PLEASE NOTE THE CHANGE OF VENUE

Visiting/directions to the museum:

New Walk Museum & Art Gallery is approximately ten minutes walk from Leicester City Council and Leicester train station and accessed along the pedestrianized New Walk.

There is a small car park situated next to the museum including two parking bays for Blue Badge holders, though due to demand, availability of parking cannot be guaranteed, particularly on event or concert occasions. On street pay and display parking is also available at the back of the museum.

The nearest major car park is the NCP situated on East Street, next to the Y Theatre.

For more details including local bus information please visit Google Maps.

A map can be found at the following link http://www.leicester.gov.uk/your-council-services/lc/leicester-city-museums/museums/nwm-art-gallery/
AGENDA

1. WELCOME AND APOLOGIES

INFORMAL SESSION

DEVELOPMENT SESSION

WELL LONDON PRESENTATION

2. WORKSHOP DISCUSSION

Presentation on ‘Well London’ by Lord Kamlesh Patel and Gail Findlay FFPH, Director of Health Improvement, Institute for Health and Human Development, University of East London.

FORMAL SESSION

BUSINESS ITEMS

3. MINUTES

The minutes of the meeting held on 29 May 2012 are attached and the Board is asked to approve them as a correct record.

4. MATTERS ARISING

Any matters arising from the minutes of the last meeting not dealt with elsewhere on the agenda.

5. ACTION LOG

The Board is invited to note the Action Log and comment as appropriate.

6. REVIEW OF MEMBERSHIP

To discuss membership issues, particularly the request to join the Shadow Board from the Leicestershire Constabulary. A letter from the Chief Constable is attached.

TRANSITION POLICY AND UPDATES

A) NATIONAL MATTERS

Lead: As appropriate

7. NATIONAL MATTERS

Any updates will be reported to the meeting.
B) REGIONAL MATTERS
Lead: As appropriate

8. REGIONAL MATTERS
Commissioning Board – To note the appointments to the Commissioning Board.

Any updates will be reported to the meeting.

C) LOCAL ORGANISATIONAL UPDATES
Lead: As appropriate

9. PCT CLUSTER
Updates will be reported to the meeting by Catherine Griffiths.

10. LEICESTER CITY CLINICAL COMMISSIONING GROUP
Potential update from CCG’s on their current funding position.

11. LEICESTER CITY COUNCIL
Implications of the Health and Social Care Act
Commissioning Healthwatch

D) GENERAL
Lead: As appropriate

12. GENERAL MATTERS
Any updates will be reported to the meeting.

NEEDS ASSESSMENT AND STRATEGY

13. JOINT STRATEGIC NEEDS ASSESSMENT
To note the publication of the Joint Strategic Needs Assessment (JSNA) at
http://www.oneleicester.com/leicester-partnership/jsna/previous-jsnas/

To receive the initial briefing on Census 2011 – population estimates for Leicester.
14. **JOINT HEALTH AND WELLBEING STRATEGY**  
   Appendix F
   
   To note and review the progress of the development of Joint Health and Wellbeing Strategy.

   Appendix F1
   Project Update on Development of Joint Health and Welfare Strategy Appendix F2 (To Follow)

**OTHER ITEMS**

15. **CULTURAL AMBITION STATEMENT**  
   Appendix G
   
   To note the Shadow Health and Wellbeing Board has informally ‘signed up’ to the Cultural Ambition Statement, and to confirm this action.

16. **EAST MIDLANDS HEALTH AND WELLBEING BOARD SIMULATION EVENTS**  
   Appendix H
   
   To agree representation as appropriate at the two planned Health and Wellbeing Board Simulation Events in the East Midlands.

17. **UPDATE ‘BRINGING THE HOSPITAL TO THE PEOPLE’**
   
   Verbal update by Catherine Griffiths following the presentation about NHS care services to the City Council meeting on 28 June 2012.

18. **ANY OTHER URGENT BUSINESS**

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**ITEMS FOR INFORMATION / NOTING ONLY**

19. **NEXT MEETING**
   
   To note that the next meeting will be held on at 2.00pm Tuesday 2 October 2012 in the City Mayor’s Office, B7, New Walk Centre.

20. **RECENT PUBLICATIONS AND BULLETINS SUMMARY**
   
   The Board is invited to note :-
Briefing note on DH publication ‘Healthy Lives Healthy People: Up-date on Public Health Funding’, http://www.dh.gov.uk/health/2012/06ph-funding-la/ Published 14 June 2012


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Appendix A

SHADOW HEALTH & WELLBEING BOARD

MINUTES OF THE MEETING HELD ON:
TUESDAY, 29 MAY 2012

at: 2.00 pm
City Mayor’s Office,
Leicester City Council New Walk Centre

Present:
Sir Peter Soulsby (Chair) – City Mayor, Leicester City Council
Councillor Manjula Sood – Assistant Mayor (Health and Community Involvement), Leicester City Council
Simon Freeman – Managing Director of Clinical Commissioning Group
Leicester City
Deb Watson – Director of Public Health and Health Improvement
NHS Leicester City
Rachel Dickinson – Strategic Director, Children, Leicester City Council
Catherine Griffiths – Chief Executive, Leicester, Leicestershire and Rutland PCT Cluster
Tracie Rees – Director of Commissioning, Adults & Communities,
Leicester City Council
Hasmukh Jobanputra – Leicester Local Involvement Network (LINk)
Nick Carter – Lay Vice-Chair of Leicester City Clinical Commissioning Group (Deputising for Professor Azhar Farooqi (Co-Chair of Leicester City CCG)

In attendance :
Mike Keen – Democratic Services, Leicester City Council
Sue Cavill – Associate Director Health Projects
NHS Leicester, Leicestershire and Rutland
Rod Moore – Deputy Director of Public Health and Health Improvement NHS Leicester City
Grace Smith – Project Portfolio Manager Leicester City Council

Observers:
Cheryl Davenport – Director of Business Development
Leicestershire Partnership Trust and Programme Director Leicestershire County Council

1. WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and all present introduced themselves.

Apologies for absence were received from: -

• Professor Azhar Farooqi, Chair, Leicester City CCG
• Councillor Rory Palmer, (Deputy City Mayor, Leicester City Council)
2. **MINUTES**

**AGREED:**

that the minutes of the meeting held on 3\textsuperscript{rd} April 2012 be approved as a correct record.

3. **MATTERS ARISING**

There were no matters arising from the minutes of the last meeting.

**WORKSHOP SESSION**

4. **WORKSHOP DISCUSSION - DEVELOPMENT OF THE JOINT HEALTH & WELLBEING STRATEGY**

Sue Cavill, Associate Director Health Projects, NHS Leicester, Leicestershire and Rutland and Rod Moore, Deputy Director of Public Health, NHS Leicester City spoke to a presentation on developing a Joint Health and Wellbeing Strategy.

The presentation provided an overview of the draft guidance for the development of a strategy and highlighted the findings from the Joint Strategic Needs Assessment (JSNA).

Information on shaping the priorities for the strategy was set out with the possible criteria for determining these. Members were informed that, at a recent JSNA Stakeholder event participants had been asked to identify the top 5 priorities and the results of this exercise were provided.

Discussion took place around identifying priorities and the means of delivery, as it was accepted that these were areas that needed to be separate.

It was stated that the next steps would be the first meeting of the Strategy Development Group held in June. Engagement activity was also to be initiated via the VAL Health and Social care Forum on 3\textsuperscript{rd} July, a LINk Engagement Event, by presentations at partnership boards and to seldom heard groups. It was anticipated that an outline of the Strategy would be ready in July and a progress report would be provided at the next meeting.

**AGREED:**

1) that the guiding principle of the Joint Health and Well-Being Strategy would be the reduction of health inequalities, with the following key priorities:-

- Addressing the major causes of premature death
- Meeting the needs of the most vulnerable in society
- Improving mental health
- Improving outcomes for children, young people and families.
2) that the nine protected characteristics under the Equalities Act be incorporated and considered within the strategy,

3) It was also agreed that for the next development session a request would be made via Cathy Ellis for colleagues from London to attend and lead a presentation and discussion on ‘Well London’ so that members could consider the applicability of this approach in Leicester.

5. NATIONAL MATTERS
There were no matters reported.

6. REGIONAL MATTERS
There were no matters reported.

7. PCT CLUSTER
There were no issues reported.

8. LEICESTER CITY CLINICAL COMMISSIONING GROUP

Funding of CCGs
Simon Freeman reported that Leicester City CCG’s funding would, following the announcement of funding allocations, be severely affected due to the way that national funding was determined. The funding formula has been based on the number of residents within the boundary as opposed to the number of registered patients on the lists of GP practices within the City. Potentially this could mean that the City CCG could be operating on £1m less funding for management costs than previously anticipated. Simon Freeman agreed to consider what, if any, support might be helpful from other partners, including the City Mayor.

The Board noted that work was ongoing in both the CCG and the City Council to try to analyse the position relating to perceived under-funding. The Board agreed that action to address the anomalies outlined would be considered and reported back at the next meeting.

9. LEICESTER CITY COUNCIL

Integrated Commissioning Board

Deb Watson reported that the first meeting of the joint integrated Commissioning Board had met earlier in the day to look at joint arrangements for commissioning moving forward. It had been agreed that Deb Watson and Simon Freeman would jointly chair this Board.
10. MEMBERSHIP OF THE HEALTH AND WELLBEING STRATEGY WORKING GROUP

Deb Watson presented the suggested membership for the Joint Health and Well Being Strategy Development Group.

The Board agreed the membership subject to both Simon Freeman (Managing Director of, Leicester CCG) and Professor Avi Prasad, (Co-Chair of LCCCG) being added to the membership of the Group.

11. STATEMENT FROM UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST REGARDING MALCOLM LOWE-LAURI

The Board received a statement from UHL that referred to the announcement that the current Chief Executive, Malcolm Lowe-Lauri, would be leaving the Trust.

The statement was noted and it was reported that there were some delays around the appointment of the next Chief Executive. This would be reported back to the Board once agreed.

12. ANY OTHER URGENT BUSINESS

Re-configuration of services
Catherine Griffiths (LLR PCT Cluster) reported that she was leading a piece of work around re-configuration of services and that it was anticipated that presentations would be given to the Board at the appropriate time. It was noted that the City Mayor offered to support the communication of this to councillors and it was agreed that this would be discussed further.

13. NEXT MEETING

It was noted that the next meeting of the Board would be held at 2.00pm on Tuesday 31st July 2012 in the City Mayor’s office.
### SHADOW HEALTH AND WELLBEING BOARD

#### ACTION LOG

**DATE OF MEETING: 29 MAY 2012**

<table>
<thead>
<tr>
<th>NO.</th>
<th>ITEM</th>
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<th>DATE</th>
<th>PROGRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>14(a)/11</td>
<td>Needs Assessment and Strategy – Leicester Health Profile</td>
<td>• The work of the Board to be focussed on a small number of issues</td>
<td>All</td>
<td>On-going</td>
<td>On-going</td>
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**DATE OF MEETING: 24 NOVEMBER 2011**

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<tbody>
<tr>
<td>20/11</td>
<td>Workshop Discussion</td>
<td>• Local priorities for future commissioning to be based on the findings of the Joint Strategic Needs Assessment</td>
<td>On-going</td>
<td>On-going</td>
<td>On-going</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Joint Specific Needs Assessments be presented to Shadow Health and Wellbeing Board for information</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• The Joint Strategic Needs Assessment Project Board to be asked to advise this Board of emerging issues as soon as possible after they are identified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23/11</td>
<td>Matters Arising</td>
<td>• The information on the Leicester City Shadow Health and Wellbeing Board attached to the agenda at Appendix C be used on partners’ websites to inform visitors of the Board’s role and</td>
<td>All</td>
<td>As soon as possible</td>
<td>Pages now uploaded onto City Council website and</td>
</tr>
<tr>
<td>NO.</td>
<td>ITEM</td>
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**DATE OF MEETING: 26 JANUARY 2012**

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<th>PROGRESS</th>
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<tbody>
<tr>
<td>2</td>
<td>Workshop Discussion</td>
<td>A report on the proposals for the establishment of a network that enables discussions to be held with key organisations in a structured way to be made to the Board</td>
<td>SC</td>
<td>3 April 2012</td>
<td>Completed</td>
</tr>
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**DATE OF MEETING: 3 APRIL 2012**

<table>
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<tr>
<th>MINUTE NO.</th>
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<th>PROGRESS</th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td>Workshop Discussion</td>
<td>Engagement to be made through existing mechanisms wherever possible</td>
<td>SC</td>
<td>ongoing</td>
<td>On-going</td>
</tr>
</tbody>
</table>
| 12         | Needs Assessment and Strategy | • Authority delegated to the Director of Public Health to develop the Health and Wellbeing Strategy and establish a working group that was representative of the Board to support her  
<p>|            |                        | • The May 2012 Health and Well Being Board to be used as a workshop to generate and agree high level health priorities | DW   | 29 May 2012     | Completed         |
|            |                        |                                                                        | DW / SC | 29 May 2012     | Completed         |</p>
<table>
<thead>
<tr>
<th>MINUTE NO.</th>
<th>ITEM</th>
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<th>PROGRESS</th>
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<tbody>
<tr>
<td>3</td>
<td></td>
<td>• The Strategy to include services beyond Health and Social Care, but only to the extent that there is no loss of focus on Health and Social Care. The Strategy could focus on health as a central issue and identify related issues. It also should be stressed that it was part of a suite of on-going work</td>
<td>DW / SC</td>
<td>29 May 2012</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assurance/performance management updates to be programmed in to the Strategy as it is developed</td>
<td>DW / SC</td>
<td>29 May 2012</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sufficient capacity to be available to enable appropriate responses to be made when the public engage with the Strategy</td>
<td>DW / SC</td>
<td>29 May 2012</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The final findings from the Joint Strategic Needs Assessment be presented to the May 2012 meeting of this Board to assist with the development of the Health and Well Being Strategy</td>
<td>RM / SC</td>
<td>29 May 2012</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The Joint Strategic Needs Assessment be developed as agreed by the Board</td>
<td>RM / SC</td>
<td>On-going</td>
<td>On-going</td>
</tr>
<tr>
<td>13</td>
<td>Leicestershire Partnership NHS Trust Application for Foundation Trust Status</td>
<td>The consultation document and questionnaire on the Leicestershire Partnership NHS Trust application for Foundation Status be sent to all Councillors</td>
<td>SC</td>
<td>As soon as possible</td>
<td>Completed</td>
</tr>
<tr>
<td>17</td>
<td>Recent Publications and Bulletins Summary</td>
<td>Bulletins to be circulated on a bi-monthly basis</td>
<td>SC</td>
<td>On-going</td>
<td>On-going</td>
</tr>
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</table>
From: Simon Cole, BA (Hons) (Dunelm), MA (Worcester), DipCrim (Cantab)
Chief Constable

My Ref: CC/jps/6.2.1
Date: 25 June 2012

Dear Sir or Madam,

I was sorry to miss the City Partnership Board last week but I am afraid I simply had to prioritise other things, particularly with the late change of topic away from health and wellbeing to culture.

I remain keen to explore the health and wellbeing aspects that are linked into policing. In particular I must press for police representation on the Health and Wellbeing Board. As I have previously corresponded with you, this is a key place where a link between drink, drugs, mental health and prisons will be made and these are all areas of business that we have a key stake in. You may be surprised to learn that last year over 400 people were taken by police officers to places of safety within Leicestershire Police. Of course that place of safety is located in the City. We dealt with over 6,000 missing people, many of whom had issues that link into health and wellbeing. Many of those missing people also come from the managed care environment, and I know that is something that will concern you.

I hope we are able to progress a good discussion on health and wellbeing shortly and I look forward to a future date for the City Partnership Board, and I hope confirmation that Rob Nixon is able to join the Health and Wellbeing Board.

Yours sincerely

Simon Cole
Chief Constable

Sir Peter Soulsby
City Mayor’s Office
7th Floor, New Walk Centre
Welford Place
LEICESTER

simon.cole@leicestershire.pnn.police.uk
www.leics.police.uk
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To: All stakeholders

Dear Colleague

Local area teams

Further to my recent letter of 20 June setting out the design of the local area teams and the geographies that they will serve, I am writing to let you know that we have made the first 16 appointments of our 25 local area team directors, as follows:

North

- Cheshire, Warrington and Wirral: Moira Dumma (currently Director of Commissioning Development at NHS Midlands and East SHA Cluster)
- Merseyside: Clare Duggan (currently Director of Strategic Change at NHS Merseyside PCT Cluster)
- Greater Manchester: Mike Burrows (currently Chief Executive of NHS Greater Manchester PCT Cluster)
- South Yorkshire and Bassetlaw: Andy Buck (currently Chief Executive of NHS South Yorkshire and Bassetlaw PCT Cluster)
- North Yorkshire and Humber: Chris Long (currently Chief Executive of NHS North Yorkshire and York PCT Cluster and NHS Humberside PCT Cluster)
- Durham, Darlington and Tees: Cameron Ward (currently Director of Commissioning Development at NHS North of England SHA Cluster)

Midlands and East

- Essex: Andrew Pike (currently Chief Executive of South Essex PCT Cluster)
- Hertfordshire and the South Midlands: Jane Halpin (currently Chief Executive of NHS Hertfordshire PCT Cluster)
- Leicestershire and Lincolnshire: David Sharp (currently Chief Executive of NHS Derbyshire PCT Cluster)
- Derbyshire and Nottinghamshire: Derek Bray (currently Chief Executive of NHS Nottinghamshire PCT Cluster)
- Shropshire and Staffordshire: Graham Urwin (currently Chief Executive of NHS Staffordshire PCT Cluster)
- Birmingham and the Black Country: Wendy Saviour (currently Interim Director of Partnerships at NHS Commissioning Board Authority)
London

- London: **Simon Weldon** (currently Director of Operations and Delivery at North West London Commissioning Partnership)

South of England

- Surrey and Sussex: **Amanda Fadero** (currently Chief Executive of NHS Sussex PCT Cluster)
- Wessex: **Debbie Fleming** (currently Chief Executive of Southampton, Hampshire, Isle of Wight and Portsmouth PCT Cluster)
- Devon, Cornwall and Isles of Scilly: **Ann James** (currently Chief Executive of NHS Devon, Plymouth and Torbay PCT Cluster)

Colleagues are continuing to work on the detailed design of the regions and local area teams to enable us to quickly develop the local presence of the NHS Commissioning Board and forge ahead with recruitment to roles throughout the teams, with the next round of recruitment to the remaining director posts taking place shortly.

The NHS Commissioning Board Authority also agreed today the key elements of the authorisation governance process for CCGs - including the decision-making, moderation, conditions and support elements. We are developing the full detail of all these processes and more information will be published in September. Meanwhile, for further information please see our [website](#) for an updated authorisation factsheet.

I will continue to keep you up to date as we progress and I would be grateful if you could share this update with colleagues.

Thank you

Yours sincerely

![Signature]

**Ian Dalton CBE**
Chief Operating Officer/Deputy Chief Executive
Executive Briefing
26 June 2012

Health and Social Care Act (2012) and Local Authority Responsibilities

Lead director: Deb Watson

City Mayor
1. Summary

This Executive Briefing:

1.1 provides the Executive with an overview of the Health and Social Care Act (2012) and the key changes resulting from it;

1.2 advises the Executive of plans and progress so far for the implementation of the new responsibilities and the transition of the public health function from NHS Leicester City to Leicester City Council and to seek views on issues relating to the implementation of this transition in Leicester.

2. Main report:

General background

2.1 The Health and Social Care Act (2012) institutes a wide range of changes in the health care and public health system in England, including new functions and responsibilities for local authorities which will take effect from 1 April 2013. These are summarised below. Appendix 1 provides further information regarding the changes, the initial implications and progress so far in planning for the authorities new responsibilities.

2.2 The main headlines of the changes brought about more widely by the Act include the abolition of Primary Care Trusts and Strategic Health Authorities by April 2013, NHS care services are to be commissioned locally by Clinical Commissioning Groups led by local GPs and overseen by a new NHS Commissioning Board (which will also directly commission some specialist services). Hospital Trusts and community ‘provider’ NHS Trusts are to become in time Foundation Trusts with greater autonomy and greater ability to earn income from non-NHS sources. A new body, Public Health England, will provide national guidance, advice and coordination to the public health system overall. Health responsibilities to transfer to Local Authorities include local lead responsibility for health strategy and partnership through new Health and Well Being Boards, leadership for public health, and the transformation of the existing LINks in to a new patient advocacy service, HealthWatch.
Key changes for the local authority

2.3 As a result of the Act Local authorities will from 1st April 2013:

2.3.1 have a new duty to promote the health of their population, to ensure that robust plans are in place to protect the local population and to provide public health advice to NHS commissioners;

2.3.2 establish Health and Wellbeing Boards, and through them lead the development of joint strategic needs assessments and joint health and wellbeing strategies, which will provide the means of integrating local commissioning strategies and ensuring a community-wide approach to promoting and protecting the public’s health and wellbeing;

2.3.3 be able to align public health responsibility with many of the levers to tackle the wider determinants of health and health inequalities and make real improvement by putting the public’s health into policies and decisions;

2.3.4 employ a Director of Public Health (DPH), who will occupy a key leadership position within the local authority and enable the delivery of these new public health functions of local authorities In this the local authority must have regard to any guidance given by the Secretary of State, including guidance on DPH appointment, termination of appointment and terms and conditions of management. Directors of Public Health have been added to the list of statutory chief officers in the Local Government and Housing Act 1989;

2.3.5 have responsibilities for commissioning specific public health services and be supported with a ring-fenced public health grant for this purpose. These services cover twenty-one areas and include:
  o tobacco control and smoking cessation services;
  o public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people);
  o interventions to tackle obesity such as community lifestyle and weight management services;

The full list of commissioning responsibilities is provided in Appendix 1 paragraph 3.18.

2.3.6 in commissioning the above services local authorities will be largely free to determine their own priorities, guided by the Public Health Outcomes Framework(see below), the local joint strategic needs assessment and the joint health and wellbeing strategy, but will be required to provide the following services mandated by the Secretary of State for Health:
  o Sexual Health services
  o Health Protection
  o Public health advice to the NHS
  o The National Child Measurement Programme
  o NHS Health Check Assessment

The Secretary of State for Health may mandate further services in future.

2.3.7 receive a ring-fenced grant for their new public health responsibilities from April
The allocation for 2013/14 itself will be confirmed at the end of 2012. The independent Advisory Committee on Resource Allocation (ACRA) will support the detailed development of the resource allocation to LAs and the creation of a formula that can be used to calculate each local authority’s target allocation;

2.3.8 participate in an incentive scheme which will pay a financial premium, to local authorities depending on the progress made in improving the health of the local population and reducing health inequalities - this will be linked to the Public Health Outcomes Framework;

2.3.9 have regard to the Public Health Outcomes Framework which sets out the government’s overarching outcomes and the domains and indicators that support their achievement. It is intended that this will provide focus to local and national priorities, a means of accountability to local populations, and a framework for the payment of a ‘health premium’ – details of which will be announced later in the 2012;

2.3.10 be required to transform the currently local authority commissioned LINks organisations into a new patient and public advocacy service, HealthWatch, by 1 April 2013;

2.3.11 retain oversight and scrutiny powers which the authority can now discharge as it thinks appropriate and will no longer be required to have a formal health Overview and Scrutiny Committee as required by previous legislation

Local plans and progress

2.4 Local plans and progress include:

2.4.1 The establishment of a shadow Health and Wellbeing Board (HWB) – chaired by the City Mayor with membership from elected members of the local authority, Clinical Commissioning Group, NHS LLR PCT Cluster and LINks/HealthWatch in addition to the Joint Director of Public Health and the Directors of Adult Social Care and Children’s Services.

2.4.2 The Joint Director of Public Health for Leicester City Council and NHS Leicester City has been in post since June 2008 following a jointly agreed appointment process.

2.4.3 The development and agreement of a Public Health Transition Plan which has been signed off by NHS LLR PCT Cluster and the City Council. The plan identifies the initial actions and timescales to address the transition arrangements and also to ensure the delivery of Public Health responsibilities during the transition year. The plan covers the following workstreams: Finance, Contracts and procurement, Workforce, Maintaining delivery, IT and information governance, Governance, Communications.

2.4.4 The Joint Director of Public Health is the executive sponsor of this transition

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NHS Leicester City has combined with NHS Leicestershire County and Rutland to form a single “NHS LLR PCT Cluster”, though both original bodies remain legal entities until 31 March 2013.
plan with overall responsibility for monitoring progress against the plan and ensuring that it meets the requirements of the legislation. The practical implementation and further development of the plan is undertaken by the Public Health Transition Group. Progress is reported through the Transition Programme Management Group to the Shadow Health and Wellbeing Board, the city council (the Executive and SMB) and the NHS LLR PCT Cluster (Board and Transition Management Team). The Transition Plan is currently on track, but on a number of items further national guidance is awaited.

2.4.5 A non-legally binding Memorandum of Understanding has been developed between the NHS LLR PCT Cluster and the City Council in relation to this plan, emphasising the mutual expectation of positive engagement and cooperation in its implementation.

2.4.6 Relevant public health staff of NHS Leicester City have been based in Leicester City Council, New Walk Centre, since November 2011. These staff remain employees of NHS Leicester City and a co-location agreement is in place. Induction into Leicester City Council have been held for all co-located public health staff and a programme of engagement with staff and elected members of LCC is underway and will continue through to and beyond April 2013. With respect to staff who will be transferring their employment from NHS Leicester City to Leicester City Council on 1 April 2013 there is close working between the HR departments of both organisations to ensure a smooth transfer of staff. Planning for this transfer is addressed in the Workforce workstream of the Public Health Transition Plan.

2.4.7 Existing contracts with providers of public health services commissioned by NHS Leicester City will novate to the City Council. The work involved in this is included in the Public Health Transition Plan and a workstream is focused on assessing the contracts held by the NHS and considering the best approach to managing their novation to the local authority on 1 April 2013.

2.4.8 Consideration of ring-fenced grant and financial implications. Please see section 5.1 below. To date a baseline assessment has been issued by the Department of Health, based on the year 2010/11, which has indicated that (except in exceptional circumstances) local authorities should expect no less than their baseline uplifted to 2012/13. Should this remain the case it is anticipated that the City Council will receive just under £17m for its new public health responsibilities.

2.4.9 A vision for HealthWatch has been agreed with the Shadow Health and Wellbeing Board, a LINks/HealthWatch Transition Board has been established and an engagement event held in March 2012. The publication by the Department of Health of regulations and the funding allocations to the authority will not be available until November 2012. A separate report will be submitted to the Executive on the implications of this for the procurement of HealthWatch.

3. Details of Scrutiny
3.1 The Health and Social Care Bill, now Act, has been considered in a number of fora, including the Overview and Scrutiny Commission, NHS Leicester City Board and the Shadow Health and Wellbeing Board. The Leicester Public Health Transition Plan has been considered and signed off by NHS LLR PCT Cluster, Leicester City Council and the Midlands and East Strategic Health Authority. In addition, the Health and Community Involvement Scrutiny Commission has been updated on a number of areas, including HealthWatch and the transfer of public health functions.

5. Financial, legal and other implications

5.1 Financial implications

5.1.1 It is stated by the Department of Health that (except in exceptional circumstances) local authorities should expect no less than their baseline uplifted to 2012/13. The allocation for 2013/14 itself will only be confirmed at the end of 2012.

5.1.2 An assessment of the total public health spend within the NHS for the financial year 2010/11 was made in September 2011. This was required by the Department of Health and undertaken locally by NHS Leicester City in cooperation with Leicester City Council. The Director of Finance for NHS LLR PCT Cluster and the Chief Operating Officer for Leicester City Council agreed a joint statement of the strengths and weaknesses of the return. This return has been used by the DH to calculate baseline estimates for 2012-13 for each of National Health Service Commissioning Board, LAs and Public Health England.

5.1.3 As a result of the above planning for 2013-14 will initially be based on the baseline 2012/13 figure indicated by the DH as £16,995m and an application has been made to the DH for an update to the baseline figures identified by them.

5.1.4 The ring-fenced grant allocation for Leicester for 2013/14 will be announced by the DH around the end of 2012. The distribution formula to be used, and any ‘distance from target’ arrangements adopted, will be announced by the DH in due course.

5.1.5 The finance workstream of the Public Health Transition Plan will consider the financial issues indicated.

Rod Pearson
Head of Finance
Health and Wellbeing
X 29-8800

5.2 Legal implications

5.2.1 This report summarises the implications for the Council as a whole on the
transfer of the public health function to the Council with effect from 1 April 2013. As part of taking over the public health function the City Council will be responsible for a number of new statutory duties as detailed in this report.

5.2.2 Under the act the City Council will be required to have its own Health and Wellbeing Board. The purpose of the Board will be to advance the health and wellbeing of the people of Leicester and to encourage integrated working. Membership of the Board will comprise at least one Councillor (and as Leicester has an elected Mayor for governance he is able to sit on the board instead of a Councillor); the Director of Adult Social Services; the Director of Children’s Services the Director of Public Health; a representative of the local HealthWatch, a representative of the relevant Clinical Commissioning Group. Other persons may be appointed to the board as the Council thinks appropriate. The Board will be a Council Committee. Note that the board will not undertake the local government scrutiny function.

5.2.3 There is no longer a statutory requirement for the Council to have a Health Overview and Scrutiny Committee but there is discretion to the Council as to what scrutiny arrangements it puts in place for scrutiny of this function.

5.2.4 The Act requires that the Council must employ a Director of Public Health and pay regard to any guidance given by the Sector of State in relation to appointment, terms and conditions and termination. The Director will be a statutory Chief Officer from the purposes of wider local government legislation.

5.2.5 The Memorandum of Understanding referred to in the report is a statement of intent for internal organisational purposes and it is not intended to make any legal obligations between the signing parties.

5.2.6 In readiness for the 1 April 2013 start date Legal Services is providing advice to the Director in relation to employment issues arising (appointment of Director of Public Health, transfer of staff currently employed by the NHS, procurement and property issues).

Anthony Cross
Head of Litigation
X 6362

5.3 Climate Change and Carbon Reduction implications

5.3.1 The Act provides an opportunity to align the Authorities public health responsibility with many of the levers to tackle the wider determinants of health and health inequalities in the short and longer term.

5.4 Equality Impact Assessment

5.4.1 The passing and implementation of the Act is intended to have a positive impact on the health and wellbeing of residents.
5.4.2 A full Equality Impact Assessment will be completed as part of the transition process.

5.5 Other Implications

5.5.1 Health Inequalities - the Act provides an opportunity to align the Authorities public health responsibility with many of the levers to tackle the wider determinants of health and health inequalities in the short and longer term.

6. Background information and other papers:

6.1 A large number of documents have been issued by central government in relation to the Health and Wellbeing Act (2012). Principal documents are:

6.1.1 Equity and Excellence: Liberating the NHS, Department of Health (2010)

6.1.2 Healthy lives, health people: our strategy for public health in England Department of Health (2010)

6.1.3 The New Public Health System and Public Health in Local Government, Factsheets, both Department of Health (2011)
http://healthandcare.dh.gov.uk/public-health-system/

6.1.4 The Leicester Public Health Transition Plan (March 2012)

7. Summary of appendices:

7.1 Appendix 1: Health and Social Care Act (2012) and Local Authority Responsibilities
Appendix 1: Health and Social Care Act (2012) and Local Authority Responsibilities

1. Introduction

1.1 The purpose of this report is:
• to provide background information to the NHS Reforms and the Health and Social Care Act (2012);
• to provide an initial view of the key changes to be implemented as a result of the Act;
• to report plans and progress so far for the new responsibilities and the transition of the public health function from NHS Leicester City to Leicester City Council.

2. General background to the NHS Reforms and the Health and Social Care Act 2012

2.1.1 The Health and Social Care Act (2012) received Royal Assent on 27 March 2012, and enabled proposals stemming from the NHS White Paper “Equity and Excellence: Liberating the NHS” and subsequent amendments.

2.1.2 The main headlines of the changes brought about by the Act are as follows.
• abolition of Primary Care Trusts and Strategic Health Authorities in 2013 –
• NHS care services to be commissioned locally by Clinical Commissioning Groups led by local GPs and overseen by a new NHS Commissioning Board (which will also directly commission some specialist services).
• Hospital Trusts and community ‘provider’ NHS Trusts are to become Foundation Trusts with greater autonomy and greater ability to earn income from non-NHS sources.
• health responsibilities transferring to Local Authorities including lead responsibility for health strategy and partnership through new Health and Well Being Boards and leadership for public health.

2.3 National changes stemming from the Act include those to the role of:
• Monitor – which will be the economic regulator for all NHS funded services;
• the Care Quality Commissions (CQC) which will continue to act as the quality inspectorate across health and social care;
• The National Institute for Health and Care Excellence (NICE) - which will continue to consider evidence in order to make recommendations on medicines, treatments and procedures though its role will be extended to include social care and its name will change to the National Institute for Health and Care Excellence .
• the Secretary of State for Health in that he will now create and issue a mandate for the NHS, which will also need to be heeded by local Health and Wellbeing Boards.

2.4.1 Much of the implementation of the above has already been underway prior to the enactment of the legislations, through the existing powers of the Secretary of State for Health.
2.5. Locally this has meant that:

- NHS Leicester City has combined with NHS Leicestershire County and Rutland to form a single "LLR PCT Cluster", though both original bodies remain legal entities until April 2013. There have been corresponding reductions in Board members and staffing.
- the Leicester Clinical Commissioning Group (CCG) has been formed and is in the process of becoming fully established. Under the auspices of the LLR PCT Cluster it will, throughout 2012, take on increasing responsibility for commissioning services and is aiming to be ‘authorised’ as a new statutory body in the first wave of approvals, Autumn 2012.
- the Leicestershire Partnership Trust (LPT) is currently in the process of applying for Foundation Trust status.
- relevant NHS Leicester City Public Health staff have moved to Leicester City Council on a co-location basis as a first step in the transition to be completed by 1 April 2013.

Important caveat regarding current understanding of the Act

2.6 It should be noted that the Health and Wellbeing Act (2012) as a Bill was complex and controversial and some 2,000 amendments were proposed to its provisions, and sections of the Act require further guidance to be issued. This paper then gives the position as currently understood and is subject to secondary legislation, regulation and guidance consequent to the Act.

3 Key changes for the Local Authority

Local Authority Responsibilities

3.1 Local authorities will:

- have a new duty to promote the health of their population, to ensure that robust plans are in place to protect the local population and to provide public health advice to NHS commissioners.
- through the health and wellbeing board, lead the development of joint strategic needs assessments and joint health and wellbeing strategies, which will provide the means of integrating local commissioning strategies and ensuring a community-wide approach to promoting and protecting the public’s health and wellbeing
- be able to align public health responsibility with many of the levers to tackle the wider determinants of health and health inequalities and will make real improvement by putting the public’s health into their policies and decisions.
- employ Directors of Public Health, who will occupy key leadership positions within the local authority and enable the delivery of these new public health functions of local authorities.
- be largely free to determine their own priorities and services, but will be required to provide a number of mandatory services.
- have responsibilities for commissioning specific public health services and will be supported with a ring-fenced public health grant

Local Authority responsibilities as part of a wider system
3.2 The above responsibilities will be acted out within the context of the NHS reforms and what is termed ‘the new public health system’. The NHS will continue to play a key role in improving and protecting the public’s health and reducing inequalities through (a) the provision of health services and ensuring fair access to those services, and (b) continuing to commission specific public health services and seeking to maximise the impact of the NHS in improving the health of the public.

3.3 There will also be a new national organisation, Public Health England (PHE) which will be an executive agency of the Department of Health and whose key purposes include:

- to be an advocate for public health focused on supporting local action, with national action only where it adds value.
- to deliver services to protect the public’s health through a nationwide integrated health protection service, provide information and intelligence to support local public health services, and support the public in making healthier choices.
- to provide leadership to the public health delivery system, promoting transparency and accountability by publishing outcomes, building the evidence base, managing relationships with key partners, and supporting national and international policy and scientific development.
- to support the development of the public health workforce, jointly appointing local authority Directors of Public Health (on behalf of the Secretary of State for Health), supporting excellence in public health practice and providing a national voice for the profession.
- to proactively publish its expert scientific and public health advice on relevant issues, and its advice to professionals and the public.

The national vision for Local Government in relation to health

3.4 Nationally key reasons for returning responsibility for improving public health to local government include its population focus, role as shapers of place, potential influence on the social determinants of health and positioning to tackling health inequalities. The goal should be to improve the health of all people, but to improve the health of the poorest, fastest.

3.5 The government’s view is that to do this successfully will require local authorities to use all the tools at their disposal in a new way and not just rely on commissioning traditional services. Tools here include the planning system, policies on leisure, key partnerships with other agencies and through developing a diverse provider market for public health improvement activities. It anticipates that Local Authorities will (a) commission a range of services from a range of providers from different sectors, working with clinical commissioning groups and representatives of the NHS Commissioning Board to create as integrated a set of services as possible; (b) work with a wide range of partners across civil society, not least the third sector, including through the shared leadership of Health and Wellbeing Boards. The H&WBB will be supported in this by HealthWatch, which will better enable people to help shape and improve health and social care services through its seat on the Health and Wellbeing Board.

Health and Wellbeing Board
3.6 The Act requires the establishment of a Health and Wellbeing Board in every upper tier and unitary local authority the purposes of which will include to:
- lead on improving the strategic coordination of commissioning across NHS, social care and related children’s and public health services
- bring together the key NHS, public health and social care leaders in each local authority area to work in partnership
- provide a key forum for public accountability of NHS, public health, social care for adults and children and other commissioned services that the health and wellbeing board agrees are directly related to health and wellbeing.

3.7 The national aspiration is for H&WBs to become “deep and productive partnerships that develop solutions to commissioning changes… collaboration must be the norm. We want elected representatives along with other key local stakeholders to be engaged in early conversations about how local services can best meet requirements rather than reacting as commentators and critics to proposals emanating from the NHS.”

3.8 The Health and Wellbeing Board is not a commissioning body. The commissioning authorities are the local Clinical Commissioning Group and the local authority.

3.9 The Health and Wellbeing Board instead leads and shapes commissioning priorities through agreeing the local Joint Health and Wellbeing Strategy. Two key pieces of work to be undertaken by the Local Authority and the CCG through the Health and Wellbeing Board is the preparation of a Joint Strategic Needs Assessment (JSNA)\(^2\), which should be the primary process for identifying needs and building a robust evidence base on which to base local commissioning plans, and preparing the high-level Joint Health and Wellbeing Strategy (JHWS) that spans the NHS, social care and public health, and potentially wider health determinants.

3.10 CCGs and the LA are under a duty to prepare the JHWS, taking in to account the guidance (‘mandate’) given by the Secretary of State, and the consideration of partnership arrangements using section 75 NHS Act flexibilities. The CCG, LA and the NHSCB are under a duty to have regard to the JSNA and the JHWS in the exercise of relevant commissioning functions.

3.11 The Health and Wellbeing Board is not a scrutiny board. The Government originally proposed that it would be, but following consultation in 2010 changed its position on this.

**Director of Public Health**

3.12 The Act stipulates that local authorities must employ a Director of Public Health and that the local authority must have regard to any guidance given by the Secretary of State in relation to its Director of Public Health, including guidance

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\( ^2 \) and also the pharmaceutical needs assessment (NB this is concerned with the availability of pharmacies and their services, rather than with medicines) will transfer to local authorities, to be discharged through the Health and Wellbeing Board, so that local needs can be considered in the round.
on appointment, termination of appointment and terms and conditions of management. Directors of Public Health have been added to the list of statutory chief officers in the Local Government and Housing Act 1989.

3.13 The DPH as a public health specialist will be responsible for all the new public health functions of local authorities, including any conferred on local authorities by regulation. It is also a statutory requirement for the DPH to produce an annual report on the health of the local population, and for the local authority to publish it. The DPH will also be statutory members of the Health and Wellbeing Board.

3.14 The Government acknowledges that in taking forward their leadership role for public health local authorities will rely heavily on the Director of Public Health and the specialist public health resources at their command and that the DPH will be a critical player in ensuring there are integrated health and wellbeing services across the locality. With regard to the ring-fenced grant, formal accountability rests with the Chief Executive or Officer of the local authority, but the Government would expect day-to-day responsibility for the grant to be delegated to the DPH.

3.15 Regarding Directors of Public Health the Government will issue further guidance which will cover:
- appointments to existing DPH vacancies in a way that ensures they are fit for purpose for the future;
- managing the transition of DPH posts to local government during 2012/13
- a process for local authorities and Public Health England (on the Secretary of State’s behalf), acting jointly, to appoint new DPH from 1 April 2013.

3.16 Regarding Public Health teams the Government believes the multidisciplinary nature of public health is a key strength of the profession and that the transfer of new public health responsibilities to local authorities in no way changes this, and indeed reaffirms the importance of attracting to public health high-quality individuals from a wide range of disciplines including, but not limited to, medicine. The Department of Health will publish a Public Health Workforce Strategy, accompanied by a formal public consultation. The strategy will seek to ensure the development and supply of a professional public health workforce, set out proposals for how learning and development will be taken forward in the reformed health system, and outline options for how public health knowledge can best be embedded across the wider workforce.

**Commissioning responsibilities**

3.17 Local authorities are expected to commission services in relation to their public health responsibilities. They may choose to commission a wide variety of services under their health improvement duty, guided by the Public Health Outcomes Framework (see below), the local joint strategic needs assessment and the joint health and wellbeing strategy.

3.18 Local authorities will be responsible for commissioning:
- tobacco control and smoking cessation services
• alcohol and drug misuse services
• public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
• the National Child Measurement Programme
• interventions to tackle obesity such as community lifestyle and weight management services
• locally-led nutrition initiatives
• increasing levels of physical activity in the local population
• NHS Health Check assessments
• public mental health services
• dental public health services
• accidental injury prevention
• population level interventions to reduce and prevent birth defects
• behavioural and lifestyle campaigns to prevent cancer and long-term conditions
• local initiatives on workplace health
• supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
• comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
• local initiatives to reduce excess deaths as a result of seasonal mortality
• the local authority role in dealing with health protection incidents, outbreaks and emergencies
• population healthcare advice to the NHS
• public health aspects of promotion of community safety, violence prevention and response
• public health aspects of local initiatives to tackle social exclusion
• local initiatives that reduce public health impacts of environmental risks.

Mandated services of local authorities

3.19 However the commissioning by local authorities of a number of specified services is mandatory. The Act includes a power for the Secretary of State for Health to prescribe that local authorities take certain steps in the exercise of public health functions, including that certain services should be commissioned or provided. Generally this is where the Secretary of State is under a legal duty to provide (as in contraceptive services), where greater national uniformity is required (as in the case of health protection) or where steps are critical to the effective running of the new public health system itself (for example, ensuring that the local authority provides public health advice to NHS commissioners). The specified mandated services so far are as follows.

Sexual health services

3.20 Commissioning comprehensive open-access accessible and confidential contraception and sexually transmitted infections (STIs) testing and treatment services, for the benefit of all persons of all ages present in the area.
Health protection

3.21 Local authorities (and Directors of Public Health on their behalf) will be required to ensure that plans are in place to protect the health of the local population. This includes NHS emergency preparedness and response, local plans for immunisation and screening, and the plans acute providers and others have in place for the prevention and control of infection, including those which are healthcare associated. The Director of Public Health will continue to provide a coordination role to protect the health of the local population when transferred to local authorities. As is currently the case the Directors of Public Health and their teams will be required to work across the system. For example with regard to screening and immunisation Directors of Public Health will:

- provide challenge and advice to the NHS Commissioning Board (which will be accountable for delivery of the national screening and immunisation programmes) on its performance at the local level and how outcomes might be improved by addressing local factors;
- champion screening and immunisation with local clinicians and clinical commissioning groups;
- contributing to the management serious incidents.

3.22 The DH factsheets (see Background Information and other papers, below) indicate that the local authority role in health protection planning is not managerial, but a local leadership function. It rests on the personal capability and skills of the local authority Director of Public Health and his or her team to identify any issues and advise appropriately. But it will be underpinned by legal duties of cooperation, contractual arrangements, clear escalation routes and transparency. Further work is on-going nationally to clarify roles and responsibilities in practice.

Population healthcare advice to the NHS

3.23 The government is preserving a key role for local authority public health teams and local authorities will be mandated to provide population healthcare advice to the NHS and public health expertise for the NHS commissioners of healthcare services. A draft model for what such a public health advice service might look like, building on existing work across the country, has been developed nationally aligned against the stages of the commissioning cycle.

The National Child Measurement Programme (NCMP)

3.24 The NCMP annually weighs and measures children in reception year and year six in maintained schools in England to provide high-quality, locally reliable data on child overweight and obesity levels and trends. This data is used to inform the planning and development of policy and programmes, locally and nationally and to raise public awareness of child obesity, and to assist families to make healthy lifestyle changes through provision of a child’s result to their parents. The quality and reliability of the data is dependent on sustaining a high participation rate within every area, and on the data being collected in a consistent way. In addition to giving local authorities funding and power to deliver the NCMP as part of their local public health responsibilities, the
Government will mandate the collection and return of NCMP data so that the programme can continue to successfully fulfil its public health surveillance function.

**NHS Health Check Assessment**

3.25 The NHS Health Check Assessment programme is for people in England aged 40 to 74 and aims to prevent heart disease, stroke, diabetes and kidney disease, which account for a significant burden of ill health and premature mortality. Eligible individuals are offered a Health Check Assessment every five years. While the provision of lifestyle advice and interventions following assessment will not be mandated, there is an expectation that local authorities will commission appropriate services and ensure that the NHS Health Check assessments are adequately followed up.

**Approach to commissioning**

3.26 The Government's view is that for all commissioning decisions, local authorities will want to:
- ensure services are delivered in ways that meet the needs of disadvantaged and vulnerable groups and which consciously respond to the three aims of the equality duty;
- work with Clinical Commissioning Groups to provide as much integration across clinical pathways as possible, maximising the scope for upstream interventions. The Health and Wellbeing Board will be critical to driving this agenda;
- to commission, rather than directly provide, the majority of services, given the opportunities this would bring to engage local communities and the third sector more widely in the provision of public health, and to deliver best value and best outcomes;
- consider the opportunities of the recent Open Public Services White Paper, where improvement requires increased choice, wherever possible, and public services that are open to a range of providers (including staff-led enterprises in various forms);
- promote choice of provider to drive up quality, empower individuals and enable innovation to improve access, address gaps and inequalities and improve quality of services where users have identified variable quality in the past.
- use their experience in commissioning services from a range of providers,
- test out new and joint approaches to payment by outcomes, such as reducing drug dependency and to extend such approaches with external investment, such as the proposals being developed on social impact bonds to improve services and outcomes.

**Ring-fenced budget and the Health Premium**

3.27 From April 2013 Public Health England will allocate ring-fenced grants, weighted for inequalities, to upper-tier and unitary authorities and local government for the new functions and responsibilities of the Act. It was intended that there would be shadow allocations to LAs for this budget in 2012/13 and allocations will go live in 2013/14. To date a baseline assessment has been issued by the
Department of Health based on the year 2010/11. It stated by the Department of Health that (except in exceptional circumstances) local authorities should expect no less than their baseline uplifted to 2012/13. The allocation for 2013/14 itself will be confirmed at the end of 2012.

3.28 The independent Advisory Committee on Resource Allocation (ACRA) will support the detailed development of the resource allocation to LAs and the creation of a formula that can be used to calculate each local authority’s target allocation.

3.29 Additionally, local authorities will receive an incentive payment, or premium, depending on the progress made in improving the health of the local population and reducing health inequalities. This will be linked to the Public Health Outcomes Framework. The detailed model has not yet been set out and will be once the baseline and potential scale of the premium have been established, and there is an agreement about how the public health outcomes framework will be used. Partners will be consulted on the premium.

Public Health Outcomes Framework

3.30 In planning and prioritising public health actions Local Authorities will have a statutory duty to have regard to the Public Health Outcomes Framework which sets out the government’s overarching outcomes and the domains and indicators that support their achievement.

3.31 The outcomes are:
- increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life;
- reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

3.32 These two outcomes together underpin the overall vision to improve and protect the nation’s health while improving the health of the poorest fastest. The framework is not only about extending life: it also covers the factors that contribute to healthy life expectancy, including what happens at the start of life and how well we live across the life course.

3.33 Annex A, attached, provides a one-page overview of the outcomes framework, domains and indicators. The framework will be supported by nationally collated and analysed data which will be published in a common format by Public Health England.

3.35 Practically speaking the Government has stressed that the Outcomes Framework is not a performance management tool, and it must not replicate the approach of the previous National Indicator Set. It should be a consistent means of presenting the most relevant, available data on public health for national and local use.

3.36 It will be for local authorities, in partnership with the Health and Wellbeing Board, to demonstrate improvements in public health outcomes through
achieving progress against those indicators that best reflect local health need (as set out in the Joint Strategic Needs Assessment, and reflected in the Joint Health and Wellbeing Strategy). It is therefore envisaged that specific progress against the measures in the framework will be being built into future Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies as appropriate. It is expected that the Public Health Outcomes Framework will be refreshed each year as data quality improves, technical capability across the public health system develops, and as an aligned approach across the NHS, local authorities and Public Health England is maintained.

3.37 There will be a strong link between the Public Health Outcomes Framework and the health premium which will incentivise action on a small number of indicators that reflect national or local strategic priorities.

3.38 Further development of indicators set out in the outcomes framework is required in order to arrive at a full set of baselines to support local service planning by the autumn of 2012. Public health observatories will play a key role in developing this in partnership with local authorities and the NHS, with the Department of Health leading the next technical stages to develop final technical specifications for each indicator over 2012-13.

3.39 Further details of the Governments plans for the health premium will be issued as part of a finance update later in 2012.

**HealthWatch**

3.40 A further responsibility of the local authority is to commission the local HealthWatch which will take on the work of the current Local Involvement Networks (LINks) and will also:

- represent the views of people who use services, carers and the public on the Health and Wellbeing boards set up by local authorities.
- provide a complaints advocacy service from 2013 to support people who make a complaint about services.
- report concerns about the quality of health care to Healthwatch England, which can then recommend that the CQC take action.

The Government’s intention is that the new organisations will be operating from April 2013, however delays in the national announcement of regulations and funding, now due in November 2012, are likely to inhibit implementation from 1 April 2013.

**4. Local plans and progress**

4.1 Despite the extended transition and uncertainty created by the passage of the Health and Social Care Act (2012) through Parliament planning and some implementation of the changes stemming from the Act has been undertaken. As indicated above there has been and remains a lack of clarity and guidance about key aspects of the changes, which now that it has been passed will either be clarified or will require local discussions and agreement on how to proceed.
Strategy

4.2 Leicester has established a shadow Health and Wellbeing Board (HWB) – chaired by the City Mayor with membership from elected members of the local authority, Clinical Commissioning Group, PCT Cluster and LiNks/HealthWatch in addition to the Joint Director of Public Health and the Directors of Adult Social Care and Children’s Services. Among other things, the shadow HWBB has undertaken development sessions in relation to its new role, agreed statements of public health priorities and the expectations of health service providers, approved plans for the JSNA and developed and agreed an Interim Health and Wellbeing Strategy for 2012/13.

4.3 The Joint Strategic Need Assessment (JSNA) – referred to in Leicester as the ‘JSNA Programme’ – is led by the multi-agency JSNA Project Board which chaired by a Deputy Director of Public Health and reports to the Health and Wellbeing Board. The previous JSNA was updated in 2011. The results of the 2012 JSNA summary and overview report has been considered by the Shadow Health and Wellbeing Board on 29 May 2012 and broad priorities for the Joint Health and Wellbeing Strategy (JHWBS) for 2013/14 agreed.

4.4 The JHWBS will now be developed by a group led by the Director of Public Health and reflecting membership of the Board, including Leicester LiNk and Leicester City CCG. The shadow Health and Wellbeing Board aims to have considered a first draft of the strategy by July, a substantive draft by September and to have fully signed off the strategy by December 2012. A full programme of engagement has been planned which will take place between June and September 2012.

4.5 The JSNA programme in Leicester also consists of a training programme, run in conjunction with Leicester University, for local authority, voluntary organisation and NHS staff on health need assessment. The first course has been held and the training programme will be further developed later in 2012. In addition to the Joint Strategic Needs Assessment – which focuses on the big picture and longer term – the JSNA programme has also undertaken in 2011/12 two Joint Specific Need Assessment (‘deep-dives’) related to Dementia and to Drugs & Alcohol. A process for systematically identifying a two or three year programme of joint specific need assessments has been developed and further topics have been agreed.

Public Health Transition Plan

4.6 A Public Health Transition Plan has been developed and signed off by the PCT Cluster and the City Council and rated by the Strategic Health Authority Midland and East as green. This lays out the issues, structures and processes for managing the implementation of the changes stemming from Equity and Excellence and Health Lives, Healthy People.

4.8 The plan makes use of the guidance currently available and seeks to build on the progress made locally in closer working and collaboration between the public health team of NHS Leicester City and Leicester City Council. Progress against timescales is therefore dependant in a number of key areas, health
protection and workforce, on further national guidance and the establishment of key structures (e.g. Public Health England).

4.9 The Plan identifies the initial actions and timescales to address the transition arrangements for the delivery of Public Health responsibilities during the transition year. These are organised by the following workstreams:
- Finance
- Contracts and procurement
- Workforce
- Maintaining delivery
- IT and information governance
- Governance
- Communications

4.10 The Joint Director of Public Health for Leicester City Council and NHS Leicester City is the executive sponsor of this transition plan and has overall responsibility for monitoring progress against the plan and ensuring that it meets the requirements of the legislation and reports progress to the PCT Cluster Transition Management Team (TMT) and Leicester City council Strategic Management Board (SMB).

4.11 The practical implementation and further development of the plan is undertaken by the Public Health Transition Group. Progress is reported through the Transition Programme Management Group to the Shadow Health and Wellbeing Board, the city council (Cabinet and SMB) and the LNR PCT Cluster (Board and Transition Management Team).

**Joint Director of Public Health**

4.12 The Joint Director of Public Health for Leicester City Council and NHS Leicester City has been in post since June 2008 following a jointly agreed appointment process. Within Leicester City Council the DPH is a member of the Strategic Management Board, is directly accountable to the Chief Operating Officer and has the status of a Chief Officer. Within the NHS sphere of operation, the DPH is a member of the PCT Cluster Board and also directly accountable to the Chief Executive of the PCT Cluster.

4.13 As indicated above further national guidance will be issued regarding the appointment or transfer of DsPH to Local Authorities.

**Public Health Team**

4.14 In line with the broad transition plan agreed between NHS Leicester City and Leicester City Council in January 2011, relevant public health staff of NHS Leicester City have been based in Leicester City Council, New Walk Centre, since November 2011. These staff remain employees of NHS Leicester City and a co-location agreement is in place. Induction into Leicester City Council have been held for all co-located public health staff and a programme of engagement with staff and elected members of LCC is underway and will continue through to and beyond April 2013.
4.16 With respect to staff who will be transferring their employment from NHS Leicester City to Leicester City Council on 1 April 2013 there will now be close working between the HR departments of both organisations to ensure a smooth transfer of staff. Planning for this transfer is addressed in the Workforce workstream of the Public Health Transition Plan.

**Transferring contracts for services**

4.17 In addition to the transfer of staff, the transition also involves the transfer of responsibility for contracting public health services related to the local authority’s new public health functions and commissioning responsibilities. This work is included in the Public Health Transition Plan and a workstream is focused on assessing the contracts held by the NHS and considering the best approach to managing the transfer from 1 April 2013.

**Financial Implications**

4.18 It is stated by the Department of Health that (except in exceptional circumstances) local authorities should expect no less than their baseline uplifted to 2012/13. The allocation for 2013/14 itself will only be confirmed at the end of 2012.

4.19 An assessment of the total public health spend within the NHS for the financial year 2010/11 was made in September 2011. This was required by the Department of Health and undertaken locally by NHS Leicester City in cooperation with Leicester City Council. The Directors of Finance for NHSLC and the Chief Operating Officer for Leicester City Council agreed a joint statement of the strengths and weaknesses of the return. This return has been used by the DH to calculate baseline estimates for 2012-13 for each of NHSCB, LA, and PHE.

4.20 As a result of the above planning for 2013-14 will initially be based on the baseline 2012/13 figure indicated by the DH as £16,995m and an application has been made to the DH for an update to the baseline figures identified by them.

4.21 The ring-fenced grant allocation for Leicester for 2013/14 will be announced by the DH around the end of 2012. The distribution formula to be used, and any ‘distance from target’ arrangements adopted, will be announced by the DH in due course.

4.22 The finance workstream of the Public Health Transition Plan will consider the financial issues indicated.

**HealthWatch**

4.23 A vision for HealthWatch has been agreed with the Shadow Health and Wellbeing Board, a LINks/HealthWatch Transition Board has been established and an engagement event held in March 2012. The publication by the Department of Health of regulations and the funding allocations to the authority
will not be available until November 2012. A separate report will be submitted to the Executive on the implications of this for the procurement of HealthWatch.

4 Background information and other papers:

5.1 A large number of documents have been issued by central government in relation to the Health and Wellbeing Act (2012). Principal documents are:

- Equity and Excellence: Liberating the NHS, Department of Health (2010)

- Healthy lives, health people: our strategy for public health in England
  Department of Health (2010)

- The New Public Health System and Public Health in Local Government, Factsheets, both Department of Health (2011)

- The Leicester Public Health Transition Plan (March 2012)

5 Further information

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### Vision

To improve and protect the nation’s health and wellbeing, and improve the health of the poorest fastest.

**Outcome measures**

- Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.
- Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

---

**1 Improving the wider determinants of health**

**Objective**

Improvements against wider factors that affect health and wellbeing and health inequalities.

**Indicators**

- Children in poverty
- School readiness (Placéholder)
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness or disability in settled accommodation
- People in prison who have a mental illness or significant mental illness (Placéholder)
- Employment for those with a long-term health condition including those with a learning, difficulty disability or mental illness
- Suicide atter rate
- Killed or seriously injured casualties on England’s roads
- Domestic abuse (Placéholder)
- Worked cease (including sexual violence) (Placéholder)
- Re-offending
- The percentage of the population affected by noise (Placéholder)
- Statutory homelessness
- Use of green space for exercise/health sessions
- Fuel poverty
- Social connectedness (Placéholder)
- Older people’s perception of community safety (Placéholder)

---

**2 Health improvement**

**Objective**

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities.

**Indicators**

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under-19 conceptions
- Child development at 2-2.5 years
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- Emotional wellbeing of looked-after children (Placéholder)
- Smoking prevalence – 7 year olds (Placéholder)
- Hospital admissions as a result of self-harm
- Diet (Placéholder)
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded deaths
- Alcohol-related admissions to hospital
- Cancer diagnosed at stage 1 and 2 (Placéholder)
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

---

**3 Health protection**

**Objective**

The population’s health is protected from major incidents and other threats, while reducing health inequalities.

**Indicators**

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plans
- Comprehensive, agreed inter-agency plans for responding to public health incidents (Placéholder)

---

**4 Healthcare public health and preventing premature mortality**

**Objective**

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

**Indicators**

- Infant mortality
- Tuberculosis in children aged five
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from lower disease
- Mortality from respiratory diseases
- Mortality from communicable diseases (Placéholder)
- Excess under 5 mortality in adults with serious mental illness (Placéholder)
- Suicide
- Emergency readmissions within 30 days of discharge from hospital (Placéholder)
- Preventable sight loss
- Health-related quality of life for older people (Placéholder)
- Hip fractures in over 65s
- Excess winter deaths
- Dementia and its impacts (Placéholder)

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Appendix E2

Health & Well-Being Board
31st of July 2012

Commissioning Healthwatch

Lead Director: Tracie Rees

City Mayor
Useful information
■ Ward(s) affected: All
■ Report author: Jo Clinton
■ Author contact details: 0116 252 6873
■ Report version number: 1.0

1. Summary

1.1 The purpose of this brief is to inform the Health & Well-Being Board of the proposed preferred option to commission a Healthwatch service in Leicester City.

1.2 An option appraisal has been undertaken both for the Local Authority (LA) Strategic Business Case and with the Leicester LINk Board to identify their preferred option to commission Healthwatch. (Summary in Section 3: Options, detail in Appendix 1). Both exercises concluded a preference for Option 2.

1.3 The Health &Well-Being Board are recommended to proceed with Option 2, to undertake soft market testing (SMT) before procuring an organisation to deliver a not for profit Healthwatch Leicester. Following SMT the Health & Well-Being Board will be presented with a decision-making report detailing the outcome of SMT with recommended next steps.

2. Main report:

2.1 The Health and Social Care Act 2012 places a statutory duty on the LA to transform their LINk (Local Involvement Network) organisations into a Healthwatch service with effect from 1st of April 2013. Healthwatch will have additional extended functions relating to community engagement and signposting.

2.2 The aim of local Healthwatch will be to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

2.3 The key requirements from the Health and Social Care Act 2012 are:

- local Healthwatch organisations must be corporate bodies carrying out statutory functions;
- they must be not-for-profit organisations;
- Local Healthwatch must be able to employ staff and (if they choose) be able to sub-contract statutory functions.

2.4 Local Healthwatch are being described as ‘social enterprises’ in order to create as much freedom and flexibility for LA’s as possible. This will allow LA’s to commission from a range of legal structures which fall under the description of
‘social enterprises’ e.g. a charity, community interest company, a company limited by guarantee. Social enterprises are businesses which exist to address social or environmental need.

2.5 In 2007/8 funds of £160,000 were made available to Council via the Area Based Grant (ABG) to deliver a LINks service in the city. At the time the LA procured the Carer’s Federation to host the LINk for a three year period. However, these arrangements have been extended as an interim arrangement pending the introduction of the Health & Social Care Act 2012, but a formal procurement exercise would be needed to secure a new Healthwatch organisation.

2.6 Although the ABG monies are no longer ring fenced, a budget has continued to be allocated for the LINk and further details relating to additional allocations for the signposting function currently provided by the NHS patient, Advice and Liaison Service (PALS) is expected in November 2012. Therefore, any procurement exercise will need to include indicative amounts pending formal notification from the DoH.

2.7 As part of the health service reforms the Health and Social Care Act 2012 also transfers the duty to provide ICAS (Independent Complaints Advocacy Service) to local authorities, effective from 1 April 2013. Indicative funding for each local authority has been communicated for the ICAS arrangements. A separate report is being developed that will outline potential commissioning options for ICAS.

2.8 The following commissioning options have been considered for Healthwatch:

Option 1: Do nothing. This is not possible as Healthwatch is a statutory requirement placed on the Local Authority, the Council has no option but to ensure that Healthwatch is operational in the city by April 2013, otherwise the Secretary for State may intervene, and impose a penalty on the City Council.

Option 2: Procure an organisation to provide a Healthwatch organisation as a social enterprise.

Option 3: Create a local Healthwatch organisation without undertaking a procurement exercise. In Leicester there is local organisation (caSE-da) who specialises in this area and has a contract with the LA who could be able to support this option; however there would be a cost to Leicester City Council outside of caSE-da’s current contract value.

Option 4: A further option was asked to be considered by the current LINk board: To jointly commission Healthwatch with Leicestershire and Rutland Council’s. This would only be to share back office functions in order to release funds for front-line staff. This is not an option in its own right but could only be undertaken as a joint approach with options 2 and 3.

2.9 The recommended approach for the local authority is Option 2. This is likely to deliver Best Value to the public. Appendix 1 provides an overview of the discussion between the local authority and LINk board regarding the three options. If this option is confirmed by Leadership soft market testing will be commence to engage the local market to support this option.
2.10 The Local Government Association (LGA) advised that the LA can put Healthwatch out to tender “subject to any regulations that might be published” - Dave Shields (LGA Associate – Healthwatch Implementation Programme).

3. Details of Scrutiny

3.1 Internal advice has been taken from legal, finance and procurement colleagues.

3.2 Externally it has been scrutinised by the existing LINk’s Board and LINKs Transition Group who expressed a preference for Option 2 (details in Appendix 1).

5. Financial, legal and other implications

5.1 Financial implications

5.1.1 The funding made available by Department of Health (DoH) to Local Authorities for Healthwatch will be in two parts - the allocation for LINks (£160k for Leicester) and the additional allocation for the new signposting functions of Healthwatch. The DoH has recently informed Local Authority commissioners that the latter allocation will not be confirmed until November 2012. The indicative amount for Leicester has been published at £74,862, making the total amount available for Healthwatch in the region of £234,862.

5.1.2 In addition to the overall funding for Healthwatch there will be funding available in 2012/13 for start-up costs to set up local Healthwatch which includes costs such as staff recruitment and training, office set up costs, and branding. This amounts to £20,462.

5.1.3 Indicative funding for each local authority has been communicated for the ICAS arrangements. The basis for the financial allocation to individual authorities is the adult social care relative needs formulae. The national allocation of funding for ICAS has been set at £14.2m in 2013/14 and an identical figure for 2014/15. The allocation for Leicester City on this basis is indicated as £92,873 per annum. However, this sum of money shall not be confirmed until later in the year when the Learning Disability and Health Reform Grant details are announced.

Rohit Rughani – Manager, Financial Accountancy

5.2 Legal implications

5.2.1 Section 183 (2) of the Health and Social Care Act 2012 requires Local Healthwatch “arrangements to be made with a body corporate which – (a) is a social enterprise, and (b) satisfies such criteria as may be prescribed by the
It is fundamental that the Regulations are implemented before completing the procurement exercise. At present, there is only guidance (‘Local Healthwatch: A strong voice for people—the policy explained’) on what the Regulations could be. If Option 2 commences prematurely consequently, there is a risk that the work may become abortive because, the Regulations may prescribe the Local Healthwatch model which will impact on how the Council procures.

5.2.2 In view of paragraph 5.2.1, it is advisable to conduct a soft market testing exercise, by consulting interested Providers to assist us shape up potential procurement for a Local Healthwatch.

5.2.3 If the Director is proposing to go with Option 2, and looking to extend LINk arrangements during the transition period, it is advisable that she negotiates staff and case records of sensitive personal data, as this information will TUPE transfer to the appointed Local Healthwatch body.

5.2.4 The Local Healthwatch contract should also be procured in accordance with the Council’s Contract Procedure Rules/EU Regulations. Legal advice should be sought once enacted on potential acquisition of functions from LINk to Local Healthwatch, TUPE implications of NHS staff or their secondment to the Council.

5.2.5 Once the client is ready to proceed with the tender exercise, the tender documentation should include a caveat “this process is subject to the published Regulations” or equivalent.

5.2.6 It is advisable the Lead Commissioner considers if this project requires political approval, in accordance with the Council’s Constitution.

Nimisha Ruparelia – Commercial Contracts (Legal Services)

5.3 Climate Change and Carbon Reduction implications

5.3.1 There are no significant climate change or carbon reduction implications arising directly from the options presented in the report.

5.3.2 However, any implications should be considered as the specifications for the Healthwatch service are drawn up and the service commissioned or established. The Council’s Environmental Policy requires that third parties delivering services on behalf of the Council “adopt equivalent environmental standards” (to the Council).

5.3.3 The carbon reduction implications of sharing back office services with Leicestershire and Rutland should specifically be considered if such an arrangement would affect the requirement for office accommodation – and the resulting need for heating, lighting, etc.

Duncan Bell, Senior Environmental Consultant, Environment Team
5.4 Equality Impact Assessment

5.4.1 An equality impact assessment has been completed for Healthwatch transition. This is will be published on the Councils website.

5.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

5.5.1 No other implications have been identified at this stage.

6. Background information and other papers:

6.1 Health and Social Care Act 2012
   DoH guidance for the development of Healthwatch

7. Summary of appendices:

7.1 Appendix 1 - Advantages and Disadvantages of each option considered For Healthwatch
## Appendix 1  LINk Boards Option Appraisal

<table>
<thead>
<tr>
<th></th>
<th>Option 2 – Procure VCS</th>
<th>Option 3 - Create</th>
<th>Joint LLR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How</strong></td>
<td>Contracting and procurement team to undertake external procurement exercise.</td>
<td>Grant-aid or single tender option would need to be considered under this option. Development agency have advised that they will be able to support the creation of Local HW.</td>
<td>Would need political buy-in. Commissioners would need to develop joint service specifications and agree costing's.</td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td>At least 6 months.</td>
<td>At least 6 months.</td>
<td>Longer than 6 months.</td>
</tr>
<tr>
<td><strong>Cost to Commission</strong></td>
<td>Procurement costs would be negligible – SCPU will lead. Start-up costs available for successful organisation.</td>
<td>Case-da will charge to support this transition. Cost unknown at this time. Agreed that it would be more expensive than option 2. Would need to use start-up costs towards this.</td>
<td>Would be more than option 2.</td>
</tr>
<tr>
<td><strong>VFM</strong></td>
<td>Would complete VFM exercise as part of procurement but would also be considered more VFM as HW would share successful organisation's infrastructure.</td>
<td>Least VFM, would need specialist posts in Finance, human resources etc. which would be costly.</td>
<td>Considered more value for money than other options as back-office functions would be shared.</td>
</tr>
<tr>
<td><strong>Localism</strong></td>
<td>Concern over national organisation winning contract – would need to give extra weightings for local organisations if this option is agreed as preferred.</td>
<td>Most favoured under this heading as HW would truly be local as it would be created locally.</td>
<td>Health and Social Care issues will be different across each area – how will shared functions be prioritised?</td>
</tr>
<tr>
<td><strong>Independence</strong></td>
<td>Believe independence is credible as HW would be subsidiary of another organisation with their own</td>
<td>LINk board believe there would be a higher risk in terms of lack of independence as the Local</td>
<td>LINk board felt that whilst there would be shared back-office functions, independence would still be possible</td>
</tr>
<tr>
<td></td>
<td>Option 2 – Procure VCS</td>
<td>Option 3 - Create</td>
<td>Joint LLR</td>
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<td>-----------------------------------------------------</td>
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<td>--------------------</td>
</tr>
<tr>
<td>HW board directing and overseeing local HW.</td>
<td>Authority would be more involved in the setting up of local HW in this option.</td>
<td>under this option.</td>
<td></td>
</tr>
<tr>
<td><strong>Legal</strong></td>
<td>‘Body Corporate’ – legal issues &amp; personal responsibilities would be passed onto successful organisation and so less risk.</td>
<td>Would need specific legal advisor – Local Authority could provide but then that would impact upon the ‘Independence’ of HW.</td>
<td>Would all the local authorities to be able to agree in terms of all the legal considerations?</td>
</tr>
</tbody>
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NHS Leicester City and Leicester City Council
Public Health
Initial briefing on Census 2011- population estimates for Leicester

1. Introduction

The first release of Census 2011 population statistics was published on July 16th 2012 and includes household counts and population estimates (by 5 year age-bands and sex) for local authorities in England and Wales. Further detailed census results will be released by the Office of National Statistics (ONS) over the next two years.

2. Estimated population

The Census 2011 population estimate for England and Wales is 56.1 million:
- an increase of 3.7 million (7.1%) since the last census in 2001
- 16.4% of the population are aged 65 and over, an increase of 10.6% in the over 65s since 2001
- 6.2% of the population are children under 5, an increase of 13.1% in under 5s since 2001

Census 2011 population estimate for Leicester is 329,900:
- an increase of 47,000 (16.7%) since the last census in 2001
- 37,200 (11.3%) of the population are aged 65 and over, a decrease of 700 (-1.8%) in the over 65s since 2001
- 24,300 (7.4%) of the population are children under 5, an increase of 5,200 (27%) in the under 5s since 2001
- the overall population of Leicester has grown at a faster rate than that of England and Wales since 2001

3. How accurate is the estimate?

The 2001 Census had been an under-estimation of the population by over 3 million people in England and Wales, and many areas, including Leicester, experienced what is believed to have been a substantial under-estimation of their population.

For Census 2011 the ONS introduced improved survey and statistical methods and there is now greater confidence that Census 2011 is a more accurate assessment of the true size of the population. ONS have indicated that the Census 2011 population estimate for England and Wales is within 0.15% (+/-) of the true population\(^1\), and that Leicester is within 2.2% (+/-) of the true population (+/- 7,300 people)\(^2\). On this basis the 'true' population count lies between 322,600 and 337,100 people.

The population estimates are based on the census count (completed census forms) and an adjustment for individuals missed by the census. In Leicester the census count from

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The returned questionnaires was 303,800, which was adjusted up to 329,900 people to account for individuals missed by the census (8%). See Appendix 1 for information on the Census 2011 process, adjustments and quality assurance procedures.

4. **How does Leicester compare with England?**

Census 2011 shows that Leicester has a much younger population than England, with a larger proportion of residents aged under 35 years, and a lower proportion 35 years and over (figure 1).

*Figure 1. Census 2011 Population estimates for Leicester and England*

5. **How does Leicester’s population estimate in 2011 compare with earlier years?**

The following sections compares Census 2011 estimates for Leicester with previous years (mid 2001 and mid-2010 - see figure 2) and the GP resident registered population from 2011 (see figure 3). These population estimates are summarised in the table below and in the sections that follow, and by age and sex in appendix 2.

<table>
<thead>
<tr>
<th></th>
<th>mid-2001</th>
<th>mid-2010</th>
<th>GP Register 2011</th>
<th>Census 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population estimate</td>
<td>282,800</td>
<td>306,631</td>
<td>352,600</td>
<td>329,900</td>
</tr>
<tr>
<td>Difference to 2011</td>
<td>47,100</td>
<td>23,269</td>
<td>-22,700</td>
<td></td>
</tr>
</tbody>
</table>

6. **Census 2011 compared with population estimates from mid-2001**

Figure 2 shows that compared with the mid 2001 census estimates, the results from Census 2011 show:
• an overall population increase of 47,100, or 16.7%, to 329,000 residents
• a larger increase in males (18%) than females (15%)
• increases in the majority of age groups, except females between 65 and 79 years
• the largest increases are for people aged in their 20s (16,100) and under 5s (5,200)
• please note, the increase in younger people in Leicester may be partly due to large numbers of immigrants and partly due to the undercount in Census 2001.

Figure 2: Population estimates from Census 2011, mid-2001 and mid 2010

Data: Office for National Statistics: Census 2011 and mid-year estimates

7. Census 2011 compared with population estimates from mid-2010

Figure 2 shows that compared with the mid 2010 estimates the results from Census 2011 show:

• an overall population increase of around 23,300, or 7.6%, from 306,600 residents
• similar increases in males and females (11,600 each)
• largest increases are seen in 10-34 year olds (13,000)
• please note, there is a difference of over 23,000 between population estimates for 2010 and Census 2011, notably in the younger age groups. These differences will have implications for population projections based on 2010 estimates

8. Census 2011 compared with GP population 2011

GP register data was extracted from the ‘Exeter’ system by ONS in May 2011 and provides a count of the resident population of Leicester registered with a GP. Comparison of this with the results from Census 2011 show (see figure 3):

• a 6.4% larger population on GP registers (352,600) than the census (329,900)
• an additional 17,200 males (9.6%) and 5,500 females (3.2%) on GP registers
• larger numbers of males aged mainly between 25 and 54 years, and females aged mainly between 25 and 34 years
• note, ‘list inflation’ is a known problem in GP registers where people may move to another area and fail to re-register immediately or to be removed from their original register in the event of death.
• further investigation is needed to understand the differences in numbers of male residents.

Figure 3: Population estimates from Census 2011 compared with the GP register 2011

Leicester Population estimates, Census 2011 versus GP register 2011

Data: Office for National Statistics: Census 2011, GP registers 2011

9. Further information

Further information is available from Census website: http://www.ons.gov.uk/ons/guide-method/census/2011/index.html. Briefings will be produced on further releases of Census 2011 data in conjunction with colleagues in Leicester City Council. Questions and comments on this briefing would be appreciated.

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Leicester LE1 6ZG
Tel: 0116 252 8364
Email: helen.reeve@leicester.nhs.uk

23rd July 2012
Appendix 1: How the Census process has been improved for Census 2011


Census field work was carried out to enumerate the population
- Around 25 million pre-addressed questionnaires were posted out to all households using a specially developed national address register
- Questionnaires could be returned by post or on-line
- Questionnaires were electronically tracked and followed up at addresses where the questionnaires had not been returned
- Data from census questionnaires was scanned, captured, coded and cleaned

Census Coverage Survey (CCS) was undertaken independently to establish the coverage of the census
- An independent voluntary survey was carried out after the Census, for a representative sample of 1.5% of all postcodes in England and Wales. CCS had a 90% response rate.
- The results were matched against the returned questionnaires and used to estimate the number and characteristics of people missed by the census, those counted more than once, and those counted in the wrong place.

Coverage Assessment Adjustment (CAA)
- Methodology developed to adjust for those missed by the Census, based on the results of the CCS
- The CCS records were matched with those from the 2011 Census and used to estimate the populations for each local authority by age and sex, balancing over and underestimates, using a combination of statistical regression and small area estimation techniques
- Households and people estimated to have been missed by the census were then imputed into the census database

Quality Assurance at LA level including
- Specially developed national address register and questionnaire tracking system combined with better use of local knowledge and data to match census records with other data sources to understand discrepancies at the aggregate level. At Local authority level this included 6 core checks and 4 supplementary checks

Core checks: Census population estimates were compared with:
1) mid-year population estimates and a range of administrative datasets.
2) administrative data at Lower and Middle Super Output Areas population distribution level
3) demographic analysis including sex ratios (the ratio of men to women) and fertility/mortality rates
4) operational intelligence indicators including questionnaire return rates, tracking information and calls to the census contact centre
5) LA area profiles compiled from correspondence post 2001
6) LA-provided intelligence based on post 2001 census correspondence, local data and relevant QA research

Supplementary checks: used specific postcode clusters included in the sample for the Census Coverage Survey to compare with administrative datasets:
1) distributions of key characteristics such as age and sex.
2) an analysis of household sizes
3) to further understand differences in aggregate comparisons.
4) Analysis of visitor and second residence

Appendix 2: Census 2011, mid 2001, mid 2010 and GP registered population estimates by 5-year age and sex in Leicester

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Helen Reeve, Public Health, 23rd July 2012
Joint Health and Wellbeing Strategy priorities engagement feedback

1. Introduction

1.1 Leicester City's Shadow Health and Wellbeing Board is developing a Joint Health and Wellbeing Strategy during April – October 2012. Building on the information in the Joint Strategic Needs Assessment 2012, and early engagement with stakeholders, the Board developed an initial set of priorities.

1.2 They then engaged a wide range of stakeholders over the period June/July 2012 in order to understand their views of the priorities, before developing the strategy further.

1.3 Meetings were held with a variety of stakeholders including City Council Partnership Boards, the voluntary sector, patients and the public, and seldom heard groups. Voluntary Action Leicester organised a meeting which was attended by more than 40 representatives of the voluntary sector, and 76 people attended a meeting organised by Leicester LINk.

1.4 This document summarises the feedback from the engagement.

2. Proposed principle and priorities

2.1 The Shadow Health and Wellbeing Board proposed the following principle and priorities for the strategy:

2.2 Guiding principle: The reduction of health inequalities

2.3 Suggested priorities:

- Addressing the main causes of premature death (i.e. death under the age of 75)
- Meeting the needs of the most vulnerable people in society
- Improving mental health
- Improving outcomes for children and young people

3. Questions

3.1 A set of questions were developed and used in a questionnaire which was circulated widely to public sector and voluntary sector stakeholders, Leicester LINk and members of NHS Leicester’s membership. The questions were also asked at the various stakeholder meetings and events. The questions were:

- Do you agree with the guiding principle and the initial priorities?
- Within these priorities, what can we do to make the biggest difference?
- What are the obstacles to improving the health and wellbeing of the people of Leicester?
- What could you or your community do to help improve health and wellbeing in Leicester?

4. Summary of all the engagement activity

4.1 Overall the engagement activity received a positive response and there was a general consensus that the suggested priorities are correct and are focusing on addressing the health inequalities gap.

4.2 The largest amount of response was regarding question number 2, which specifically asks what we can do to make the biggest difference. A number of common themes were identified throughout the engagement activity. As well as specific health needs, the themes focused on process and access issues, and as such many of them could be seen as cross-cutting themes for the strategy, relating to several or all the priorities. They are summarised below.
• Improve communications - use plain English, greater provision of interpreters and consider communications mechanisms
• Commissioning process – encourage greater joined up working and commissioning of services – reduce bureaucracy and increase transparency
• Engage and develop communities and drive locally based services – improve signposting and access and invest in education, guidance and advice and outreach work
• Early intervention and prevention should be a key vehicle in service delivery
• Focus on the quality of drug and alcohol treatment and its relationship with offenders and mental health
• Consider wider determinants, particularly housing, ensuring there is adequate and affordable stock provided within social and private provision
• Mental Health – reduce the stigma; consider mental health in children and young people, and offender mental health

5. Detailed feedback summary

5.1 More detail from the feedback is summarised below.

6. Meeting with Head of Economic Regeneration, 28 June 2012

6.1 At this meeting the following points were made:
• There is a link between unemployment and poor health
• Consistently, the sector with the most unfilled vacancies is social care. Employment in that sector is unpopular, and has a high turnover (data is available to illustrate this)

6.2 It was suggested that the Joint Health and Wellbeing Strategy could:
• Include a requirement through procurement for suppliers of social care to invest in workforce skills and development, so that work in social care became more attractive
• Encourage apprenticeships through incentivising the supply chain, working with the Skills Council for Health and Social Care
• Encourage a business support programme re. opportunities in care, which could include recruitment fairs

7. VAL Health and Social Care Forum, 3 July 2012

This meeting was attended by around 40 people. Four tables discussed the four key questions (others discussed county council issues):

7.1 Do you agree with the guiding principle and four key priorities?
One group said yes, the others had additional points to add. They included:
• Good that mental health included – should be joint commissioning of mental health
• The priorities are too general eg who are vulnerable people
• Where is the accountability?
• How will the strategy match commissioning when commissioning is so silo-driven?

7.2 Within these priorities, what can we do to make the biggest difference?
• Joined up working, joint commissioning
• Early interventions, preventative work, health promotion (eg health checks), housing related support eg for vulnerable adults
• Community support alternatives for mental health, more local community empowerment, community-based services
• Vulnerable groups include LGBT, mental health, learning disabilities, immigrant community, unemployed, deprived, carers – equal access important
• Involve the VCS – fears re funding and sustainability

7.3 What are the obstacles to improving the health and wellbeing of the people of Leicester?
• Environment, language, cultural awareness
• Difficulty navigating services, need better signposting, variety of ways to access information, concerns re 111 number
• Lack of joint commissioning
• Bureaucracy, tendering, commissioning structure
• Financial situation/cuts, lack of investment in the voluntary sector
• In mental health, that people have to wait until seriously ill before they can access services
• Not sharing information, including local data

7.4 What could you or your community do to help improve health and wellbeing in Leicester?
• VCS know their communities geographically and culturally, so have knowledge that could influence strategy
• Integration of VCS with neighbourhood services
• By building communities – developing local community groups

7.5 Overall general points:
• It is important for health and social care issues to be brought together
• Involve the voluntary sector
• Early intervention and giving children the best start is important
• Tackle deprivation
• Homelessness and housing a key issues
• Social as well as health inequalities are important
• Advice services are central – communication is important

8. Discussion with Stronger Communities Partnership, 5 July 2012

8.1 The following points were made:
• The Partnership agreed with the priorities
• It would be good to have a sum of money that could go straight to community groups to help promote health
• Campaigns to help people understand how to improve their health can work well (eg a campaign in Canada called ‘Participation’)
• Measures should be taken to help people improve their physical activity; this could include working with the Sports Partnership; joint commissioning between the CCG and the city council; work in schools; a number of pilots – but if they work, there should be the capacity to roll them out; social marketing; the use of technology (eg Wi’s); working with community groups
• The SHWB should work with the Stronger Communities Partnership as they developed their volunteering strategy, as this could link with a physical activity programme
• Simon Cole, Chief Constable of Leicestershire, is now the national lead for the Association of Chief Police Officers on Mental Health and Disability issues and will be interested in supporting the mental health strand of the strategy
• The Stronger Communities Partnership have a multi-agency partnership working with refugees and asylum seekers and a New Arrivals Strategy Group chaired by Mark Wheatley, the Public Health representative on the Partnership – the strategy element re vulnerable people could liaise re this

9. Meeting with Action Deafness group at St Matthews Centre, 5 July 2012

9.1 This meeting was attended by 10 people. The following points were made:
• The group agreed with the priorities, but thought they should contain more detail
• Mental health in children is important
• Deaf people need better access to services and knowledge of services
There are a number of problems to do with communication and deaf people:
- There is a literacy issue within the BME deaf community which means they can’t communicate with their doctors by writing things down
- Although interpreters are usually available at hospital, they aren’t always booked in for consultations with GPs. Also, at hospital, people’s names will be called even though they can’t hear
- It would be good if front line staff (eg receptionists) had interpreting/signing skills
- When deaf people visit a clinic where they must press a button for entry, it would be good if there was a video link

Families of deaf people need support as well as deaf people
Day Centres (such as those run by Age Concern) should find out from the people who attend them whether they need help at home

10. Meeting with Safer Communities Partnership, 10 July

10.1 The Partnership were happy with the principle and priorities.

10.2 The areas where their work overlaps with health issues include:

- Premature death – causes include alcohol
- Vulnerable people – offenders often have issues with drugs and alcohol, and this also links to mental health issues
- Troubled families – links across all the priorities
- Antisocial behaviour – mental health features highly

10.3 With regard to particular issues to focus on within the priorities, the partnership suggested:

- Work with offenders, engaging with their health needs, including initiatives in deprived areas
- The psychological impact of offending on victims
- Link the strategy’s outcomes to the Partnership’s outcomes
- Working together with regard to preventative services for people who require adult social care or other care – the police currently often are involved in responding to issues where they don’t have specific expertise eg mental health crises

10.4 The group felt that obstacles included:

- Many vulnerable groups/individuals are not registered with GPs, and need to be registered

10.5 Suggestions included:

- Work in partnership so that interventions led by this group are included in the broader strategic picture
- Have clarity about who is leading and driving interventions (eg multiagency interventions), as sometimes this is unclear
- Use empty shop fronts for promotional messages

11. Leicester LINk event, 12 July

11.1 Leicester LINk organised an event on 12 July to gather feedback from local networks, organisations, patients and members of the public about the developing Joint Health and Wellbeing Strategy. The full report from this event is available at Appendix A.

11.2 The event was attended by 76 people, and groups represented included people with physical and sensory disabilities, users of mental health services, delegates from the probation service, homeless services, and people with long term conditions (eg HIV, chronic heart disease,
11.3 The delegates broadly agreed with the principle and four suggested priorities, although they felt they should be clearer eg about what ‘vulnerable’ means.

11.4 Key points were:

- **Commissioning process**
  
  In order to utilise available skills and resources commissioners should ensure a range of providers including the community and voluntary sectors, using evidence from research based on case studies to gain grassroots feedback from services users. The recommendation was made to redirect funding so that more is allocated to lower level services to benefit more community members and to enable effective early intervention. Commissioning should make provision for the priority groups identified in the strategy to provide measurable equity of access and outcomes.

- **Accountability and scrutiny**
  
  Realistic achievement in outcomes, focusing on presenting measurable targets: ‘see rather than be told’. People want to be involved in making decisions on the spending and priorities in generally; engaging with local residents should be a part of the budgeting process, local ownerships of projects and decisions. People not only want to get involved to scrutinise the service but also to provide local intelligence, knowledge and skills of those who are going to be impacted on.

- **Prevention and early intervention**
  
  Early intervention and prevention should be a key vehicle in service delivery. People would like to see services working together to provide education, health literacy, and awareness to all at the early stage. Programs and initiatives should aim at promoting better understanding of illnesses and risks; there should be more investment in screening/accessible screening.

- **Housing**
  
  In relation to housing it is necessary that there is adequate and affordable stock provided within social and private provision. Greater consideration should be given to homelessness and rough sleepers – suitable housing should be provided to all not just for people who can afford it. Further improvement and better allocation of resources is needed.

- **Community education and awareness**
  
  There was a widespread belief that more awareness and education within communities is needed. Set up initiatives ‘on the ground’ delivered by community members and local leaders to enable communities to access information and services related to the effective management of behaviour and wellbeing. Targeted services should be commissioned and be delivered in a variety of community settings, to provide a less stigmatising environment, in particular in activities relating to health promotion and awareness to change people’s lifestyles.

- **Communication**
  
  Appropriateness of communication, being listened to, understanding the structures and process were recorded as the most important while dealing with services. There were considerable barriers identified to communication both in spoken and written language. Using plain English, face to face interactions and greater provision of interpreters were strongly recommended by participants. Remember that not everyone has access to IT (digital exclusion), particularly people from deprived neighbourhood and older generation.

- **Engagement/ Community Outreach**
  
  - Delegates would like to see better use of community feedback and responses by sharing information about the community needs amongst decisions makers - ‘using what is out there in the community rather than trying to reinvent the wheel’.
In order to achieve desirable outcomes for the community, services should be integrated into other community based support services. Implementation of more community based information and training sessions to increase awareness and access to services through community media channels. Promotional materials should convey messages about general health and wellbeing and support provided.

Greater provision of empowerment initiatives and advocacy support to encourage people to ask questions; educate members of the public via community groups, faith leaders and outreach work.

12. Meetings with members of the Somali community, 16 and 17 July

12.1 Two meetings were held with members of the Somali community. On 16 July 12 men and one interpreter attended, and on 17 July 12 women and one interpreter.

12.2 They agreed with the principle and priorities.

12.3 The issues where they felt a difference could be made included:

- Communication and interpretation – poor communication caused by language issues is a problem and can limit access to GPs and other health services. In some cases GPs do not provide interpreters
- An outreach programme and more space and access to community activities eg social classes, gym
- More education, information and support about health issues including pregnancy, mental health eg awareness sessions, programmes on Eva FM to promote healthy eating/diet, healthy lifestyles and wellbeing
- Tackling housing issues including overcrowding, sanitation problems in communal areas of housing (rubbish not being collected, rats problem), industrial areas next to housing
- The prevalence of the use of the herb ‘khat’ among the community – women felt that this impaired users’ involvement in society and they were surprised it is freely available in this country – in other parts of Europe it is restricted.

13. Survey results

13.1 Responses to the questionnaire were received from 95 people, replying either as individuals or as representatives of organisations. Forty three people represented organisations; the rest of the responses were from individuals.

13.2 Appendix B shows the detail of the responses. Below is a summary:

13.3 Question: Do you agree with the guiding principle and the initial priorities?

Ninety six per cent of respondents agreed with the guiding principle, and 86.2% agreed with the suggested priorities. Overall the feedback suggested both organisations and individuals felt the priorities were addressing inequalities.

13.3.1 Organisations

The organisations responding to this question highlighted a small number of issues:

- A greater focus needed on dementia, support for carers and quality drug and alcohol treatments
- The priorities are broad – they sound good in theory but could have many holes in practice
- Need to be clear on the definition of vulnerable adults and who this may include

13.3.2 Individuals
Like the organisations, many of the individuals responded highlighted similar concerns. They agreed that dementia, care and drugs and alcohol were a priority. There was also a sense that the priorities were too vague and needed to be clearly defined.

13.4 Question: Within these priorities, what can we do to make the biggest difference?

13.4.1 Organisations

The organisations responding to this question highlighted a number of options:

- Focus on prevention – be proactive rather than reactive
- Work closely with the community, improve education, advice, guidance and empower people. Develop community champions to inspire positive choices - a focus on the mental toolkit of positive wellbeing.
- Improve communication mechanism to better engage with local issues
- Make GPs and surgeries more friendly and accessible to young people and the homeless. Utilise GPs to signpost patients to other local services
- Improve partnership working across the statutory and voluntary agencies, look for opportunities for cross border working with the county
- Look to reduce the sigma around mental health, consider investing in a crisis mental health team
- Caring for the most vulnerable people in society – the homeless and disabled

13.4.2 Individuals

The individual comments were very similar the comments made by the organisations, however there was a larger focus on the importance of effective communications and the need for community/local based services. The lack of translator services was also a common problem that was highlighted. Access and education could be improved and that it was not only children who needed education. Reducing the stigma surrounding mental health and invest in and stress/anxiety classes. One individual stated that GPs should respect the patients and many individuals felt that GPs should be used to signpost and promote other services. Drugs, Alcohol, smoking, physical diet and young people were also mentioned on a number of occasions.

13.5 Question: What are the obstacles to improving the health and wellbeing of the people of Leicester?

13.5.1 Organisations

The organisations responding to this question highlighted a number of issues:

- Poverty/financial inequality, including impact on access to transport and thus to the countryside; access to sport and healthy food; housing conditions
- Social inequality, with different problems affecting different communities. People feeling disempowered to change themselves
- A perceived gulf between professionals, who can appear judgmental, and people accessing services, for example young people, homeless people, people with mental health needs, people with disabilities, LGBT community, other communities. Sense that the professionals do not understand the day to day realities of living with or in various conditions. Lack of engagement with local people in planning and delivery of services
- Government cutbacks, poor investment in community sector
- Lack of engagement by commissioners with voluntary sector
- Drink and drugs, including the lack of out of hours drink and drug services
- Lack of knowledge and information about illness, how to stay healthy, and what services are available
- Poor access to services, particularly for hard to reach groups
- Service delivery that is not joined up

13.5.2 Individuals
Individuals’ views of obstacles mirrored those given by the organisations, with a particular emphasis on financial inequalities, including poor housing, unemployment, and the sense that some groups (such as asylum seekers and refugees) were neglected or excluded. Racism was also mentioned. Government cutbacks were mentioned by several people. One person felt that too much was invested in big hospital trusts, and the money should be spent on community, housing, education and the 3rd sector. People also talked about the lack of information and education about health and health services, including information for young people about mental health. Additional obstacles included:

- Language barriers and communication issues – this was mentioned by a number of people
- Lack of a body ‘with teeth’ to scrutinise the Health and Wellbeing Board
- GPs’ lack of awareness of problems, reluctance to spend money. Difficulty of getting access to a GP who ‘knows you’
- Bureaucracy and inadequate management
- Lack of specialist services for people with learning disabilities

13.6 Question: What could you or your community do to help improve health and wellbeing in Leicester?

13.6.1 Organisations

The organisations responding to this question were keen to work in partnership – this was particularly true of public sector and voluntary sector groups. They had a number of suggestions of how they could help improve health and wellbeing:

- Develop community solutions, including community based health and wellbeing advice and activity projects for specific groups such as frail elderly, people with disabilities etc;
- Woodland Trust projects offering free trees for community groups to plant
- Development of workplace wellbeing strategies and plans
- Developing information about health and wellbeing, including being part of a FCS/NHS group mapping the benefits to health of advice and information (suggestion by Citizens Advice Bureau)

A number of the groups named specific initiatives which they would like to tie in with the Joint Health and Wellbeing Strategy.

13.6.2 Individuals

Like the organisations, many of the individuals’ suggestions for how they could help focused on the community. They included:

- Keep an eye on old people like they used to years ago and try to help people who have disabilities doing shopping etc/ help to create a more caring and sharing society
- More volunteers working on preventative programmes eg leafleting neighbourhoods with health information
- Involvement in promoting awareness of mental health issues
- Demand better health services
- Support for community food buying

14. Conclusion

14.1 Additional feedback is still being gathered and will be taken into account in the final development of the strategy.

23 July 2012
Appendix A

Introduction

Leicester City Local Involvement Network (LINk) and a Shadow Health and Wellbeing Board jointly hosted engagement event dedicated to the topic of ‘Joint Health and Wellbeing Strategy’ on 11 July 2012 at Adult Education Centre in Leicester. The event was a successful way of consulting the public about development of the Health and Wellbeing Board and its plans, whilst also engaging them in a dialogue. Leicester’s Shadow Board is currently in the early stages of developing a strategy for the City.

The health and social care reform, set out in the Health and Care White Paper, and now being enacted following amendments to the Health and Social Care Act passed in March, radically changing the health landscape and partnerships responsible for prioritising and commissioning health and care services. Health and Social Care Act 2012 creates new bodies and new partnerships at local level and transfers responsibility for public health from the NHS to local government. Greater levels of public involvement in health and allowing more local control over commissioning decisions are the central objectives of these reforms.

The act puts in place new body called Health and Wellbeing Board - local partnership bringing together those responsible for commissioning health and care services locally. The Board is responsible for developing Joint Strategic Needs Assessment (JSNA) and joint Health and Wellbeing Strategy (JHWS) for each locality.

The event was very well attended and generated a great feedback for all involved. Delegates represented a wide range of networks and organisations, and most importantly general members of the public. The community based projects were very well represented by local infrastructure groups to include physical, sensory, and mental health services users. Other delegates included representatives from probation service, homelessness people and long standing illness (e.g. HIV, chronic heart disease, Alzheimer). There were a number of delegates voicing ethnic groups in the City, to include, the Race Equality Centre, the representatives from Chinese, Somalis and Asian Community.

Summary

In general participants agreed with the guiding principle and four key priorities for the Joint Health and Wellbeing Strategy to reduce health equalities in the City, so that everyone has the same chance of good health. People felt the definition of ‘the most vulnerable people’ needs clarification and better description to include all nine protected characteristics, people with communication difficulties and those how do not know the system very well.
Implementation of the strategy should focus on and promote partnership and joined up approach not just between health and social care providers within statutory and voluntary sector but also within health and non-health services to provide holistic and meaningful initiatives within mainstream services. Many local organisations would like to work together and would welcome strategic leadership. Some existing services were seen as too fragmented and lacked co-ordination. Better audit and mapping of resources is needed to ascertain the right level of local service infrastructure.

Prevention and early intervention are vital. Preventing people from illnesses and improving lifestyles risks factors were highly recognised by the delegates. A range of flexible non-judgemental services is required to meet individual needs.

Development of outreach schemes and empowerment initiatives for the communities was seen as the key to prevention, particularly for the most vulnerable groups or those with need more dedicated support.

Understanding patient experiences of services by commissioners were discussed. People felt that by allowing patients and the public to be at the centre of the commissioning process will define the outcomes of service reconfigurations from the patient perspective as a ‘measurable’ patient experience and thus lead to better and more effective commissioning.

A consistent range of evidence based models at different levels of need should be agreed alongside with tangible performance and outcomes framework.

Within the discussions, there was the understanding that resources and money is not the same thing. “Resources” refers to more than money, such as peoples’ time, equipment, venues and expertise etc; and it has to be recognised by decision makers.

**Event overview**

A total of 76 delegates of organisations, stakeholders and the general public were brought together to provide input and share their views on four suggested priorities for the Joint Health and Wellbeing Strategy. This was achieved through a short presentation and two workshops. The information gathered will be taken forward and used in formulating the strategy plans and objectives.

The day was opened by the LINk Chair- Hasmukh Jobanputra, following by the presentation from Sue Cavill- Associate Director Health Projects, NHS Leicester, Leicestershire and Rutland, outlining a background to the Shadow Health and Wellbeing Board and the Joint Health and Wellbeing Strategy. The audience was also presented with the key facts from the Joint Strategic Needs Assessment.

The main aim of the session was to consult local residents in planning for Leicester’s future health and wellbeing. The initial priorities set out by the Board were presented and are listed below.

The guiding principle for the Joint Health and Wellbeing Strategy is the reduction of health inequalities. The four suggested priorities for the Strategy are as follows:

- Addressing the main causes of premature death (i.e. death under the age of 75)
- Meeting the needs of the most vulnerable people in society
- Improving mental health
- Improving outcomes for children and young people

The attendees were asked to contribute to the workshops and table top discussion exploring the following four key questions:

1. Do you agree with the guiding principle and the initial priorities?
2. Within these priorities, what can we do to make the biggest difference?
3. What are the obstacles to improving the health and wellbeing of the people of Leicester?
4. What could you or your community do to help improve health and wellbeing in Leicester?

Participants were also encouraged to complete individual questionnaire so that views could be collated and presented as part of the Joint Health and Wellbeing Strategy.

**Feedback from attendees**

**Facilities Group Discussion:**

At the end of the morning session, delegates were given the opportunity in groups to discuss the suggested priorities for the Health and Wellbeing Strategy against four key questions. The key points arising were:

**Commissioning process**

In order to utilise available skills and resources commissioners should ensure a range of providers including the community and voluntary sectors; using evidence from research based on case studies to gain grassroots feedback from services users. Recommendation was made to redirect funding so that more is allocated to lower level services to benefit more community members and to enable effective early intervention. Commissioning should make provision for the priority groups identified in the strategy to provide measurable equity of access and outcomes.

**Accountability and scrutiny**

Realistic achievement in outcomes, focusing on presenting measurable targets: ‘see rather than be told’. People want to be involved in making decision on the spending and priorities in generally; engaging with local residents should be a part of the budgeting process, local ownership of projects and decisions. People not only want to get involved to scrutinise the service but also to provide local intelligence, knowledge and skills of those who are going to be impacted on.

**Prevention and early intervention**

Early intervention and prevention should be a key vehicle in service delivery. People would like to see services working together to provide education, health literacy, and awareness to all at the early stage. Programs and initiatives should aim at promoting better understanding of illnesses and risks; it should be more investment in screening/accessible screening.

**Housing**

In relation to housing it is necessary that there is adequate and affordable stock provided within the social and private provision. Greater consideration should be given to homelessness and rough sleepers – suitable housing should be provided to all not just for people who can afford it. Further improvement and better allocation of resources is needed.

**Community education and awareness**

There was a widespread belief that more awareness and education within communities is needed. Setting up initiatives ‘on the ground’ delivered by community members and local leaders to enable communities to access information and services related to the effective management of behaviour and wellbeing. Targeted services should be commissioned and be delivered in a variety of community settings, to provide a less stigmatising environment, in particular in activities relating to health promotion and awareness to change people’s lifestyles.
Communication:
Appropriateness of communication, being listened to, understating the structures and process were recorded as the most important while dealing with services. There were considerable barriers pointed to communication both in spoken and written language. Using plain English, face to face interactions and greater provision of interpreters were strongly recommended by participants. Remember that not everyone has access to IT (digital exclusion), particularly people from deprived neighbourhood and older generation.

Engagement/ Community Outreach
Delegates would like to see better use of community feedback and responses by sharing information about the community needs amongst decisions makers- ‘using what is out there in the community rather than trying to reinvent the wheel’.
In order to achieve desirable outcomes for the community, services should be integrated into other community based support services. Implementation of more community based information and training sessions to increase awareness and access to services through community media channels. Promotional materials should convey messages about general health and wellbeing and support provided.
Greater provision of empowerment initiatives and advocacy support to encourage people to ask questions; educate members of the public via community groups, faith leaders and outreach work.

Event Evaluation:
A short evaluation form was circulated to all participants at the event. This was used to ascertain the audience feedback of the day and formulated this report. A total of 14 responses were received, and can be summarised in a chart below:
The majority of delegates, who responded to the question of ‘what did you gain from the event’, stated that they gained greater understanding of changes being made to healthcare locally and that the City has a lot of work to achieve. Comments in this respect included:

- Achieve greater understanding of the challenges
- Better knowledge of basic problems in Leicester
- Knowing the aims of what the health and wellbeing board would like to achieve
- Good networking opportunities and have early involvement to shape the strategy and have own organisational input

It was general consensus among attendees to have another event in the future to see the progress and evaluation of the four suggested priorities. Service users acknowledged that they would like to have more time to discuss their contribution into strategy. Many felt commissioners don’t understand those users who access the service.

Delegates who recorded general comments about event organisation and the format of the day were largely constructive, and included:

- Accessibility - difficulty in locating Hansom Hall (lift and direction could be improved)
- Needed more time – longer event
- Acoustic were awful
- One person facilitating group discussion - hard to hear group members

When delegates been asked ‘is there anything else they would like to have covered at the event’, following comments were recorded:

- More specific
- How to get and educate/train volunteers
- Showing practical measures
- Five years plan

Event evaluation was analysed using ‘Survey Monkey’ facilities and full report can be obtained on request.
Appendix B

Health and Wellbeing Strategy
Planning for Leicester's future health and wellbeing – have your say
Total number of questionnaires completed: 95

Question 1: If you are representing an organisation or group, please tell us which one

Responses 42
"20-20 vision of VOICE" Cancer Appeal
Braunstone area - city councillor for area
CANP KONP
Carers Action Group
Citizens Advice Bureau
De Montfort University
Drug and Alcohol Action Team, LCC
First Step
Foundation Housing Association - Supported Housing
Groundwork Leicester and Leicestershire
HEALTH AND COMMUNITY INVOLVEMENT COMMISSION LEICESTER CITY COUNCIL
LASS
Leicester City Council x2
Leicester City Council - Adult Skills and Learning
Leicester City Council Sport Services
Leicester City Council, Community Services
Leicester City of Sanctuary
Leicester Lesbian Gay & Transgender Centre
Leicester Libraries (Leicester City Council)
Leicester Sports Partnership Trust
Leicestershire Partnership NHS Trust
Leicestershire Police
LINK
LLR NHS Cluster - Frail Older People Lead
Magacley Relief and Development Ass
Mental Health Network for Change
mosaic: shaping disability service
Network for Change x6
RECOVERY Charity
The Carers Centre (Leicestershire & Rutland)
The Woodland Trust
Trade Sexual Health
Vista - Society for the Blind x2
YMCA
YMCA Leicester - Y-Pod Project
Question 2: The guiding principle for the Joint Health and Wellbeing Strategy is the reduction of health inequalities, so that everyone has the same chance of good health.

The guiding principle for the Joint Health and Wellbeing Strategy is the reduction of health inequalities, so that everyone has the same chance of good health. Do you agree with this principle?

96%

-4%

Question 3: Do you agree with the four priorities?

The four suggested priorities for the Joint Health and Wellbeing Strategy for Leicester are: a)

86.2%

13.8%
If no, what do you think the priorities should be:

"a" should be the least of the priorities. The actual idea that death pre 75 yrs is ridiculous as there is no actual book of individuals longevity! Would a S.I.D.S death be considered as 74.5 years premature? Estimations play a wrongfull role in medicine.

Addressing most possibly the wrong word nearly all causes have been widely publiised funding towards more in depth research and implementation into the nhs is required. Broadly agree but would want to improve outcomes for everyone irrespective of age

However, the needs of carers must be recognised within this as they are twice as likely to suffer ill health as the general population, a situation likely to become worse without preventative approaches

I am over 75

I think that 'supporting disabled people to maintain best health' needs to be added

If no, what do you think the priorities should be?

Improving patients outcome   More help for cancer patients   obesity and alcohol problems also important   most importantly help the poorer areas patients to improve outcomes

Improving work life balance

In addition to the existing 4 priorities there is a need for a 5th improving Health and Wellbeing outcomes for LGBT People.

It's not that I don't agree that these are important I just think 4 may be too many. I would prioritise improving mental health and addressing the main causes of premature death. The others seem very vague.

mosaic would agree with those but there needs to be an additional one which is about the long term health of disabled people and people with learning disabilities. Disabled people who use wheelchairs often have little opportunity to have the same amount of exercise as non-disabled people. People with learning disabilities often do have the importance of the ways to maintain good health explained to them. There are lots of examples around the country of the way in which sport has been adapted for exercise for disabled people other than just the traditional wheelchair exercise groups. The use of alternative therapies as well as things like relaxation can add to the health of disabled people, especially any mental health issues as a result of 'loss' in relation to disability.

Remove the age qualification in a); it's unnecessary. Replace b) with "Improve Social Care for the elderly and the most vulnerable people in society".

These will only reduce health inequalities if you define action under each to do so e.g. support people to study or return to work.

They are hard to disagree with because they are too broad/vague. They sound good in theory but could have many holes in practice. I realise its difficult without making the priorities too long but I think each point needs to be teased out more e.g. to explain who are the most vulnerable, what does improving mental health mean?

They need unpacking.

This are too limited. what about issues relating to - Inequity in service provision. - Focus on outcomes for older people. - Focus on promoting public health locally without just focusing on causes of death.

Would suggest that in addition there also needs to be a focus on caring for those with dementia (or incorporate within priority C)

Wrong suggestions - How can they be priorities???

yes, but who defines most vulnerable?

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**Question 4: Within these priorities, what can we do to make the biggest difference?**

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- interpreter - health (mental) - access - space (tenancy ass)
- Make GP surgeries more friendly and accessible for young people and vulnerable people. - Look at GP registration progress (Homeless) - Look at confidence building for young people to reduce teenage pregnancy. - Make healthcare more accessible to homeless.
- Promoting public health around local issues.

"b"... Meeting the needs of the most vulnerable people in society; i.e., those needing hospital treatment.
1. Weekly stress/anxiety/depression groups in several locations in the City (contact Suffold MIND, Bury St Edmonds for an excellent model of how it works). 2. Support groups/community monthly sessions to aid in simple hearing aid maintenance (replacing tubes, cleaning, etc). 3. Develop direct resources to combat teenage pregnancy and the spread of STD! 4. Improve disabled access throughout the City, example: taxis are not allowed to drop off or pick up clients at shopmobility at Haymarket Bus Station) Access and Advice and Information acting as both prevention and helping to resolve a person's issues impacts on Health and Wellbeing The list is link is long proven and needs recognising by Commissioners.

Address the needs of poverty and education
Addressing Drug addiction (inc Tobacco/drink!) ; obesity:care of the increasing elderly population
EDUCATION and not just for kids!!!
Advertise more the advantages of screening
advertise more to the public, involve them more, motivation, stimulation, fund raising, participation.

Agree the strategy and then DELIVER
Be proactive rather than reactive Make resources and information accessible to all Break down the stigmas around mental health
Break down even more of the organisational barriers that exist at all levels within the public sector to provide a coordinated service to the customer who ever they are. The need to recognise the importance of information sharing, improved communication to the customer and resource allocation which gives an improved return for the customer.

Caring for the most vulnerable people in society - the homeless and disabled
Children
Communicate well with the local communities
Consider "prescriptions" for preventative services and low level interventions that can help to reverse trends towards poor health - e.g. obesity, social isolation
Cutting stigma for mental health
d
Education, education and sufficient financial support for the vulnerable (economically deprived). Early intervention. Strengthen Health Visitor service.

Enabling services to meet the needs of people with learning disabilities. many of the inequalities have been caused by services not being able to make adjustments in relation to communication

Engage appropriately with disabled people offering exciting opportunities rather than make people feel guilty about tackling health issues. Disabled people have a lot to contend with, especially adapting to an acquired disability. Activities that might improve health should be communal and interesting - an alternative to a day centre but there is a need for transport and this cannot be ignored.

Ensure that funding is made for mental health charities such as Network for Change.
Ensure the Commissioning Group maintains services free to all, and doesn't have a postcode lottery. fast local treatment for life- threatening events- e.g. heart attacks or breathing difficulties, or mental breakdown.

Flesh them out and make them more specific
Fund prevention services, address the causal inequalities that then lead to health inequalities - decent housing, schooling, low incomes, deprivation
Get GPs to respect people and make GPs aware of local services so they can refer people to social/leisure facilities.
Greater community based services in partnership with community and 3rd sector health and social care providers, education, housing and employment organizations. Develop a joint health and well-being charter statement for all services to sign up to. In terms of mental health provision put more money into prevention and early intervention to avoid expensive health interventions such as acute care. Commission more from the independent sector not LPT.

Have a very targeted approach rather than spread the resource too thinly.

Having more services in community, e.g. translator

Health organisation work for collaboratively - need more organisation like Cancer network

HIV is a significant contributor to health inequalities, premature death and affecting vulnerable people - one of the things we have identified to make a difference would be to deliver some of the regular clinical check up services in the specialist HIV voluntary sector organisations another is to increase HIV testing from a range settings - in the community and health providers (GPs) perhaps more cheaply using trained volunteers within clinical governance frameworks. Thirdly the experience of working with vulnerable communities on HIV can be extended to cover other health issues such as hepatitis, TB, sickle cell, etc. Working with the local community groups to test outcome community health empowerment models may help over the next year to identify how communities can help themselves to meet the health outcomes.

I believe GPs have the great opportunity to identify members of the community that might benefit from programmes already in place but my experience as well as others they tend to judge you the moment you enter the door. Some don’t even question behaviour that pretty obvious with mental health.

I think the services should be reviewed and care should be provided locally for those areas in most need. These should also be advertised locally in schools, places of worship, health centres etc

Improve access to Mental Health services

Improve crisis services re MH vulnerable people MUST include drink and drugs

Improve education and empower people Localise and prioritise services

Improve mental health and remove the stigma of mental health problems

Improving outcomes for children and young people. To reverse current trends particularly in terms of obesity and inactivity, smoking cessation young people who have not had their bad habits engrained in their daily lives.

Interpreter Housing problem More access to local resource

Invest more in community based early intervention, prevention, information, advice and guidance and support services - particularly investment in the voluntary and community sector to enhance engagement. Much greater investment and access to voluntary sector community support services required, particularly to address social isolation of those with ongoing more severe/complex mental health issues and all carers.

It will be important to target particular areas of the City and specific types of population to ensure reduced resources target specific individuals to achieve a healthier lifestyle. The initiatives should focus on whole families particularly in the areas of healthy eating and challenging inactivity. It will be important to note that in the area of inactivity Sports National Governing Bodies have been tasked with engaging with 14 to 25 year olds and there are opportunities to share resources to deliver specific programmes

LGBT people suffer from significantly poorer health then the population at large and tend to recover less well. This is well evidenced at local national and international levels. Evidence also demonstrates that LGBT people tend to lack trust in NHS and local authority health and social care services. A substantial proportion of LGBT people would like to see the provision of LGBT specific services and other LGBT people wish to see mainstream service provision provided in an appropriate way for LGBT people. This indicates that there should be a twin track approach providing LGBT specific provision and undertaking a major LGBT training & awareness programme for LGBT people. The Leicester LGBT Centre can draw on a range of experience and expertise in implementing such a strategy if it receives the necessary policy and financial support from the NHS and local authority sources.

Listen and believe what the patient is saying

LISTEN and LEARN then act on the reality that people face day to day. A sticking plaster is no good to fix a gaping hole

Main causes of premature death as the life expectancy differences in our communities are too large

Make the services available more transparent and accessible. Improve the patient experience especially when attending Leicester’s hospitals.
massive innovative engagement with local communities to mobilise a sense of possibility and purpose with regard to altering seemingly pre-ordained outcomes. Getting champions in communities to live out and inspire others to live out positive choices with regard to determinants of ill health. A focus on the mental toolkit of positive wellbeing and a sense of how to control and manage choices and impulses around food and exercise.

More prevention services
more support for patients and family members / carers
More therapies for mental health
More to raise awareness and de-stigmatise mental health

Noticing things early - regular m.o.t's for risk groups (e.g. over 50s, overweight people, smokers etc)
Prevention rather than cure interventions must be a priority in the promotion of good health and wellbeing

Provide the services that people need which means finding out and targeting those most in need. Communication needs to be improved - some people are not being engaged particularly the BME community. Look at the savings services cost not just what the services cost before deciding what to do. Mental Ill-Health is on the increase yet has been underfunded for several years - there needs to be more investment in this area. Mental Health and Vulnerability cover all these priorities a-d and addressing this across all areas may produce the biggest difference. Improve partnership and joint working particularly with the NHS. The NHS need to invest and work with everyone in the City not separately fund - the same can be said of LCC. Some of these areas are cross border - can work be done with the County to make savings or reach more people? Some of these are funded by areas - NHS and City do not neatly overlap and these need to work together if we are to have meaningful outcomes. Write into all contracts elements of health and wellbeing - both for staff and service users - generate a health and wellbeing culture.

Put more into the NHS even if it means raising income tax a bit.

Recognise that there are many sources of provision - not always available only from NHS. Map what provision is available so that we do not remove smaller charities and then provide inadequate provision as core NHS provision.

Reduce deprivation and inequalities in social care and ensure commissioning works in the same way as strategies, i.e. crosscutting not silo, can't have a holistic strategy, that looks at social care and deprivation and then have silo'd commissioning.

REMOVE THE STIGMA OF MENTAL HEALTH

Replacing "weaker" members of the management team with people from private industry with a proven track record in project management and who have demonstrated they can deliver required outcomes in a hostile environment especially in terms of poor support from inadequate subordinates and traditional NHS superiors.

Smoking is still a major issue, more positive attention is required. Don’t hand out leaflets talk directly to smokers. most important young mothers with children.

Something that is long term and don’t have very extreme mental health issues.

Speak to the voluntary groups who deal with specific communities and have a wealth of experience of the communities the serve

Strengthen your involvement so you can see weather this priorities are being implemented.

Support carers who provide hours of free care and may then suffer from MH or physical health issues.

support preventative services

Target awareness and engagement programmes that show how changes in lifestyle, including diet and behavioural issues including exercise can change health outcomes

Target the determinacy of health e.g. work - health literacy

Targeting whole families to reduce health inequalities for children

Targeted work. As an example drug and alcohol interventions will support those communities who often suffer most from poor health. Good quality Drug and Alcohol Treatment needs to be available to provide the means for such vulnerable groups to recover from their dependence and make improvements to their health, and to public health e.g. BBV transmission rates.
The Woodland Trust would like to see a focus on ensuring that as many people as possible have access to natural green space, including trees and woods, close to their homes. Some of the key benefits provided by trees and woods in relation to health and wellbeing are listed in our publication Woodland Creation Why it Matters ...see http://www.woodlandtrust.org.uk/SiteCollectionDocuments/pdf/woodland-creation/woodland-creation2009.pdf and include reduction of urban temperatures in summer, removal of pollutants from the atmosphere etc. We have developed a woodland access standard which reveals that in Leicester City only 0.3% of the people have access to a 2 hectare wood within 500m of their home....this is one of the lowest figures for any council in the country.

There is a real need to embed some conditions / disabilities into the priorities... for example Sight Loss would cut across all of the priorities above but unless its embedded in the pathways of services relating to them critical gaps could appear thus leading to major impacts on individuals who suffer with a sight loss. The use of voluntary sector organisation that have specialisms in providing services should also be encouraged to bridge gaps in inequalities of service provision, the use and development of social enterprises could also make a difference.

To educate the people and give them more awareness
To ensure that health and social care inequalities are prioritised within each overarching priority. To involve specialist voluntary sector providers to help bridge the gaps in service provision and encourage social enterprise. to use current data from those organisations who hold it so the priorities make the difference in areas of fact and not based on national statistics. Use eligibility criteria more efficiently and use personalisation to offer more choice and control
To have better joined up working including statutory and voluntary agencies, offering a more holistic approach and understanding of individual and community needs - wider needs including housing, education, physical and mental health. Without addressing the wider needs little longterm positive outcomes can be achieved.

We provide skills support to long-term unemployed and I think that the situation on mental health is getting worse and will only grow if we don't address levels of stress.
with mental health the psychiatric wards should evolve from just a holding place to a place where actual therapeutic intervention begins. this would stop those who are discharged without beginning to be supported to work on the issues that are problematic to them having to be re-admitted simply because nothing had been put into place before discharge, and their time in hospital did not actual move them towards recovery. it might also be good to raise the profile of the cost to people of some care/intervention such as that relating to obesity to help people make better life choices. perhaps monthly figures could be posted at surgeries.

Question 5: What are the obstacles to improving the health and wellbeing of the people in Leicester?

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- Working together - NHS email - Image of doctors and nurses by young people - Resources - views of professionals of young people and homeless people
1. Interpretation - ESOL  2. Time
1. Our community should be involve with what is going on in our local area  2. More communication between local authority and community
Access to information. Funding.
Access to services - particularly for 'hard to reach' groups
Accessibility for vulnerable groups. Registering, having complex needs understood by practitioners, getting appointments (visiting hours, etc)
Alcoholism and Drug-taking. Lack of education and information on keeping fit.
An obesigenic environment A sense of hopelessness about capacity for personal and community change Not enough visible positive role models present for people lack of belief (and knowledge of the techniques involved) that individuals can be powerful agents of change for themselves and their families Poverty/unemployment/ Leadership and engagement around developing the alternatives to the status quo
Behavioural change particularly for priority A which will require long-term sustained effort to change attitudes to lifestyle factors such as smoking, diet, exercise.

Better shared working. Need to improve health literacy

Big health inequalities

Communication is still a big issue - some people do not understand (and it is not always language), some people are still not being reached. Produce reports of the successes and outcomes so that people can see how effective the strategy is - or isn't. Funding - there is never going to be enough money. Services are being cut without a proper assessment of what is needed - if this carries on there will be a waste of the training and experience that has been built up over a number of years. Housing related support is being disaggregated and services may be decommissioned - HRS has been shown to be cost effective and has been proven as making a difference (check out the Cap Gemini report on Housing Related Support done for Supporting People). If people cannot be helped in their own homes, hospital beds will stay full. Housing is an essential part of everyone's lives and can impact dramatically on the priorities. Work closer with Housing Providers. The assessment criteria currently used - critical and substantial - may not be sufficient when looking at mental health. People with mental ill-health can often go through cycles of being very ill and being less ill - there is a danger that if not considered ill enough at the time of assessment these people will fall through the net. This needs to be addressed. Assessors need to be adequately trained and monitored. BME groups are not being reached sufficiently - more needs to be done and there needs to be a better understanding of culture and language issues. Reporting of outcomes needs to be clarified - what is success? Will targets be set - will they be realistic? We need a definition of vulnerable which everyone understands - this is not the case currently.

Cost

Cost and limited resources

Cultural; institutional; lack of willingness to embrace change; funding issues

Deep seated social and economic inequalities

Economical pressures, non joined up service delivery, non understanding of changes in the provision of health and social care.

Education from the youngest up.

For people with learning disabilities there is a lack of commissioning of specialist health services and acknowledgement and support for them to develop a wider role in enabling generic services to meet the needs of people with learning disabilities

Funding

Government cutback in funding thus services.

Government financial cutbacks

GPs lack of awareness and lack of money.

Housing conditions, diet, stress, drink, drugs

I don’t know. If I’m typical, reluctance to go to the doctor.

I think it is more to do with people’s ability to improve their own knowledge. It’s only when something goes seriously wrong to a close family member/friend, when they wonder why the systems, services or NHS failed.

IGNORANCE BY THE GENERAL PUBLIC

In the first instance poverty stops people from being more active and not buying the right kinds of food. Every effort should be made to challenge the barriers to participate more in healthy eating and physical activity initiatives

Inadequate management who are politically motivated, staid in their ways and incapable of thinking "outside the box". A new approach is needed to make the required step-change in health outcomes happen.

Information - particularly with the diverse population and languages it is hard to let people know what services are there to help.

Knowledge of what is available across Leicester and how to access it. Need to work far more in partnership - waiting lists need to be shortened and provision should be realistic.

Lack of communication, not involving the above, not listening to community groups or voluntary groups

Lack of co-ordination

Lack of investment, deprivation.
Lack of joined up and integrated services a failure to focus at least a part of all NHS interventions on health promotion

Lack of knowledge and understanding of what causes premature death and mental health problems and provide people with help and motivation to change behaviours that will affect outcomes.

Lack of Knowledge, feeling out of the mainstream, sidelined, unimportant (especially members of some ethnic groups). Lack of joint-up thinking. Poor housing Neglect of vulnerable people, like asylum seekers and refugees.

Lack of out of hours drink, drugs and MH services; HUGE problem

Lack of properly resourced policies Politicians People who have not got a clue to reality faced by disabled and the vulnerable in Leicester and the impact this lack of knowledge has on the individual and their carers.

Lack of resources & long waiting lists.

Lack of sufficient high quality and coordinated health services.

Language

Language barriers Economic barriers Educational differences

language barriers, cultures of communities and communication with groups

Many and varied including the Health and Social Care Act; lack of financial and other resources; lack of knowledge and skills; failing to take a holistic approach; failing to meet individual needs; vested interests including political; bureaucracy; privatisation of health and social care et alia

Money - cuts, savings in an inappropriate manner. Bad communication between groups Insolent management and any finance with above.

most people feel left out of programmes that improve health for example there is a programme for helping women improve their health called Be Active by the time I heard of it it had been running for quite sometime and I am still waiting to get a slot. there seem to be certain members of the society that get in and are in the know.

Not a very good understanding of what does it mean. That if we smile we are fine or if we look OK means we are OK.

not everyone will come forward when they are unwell. the number of huge practices growing with loads of GP's means that you no longer have a GP that knows you and that you can have instant confidence in and who is aware of your history. there needs to be a raising of awareness of mental health for young people and maybe this could start in schools so that young people can become aware of stressors and symptoms and remove the fear in flagging it up.

Open-Ended Response

People should be told that the reason they are not feeling well even if it hurts their feelings,

Poor investment in preventative services and a narrow view of health - need to consider health in an holistic manner and look at all policies across authorities from a health improvement perspective. For example, libraries are a good source of information but individuals seeking information need someone present to discuss their information needs rather than a machine to deposit books with.

Poverty, deprivation, unemployment, social and cultural isolation, inadequate housing/homelessness. Insufficient low level networks of community support e.g. social groups/advice, drop-ins at community/neighbourhood centres where people can access support easily and quickly and be linked in to other appropriate services. Need holistic approaches to health and wellbeing (mental and physical) and commitment to JOINT commissioning of LOCAL MENTAL HEALTH SERVICES. Big obstacles is poor investment in value for money community sector.

poverty, financial inequality, poor supply of good food in outer estate areas, cost of travel

Poverty, learning disability in the widest sense- not able to understand the consequences of behaviour poverty, long standing joblessness/families who have not worked for generations, numbers of fast food options and lack of understanding of healthy eating, culture of residents, housing, education education.

racism, catchment areas, gp's not wanting to spend money

Religion and Tradition not to mention money.
See answer to question 4. Use the local mechanism to consult and communicate with local people. Don't think that professional knows best and be more receptive to local residents views and make changes accordingly and feedback these through the different communication channels available. There is an apparent reluctance to involve and engage local people in the planning and delivery of services.

Social Attitudes. Many people are not directed to improve their personal health. More open advice, health shows, same place same time, every week not once in a while.

Stigma and discrimination and lack of confidence and information about health issues and where to access support plus fear that the support won't be given.

That Commissioners do not engage with the VCS.

The current social climate....poverty & worklessness...........the actual climate (Leicester is in a dampish river basin) Ignorance

The disproportionate investment in large hospital trusts which could be better served by investing in the community, housing, education and the 3rd sector. Lack of joint working across health, social care, housing and education. Generally consumerism and the lack of emphasis on solidarity and the breakdown of community.

The lack of a body with teeth to scrutinise the HWB on its progress with reducing Health Inequalities.

Lack of shared decision making about priorities.

The lack of good managers who care and will go the extra mile for people. That the board will get lost in politics.

The main issue is poverty. People are aware they should eat healthier and be more active, they simply feel they cannot afford to do so. Creating free or cheap access to sport activity and health eating programmes has been successful. The issue is how is that then sustained in future years. Work in schools needs to be prioritized to ensure those most at risk of obesity are identified and worked with to achieve successful outcomes.

The obstacle to improving the health & wellbeing of LGBT people in Leicester are (1) Ignorance of the health and wellbeing disadvantage faced by LGBT people in Leicester (2) A lack of awareness of LGBT issues in policy makers, commissioners and service delivery staff (3) The reluctance of LGBT people to access mainstream service delivery particularly GP's (4) The lack of confidence of LGBT people in health and social care support delivered within their own homes (5) The lack of LGBT specific service provision for the substantial numbers of LGBT people who are requesting such a service.

The people of Leicester are not a homogenous group and each community face different barriers. Often it is a lack of capacity - physical, mental or financial.

The very urban nature of the city of Leicester does present a problem in ensuring access to natural greenspace and this was highlighted to us in a meeting with council officers a year or so ago. We know that the council has run a campaign on urban tree planting and we would like to see more such initiatives linked to the health benefits which trees can provide. We would also like the Council to consider use of developer funding (eg CIL and section 106 funds) to require provision of new natural green space when new housing developments are planned. We have worked with the Stepping Stones project in areas around the suburbs of Leicester to help encourage people in those areas to have access to natural greenspace and the surrounding countryside. Lack of public transport can be a barrier for some less affluent urban communities in preventing them from getting out into the countryside, as can the cost of bus fares.

the Welfare Reform Act

There are a lot of things to tackle and help the people like more seminars

There has been a real shift in the provision of health and social care services leading to quite a lot of disjointed partnership working, the ever changing financial climate, use of national rather than local statistical evidence often means the real needs of local communities are not highlighted, in fact in recent JNSA in other counties the local data has not been used at all thus showing that physical and sensory was not a priority when in fact the numbers with Physical and sensory disabilities were more than that of some long term conditions or mental health.

There needs to be adequate funding for mental health charities such as Network for Change.

Time restraints of patients and lack of interest/understanding/willingness to participate

Timely access to services. Ignorance Changes to the NHS
To reduce the bureaucracy of the system

Transport, understanding the importance, the feeling that you are guilty of your lack of good health, an understanding of the way in which people have to live their lives on low incomes, the arrogance of professionals who think people can adapt to the way they think without changing their own attitudes.

**Question 6: What could you or your community do to help improve health and wellbeing in Leicester?**

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>answered question</td>
<td>71</td>
</tr>
<tr>
<td>skipped question</td>
<td>24</td>
</tr>
</tbody>
</table>

- More training for staff and young people
- Change reception hours
- Change registration process
- Change appointment card
- Stop receptionists asking people in reception why they want to see the GP

1. Design and deliver LGBT training & awareness for NHS and social care staff.  
2. Provide a venue at the LGBT Centre for LGBT specific service provision.  
3. Undertake research into LGBT health & wellbeing needs in Leicester.  
4. Enable the development of a partnership approach to the design and delivery of health & social care to LGBT people.  
5. The LGBT Centre can identify and engage people in Leicester who have the necessary expertise and experience to deliver health & wellbeing services to LGBT people.

[At the moment I need to focus on dealing with my own complex health care needs.]  
adopt the Direct Service Model in Health Watch, more like Citizens Advice. Open and available in Hospitals etc. Be where the people are, not hidden away in a Business Park. Plenty of empty shop units with low rent and rates.

As individuals we can set an example in our shopping, cooking, exercising  be involved in local projects to get people more active  set up opportunities for people to learn more about choices, impulses, motivation

Awareness raising  Community screening  Doctors - through TV  Through Mosques  
BE involved in the initial planning process and not as a tick box exercise

Better work life balance  
brake down barriers,  
Bring reality alive by being involved in a meaningful way

Collective responsibility of all. Conserve resources, support policy and get political  
Community funded initiatives  
Continued support of Square mile project  Development of workplace wellbeing strategy  
Deliver Health literacy interventions.  
Demand better health services

Education and information on ending alcohol and drug abuse. Also information on Wellbeing.  
Encourage fitness by all means possible  encourage people to be more responsible for their own health  
Encourage walking, cycling, and the opportunity to get together for companionship, so that everyone feels valued, not labelled as a health condition that may limit their activity

**ENDEVOUR TO EDUCATE THE PEOPLE OF LEICESTER**

Ensure frontline staff are trained to understand client needs and various ways to respond to these. Offer ‘one stop shop’ service - giving a full health and wellbeing assessment and signposting to a broad range of services appropriate to needs.

Focus on the contribution we can make as a large employer in the city and the reach this has into communities - having a clear comes campaign with our own staff.

Get involved with Patient involvement groups, forums and influence health and social care providers highlighting areas of need. To support the big society or creation of social enterprises  
Have a local Health Strategy which is community owned
have good voluntary sector interventions in place, these should be increased and promoted more widely.

Have more of a voice in local authority decision making and commissioning, as VCS organisations or support groups are entrenched in their communities and are experts at working in their fields and with their client group.

Health awareness stands at fetes and events

Help to create a more caring and sharing society (Not however the Big Society policy which is flawed) by helping to champion the community, voluntary and social enterprise sectors.

help various organisations

High light failures in the "system" and monitor remedial actions (if given the mechanism to do this).

Hold CCG board to account and insist on openness and honestly.

I volunteer in sport and that's enough.

I'd love to be involved in promoting awareness of mental health issues and helping in this area.

Improve community based services as people are more likely to find and trust these services.

Keeping an eye on old people like they use to years ago and try to help people who have disabilities doing shopping etc.

Leicester Sport Partnership Trust has a key aim of improving health and wellbeing. Our resources and those of our steering group and spot specific development groups are geared to this key outcome.

Members of the steering group currently work in partnership to achieve healthy outcomes and we are keen to expand that work.

Libraries act as informal and trusted sources of health information. e.g. Books on prescription scheme could be adopted where self-help books could be purchased and located in all libraries. Recommended titles bought and recommended by GPs for patients to increase self-help.

Provide convenient and well-used community venues (libraries) for drop in information surgeries on targeted health issues. e.g. smoking cessation, early symptoms of cancer detection. We continue to work with charities and NHS trusts on targeted work in vulnerable communities. Open days or health fairs at Libraries, often in cooperation with other local facilities such as Leisure Centres to raise awareness of conditions and what can be done to combat them. These have been very well attended. Help promote health messages by including short health messages on our emails to customers etc etc.

Listen

Listen to correct subdivision of groups and priorities so they can be managed well.

LPT is committed to the further integration of services but we need to have much clearer shared goals with other parts of the NHS and outside agencies on health promotion interventions.

More alert and aware what is needed to us

More mobile screening units

more support and education on wellbeing

More volunteers working on preventative programs Leafleting neighbourhoods with health information

Most communities are broken we live in a multicultural society and yet is difficult to get communities working together. Most community events are dominated by certain groups and there is less participation from other groups, so whilst all efforts are put in place to help it may be difficult to get a big chunk of the community involved.

Move out of the city to less polluted rural areas

My voluntary sector organisation could offer more support to people with severe and enduring mental health problems who can purchase our services via a Personal budget (social care and health). ALSO CRUCIALLY we need funding to provide support/groups to address the needs of the majority of people with severe and long-term mental health issues who won't qualify for social care personalisation under current restricted eligibility criteria - and who may have particularly complex problems, be 'difficult to engage' / 'hard to reach' and/or may be from BME communities i.e. our Centre needs funding for early intervention and prevention of more serious/chronic problems, crises, re-admissions, homelessness etc, which end up costing statutory services more i.e. with relatively little funding we can prevent unnecessary distress and provide more cost-effective services.
Offer the venue and find the people who would benefit from the input of trained professionals. We want to run a healthy living group which would cover exercise adapted to the needs of the customers including buying, cooking and sharing healthy food. It would only take a small amount of funding to get this off the ground.

Open-Ended Response

Parks and Sports facilities (free to use). Help with housing. Improve community cohesion
Pay more tax
Promote acceptance of mental health within the community.
Provide local flexible space with community facilities which are more accessible to people of all ages in a less threatening environment. Build on the Healthy Living Centres experience in the north-west area of the city to other areas but without spending large amounts of scarce finances. Provide a conduit into local grave vines to communicate to local people and build confidence to use services from local facilities. This especially applies to the frail elderly who can seek reassurance local and be provided with a service that safeguards their health and dignity. Provide facilities to advertise campaigns, use local staff to reinforce messages, organise local events with taster sessions and provide sustainable activities on a regular basis through a coordinated approach at a local level.

provide the services that people actually need not what you think they need - have the evidence. Help engage the most difficult to reach. There are lots of agencies/organisations with a wealth of information and experience that just goes to waste - this should be brought together to inform and develop outcomes. We have health and well being as part of our holistic assessment because we realise how important this is. We can and do help promote positive health and wellbeing - this can be expanded.

Reach these groups, targeting them with a range on interventions to promote and imbed healthy, sustainable lifestyles.
See comments above.
Socialise with different communities.
Spend more time working together to develop information for people which clearly outlines what is available to meet the differing needs of whole community, not expect people to know themselves where to go for support.

Sports currently work closely with Public Health to deliver a wide range of initiatives across the City. This work must continue if we are to develop a healthier population
Support above, share evidence, learning as part of strategy. Continue to promote Fit for Work Service which need to be commissioned locally.
support for community food buying
Support the commissioning of drug and alcohol treatment.
Tackle the above as effectively as possible

Talk about the need for mental health and make the CPT function properly
The Woodland Trust has a number of schemes and products to help local communities plant trees and create woodland to help improve their health and wellbeing. One of these is our community tree packs which contain 100 or 400 trees and are available free of charge to any community group. We would be happy to talk to the Health and Well Being Board about this and other ways in which we may be able to help. We would also like to have input into drawing up effective policies on the natural environment for your health and wellbeing strategy
They rely on the healthy centre only
To find out interpreter for our community in order to reduce the community language barriers
very definitely we have several evaluation reports that could help lead on developing some new models of practice.

We can offer training, advocacy, information and advice for carers. We could offer counselling, befriending and other service aimed at reducing social isolation and giving carers a life outside of caring which would help them to maintain better health
We can work with health services but they need to keep up with demand created by us.
We have a lot of areas where we can improve health and wellbeing - we already provide REMIT courses for those with mental health problems but we also encourage healthy activity to staff and students and we plan to make the cafe in the adult ed college more healthy eating focussed.
Work in partnership with the NHS to address the above
Would be happy to be part of a VCS/PCT etc work group mapping benefits on health re advice and information.
Question 7: Equalities Monitoring

First part of Post Code

Age

Disability
Disability

The Equality Act 2010 defines a person as disabled if they have a physical or mental impairment, which has a substantial and long-term effect (i.e. 2.2%)

31.9%

65.9%

Answer Options

<table>
<thead>
<tr>
<th>Physical impairment (e.g. difficulty using your arms or mobility issues which means using a wheelchair or crutches)</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory impairment (e.g. being blind/having a serious visual impairment, being deaf/having a serious hearing impairment)</td>
<td>25.0%</td>
<td>7</td>
</tr>
<tr>
<td>Mental health condition (e.g. depression, schizophrenia)</td>
<td>10.7%</td>
<td>3</td>
</tr>
<tr>
<td>Learning disability (e.g. Down’s syndrome or dyslexia) or cognitive impairment (e.g. autism, head injury)</td>
<td>50.0%</td>
<td>14</td>
</tr>
<tr>
<td>Long-standing illness or health condition (e.g. cancer, HIV, diabetes, chronic heart disease, epilepsy)</td>
<td>7.1%</td>
<td>2</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>28.6%</td>
<td>8</td>
</tr>
<tr>
<td>Other, such as disfigurement (please write in)</td>
<td>10.7%</td>
<td>3</td>
</tr>
</tbody>
</table>

Gender

What is your gender?

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Prefer not to say</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.5%</td>
<td>48.4%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Sexual Orientation
Which category best identifies your sexual orientation?

- Heterosexual / Straight: 2.6%
- Lesbian / Gay: 3.8%
- Bisexual: 5.1%
- Prefer not to say: 88.5%

Ethnicity

Which of the following categories best describes you?

- White
- English/Welsh/Scottish/Northern Irish/British
- White Irish
- White and Black Caribbean
- White and Black African
- White and Asian
- Any Other White Background please specify
- Indian
- Pakistani
- Bangladeshi
- Any other Asian background please specify
- African

Gender reassignment
Do you, or have you ever considered yourself as Transgender?

- 31 -

Marriage / Civil Partnership

Please indicate from the following categories which best describes your relationship status:

- Single
- Married / Civil Partnership
- Partnered / Living with partner
- Separated
- Divorced
- Widowed / Surviving partner
- Prefer not to say

Pregnancy / Maternity
If you answered female: Are you currently pregnant or have you given birth in the last 26 weeks?

- Yes: 2.5%
- No: 97.5%
- Prefer not to say: 0.0%

Religion / Belief

Which category best describes your religion or belief?

- None: 35.6%
- Christian (including Church of England, Catholic, Protestant and all other Christian denominations): 41.1%
- Buddhist: 17.8%
- Hindu: 1.1%
- Jewish: 0.0%
- Islam: 17.8%
- Sikh: 1.1%
- Baha'i: 0.0%
- Jain: 0.0%
- Prefer not to say: 3.3%
Progress report on the development of the Health and Wellbeing strategy

1. Introduction

Following on from the broad priorities identified by the Health and Wellbeing board at its meeting on 29 May 2012 the Joint Strategy Development Group has met three times. It has worked to the general guidance given by the Health and Wellbeing Board to create a strategic approach to reducing health inequalities in the city by:

- Reducing premature deaths
- Supporting vulnerable people
- Improving mental health and
- Improving outcomes for children and young people.

2. Progress to date

2.1 Engagement - A process of engagement has been carried out with a range of groups, including four partnership boards so far, three seldom heard groups, VAL health and social care forum (40 people) and an engagement event organised by Leicester LINk (76 people), which a wide range of stakeholders attended, including members of the LINk and representatives of a number of voluntary and public sector bodies. A questionnaire has been circulated electronically to the Shadow Health and Wellbeing Board electronic engagement network, MPs, Leicester City Councillors, Voluntary Sector via VAL, LINk members and individuals in NHS Leicester City’s membership scheme, and distributed at events. Ninety five questionnaires have been completed, representing individuals and organisations. Presentations are scheduled for the CCG’s locality meetings later in the summer to gather feedback from GPs.

Analysis of the data so far shows broad agreement with the principle and priorities, but a number of people questioned what the definition of ‘vulnerable’ was and felt the term was too broad.

Emerging themes included issues to do with the process of service delivery, such as communication difficulties, requests for more community engagement, discussion of wider determinants of health such as housing, and a number of mental health issues including drug and alcohol abuse. A copy of the engagement feedback analysis has been circulated to the Shadow Health and Wellbeing Board.

2.2 Emerging strategic shape – Strategy Development Group members have made use of the Joint Strategic Needs Assessment and other documentation to prepare initial summaries of each of the broad strategic objectives proposed by the Board. In the light of these and the feedback so far from the engagement process, an organising framework for the strategy has
been developed as work in progress. This is show in figure 1. The group has found it necessary to reformulate some areas of the proposed strategy in light of the difficulties posed by the use of the term “vulnerable”.

**Figure 1 Draft current thinking**
The overall aim of the strategy is to reduce health inequalities in the city. Current thinking is that the strategy will identify four specific high-level outcomes, along with priority areas for action (bullet points below). When the overall shape of the strategy is settled, the priority areas for action will be expanded to identify the specific strategic actions to be taken forward for each priority area.

**Outcome 1: Improve outcomes for children and young people.**
- Ensure readiness for school at 5 years (physical, emotional, behavioural and cognitive)
- Reduce child poverty
- Reduce infant mortality
- Promote healthy lifestyle in children and young people

**Outcome 2: Reducing premature mortality**
- Reduce smoking
- Increase physical activity
- Reduce harmful alcohol consumption
- Improve the identification and management of cardiovascular disease, respiratory disease and cancer

**Outcome 3: Supporting independence**
- Improving support for people with long term conditions
- Supporting independent living for older people, people with dementia and carers

**Outcome 4: Improving mental health and emotional resilience**
- Promote the emotional wellbeing of children and young people
- Address common mental health problems in adults
- Support people with severe and enduring mental health needs

### 2.3 Synergies and crosscutting themes
The strategy development group will be looking to integrate actions wherever it can and may make recommendations in response to some of these. One theme that is standing out currently is the need for engagement and community development as a prominent part of the strategy. It is clear that no matter how great the evidence for interventions, if they are not supported by a fully engaged population then the benefits will not be as great as they otherwise would be. Maximising the engagement at the community and service level in improve health and wellbeing may also form a priority, consistent with the public sector themes of choice, control and empowerment.
2.4 General approach to actions to be proposed - The general approach that the group is pursuing is to concentrate on a limited number of areas in each priority, which are in turn,

- underpinned by good evidence of effective interventions
- capable of being scaled up for impact commensurate with the problem
- sustainable in the medium/longer term
- requiring complementary inputs from a range of organisations and sectors

3. Further areas to be addressed

A number of further areas have been identified for inclusion and in some drafting is underway. These include:

- overarching vision and values
- snapshot of health and wellbeing in Leicester
- commissioning challenges that need to be overcome
- partnership working and joint commissioning
- relevant outcome frameworks
- targeting
- the wider determinants of health - including housing and transport and a need to make, as with education, progress on these for the longer term.
- equalities
- engagement

4. Next steps

The next stage with this part of the strategy is for the Strategy Development Group to identify and summarise detail on what the above strategic framework would mean in terms of strategic actions.

The timeline will be as follows:

- first week in September – initial draft agreed and sent to CCG for submission as part of their Authorisation process, this will require sign off as a draft by, for example, the Chair, CCG MD or DPH.
- 2 October – SHWB agrees substantive draft of the strategy
- Further amendments made, and by December 2012 final strategy agreed

5. Recommendations

The Health and Wellbeing Board is asked to:

- note the progress reported above and comment as appropriate.
- agree who should agree the initial draft to be sent to the CCG as part of their Authorisation process as indicated in section 4, above.

Deb Watson, Joint Director of Public Health.
(report author Rod Moore with contributions from Sue Cavill)
26 July 2012
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The Cultural **Ambition** for the City of Leicester
International, Original, Together

The Cultural Ambition is a short, evidence-based statement presenting culture’s role in transforming our city. It provides a common flag around which professionals, practitioners, businesses, consumers and the general public can gather.

Focusing on three themes – international, original and together – it proposes shared goals, and encourages commitment and new ways of working, whilst securing, strengthening and adding to the city’s cultural assets.

**Leicester’s Cultural Ambition** is to build on our international connections, magnify our originality and bring people together. It will create a thriving global city where people flourish, where opportunities are created, where ‘We Are Leicester’.

**Culture**

Leicester is a city brimful with creative talent and home to world-class heritage, art and festivals. From the Golden Mile to the Comedy Festival, from the world premiere of Desh to the Jewry Wall, from Sue Townsend to Joe Orton: what happens, and who lives and works here make Leicester a city to celebrate.

There are many stories from across the city where culture has shaped lives, created opportunity and increased Leicester’s profile on a UK and World stage. But we can achieve more; culture is a force for economic regeneration, social cohesion, well-being and civic identity.

**The Ambition** will achieve:

By building on our international connections, our originality and by bringing the city together, our Cultural Ambition will specifically aim to ensure that in Leicester:

- Our communities connect through a sense of pride, place and identity;
- New work is created, new talent is nurtured and new ways are found for self expression;
- Every child and young person will thrive through a rich and adventurous cultural education;
- Economic growth will flourish through investment, enterprise and business development.
To achieve the Ambition and its goals, the city and those signing-up to the Ambition need to:

- Show their support for culture, promote what’s available and celebrate cultural successes;
- Develop new, bold and innovative approaches to culture and reinforcing its role in the city;
- Sustain Leicester’s cultural assets and maximise the resources and opportunities that these offer to achieving the Ambition;
- Ensure that communities and individuals are supported and enabled to achieve their own cultural ambitions;
- Operate in ways that are truly sustainable - environmentally, socially and economically.

The Ambition – will you sign up?

Anyone can be involved in helping to realise the Cultural Ambition for the city:

Members of the public can be engaged as creators, consumers, volunteers for projects and act as ambassadors for our city. Businesses can provide space for cultural activity, advocate for culture to clients and colleagues, demonstrate the link between culture and a city fit for business. Service providers across the city – not just culture, but education, welfare, health – can start to explore how cultural engagement can change lives positively. Cultural organisations and individuals can operate in a new environment of collaboration, ambition, facilitation and delivery.

The Culture Partnership Board, the City Council and our many partners across the city will build partnerships, links and practical projects that work towards these goals: establishing action plans and implementation programmes that will make the Ambition a reality.

But we can only achieve this by all of us working together. If you support the principles of the Leicester Cultural Ambition, register now: www.yet to be confirmed.

Make a statement of Ambition and together we can make it a reality!
# Health and Wellbeing Board Simulation Events

**25th September 2012 and January 31st 2013**

**Who should attend?**

Health and Wellbeing board members in the following roles:

- Elected Members
- CCG representatives
- Service user representatives
- Directors of Public Health
- Directors of Adult Social Care and Children’s services
- NHS Mangers
- Representatives from the third sector

**Tuesday 25 September 2012: Simulation Event**

Health and Wellbeing Boards (HWBs) are vital to the better integration of public health, social care and the wider NHS. However, they face the challenge of complex change in a time of severe austerity, and rising demand for services against a background of increased health inequalities in local communities.

**31st January 2013: Follow up event**

Safe space for learning and working with these challenges

Health and Wellbeing Boards are likely to be different in nature and character from other council committees. Tensions will inevitably arise as cross system priorities are agreed upon and commissioned. Shared leadership will be central to the Board’s overall effectiveness.

The LGA has commissioned the Institute of Local Government Studies and the Health Service Management Centre, at the University of Birmingham, to design and deliver a series of ‘simulation events.’ These **FREE** events will provide an opportunity for HWB members to explore challenges, and understand the inherent complexities and conflicts of interest within their roles, within a safe and developmental space. In doing so, they encourage accelerated learning and strengthen the shared leadership capacity of Health and Wellbeing Boards.

**How will this benefit Health and Wellbeing Boards?**

Board members will gain insight into how well they are working together in dealing with realistic dilemmas and challenges, and will feel more confident in making difficult decisions. The events will help HWB members to shift their focus from individual organisational interests towards a collaborative approach to agreeing priorities and deploying resources to tackle the health and wellbeing needs of the community.

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For more information and to book your FREE place, please complete the registration details below and e-mail to Ron Rushbrook: ron.rushbrook@dh.gsi.gov.uk

0115 8526980

*no later than 8th August 2012*
Where and when will the events be held?
There will be two events in the East Midlands. The first event, to take place on Tuesday, 25th September 2012 at Trent Vineyards, Lenton Lane, Nottingham NG7 2PX, will provide attendees with opportunities to work together on real life scenarios in Board teams, and to focus on next steps and action planning. The second event, on 31st January 2013, at Notts County Football Ground will allow the same Board teams to come together again to reflect on the progress that has been made since September, and to identify further actions, in preparation for the ‘go live’ date on 1st April 2013.

Who should attend?
The Chair of each Board in the East Midlands will be able to nominate a team of between 4 -7 members to attend the two events. Teams must include some of the following roles: service user representative, Director of Public Health, GP, elected member, Directors of Adult Social Care and Children’s Services, NHS manager, and representatives from the Third Sector.

What else should we expect?
Prior to the event HWBs will be sent a short questionnaire, which should be completed by the Board. This is designed to provide an opportunity to collectively think about a range of issues and factors related to your current context and challenges. Completion of this questionnaire will be repeated after the event, thus providing valuable before and after information for evaluation.

Please note that arrangements for the events, including maps and venue information, programme and so on, will be circulated to attendees in due course.