

**Neighbourhood health and social care teams** with single referral pathways & assessment processes, working in specific GP localities, **with one IT system**

A new model of integrated care, fully utilising **joint teams across neighbourhood areas** to deliver seamless care

This plan moves us towards the goals set out in the 2020 column in a systematic fashion.

# Chapter 2: Progress to date

## Analysis of system performance

The LLR health & social care system has been under sustained pressure for much of 2016/17, reflected in declining performance on a number of key indicators in the City, particularly access to General Practice and A&E waiting times. A summary of the key challenges noted in 16/17 is reflected below:

| | |
|---|---|
| LLR system performance challenges in 16/17 | A&E 4 hour standard - 79.6% vs target of 95% |
| | Ambulance handover times - 27.35minutes vs target of 15 minutes |
| | Demand for acute care overall - A&E saw c5% growth in attendance |
| Leics City performance challenges in 16/17 | Access to General Practice - Ease of making an appointment with GP fell from 68% to 63% |
| | Mental health Delayed Transfers Of Care - between 12-15% of all occupied bed days |
| | Permanent admissions to residential care - 282 people were admitted vs target of 260 |
| Overall financial challenge | CCG acute budget significantly over plan (+£2,407,046) |
| | Adult social care budget pressures of c£14m in 16/17 |
| | Acute provider deficit - £27.2m in 16/17 |



Despite these challenges, the City saw some positive movement during 16/17 against some key indicators. For example, for Non-elective admissions, the City noted a 2.62% reduction in non-elective admissions compared to 15/16 – this has not been seen in recent times and goes against the national trend of increasing activity.

### Other challenges

Although really good progress has been made on data integration by using the NHS number on social care records, implementing PI Care and Healthtrak, and deploying the risk stratification (ACG) tool in primary care, further work is needed on the integration of data and IT systems throughout LLR so that we have:

- A more systematic approach to business intelligence overall
- The architecture is in place to implement the electronic summary care record (SCR2).

SCR2 is a large programme of change within the LLR Digital Roadmap. It impacts on direct care for patients, in particular on services where multiple professionals need access to shared records, such as in urgent care, home first, integrated locality teams, and all the associated case management in primary care and community settings. The Leicester City BCF plan has an overall dependency on the development of an LLR wide solution for the electronic summary care record with an expectation of solutions being implemented from 2017/18.

The directive from NHS Digital in early 2017 about restrictions imposed on LA's accessing SUS (hospital) data, and the ability to link this data with other data sources, have presented further challenges to our locally ambitious plans for data integration. In particular system wide analysis using PI Care and Healthtrak has been inhibited.

## Progress against BCF metrics in 16/17

Addressing overall system performance is a key priority in the LLR STP and will require further transformative work via both the BCF and the wider system. The Leicester City BCF performed well within the context described above, with year on year activity increasing within the services commissioned and the outcomes noted also improving.

Overall performance summary shows that 2 of the 5 BCF targets were achieved:

| Metric | Plan 16/17 | Actual 16/17 | Status |
|---|---|---|---|
| **DTOC** | 8.0/100,000 | 11.9/100,000 | Not Achieved |
| **Non elective admissions** | 32888 | 33092 | Not Achieved |
| **Residential Care** | 260 | 282 | Not Achieved |
| **Reablement** | 90% | 91.3% | Achieved |
| **Dementia prevalence** | 70% | 82% | Achieved |



Although the Non elective admission target was not achieved, it is important to note that the target was missed by only 203 admissions and represented a reduction of 2.62% (893 admissions) on the 15/16 position.

As part of our planning process, we have analysed performance against each of these metrics in depth in order to target our 17/18 plans. A summary of performance in 16/17 and a brief opportunity analysis is detailed for the BCF metric areas below. Further detail of our plan is outlined in Chapter 4.

### Non-elective admissions (General and Acute)

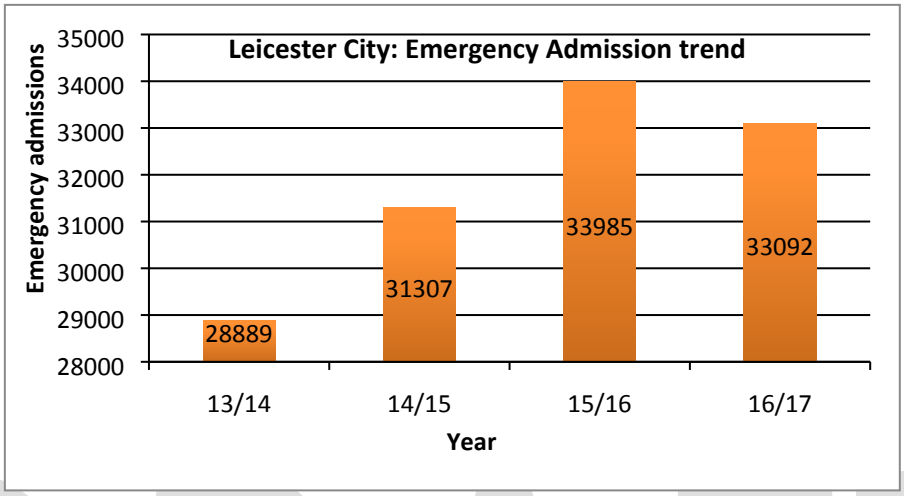
**Performance in 16/17**

Despite activity in every BCF scheme reaching capacity in 16/17, Leicester City missed our non-elective admissions target by 0.62% (203 admissions) – although this is a significant improvement against previous years where the target has been missed by a much larger percentage.

Clinical audit of BCF schemes shows significant impact on the non-elective admission rate and this is noted in our activity profile at UHL:

| Commissioner (16/17) | Variance to: | |
|---|---|---|
| | **Contracted activity plan** | **Activity in 15/16** |
| **NHS LEICESTER CITY CCG** | +0.62%<br>(+203 admissions) | -2.62%<br>(-893 admissions) |

Given the national and local trends of rising emergency admissions, this is a significant achievement for the City. Equally when comparing our own trends over the last few years, the performance improvement is even starker:




No coding changes in emergency admissions have been noted in 16/17 and our partner CCG's in LLR have experienced significant rises against both contracted activity and year on year growth; therefore this is likely to be a 'real' reduction in activity. Clinical audit has shown a reduction in admissions of c1560 in 16/17 from the schemes provided via the BCF.

**Opportunity analysis for 2017/18**

Our 17/18 non-elective reduction plans continue to be ambitious – only schemes with specific cohorts of patients have been counted for admission reduction, both to prevent double count and to ensure that the scheme is measurable.

## Admissions to residential and care homes

**Performance in 16/17**

Admissions to care have been closely monitored with new placements scrutinised by Quality Assurance Panel to ensure appropriate decision making. Placement directly from hospital into long term care does not happen routinely and the use of "home first" or intermediate care services are a primary discharge option. Appropriate use of interim placements are made to avoid DTOC but with capacity in the community services prioritised for hospital discharge, this is only used in necessary cases where a bed is needed to meet patient needs, rather than to simply avoid DTOC. These measures have led to 282 permanent admissions to residential homes during 16/17 against a target of 260.

**Opportunity analysis 2017-19**

Admissions to care have reduced each year during the lifespan of the BCF, except for the increase noted in 16/17. Processes have been strengthened for 17-19, with the process supported by the effective crisis response services funded by the BCF and the responsive discharge pathways which ensure people are returned home quickly. In 2017/18 we will be implementing extended reablement

at home services with a 24/7 support plan, to further avoid admissions to short or long term care. We anticipate that this will enable a sustained reduction in care admissions for 2017 -19.

## Effectiveness of reablement

**Performance in 16/17**

Our reablement teams have been embedding best practice through 16/17, with the changes in pathway and process resulting in 91.3% of patients who received reablement still at home 91 days after hospital discharge.

**Opportunity analysis 2017-19**

Reablement is offered to people who will benefit from this service; increased use of patient frailty tools in hospital settings is assisting with identification of people who will benefit or will not benefit from reablement, to ensure it is targeted at the right cohort. This supports the delivery of targets around 91 day independence. Reablement services are being extended to people who were previously being directed into bed based services, by offering a 24/7 home first model utilising commissioned domiciliary care alongside reablement service provision. We anticipate that the numbers of people receiving reablement will not change significantly but the outcomes should continue to be at or above target.

## Delayed transfers of care

**Performance in 16/17**

During 16/17, BCF teams worked closely across commissioner and provider to reduce DTOC rates, including participation in the implementation of the 'Red2Green' process at UHL to minimise delays. Despite significant improvement in delays in acute beds, our focus now needs to shift to delays in mental health, learning disabilities and in our community beds. In 16/17, delays amounted to 11.4 per 100,000 patients against a target of 8.0 delays per 100,000 population.

Of these, our social care delays have been minimal through the year with the majority of delays being noted for NHS-attributable delays. When broken down, our delays are no longer at the acute site but have become much more evident in mental health, learning disabilities and in our community beds – these delays are to principally attributable to delays in the CHC process and patient and family choice.

**Opportunity analysis for 2017-19**

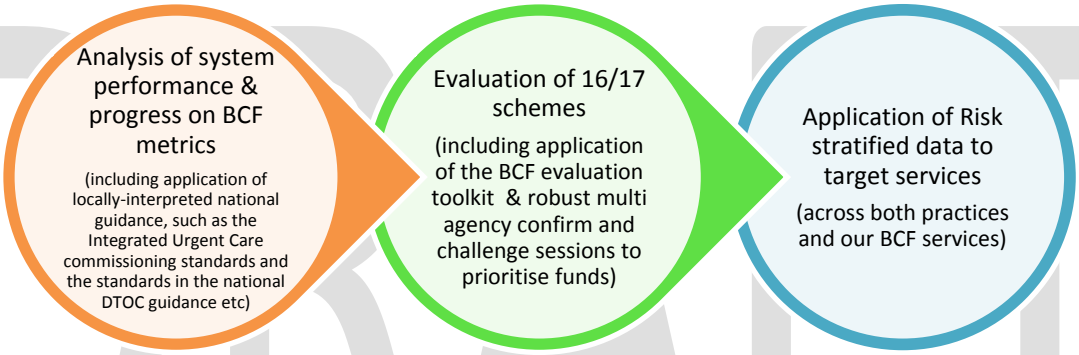
Given the level of delay noted, delivery of the standard expected (3.5% delays of all occupied beds) will be ambitious. The required transformative change will be led by a sub-group of the LLR STP under the aegis of the Home First Programme Board. The work plan has been agreed with the LLR A&E Delivery Board and includes recommendations from both an ECIP (Emergency Care Improvement Programme) review and an LLR gap analysis against the 'High Impact Changes' framework.

# Chapter 3: Our evidence base

### Our local evidence based planning process

The Leicester City BCF has been designed as part of a wider system-wide change across the LLR health and social care economy via our STP. LLR was also an urgent and emergency care Vanguard and the BCF services form a core part of testing out new models of care and new ways of delivering services within a wider footprint.

Our original BCF plan outlined our analysis of national and international literature regarding how various joint interventions have worked elsewhere. Following this, we have analysed three sets of data and collectively used this intelligence to design our place-based system locally;




We have then applied local knowledge and the analysis from our Risk stratification system to target our service delivery model to the right cohorts within our population.

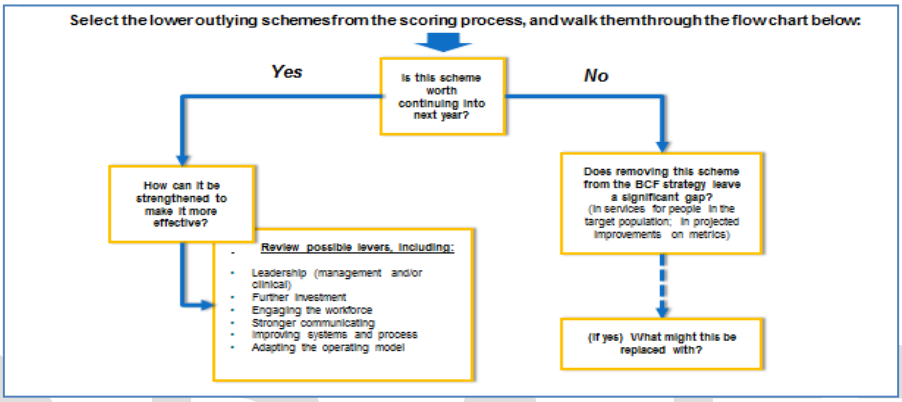
As part of our evaluation process, we have also self-assessed the interventions in the Leicester City BCF against those in the recent Health Foundation report, "*Shifting the balance of care – Great Expectations",* published in March 2017. 27 initiatives were reviewed academic and grey literature) across elective, non-elective and community care and of these 10 were relevant to the BCF. Our self-assessment showed that:

- 4 of our schemes are in the 'most positive evidence' category
- 3 schemes are in the 'emerging positive evidence' category
- 3 schemes are in the 'mixed evidence' category

None of the schemes funded via the Leicester City BCF are in the category of 'evidence of potential to increase costs'.

## Evaluation of 16/17 schemes

We know we have made progress in 16/17 through the implementation of BCF schemes in the City; each intervention resourced has been evaluated using the BCF evaluation toolkit. Services were scored based on the guidance in the toolkit and those which scored low were then taken through part b of the process to determine how best to proceed as described in the diagram below:




This process was chaired by an Independent Lay Member of the CCG Board and all decisions were ratified by the Joint Integrated Commissioning Board.

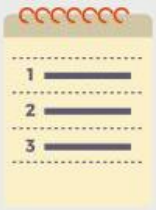
As a result, each scheme has been either up scaled or re-focussed in readiness for 2017/18. Key changes include expansion of our Integrated Crisis Response Teams & Health Transfer Team and enhanced, targeted use of our ACG system (described below) to target our services to those patients who need them the most.

## Usage & efficacy of schemes in 2016/17

As the infographic below shows, the number of people being offered a much more integrated pathway of care has increased and that our patients are experiencing joint health and social care in their own homes where possible:

# Leicester City Better Care Fund

## Service usage




**Care plans**
15,000 care plans completed since inception

500 people per month accessing preventative services via **the Lifestyle hub**

Creation of one co-located health and social care team

100 patients per month treated by our **mental health planned care team**

3000 patients per month seen and treated by **2 hour, in home health and social care crisis teams**

2 City **Night nurses** are in place to prevent overnight admissions

**Joint board rounds between health and social care** take place in our Integrated Care Centre

**46 ICS beds** have enabled flow across LPT and UHL sites

**Over 1000 at risk patients per month** access the healthy homes programme

Patient outcomes have also improved over the lifetime of the Leicester City BCF. Our most recent 'Outcomes Framework' results, released in March 2017, show that we have improved outcomes in a number of areas. These include:


Whilst these are not all directly attributable to the interventions delivered via the Better Care Fund, the systematic health and social care offer to our patients (particularly those vulnerable to hospital admissions) will have contributed to these improvements.

## Chapter 4: Developing the 2017-19 BCF plan for Leicester City

Since the inception of the BCF, Leicester City health and social care commissioners have embraced systems thinking, applying this to both strategic and operational plans. This is reflected in our pre- and post-hospital systems of care which have proven successful in keeping our patients safe at home or getting them back to their own home safely following an episode of ill health.

This chapter of our plan describes firstly how we have used risk stratification and other business intelligence to identify our focus cohorts, the systems of care we have put into place for these

patients and then a brief description of the actions being taken to improve or embed processes during 2017-19 for these cohorts.

## Our risk stratification programme – using Adjusted Clinical Groups to target our resources effectively

In order to identify the opportunity to improve quality and reduce costs, we have jointly been applying an iterative cycle of:

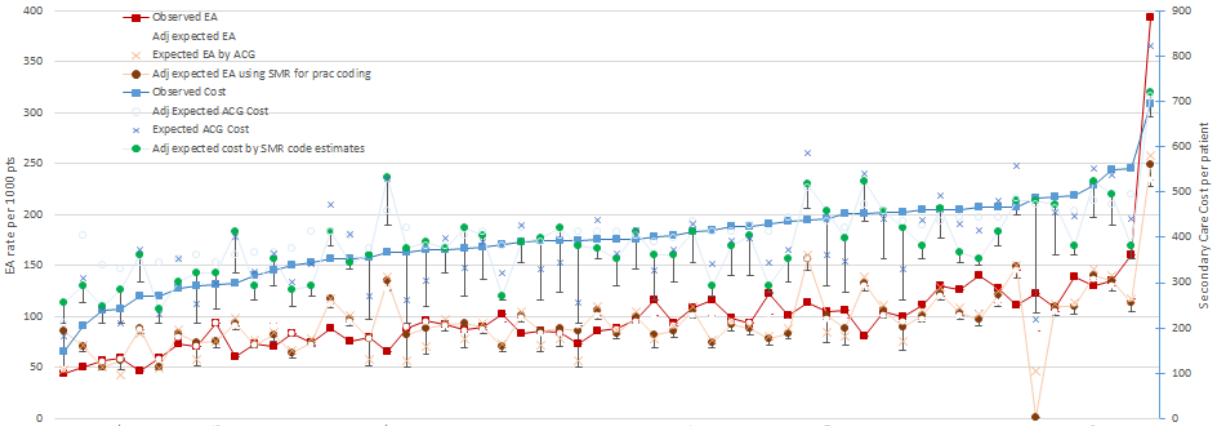
(a) population profiling,
(b) case-finding (identification of opportunities for clinical and health and well-being improvements of identified sub-groups of patients at practice level)
(c) resource allocation to address inequalities
(d) evaluation based on case-mix adjustment to fairly analyse variation in performance and identify realistic opportunities for improvement

The Adjusted Clinical Groups (ACG) system, licensed from Johns Hopkins University School of Public Health, is the central platform for supporting all elements of this cycle. The outputs from this risk stratification system are being used in conjunction with other data sets such as public health data and pathway data supplied by the PI Track and Care system to implement an intelligence-driven strategy which targets historical health inequalities in the city as a means of improving clinical outcomes and patient experience.

### Population profiling - quantifying levels of unmet need, addressing issues of service quality and/or inefficiencies in service delivery

Every GP practice population in the city has been risk stratified using the ACG system. Aggregation of these data to CCG level shows that it is multi-morbidity rather than age which is the main driver of secondary care cost. For example, we know that our multi-morbid patients aged 20-44 with 7 or more LTC's cost as much in acute hospital care as those aged 80+ with similar morbidity.

Our analysis however, also tells us that multi-morbidity is not evenly distributed between our practice populations. Some practices will require more resources as they have a greater burden of ill health to manage. Equally, we know that there is wide variation in the actual amount of acute activity per patient (the observed rate) when compared to the amount expected based on the burden of ill health (the expected) across the City:




*Observed vs expected secondary care cost for Leicester City Practices*

This type of evaluation in combination with other data (such as identifying the characteristics of the practices above who have an lower observed vs expected rate of acute usage by mapping this against their Patient Experience Scores) has allowed us to more accurately identify practices where variation in activity may not be warranted.

## Application of the data

In order to co-produce a manageable and targeted cohort, we have drilled down from CCG population level through the levels of our Health Need Neighbourhoods to practices.
We have subsequently used this analysis to work with our partners to design and implement a range of primary and secondary prevention services, targeting those with complex health and social care needs. It also forms the basis of a primary care improvement programme focusing on continuity of care, improved access for frail patients and clinical coding/record keeping.

Through the provision of high quality, integrated health and social care services, our core aim is to reduce the probability of an emergency admission and subsequent requirement for adult social care services in this cohort. In 2017-19, our plans include embedding this process into our Integrated Locality Teams.

Combining these sources of intelligence, leads us to a target the following segments of the population:

1. Over 18's with 5 or more chronic conditions
2. All adults with a 'frailty' marker, regardless of age but related to impaired function
3. Adults whose secondary care costs are predicted to cost three or more times the average cost over the next twelve months

This gives us a target BCF cohort of approximately 92,104 patients; this relatively more complex cohort of patients have an average probability of emergency admission to hospital of 46% in the next 12 months. These patients over a 12 month period have had 39,745 ED attends (£5.3m), 33,699 elective admissions (£34m) and 29,630 non-elective admissions (£49m).

However, in recognition that this cohort is still fairly large, we have undertaken further analysis to identify where and how to target our resources. We have limited the second sub-cohort above to c3% of the total population, based on a combination of clinical judgement and risk stratified 'score'.

For this sub-cohort in 2017/18, we will be implementing a primary care incentive scheme which will support practices to lead on delivery of integrated care across all sectors for those with specific complex combinations of LTCs. The scheme supports primary care to provide extended consultation appointments (to increase productivity and quality and improve patient experience) for these patients and to proactively book appointments with the clinicians or other professionals best placed to deliver key aspects of the patient's integrated management plan, recognising that continuity of care from the same clinician has a significant impact on the patient's outcome.

## Our Integrated system of care

We recognised at the inception of the BCF that delivering safe and effective health and social care cannot be done from within organisational or commissioning silos. It requires cooperation between and within numerous organisations and services, and collaboration between clinicians and supporting staff who place patient care at the centre of all they do. This understanding has led to the construction of an integrated system of care for the population of Leicester City which spans multiple programmes of work (including primary care & urgent care) which is led primarily via the Leicester City Integrated Systems of Care Programme Group (ISOC). This group oversees the delivery of the entirety of the City BCF. The diagram below shows the key areas of focus, the services included and the Programme under which is sits:



**Prevention, early detection & improvement of quality of life**
(City ISOC)

- The Leicester City Lifestyle Hub
- The Leicester City prevention checklist
- Planning for Integrated Care in General Practice
- Integrated Locality Teams

**Reducing time spent avoidably in hospital**
(LLR A&E Delivery Board/LLR Home First/City ISOC)

- 24/7 2 hour health and social care crisis response, inc. falls service
- Access to Urgent care servicesPrimary care hubs
- Clinical Navigation Hub
- Integrated Crisis Response Service
- Health Transfers Team
- Integrated Discharge Team

**Services to maintain independance**
(LLR Home First)

- Reablement services
- Housing Services

The key interventions/services within this system funded through the BCF are detailed below.

## Key Interventions to be delivered

### Focus 1: Prevention, early detection & improvement of health related quality of life

In order to have a significant impact on the prevention of disease and reduction in health service and ultimately social care demand, action on prevention must be increased. The Joint Strategic Needs

Assessment 2017 for Leicester identifies that overall the city has big challenges, with low life expectancy and healthy life expectancy and high levels of disease related to lifestyle factors e.g. cardiovascular disease and respiratory disease. Rates of both adult and childhood obesity continue to increase both nationally and locally and although reducing, rates of smoking continue to be high locally, leading to high levels of estimated prevalence in long term conditions. Equally, utilisation of the ACG System within the population of Leicester City CCG has demonstrated that there is a clear relationship between multi-morbidity, usage of the wider system and subsequent cost. People associated with the highest costs were those with 7 or more chronic conditions, with costs consistently high in pharmacy and secondary care usage and predicted costs in social care.

### The Leicester City Lifestyle Hub

The World Health Organisation has estimated that 80% of cases of cardiovascular disease and 40% of cases of cancer could be avoided if common lifestyle factors were eliminated. The conditions most strongly related to health inequalities, such as cancer, cardiovascular disease and respiratory diseases are associated with lifestyle behaviours and factors such as smoking, obesity, physical activity, alcohol intake and substance misuse.

In order to ensure those patients requiring these services can access them with ease, an integrated lifestyle service for Leicester City has been developed for smokers, those who are obese, inactive or have poor diet. This includes a single point of access for GPs and other professionals, a person-centred approach considering the individuals wider social issues such as debt, housing etc., a generically trained lifestyle team to provide both 1-1 intensive support and group-based sessions, specialist support from e.g. smoking cessation advisors, dieticians and exercise professionals where necessary and additional support from a team of volunteers.



### Planning for Integrated Care in General Practice - Integrated Locality Teams

We started this programme of work in 2016/17 and will build upon these foundations through 2017-19 through the implementation of newly formed Integrated Locality Teams. Our GP's, community services and social care teams will work together within the primary care setting for a cohort of multi-morbid patients. As described earlier in this plan, the Leicester City cohort for this service is 92,104 patients across the city, with c3% of these patients selected for more intensive work. These patients will be provided with a combination of interventions, including targeted longer GP appointments, case management and further education on condition management.

Since November 2016 the following activities have been undertaken within the Integrated Locality Teams workstream:

- Setting up a multi-agency Programme Board as one of the key workstreams of the STP - with joint SROs across health and care, and joint clinical leads across primary and secondary care and developing a PID.
- Identification of 11 locality leadership teams across LLR comprised of designated senior professionals from primary care, CCGs, social care and community nursing teams and undertaking a readiness self-assessment with them.
- Assessing and adapting the learning from MSCP Vanguard sites, including in particular Hampshire and Sunderland, to inform the local model.

- Via risk stratification, defining the cohorts in scope for integrated locality teams to focus on and providing data analysis packets by locality and a self-serve guide to promote the ongoing use of this analysis.
- Defining the model of case management, care coordination, and how multidisciplinary working should develop.
- Defining the key evidence based interventions that should be applied to the patient cohorts to improve case management, care coordination and reduce acute/urgent care spend and developing a framework for evaluating the impact of integrated locality teams.
- Developing a governance and accountability framework for integrated locality teams, and in support of the early discussion on accountable care systems.
- Delivering a leadership development programme for integrated locality teams
- Using a range of the above outputs to create a "manual" for integrated locality teams for LLR to help structure their operational work, and capture learning and impact in the early stages of implementation.
- Setting up test beds across LLR with initial evaluation from September 2017.
- The programme has also adopted existing transformation work related to end of life, falls and cardio-respiratory services into its remit given the alignment with the work of integrated locality teams and their patient cohorts.

The Leicester City BCF supports delivery in this area by providing investment associated with various components of the model:

| Service | Investment | Status |
|---|---|---|
| **The Lifestyle hub** | £100,000 | LIVE |
| **Risk stratification** | £69,146 | LIVE |
| **Planning for Integrated Care** | £1,242,119 | LIVE |
| **Carers Funding** | £650,000 | LIVE |

### Focus 2: Reducing the time spent avoidably in hospital (In home crisis services, discharge services and services to maintain independence)

These services service cover both pre- and post-hospital services across the City and largely pertain to workstreams under the LLR Home First Programme Board & the LLR A&E Delivery Board. As these are embedded services, the focus for 2017-19 will be to transform pathways into LLR pathways where possible, making it easier for patients at risk of hospitalisation or following hospitalisation to access services from an acute or community bed, regardless of whether they are a City patient or a patient with one of our partner Leicestershire and Rutland CCG's.

Currently City patients at risk of hospital admission have access to a 24/7 2 hour health and social care response service, including mobile paramedics, mobile social care staff and mobile nursing support. Similar services also cover patients requiring discharge from hospital. This service is now embedded within the Leicester City system and the discharge elements of this will morph into the new LLR Integrated Discharge Team.

This offer includes the Lightbulb service, which provides specific staffing resources for supporting hospital discharges relating to housing issues. Staff are based at Leicester Royal Infirmary and the Bradgate Unit, working closely with the integrated discharge team to support patients with a range of housing solutions such as homelessness, rent/tenancy issues, furniture packs, cleaning and

clearing patients homes that have become cluttered or unsuitable (e.g. due to hoarding), moving furniture to accommodate a change in the person's mobility/reduce risks of falls, expediting adaptations, and tackling heating problems.

### Reducing the time spent in hospital – discharge services/services to maintain independence (LLR Home First Programme)

The Home First Workstream will consider both pre- and post-hospital services within its remit and will work closely with the LLR A&E Delivery Board and the LLR Discharge Working Group in delivering its objectives. The key immediate action will be to improve hospital discharge with many of these actions already being implemented in light of an ambitious DTOC target:

1. A new integrated dashboard for monitoring delayed transfers of care which provides weekly performance management data by setting of care. This is supported by all the existing daily operational management activities across NHS and LA partners to address individual cases and maintain system flow.
2. Implementation of a new integrated discharge team at the acute trust, with similar developments planned for non-acute sites later in 2017/18.
3. Implementing the Trusted Assessor model.
4. Options for further interim/discharge to assess beds - being led by the Home First workstream during 2017/18.
5. New CHC processes, implemented with effect from July 2017 via Midlands and Lancashire Commissioning Support Unit.
6. Improvements to processes in support of hospital discharge within hospital sites using the red to green system (once the patient is medically fit for discharge, rapid and coordinated activities across the hospital to ensure discharge happens at pace, e.g. senior clinical decisions early in the day, prompt access to medications for discharge, effective transport etc.)
7. Improvements to patient/family choice policies and supporting materials.



The target for improvements to hospital discharge in 2017/18 have been agreed at the LLR A&E Delivery Board, with the LLR system working towards the 3.5% target, as per the BCF planning framework .

### Mental health discharges

In early 2017 a strategic senior level group was established to identify and agree actions required to ensure sustained reduction in AMH DTOC levels. This group is chaired by the LPT Medical Director with representatives from CCG's, Local Authority Social Care, Housing and NHS England. Originally, a target was set of achieving 5% DTOC level of bed occupancy by January 2018 from current levels of circ. 12-15%. In light of the national requirements for a 3.5% DTOC level, this trajectory is under revision.

**Key actions being taken:**

**Strengthened weekly clinical discharge meeting** - The purpose of this meeting is to track every patient's progress through the care pathway and challenge and resolve the barriers that may affect the planned discharge date. This is chaired by the Clinical Director from Leicestershire Partnership

Trust and involves the ward based medical and nursing staff as well as representatives from housing and social care.

**Strengthening data reporting** - Internal LPT data quality process has been strengthened to ensure the patient coding details are reviewed and checked prior to submissions.

Key actions currently in train are summarised below:

| Area | Action | Completion by |
|---|---|---|
| **Patients with no recourse to public funds ( NRPF)** | Develop a guidance sheet for inpatient unit staff understand future options available to support early discharge. | September 2017 |
| DToC **Exercising Choice** | To develop a local shared agreement in relation to Mental Health, based on UHL Exercising Choice policy. | September 2017 |
| **Information sharing agreement** | Ensure ISA for sharing PII regarding DTOC from localised meetings across stakeholders. | September 2017 |
| **Discharge support** | Review function of Housing Enablement and Assertive In reach teams to maximise staffing resource to deal with patient's housing issues. | October 2017 |
| **Development of Housing step down/ move on facility** | Pilot a 5 unit supported accommodation 'move-on' scheme with local housing provider for patients fit for discharge but awaiting long term accommodation to be finalised. | October 2017 |
| **Access to longer term housing for people with mental health support needs.** | To explore alternative housing solutions through the Hospital Housing Steering Group (hosted by Blaby District Council). | Ongoing |
| **Development of local a Psychiatric Intensive care Unit ( PICU Beds)** | Explore local opportunity to provide 6 PICU beds to reduce the need to consider out of area placements. | December 2017 |
| **Review of rehabilitation pathway** | To ensure pathways in line with national best practice and scope need for development of community and supporting housing rehabilitation schemes to support flow | October17-March 2018 |

This workstream will be aligned to governance structures of both the BCF and the A&E Delivery Board to ensure that focus remains on delivery of agreed actions.

**Reducing the time spent in hospital – Access to urgent care services (LLR A&E Delivery Board)**

During 2016/17 LLR partners have been working towards a new model of integrated urgent care in line with the NHS England Five Year Forward View, through our participation across LLR in the national Urgent Care Vanguard programme. This work has culminated in a procurement for a new model of service for April 2017 onwards which has the following key design principles:

- Responsive, accessible person-centred services as close to home as possible.
- Services will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services that are innovative and promote care in the right setting at the right time.
- Urgent care services in LLR will be consistently available 24 hours per day, seven days a week in community and hospital settings.
- Clinical triage and navigation is a central part of the new integrated urgent care offer, reducing demand on ambulances and acute emergency services.

The main changes to urgent care which will be delivered by the new service model are:

- The creation of a clinical navigation service, providing telephone advice, assessment and onward referral for people calling NHS 111 and 999.
- The clinicians working in the service will have access to patients' primary care records and care plans, where relevant, and will be able to directly book patients into primary and community urgent care services.
- The service will include warm transfer callers to specialist advice for mental health, medication and dental issues.
- Future plans for the navigation hub include bringing it together with a professional advice line and integration with a single point of access for social care.
- Extended access to primary care across LLR – so that patients can access primary care services 8am to a minimum of 8pm every day of the week.
- Urgent Care Centres will offer a range of diagnostic tests and medical expertise for people with more complex or urgent needs, and we will strengthen community based ambulatory care pathways which can avoid admission without the need to referral to acute hospital.
- An integrated streaming and urgent care service at the front door of Leicester Royal Infirmary Emergency Department, staffed by senior GPs working within the rebuilt Emergency Department.
- A 24/7 urgent care home visiting service across LLR, including out of hours home visiting and an acute visiting service for people with complex needs or living in care homes.

The Leicester City BCF supports delivery of the new Home First model by providing investment associated with various components of the new model:

| Service | Investment | Status |
|---|---|---|
| **Reablement funds - LA** | £825,000 | LIVE |
| **Strengthening ICRS - LA** | £985,000 | LIVE |
| **Assistive technology** | £259,139 | LIVE |
| **Intensive Community Support Beds - LPT** | £889,126 | LIVE |
| **Unscheduled Care Team - LPT** | £477,615 | LIVE |
| **MH Planned Care Team - LPT** | £236,178 | LIVE |
| **Reablement - LPT** | £1,137,375 | LIVE |
| **Housing team** | £41,164 | LIVE |
| **Health Transfers Team** | £326,621 | LIVE |
| **MH discharge team** | £43,222 | LIVE |

The Leicester City BCF supports delivery of the new model of urgent care by providing investment associated with various components of the new model:

| Service | Investment | Status |
|---|---|---|
| **Clinical Response Team** | £1,365,000 | LIVE |
| **Enhanced night nursing - LPT** | £92,619 | LIVE |
| ***Other non-BCF investments*** | | |

## Chapter 5: National conditions

### National Condition 1: Plans to be jointly agreed

The BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review and the use of the iBCF, has been jointly agreed by the JICB, Leicester City Council and the CCG in July 2017 and the Health and Wellbeing Board in August 2017.

In agreeing the plan, Leicester City CCG and the local authority have engaged with health and social care providers likely to be affected by the use of the Fund in order to achieve the best outcomes for local people. This has been done through a transparent and open evaluation process, which all stakeholders have been party to and then approved by both the Integrated Systems of Care Programme Group and the Joint Integrated Commissioning Board. Presentations have been made to the UHL executive team and formal approval of 17/18 plans is expected at the Health and Wellbeing Board in August 2017.

There is joint agreement across commissioners and providers as to how the BCF will contribute to a longer term strategic plan – this has been demonstrated in earlier chapters of this plan. The implications for local providers have been set out clearly for HWBs so that their agreement for the deployment of the Fund includes recognition of the service change consequences. This is especially true for the acute trust who will see a reduction in both activity and length of stay if current projections are realised.

The DFG allocation (£2,035,322) has been agreed with the Housing Department when setting the budget for 2017/18. There is an agreed plan to deliver adaptations, with a policy in place and well established joint working arrangements across housing, social care and health.

### Health inequalities

Developments within the BCF Plan are subject to an equality, quality and privacy impact assessment and the evidence base supporting the BCF Plan has been tested with respect to Leicester City Joint Strategic Needs Assessment. An equality, quality and privacy impact assessment has also been undertaken.

### National Condition 2: Social Care maintenance

Adult Social Care Services continue to be protected; through the allocation of resources to ensure both eligible needs and preventative needs can be supported. The level of protection has been maintained in line with inflation for 17/18 and 18/19, with additional funding allocated to social care in 2017/18 to recognise the increasing pressures through rising demand. This level been jointly agreed with all partners through a transparent process of funding allocation, overseen for the Health and Wellbeing Board by the Joint Integrated Commissioning Board. This takes account of the whole system and has been actioned to ensure there is no adverse impact on the wide Health and Social Care system. Each of the social care interventions have evidenced that they support the aims of the BCF plan, the STP and will also benefit health.

The comparison to 2016/17 is set out in the BCF planning template and the approach is consistent with the guidance outlined in the BCF Planning Framework (July 2017), with the transfer to social care in 18/19 exceeding the transfer in 17/18.

### National Condition 3: NHS commissioned out of hospital services



The plans set out in the planning template demonstrate the breadth of the investments in NHS out of hospital services through the Leicester City BCF.

The proportion of the plan invested in these services is set out below and meets the national condition as outlined in the BCF Planning Framework:

| | 2017/18 £000 | 2018/19 £000 |
|---|---|---|
| **NHS Commissioned Out of Hospital ring fence** | £6,323,613 | £6,443,761 |
| **BCF Plan – Total NHS commissioned out of hospital spend** | £7,485,448 | |
| **Variance** | | |

As part of our core delivery offer our Better Care Fund plans include seven-day working across the system (where applicable & feasible) as a standard expectation to support the flow across the health and social care system. For example, most schemes mobilised since the start of the Better Care Fund have been on a seven-day service expectation. This includes the Clinical Response Team, the Unscheduled Care team and the Planned Care Team and these will continue in 17/18.

### Non-elective admissions

An additional target has not been set for 17/18 and 18/19 for non-elective admissions. However, a proportion of funds are being held in a contingency pool as per the guidance; this is to ensure that if preventative measures are unsuccessful, the financial position of the CCG is not compromised. Funds will be released as per the guidance issued. This is set out in Chapter 6 of this plan.

### National Condition 4: Managing Transfers of care

The LLR health and social care system is working together to assess our position against the 'High Impact Change Model for Managing Transfers of Care' – this mapping is available as Appendix X with the position agreed by the LLR A&E Delivery Board. The local BCF services funded from the Leicester City BCF will support any process and/or service changes required to implement improvements in the 8 areas identified in the model. These are set out in greater detail later in this plan and have been drawn from a variety of national literature, including the relevant 'Quick guides' and the Social Care Institute for Excellence.

The local system has proposed a trajectory via the A&E Delivery Board to achieve the target of 3.5% of occupied bed days by March 2018. This has been agreed with NHS Improvement and presents a realistic assessment of delivery – this is principally because the City system has been focusing on reducing DTOC's in our acute provider for the last year, with processes greatly improved. Our focus will now shift to our community and mental health trust where delays are less due to process issues but long-standing issues of step-down housing availability and patient choice and these delays are not amenable to short term solutions. Key actions being taken (including those from the High Impact Change Model) are described in Chapter 4.

## Delivery of former national conditions

**Delivery of 7 days services (national condition 3 from BCF policy 16/17)**

Our commitment to delivery of 7 day services has not wavered despite this national condition being removed for 2017-19. The BCF since inception has mandated services on a 7 day basis, with each service commissioned as part of a crisis response done so on a 7 day basis.

| BCF Intervention | Impact on 7 day service provision |
|---|---|
| Services for complex patients | Enhanced access to primary care, inc access to Hubs on a 7 day basis |
| Clinical Response Team/Home Visiting Service | 7 day service to prevent hospital admissions |
| Unscheduled Care Team | 7 day service to prevent hospital admissions |
| Intensive Community Support service | 7 day service to prevent hospital admissions and increase weekend discharge |
| Planned Care Team | 7 day service to prevent hospital admissions and increase weekend discharge |
| Mental Health Discharge Team | 7 day service to prevent hospital admissions and increase weekend discharge |

**Better data sharing between health and social care (national condition 4 from BCF policy 16/17)**

Leicester, Leicestershire and Rutland are seen as national exemplars in data sharing due to the early adoption of the NHS number onto social care records (currently at 98%), the adoption of the ACG tool in primary care for risk stratification and the adoption of the PI Care and Healthtrak tool since 2015/16, and the application of these tools during 2016/17 to support a range of transformation priorities including the emerging workstreams of the STP.

The development of the summary care record solution for LLR is a further critical enabler to the STP and Integration Programme across LLR. Phase 2 of this development is currently in progress and the milestones for this are summarised below:

| Phase | Activity | Timescales |
|---|---|---|
| Phase 1 | The Integrated Care Planning (ICP) template was successfully rolled out across primary care during March and April 2017. This feeds the patient's Summary Care Record with care planning information, when explicit patient consent is recorded. The template also enables the recording of that consent. Once consent is recorded, the SCR is updated in real-time every time the GP record is amended. | March- April 2017 |
| | The ICP template will be updated on a quarterly basis with version 2 of the template rolled-out in August 2017. | Quarterly |
| | Initial focus will be on patients who are case managed in primary care, via new integrated locality teams including those with the frailty. | By October 2017 |
| | The aim is that all LLR patients will have an enhanced SCR, other than the small number who dissent. | By April 2018 |
| Phase 2 | The focus in on secondary and community care providers using the information either accessed through SCR directly, or via SCR links in other clinical IT systems (such as SystmOne). | Live |
| | Monitor the uptake of patients consenting to enhanced SCRs, and the number of SCR views by provider. The most significant aspect of this communications drive is consent. | Ongoing |
| | Other Phase 2 workstreams are looking at streamlining the Special Patient Note (SPN) process, and maximising the benefits of SystmOne sharing in LLR. | Ongoing |
| Phase 3 | The focus of this phase is sharing health records with Adult Social Care staff, through the SCR. NHS Digital are in the process of discussing national issues related to this. In July, plan is to meet with some of NHS Digital SCR Clinical and Product Leads to progress the matter, and try to influence their national steer on social care sharing. | Timescale TBC |

The adoption of the SCR2 within integrated locality teams will be a particular focus of the Leicester City BCF in 2017/18.

**Joint approach to care planning and assessments (national condition 5 from BCF policy 16/17)**

The BCF plans described demonstrate our commitment to joint assessments and joint care planning, and this commitment is embedded within the development of Integrated Locality Teams across the City. This is described earlier in this plan.

# Chapter 6: Overview of funding contributions

### 17/18 Investments

Funding has increased in line with planning guidance released and contributions are outlined below:

| | 2017/18 | 2018/19 |
|---|---|---|
| **BCF Pooled Total balance** | £33,242,254 | £37,235,635 |
| **Local Authority Contribution balance exc iBCF** | £2,035,322 | £2,216,673 |
| **CCG Minimum Contribution balance** | £22,252,794 | £22,675,597 |
| **Additional CCG Contribution balance** | £0 | £0 |
| **iBCF** | £8,954,138 | £12,343,365 |

Aligned to the services above, the expenditure plan for the 17/18 BCF is as follows:

| Scheme Name | Total 16/17 Expenditure (£) | 2017/18 Expenditure (£) | 2018/19 Expenditure (£) | New or Existing Scheme | Agreed at BCF joint confirm and challenge? | Impact on service |
|---|---|---|---|---|---|---|
| **Risk Stratification/IT** | £64,000 | £69,146 | | Existing | Yes | None |
| **Lifestyle Hub** | £100,000 | £100,000 | | Existing | Yes | None |
| **Clinical Response Team** | £1,380,015 | £1,365,000 | | Existing | Yes | None |
| **Assistive Technology** | £213,321 | £259,139 | | Existing | Yes | None |
| **LPT Unscheduled care team** | £469,216 | £477,615 | | Existing | Yes | None |
| **ICRS** | £835,000 | £985,000 | | Existing | Yes | Expansion |
| **Night Nursing team** | £90,990 | £92,619 | | Existing | Yes | None |
| **Services for complex patients** | £1,220,277 | £1,242,119 | | Existing | Yes | None |
| **Mental Health Planned Care Team** | £232,025 | £236,178 | | Existing | Yes | None |
| **Housing team** | £40,440 | £41,164 | | Existing | Yes | --- |
| **Health Transfers Team** | --- | £326,621 | | New | Yes | Expansion |
| **MH Discharge team** | £42,462 | £43,222 | | Existing | Yes | None |
| **ICS (+)** | £883,614 | £889,126 | | Existing | Yes | None |
| **Reablement - LPT** | £1,137,375 | £1,137,375 | | Existing | Yes | None |
| **Existing ASC Transfer** | £5,901,968 | £5,901968 | | Existing | Yes | None |
| **Carers Funding** | £650,000 | £650,000 | | Existing | Yes | None |
| **Reablement funds - LA** | £825,000 | £825,000 | | Existing | Yes | None |
| **2017-18 ASC Increased Transfer** | £5,650,000 | £5,650,000 | | Existing | Yes | None |
| **Performance Fund** | £1,926,540 | £1,961,024 | | Existing | Yes | None |
| **Uncommitted** | £194,757 | --- | | New | Yes | --- |
| **DFG** | £2,035,322 | | | Existing | Yes | --- |

As the above table shows, financial allocations have been made to cover requirements for implementation of the new Care Act duties, carer-specific support, reablement and the Disabled Facilities Grant. The use of the iBCF is described below.

### Risk pool

The creation of a £1.9m risk pool from within the BCF during 2017/18 is in recognition of the need to achieve further savings and headroom so that the plan can become more sustainable in the medium term. This is due to the significant financial pressures affecting partners in 2017/18, and the fact that, unlike the previous two financial years, the BCF plan does not have the benefit of any other contingencies or reserves to draw on from 2017/18 onwards.

This pool is not linked to emergency admissions performance as the BCF plan for 2017/18 – 2018/19 does not include any activity or investments above or beyond CCG operating plans assumptions. However, given the risk of unplanned activity in the area of non-elective care, the pool has been agreed as a contingency measure and has been ring fenced from the CCG allocation, without compromising the minimum transfer to the LA. This arrangement is consistent with guidance with release of the funds to be approved at the Joint Integrated Commissioning Board at the end of each quarter where relevant.

### iBCF

The spring budget this year contained an announcement of a new adult social care grant of £2bn over the next three years of which £1bn is available in 2017/18.

For Leicester City Council the sum allocated from this non-recurrent grant is:

| | 2017/18 | 2018/19 |
|---|---|---|
| iBCF | £8,954,138 | £12,343,365 |

The Government has made it clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in the local care systems. It is also expected to ensure that the High Impact Changes for reducing delayed transfers of care will be implemented within local health and care systems.

The City Council continues to prioritise the meeting of social care need in the utilisation of these funds. The Council has a strong commitment to supporting the most vulnerable in our community and in ensuring that sufficient funds are made available to effectively meet these needs. This commitment was the key driver behind the decision for 2016/17 in utilising Council reserves to meet the growing pressures on the ASC budget.

Likewise the City Council retains its commitment to working as an effective partner in our local health and social care economy. It can demonstrate with its ongoing commitment to funding throughout challenging financial times that it is effective in working with NHS partners. The council have in the recent years:

a) Seen significant reduction in the DTOC numbers to an all-time and potentially sustainable low;

b) Moved away from a reliance on formal discharge notices to a far more proactive case finding model in hospital setting which ensure that on average between 65% to 70% of all discharges from hospital where there is adult social care involvement take place prior to a formal notice of discharge having to be issued;
c) Sustained a 'Level 1' status on regular daily escalation meeting / teleconferences reporting for the last three years – through being in a strong positon to meet social care need where necessary from hospital discharge;
d) Continued staffing engagement in developing the new models of care that underpin key developments in the original BCT and now STP agenda, and are fully committed to the development of integrated teams, discharge planning improvement and prevention;
e) Retained a small but essential staffing function around transformation and developing new systems – which supports our continued improvement and development of models of care and delivery.

The City Council's current budget profile supports continued investment over the period up to 2019/10 in areas that although not statutory, enable us to support meeting social care need and in supporting the whole health and social care system.



Investment in professional staffing levels - £1.2m

Through a use of resources analysis undertaken in early 2016 it was identified that the Department was staffed at a higher level than both regional comparators and the national average in relation to professional social work, OT and assessment and case management staff – in the region of some 30%.

The council's agreed savings plan removes some 20% of the staffing from these areas over 2017/18 to 2019/20, but the council is electing to retain a slightly higher staffing ratio than regional comparators / England average as this continues to support them in dealing with key pressure points, such as hospital discharge effectively. This additional staffing investment equates to in the region of £1.2m (around 35 social work posts) and the council will continue to deploy these staffing resources in key areas mainly:

a) the Hospital Transfers Service (enabling discharge and into reablement services or 'home first')
b) the 'front door' Contract and Response Team
c) emerging integrated community teams, where activity would be aimed at deflecting admission to hospital and prevention of long term need

Reinvestment of intermediate care resources - £150K

With the decisions to close the Kingfisher Unit (37 bedded short term beds) and transfer social care intermediate care beds to a commissioned model (12 beds), the council reduced the overall savings delivered (from a planned £600K) by £150k, and re-invested this sum back into the Reablement Service (RS). This reinvestment was to ensure that the council could extend the service hours of the RS into late evening and overnights, to support effective discharge from hospital and the 'home first' principle;

Establishment the Enablement Service - £3.2m

In seeking to reduce the demand for statutory services the council has invested heavily in 2016/17 onwards in preventative and enabling services. The new Enablement Service, established in mid-2016, is aimed at supporting people with physical disabilities, learning disabilities and mental health needs to gradually move away from statutory support. The Service supports people into a range of self-care, peer support, low level equipment and adaptations and universal services. This aims to reduce the reliance on long term person to person care and support.

This service is wholly discretionary and does not need to be provided as a statutory eligible service. The council has opted to invest in this service, even in these financially challenging times, as it is assured that it can support a longer term reduction in demand for adult social care.

The council will formally evaluate the success for the Service in 2018/19, and will implement a planned reduction of £700K in 2019/20, but at the moment the current plan is to retain a recurring investment of £2.5m.

Investment in Prevention and Crisis Intervention - £1m

The council continues to maintain a number of services that are aimed at preventing need and supporting people out of non-social care crisis so as to ensure that they do not default into ASC as their housing, family and self-caring skills deteriorate.

These services are mainly delivered through existing contracts and grants with independent sector and voluntary sector organisations. On current data it is estimated that this range of services is supporting around 500 – 1,000 people a year to maintain their own lives and self-caring skills and there is strong evidence to demonstrate that these services are diverting people away from a trajectory which leads to dependence on statutory social care.

The total of these predominantly non-statutory services continuing financial commitments is £5.5m. The new Adult Social Care Grant facilitates the continued investment in these service areas, as well as enabling the reduction in the use of one-off reserves. In turn as stated earlier this potentially provides for a 'safety net' in 2019/20, where some reserves that would have been used in 2017/18 and into 2018/19 may be available for use in later years, subject to other financial pressures across the Council's overall service and budget profile.

However, should further funding requirements arise through 17-19, these will be considered through the JICB as per normal joint commissioning processes. This has been agreed through our BCF governance structures and at the LLR A&E Delivery Board.

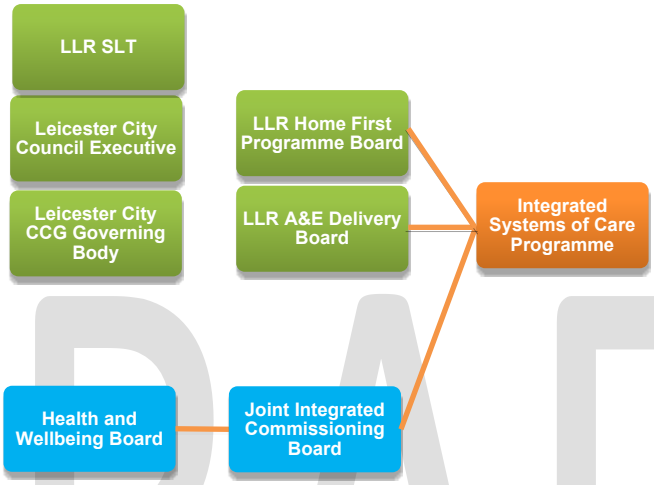
## Chapter 7: Programme Governance

In April 2013, both the Leicester City Health and Wellbeing Board and the Joint Integrated commissioning Board were formally established. The JICB holds responsibility for delivery of the HWB strategy as well as overseeing joint commissioning between Leicester Clinical Commissioning Group and Leicester City Council. This joint accountability has been integral to successful strategic oversight & management of delivery of the BCF. With the advent of the LLR STP, much of the work has been enveloped into STP-owned workstreams. The BCF has effectively become an enabler to the successful delivery of STP workstreams, reporting into various different programme boards

across LLR. However, oversight and delivery of the Leicester City BCF remains within the BCF structure below.

## Governance

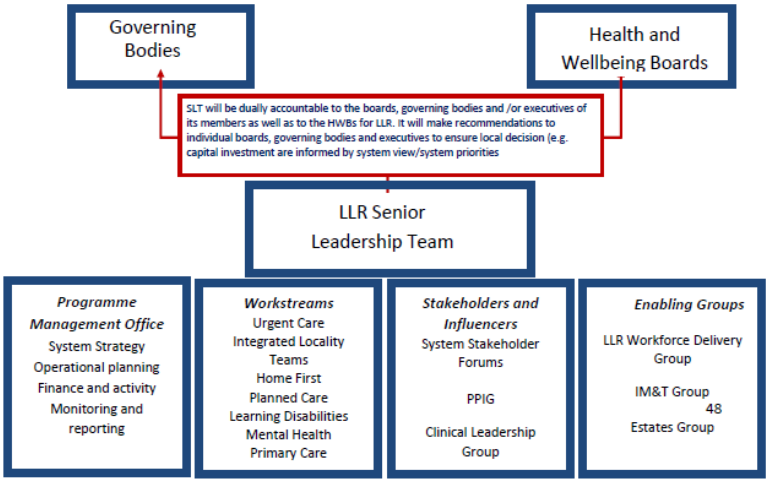
The governance of the Better Care Fund Programme builds on a mix of strong existing partnership groups, with the key delivery group being the Leicester City Integrated Systems of Care Group (ISOC).




*Leicester City Better Care Fund programme structure*



Given the emerging STP programme structure, the majority of the BCF is delivered through matrix working with partners, and project/delivery leads come from a wide range of partner organisations, including on an LLR wide basis. The structure above sits within the STP structure shown:




## Governance arrangements: strategic oversight

Strategic oversight is provided by the Leicester City Joint Integrated Commissioning Board (JICB) which is the delivery function of the HWB. The JICB consists of executive leaders from the health

and social care economy, including the Managing Director of Leicester City CCG, the Chief Operating Officer of the Local Authority, the Director of Adult Social Care, Directors of Finance for the CCG and the local authority as well as clinicians from the CCG and public health.

Monthly progress reports are provided, including progress against milestones, expected vs actual activity data and any risks associated with the programme. The same report is sent to the STP governance process to ensure key stakeholders are sighted on progress. Quarterly updates are also provided to the UHL executive team.

### Governance arrangements: delivery

The delivery of each work stream of the BCF is overseen by the Integrated Systems of Care Programme Group (ISOC), which meets monthly. This is chaired by an independent lay member of the CCG and consists of the following stakeholders:

- the four Chairs of the general practice 'Health Needs Neighbourhoods' in the CCG;
- Director of Adult Social Care, Local Authority;
- Deputy Director of Strategy & Implementation, CCG;
- Lead Nurse, CCG;
- Heads of Service at the Local Authority;
- Head of Strategic Change, UHL;
- Heads of Service at LPT;
- Heads of Service at SSAFA;
- Heads of Service at EMAS;
- Workstream Project Managers across organisations.

Relevant functions across the organisations attend for specific items as required. Each project completes a highlight report, outlining expected and actual progress, benefits realised vs benefits expected, key risks and quality issues and actions for the coming month. Any remedial actions are agreed and monitored here, with unresolved issues being escalated to the JICB Chair within 1 working day.

However, as the workstreams re-align to the emerging STP workstreams, this structure will change. Currently, all work from relevant LLR STP workstreams is funnelled through ISOC to ensure that interdependencies with the established City system of care are noted, with no unintended consequences.

### Performance management of the programme

As the BCF is one of the key enablers to multiple streams of work across the CCG, Local Authority and provider organisations, a comprehensive suite of monitoring has been formulated. These outcome measures have been agreed at the BCF Implementation Group, with input from all partner commissioner and provider organisations across the Health and social care economy and align to HWB strategy, the JSNA and the CCG Operational Plan and five year STP plans.

*Strategic level – Quarterly reporting to the JICB and CCG Integrated Governance Committee*

At a strategic level, an overarching system dashboard has being formulated, covering the national metrics as well as other relevant metrics to manage flow at a system level. These have been drawn

from the ASC, NHS and public health outcomes frameworks as well as local flow measures and enables all health and social care organisations to understand the quality of services and the patient flow through the system in terms of inflow, throughout and outflow metrics.

Monitoring at this level has enabled the JICB and the CCG Integrated Governance Committee to understand issues affecting performance and intervene early to mitigate more strategic issues. For example, monitoring at this level has enabled early identification of issues affecting delayed transfers of care within mental health units and has accelerated multi-organisational change to improve patient experience and performance.

*Operational Level – Monthly reporting to ISOC*

Underneath this, sits a comprehensive Integrated Care QIPP Dashboard, specially produced to support the performance management function for the BCF Programme. This shows a suite of local metrics and expected benefits by project, providing a coordinated view which aids understanding of any barriers to achievement of the overarching national metrics, as well as providing further commissioning intelligence across the Leicester City health and social care system.

*Practice level – Weekly reporting*

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model. Examples of these are provided in Appendices X and X.

## Assessment of Risk and Risk management

The ISOC also oversees the joint BCF Risk log; this is a fully populated and comprehensive risk log, developed in partnership with all stakeholders. Risks considered in the log cover:

- Risks to delivery & subsequent organisational impact
- Financial risks to CCG's, Local authority and providers
- Risks to patient care and/or experience

Risks are escalated at project level to the Deputy Director of Strategy (CCG) who holds the risk log. The log is updated to reflect the risk and signed off by the risk owner. Any risks above the Risk Threshold in the CCG/LA risk management policies are escalated appropriately. The risk log is interrogated monthly at the Integrated Systems of Care Programme Group to ensure that risks are managed and escalated where appropriate if mitigations are not secured.

The risk log as at March 2017 is available as Appendix X.

## Chapter 8: National metrics

The following table sets out the performance trend noted over the last 4 years and our proposed trajectory for the two year period of this BCF plan based on this analysis:

| | 2013/14 actual | 2014/15 actual | 2015/16 actual | 2016/17 actual | 2017/18 target | 2018/19 target |
|---|---|---|---|---|---|---|
| **Non-elective admissions** | 28889 | 31307 | 33985 | 33092 | 37345 | 36981 |
| **Delayed Transfers of Care** | --- | 5.02% | 2.69% | 4.03% | 3.50% | 3.50% |
| **65+ admissions** | 291 | 287 | 258 | 282 | **266** | **254** |
| **At home 91 days after hospital admission** | 86.9% | 84.3% | 91.5% | 91.3% | **91.6%** | **92.0%** |



These targets have been set following analysis of both performance of the system through the last 4 years and also take into account delivery of scheme-level benefits through 16/17. For example, we know through clinical audit that our pre-hospital pathway accounted for c1560 non-elective admissions being saved in 16/17. However, expected growth and coding changes at the acute trust have also been taken into account hence the rise in planned admissions in 17/18.

The opportunity analysis outlined in chapter X provides further detail of how these targets will be reached.

These targets have been agreed through the BCF governance structures as well as through the A&E Delivery Board and the LLR Home First Programme Board.

## Chapter 9: Delayed Transfers of Care

Leicester, Leicestershire and Rutland CCG's via the A&E DB has proposed a trajectory and action plan in discussion with NHS Improvement to bring the number of beds occupied by delayed patients down to 3.5% by March 2018. According to paragraph 66 of the BCF planning requirements, 3.5% equates to 9.4 average patients per day per 100,000 population. Applying this to Leicester's population of 268,644 gives the number of days delayed in March as 782.8. Work is underway to set a trajectory in terms of maximum days delayed per month for each local authority, split by attributable organisation, which will bring us to 782.8 total days delayed for Leicester by March 2018.

This work has the support of the Urgent and Emergency Care team, all 3 CCGs, all 3 local authorities, our 2 main providers locally, University Hospitals of Leicester and Leicestershire Partnership Trust, and the Sustainability and Transformation Plan Senior Leadership Team. The trajectories are

supported by a comprehensive plan of action which includes the development of Integrated Discharge Teams, improvements to the Continuing Health Care process, improvements in pathways to community hospitals, new trusted assessment models, and plans to bring down levels of delays due to patient choice as detailed in earlier chapters of this plan. As an integrated plan with the support of all partners locally, we believe that this local plan, agreed with NHS Improvement, is achievable.

Further details of how this will be delivered are set out in Chapter X.

## Approval and sign off

As per front sheet of this document, the Leicester City BCF has been approved by the JICB, the CCG Governing Body and the Health and Wellbeing Board.