East Midlands Councils

A Healthier Future for the East Midlands?

February 2015

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Public Health England

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Foreword

The importance of health, and how health services are funded and delivered, needs little explanation. Alongside the very real impact on the health and wellbeing of people in our local communities, with the General Election in May 2015, the NHS will be a key political battleground. All parties have promised to protect NHS funding meaning that planned public spending cuts will fall disproportionately on other government departments.

The NHS has been subject to a series of major structural reorganisations – particularly affecting how health services are commissioned. With the latest reforms still bedding down, no political party is seriously suggesting more of the same. The focus is instead on how to deliver better outcomes, more efficiently; through the adoption of different approaches to delivery, preventing ill health and reducing health inequalities in order to reduce demand. As a consequence, the leadership, commissioning and service delivery roles of local government become much more important.

In a review of health outcomes and practice in this region, the following report examines a number of issues of importance; but in particular, four priority areas are highlighted:

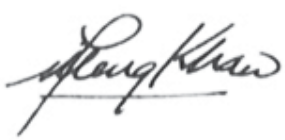
- **Inequalities in health outcomes.**
- **Inequalities in funding for healthcare.**
- **Recruitment and retention of the health workforce.**
- **The need for collective leadership.**

Too many decisions that affect the health and wellbeing of local communities are taken at the national level. To improve health outcomes of people living in this region, there needs to be a greater devolution of responsibilities to the local level - allowing local decisions makers to better focus resources on specific priorities and challenges.

We need to build upon the collective work that already exists in parts of the region – but remains lacking elsewhere, particularly *between* sectors. And so it is intended that the conclusions and recommendations of this review will support further joint work between councils, MPs, the NHS, Public Health England and wider health partners by highlighting those issues where collective leadership can help address the key health challenges for this region.

Cllr Jon Collins
Chair, East Midlands Councils

Cllr Roger Begy
Chair, Health Review Panel



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East Midlands Councils

Members of the Health Review Task Group

Cllr Roger Begy OBE (Chair)

Cllr Roger Begy has been Leader of Rutland CC since 2003 and is on the East Midlands Councils Executive and Chairman of the Regional Improvement Board. He is a shadow governor of Leicestershire Partnership Trust and is a member of the Better Care Together Partnership Board in Leicestershire Leicester & Rutland. Roger is a board member of Midlands Arts Council and the LGA People & Places board.

He is Vice Chairman of the Regional Services Network that focuses upon rural issues. He received the OBE in 2008 for services to Further Education.

Cllr John Boyce

Cllr John Boyce is the Leader of Oadby and Wigston Borough Council.

He is the District Council representative on the Leicestershire Health and Wellbeing Board and also the Chair of the Borough Council's Health and Wellbeing Board.

Cllr Robin Brown

Cllr Robin Brown was elected to Northamptonshire County Council in May 2003 and is currently the council's Cabinet Member for Public Health and Wellbeing and Chair of the Northamptonshire Health and Wellbeing Board.

Andy Gregory

Andy joined the NHS in 1991 and has worked in a variety of roles in the development and management of primary care and community services, performance, planning and commissioning.

Andy has led the development of clinical commissioning across East Midlands, West Midlands and East of England and was part of the national authorisation team before successfully being appointed to Chief Officer, Hardwick CCG in September 2012.

Andy completed the Kings Fund Top Leaders Programme in 2013 and recently became a member of the East Midlands Health and Well Being Board Leadership group and undertakes national LGA peer review assessments.

Dr Fu-Meng Khaw

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Cllr Alex Norris is Nottingham City Council's lead member for Adults, Commissioning and Health.

He is the Chair of Nottingham's Health and Wellbeing Board. Their priorities include; integrating health and social care, improving Nottingham's mental health, supporting Priority Families and reducing the impact of drugs and alcohol in the city.

Mike Sandys

Mike is Director of Public Health (DPH) for Leicestershire and Rutland County Councils being appointed to the post in February 2014.

Mike joined the NHS in the late 1980s and has worked in public health since 1992. His public health career has seen him work in a number of public health intelligence, research and development and manager roles in both the NHS and academia.

Dr David Sharp

David has been a director in the NHS since 2000. He holds a Doctorate in Business Administration and is a part time professor with specialties in change management and also in the funding of healthcare.

David has been Chief Executive and Finance Director in NHS organisations in Derbyshire and Nottinghamshire and took on his recent role as Director within NHS England in November 2012. His experience in the NHS includes acute, mental health and primary care.

1 Introduction

1.1 The importance of health, and how health services are funded and delivered, needs little explanation. Alongside the very real impact on the health and wellbeing of people in our local communities, with the General Election in May 2015, the NHS will be a key political battleground. All parties have promised to protect NHS funding meaning that planned public spending cuts will fall disproportionately on other government departments.

1.2 However, with the emphasis of health policy (if not yet practice) moving more towards prevention and care in or as close to the home as possible; the leadership, commissioning and service provision roles of local government become much more important. These include social care in the home, transport (cycling and walking), recreation, increasing the capabilities of communities to look after their most vulnerable members, targeted services for high risk groups (e.g. troubled families, repeat offenders), the economy (particularly unemployment) and housing.

1.3 The NHS has been subject to a series of major structural reorganisations – particularly affecting how services are commissioned. With the latest reforms still bedding down, no political party is seriously suggesting more of the same. The focus is instead on how to deliver better outcomes, more efficiently, e.g. through the adoption of different approaches to delivery, preventing ill health and reducing health inequalities in order to reduce demand. Collaboration between local government and CCGs in the region is progressing well but still in its early stages so a review of progress and opportunities for increased collaboration and leadership against mutual priorities is timely.

Conclusions and Recommendations

1.4 At the regional level, there is generally a good geographical fit between local government and NHS organisations that cover, commission or provide services across the East Midlands region, e.g. Public Health England, NHS England Area Teams, East Midlands Ambulance Service and Clinical Commissioning Groups. There is, therefore, good potential for improving health outcomes, unity of purpose and collective leadership through collaboration between these agencies, councils, MPs and wider health partners.

1.5 This review is intended to complement the work already undertaken by health and wellbeing boards and local health scrutiny committees through 'adding value' and support in addressing the joint priorities of councils, MPs and key health partners.

1.6 While the full report highlights a range of issues of importance to the region, the following four priority outcomes have been identified in undertaking this review:

- Reducing inequalities in health outcomes.
- Eliminating inequalities in funding for healthcare.
- Improving the recruitment and retention of the health workforce.
- Effective cross sector, collective leadership.

Inequalities of Health Outcomes in the East Midlands

1.7 In most aspects, the health of the East Midlands is close to the national average. It is not the worst region in the country, but neither is it the best. However, within the East Midlands there are major health inequalities and these are widening across many parts of the region. As a region, we will never meet, or even get near to, national expectations of health outcomes unless these disparities are addressed.

1.8 The current health profile is unacceptably poor. The East Midlands should be better than average in terms of health – and the wide variations in health outcomes are unjustifiable. For example:

- People in Derby, Leicester and Nottingham have a life expectancy significantly less than the national average.
- There are huge disparities within communities, e.g. men living in the most deprived wards of Derby have 12 years less life expectancy than men in the most prosperous wards.
- There is a disproportionate number of people that are likely to experience poor health affecting their everyday life before they turn 60; meaning over 15 'unhealthy' years, with associated impact on their quality of life, increasing social care and welfare costs, and costs to the wider economy caused by absence from work.

- There are high levels of deaths from causes considered preventable; particularly in the 3 cities, North Nottinghamshire/Derbyshire and East Lincolnshire.
- Higher than national levels of obesity, smoking and alcohol related admissions to hospital.
- Smoking in pregnancy is the major concern across the East Midlands with levels significantly higher than the national average - and urgent action is needed to reverse the rising trend.

1.9 There is also significant inequality in the treatment and prevention of mental compared to physical ill health with high proportions of people with mental ill health not receiving treatment and some parts of the region exhibiting higher levels of depression than others.

1.10 Common understanding of health inequalities and priorities is an important first principle in ensuring health agencies and local councils are able to target resources and identify opportunities for collective intervention.

1.11 **Key Recommendation:** A clear statement of the most effective measures to improve health outcomes and reduce inequalities in physical and mental health is developed involving health agencies and local councils in the East Midlands that prioritises the allocation of resources and identifies best practice.

Inequalities in Funding for Healthcare in the East Midlands

1.12 The East Midlands is underfunded across its health system – this is not only unjust but it also means that the region is unable to tackle the big issues that we know the health, social care and public health systems face.

1.13 The latest national data (2012/13) shows that total spending on health in the East Midlands is the 2nd lowest in the county, only the North East received lower levels of funding.

1.14 In terms of spending per head, the situation is only a little better; a health spend of £1,850 per head of the population in this region compares unfavourably to the national average of £1,912 for England and £1,937 for the UK. Spending per head was higher in North East, North West, Yorkshire and the Humber, West Midlands and London - with only the East of England, South East, and South West receiving lower levels.

1.15 CCG Programme Budget Baseline Allocations show that:

- Allocations per head for the East Midlands in 2014/15 are lower than the England average.
- In Northamptonshire, NHS Nene CCG is -6.99% below target and NHS Corby CCG, the worst hit, is -11.32% below target, with underfunding of -£186 per person. West London is the most overfunded, with +£508 per head over the target amount.
- The NHS Midlands and East area is further below its target allocation than anywhere else in 2014/15, and will continue to be so in 2015/16.
- This is despite Government policy being to move all areas to their target fair funding allocation as soon as possible.

1.16 **Key Recommendation:** The Department of Health should require NHS England to move local commissioners to their target allocations within a maximum of 2 years.

Recruitment and Retention of the Health Workforce

1.17 Unless this region addresses the problems in GP and nurse recruitment, then with the numbers of GPs set to retire in the next few years – this region will face a crisis in primary care.

1.18 Primary care is under massive pressure – and the problems of GP retirement and lack of trainee doctor recruitment and retention means that we are facing a real crisis imminently. For example:

- 30% of GP training vacancies in this region remain unfilled, against a 99% fill rate in London and a UK average of 90%.
- The East Midlands has one of the lowest levels in England of full time nurses per head of population (5.2 nurses per 1,000 population compared to an England average of 5.6).

1.19 This region has the joint lowest number of consultants per head of population in the country. There is almost double the number of consultants per head of the population in London than in the East Midlands.

1.20 All the evidence suggests that more effective primary care will reduce demand on acute services including accident and emergency. It is therefore particularly important that the numbers of GPs are increased to meet requirements. We welcome the plans to expand the general practice workforce announced in January 2015 but urge NHS England and partners to maintain a particular focus on the East Midlands given the issues this report has identified.

1.21 **Key Recommendation:** To improve the recruitment and retention of key healthcare staff, all parts of public sector in the region should collaborate to make this region a great place for medics to train and work – with a priority for increasing the numbers of GPs.

Collective Leadership

1.22 The scale of the challenges facing health are not solely ensuring adequate levels of funding to meet future demand for health and social care – they are also about reform of decision-making and resource allocation to deliver better health outcome at reduced cost.

1.23 Failure to take action is morally and financially unsound. We need a new sense of collective leadership and unity of purpose; bringing together leaders from the NHS, universities, LEPs, industry and local councils to develop strong and powerful partnerships in order to drive improvements in healthcare across our region.

1.24 A new approach to NHS reform is needed where the Government devolves more authority and accountability to local councils and the NHS organisations responsible for delivering care – allowing leaders in local government and the health sector to improve the focus and quality of services and develop new models of care against local priorities.

1.25 **Key Recommendation:** Council and NHS leaders should together develop a new model of collective leadership to improve health outcomes which requires:

- Greater local autonomy for policy setting and integration of funding.
- A collaborative approach with other parts of the public sector including police, universities and LEPs.
- Working towards a fully integrated whole place/whole system approach backed by place-based budgets for the prevention and treatment of ill health.

2 Context

A consensus is emerging around the need for preventative care and early intervention. More services need to be delivered using a holistic, person-centred approach. Interest in collaborative approaches involving pooled or aligned commissioning is growing.

2.1 A high level review of government policy statements, independent reviews and recent political 2015 election related statements has been undertaken. The summaries below have been selected because of the links they make between achieving better health outcomes and areas of local government responsibility.

2.2 Three white papers were issued by the Government early in the current Parliament – 'Healthy Lives Healthy People' (2010 and 2011 Update), 'No Health without Mental Health' (2011) and 'Caring for the Future; Reforming Care and Support' (2012). Taken together they:

a. Accept the substantial scale and nature of the health challenge – especially given demographic changes - and the (unsustainable) costs associated with a business as usual approach.

b. Recognise that Whitehall driven solutions will not work when the nature of problems and solutions vary from place to place.

c. Propose that individuals and communities play a bigger role in looking after their own needs and promote greater independence including greater support for carers and personal budgets.

d. Recognise that local authorities have been given responsibilities for public health because of their community role and the opportunity to develop solutions covering the full range of services including leisure, housing, planning, transport, employment and social care.

e. Emphasise the need for action in early years – a 'life course' approach - recognising that many lifestyle choices are influenced from a young age and even before birth.

f. Explicitly recognise that ill health has an impact wider than the health budget – with implications for the economy (mental health problems cost the UK economy £8.4bn a year in sickness absence), benefits take up, school attendance, educational attainment and social problems such as homelessness, crime and substance abuse.

g. Recognise that wider issues such as being in employment, having good housing and a supportive community and family life is likely to prevent health problems while the opposite is likely to create them.

h. Require a parity between mental and physical health services.

i. Want to stop people being 'bounced around' between services

2.3 The Kings Fund – a respected health based think tank – commented on the Government's policies in 2012 (Transforming the Delivery of Health and Social Care – The case for fundamental change). Amongst other things it was concerned that the NHS is still too focused on treatment of illness rather than the promotion of health and that prevention remains the poor relative. It notes the need to do more in primary care to support people to improve their health, a potential increased role for the third sector and for local government to work through 'transport, leisure, planning and education departments to improve population health'.

2.4 In its view, Health and Well Being Boards are well placed to provide leadership at a local level, and to develop strategies for health improvement that 'move beyond traditional silos to focus on communities and populations'. It also considers that funding reductions in social care mean it is more difficult to act early to help people in their own homes and that services for children remain fragmented.

2.5 An Independent Panel was asked by Ministers in early 2014 to recommend changes which would help public services deal with demographic changes, increasing expectations and the need to reduce the cost of public services. In its report 'Bolder, Braver and Better: why we need local deals to save public services' (2014) the panel calls for three fundamental changes:

a. That local and central government use the person-centred approach of the Troubled Families programme to design services for groups and individuals with multiple and complex needs.

b. More easily accessible and more flexible up-front funding for the up-front costs of transformation.

c. Radical improvements in how data and technology are used to provide smarter services.

2.6 The Panel held a roundtable with national health agencies from which the following strong message emerged:

"Creating the scale and pace for transformation required a deepening of trust between agencies. This could be positively supported by central government with a narrative that was more closely aligned to what was perceived as the "real" issues for a locality. This would probably mean greater flexibility, or as much flexibility as possible, for any new funding initiatives. It was also considered more helpful if new funding was targeted specifically at people, not services."

2.7 The Chair of the Panel said:

"It is clear that the traditional approach to public services is not working. It is no use for individual organisations – be it council, police, health, Jobcentre Plus or another – to concern themselves with just one aspect of somebody's very complex problems. This has, tragically, not delivered better outcomes for a great many people and it has not reduced the need for costly support. We have called for the government and places to work together and create better interventions for those groups of people who contribute, for whatever reason, to the increasingly high demands on public services."

2.8 In his Autumn Statement 2014, the Chancellor commented on the need for reforms in the next Parliament to 'drive out waste and inefficiency and improve outcomes'. He described the benefits of some initiatives to integrate public services and cited the Troubled Families Programme and Better Care Fund as examples of measures to encourage this integration. He welcomed the contribution of the service transformation panel (above) and stated that 'further integration of services will be delivered by developing and extending the principles underpinning the Troubled Families Programme approach to other groups of people with multiple needs'.

2.9 In a recent statement, the SoS for Health Jeremy Hunt indicated that "choice is not the main driver for service improvement". He noted the need for somebody with whom the 'buck' stopped to have the support necessary to keep somebody with complex needs out of hospital. His opposite number Shadow SoS for Health Andy Burnham – commenting on the relationship between social care and health service funding notes that "in the ageing century it's not going to be possible to keep disaggregating people's needs into different silos."

Conclusions

2.10 There seems to be a policy consensus that:

a. Single service approaches do not work satisfactorily because the needs of many people with high use of public services are complex.

b. The impact of these complex needs has 'cause and effect', e.g. unemployment can lead to a range of health problems and an ongoing health problem can lead to unemployment.

c. There is a need for a 'buck stops here' approach to co-ordinate preventative and early intervention and other services through a holistic person-centred approach.

d. More services should be integrated and jointly commissioned through pooled budgets.

e. More effective prevention is needed at individual and community level if costs are to be contained.

f. People need to do more for themselves and each other.

g. Collaborative approaches involving pooling or aligning commissioning and transformation budgets are helpful.

3 An Overview of Health – Roles and Responsibilities

The Health and Social Care Act 2012 heralded some of the most wide-ranging reforms in the way the NHS commissions secondary/acute care since it was founded in 1948. The organisations responsible for commissioning health services in the East Midlands need the ability to innovate and use budgets in the most effective way if they are to achieve the greatest impact on health outcomes.

3.1 Primary health care provides the first point of contact in the health care system. The main source of primary health care is general practice – the local GP, but primary care is also provided by NHS walk-in centres, dentists, pharmacists and optometrists. Primary health care involves providing treatment for common illnesses, the management of long term illnesses such as diabetes and heart disease and the prevention of future ill-health through advice, immunisation and screening programmes. Secondary, or 'acute', care is the healthcare that people receive in hospital; ranging from unplanned emergency care or surgery, to planned specialist medical care or surgery.

3.2 It is now over 18 months since the Health and Social Care Act 2012 came into force and with it some of the most wide-ranging reforms of the way the NHS commissions secondary/acute care since it was founded in 1948. Most of the changes took effect on 1st April 2013 and have had an effect on who makes decisions about NHS services, how these services are commissioned and the way money is spent. Some organisations such as Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) were abolished, and other new organisations, such as clinical commissioning groups (CCGs), have taken their place.

National Structures

3.3 The Secretary of State for Health has ultimate responsibility for the provision of a comprehensive health service in England, and ensuring the whole system works together to respond to the priorities of communities and meet the needs of patients.

3.4 *The Department of Health* (DH) is now responsible for strategic leadership of both the health and social care systems, but is no longer the headquarters of the NHS, nor does it directly manage any NHS organisations.

3.5 *NHS England* was originally established as the NHS Commissioning Board in October 2012. It is an independent body, at arm's length from government. Its main role is to improve health outcomes for people in England and:

- Provide national leadership for improving outcomes and drive up the quality of care.
- Oversee the operation of clinical commissioning groups.
- Allocate resources to clinical commissioning groups.
- Commission primary care and specialist services.

3.6 *Public Health England* (PHE) was established in April 2013, and brings together a number of services and statutory functions to deliver an integrated offer of services, advice and support to local stakeholders across the three domains of public health; health protection, health improvement and healthcare public health.

3.7 *Healthwatch England* is the national consumer champion in health and care. It has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

Sub National Arrangements

3.8 Public Health England has 4 regions (North of England, South of England, Midlands and East of England, and London) and currently 15 local centres, with London being an integrated Centre and Region. From 1st July 2015 PHE will be operating from 9 Centre footprints. The current East Midlands Centre footprint is Derbyshire, Leicestershire, Lincolnshire, Nottinghamshire and Rutland, and the new footprint will also include Northamptonshire. The East Midlands Centre provides expert services, advice and support to the local public health system. It works with local government, the NHS and other stakeholders to protect and improve health and reduce health inequalities across the East Midlands.

3.9 The East Midlands is within the Midlands and East of England NHS region. The local presence of the NHS is through its newly formed Sub-Regions; NHS North Midlands includes Derbyshire and Nottinghamshire and

NHS Central Midlands covers Leicestershire, Lincolnshire, Northamptonshire and Rutland. The NHS Sub Regions work with CCGs, local authorities, Public Health England, Health Education East Midlands, local Healthwatch bodies and the NHS Trust Development Authority to improve health outcomes. NHS Sub-Regions have direct commissioning responsibilities, such as primary care, primary dental care, screening and immunisation services, amongst others.

Local Structures

3.10 Primary care trusts (PCTs) used to commission most NHS services and controlled 80% of the NHS budget. On 1st April 2013, PCTs were abolished and replaced with Clinical Commissioning Groups (CCGs) – the cornerstone of the new health system. CCGs have taken on many of the functions of PCTs and in addition some functions previously undertaken by the Department of Health.

3.11 CCGs are GP-led organisations responsible for buying and planning the majority of health services, including emergency care, elective hospital care, maternity services and community and mental health services. There are 211 CCGs altogether, responsible for a budget of approximately £65bn (around 60% of the total NHS budget), commissioning care for an average of 226,000 people each. The East Midlands region is covered by 20 CCGs with a total programme budget allocation of a little over £5.1bn, commissioning care for an average of 232,000 people each, ranging from 650,000 people in Nene CCG, to 73,000 people in Corby CCG.

3.12 The Health and Social Care Act 2012 established new responsibilities for local councils to improve the health of their populations, backed by ring-fenced grant and a specialist public health team, led by a Director of Public Health. The new public health functions include:

- Health Improvement – to improve the health of their local population.
- Health Protection – to protect the health of the local population against a range of threats and hazards.
- Healthcare Public Health – the requirement to provide public health advice to NHS commissioners.

3.13 *Health and Wellbeing Boards* are central to the vision of a more integrated approach to health and social care – and are one of the features of the recent health reforms that have met with widespread support in providing a sense of local purpose and a strong partnership between CCGs and the local authority. Established by every upper tier local authority, their role is to provide a forum for local commissioners from the NHS, public health, elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health through:

- Increasing democratic input into strategic decisions about health and wellbeing services.
- Strengthening working relationships between health and social care.
- Encouraging integrated commissioning of health and social care services.

3.14 Ultimately, the key challenge is whether Health and Wellbeing Boards add value through offering a strong, credible and shared leadership that engages partners in making a real difference for local people.

3.15 *Local Healthwatch* are independent organisations for citizens and communities to influence and challenge the local provision of health and social care services. It has a seat on the statutory health and wellbeing boards, ensuring that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment (JSNA) and the authorisation of Clinical Commissioning Groups.

Conclusions

3.16 A number of organisations have responsibility for, and influence on, the commissioning of health services in the East Midlands. These agencies need a common vision, aligned aims and objectives, clear evidenced based priorities and the ability to innovate and use budgets in the most effective way if they are to achieve the greatest impact on health outcomes.

Recommendation

3.17 Health agencies and Local Authorities should ensure that the visions, aims, objectives and priorities are aligned across multiple strategies, plans and budgets.

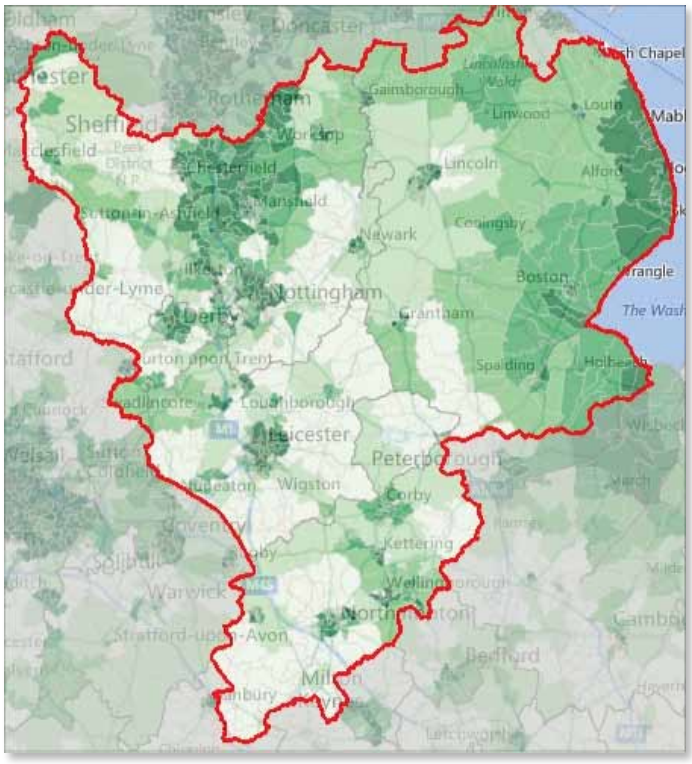
4 Inequalities of Health Outcomes in the East Midlands

In most aspects, the health of the East Midlands is close to the national average. It is not the worst region in the country, but neither is it the best. However, within the East Midlands there are major health inequalities and these are widening across many parts of the region.

4.1 Given its socio-economic profile, the East Midlands should be better than average in terms of health – and the wide variations in health outcomes are unjustifiable. This is despite the significant efforts of a number of organisations including local government, the health sector and universities.

4.2 Many health challenges are linked to socio-economic factors. The poorest performing wards for health outcomes tend to be areas with high levels of deprivation; in large cities; on the coastal strip of Lincolnshire; and in areas of industrial decline, e.g. Nottinghamshire, Derbyshire, and Corby (see figure 1).

Figure 1
% living in income deprived households reliant on means tested benefit. 2010 *(source: DCLG)*



Life Expectancy and Healthy Lives

4.3 Life expectancy at birth is similar to the national average for both men and women living in the East Midlands.

Life expectancy at birth (years)	Men	Women
East Midlands	79.1	82.9
England	79.2	83.0

4.4 However, across the East Midlands there is wide variation, with significantly higher life expectancy in Leicestershire and Rutland; and, significantly lower life expectancy in Derby, Leicester, Nottingham and Nottinghamshire compared to the national average. There are also large disparities in how long people live within areas; in Derby City life expectancy is 12.2 years lower for men and 9.0 years lower for women living in the most deprived areas compared to the least deprived; and in North West Leicestershire the gaps are 12.5 years for women and 8.1 years for men.

Life expectancy at birth (years)	Men	Women
Leicestershire	80.1	84.0
Rutland	81.0	84.7
Derby	78.6	82.8
Leicester	77.0	81.8
Nottingham	76.9	81.5
Northamptonshire	79.3	82.7
Nottinghamshire	76.9	81.5

4.5 As well as living longer, there should be an emphasis on healthier, more productive lives. In the East Midlands generally, both men (63.2 years) and women (63.6 years) can expect to live in good health almost to retirement age with people in Northamptonshire, Leicestershire and Rutland retaining good health well into their 60s and even to their 70s. However, men and women in Derby, Leicester and Nottingham are significantly more likely to experience poor health affecting their everyday life before they turn 60. This means that many individuals face over 15 'unhealthy' years, with associated quality of life concerns and increasing public costs including care needs and benefits.

The Big 5 Killers

4.6 Heart disease, stroke, cancer, respiratory and liver disease - these five big killers account for more than 150,000 deaths a year among under-75s in England alone and estimates indicate that 30,000 of these are entirely avoidable. Excess weight, lack of physical activity, smoking and increasing intake of alcohol are all major risk factors associated with these preventable causes of death.

4.7 In this region, more than 200 deaths per 100,000 population are related to preventable infections, heart disease, stroke, diabetes, cancer, respiratory and liver disease, mental health issues, substance and alcohol misuse and poor quality healthcare (preventable deaths are higher in the cities of Derby 207, Leicester 234 and Nottingham 247). The costs to the health and social care system of not tackling the preventable 'big killers' are significant.

Preventable deaths	CVD	Respiratory disease	Liver disease	Cancer
Derby	63.0	-	20.7	-
Leicester	73.2	22.0	22.7	-
Nottingham	75.3	31.3	26.4	107.1

(All figures are per 100,000 person population. Only death rates which are significantly higher than average are shown).

4.8 More than twice as many people from the poorest backgrounds die of circulatory disease than those from the most affluent backgrounds, and whilst the number of people overall who engage in multiple risky health behaviours (such as excessive drinking, smoking, or having a poor diet) has reduced, people from poorer backgrounds and the most vulnerable are still more likely to undertake three or more of these behaviours.

4.9 Excess weight in adults is significantly higher than the national average in the East Midlands with two thirds of adults being overweight or obese in 2012 (65.6% compared to 63.8% nationally). This is a particular problem for county areas (ranging from 66.4% in Nottinghamshire to 68.2% in Lincolnshire) rather than the city areas (Leicester is significantly better than the national average at 57.0%).

4.10 Levels of smoking remain a problem, particularly in Nottingham with almost a quarter of adults (24.4%) still smoking in 2012, and among the routine and manual populations living in Lincolnshire with more than a third (35.6%) still smoking in 2012.

4.11 However, health agencies and local councils highlight smoking in pregnancy as the major concern across the East Midlands; with 15.1% of pregnant women reported smoking at the time of their baby's birth. This is well above the national average of 12.7% and urgent action is needed to reverse the rising trend.

4.12 Smoking in pregnancy impacts on the developing foetus and is known to cause miscarriages, stillbirth and low birth weight. In the East Midlands in 2012, 7.3% (4,037) of babies born had low birth weight. This is the most significant factor in infant deaths and in developmental problems that have an adverse impact on educational attainment.

4.13 Alcohol related admissions are also significantly higher in the region as a whole at 646 per 100,000 population compared to 637 nationally. The cities again fair worse with Nottingham City a particular cause for concern.

Alcohol related admissions 2012/13	Per 100,000 population
England	637
East Midlands	646
Leicester	717
Derby	742
Nottingham	878

4.14 A more detailed health profile (Appendix 1) and Figures 2-5 illustrate that life expectancy can be improved if deaths from causes that are considered preventable are reduced.

Areas that are lighter for life expectancy in the first map (signifying lower life expectancy) are darker in the second map (signifying higher preventable mortality).

Figure 2
Male Life Expectancy – age in years, 2008-2012

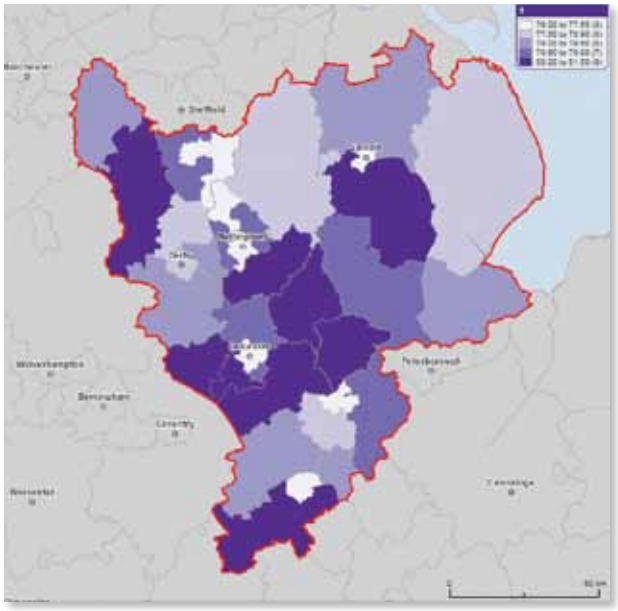


Figure 3
Male mortality from causes considered preventable, age-standardised rate per 100,000 population, 2011-2013

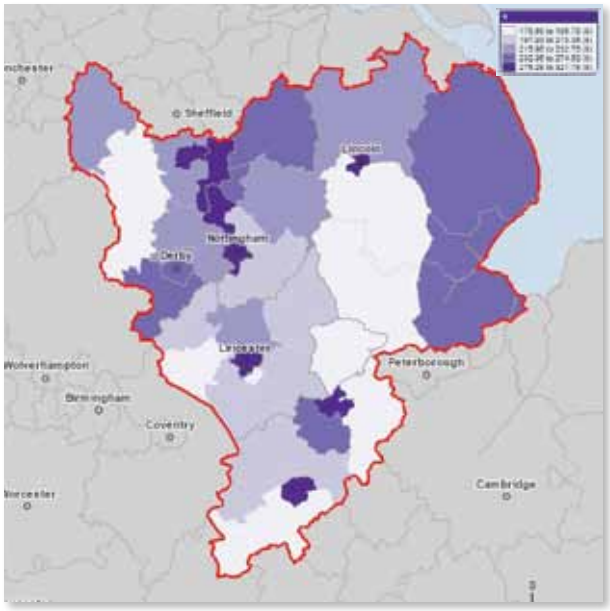


Figure 4
Female Life Expectancy – age in years, 2008-2012

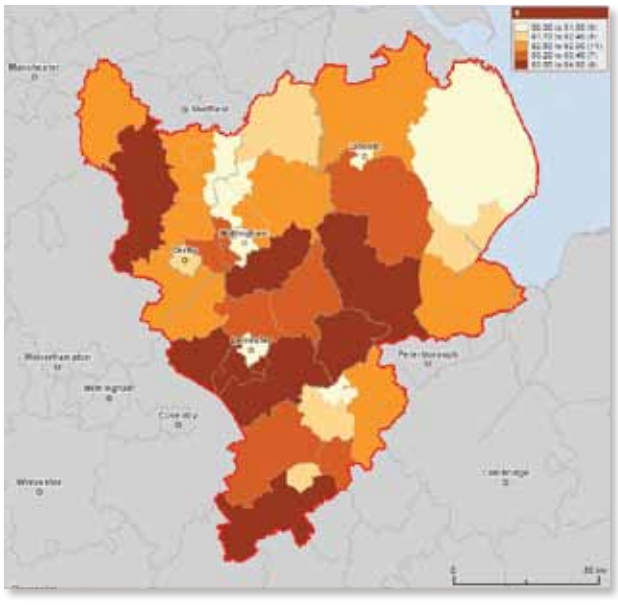
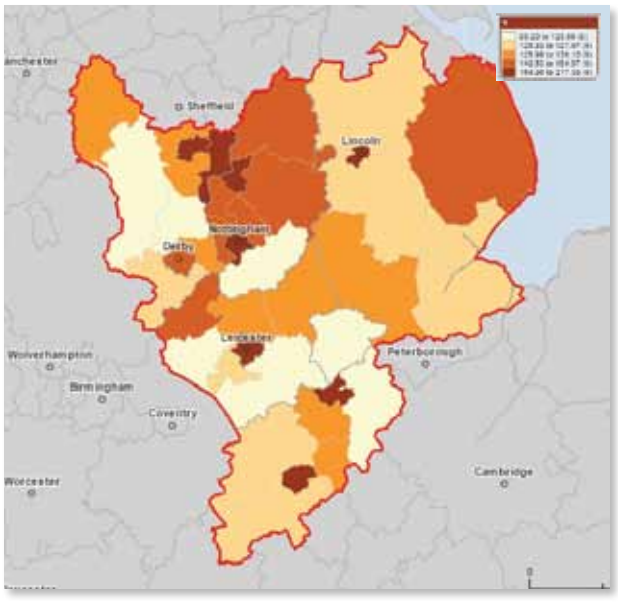


Figure 5
Female mortality from causes considered preventable, age-standardised rate per 100,000 population, 2011-2013



Mental Health

4.15 Mental ill health is a significant health challenge – and the statistics surrounding mental health are salutary:

- Among people under 65, nearly half of all ill-health is mental illness.
- Mental illness is generally more debilitating than most chronic physical conditions.
- Only a quarter of all those with mental illness such as depression are in treatment.
- 75% of all chronic mental health problems start before the age of 18 – but only a quarter of children and teenagers aged up to 15 with mental health problems receive any support, and just 6% of the mental health budget is spent on children.
- Physical and mental health treatment need greater integration – all too often they remain in separate silos within health services.
- People with poor physical health are at higher risk of experiencing mental health problems, and people with poor mental health are more likely to have poor physical health.
- Currently people with poor mental health have the life expectancy of people who lived in the 1950s – some 10 to 15 years shorter than the current average.

4.16 As with physical health there are considerable variations in mental health outcomes across the region. Hardwick and Nottingham City CCGs areas both have significantly higher levels of long-term mental health problems than national levels. The majority of CCG areas report levels of depression that are above the national average with 6% of the adult population registered as suffering from this condition. Spend on prescribing shows that some areas with a higher prevalence of depression have lower spending on antidepressants, such as Corby CCG with over 8% of the adult population registered as suffering with depression and the lowest spending (Figure 6). Detentions under the Mental Health Act are also higher than the national average in Leicester and Nottingham City CCGs (22.5 and 25.6 per 100,000 population compared to 15.5 nationally, respectively).

4.17 Attendances at A&E for psychiatric disorders are highest in Mansfield and Ashfield CCG at 424.3 per 100,000 population, and also higher than the national average (243.5) in CCGs in surrounding Nottinghamshire, Lincolnshire and Northamptonshire (black diamonds in figure 7). However, for Nene in Northamptonshire and Lincolnshire East CCGs the proportion of patients reporting that they have a long term mental health problem is lower than nationally. This may also indicate issues with reaching people who have mental health issues.

4.18 Although depression rates are lower than average in Nottingham City CCG, the proportion reporting that they have a long term mental health problem is significantly higher than average in Nottingham City and Hardwick CCGs (the pale red bars in figure 7). This may indicate differences in the kinds of mental health issues that are prevalent in these populations or differences in the reporting of both measures.

4.19 NHS England estimate that people unable to work because of mental illness costs the UK economy approximately £70bn a year, equivalent to 4.5% of gross domestic product, once absences, productivity losses and benefit liabilities are taken into account:

- 800,000 people are currently signed off sick from work and claiming disability benefits for mental health issues.
- A further 400,000 people claiming other out of work benefits do so because of mental health reasons.
- On the other hand, 60-70% of people with common mental disorders (such as depression and anxiety) are in work and so there is a strong economic imperative to keep them in work and address their mental health.
- Further research has shown that 43% of those accessing homelessness projects in England suffer from a mental health condition.

Figure 6
Proportion of the GP registered patients that have depression known to GP, 2012/13 and cost of GP prescribing for antidepressant drugs, net ingredient cost per 1,000 standardised population (2013/14, Q4). Source: PHE Common Mental Health Disorders

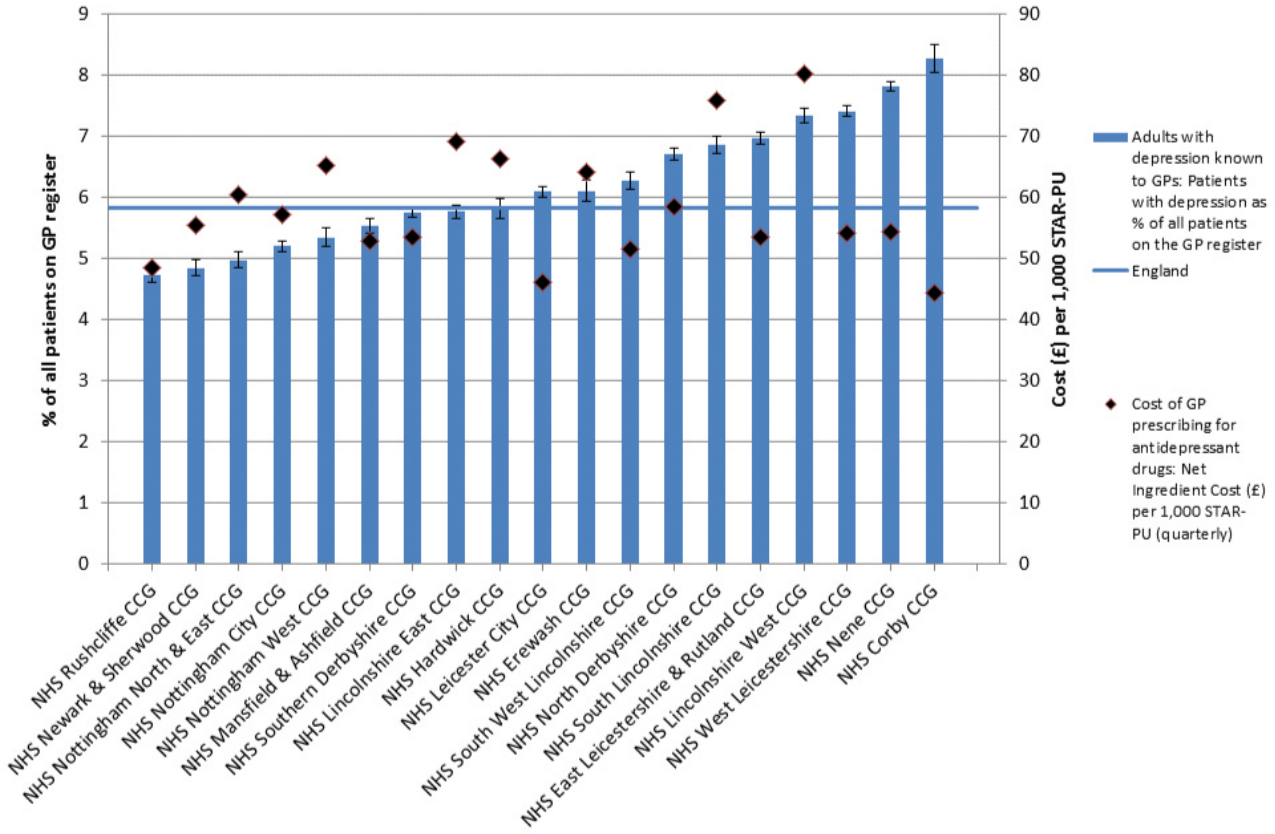
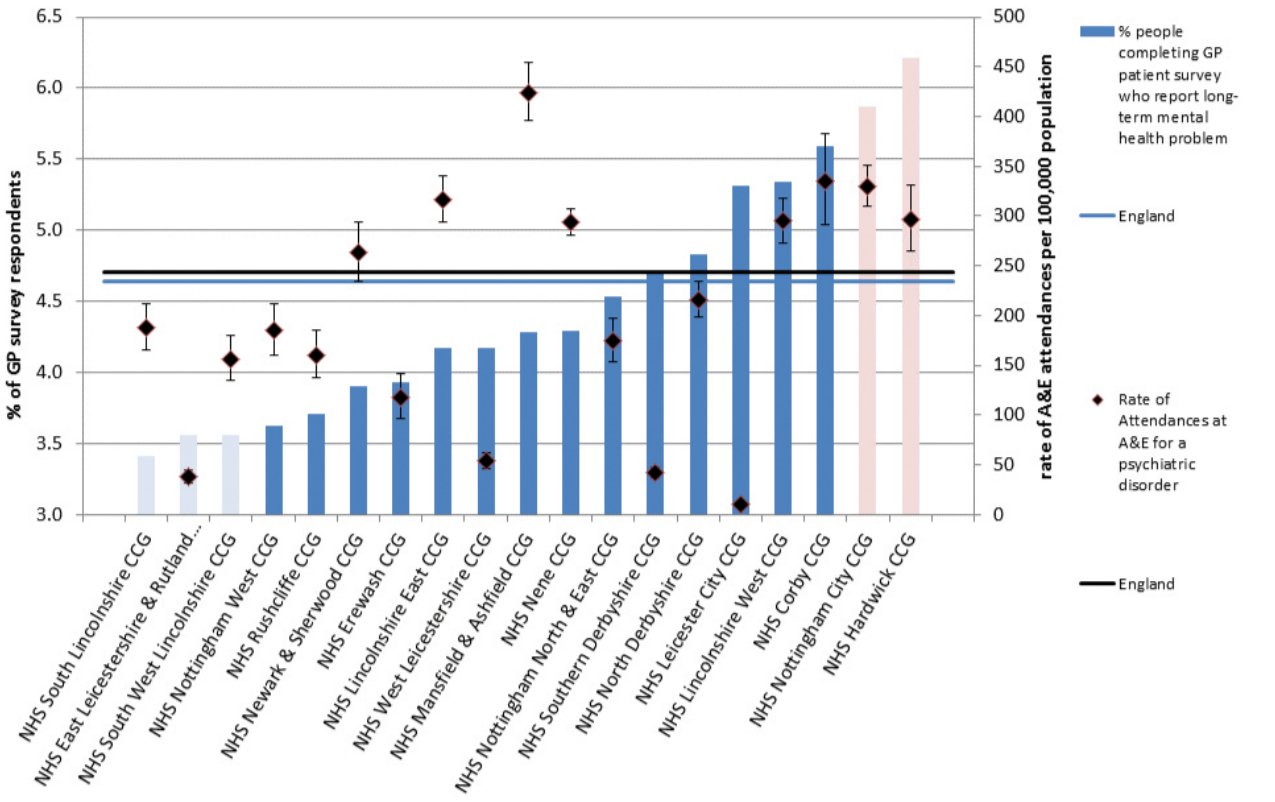


Figure 7
% of people completing patient survey who reported a long-term mental health problem, 2012/13 and the rate of A&E attendances for a psychiatric disorder per 100,000 population (2012/13). Source: PHE Community Mental Health Profiles



4.20 All too often, people with mental health conditions find themselves in contact with the police when more appropriate support is unavailable. Police sources estimate that responding to day-to-day incidents, where someone needs immediate mental health support, occupies 25-40% of police time. Data regarding the use of Section 136 of the Mental Health Act powers by police to detain people in need of 'care and control' provide some context about how we respond as a society to people experiencing a mental health crisis.

> *"We deal with more vulnerable people each day than we make arrests"*
> ***Simon Cole, Chief Constable, Leicestershire Police.***

Detentions under Section 136 in police and hospital based 'places of safety' (including detainees aged under 18), 2013/14

England — number ([1])

		All		Under 18	
		Police	Health	Police	Health
England Total	**24,296***	**829**	**18,461***	**236**	**517***
Derbyshire Constabulary	-	78	-	1	-
Leicestershire Constabulary	311	36	275	2	-
Lincolnshire Police	552	333	219	25	0
Northamptonshire Police	383	61	322	5	0
Nottinghamshire Police	1,037	321	716	14	36

Data source: Police Force IT Systems (All Forces and Constabularies of England) Copyright © 2014, Association of Chief Police Officers. All rights reserved.

[1] " - " denotes data not available. These figures were based on figures extracted from local police force custody databases in response to the question: "How many Section 136 detentions did your force have from 1st April 2013 to 31st March 2014 that went directly to a police station?" (This figure does not to include anyone who was arrested for a substantive offence and subsequently arrested whilst in custody).

Conclusions

4.21 In most aspects, the health of the East Midlands is close to the national average. It is not the worst region in the country, but neither is it the best. However, within the East Midlands there are major health inequalities and these are widening across many parts of the region. As a region, we will never meet, or even get near to, national expectations of health outcomes unless some of these disparities are addressed. This includes tackling mental health issues with the same priority as physical health.

4.22 Improving health outcomes and correcting inequalities in outcomes in particular cannot be achieved solely through clinical interventions. Much has already been achieved through area initiatives - the linking of employment outcomes with health outcomes, community development, and prevention measures around smoking, diet and exercise and housing services. The effectiveness of these measures needs to be better understood to convince decision makers, particularly within the health community about the value of wider preventative investment.

4.23 In the face of medical and economic evidence, the challenge is to address mental health with the same urgency as that for physical health. This should not only improve the outcomes for people with mental health problems but also save money and give taxpayers much better value for every pound we spend. Part of the solution lies in putting funding, commissioning and training on a par with physical health services, and working in a more integrated way, e.g. with the Institute of Mental Health - one of the leading mental health institutes in the UK.

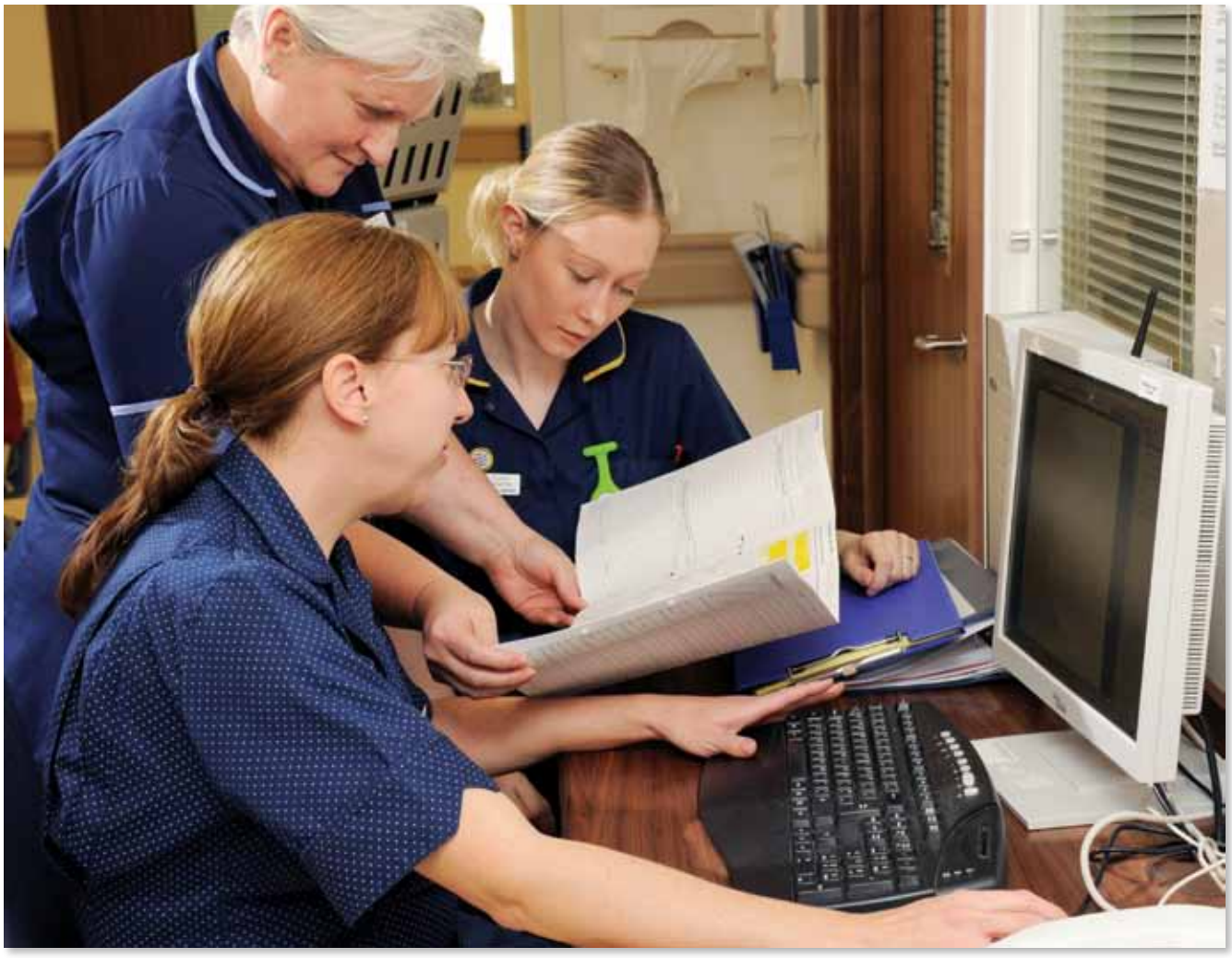
4.24 Given its socio-economic profile, the East Midlands should be better than average in terms of health – and the wide variations in health outcomes are unjustifiable. Until the most effective measures to reduce inequalities are understood, then joint action, including securing the support of MPs for measures to address them, will be much more difficult. Health inequalities represent the 'golden thread' of this review; one that requires improvements to primary, acute and mental health care, better funding and leadership; while also dependent upon economic growth, housing, employment and skills development.

Recommendations

4.25 **Key Recommendation:** A clear statement of the most effective measures to improve health outcomes and reduce inequalities in physical and mental health is developed involving health agencies and local councils in the East Midlands that prioritises the allocation of resources and identifies best practice.

4.26 All Health and Wellbeing Boards should be informed by a Joint Strategic Needs Assessment (JSNA) that includes the information needed to plan services to integrate the mental and physical health needs of their populations.

4.27 Employment is central to mental health and as such employment status should be a routine and frequently updated part of all patients' medical records. This will provide the baseline data for employment status to be an outcome of all medical specialties, including primary care.



5 Funding for Healthcare in the East Midlands

The East Midlands is underfunded across its health system – this is not only unjust but it also means that the region is unable to tackle the big issues that we know the health and public health systems face.

An Overview of Funding

5.1 Each year the Department of Health receives over £110bn to fund health services in England. It passes around 90% of this money to NHS England that has the responsibility for commissioning healthcare.

5.2 The vast majority of NHS funding comes from central (UK) taxation. The NHS can also raise income from patient charges, sometimes known as 'co-payments'. Devolved administrations have control over the level at which these are set. Types of 'co-payments' include:

- Prescription charging
- Dental Charging
- Other sources of income, e.g. charging overseas visitors and their insurers for the cost of NHS treatment, car parking charges etc. In addition, NHS Trusts can earn income through treating patients privately.

5.3 Measuring health funding at the sub-national level is not straightforward. Expenditure is allocated on the basis of the region that benefited from the expenditure; or whom the expenditure was for - but these figures are only intended to give a broad overview and should not be regarded as a precise measure. This is because it is not always easy to decide who benefits from particular expenditure – aside from any simplifying assumptions made in compiling the data.

5.4 Notwithstanding the caution, the latest data released in July 2014 shows that health spending (both in total and per head) in the East Midlands during 2012/13 was some way below the average for England, Scotland, Wales and Northern Ireland.

5.5 Table 1 below shows total spending overall per region, ranked from lowest to highest spend. The East Midlands recorded the second lowest level of expenditure. Only the North East spent less. Table 2 shows that 2012-13 spending per head on health in the East Midlands was £1,850 (96%) against £1,912 England wide (99%), and £1,937 for the UK (100%).

Table 1: Total Spending per Region (2012/13)

Region	£million
North East	5,595
East Midlands	8,451
South West	9,628
East	10,260
Yorkshire and the Humber	10,483
West Midlands	10,932
North West	15,066
South East	15,107
London	16,772

Table 2: Spending per Head of the Population (2012/13)

2012 - 2013	£ Health/ head	Health/head, indexed
North East	2,150	111
North West	2,127	110
Yorkshire and the Humber	1,972	102
East Midlands	1,850	96
West Midlands	1,937	100
East	1,737	90
London	2,019	104
South East	1,731	89
South West	1,803	93
England	1,912	99
Scotland	2,115	109
Wales	1,954	101
Northern Ireland	2,109	109
UK identifiable expenditure	1,937	100

5.6 Again, the East Midlands appears to be losing out. Spending per head was higher in North East, North West, Yorkshire and the Humber, West Midlands and London. It was also higher England-wide and in Scotland, Wales and Northern Ireland. Only the East of England, South East, and South West received lower levels of spend per head.

5.7 In 2014/15, £79.1bn was allocated to individual commissioners through a funding formula:

- NHS England allocated £64.3bn (81% of the total) to 211 CCGs to commission hospital, community and mental health services.
- NHS England allocated £12bn (15% of the total) to its 25 area teams to commission primary care.
- The Department of Health allocated £2.8bn (4% of the total) to 152 local councils to commission pubic health services, e.g. smoking cessation programmes.

5.8 Not included is funding that NHS England manages centrally or separate administrative funding to CCGs and NHS area teams.

a) Funding for Clinical Commissioning Groups

5.9 Funding allocated to Clinical Commissioning Groups (CCGs) can be considered at a more local level. In 2015/16, CCG Programme Budget Baseline Allocations show that:

- Allocations per head for the East Midlands in 2014/15 are lower than the England average.
- A similar disparity will continue through to 2015/16.

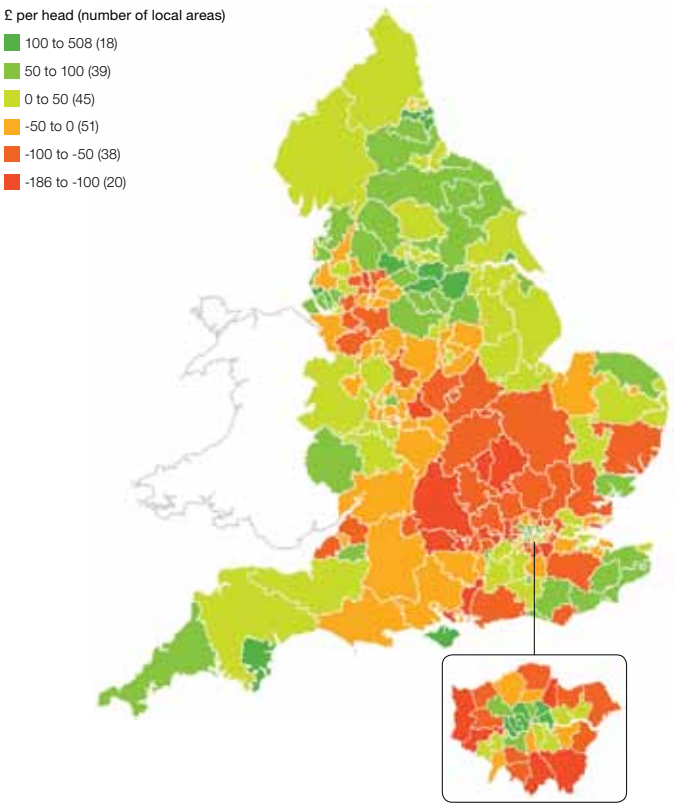
5.10 Target allocations are calculated to give those local areas with greater healthcare needs a larger share of the available funding (their fair share). The allocations also aim to contribute to a reduction in health inequalities. In its recent report, 'Funding Healthcare: Making Allocations to Local Areas', the National Audit Office concluded that:

- There is wide variation in the extent to which £79 billion in central funding allocated to local health bodies differs from target allocations that are based on relative need.
- In 2014/15 for England overall, over three-quarters of local authorities, and nearly two-fifths of clinical commissioning groups, are more than 5% above or below their target funding allocations.
- There is a clear relationship between the financial position of CCGs and their distance from their target allocations. Specifically, the 20 clinical commissioning groups with the tightest financial positions received, on average, 5% less than their target funding allocation. Of these 20 CCGs, 19 received less than their target allocation. Of the 20 CCGs with the largest surpluses, 18 had received more than their target allocation.
- The Department and NHS England decide current funding allocations without fully considering the combined effect on local areas.
- NHS England has limited assurance around some key data underpinning the allocations. In particular, GP list data, which is used to estimate local population numbers, may not be accurate where there are transient populations or high inward migration.

5.11 The maps below show that 18 local areas received at least £100 more per person than their target funding allocation, of which none were in the East Midlands; and 20 CCGs (including Corby, in the East Midlands) received at least £100 per person less than their target funding allocation. From 2014/15 the Department and NHS England introduced new approaches to assessing need in calculating allocations for clinical commissioning groups which use more detailed data than the approach used in previous years, but an unacceptable number of CCGs remain too far removed from their target allocations.

Aggregated distances from target funding allocations for healthcare by local area, 2013-14

Eighteen local areas received at least £100 more per person than their target funding allocation, while 20 received at least £100 per person less



Source: National Audit Office analysis of Department of Health, NHS England and Office for National Statistics data

Region	£million
	£ per person
North Derbyshire	£88
Bassetlaw	£71
South West Lincolnshire	£48
Hardwick	£28
Lincolnshire East	£27
South Lincolnshire	£24
Lincolnshire West	£18
Nottingham City	£0
Mansfield and Ashfield	-£18
Newark and Sherwood	-£20
Rushcliffe	-£23
Nottingham West	-£31
Nottingham North and East	-£34
Erewash	-£44
West Leicestershire	-£67
Leicester City	-£82
East Leicestershire and Rutland	-£87
Nene	-£88
Milton Keynes	-£110
Corby	-£186

5.12 In the East Midlands:

- CCGs which make up the Leicestershire & Lincolnshire Area Team are collectively expected to be -2.40% below their target allocations in 2014/15, and this pattern will continue into 2015/16 unless a new approach is adopted.

- In Northamptonshire, NHS Nene CCG is -6.99% below target and NHS Corby CCG, the worst hit, is -11.32% below target, with underfunding of -£186 per person. West London is the most overfunded, with +£508 per head over the target amount.
- The Midlands and East area is further below its target allocation than anywhere else in 2014/15, and will continue to be so in 2015/16.

5.13 The Committee of Public Accounts has challenged NHS England and the Department of Health on these funding disparities, and in particular the:

- Slow progress in moving allocations towards fair shares.
- Lack of coordination across the health allocations and with other government funding streams.
- Failure to engage with the advisory body early when developing the new primary care formula.
- Shortcomings in the population data, which may result in allocations not reflecting the additional needs of areas with high inward migration.
- Lack of evidence on what level of adjustment should be made for health inequalities.
- Decreasing proportion of health spending committed to primary care, despite this being a key factor in addressing inequalities.

5.14 In response, NHS England told the Committee that it planned to move local commissioners to their target allocations more quickly in the future. Recent developments have been positive with a welcome announcement of using part of the additional £1.1bn NHS funding to bring all CCGs to within 5% of their target allocation by 2016/17 whilst also directing funding towards distressed health economies. Specifically, for 2015/16, while every CCG will get real terms budget increase, more of the extra funding is going to under-target areas than had previously been expected. This will have a positive effect on allocations to the East Midlands (on average) since more areas were under- and over-funded.

b) Funding for Local Authorities

5.15 Local authority budgets include a range of resources and funding that could be applied more effectively through greater collaboration with the health sector within a whole place approach to reduce ill health.

Public Health

5.16 The National Audit Office published 'Public Health England's Grant to Local Authorities' in December 2014. Its findings relate to local authority public health spending and outcomes, governance and accountability arrangements, and supporting and advising local authorities.

5.17 On value for money the NAO concludes:
'PHE has made a good start at building effective relationships with local authorities and other stakeholders. By design, PHE has been set up without direct, timely levers to secure the public health outcomes the Department expects, so PHE provides tools and data, support and advice to help local authorities to meet public health objectives. Its ability to influence and support public health outcomes will be tested in future should the grant cease to be ring-fenced. In parts of the system, local authority spending is not fully aligned to areas of concern. There is a difficult balance between localism and PHE's accountability for improving outcomes, and it is too early to conclude yet on whether PHE's support is delivering value for money'. [2]

5.18 The issue this raises about aligning local authority spending to areas of concern is noteworthy. There is an expectation that local authorities will use the tools that PHE has developed to understand their public health needs and spending, yet the NAO's analysis found that spending on different aspects of public health varies significantly between local authorities, noting that this is unsurprising given local autonomy and differing needs and circumstances. In the example quoted, local authorities where alcohol misuse worsened the most between 2010/11 and 2012/13 were spending significantly less on alcohol services in 2013/14.

5.19 The report also notes that poor data quality has at times limited the quality of both PHE's and local authorities' accountability and reporting. 'Delays of up to 5 months in LA's provisional spending data', and the 'flawed quality' of some provisional data on public health spending will not improve the Local Authority case for enhanced freedoms and flexibilities. The recommendations in the NAO's report are directed at PHE, but it is clear that LAs should ensure that they co-operate fully with the work of PHE and CLG to improve the quality of their final spending data if they are to be able to present a robust case for further devolution of powers.

[2] http://www.nao.org.uk/wp-content/uploads/2014/12/Public-health-england's-grant-to-local-authorities.pdf

Adult Social Care

5.20 The bill for health and social care is one of the biggest components of council expenditure. The current arrangements for adult social care are inadequate to meet the demand-led pressures that continue to rise as the population ages. The East Midlands experienced a 10.3% increase in people receiving services in 2012/13, and was only one of two regions that experienced an increase. Capacity and options for further savings are limited; with over £335m savings across the region already secured. The Care Act 2014 requires local authorities to help prevent people developing care needs. This is likely to increase costs further.

5.21 This has a number of implications. For example, the reduction in those receiving home care from local authorities will make it more difficult for the NHS to reduce the length of stay in hospitals – the crisis in A&E waiting times this winter led many commentators to highlight the adverse effect of reducing social care spending. The pressures on adult social care budgets are likely to require larger cuts in other local authority services which will decrease the opportunities to use those services to reduce and prevent ill health.

The Better Care Fund

5.22 A summary of the Better Care Fund is included in the Appendix 2 to this report. The process has been beset by changes which have increasingly led towards the fund being focused on urgent care and acute health savings. Signing off BCF plans is a rolling programme; at 21st January 2015, 6 plans within the region were fully approved; the remaining areas resubmitted on 9th January and the outcome should be known in February 2015.

Other Resources

5.23 Other relevant resources and workstreams include Transformation Funding, Troubled Families, housing capital funding and council borrowing, and health and the economy. The key points are summarised in the table on page 25, which follows the recommendations.

Conclusions

5.24 NHS organisations are experiencing an unprecedented pressure on their budgets. Further savings can be found from improvements in productivity and shifting more 'care services' out of the acute sector. However, if the cost of essential services is to be met, then the new funding must meet the costs of transforming services including effective community-based services, rather than short-term fixes or propping up unsustainable provision.

5.25 With the pressures on public finances, the effective and fair basis for the allocation of healthcare funding becomes ever more important. While health has been one of the protected areas of Government spending, funding has increased by an average of just 1.2% in real terms in the four years to 2014/15. This is exceeded by the cost inflation of many healthcare treatments, and occurs at a time of increasing demand for healthcare services. The challenges for the financial sustainability of the healthcare system are clear.

5.26 The current funding allocations are not only unjust but also mean that the region is unable to tackle the big issues that we know the health and public health systems face. However, this is not just another plea for more money. With the almost limitless potential for acute care to absorb any new money, more important is the need for a new model of collective leadership that can offer better outcomes by applying all measures and funding streams that can have a beneficial effect on health outcomes.

Recommendations

5.27 **Key Recommendation:** The Department of Health should require NHS England to move local commissioners to their target allocations within a maximum of 2 years.

5.28 NHS England and the Department for Health should develop more robust population measures to take account of more turbulent population flows which particularly affect areas with high inward migration or significant seasonal flows.

5.29 The region should take maximum advantage of one-off funding such as the Government's Transformation Programmes.

Funding/Workstream	What are the opportunities?
Transformation Funding There are various funding streams being made available by the government to fund service transformation. Much of the £110m made available so far by DCLG for local authorities has been used to create single management teams and shared services between local authorities. Overall only £5m (4.5%) has been won by East Midlands' local authorities. Only 1 of the 9 successful East Midlands local authority projects have listed a health agency as a partner.	There is considerable opportunity to increase the share of transformation funding available in the region and for joint approaches with CCGs and other health agencies to achieve mutually beneficial objectives.
Troubled Families The revised Troubled Families programme now explicitly includes health outcomes in the criteria for referring families for support but all of the criteria relate to health risk indicators.	The Government has indicated that it would make £200m available as reward funding in the next parliamentary term.
Housing Housing plays an important role in the integration of health and care. Better alignment of existing services and support for people who continue to live in general needs housing is urgently needed, as is a wider range of choices offering housing-with-care.	EMC's 'East Midlands Prospectus for Devolution' calls on Government to devolve full responsibility for housing capital budgets and to relax the rules that prevent councils building much needed housing.
Local Enterprise Partnerships and Health The region is home to a powerful combination of healthcare assets including universities, teaching hospitals, research intensive NHS Trusts, and a strong base for life and bio-sciences start-ups that include BioCity, MediCity, and the Charnwood Biomedical Campus. To put into context the economic significance of the health sector: ▪ There are an estimated 251,000 people employed in the health sector in the East Midlands. ▪ The East Midlands accounts for 8.5% of the England's health sector workforce, accounting for just over 13% of the region's employment. For example, in the Greater Lincolnshire LEP area, it is forecast that the sector will increase its economic value from £1.55bn p.a. to £1.89bn p.a; 60,000 employees to 66,000.	Specific focus should be on securing better engagement between the health sector and Local Enterprise Partnerships (LEPs). This brings the potential to stimulate research, to improve the 'attractiveness' of the region to all clinicians and address the current shortages in primary and secondary care, with the aim of developing the East Midlands as a great place to study and remain. Better engagement between the health sector and LEPs will: ▪ Build a culture of partnership and innovation. ▪ Speed up the adoption of innovation into practice to improve product development and clinical outcomes. Increase research participations and translate research into practice – making the East Midlands an attractive and cost effective provider of clinical research study delivery

6 Recruitment and Retention of the Health Workforce

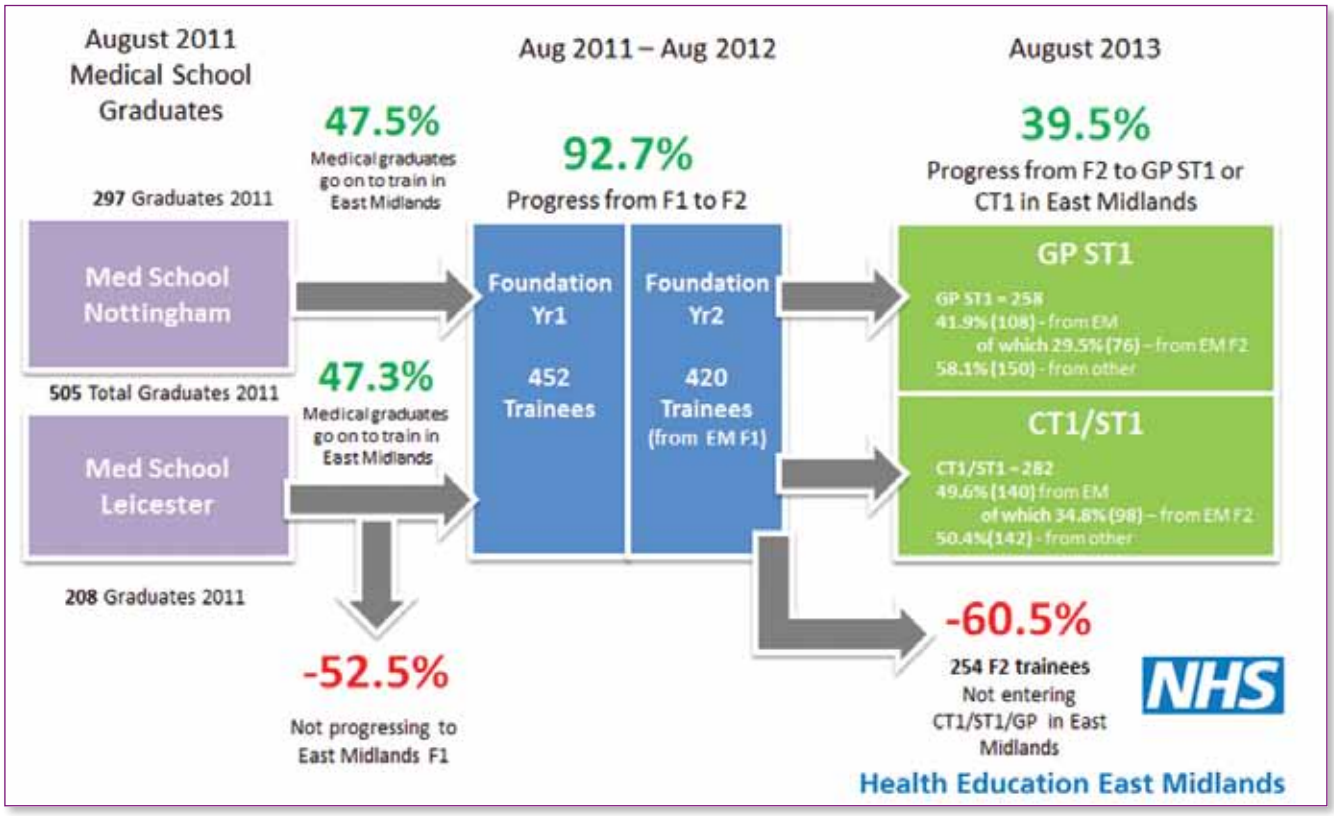
Unless this region addresses the problems in healthcare recruitment and retention, then with the numbers of GPs and nurses either leaving or set to retire in the next few years, it will face a crises in primary care.

6.1 The country has an ageing population. In the East Midlands, the demographic pressures are likely to be particularly acute with a higher proportion of elderly population than nationally. Between 2012 and 2022, the East Midlands population aged 75-79 is projected to increase by 46%; and those aged 90+ by 57%. The positives of people living longer bring increased health care needs and costs.

6.2 The implications of a disproportionately ageing population are clear - the health workforce must have the capacity and skills to effectively manage an increase both in demand, and in the complexity of that demand due to a rise in the number of patients with multiple health needs. Currently, about 15m people in England have a long-term condition. By 2025, the number of people with at least one long-term condition will rise to 18m (The Kings Fund, 2013). However, fewer newly qualified doctors are choosing to become geriatricians, at the very time when increasing lifespans mean that more are needed.

6.3 The Royal College of GPs in 2013 estimated that by 2021 there could be 16,000 fewer GPs than are needed, while the Royal College of Nursing has forecast a shortfall of 47,500 nurses by 2016 and 100,000 by 2022, as more nurses retire, or go abroad to work, and fewer nurses start training. These are the 'big' nationwide headlines but regionally the situation is stark.

6.4 A report by the Royal College of Physicians found that there is a large variation in the number of consultant physicians per head of population across the country. Patients in London have almost double the number of consultants as patients in the East Midlands, and this region has the joint lowest numbers of consultants per head of the population than anywhere in the country.



"Given the association between senior hospital doctors and lower hospital mortality, such disparity across the country is concerning. There is a worrying correlation between hospital consultant staffing levels and hospital standardised mortality ratios…. This suggests that London has the right staffing levels and that the rest of the country needs to catch up." [3]

6.5 The region, with its two well-regarded medical schools, is a major centre for training - but medical graduates all too frequently leave once qualified. Of the 505 students who graduated from the medical schools in Nottingham and Leicester in August 2011, 53% moved out of the region for their foundation training over the next two years; and by August 2013, 61% were in further training positions outside the region. This inability to retain medical graduates from the region's medical schools means a significant loss of expertise and capacity at every stage of training and career progression; making it one of the least popular target destinations for all types of medical training specialisms.

6.6 Part of the problem is down to 'intake' – the region's medical schools generally draw students from outside the region who are therefore inclined to return home after graduation. Many will not 'put down roots' while here, as a central location with good transport links mean that many find it easy to return home at weekends during study. Alongside this, there are academic/professional concerns which are being addressed. The East Midlands is not seen as a prestigious training or working environment, and is considered to have limited opportunities, because of a lack of awareness of what the region has to offer. It is considered to be less competitive compared to other regions with a variable standard of educational experience across the region. There is also an awareness of the impact of service pressures affecting time for teaching/learning.

6.7 Recent data and analysis provided by Health Education East Midlands (HEEM) demonstrates the significant challenges filling GP training vacancies in this region, of which over 30% remained unfilled last year, against a 99% fill rate in London and a UK average of 90%. Nevertheless, steady expansion of GP numbers is planned with a national target of 3,250 by 2015, and a regional target of 280. In 2014, the target was 262, however, of those almost a third were unfilled.

6.8 There are similar concerns about recruitment and retention throughout the health system. For example, the East Midlands has one of the lowest levels in England of full time equivalent qualified, contracted nurses per head of population (5.21 nurses per 1,000 population compared to an England average of 5.58). [4]

6.9 This problem remains, despite the best efforts of HEEM and others to improve recruitment and retention that include promoting the postgraduate medical specialty schools; championing the development of quality improvement skills in the East Midlands workforce; improving foundation training and increasing places in local communities; providing additional support and early intervention to help trainees achieve their potential, including international graduates adapting to British systems; and developing high quality educational fellowships.

6.10 However, in support of these measures, there are wider initiatives that could be implemented. If more health professionals are needed in the East Midlands – then more must be done to attract them to the region. There is a need to better market the opportunities and 'offer' of this region – and there are clear benefits; not just for better health outcomes but also in terms of economic value added, of skilled health professionals and their families coming into a local area.

6.11 One of the key findings of recent reviews of students and young doctors was the lack of knowledge about the East Midlands. Many medical students and qualified health professionals either do not know what this region has to offer or have misconceived ideas about its lack of offer. With effective and targeted marketing of this region, particularly in terms of leisure, culture, housing, improving transport accessibility, career prospects and wider quality of life, the East Midlands becomes more attractive to both medical students and trained health professionals. This is not just an issue for health sector partners – but requires the leadership of LEPs, local councils, wider East Midlands' wide organisations such as the Academic Health Science Network and destination management partnerships.

[3] 'Hospital Workforce; Fit for the Future?', Royal College of Physicians, March 2013

[4] Source: Health Education England, 2014.

6.12 Part of the approach also lies in making local communities more 'welcoming' to medical students and professionals. Not all are highly paid clinicians, and medical schools have indicated that a 'package' developed around medical students would make many areas of the East Midlands more attractive to student placements. In particular, in response to a specific community issue, i.e. a shortage of local health practitioners, local partners could offer transport and leisure discounts, or a wider package of measures designed to both attract and retain students and staff. This encouragement to interact and integrate into local communities would help young health professionals to put down roots in the region and help them to see the value in their individual contribution to the health of the local population, which is known to motivate career choice.

Conclusion

6.13 The problems of recruitment and retention of healthcare professionals are a fundamental obstacle in addressing the health priorities for this region. The problem is particularly acute for primary care; the numbers of GPs per head of the population are amongst the lowest in the country and the East Midlands has the lowest successful 'fill rate' for GP posts of any region. This is of particular concern as care is shifting closer to home and good primary care is known to reduce pressure on acute services including A&E.

6.14 Further work is required to encourage doctors to train in the East Midlands; and to ensure that those who do train here, stay here. The sector may learn from what works elsewhere. For example, in Ontario, Canada, preferential treatment is given to local applicants on the basis that local applicants are far more likely to stay in the local area after graduation than those elsewhere, and this is a direct intervention in meeting local need. Alongside this, tied scholarships, such as those operated in Queensland, certainly merit consideration. Whatever approach is favoured, the region needs to better demonstrate good practice – with its strong record of health and research excellence, recruitment and retention will be improve if the region is seen to offer more in the way of career and professional development.

6.15 Improving the recruitment and retention of key healthcare staff is a priority – but the potential to do this is firmly within 'local hands'. This is dependent upon all parts of the East Midlands public sector getting behind efforts to make this region a great place for medics to train and work. As part of this, it is essential that the benefits of training in this region are better publicised. This requires health agencies, local councils and LEPs to better highlight the opportunities in the East Midlands and the benefits of place; both in terms of staying here or re-locating.

6.16 The new plan to expand the general practice workforce announced in January 2015 is welcome, but NHS England and partners should maintain a particular focus on the East Midlands given the issues this report has identified.

Recommendations

6.17 **Key Recommendation:** To improve the recruitment and retention of key healthcare staff all parts of the public sector in the region should collaborate to make this region a great place for medics to train and work – with a priority for an increased number of GPs.

6.18 Local Authorities, LEPs, East Midlands' partnership organisations and HEEM should better promote the benefits of locating within the East Midlands. In developing a more positive profile, partners should effectively showcase both the career benefits of being based within the East Midlands, while LEPs and local councils promote the social and economic, cultural and leisure benefits.

6.19 The health sector, through the leadership of Health Education East Midlands, should be supported to develop and implement incentives to encourage key medical staff to train in the East Midlands; and to ensure that those who do train here, stay here.

7 Collaboration and Leadership

The scale of the challenges that lead to, or are caused by, ill health will not be solved without effective collaboration, a new collective sense of leadership and unity of purpose between the health sector, universities, councils and LEPs. Failure to take action is morally and financially unsound.

7.1 Despite the intent in Government policy, action by central government departments and agencies tends to continue on previous paths of 'initiative-itus' and central control. What is needed, however, is greater collaboration, unity of purpose and a collective sense of leadership at the sub-national level to address the deep-rooted health problems for this region.

7.2 There is a strong case for change:

- Nationally, policy and opinion is moving towards prevention, community and person centred approaches all of which local authorities are best placed to lead.
- Health reforms have moved commissioning to more local agencies (CCGs, NHS Area Teams and Local Authorities) with Health and Wellbeing Boards making good progress towards co-ordinating local health systems.
- Unacceptable health inequalities in the region have existed for many years and successive health regimes have failed to reduce them.
- National approaches have failed to address disparities in the distribution of health professionals.

Local Leadership – A Role beyond the Public Health Grant

7.3 With public health now settled in local government, there is an immediate opportunity for local councils to consider their broader role in improving health and reducing inequalities by applying a whole systems/approach to their public health responsibilities.

7.4 The public health debate needs to move beyond a focus on how the public health grant is spent. In order to make better use of the opportunity of being based in local authorities, public health should prioritise its advocacy and influencing role with other council departments, thus developing a 'whole local government approach' to reducing health inequalities. However, this is likely to require a big change in thinking about how staff are allocated and financial resources used to prioritise health inequalities.

7.5 As a local partner, councils can lead organisations across health, education, social care, the economy and transport in helping them understand the impact on health which they can have. At a policy level, councils can maximise their health impact by applying concepts such as Health in All Policies (HiAP) and toolkits like Health Impact Assessment (HIA).

Integration

7.6 Local government must be given more freedom to lead effective integration in order to take advantage of opportunities for cross-sector working to meet local needs. This would entail moving from a standardised 'one size fits all' approach to one in which procurement of local services is able to reflect the circumstances and needs of each locality. Two facts should give the Government confidence to allow this degree of flexibility; local authorities' track record of consistently balancing their budgets and because Health and Wellbeing Boards, although still relatively new, have made great strides in building relationships and creating mechanisms to bring the health system together at the local level.

7.7 Demographic changes, technological advances and the changing pattern of disease are pushing up the numbers of patients with complex needs who require treatment in the community. There is the opportunity to implement radical reforms that will have real benefit for the health outcomes of local communities while driving down the costs associated with care in the acute sector. This is not about structural reform. With local authorities better placed to take a population health-based approach to designing services, health and social care can be delivered in a more orderly way with the NHS focusing its resources on meeting people's acute healthcare needs, while the 'care' service including mental health care, adult social care and care in the community is locally-led, commissioned and resourced.

7.8 There is a need to redefine the approach to primary care and to build better working relationships – current levels of confidence and trust are not conducive to joint leadership between the health sector and local government. Genuine co-commissioning remains some way off but as an absolute minimum, collaborative work and leadership should be consolidated through the full alignment of commissioning that will support the move from individual schemes (e.g. BCF) to more joint commissioning and ultimately to full integration and a co-commissioned model.

Collective Leadership on Health

7.9 The General Election will come at a pivotal time for health and social care; financial pressures are set to increase further as the costs of treatment continue to rise through in an increasing and ageing population – alongside increasing public expectations of levels of care. All this is set alongside substantial reductions in local council budgets which have led to significant cuts in adult social care.

7.10 At a time when operational pressures risk crowding out other concerns (the current A&E winter crisis is a good example), the need for confident leadership in articulating a clear and compelling vision has never been more important. Politicians, both at the national and local level, need to be honest with the public about the scale of these challenges; it is not solely how to provide adequate levels of funding to meet future demand for health and social care – but it is also how to reform decision-making and resource allocation in order to unlock better outcomes at reduced cost.

7.11 There currently does not exist any forum where the regional decision makers are able to come together to address key health priorities. There are sector partnerships, but these are inevitably limited in scope. If the important issues are to be addressed through health and the wider public and private sector, then bringing together key decision makers from all sectors to jointly consider the priorities and agreed approach is the only way forward.

7.12 This work should build upon the East Midlands' strong reputation for engagement and collaboration. [5] This exists in some parts of the healthcare profession – but is lacking elsewhere, particularly between sectors. Brokered in partnership with organisations including East Midlands Leadership Academy, and Academic Health Science Network, a leadership summit is needed to bring together leaders from the NHS, universities, LEPs, industry, the VCS and local councils to develop strong and powerful partnerships in order to drive improvements in healthcare across our region. Particularly important is the way in which leaders are supported and developed to work effectively across organisational and geographical boundaries, with the ability to influence and join-up services where necessary.

7.13 Health and Wellbeing Boards must continue to be at the forefront of reform with local areas having the responsibility for developing their own priorities for improving health and wellbeing and putting in place a range of support, services and information to meet their population's needs. The collective weight of GPs, local government and health partners gives Boards added value and should enable them to begin to set the agenda for integrated care locally. However, to meet this responsibility, the leadership and capacity of these boards must continue to be genuinely 'geared up'.

A New Model of Local Leadership

7.14 A new approach to NHS reform is needed where the Government devolves more power and accountability to local councils and the NHS organisations responsible for delivering care. The role of Westminster politicians should be strategic; making decisions about funding, setting the direction of policy and being accountable to Parliament for the performance of the NHS as a whole – leaving leaders in local government and the health sector to improve the focus and quality of services and develop new models of care against local priorities. *The NHS Five Year Forward View (October 2014)* setting the new way of working is illustrative of the challenge - and the need for councils to be seen as a genuine and full partner - as it contains little reference to social care and local government.

[5] As evidenced by a number of partnerships within health; e.g. Health Education East Midlands, East Midlands Leadership Academy, East Midlands Academic Health Science Network, East Midlands Strategic Clinical Senate, Collaboration for Leadership in Applied Health Research and Care East Midlands.

7.15 A new model of leadership will involve NHS England Area Teams having the freedom to direct resources in a more innovative way that involves varying the national model of 'expected outcomes' with the use of funding against actual local priorities. This would require support from Department of Health/NHS as local partners and delivery should not be held to account in the same way as before – rather local leadership would be accountable against the outcomes agreed through local political negotiation and agreement.

7.16 Alongside this, public health budgets should no longer be ring-fenced with the understanding that local authorities will take a whole place approach to reducing ill health using all the levers that have been referred to in this report so that the overall impact on health outcomes will be much greater than the impact of public health spending alone.

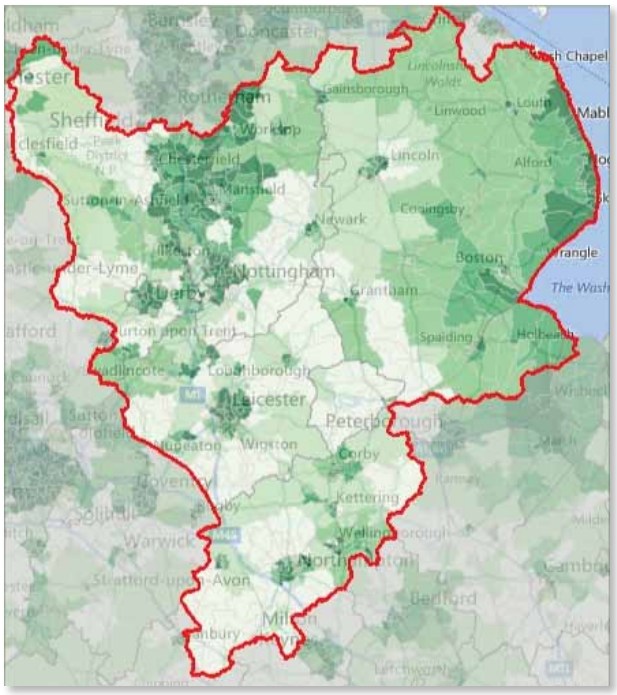
Recommendations

7.17 **Key Recommendation:** Council and NHS leaders should together develop a new model of collective leadership to improve health outcomes which requires:

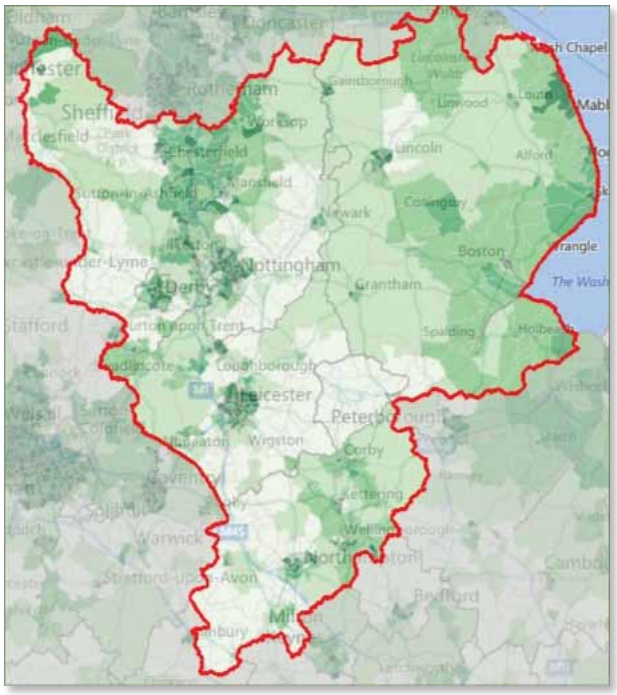
- Greater local autonomy for policy setting and integration of funding.
- A collaborative approach with other parts of the public sector including police, universities and LEPs.
- Working towards a fully integrated whole place/whole system approach backed by place-based budgets for the prevention and treatment of ill health.

8 Appendix 1: Health Profile

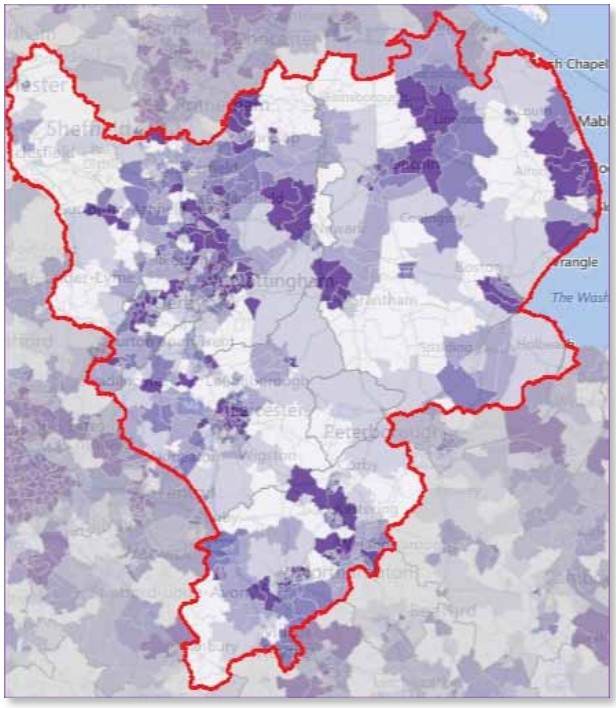
% aged 0-15 living in income deprived households, 2010 - source: DCLG



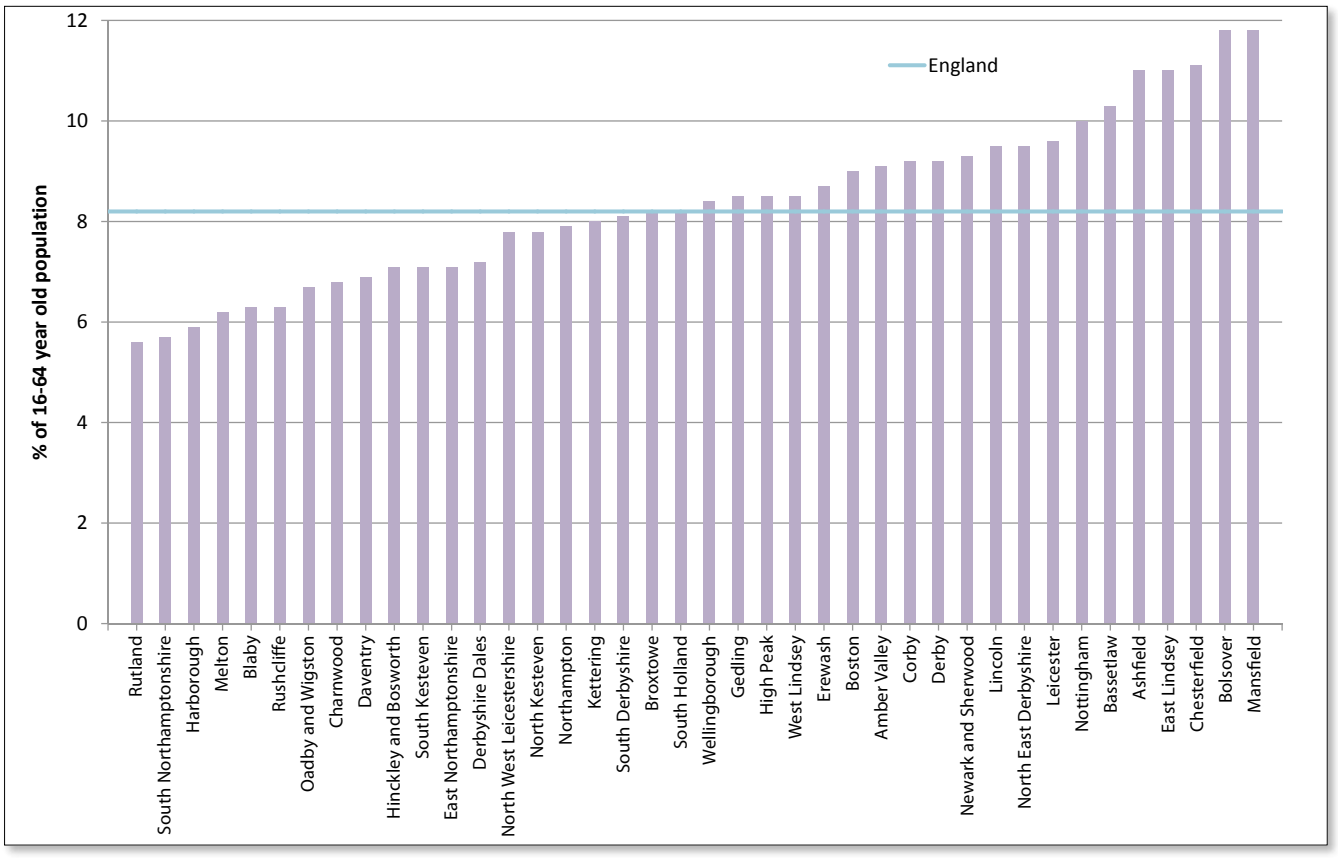
% of people who live in pension credit Affecting Older People Index, 2010 – source: DCLG



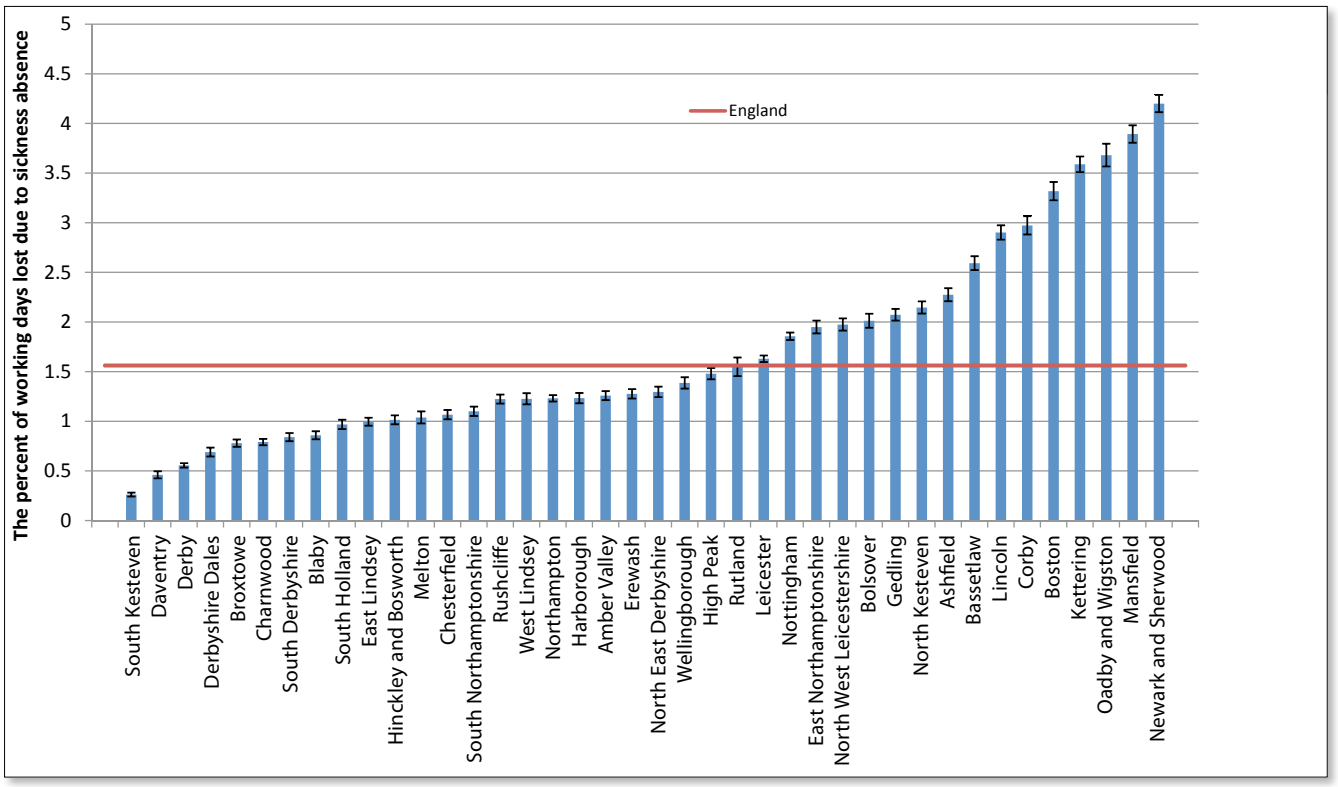
Births with birth weight less than 2,500g as a proportion of live and still births with valid weight, 2008-2012 – source: ONS



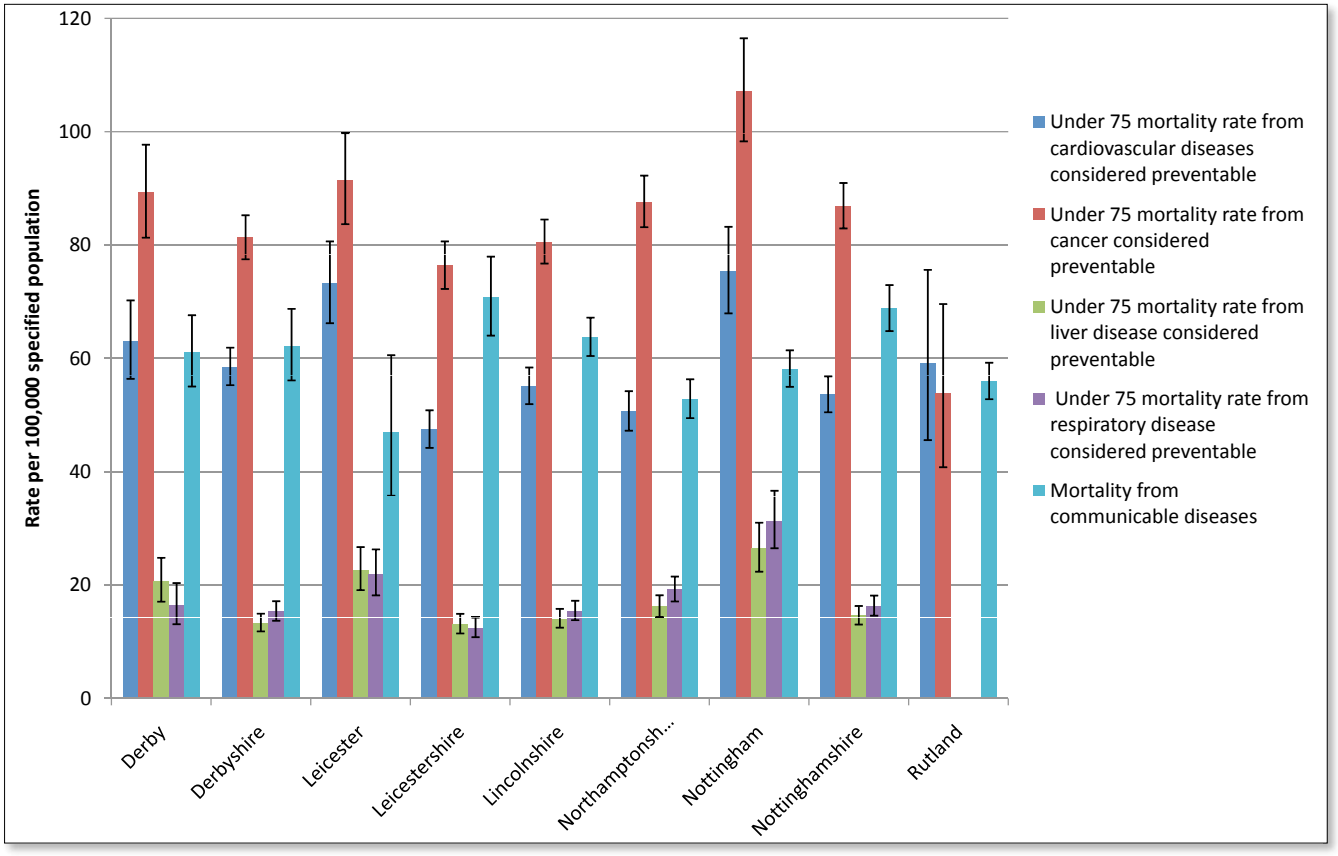
Proportion of the population aged 16-64 that reported day-to-day activities were limited, 2011. Source: NOMIS Census 2011



The percentage of working days lost due to sickness absence by local authority, 2010-2012. Source: Public Health Outcomes Framework (PHOF)



The rates of under 75 mortality from preventable causes (CVD, cancer, liver and respiratory disease) and overall mortality from communicable disease, 2010-2012. Source: Public Health Outcomes Framework (PHOF)



Tables: Public Health Outcomes Framework (PHOF); Overarching Indicators and Wider Determinants

Indicator	Period	England	East Midlands	Derby	Derbyshire	Leicester	Leicestershire	Lincolnshire	Northamptonshire	Nottingham	Nottinghamshire	Rutland
0.1i - Healthy life expectancy at birth (Male)	2010 - 12	63.4	63.2	62.1	64.3	57.4	64.9	64.6	65.0	58.7	61.1	65.8
0.1i - Healthy life expectancy at birth (Female)	2010 - 12	64.1	63.6	59.7	63.6	57.3	66.7	64.6	65.0	58.8	63.2	70.3
0.1ii - Life Expectancy at birth (Male)	2010 - 12	79.2	79.1	78.6	79.3	77.0	80.1	79.1	79.1	76.9	79.3	81.0
0.1ii - Life Expectancy at birth (Female)	2010 - 12	83.0	82.9	82.8	83.1	81.8	84.0	82.9	82.7	81.5	82.8	84.7
0.1ii - Life Expectancy at 65 (Male)	2010 - 12	18.6	18.3	18.2	18.3	17.3	18.9	18.6	18.4	16.8	18.2	20.1
0.1ii - Life Expectancy at 65 (Female)	2010 - 12	21.1	21.0	21.3	20.9	20.3	21.8	21.1	20.8	20.5	20.8	22.0
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Male)	2010 - 12	0.0	-0.1	-0.8	0.1	-2.2	0.9	-0.1	-0.1	-2.3	0.1	1.8
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Female)	2010 - 12	0.0	-0.1	-0.2	0.1	-1.2	1.0	-0.1	-0.3	-1.5	-0.2	1.7

Indicator	Period	England	East Midlands	Derby	Derbyshire	Leicester	Leicestershire	Lincolnshire	Northamptonshire	Nottingham	Nottinghamshire	Rutland
1.01i - Children in poverty (all dependent children under 20)	2011	20.1	18.4	23.7	16.4	30.0	11.6	16.5	15.8	34.4	17.0	8.0
1.01ii - Children in poverty (under 16s)	2011	20.6	19.1	24.3	17.1	30.0	12.1	17.2	16.6	35.2	17.7	8.4
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception	2012/13	51.7	49.8	40.9	49.6	27.7	46.3	65.4	49.6	39.9	56.6	57.3
1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2012/13	36.2	32.1	27.6	31.7	20.7	24.7	47.4	33.3	27.9	37.1	25.0
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2012/13	69.1	68.4	59.0	65.9	66.9	73.8	76.5	67.7	62.6	66.5	71.8
1.02ii - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2012/13	55.8	52.6	44.5	50.3	57.6	56.3	61.2	51.6	50.6	49.4	53.7
1.03 - Pupil absence	2012/13	5.26	5.35	5.47	5.20	5.15	5.10	5.43	5.40	6.04	5.47	4.36
1.04 - First time entrants to the youth justice system	2013	441	458	543	350	760	391	418	469	847	362	241
1.05 - 16-18 year olds not in education employment or training	2013	5.3	4.8	7.5	4.8	6.7	3.4	4.4	5.7	6.3	3.1	1.8
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Persons)	2012/13	73.5	72.3	74.7	77.4	71.8	61.6	74.5	72.5	66.6	73.7	72.3
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Male)	2012/13	73.2	72.5	76.5	77.4	70.1	61.1	74.4	73.5	69.6	73.5	73.7
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Female)	2012/13	74.0	72.1	72.2	77.3	74.3	62.4	74.7	71.0	62.3	74.1	70.4
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons)	2012/13	58.5	54.4	87.5	87.8	31.5	42.8	12.8	74.8	18.4	22.5	27.8
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Male)	2012/13	57.3	51.3	85.6	86.0	31.2	46.1	11.4	71.9	16.8	21.0	26.8
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Female)	2012/13	59.8	58.0	89.4	89.6	32.0	39.3	14.4	77.7	21.3	24.6	29.3
1.07 - People in prison who have a mental illness or a significant mental illness	2012/13	4.35	-	-	-	-	-	-	-	-	-	-
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2012	7.1	5.9	5.5	4.3	8.1	4.1	6.3	6.5	6.1	6.9	-5.3
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2013/14	65.1	67.2	64.7	71.6	53.5	70.7	69.5	73.6	58.5	64.1	66.0
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2012/13	62.3	62.8	60.7	59.3	58.9	66.4	67.8	64.4	57.0	67.8	67.3

Indicator	Period	England	East Midlands	Derby	Derbyshire	Leicester	Leicestershire	Lincolnshire	Northamptonshire	Nottingham	Nottinghamshire	Rutland
1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week	2010 - 12	2.5	2.6	0.8	2.3	2.6	2.1	2.5	2.7	3.4	3.3	3.1
1.09ii - Sickness absence - The percent of working days lost due to sickness absence	2010 - 12	1.6	1.6	0.6	1.2	1.6	1.3	1.6	1.7	1.9	2.4	1.5
1.10 - Killed and seriously injured (KSI) casualties on England's roads	2011 - 13	39.7	44.7	33.1	41.6	27.7	31.4	61.5	46.8	43.7	52.4	52.2
1.11 - Domestic Abuse	2012/13	16.6	20.9	21.9	21.9	22.3	22.3	17.3	16.0	24.3	24.3	22.3
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2010/11 - 12/13	57.6	47.0	81.5	43.8	56.1	27.7	53.4	41.7	71.2	43.2	29.3
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	2013/14	11.1	10.2	14.1	7.3	17.1	7.6	7.8	10.5	19.9	9.4	5.6
1.12iii- Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	2013/14	1.01	0.89	1.26	0.66	1.51	0.72	0.85	0.99	1.31	0.70	0.36
1.13i - Re-offending levels - percentage of offenders who re-offend	2011	26.9	26.0	27.2	23.8	29.1	21.3	25.8	23.7	30.4	27.2	14.4
1.13ii - Re-offending levels - average number of re-offences per offender	2011	0.78	0.73	0.78	0.62	0.91	0.60	0.75	0.65	0.90	0.72	0.31
1.14i - The rate of complaints about noise	2012/13	7.5*	4.9*	3.9*	4.4*	6.8	4.4*	4.9*	7.0*	5.8	3.5*	3.5*
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2011	5.2	3.3	4.6	3.5	4.7	2.5	2.3	3.2	6.3	2.6	0.8
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2011	8.0	5.1	6.1	6.3	6.6	5.1	3.2	5.0	7.7	4.3	1.2
1.15i - Statutory homelessness - homelessness acceptances	2013/14	2.3	1.9	3.0	1.2	0.7	1.6	1.8	2.8	3.5	1.4	1.7
1.15ii - Statutory homelessness - households in temporary accommodation	2013/14	2.6	0.4	0.3	0.2	0.5	0.3	0.3	0.6	0.7	0.3	0.2
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2013 - Feb 2014	17.1	15.5	11.1	13.3	12.0	16.7	10.7	22.2	7.8	16.9	*
1.17 - Fuel Poverty	2012	10.4	13.2	16.0	12.8	21.3	11.3	12.2	11.2	18.4	12.1	11.9
1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like	2012/13	43.2	39.7	45.9	34.6	38.6	40.8*	37.4	41.9	37.4	40.4	44.6*
1.18ii - Social Isolation: % of adult carers who have as much social contact as they would like	2012/13	41.3	37.6	36.9	44.7	32.0	40.6	37.1	33.2	38.4	32.1	46.5*

9 Appendix 2: The Better Care Fund

Local government and health partners have worked hard on agreeing and concluding the Better Care Fund negotiations. This has been a difficult process made more so as it kept changing.

The £3.8 billion Better Care Fund (BCF) was announced by the Government in the June 2013 Spending Round, to support transformation and integration of health and social care services to ensure local people receive better care. [i] BCF was introduced as:

'A single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities… with the aim of delivering better, more joined-up services to older and disabled people, to keep them out of hospital and to avoid long hospital stays'

Local authorities across England received £200 million in 2014/15 from the Department of Health to prepare for the first full year of the Fund in 2015/16. The Fund consists of existing funding, with no new money except a small proportion allocated in support of early work on the implementation of the Care Act (£135m nationally).

The minimum amount to be pooled for the Better Care Fund is £3.8bn. In the 2013 spending round the planning assumption was that £1bn savings would be realised from the implementation of the BCF in 2015/16.

This has been a complex and difficult process to implement especially as the framework for the BCF has been subject to multiple policy changes and changing benefits assumptions over the course of 2014/15.

A report from the National Audit Office, 'Planning for the Better Care Fund' has reviewed the process to date. It reports that the initial BCF plans submitted in April 2014 did not meet ministers' expectations or offer the level of savings expected. Also the level of engagement with acute provider trusts was found to be variable, and in some areas did not provide sufficient assurance that plans had been locally agreed.

Local areas said in their April 2014 plans they would save £731m; but NHS England estimated that the same plans would only generate £55m of credible annual savings from the Fund. Local areas were instructed to submit revised plans based upon stronger evidence by September within the following framework:

- The introduction of pay for performance scheme linked to achieving a reduction in total emergency admissions of 3.5%.
- £1 billion of the NHS additional contribution to the BCF had to be commissioned by the NHS on out of hospital services or be linked to the corresponding reduction in total emergency admissions.

In their September 2014 plans local areas proposed savings of £532m in 2015/16, of which £314 million would be saved for the NHS from fewer emergency admissions to hospitals and fewer delayed transfers from hospitals.

In November 2014,[ii] the NAO report found that the Better Care Fund will not deliver even a third of the planned £1bn savings as early preparations were 'inadequate' and 'did not match the scale of the ambition'.

'The Better Care Fund is an innovative idea but the quality of early preparation and planning did not match the scale of the ambition. The £1 billion financial savings assumption was ignored, the early programme management was inadequate, and the changes to the programme design undermined the timely delivery of local plans and local government's confidence in the Fund's value…….To offer value for money, the Departments need to ensure more effective support to local areas, better joint working between health bodies and local government, and improved evidence on effectiveness.'

Amyas Morse, head of the National Audit Office.

The changes introduced during this summer risk undermining the Fund's core purpose of promoting locally led integrated care, and reduce the resources available to protect social care and prevention initiatives. Both the LGA and the Association of Directors of Adult Social Services are concerned that linking only NHS emergency admissions to payment for performance undermines the programme's aim of integrating health and social care better to improve outcomes for service users.

[i] HM Treasury, Spending Round 2013, June 2013, available at: https://www.gov.uk/government/publications/spending-round-2013-documents

[ii] Planning for the Better Care Fund

The East Midlands Position

As noted above, revised BCF plans were submitted by 19th September and subsequently went through a Nationally Consistent Assurance Review (NCAR) process. The outcome of the NCAR categorised plans into one of four assurance categories: approved, approved with support, approved subject to conditions, or not approved.

Plan Approvals: Comparison of Plans

Status	England-wide	East Midlands	Common issues driving status
Approved	6	1	High quality plans where any actions were easy to resolve and delivery risk was low. Plans were well articulated.
Approved with Support	91	5	Outstanding actions but could be resolved in a relatively straightforward way
Approved with Conditions	49	2	Material actions that need to be addressed that will take some effort to resolve. Material outstanding risks relating to the National Conditions or non-elective targets.
Not Approved	5	1	Plan not submitted Plans not jointly owned. Plan of poor quality.

Signing off BCF plans became a rolling programme as areas in the 'approved subject to conditions' and 'not approved' categories resubmitted updated plans. By the end of December 2014 6 plans within the region were fully approved. The remaining areas resubmitted on 9th January and the outcome should be known in February.

Area	NCAR Outcome	January 2015
Derby City	Approved with Conditions	Should be confirmed early Feb 2015
Derbyshire	Approved with Support	Approved
Leicester City	Approved with Support	Approved
Leicestershire	Approved with Support	Approved
Lincolnshire	Approved with Conditions	Should be confirmed early Feb 2015
Northamptonshire	Not Approved	Should be confirmed early Feb 2015
Nottingham City	Approved	Approved
Nottinghamshire	Approved with Support	Approved
Rutland	Approved with Support	Approved

10 Appendix 3: Good Practice Examples

Meeting Accommodation Needs - Good practice case study:

Mansfield District Council Hospital Discharge Scheme Pilot

Mansfield District Council is working in collaboration with Adult Social Care and Health to secure early intervention and discharge from hospital and residential care. The Council's Housing Needs staff work alongside colleagues at Kings Mill Hospital and help speed up discharge of medically fit patients. During the initial 8 week period the pilot secured appropriate outcomes for over 40 cases. The scheme formally commenced in October 2014 and will run to the end of March 2015. The support provided by the Council includes:

- Locating alternative suitable accommodation across the rented sector
- Providing key safe installation and minor adaptations
- Installing lifeline and telecare
- Prioritising existing adapted accommodation to meet the needs of those requiring discharge
- Providing temporary accommodation to facilitate discharge
- Provide specialist support for those with complex needs
- Signposting and arranging for appropriate support to be delivered to meet individual need and improve health and wellbeing
- Treating all hospital and residential care discharges as a priority
- Developing a 24/7 supported assessment unit
- Supporting the A&E Department engaging with those who have a social need and freeing up hospital staff to deal with medical emergencies, including a weekend pilot to build resilience against winter pressures.

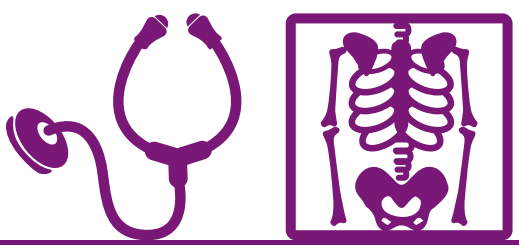
The Light Bulb Project in Leicestershire

The Leicestershire Light Bulb Project is part of a wider approach of reducing health inequalities by tackling the wider determinants of health. Public health has had a key partner role as part of the Better Care Fund (BCF), working with district councils, adult social care, and health and voluntary organisations to develop an evidence based approach.

The Light Bulb Project is an innovative project that will enable and empower people to remain independently at home by delivering integrated practical housing support. This will be through a single, trusted and easily accessible service that is tenure neutral, income generating, stigma free and shaped around a person's needs – not an organisation's threshold or capacity.

The project brings together housing support budgets across Leicestershire's seven district and county councils to provide a range of services including home adaptations, disabled facilities grants, affordable warmth, home safety, housing based support, handy person services, assessments, aids and equipment assistive technology.

It will improve system efficiency, quality, access and reduce avoidable hospital admissions (especially due to home injuries), hospital bed days and falls. In providing a 'proportionate universal' service, it is available to local people, regardless of tenure or levels of income although people not eligible for publicly funded housing support would be able to pay for services, thus contributing towards the on-costs of the organisation.



Cost Rationale The Light Bulb Project is developed on evidence that housing adaption is a cost effective intervention for health and social care, with the NHS spending £2.5bn a year on illness due to poor housing, £146m treating accidental home injuries in children and young people, and £2bn on falls and fractures in over-65s.

Specifically for this project, the National Institute for Health and Care Excellence has also estimated that offering home safety assessments to families with young children and installing safety equipment in the most at risk homes would cost £42,000 per average local authority. If this prevented 10 per cent of injuries, it could save £80,000 in prevented hospital admissions and emergency visits, with further savings in associated GP visits and for ambulance, police and fire services.

Effective use of public health's partner role, such as the Light Bulb Project, will therefore deliver significant overall health and wellbeing outcomes to the Leicestershire population, while supporting a reduction in health inequalities across the county. A phased rollout is due to start in April 2015/16.

Health and Care in Greater Lincolnshire - The Way Forward 2014

Greater Lincolnshire Local Enterprise Partnership (LEP) is committed to championing a world-class health and care sector in Greater Lincolnshire which is strong and vibrant, and based on innovative and collaborative partnerships. Lincolnshire's Director of Public Health is a member of Greater Lincolnshire LEP's Board and has led the preparation of a strategy for growing the economic value of the health and social care sectors: Health and Care in Greater Lincolnshire - The Way Forward 2014.

The LEP wants to see the Health and Care Sector as being a vibrant sector that offers great places in which to work and have a career, and which provide the right environment for local research, innovation, technology and service provision that leads to economic growth.

http://www.greaterlincolnshirelep.co.uk/assets/downloads/285_GLLEP_Care_Sector_Brochure.pdf

11 Appendix 4: Wider Health Partners

NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC East Midlands)

It is one of 13 regional CLAHRC partnerships funded by the National Institute for Health Research (NIHR).

It works with more than fifty local partners from universities, the NHS, industry and the public to improve health outcomes across the region: delivering and implementing world class health research to ensure healthier and longer lives for East Midlands' residents.

East Midlands Academic Health Science Network (EMAHSN)

It is one of 15 regional Academic Health Science Networks around the country.

It was set up by NHS England in 2013 and its remit is to identify and spread innovation at pace and scale: bringing together the NHS, universities, industry and social care to transform the health of the 4.5m East Midlands residents and stimulate wealth creation.

Health Education East Midlands (HEEM)

It works as part of NHS Health Education England (HEE) and its goal is to develop a high quality, safe and sustainable workforce with the best possible education and training for students, trainees and staff.

It acts as a 'convenor' of the East Midlands health system: bringing people together across NHS, social care and the third sector: working on large scale change, championing education and training as a lever for improvement and acting as an exemplar for workforce best practice and innovation.

East Midlands Leadership Academy

It serves the leadership and development needs of all NHS organisations in the East Midlands, and also provides the regional home for co-ordination of national leadership activity and government priorities.

It promotes and delivers senior development across the region: building leadership capacity and capability in all of its member organisations by designing, commissioning and delivering high quality leadership development interventions and activity.

East Midlands Strategic Clinical Networks (EM SCNs)

It supports improvement in the quality and equity of care and outcomes of the East Midlands population with a focus on cancer, mental health, children's and maternity services and cardio-vascular disease.

It brings together those who use, provide and commission the service to make improvements in outcomes for complex patient pathways using a 'whole system' approach: supporting decision making and strategic planning, and working across the boundaries of commissioner, provider and voluntary organisations as a vehicle for improvement for patients, carers and the public.

East Midlands Strategic Clinical Senate (EM Senate)

It plays a unique role in the commissioning system by providing strategic clinical advice and leadership across the East Midlands to clinical commissioning groups (CCGs), health and wellbeing boards and the Area Team of NHS England.

It provides multi-disciplinary clinical leadership: working with patients and the public to provide independent advice on issues that will transform health care, better integrate services and ensure future clinical configuration of services are based on the considered views of local clinicians, and are in the best interest of patients.

NIHR Clinical Research Network East Midlands (NIHR CRN EM)

It is one of 15 regional CRNs, and provides the infrastructure that supports high quality clinical research to take place, ensuring East Midlands patients benefit from new and better treatments.

It achieves this by helping researchers to set up studies quickly and effectively, supporting the life sciences industry to deliver research programmes, providing health professionals with research training, and working with patients to ensure their needs are placed at the heart of research activity.

NIHR MindTech

It is one of eight NIHR Healthcare Technology Co-operatives in England. Each one concentrates on different areas of unmet need – their focus is mental healthcare and dementia – and they bring together healthcare professionals, researchers, industry and the public.

It achieves this using clinical and technical expertise to build collaboration: developing and testing a range of new technologies, and provides advice and knowledge exchange to help increase their adoption.

Institute of Mental Health

It is the UK's prime location for inter-disciplinary research in the mental health field. A partnership between Nottinghamshire Healthcare NHS Trust and the University of Nottingham, they bring together the healthcare and education sectors to promote research, support clinical practice, provide educational courses and act as an expert resource in promoting best practice.

Since its formation in 2006 they have pioneered education provision and innovative service-facing research that supports their mission: to improve people's lives through innovating, developing, exploiting and distributing knowledge about mental health.

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This document has been printed on recycled paper.

Published February 2015.