LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 19 DECEMBER 2024

Time: 9:30 am

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

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

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

For Monitoring Officer

NOTE:

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

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

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

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

MEMBERS OF THE BOARD

Councillors:

Councillor Sarah Russell, Deputy City Mayor, Social Care, Health and Community Safety (Chair)

Councillor Elaine Pantling, Assistant City Mayor, Education

Councillor Geoff Whittle, Assistant City Mayor, Environment and Transport

2 Vacancies

City Council Officers:

Laurence Jones, Strategic Director of Social Care and Education

Rob Howard, Director Public Health

Dr Katherine Packham, Public Health Consultant

1 Vacancy

NHS Representatives:

Caroline Trevithick, Chief Executive, Leicester, Leicestershire and Rutland Integrated Care Board

Rachna Vyas, Chief Operating Officer, Leicester, Leicestershire and Rutland Integrated Care Board

Dr Avi Prasad, Clinical Place Leader, Leicester, Leicestershire and Rutland Integrated Care Board

Helen Mather - Head of Childrens and Young People and Leicester Place Lead, Integrated Care Board

Dr Ruw Abeyratne, Director of Health Equality and Inclusion, University Hospitals of Leicester NHS Trust

Jean Knight, Deputy Chief Executive, Leicestershire Partnership NHS Trust

Paula Clark, Interim Chair, Leicester, Leicestershire and Rutland Integrated Care System

Healthwatch / Other Representatives:

Benjamin Bee, Area Manager Community Risk, Leicestershire Fire and Rescue Service

Harsha Kotecha, Chair, Healthwatch Advisory Board, Leicester and Leicestershire

Kevin Allen-Khimani, Chief Executive, Voluntary Action Leicester

Rupert Matthews, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Kevin Routledge, Strategic Sports Alliance Group

Phoebe Dawson, Director of Leicester, Leicestershire Enterprise Partnership

Barney Thorne, Mental Health Manager, Local Policing Directorate, Leicestershire Police

Professor Bertha Ochieng – Integrated Health and Social Care, De Montfort University

Information for members of the public

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The aim of the Regulations and of the Council's policy is to encourage public interest and engagement so in recording or reporting on proceedings members of the public are asked:

- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information
If you have any queries about any of the above or the business to be discussed, please contact **Kirsty Wootton, Governance Officer, kirsty.wootton@leicester.gov.uk.**

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

PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

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

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF THE PREVIOUS MEETING **Appendix A (Pages 1 - 10)**

The Minutes of the previous meeting of the Health and Wellbeing Board held on 26th September 2024 are attached and the Board is asked to confirm them as a correct record.

4. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

5. DEAR ALBERT **Appendix B (Pages 11 - 20)**

An overview from Dear Albert to illustrate the contribution that lived experiences can make to Health and Wellbeing and how it can help deliver productive components of integrated social care through community rehab, recovery focus and a hybrid approach.

6. CHANGING FUTURES **Appendix C (Pages 21 - 50)**

The Changing Futures Programme in Leicester has been running operationally since September 2022. In the two years of operational delivery, support has been provided to 162 people facing multiple disadvantages. This presentation will demonstrate the outcomes of this support with a specific focus on health outcomes.

7. WORKWELL PROGRAMME **Appendix D (Pages 51 - 72)**

The purpose of this report is to inform the Health and Wellbeing Board of the delivery plan for Leicestershire, Leicester City and Rutland (LLR) WorkWell, and how the programme will be placed in General Practice to support the population that may have barriers in returning to work and to thrive in work.

8. LEDER OVERVIEW AND ASK **Appendix E (Pages 73 - 86)**

An update and overview of the LeDer work programme which prompts a discussion on how to better improve mainstream services to support people with Learning Disability and Autism to access these.

9. HEALTHY WEIGHT **Appendix F (Pages 87 - 90)**

A review of the logic model to agree on items that will be monitored.

10. INTEGRATED HEALTH AND CARE GROUP UPDATE **Appendix G (Pages 91 - 108)**

A standing item to provide an update of activity at the Leicester Integrated Health and Care Group.

11. HEALTH AND WELLBEING BOARD ANNUAL REPORT **Appendix H (Pages 109 - 156)**

An overview will be provided of the Health and Wellbeing Board annual report.

12. DATES OF FUTURE MEETINGS

The Board will be asked to note the remaining meeting for 2024/25:

- Thursday 6 March 2025

Meetings of the Board are scheduled to be held in Meeting Rooms G.01 at City Hall unless stated otherwise on the agenda for the meeting.

A development session has been scheduled for February. This will be held at Town Hall and further details will be circulated in due course.

13. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 26 SEPTEMBER 2024 at 9:30 am

Present:

Councillor Russell (Chair)	Deputy City Mayor, Health, Social Care, Health, and Community Safety, Leicester City Council.
Councillor Elaine Pantling	Assistant City Mayor, Education
Councillor Geoff Whittle	Assistant City Mayor, Environment and Transport
Jo Atkinson	Deputy Director Public Health, Leicester City Council
Rachna Vyas	Chief Operating Officer, Leicester, Leicestershire and Rutland Integrated Care Board
Glyn Edwards	Group Head of Strategy & Partnerships, Leicestershire Partnership NHS Trust.
Kash Bhayani	Healthwatch Advisory Board, Leicester and Leicestershire.
Kevin Allen-Khimani	Chief Executive, Voluntary Action Leicester.
Helen Mather	City Place Lead - Leicester, Leicestershire, and Rutland Integrated Care Board (LLR ICB)
Dr Katherine Packham	Public Health Consultant, Leicester City Council.
Kevin Routledge	Strategic Sports Alliance Group.
Phoebe Dawson	Director of Business and Skills for Leicester and Leicestershire Business and Skills Partnership.
Professor Bertha Ochieng	Professor of Integrated Health and Social Care, De Montfort University.

In Attendance

Diana Humphries	Programme Manager, Public Health, Leicester City Council
Natasha Bednall	Lead Commissioner, Adult Social Care, Leicester City Council
Claire Mellon	Programme Manager, Public Health, Leicester City Council
Annie Traynor	Head of Operations and Delivery, NHS
Mary Hall	Consultant in Public Health, Leicester City Council
Ruth Lake	Director of Adult Social Care & Safeguarding, Leicester City Council
Gemma Barrow	Healthwatch Manager
Hardip Chohan	Head of Operations & Services, Voluntary Action Leicester
Mark Wheatley	Programme Manager, Public Health, Leicester City Council
Mayur Patel	Head of Integration and Transformation, ICB
Dr Arshad Khalid	GP & Cardiology Outpatients at Glenfield Hospital.
Georgia Humby	Governance Services, Leicester City Council.
Kirsty Wootton	Governance Services, Leicester City Council

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85. APOLOGIES FOR ABSENCE

Benjamin Bee, Area Manager Community Risk, Leicestershire Fire and Rescue Service
Caroline Trevithick - Chief Executive, Leicester, Leicestershire and Rutland Integrated Care Board
Harsha Kotecha – Chair, Healthwatch Advisory Board, Leicester and Leicestershire
Jean Knight - Deputy Chief Executive, LPT
Laurence Jones – Strategic Director for Education and Social Care
Pauline Tagg – Interim Chair, Integrated Care System
Rob Howard – Director of Public Health,
Ruw Abeyratne - Director of Health Equality and Inclusion, University Hospitals of Leicester NHS Trust

The Chair noted that the Fire and Rescue Service, Police and the Police and Crime Commissioner were organisations not represented at the meeting.

86. DECLARATIONS OF INTEREST

The Chair asked Members to declare any interests in the meeting for which there were none.

87. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health and Wellbeing Board held on 27 June 2024 were agreed to be a correct record.

88. QUESTIONS FROM MEMBERS OF THE PUBLIC

It was noted that no questions from members of the public had been received.

89. BCF 24-25 PLANNING

The Director for Adult Social Care & Safeguarding presented the report in which it was noted that:

- Better Care Fund (BCF) arrangements had been in place for 10 years and have strengthened relationships across the health and social care sector. The submission required approval and sign off by the relevant organisations, including the Health and Wellbeing Board where further information could be provided throughout the year if desired.
- Preventative services are provided which enables individuals to stay well and to stay independent. Home first was also highlighted as a focus to keep individuals in the community, preventing unnecessary hospital

admissions. There had been a good track record of timely discharge from hospitals and encouraging ongoing independence. Partnerships with voluntary and community sector organisation also ensure those who could be excluded have their needs met.
- The proposal had not changed – the funding arrangements have been uplifted and compliant with planning guidance.

As part of the discussion, it was noted that the BCF had positive results, with the most important metric being people remaining at home which was exemplary in this service based on performance and data which should be celebrated.

The Chair further noted the strong track record of the BCF and the positive impact of genuine partnership working that continues to be seen and thanked the team for their work.

AGREED

- The report was supported.

90. MENTAL HEALTH PROGRAMME BOARD UPDATE

The Lead Commissioner in Adult Social Care presented the Mental Health Programme Board update in which it was noted that:

- The Board brings together lots of partners including health, social care and the VCSE, along with those with lived experiences and carers to drive forward actions.
- It is a place-based Board in the City, meaning that developments are based on data collected which has ensured developments are tailored to the City's needs.
- There had been progress establishing a voluntary sector representative as part of the Better Mental Health network.
- The current strategy ends in 2025 in which the Board will be looking at how it could be refreshed and particularly how it could sit alongside Healthy Minds.

As part of discussions, it was noted that:

- The Board is not a collaborative but a partnership where organisations come together to work in the interests of residents and the place-based approach is therefore essential for this.
- There had been confusion amongst the voluntary and community sector about the Joy app, including who it is relevant to, the route to appeal for service users and who controls due diligence. It was highlighted that the app is a misnomer as it is not actually an app.
- The Better Mental Health is a great idea in principle, but concerns were raised about how other organisations beyond LTP could raise agenda items.

- Perinatal mental health was a concern and should be a focus for those working in the different communities given the effect on both the family and child.
- Measuring the impact at a community level and across projects was queried and requested to be considered.
- The Loudspeaker group had been facilitated by Mosaic for those with mental health concerns, learning disabilities and autism - providing advocacy for those with lived experience and further involvement through a strengthened relationship.

The Chair highlighted the importance of having a range of feedback and learning lessons, noting MyChoice as a good example to be considered following comments about the Joy app. The challenge of supported living accommodation amidst the ongoing housing crisis was also identified by the Chair as a red alert on the delivery plan.

AGREED:

- The joy app to be looked into further with a conversation to be arranged between the ICB and VCS and feedback taken back to relevant teams.
- To consider how to promote the Loudspeaker group.
- Further conversations to take place between the ICB, Mental Health Programme Board and VCS.
- An update to be provided to the Board in 6 months.

91. HEALTHWATCH - END OF YEAR REVIEW OF PRIORITIES & FUTURE PLANS

The Healthwatch Manager presented their annual end of year review of priorities and future plans in which it was noted that:

- The report gave a summary of the contract for the last 12 months as an independent statutory body ensuring health services receive and act on feedback from local people.
- Over 8000 individuals sought information or gave feedback of experiences. Issues were found in accessing GP services, dentistry and young people's mental health.
- Engagement occurred with different communities, including asylum seekers and Bangladeshi women to empower and actively listen to different patient groups. This allowed insights of services including how it is being used, how it is accessed and any barriers that may face different groups.
- Issues were raised around; availability, equality, language barriers, access to mental health services for certain groups and women's health. Identified concerns are shared with service providers and helps inform communities what is available and where it can be accessed.
- Key impacts of work have been seen in the LLR Dementia Strategy, signposting, wheelchair access and patient flow at the LRI Adults Emergency Department.

- A better understanding of what will happen when services are accessed has reduced complaints.
- NHS dentistry remained a key priority as access and affordability has been raised as an issue. Healthwatch engaged with the ICB and regional commissioners to ensure local provision aligned with the National Recovery Plan.
- Key priorities identified for 2024-25 include GP access, NHS dentistry and young people's mental health services. The work programme for the next 12 months included children's emergency department at the LRI, eye care services and supported living for the deaf community.

As part of discussions, it was noted that:

- Voluntary Action Leicester is the contract provider for Healthwatch. It is a joint commissioned contract and individuals within the team represent each area. Concerns were raised as to whether the City is appropriately represented with dentistry access issues and tooth decay highlighted as an example of what differences in Rutland and County compared to the City. Assurances were provided that data is captured for each area to ensure focused work can occur, but as a joint commissioned contract, efforts have to be split and some boards only have one seat for Healthwatch, so only one representative can attend.
- Access to NHS dentistry had been raised as a concern and focus needs to be on preventative work to tackle the issue of tooth decay. Members of the Board noted they would like to see more work on preventative programmes to address issues.
- Partnership working with Public Health would ensure the public's voice is fed into their work.
- Both staff and the public have lacked information on appropriate pathways, so work is needed to ensure that information is known and can be appropriately filtered down.
- The contract moving to VAL provided an opportunity to engage with different sectors and hear more experiences on wider issues. However, Members highlighted that several communities are underserved in the City and the County and requested further data to understand if any voices are missing as there is a risk that only the loudest voices are being heard.
- UHL thanked Healthwatch for the work done in the Emergency Department and noted their commitment to strengthening their relationship with both Healthwatch and the VCS.

AGREED:

- The Chair thanked the team for the report.
- Comments from discussion be considered.

92. PREVENTION & HEALTH INEQUALITIES STEERING GROUP

The Consultant in Public Health presented an overview, and it was noted that:

- The Steering Group was established in June 2024 with a vision of being a preventative focused group. It meets monthly and is comprised of officers across health and social care along with health providers.
- The group had focused on a handful of priorities that could be action focused. These are preventative actions, based on data and evidence that could quickly make changes.
- There was a stakeholder workshop in August and detail of the discussion was outlined in the report pack. A particular focus was on how to work together and how delivery can be approached. The steering group met following the workshop to narrow down the priorities.
- For each priority area, task and finish groups will be established to work on small, specific actions that can be boosted by joint working with partners and ensure visible results.

As part of the discussion, it was noted that:

- The healthy weight priority will include work with children, so a priority specifically for child obesity was not identified.
- Healthy weight is the biggest factor in overall health, there are approximately 200 diseases associated with weight. It is challenging the health system, but nobody has a quick solution to manage this issue.
- Healthy weight requires a whole system approach and whilst more could be done it requires further commitment and investment.
- The Darzi Review report recently published could impact the approach moving forward.
- Consideration of how to utilise and work with VCS and communities will be explored once task and finish groups are set up.
- A new system has been embedded for health checks. It has changed from the priority of age into a new systematic approach targeting those with risk factors. Having to make these decisions based on resources available.

AGREED:

- The Board to receive regular updates on the priorities.

93. HEALTH AND WELLBEING BOARD PRIORITY LOGIC MODELS

The Consultant in Public Health introduced the item and invited colleagues to highlight the key points for the four identified priority themes. It was noted that the focus on the Boards priorities had not reduced the importance of the others. There were originally 19 priorities in the Health and Wellbeing Strategy and the workshop had identified 4 for further focus, including childhood immunisation;

healthy weight; hypertension prevention and case finding; and mental health and wellbeing related to social inclusion and supportive networks. The annual report would continue to provide updates on all priorities.

As part of updates on the 4 priorities it was noted that:

Childhood immunisations:

- There had been a decline in uptake over the last decade, and rising cases of infectious disease. Uptake across the city had varied.
- Recent publication of national vaccination strategy, with a move to the ICB holding more responsibility. However, this had been delayed until 2025 as NHS England indicated some systems were not ready which was disappointing as the local ICB felt ready.
- Vaccinations are key to supporting the NHS through the winter.
- Targets are pregnant women, children and young people. Educating parents help uptake but issues have been identified around access for working parents and better convenience could help through pop up vaccination facilities.
- The practises with the lowest uptake had been identified and work has been ongoing with them.
- More babies are being born than health professionals have the capacity to vaccinate so more nurses are being trained to vaccinate.
- A super vaccinator shift occurred in August, providing an additional 1000 vaccinations.
- The roving health care unit continued to be used to enable more vaccinations and build confidence. Funding is due to end later this year, but the ICB is looking to procure it on a longer-term basis.
- NHS England funding had been used to set up a community street team who help encourage vaccinations and are multi-lingual to engage with different communities.
- There had been an extensive communications campaign and a vaccine hub wis to be launched to provide information about how to access vaccinations across the life course.
- Work is occurring in schools and services need to be ready for new and seasonal outbreaks. Still having to use practise level data, all other data is held by NHS England as they still commission the service and there had been difficulty recording KPI for vaccinations due to timescales used.

Hypertension:

- Life expectancy in Leicester is below the national average with deprivation a key factor. Other risk factors include healthy diet and exercise, smoking, alcohol and obesity.
- An estimated 24,000 individuals are undiagnosed. A national screening programme was considered inappropriate, but resources are being targeted.
- 3000 monitors have been purchased, 900 for targeted areas.
- Community pharmacists are increasingly involved in delivering healthcare, can provide opportunistic health checks.

- Digital transformation in health check services where patients can collaboratively populate their notes.
- Health checks being offered for 40–74-year-olds who are not thought to have had existing conditions.
- NHS England grant allowed targeted checks in areas of high incidence which uncovered lots of new cases.
- A new communications campaign is planned to support medication adherence.

Healthy weight:

- It is a huge area of work involving various partners, a steering group and action plan. All the work being done could not be reflected in this update, instead this was focused on what the Health and Wellbeing Board could help with.
- Healthy weight can be a sensitive subject and basic messages need to be shared with a focus on effective promotion of healthy lifestyles. Work includes training work programmes in different workforces and more staff training in Primary Care Networks and joint working.
- Maternity and social care are priority groups. Targeted focus on pregnant women as there have been higher levels of excess weight in this group. There have been walking programmes, buggy walks, working with leisure centres for them to become lifestyle hubs and training for midwives.

Mental health and wellbeing:

- Poor mental health as a consequence of poverty and social isolation is high in Leicester.
- An annual report will show progress from the action plan.
- Partnership board working with ICB, LPT and VCSE which has looked at work in communities.
- There are lots of offers available, but they need to be linked together to ensure the offer is not disjointed.

As part of the discussion, it was noted that:

- An impressive amount of work has been done on the childhood immunisations.
- Women’s health hubs all have hypertension tests, and the pharmacy programme is allowing people who wouldn’t normally see a GP to be seen.
- Nationally, the focus of hypertension is those aged over 50, whereas Leicester has gone beyond to look at the cohort of those in their 40’s.
- There is no focus on children, young people or residents in care home in healthy weight. This is despite Leicester’s childhood obesity levels being one of the worst.
- Engaging children needs to be addressed along with a focused session on the food plan for healthy weight.
- There has been lots of work with younger age groups on healthy weight but this has not been reflected here.
- Mental health cafes have been really well received in the communities.

Outcome measures need to be demonstrated, as well as the potential impact to communities and areas to attract funding. VAL had been working with organisations to address sustainability.

- It would be good to see qualitative data such as focus groups, feedback or case studies or quality reviews to see how services have impacted individuals to promote interventions.

It was noted that the logic models will be monitored and evolved. Two subgroups of Health and Wellbeing Board had merged and meet monthly to receive updates that will be reported to the Health and Wellbeing Board.

Agreed:

- The report was noted.
- The Board to receive regular updates on the priorities.
- Comments from discussion to be considered.

94. DATES OF FUTURE MEETINGS

The Board noted the date of future meetings.

95. ANY OTHER URGENT BUSINESS

It was noted that there was no other urgent business.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Lived Experience contributions to Health and Wellbeing
Presented to the Health and Wellbeing Board by:	Jon Roberts
Author:	Jon Roberts

EXECUTIVE SUMMARY:

An illustration of how Lived Experience can deliver productive components of integrated social care. Community Rehab. Recovery focused. Hybrid approach.

RECOMMENDATIONS:

Imbed Lived Experience into future treatment models.

The Health and Wellbeing Board is requested to:

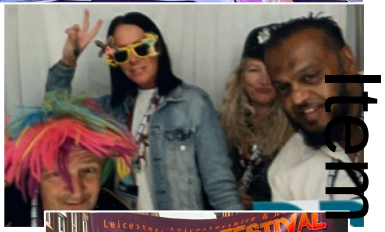
Consider how the Lived Experienced/Mutual Aid model, becoming better established within addiction treatment, can be applied to other areas of social care.

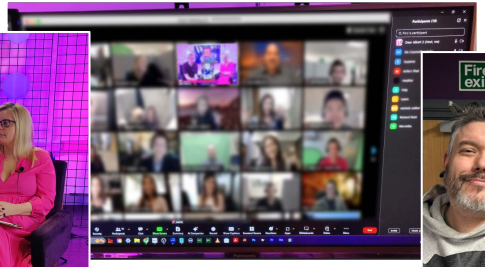
DearAlbert

Mission:

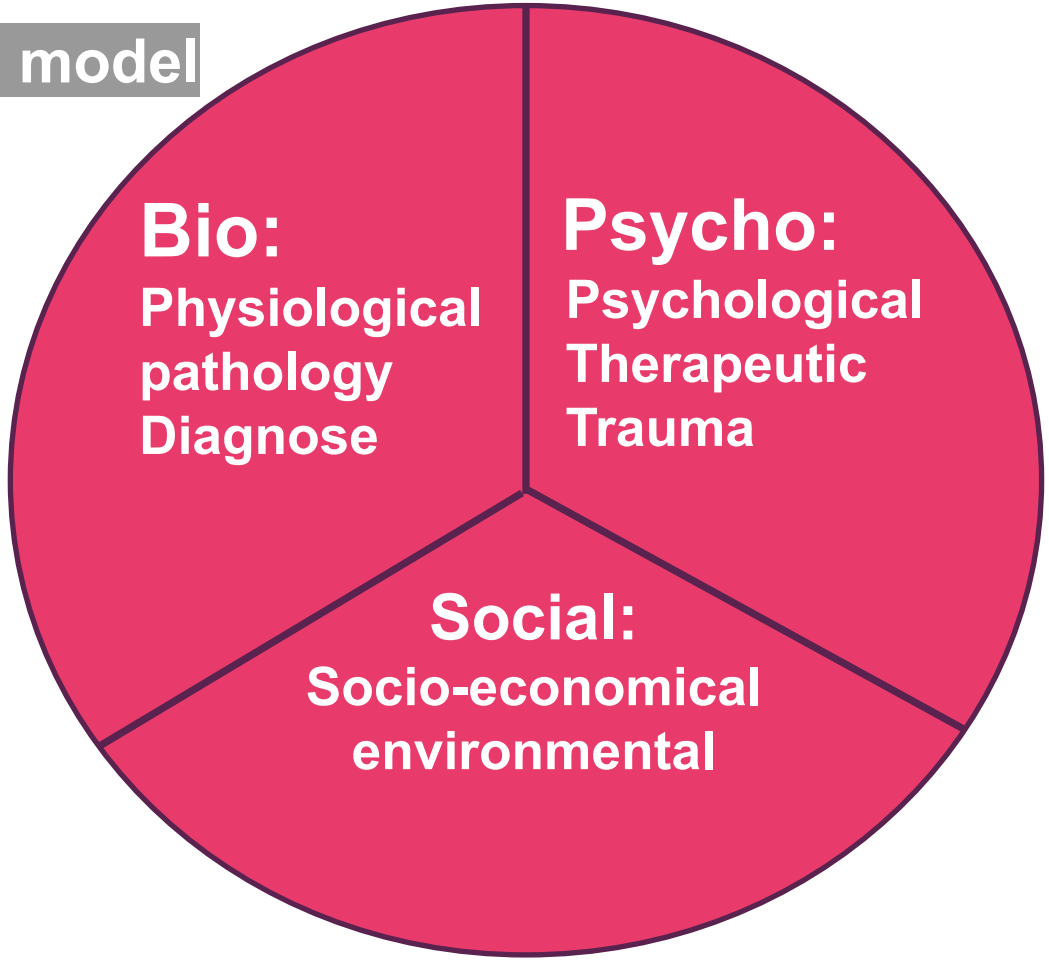
To build sustainable recovery communities that become support networks for those in and seeking recovery from substance use.

Jon Roberts - Health & Wellbeing Board (19/12/24)

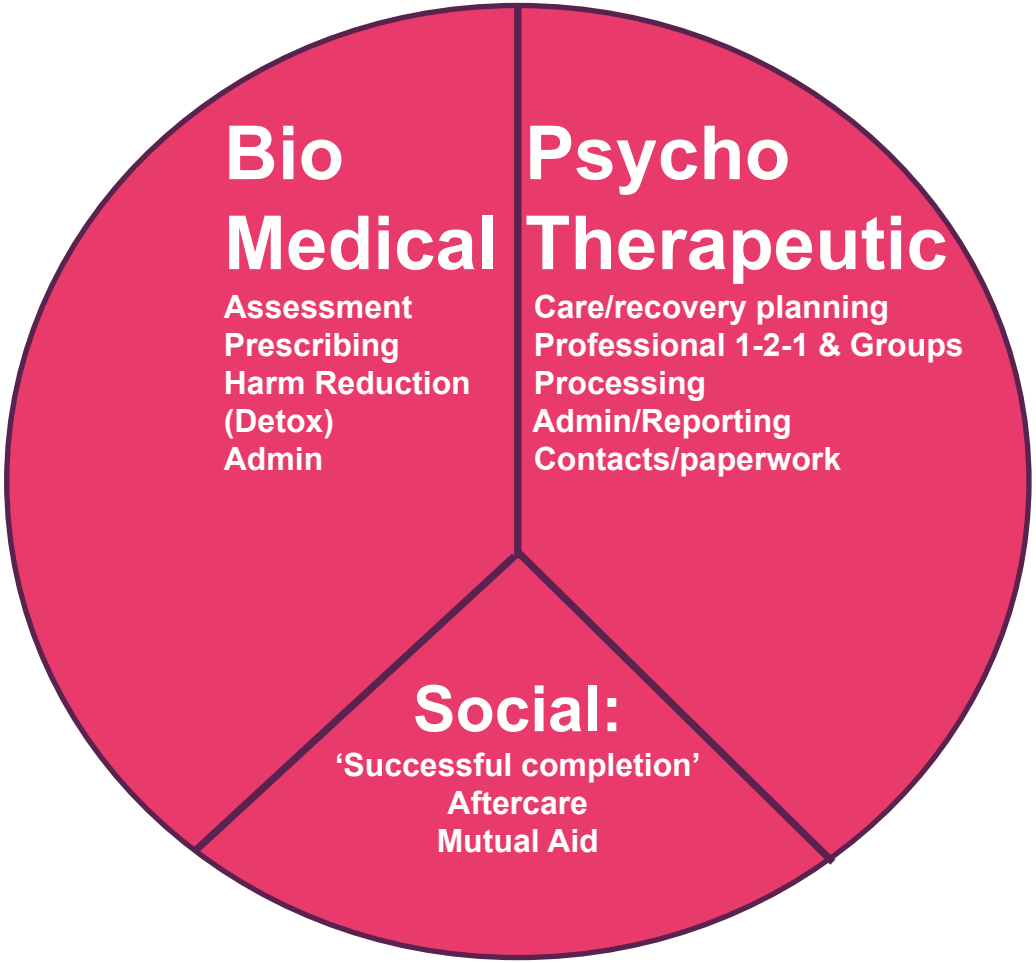




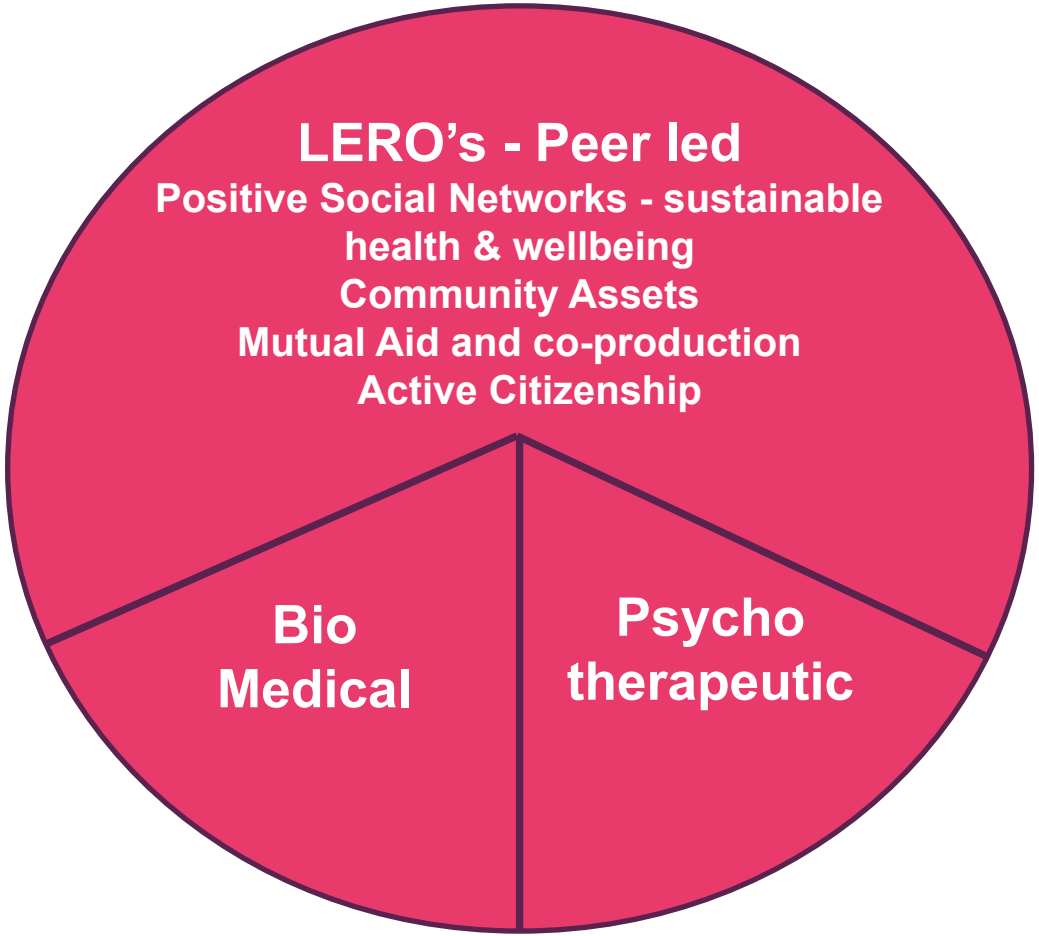
The Biopsychosocial model (BPS)



Actually…


Bio Medical
Assessment
Prescribing
Harm Reduction
(Detox)
Admin
Psycho Therapeutic
Care/recovery planning
Professional 1-2-1 & Groups
Processing
Admin/Reporting
Contacts/paperwork
Social:
'Successful completion'
Aftercare
Mutual Aid

As we see it...


LERO's - Peer led
Positive Social Networks - sustainable health & wellbeing
Community Assets
Mutual Aid and co-production
Active Citizenship
Bio Medical
Psycho therapeutic

RECOVERY PATHWAY

Entry Point

Dear Alberts Sunday Breakfast Club for those experiencing Homelessness

Other example entry points into Dear Albert & The Stairway Project:

- Outreach
- In Reach
- Walk In
- Referral

Lived Experience Harm Reduction Interventions

- Cooked Breakfast
- PIE
- Exposure to non-using cultures
- Introduction to the Recovery Community
- Naloxone Distribution
- One Hit Kit Distribution
- Hep C testing
- Condoms & Sanitary products
- Referrals/Signposting
- Information, Advice and guidance
- Recovery Literature

Engagement

Community Rehab

- Delivered by The Recovery Community
- Managed by Dear Albert

*'Better than well'**

Service User
- LE Assessment
- Commitment to change
- Structured Recovery Programme at The Stairway Project

Programme Participation:
- Becoming involved
- 'The Voice of LE'
- Forums / Shares / Networking
- feedback and contributions to service design

Volunteering:
- Giving back
- Active member of Recovery Community
- Training
- Group Co-Facilitation / Interventions

Paid Employment:
- Move away from the benefit system
- Phased return
- Benefit related pay
- Further Training

Period: **Q1 2024 in numbers**

Unique visitors ➜ **1003** (Service Users)

Footfall ➜ **3230** (Service Users)

Groups delivered ➜ **276**

A hybrid / co-produced model…

*Professor David Best

Make a fresh start

you do the MAFs UK

POD

ARTS & CRAFTS group

FREEDOM WRITERS

lived experience Hope! homelessness forum

Women's group SWAP

PLUMB group

MUSIC group

UK SMART Rec
Self-Management and Recovery Tr

ACT Peer Recovery
Focus On Behaviour

MyPLACE

Monday DROP IN

YOURTIME

TURNING POINT
inspired by possibility

No.5

CF
Changing Futures Leicester

Leicester's Homelessness Charter
TACKLING HOMELESSNESS TOGETHER

HM Prison & Probation Service

Framework
For your future

POLICE & CRIME COMMISSIONER for Leicestershire
Prevention | Partnership | Protection

Leicester City Council

THE HEPATITIS TRUST

AA RECOVERY

NA

HOPE FAITH COURAGE CA

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Changing Futures Programme
Presented to the Health and Wellbeing Board by:	Rebecca Lopez
Author:	Rebecca Lopez

EXECUTIVE SUMMARY:

The Changing Futures programme is a £77 million joint initiative by the Ministry of Housing, Communities and Local Government (MHCLG) and The National Lottery Community Fund, the largest community funder in the UK.

The National Lottery Community Fund has invested over £21 million, adding to the £55million of Government funding, extending the length of the programme to help local partnerships develop longer term and more effective support for those in need. The funding for this programme ends on 31st March 2025.

The Changing Futures Programme in Leicester has been running operationally since September 2022 and we closed to new referrals at the end of September 2024. In two years of operational delivery, support has been provided to 162 people facing multiple disadvantage.

The Presentation will demonstrate the outcomes of this support with a specific lens on Health Outcomes.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: Consider further funding arrangements post April 2025 for the Changing Future Programme so that we can continue to provide support to the most disadvantaged residents of the city and continue to identify changes within the system to improve outcomes as well as streamlining processes and embedding partnership models of support.

Changing Futures Leicester

Health and Wellbeing Board Report December 2024

Ministry of Housing, Communities & Local Government

COMMUNITY FUND

What is Changing Futures?

The Changing Futures programme is a £77 million joint initiative by the Ministry of Housing, Communities and Local Government (MHCLG) and The National Lottery Community Fund, the largest community funder in the UK.

The National Lottery Community Fund has invested over £21 million, adding to the £55million of Government funding, extending the length of the programme to help local partnerships develop longer term and more effective support for those in need. The funding for this programme ends on 31st March 2025.

The Changing Futures Programme in Leicester has been running operationally since September 2022 and we closed to new referrals at the end of September 2024. In two years of operational delivery, support has been provided to 93 people facing multiple disadvantage. Of these 60% were male and 40% were female. A total of 57 people successfully moved on from support after an average of 8.7 months with a further 36 currently receiving support.

This report considers support provided to individuals, outcomes achieved and learning, identified systems change and good practice developed because of this.

Who are we?

Changing Futures in Leicester is a multi- disciplinary program which consists of the following:

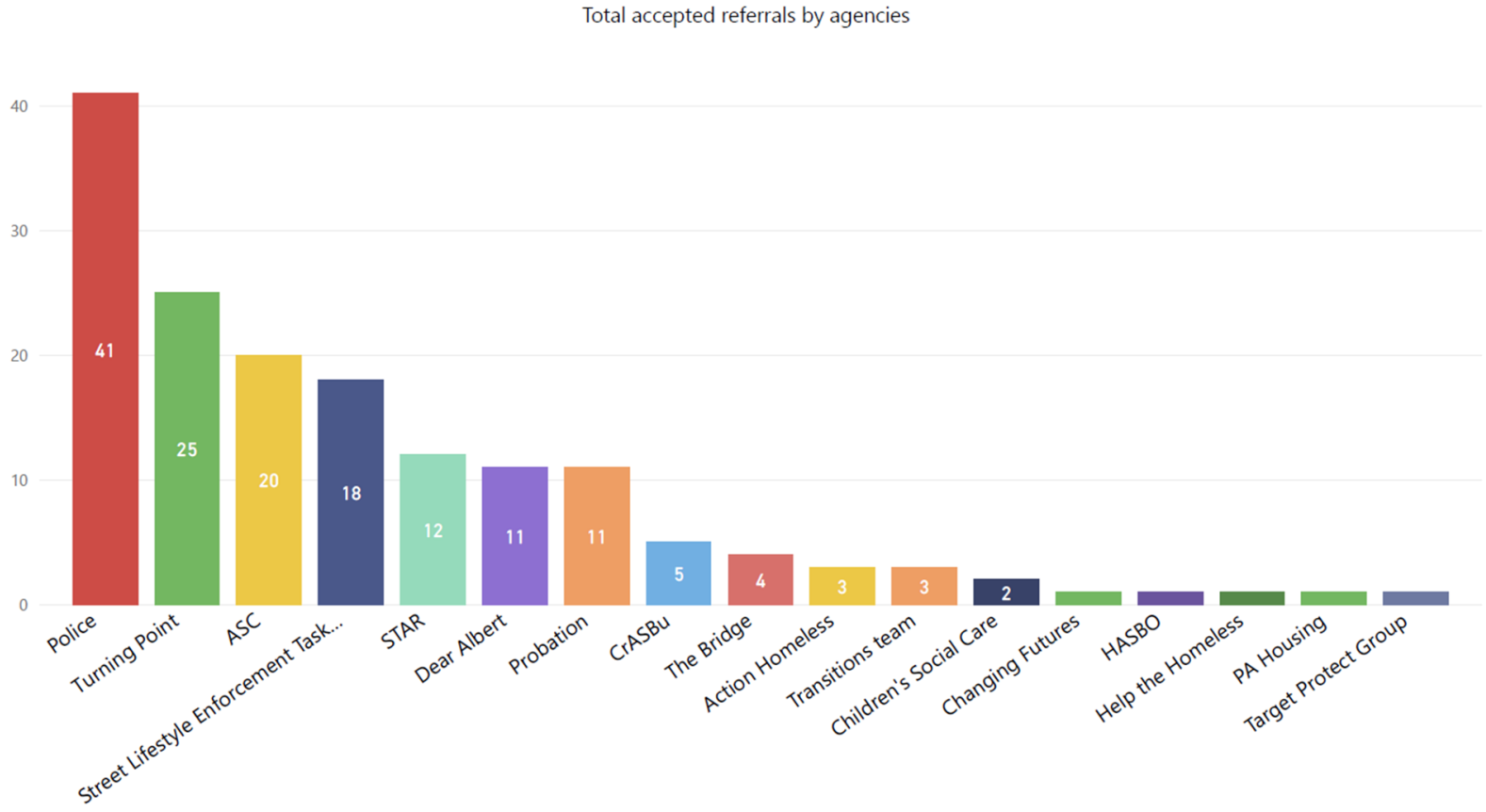
- Intensive Support Workers (ISW): frontline staff who work directly with beneficiaries to help them to engage with services and get the support they want and need.
- Seconded Team Members: These consist of a Turning Point Substance Use Treatment Worker, 2 Police Officers; one specialising in Street Lifestyle Enforcement with Support and one specialist officer working with Women involved in Sex Working and a Lived Experience Co-ordinator.
- Team Manager and Administrator who manage, guide and support the ISWs
- Data Analyst
- Programme Manager

A steering Group made up of partners from across a wide range of services provides oversight to the programme, including agreeing a service delivery plan. The steering group meets quarterly. We are also working with Dear Albert as our Lived Experience Partner.

Referrals to Changing Futures Leicester

Between September 2022 and August 2024 there were 162 successful referrals to Changing Futures Leicester.

The successful referrals came from Statutory Services such as Police (25.6%), Probation (6.8%), Adult Social Care (12.5%) and support services such as STAR (7.5%) although the voluntary sector also contributed a significant number of referrals.



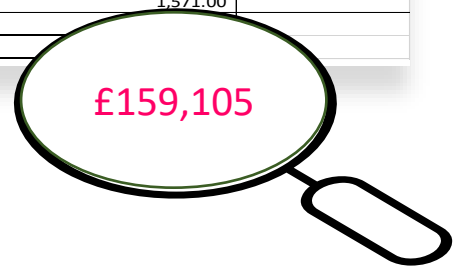
Changing Futures works with partners and with people with lived experience to look at strategies to be able to work more effectively with those with multiple disadvantage.

- **Outreach** with Partners such as Dear Albert and Turning Point better engage with Clients and to introduce ISWs and the Changing Futures programme.
- **Community Safety Partnership (CSP) Beat Bus** with colleagues from Turning Point, Housing and The Hep C Trust, which we are taking to areas in the city where it is reported that sex working is taking place to introduce services, encourage engagement and facilitate testing for Hepatitis C.

The Cost of Multiple Disadvantage

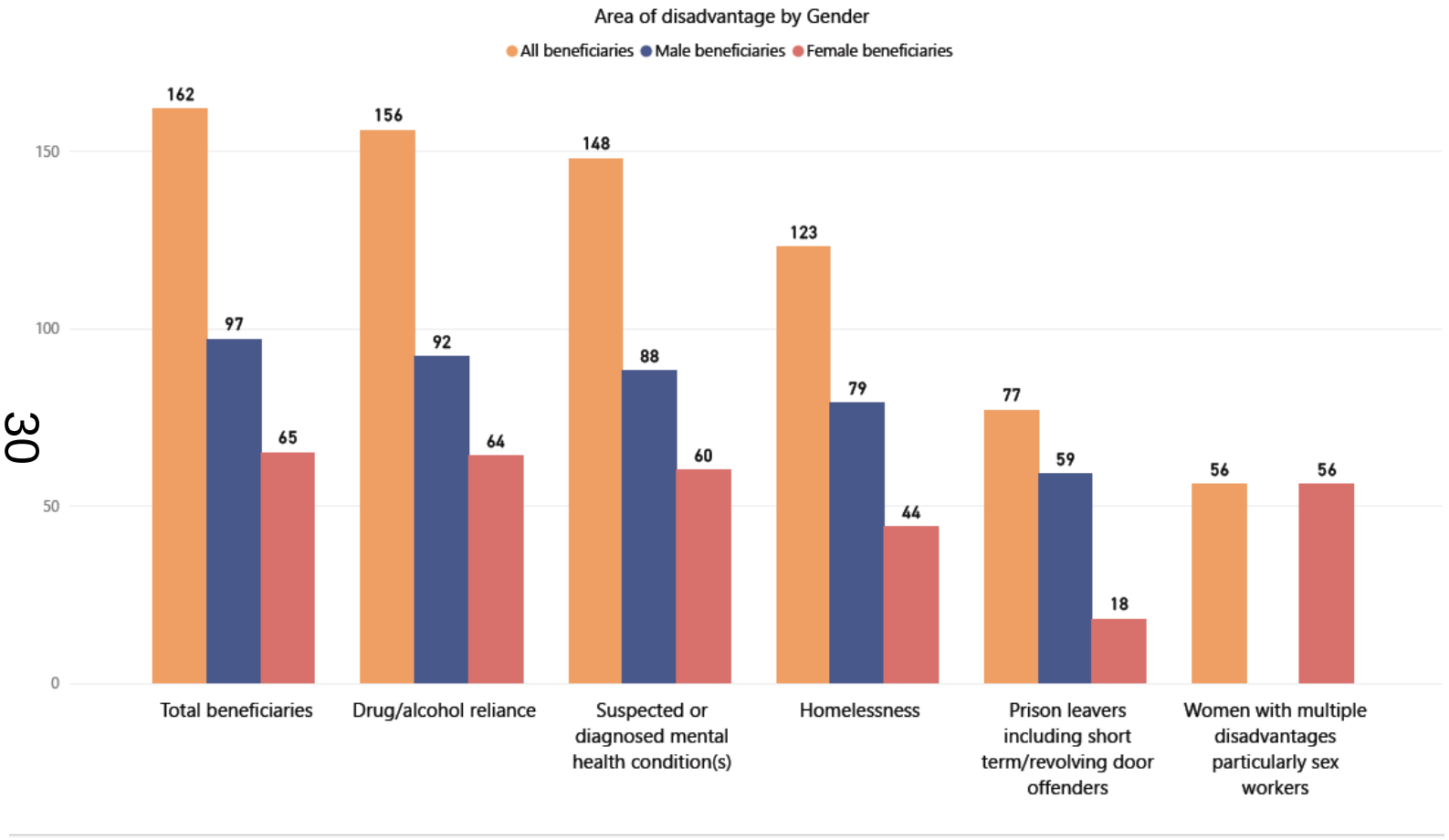
Public service	Service intervention	Unit	Notes	Price	
Health					
	Ambulance	35		£ 13,195.00	
	Amulance service calls	30		£ 2,760.00	
	A&E Admissions	79		£ 24,727.00	
	Walked out A&E Admissions	42	Did not wait to be seen. Cost of no investigation and no significant treatment.	£ 5,922.00	
	Non-elective short stay inpatient	11		£ 10,549.00	
	Non-elective long stay inpatient	8		£ 38,736.00	
	CT Head scan	5		£ 680.80	
	X-ray	3		£ 225.00	
					£ 96,794.80
Police					
	Arrests	5		£ 2,035.00	
	Anti-social behaviour incidents - further action necessary	5	Cost of dealing with incident	£ 3,995.00	
	Anti-social behaviour incidents	21	Police intervention (remedial action) and Community Safety anti-social behaviour with Police involvement. (Including Safeguarding PPN)	£ 4,200.00	
	Police call-outs	47	Simple police reporting of incident, no further action taken and Community Safety reporting	£ 2,632.00	
	Police intervention taken to LRI	5		£ 785.00	
	Robbery	3		£ 3,591.00	
	Violence with injury	9		£ 12,051.00	
	Theft	3		£ 141.00	
					£ 29,430.00
Mental Health					
	A&E mental health liaison services	3		£ 912.00	
	Crisis resolution team for adults with mental health problems	1		£ 47.00	
	Mental health initial assessment	3		£ 903.00	
					£ 1,862.00
Drug and Alcohol					
	Drug and Alcohol advice and information	8		£ 488.00	
	Drug and Alcohol crisis management intervention	41		£ 4,961.00	
	Residential rehabilitation for people who misuse drugs or alcohol	20	Number of days	£ 2,328.60	
					£ 7,777.60
Housing					
	Temporary accommodation	296	Number of days	£ 5,920.00	
	Rough sleepers cost for local authority	68	Number of days homeless	£ 1,971.32	
	Support costs for homelessness services (accomodation based)	296		£ 10,022.56	
	Homelessness application	1		£ 3,266.00	
	Administering a decision on a homelessness application	1		£ 490.00	
					£ 21,669.88
Social Care					
	VARM Meetings	10	Cost of MARAC used	£ 1,571.00	
TOTAL				**£**	

A cost analysis of the contact with 'The System' of one Changing Futures Beneficiary gave a total cost of over £159,000 over a period of 12 months, which may be avoided through intensive support. This included 79 A&E Admissions, 65 Ambulance calls, 47 police call outs, as well as 296 days in temporary accommodation and 18 Hospital Admissions.



Most Changing Futures beneficiaries in Leicester fall into the age bracket of 25 – 50. This is likely due to increased mortality rates amongst people facing multiple disadvantage.

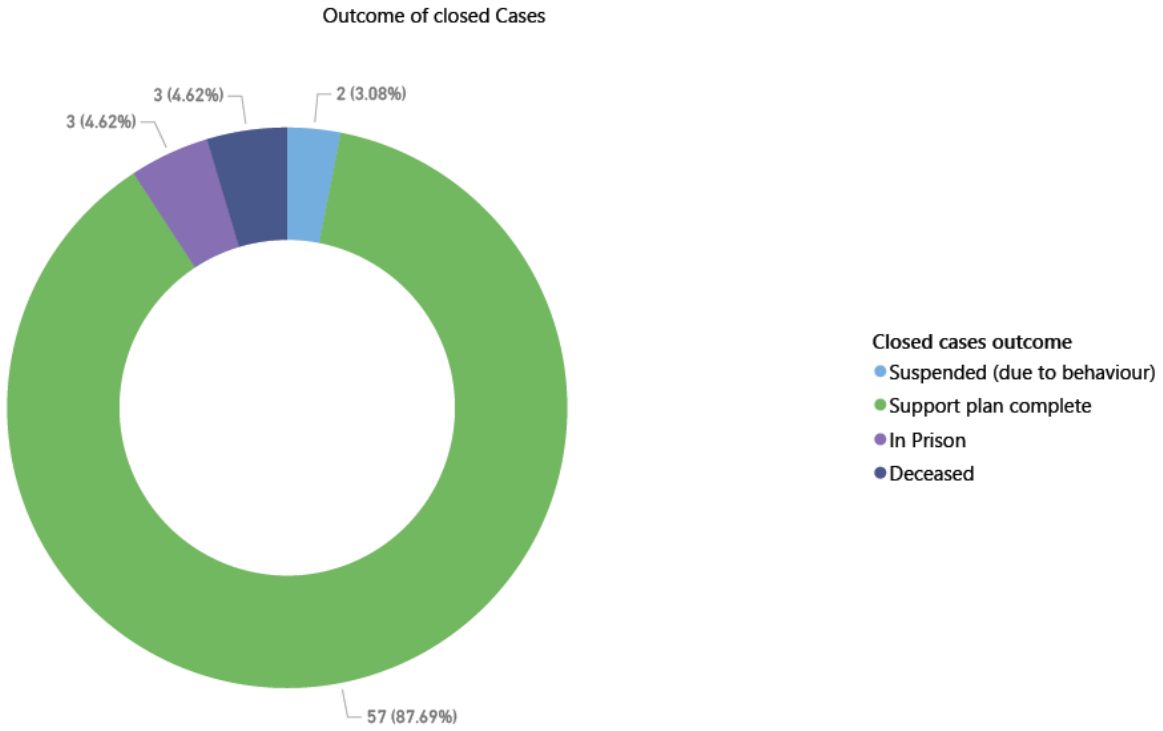
Specific information on the number of deaths of people experiencing multiple disadvantage is not recorded. A report from the Fulfilling Lives programme found that people with multiple disadvantage die 5 times earlier than those without. The average age of death was 43 for men and 39 for women compared to 76 years for men and 81 years for women across the general population.



Areas of disadvantage by Gender

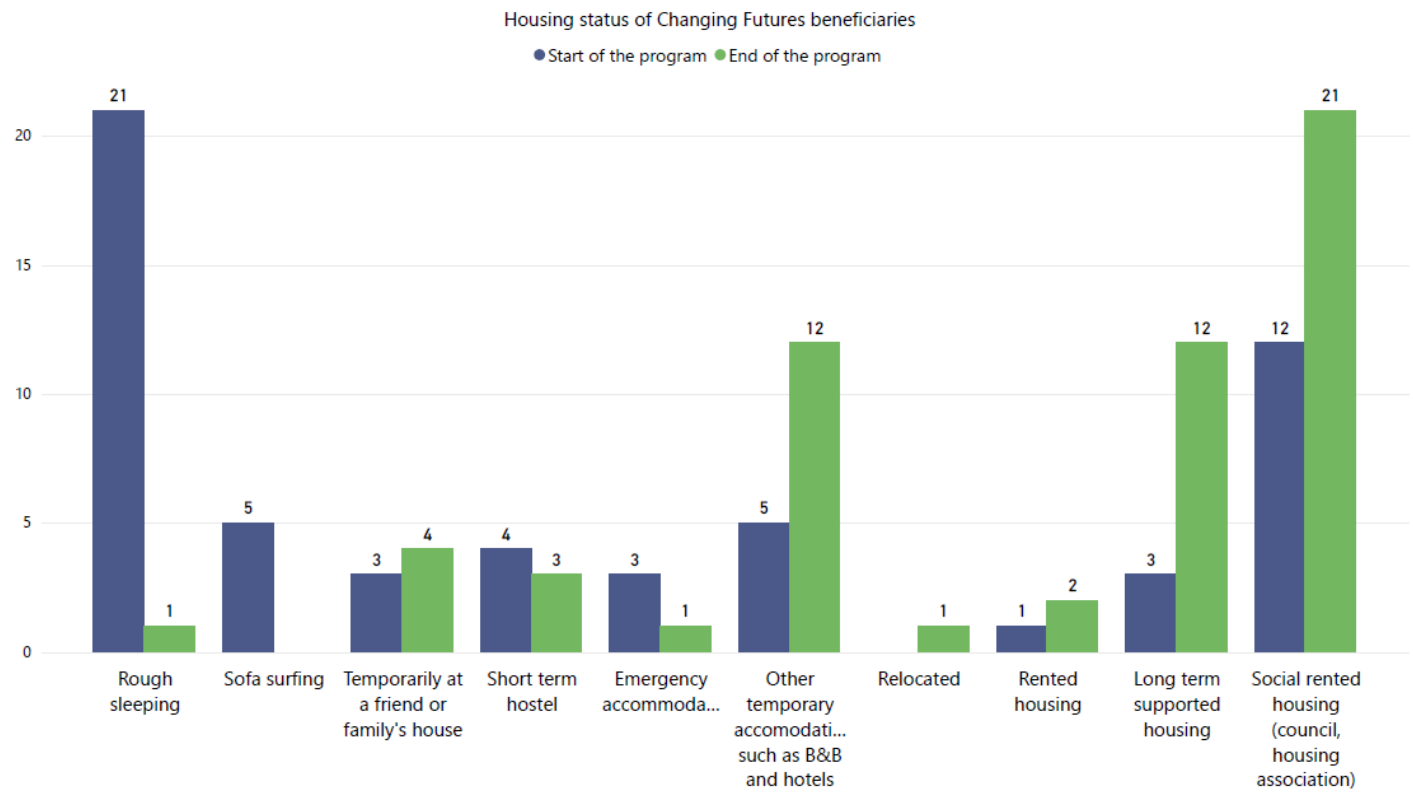
September 2022 - September 2024

Beneficiary Outcomes



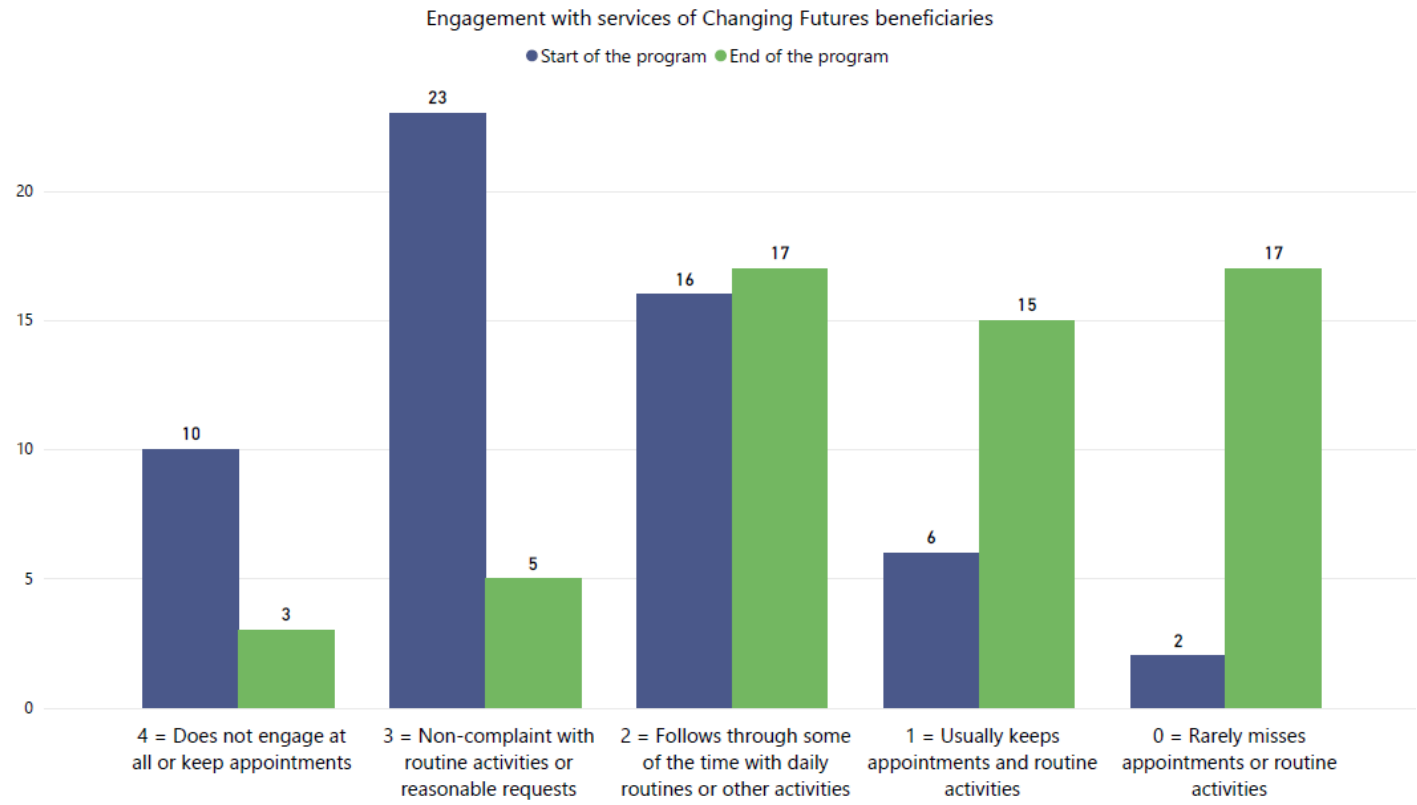
Housing Status

- The majority of beneficiaries were rough sleeping or in unsettled accommodation at the point of referral to Changing Futures.
- At the end of support, most beneficiaries were in their own tenancies or other long term or settled accommodation

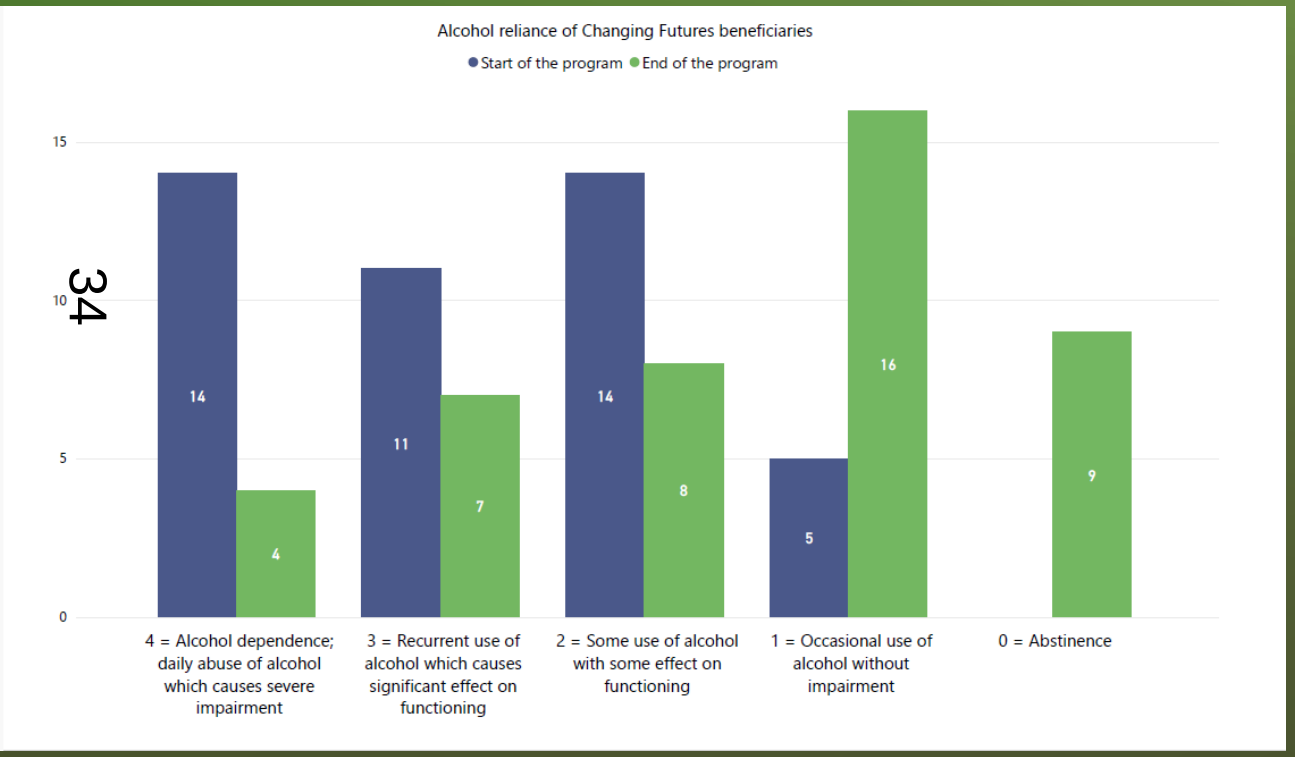


Engagement status

- The majority of beneficiaries were referred to Changing Futures, due to being unable to engage with other services.
- By the end of support, most beneficiaries were engaging well with the services identified to help them achieve their goals



The majority of beneficiaries were dependent on drugs and/or alcohol to a level which was causing them severe impairment at the point of referral to Changing Futures.
By the end of support most beneficiaries had reduced their use to less harmful levels and some had become abstinent.



Prison Leavers

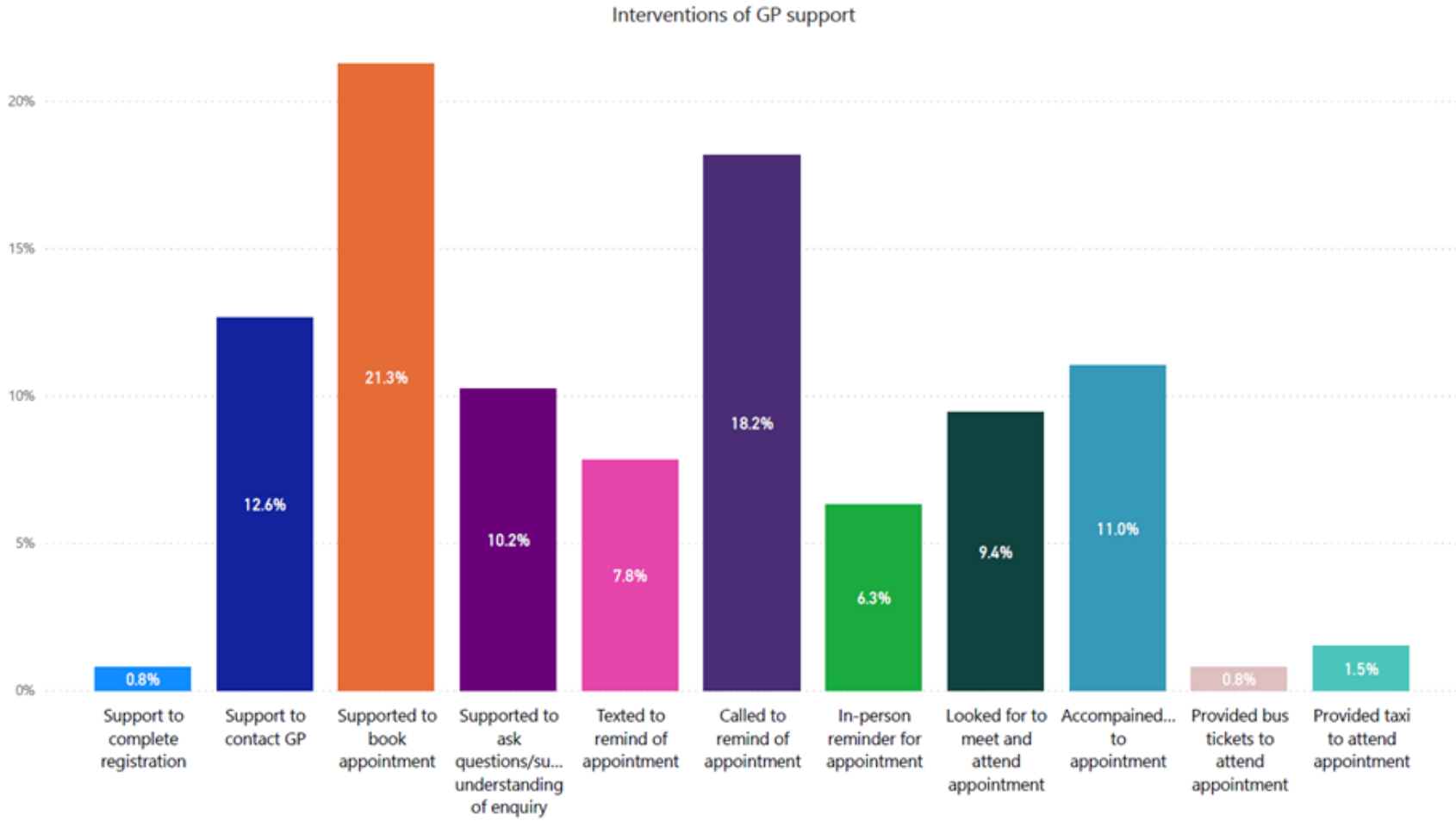
Of total of 162 successful referrals by September 2024, 77 of Changing Futures beneficiaries were prison leavers which represents 47.5% of all the people referred to Changing Futures

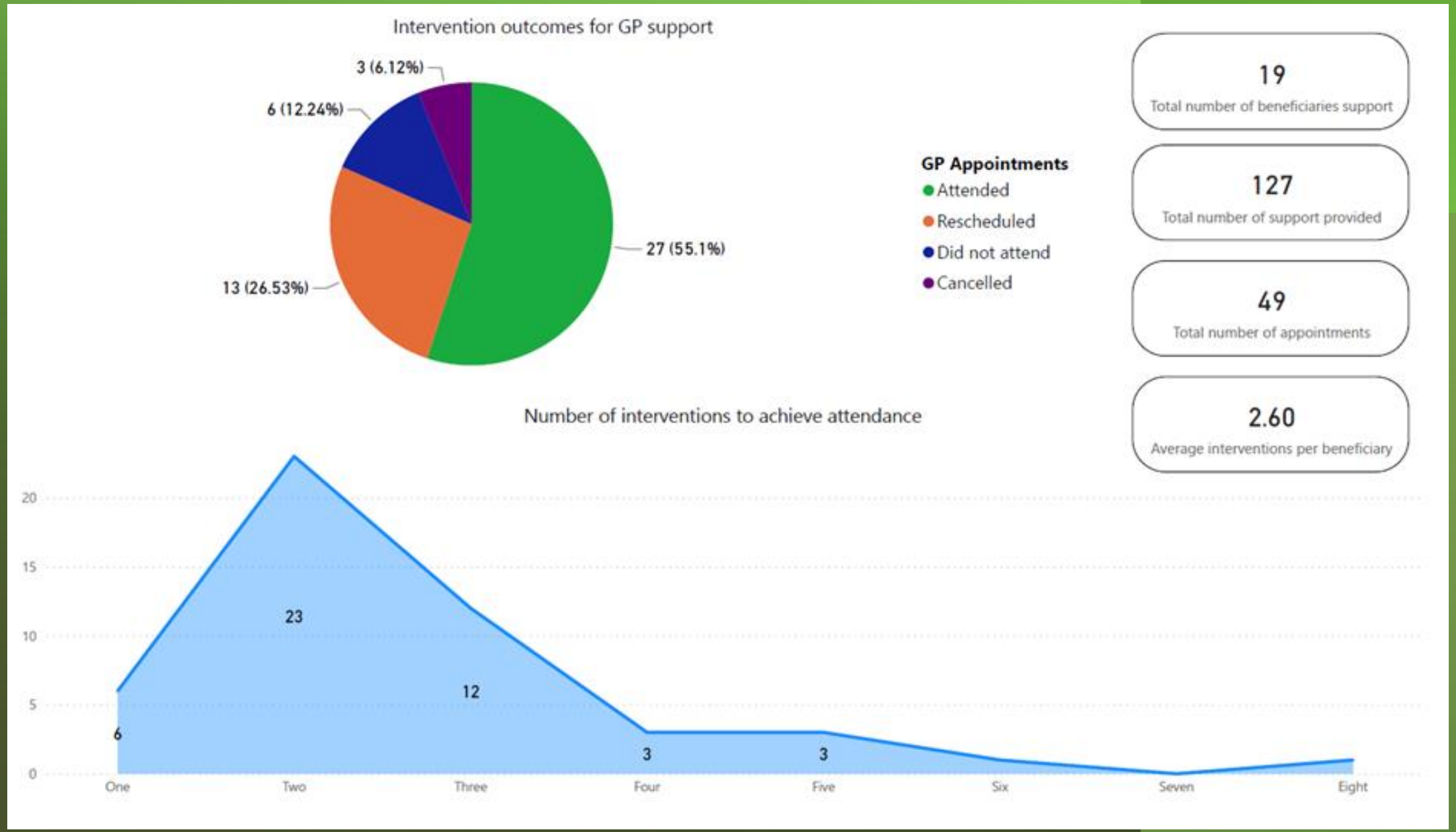
Intensive Support Workers offer one to one support before release to ensure that relevant appointments and referrals for support are made. On the day of release Intensive support workers will meet individuals at the prison and accompany them to all appointments to ensure that they are linked in with health services and benefits and will also support them to link in with the Housing Pathway.

Changing Futures are also part of the LLR Prison Release Steering Group which is a multi-agency meeting aimed at co-ordinating services around prison leavers and who are currently working on an Early Release Pathway for Prison Leavers.

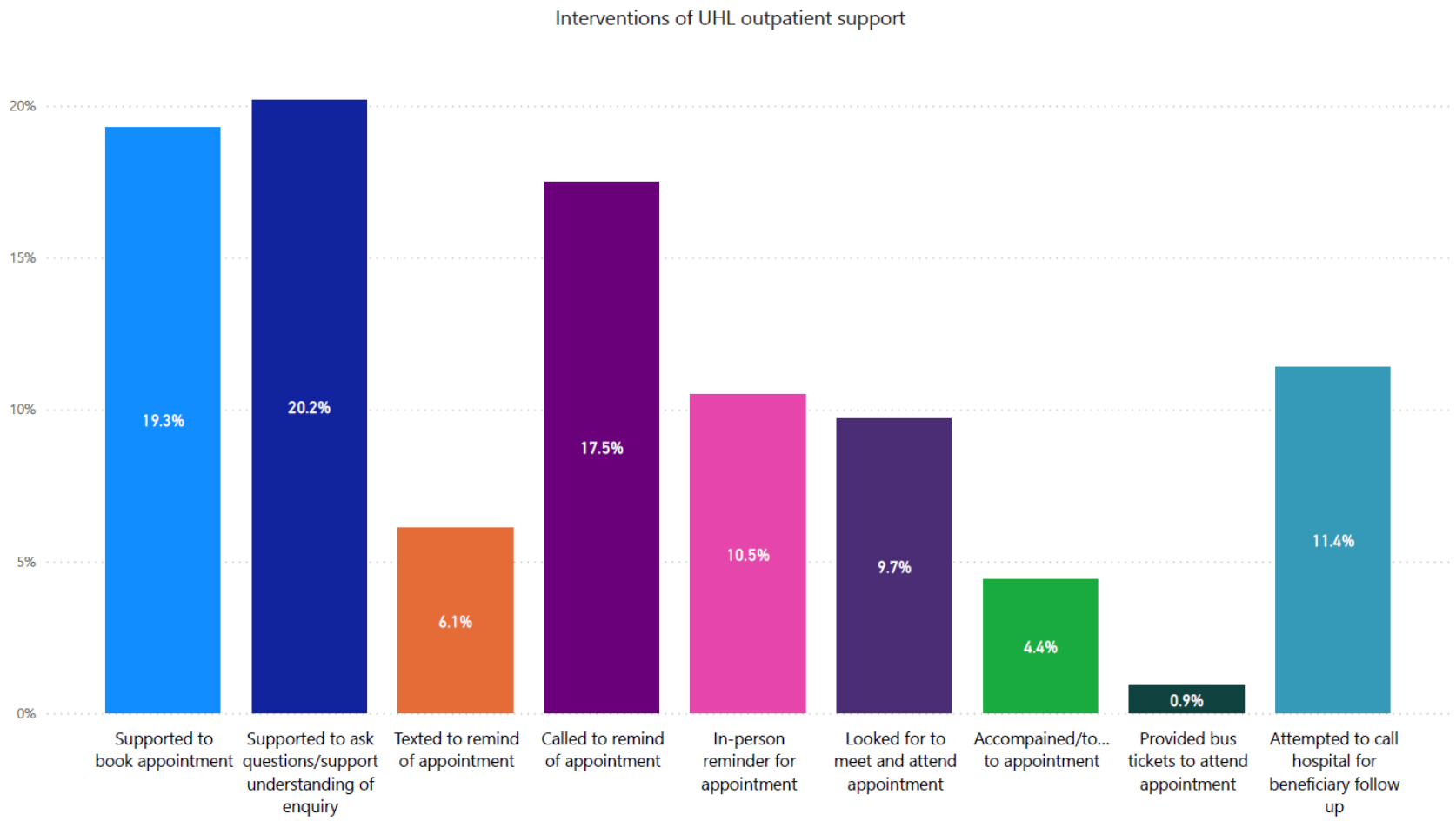
Changing Futures Support Around Health and Wellbeing

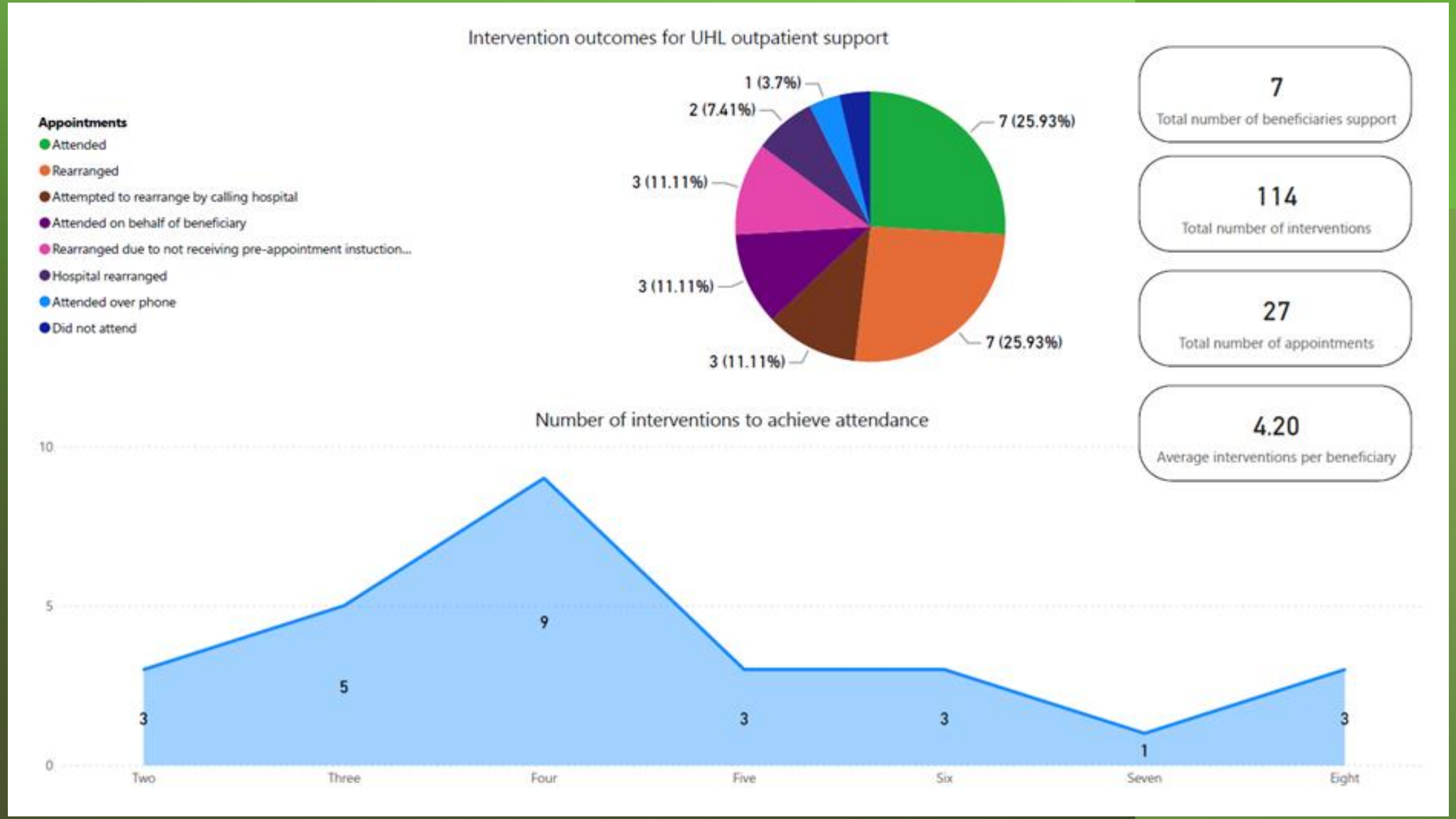
Support to Access Primary Healthcare

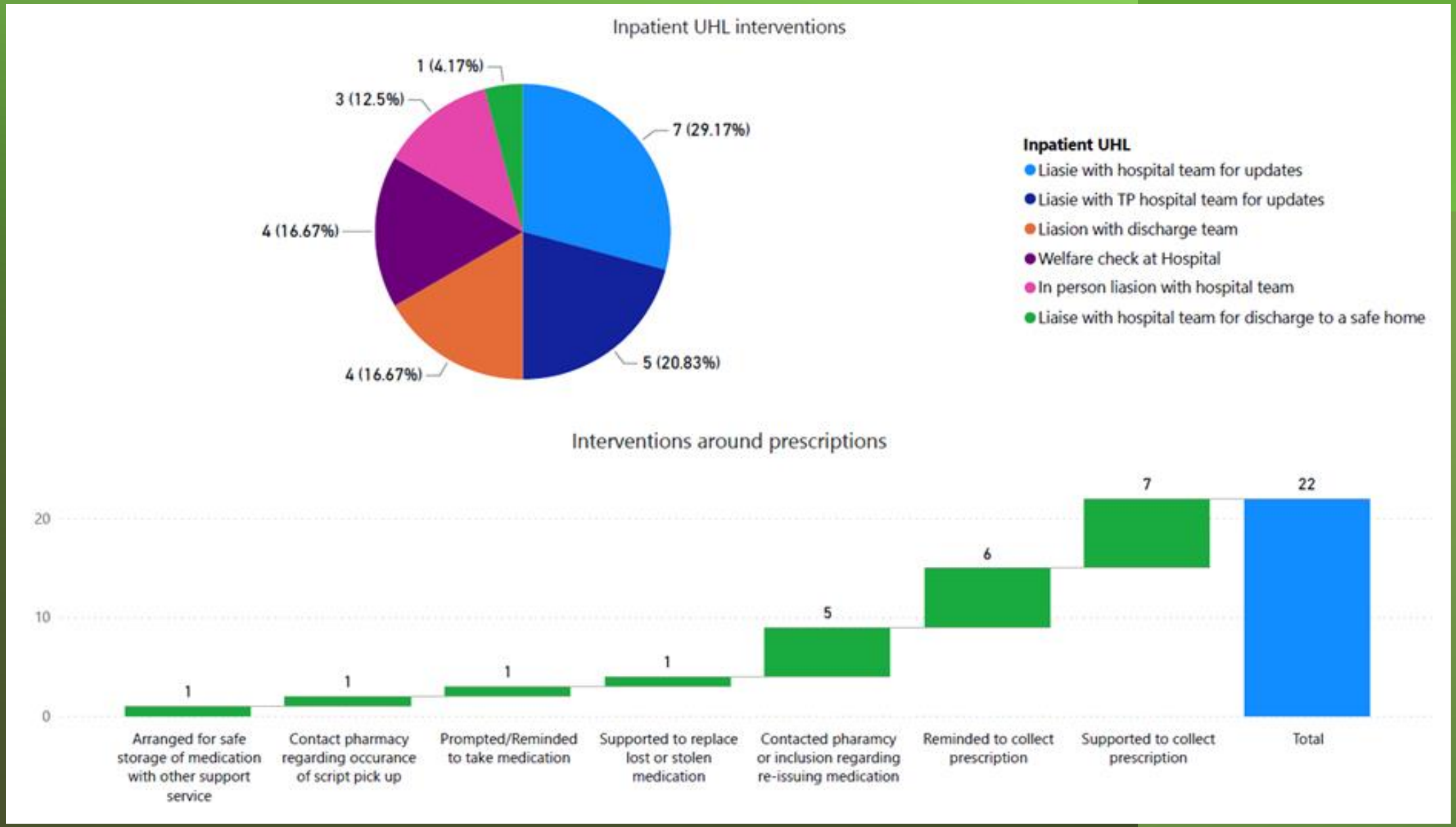



Intervention outcomes for GP support
3 (6.12%)
6 (12.24%)
27 (55.1%)
13 (26.53%)
GP Appointments
Attended
Rescheduled
Did not attend
Cancelled
19
Total number of beneficiaries support
127
Total number of support provided
49
Total number of appointments
2.60
Average interventions per beneficiary
Number of interventions to achieve attendance
20
15
10
5
0
23
12
6
3
3
One
Two
Three
Four
Five
Six
Seven
Eight

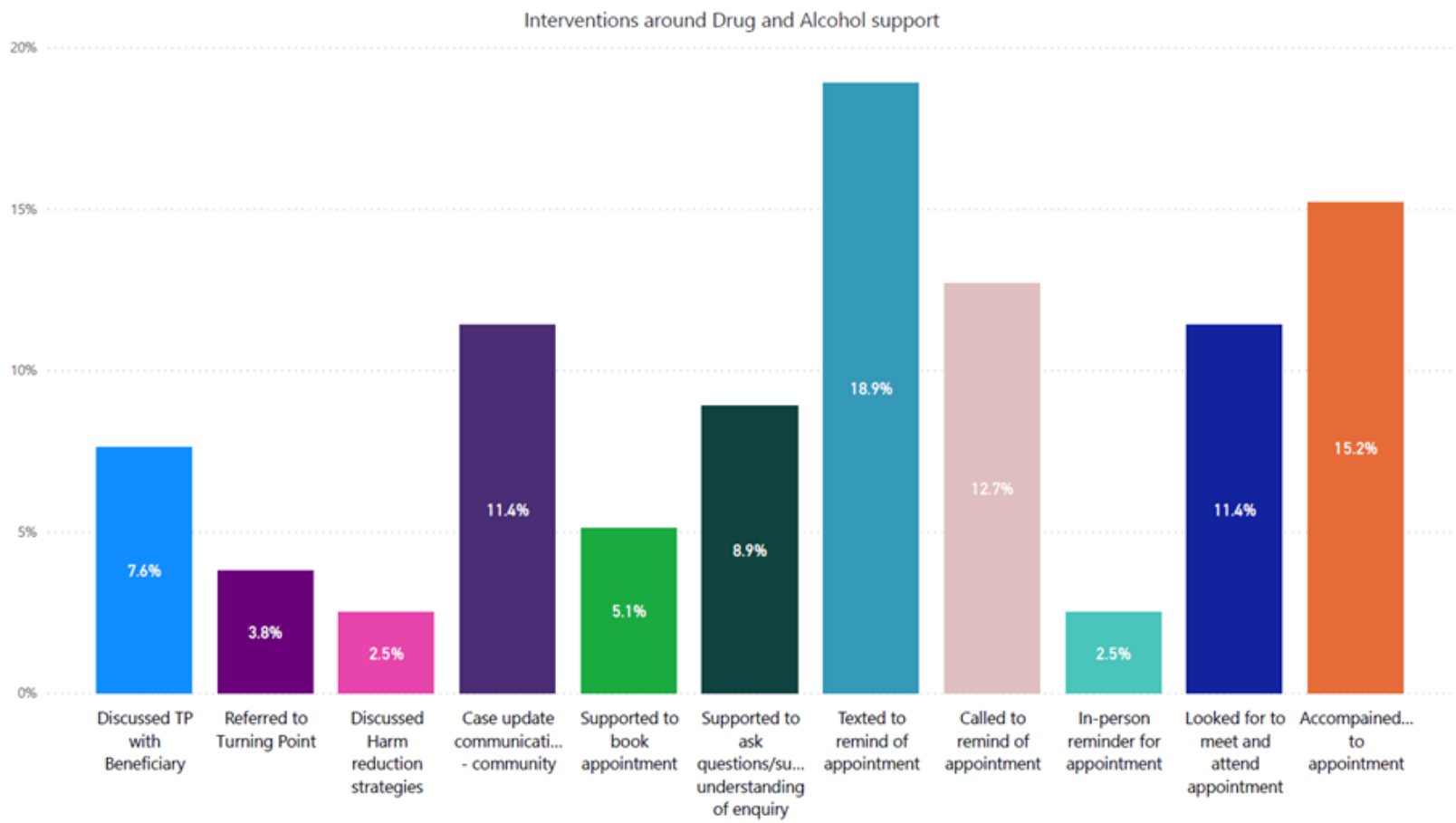
Support to Access UHL Outpatient Appointments and Inpatient Treatment and to Access Medication

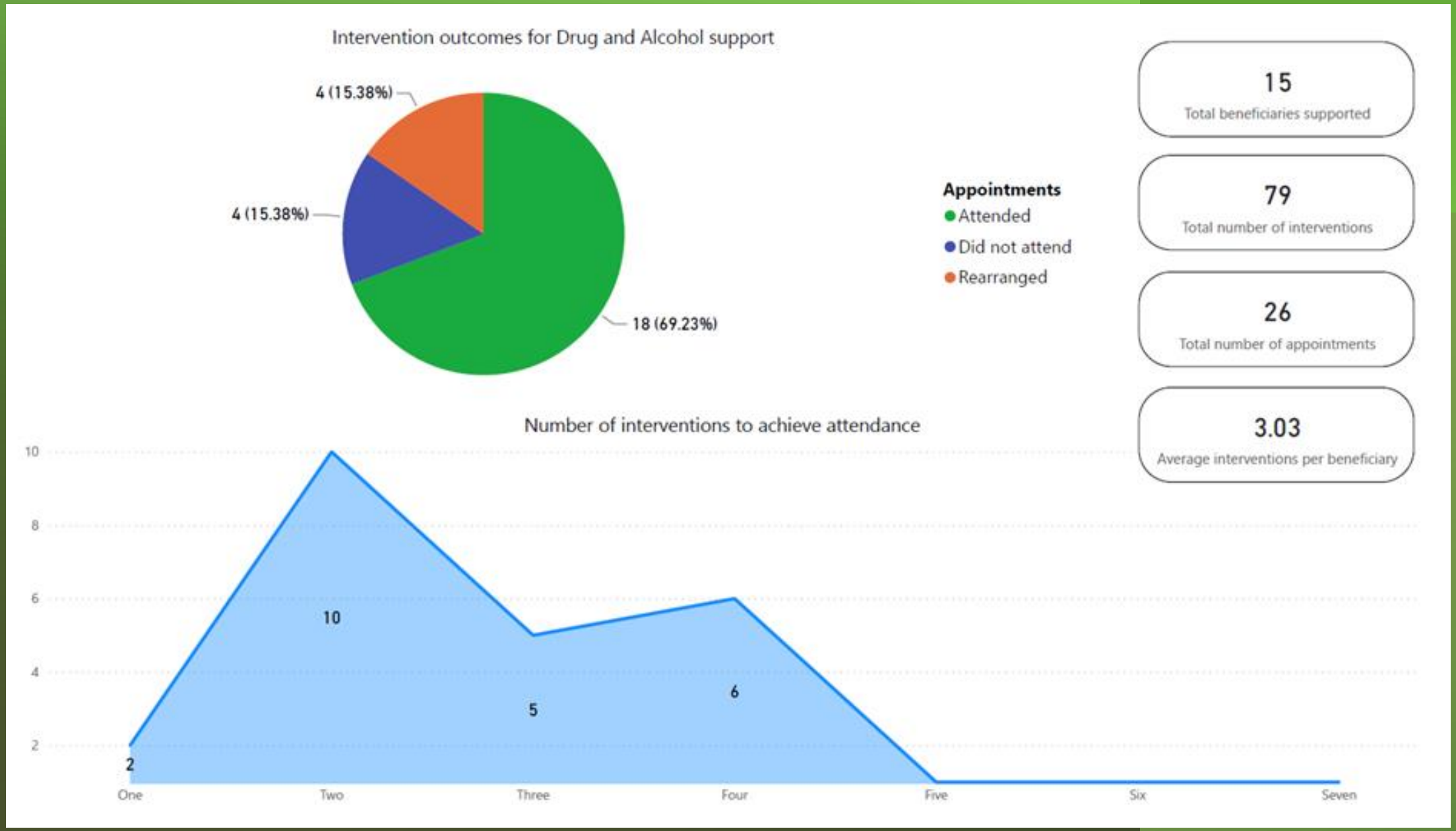


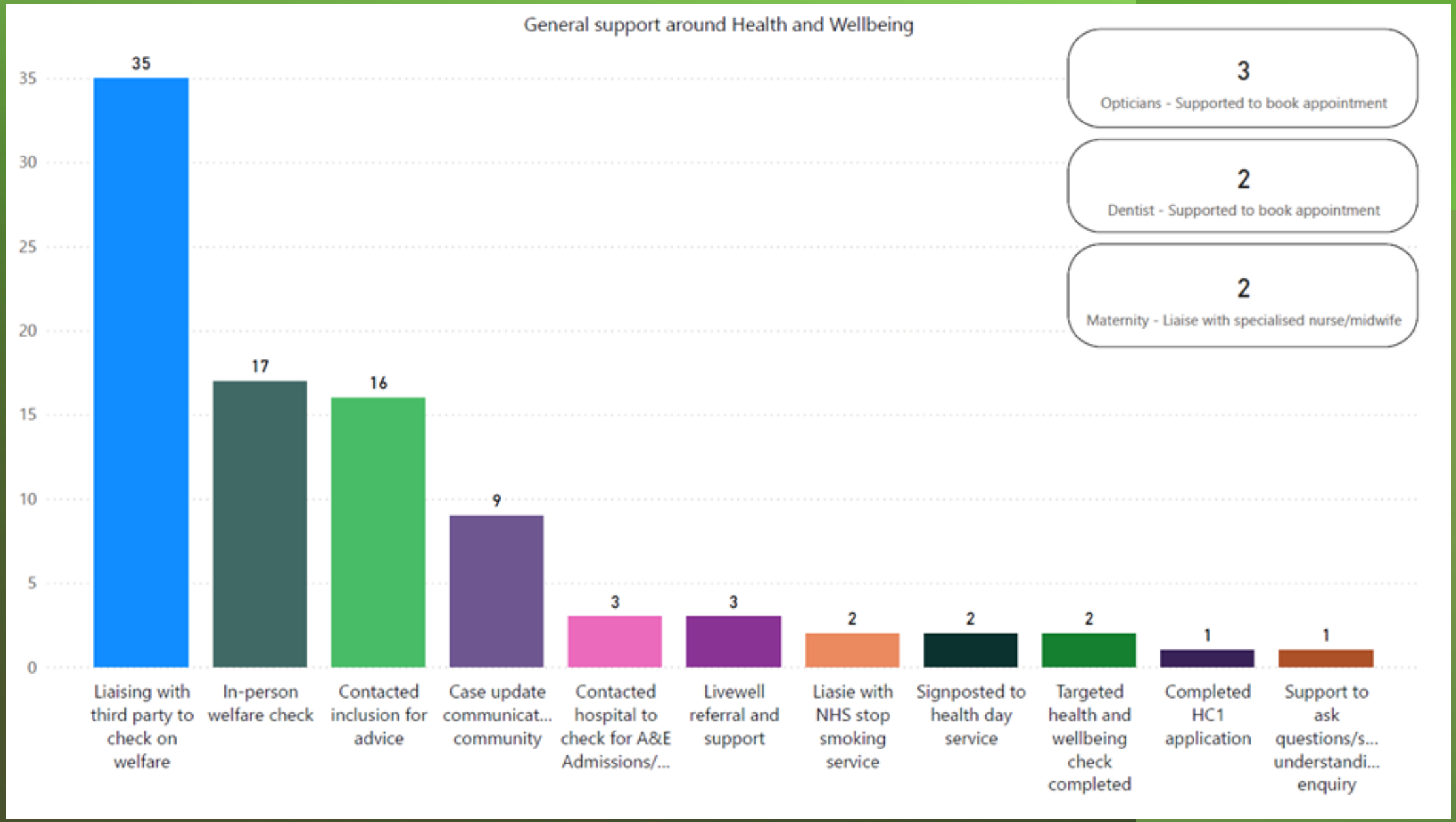

Intervention outcomes for UHL outpatient support
Appointments
Attended
Rearranged
Attempted to rearrange by calling hospital
Attended on behalf of beneficiary
Rearranged due to not receiving pre-appointment instuction...
Hospital rearranged
Attended over phone
Did not attend
1 (3.7%)
2 (7.41%)
3 (11.11%)
3 (11.11%)
3 (11.11%)
7 (25.93%)
7 (25.93%)
7
Total number of beneficiaries support
114
Total number of interventions
27
Total number of appointments
4.20
Average interventions per beneficiary
Number of interventions to achieve attendance
10
5
0
3
5
9
3
3
1
3
Two
Three
Four
Five
Six
Seven
Eight


Inpatient UHL interventions
1 (4.17%)
3 (12.5%)
7 (29.17%)
4 (16.67%)
5 (20.83%)
4 (16.67%)
Inpatient UHL
Liasie with hospital team for updates
Liasie with TP hospital team for updates
Liasion with discharge team
Welfare check at Hospital
In person liasion with hospital team
Liaise with hospital team for discharge to a safe home
Interventions around prescriptions
20
10
0
1
1
1
1
5
6
7
22
Arranged for safe storage of medication with other support service
Contact pharmacy regarding occurance of script pick up
Prompted/Reminded to take medication
Supported to replace lost or stolen medication
Contacted pharamcy or inclusion regarding re-issuing medication
Reminded to collect prescription
Supported to collect prescription
Total

Support to Access Support Around Drugs and Alcohol Use




Intervention outcomes for Drug and Alcohol support
4 (15.38%)
4 (15.38%)
18 (69.23%)
Appointments
Attended
Did not attend
Rearranged
15
Total beneficiaries supported
79
Total number of interventions
26
Total number of appointments
3.03
Average interventions per beneficiary
Number of interventions to achieve attendance
10
8
6
4
2
10
5
6
2
One
Two
Three
Four
Five
Six
Seven


General support around Health and Wellbeing
35
30
25
20
15
10
5
0
35
17
16
9
3
3
2
2
2
1
1
Liaising with third party to check on welfare
In-person welfare check
Contacted inclusion for advice
Case update communicat... community
Contacted hospital to check for A&E Admissions/...
Livewell referral and support
Liasie with NHS stop smoking service
Signposted to health day service
Targeted health and wellbeing check completed
Completed HC1 application
Support to ask questions/s... understandi... enquiry
3
Opticians - Supported to book appointment
2
Dentist - Supported to book appointment
2
Maternity - Liaise with specialised nurse/midwife

The impact of Changing Futures Intensive support on beneficiaries and the services that they interact with include:

Improved Health Outcomes for beneficiaries

- •Improving GP registrations and access to Primary Healthcare
- •Reducing inappropriate A&E attendance
- •Improving attendance to outpatients' appointments
- •Increased access to maternity care for women facing multiple disadvantage.

•Reduction in homelessness and rough sleeping

- •Support for people to access services and systems to access appropriate Temporary or Settled Accommodation
- •Support for tenants with complex need leading to increased Tenancy sustainment.

•Increased engagements with Drug and Alcohol Treatment Services

- •Support for people to access services providing treatment.
- •Support around Harm Reduction
- •Support to access Mutual Aid spaces.

•Reduction in Street Lifestyle Activities around the City Centre

- •Support to access relevant income and to manage this safely.
- •Support to access treatment services and with prescriptions where applicable.
- •Support to access day services and temporary accommodation.

•Reduction in Offending Behaviour

- •Support to access relevant income and to manage this safely.
- •Support to access treatment services and with prescriptions where applicable.
- •Support to access day services and temporary accommodation.

In addition, Changing Futures uniquely offer intensive support to people being released from prison, including prior to release.

From April 2025 without a continuation of funding for the programme the provision of Intensive Support for Individuals facing multiple disadvantage (Including Prison Leavers, those involved in Street Lifestyle Activities and those with the highest impact on services within the city) will no longer be provided.

Pre-Tenancy Training

- We have worked with partners to develop and deliver a programme of Pre-Tenancy Support in Leicester.
- The training is aimed at people facing Multiple Disadvantage, who have an offer of settled accommodation, or have moved to settled accommodation in the last 12 months. The partners that we worked with to deliver this training are: Dear Albert, Leicester Homeless Charter, Action Homeless, Public Health, National Energy Advice, St Mungo's, Turning Point, Leicester Adult Education, Leicester City Council Floating Support Services, No. 5, The Hepatitis C Trust and a number of volunteers from lived experience.

"As a Leicester resident with lived experience of rough sleeping, supported accommodation and my own tenancy - it has been fantastic to be part of this pilot. I was made to feel valued, welcome and supported from the get-go. I've really enjoyed meeting professionals and participants and it's great that I've been encouraged to give my experience to help shape the modules.

I didn't have anything like pre tenancy training in my past so how cathartic that I was able to help support and co-present part of this program. It's been a great insight into some of what parts of Leicester's teams of professionals do and how much they care for the city"

Getting together as a group and discussing our experiences was good. Because it makes me realise, I'm not the only one struggling.

Systems Change

As we move into our final year, we are committed to continuing to work with partners on key pieces of work:

Development of a referral pathway with UHL around HIU/HFU with a dedicated Intensive Support Worker to work with identified individuals. We will also be collecting Health Related data alongside the work around the referral pathway in order to evidence the impact of Intensive Support on health outcomes and health inequality.

Development of Pre-tenancy Training – we hope to identify external funding for this which will include a member of staff to co-ordinate.

Development of Safer Sex Worker packs and Working Group around Gender Specific Services for Women. We are hoping to identify external funding for the creation of more packs which will be available city wide, and we will continue to develop the working group with Action Homeless as the lead partner on this work.

Development of the Frontline Community of Practice. We will look to identify an independent chair to co-ordinate this and we will work with partners to develop the COP over the next 12 months.

Continuation of the Case Study Workshops and possible development into a Community of Practice locally. We will work towards identifying an independent chair to continue to co-ordinate and facilitate these.

We will also continue to try to embed MTAM as a process within the system, which will hopefully have the added elements of Trauma Informed Risk Assessments/Safety Planning that we are currently working on locally.

CASE STUDY 1

EMPLOYMENT

FINANCIAL SUPPORT

+

CHANGING FUTURES

Ongoing engagement with Local Supported Employment Team

Support from CALS (Financial Management and Support)

CB was referred to Changing Futures by Child Social care, who identified concerns that they were unable to look after themselves effectively. Concern was also raised around problematic opiate and alcohol use as well as poor coping mechanisms and a decline in mental wellbeing.

The referrer was concerned that CB struggled to maintain engagement with services and that they were at risk of falling by the wayside without a person-centred support plan in place to help empower and enable them to achieve

The allocated 'Intensive Support Worker' spoke with at length with CB about the concerns raised and found that they were struggling financially and regularly using local food banks. CB's goals were to access help claiming appropriate benefits and dealing with arrears as well as gaining employment.

While CB didn't agree that they had substance use problems they agreed to engage with service assessments and follow-ups as part of the work with their Intensive support worker.

Through positive work between the ISW and CB over, 7 months, this case was closed with CB engaging positively with services around accessing employment, as well as receiving tailored support to further their financial management. They had been assessed as not requiring further support around opiate usage or mental health after engaging in assessments with both services.

CASE STUDY 2

CHILD ACCESS

TO MOVE HOME

A FRESH START

+

CHANGING FUTURES

Engaging with Child Social Care and having contact with her children

Not using substances

In a new home

Engaging with STAR

CB was Referred to Changing Futures by Social Care. She was using substances and pregnant at the time. The referrer was worried as CB was not engaging with health or any other service and this made hers a particularly high-risk pregnancy.

CB's completed disengagement from services continued for a number of months. Due to the increased risk of mortality to mother and baby, a multi-agency plan was put in place to ensure that professionals were attempting

After the birth of her child the ISW went to see CB in hospital and CB made it clear that her primary goal was to move home. The ISW assisted in arranging and supporting engagement with the housing team around this and a new home was found for CB.

After making a number of referrals to charities to support the move and furnish the new property the ISW continued to work with CB until she was settled and able to manage and engage with services independently.

CB is now settled and drug free with regular contact with her children. Over ten months the ISW worked hard first to engage CB and then to facilitate the realisation of goals that have improved her quality of live.

Follow up with CB has since shown that she continues to do well and is thriving in her new home.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE 19 DECEMBER 2024

Subject:	LLR WorkWell Programme
Presented to the Health and Wellbeing Board by:	Louise Young – Deputy Chief People Officer (Joint SRO WorkWell) LLR ICB
Author:	Glenn Halliday – Strategic People Lead Work & Health Integration (WorkWell Lead) LLR ICB

EXECUTIVE SUMMARY:

1. The purpose of this report is to inform the Health and Wellbeing Board of the delivery plan for Leicestershire, Leicester City and Rutland (LLR) WorkWell, and how the programme will be placed in General Practice to support the population that may have barriers in returning to work and thrive in work. With considerations to languages and skills of the target area within City.

RECOMMENDATIONS:

2. The Health and Wellbeing Board is requested to:

    a. note the update on the WorkWell programme for LLR and that seven Primary Care Networks (PCNs) within Leicester have signed up to host and deliver the Programme, and;
    b. Support the implementation of WorkWell within Leicester.

Policy Framework and Previous Decisions:

3. A meeting of the Health and Wellbeing Partnership (the 'ICP') approved the submission of a bid to the Department of Health and Social Care (DHSC) at a special meeting of that board on the 15th August 2024. The bid was approved on the 3rd May 2024.

Background:

3. WorkWell, a joint Department of Work and Pensions (DWP) and DHSC pilot, is a demonstration of the Government's ambition to combine cross-government efforts to ensure everyone can reach their potential. Further, WorkWell supports the key aims of the major condition's strategy, with mental health and musculoskeletal health conditions being the most common conditions which lead to health-related labour market inactivity.

4. The LLR programme is one of 15 national vanguards being established to provide this service. WorkWell services are expected to begin service delivery from autumn 2024.

5. WorkWell recognises that reversing the trend in inactivity cannot be achieved by programmes acting in siloes - it requires an integrated whole-systems approach to addressing health-related barriers to work at a local level.

What is WorkWell?

6. WorkWell focuses on early intervention and support, offering participants an expert assessment of their health-related barriers, along with a tailored plan to address these. It will also serve as a pathway to existing local services to help people get the support they need.

7. WorkWell will provide advice and support to employers, and it will triage, signpost and send referrals to clinical and non-clinical support including wider community provision, for example, care navigation teams, work health coaches, accessing healthy lives programmes, or debt advice.

8. The service will be available to people with a disability or health condition who:
    - Need support to remain in work;
    - Need support managing a condition in order to return to work from sickness absence, or;
    - Need support to start work.

9. It is envisaged that the WorkWell service will be based on the principles of personalised care and delivered by a multi-disciplinary team. It is known that work is an important social determinant of health, both directly and indirectly on the individual, their families and communities. A healthier population is also a wealthier and more productive one. Data shows the longer an employee's sickness absence lasts, the less likely they are to return to work.

10. It is known that work and health are inextricably linked. Being in work raises living standards and pulls people out of poverty, and a prolonged absence from work can lead to a deterioration in health and wellbeing, both due to financial strains and the absence of positive psychological and social support.

11. Recruitment is under way by PCNs for a new specialist role of 'work and health coach' and employed by host practice. It is expected that work and health coaches will be able to provide:
    - An initial assessment of barriers to employment;
    - Return-to-work/thrive-in-work planning, with clear objectives that address physical, psychological and social needs;
    - Employer liaison - if the participant consents, the employer can be contacted to share the work plan and provide advice;
    - Advice on workplace adjustments;
    - Personalised work and health support with follow-up as required, including ongoing support in the form of locally determined, low intensity appointments to take stock of progress and recommend further actions and activities.

12. WorkWell services will be locally led in response to population need, building on existing supports to provide an integrated, local work and health service. Integrated Care Systems, including local authorities, will play a central role in convening local partnerships to design and deliver WorkWell, alongside wider partners including jobcentres.

13. Individuals can be referred to WorkWell through their employer, local services within their area, primary care providers such as GPs, Jobcentre Plus and through self-referral.

14. The LLR WorkWell service will:
    - Offer a delivery vehicle to Integrated Neighbourhood Teams (INTs) (working in communities across LLR);
    - Build on existing local services and provide a triage, referral and signposting service to other services;
    - Release pressure within primary care;
    - Bring health and wellbeing benefits to being in work. In LLR, according to NHS Digital, there are approximately 20,000 individuals yearly requesting a fit note, all eligible for a WorkWell service. Assuming 4,000 to 6,000 of these are a first or second episode, they would be the prime candidates for the service;
    - Achieve key performance indicators and outcomes that are agreed with the national team. These are likely to include: return to work, remain in work, reduced health barriers to working or looking for work, and user experience;
    - Support economic growth;

- Inform the development of an LLR Integrated Work and Health Strategy.

15. We will focus our efforts across Leicester where there are the highest levels of economic inactivity and long-term conditions, particularly musculoskeletal (MSK) and mental health conditions.

16. Seven PCNs in City have agreed to participate in the WorkWell programme. The remaining are in discussion, to onboard with the programme.

Resource Implications:

17. Funding for WorkWell is via an DHSC grant award. Across 2024/25 and 2025/26, around £57 million is planned for approximately15 Vanguards to design and deliver WorkWell Vanguard Services across both financial years. The value of the grant award for LLR is £3,770,800.

Background Papers:

https://www.gov.uk/government/publications/workwell/workwell-prospectus-guidance-for-local-system-partnerships

Circulation under the Local Issues Alert Procedure:

N/A

Appendices:

1. LLR ICB EIA Stage 1
2. LLR WorkWell Full Delivery Plan – separate attachment

Officer to contact:

Louise Young, Deputy Chief Officer – People and Transformation.
Telephone: 07886 455817
Email: Louise.Young36@nhs.net

Relevant Impact Assessments

Equality Implications:

There are no equality implications arising from the recommendations in this report.

Human Rights Implications:

There are no human rights implications arising from the recommendations in this report.

Crime and Disorder Implications and Environmental Implications:

Not relevant.

Partnership Working and associated issues:

The LLR WorkWell Programme may increase capacity in Talking Therapies, Individual Placement Support and Occupational Health.

Appendix 1: LLR ICB Stage 1 EIA

Stage 1 Equality, Health Inequality Impact and Risk Assessment

Title of Assessment:
Impact Assessment – LLR WorkWell Programme: Local Support for People to start, stay and succeed in work

- **Person Responsible:**
  - Louise Young, Deputy Chief Officer – People and Innovation
  - Telephone: 07886 455817
  - Email: Louise.Young36@nhs.net

- **Service Area**: LLR ICB People and Innovation

- **Overview of Programme:**

The LLR WorkWell programme backed by the Department for Work and Pensions (DWP) and the Department of Health and Social Care (DHSC), aims to nationally

support around 60,000 long-term sick or disabled people to start, stay, and succeed in work through integrated work and health support. The LLR programme is one of 15 national vanguards being established to provide this service. WorkWell will focus on early intervention and support, offering participants an expert assessment of their health-related barriers to work along with a tailored plan to address these. It will also serve as a pathway to other local services to help people get the support they need. WorkWell will provide advice and support to employers where appropriate; triage, signposting and referrals to clinical and nonclinical support including wider community provision, for example, debt advice. It will be delivered to a large extent by the recruitment of Work and Health Coaches, supported by a wider multi-disciplinary team within health and care settings in LLR, accessible via a digital referral hub, used by health and care professionals and with the ability for people to self-refer into the service. Individuals can be referred to WorkWell through their employer, local services within their area, primary care providers such as GPs, Jobcentre Plus and through self-referral.

The service will be available to people with a disability or health condition who need support to remain in work, need support managing a condition in order to return to work from sickness absence or need support to start work.

It is envisaged that the WorkWell service will be based on the principles of personalised care and delivered by a multi-disciplinary team. We know that work is an important social determinant of health, both directly and indirectly on the individual, their families and communities. A healthier population is also a wealthier and more productive one. Data shows the longer an employee's sickness absence lasts, the less likely they are to return to work.

Equality, Health Inequality Impact and Risk Assessment

Section one: equality impact

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

1. Will this (decision / proposal / change) affect / impact on people in any way? (e.g., population, patients, carers, staff)?
   Yes

2. Is this decision or change part of a transformation programme or commissioning / decommissioning review?
   No

3. Is this a decision that may change or potentially change the delivery of a service / activity or introduce a charge?
   No

4. Will this (decision / proposal / change) potentially reduce the availability of a service or activity or product (e.g., prescriptions)?
   No

5. Is this a review of a policy, procedure, protocol or strategy?
   No

6. Is this (decision / proposal / change) about improving access or delivery of a service?
   Yes

7. Will this (decision / proposal / change) potentially negatively impact groups covered by the Equality Act and other vulnerable groups?
   No

8. Will this (decision / proposal / change) affect Employees or levels of training for those who will be delivering the service?
   No

9. Will this (decision / proposal / change) have any **positive** effect / impact in reducing health inequalities?
   Yes

10. Will this (decision / proposal / change) have any **negative** effect / impact on health inequalities?
    No

Section two: Equality Risk

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

11. To reach your (decision / proposal / change) have you considered any information / supporting documents?
    Yes
    Integrated Care Strategy 2023-2028
    Leicester, Leicestershire and Rutland ICB 5 Year Plan
    LLR Workforce Sharing Agreement
    Accessibility Information Standards
    General Practice Quality Assurance Toolkit
    Public Sector Equality Duty Act

12. Have you engaged or consulted with people or stakeholders / staff that may be affected by the (decision / proposal / change)?
    Yes
    Group A - Target population groups for WorkWell
    Group B - Staff directly delivering the service /
    Staff/stakeholders referring into the service
    Group C - WorkWell partnership groups / Staff in LLR
    ICS partner organisations
    Group D - Other local stakeholders

Group E - National stakeholders

13. Have you taken specialist advice regarding impacts of the (decision / proposal / change)
    Yes
    Discussions via the WorkWell Steering Group - reports into the Integrated Care Partnership Board (ICP), who have overall accountability for WorkWell and the development of the LLR Work and Health Strategy.

14. Have you considered how this can address and eliminate discrimination, harassment and victimisation?
    Yes
    Incorporating diverse employee groups
    Programme is open to participants with any protected characteristics
    Wellbeing offerings e.g., flexible hours, mental health support to ensure accessibility for all, including marginalised or vulnerable groups

15. Have you considered how this can help to address inequality issues to enable all groups to access services?
    Yes
    Awareness and outreach -targeted communication to relevant stakeholders
    Ongoing monitoring – data analysis to identify gaps and continuously improve accessibility and inclusivity

16. Have you considered how this can help foster good relations and community cohesion within communities?
    Integrated care partnerships – collaboration with local authorities, local vendors, organisations, health and wellbeing boards fostering economic and social connections with shared values.

17. Can you address or minimise any negative impacts that may represent an equality risk?
    We have targeted areas in LLR where there are the highest levels of economic inactivity and long-term conditions, particularly musculoskeletal (MSK) and mental health conditions. There has been high interest in the programme and have engaged 21 PCNs offering services beyond target areas.

    Conduct regular equality impact assessments to identify potential disparities in access, participation or outcomes for underrepresented groups
    Monitor data and feedback – collect disaggregated data to identify gaps or unintended impacts and adjust accordingly.

18. Will your decision reports be available to the public?
    Yes – ICP Board

Section three: human rights impact

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

19. Is there any concern that Article 2: Right to life may be breached?
No

20. Is there any concern that Article 3: Right not to be treated in an inhuman or degrading way may be breached?
No

21. Is there any concern that Article 5: Right to liberty may be breached?
No

22. Is there any concern that Article 6: Right to a fair trial or hearing (this includes right to fair assessment, interview or investigation) may be breached?
No

23. Is there any concern that Article 8: Right to respect for private and family life may be breached?
No

24. Is there any concern that Article 9: Right to freedom of thought, conscience and religion may be breached? E.g., right to participate (individually or as a group) religion / belief
No

25. Is there any concern that Article 10: Right to freedom of expression may be breached? E.g., concern that people won't be able to have opinions and express their views on their own or in a group
No

26. Is there any concern that Article 14: Right not to be discriminated against in relation to any human rights, may be breached?
No

27. Is there any concern the obligation to protect human rights may be breached? E.g., concern that systems, processes and monitoring will not identify human rights breaches.
No

Section four: Assessment Comments

28. Further comments from individual / team drafting this assessment:
No

End

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LLR WorkWell Programme

Glenn Halliday

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The Programme

What is WorkWell?

- WorkWell is a low intensity assessment, triage and support service. Participants will receive light-touch holistic support through return to/thrive in work plans and referrals into local services.

Who is WorkWell for?

- The service will be available to anyone with a disability or health conditions who needs support to start, stay and succeed in work.

Where is WorkWell being trialled?

- 15 ICBs have been selected as WorkWell pilot sites and will receive 2 years of grant funding. Services are due to go live 1st October 2024.

LLR WorkWell Programme –The Pilot

- LLR is one of just 15 areas in England which will benefit from the WorkWell pilot, which is funded by the Department for Work and Pensions (DWP) and the Department for Health and Social Care (DHSC).

- The service will link people to local support services, offering tailored help to stay in or return to work. It will focus on people in work who are struggling due to a health condition or disability, those who are on long-term sick leave and at risk of losing their job, or recently unemployed people facing a barrier to return to work due to a health condition or disability.

- As part of the WorkWell journey, participants – who do not need to be claiming any Government benefits – will work closely with a Work and Health Coach to understand their current health and social barriers to work and draw up a plan to help them overcome them

LLR WorkWell Focus

- Across the LLR ICB area there will be a specific focus on those areas with the highest levels of economic inactivity and long-term conditions, particularly musculoskeletal disorders and mental health:
- Leicester city
- Charnwood: Loughborough Lemyngton & Hastings, Storer and Queens Park, University, Shelthorpe & Woodthorpe, Syston West and Shepshed East.
- Harborough: Market Harborough Central.
- Hinckley and Bosworth: Barwell, Hinckley Central and Hinckley Clarendon Park.
- North West Leicestershire: Agar Nook, Coalville.
- Oadby and Wigston: Wigston Town, South Wigston.
- Rutland: Greetham, Exton, Martinsthorpe, Lyddington, Ketton and Braunston & Belton.

People will be able to self-refer to WorkWell, or they can be referred through their employer, primary care providers such as GPs, or local services including Jobcentre Plus.

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Supporting to deliver the Five-year plan – Pledge 13

2023/24-2028/29

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Delivered Across Our Life Course Approach

- Best Start in Life
- Staying Healthy and Well
- Living and Supported Well
- Dying Well

Our Vision: Working together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives

Core Purpose of our ICS (Our Strategic Objectives)

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experience and access	Enhance productivity and value for money	Help the NHS support broader social and economic development	Deliver NHS constitutional and legal requirements

Our Principles : Everything we do is centred on the people and communities of LLR and we will work together with respect, trust, openness and common purpose to:

Ensure that everyone has equitable access to health and care services and high quality outcomes	Make decisions that enable great care for our residents	Deliver services that are convenient for our residents to access	Develop integrated services through co-production and in partnership with our residents	Make LLR health and care a great place to work and volunteer	Use our combined resources to deliver the very best value for money and to support the local economy and environment

Our Delivery Priorities

Improve Health Equity	Preventing Illness	Keeping People Well	Right care at the right time	Health and Wellbeing Hubs	Elective Care	Learning Disabilities and Autism	Mental Health	Children and Young People	Women's Health and Maternity	Our People

Our Pledges to local people

Pledge 1 Improve the health of our most deprived communities and narrow the gap between those who have the best and the worst health	**Pledge 2** Spend more money on preventing people becoming ill in the first place	Pledge 3 Identify the frailest in our communities and wrap care and support around them	**Pledge 4** Improve access to GP appointments **Pledge 5** Reduce ambulance Response times **Pledge 6** Reduce A&E waiting times	**Pledge 7** Provide more joined up, holistic and patient-centred care, delivered closer to home.	**Pledge 8** Reduce waiting times for hospital treatment	**Pledge 9** Increase the percentage of people on GP learning disability registers who receive an annual health check and health action plan	**Pledge 10** Reduce inequity in access to mental health services across each of our neighbourhood	**Pledge 11** Improve access to, experience of, and outcomes for children and young people - with a special focus on driving up health equity.	**Pledge 12** Listen to voices of women and girls to co-produce and transforms services.	**Pledge 13** We will shape our people & services around the needs of people by building a one team & culture to maximise the people potential of the LLR population.

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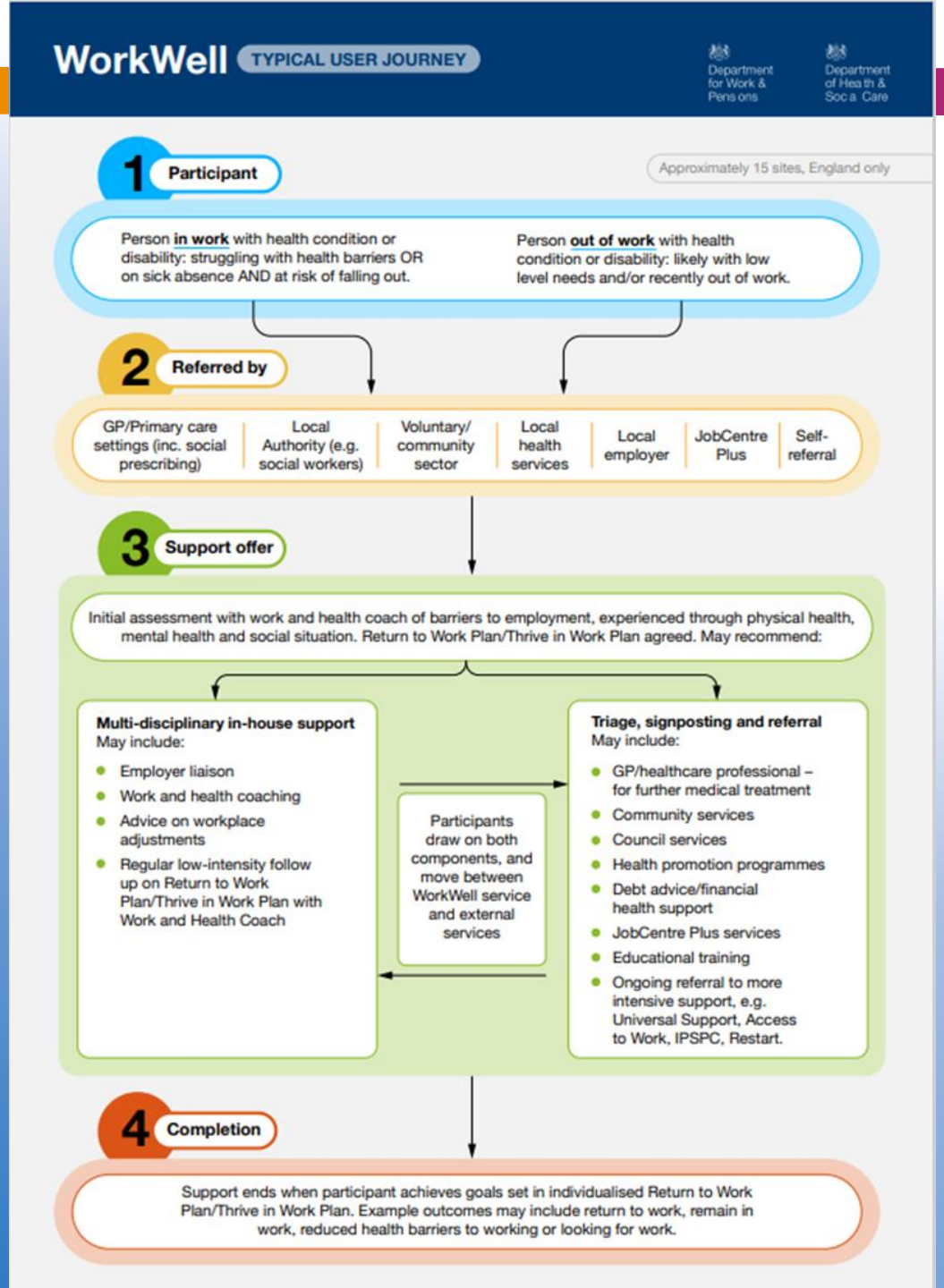
WorkWell People Journey


WorkWell
TYPICAL USER JOURNEY
Department for Work & Pensions
Department of Health & Social Care
1 Participant
Approximately 15 sites, England only
Person in work with health condition or disability: struggling with health barriers OR on sick absence AND at risk of falling out.
Person out of work with health condition or disability: likely with low level needs and/or recently out of work.
2 Referred by
GP/Primary care settings (inc. social prescribing)
Local Authority (e.g. social workers)
Voluntary/ community sector
Local health services
Local employer
JobCentre Plus
Self-referral
3 Support offer
Initial assessment with work and health coach of barriers to employment, experienced through physical health, mental health and social situation. Return to Work Plan/Thrive in Work Plan agreed. May recommend:
Multi-disciplinary in-house support
May include:
Employer liaison
Work and health coaching
Advice on workplace adjustments
Regular low-intensity follow up on Return to Work Plan/Thrive in Work Plan with Work and Health Coach
Participants draw on both components, and move between WorkWell service and external services
Triage, signposting and referral
May include:
GP/healthcare professional – for further medical treatment
Community services
Council services
Health promotion programmes
Debt advice/financial health support
JobCentre Plus services
Educational training
Ongoing referral to more intensive support, e.g. Universal Support, Access to Work, IPSPC, Restart.
4 Completion
Support ends when participant achieves goals set in individualised Return to Work Plan/Thrive in Work Plan. Example outcomes may include return to work, remain in work, reduced health barriers to working or looking for work.

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LLR WorkWell Leadership & Operating Model

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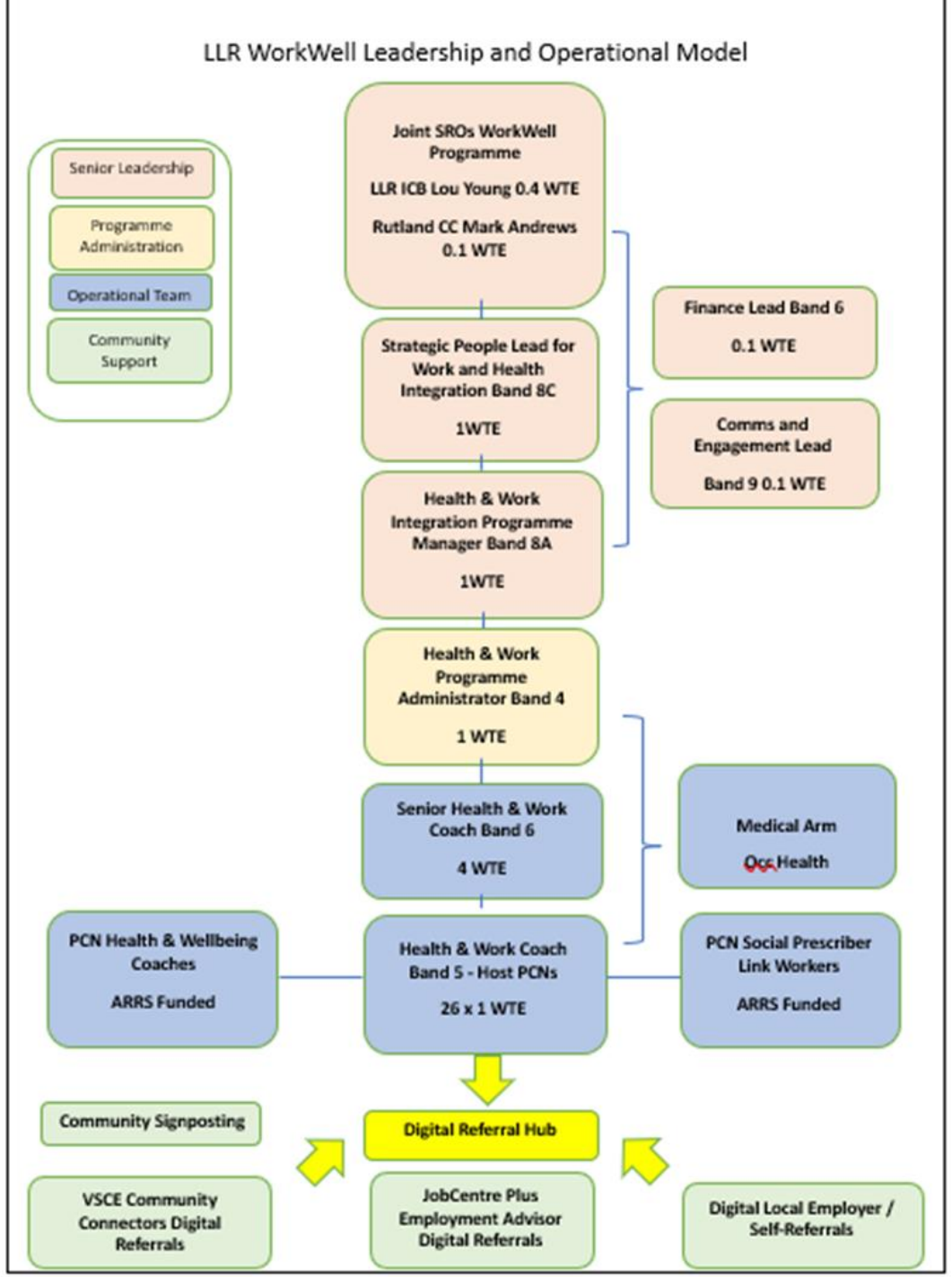
LLR WorkWell Leadership and Operational Model
Senior Leadership
Programme Administration
Operational Team
Community Support
Joint SROs WorkWell Programme
LLR ICB Lou Young 0.4 WTE
Rutland CC Mark Andrews 0.1 WTE
Strategic People Lead for Work and Health Integration Band 8C
1WTE
Health & Work Integration Programme Manager Band 8A
1WTE
Finance Lead Band 6
0.1 WTE
Comms and Engagement Lead
Band 9 0.1 WTE
Health & Work Programme Administrator Band 4
1 WTE
Senior Health & Work Coach Band 6
4 WTE
Medical Arm
Occ Health
PCN Health & Wellbeing Coaches
ARRS Funded
Health & Work Coach Band 5 - Host PCNs
26 x 1 WTE
PCN Social Prescriber Link Workers
ARRS Funded
Community Signposting
Digital Referral Hub
VSCE Community Connectors Digital Referrals
JobCentre Plus Employment Advisor Digital Referrals
Digital Local Employer / Self-Referrals

Next Steps…

- LLR 9 Coaches initially and to increase to 30 in total, to prepare for the peak period in January 24 to January 25.
- Engage Care Navigation Teams in place, as an enabling function within General Practice
- Embed Digital Referral Platform – Currently using JOY with our Social Prescriber Link Workers, and to extend JOY to add Case Management

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	LeDeR High Impact Actions
Presented to the Health and Wellbeing Board by:	Siouxie Nelson – LeDeR Clinical Lead
Author:	Siouxie Nelson

EXECUTIVE SUMMARY:

This report updates the Health and Wellbeing Board on the Midlands LeDeR Report and the High Impact Actions resultant from it.
This report compliments the agreement of the Joint Health Overview and Scrutiny Committee in July 2024 to scrutinise all reports presented to them to ensure that the needs of autistic people and people with a learning disability are responded to effectively.
There is a recognised and profound inequality in the life expectancy of people with a learning disability living in LLR and the Midlands.
The LDA Collaborative has significantly improved the uptake of Annual Health Checks for people with a learning disability - LLR is now ranked 1st in the Midlands and 5th nationally. However, LeDeR reviews evidence the need to improve the response to peoples' identified needs following these reviews.
The LDA Collaborative's LeDeR Programme undertakes timely reviews of the lives and deaths of autistic people and people with a learning disability who die – LLR is now ranked 2nd in the Midlands and 8th nationally. However, further action is required by all services and commissioning teams to respond to the learning from these reviews. Of note are the need to:

1. make reasonable adjustments to improve access to care,
2. intervene earlier to prevent premature death from cardiovascular and respiratory conditions
3. improve cancer screening and uptake of immunisation and vaccination
4. introduce quality assurance processes to stimulate, co-ordinate and monitor improvements in all partnerships/collaboratives

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

Consider as part of the LeDeR High Impact Actions, how does the board ensure that the needs of the population of people with a learning disability and autistic people in LLR are included in every paper, presentation, pathway and service that is delivered? How are these benchmarked with quality outcome frameworks?

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LeDeR
High Impact Actions
2024 - 2025

Siouxie Nelson – LeDeR Clinical Lead

19th Dec 2024

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What are the High Impact Actions?

1. **Reduce <u>avoidable</u> mortality** in the 3 clinical priority areas for **Learning Disability and Autism**
    - o **Cancer, Respiratory and CVD.**
2. **Focus on co-morbidities associated with premature death and DNACPR/RESPECT**
3. Assure and Sustain Performance:
    - o LeDeR review completion within 6-month KPI
4. Improve the quality of LeDeR reviews and actions from learning
    - o Facilitate peer review opportunities
5. Improve access and understanding of **importance of LeDeR reviews**
    - o Communicating more with stakeholders encouraging referrals to LeDeR to better understand the experience of LeDeR for families and relevant others particularly **minority ethnic groups** and autistic people
6. Improve accuracy of **Learning Disability Registers** & Increase the quality and **uptake of AHC**
    - o To support continued improvements in data accuracy for thematic analysis
    - o Improve the quality of AHC's

Saira

- Female
- Rett Syndrome
- Profound Learning Disability
- 42yrs
- Cause of death:
  1a) Cervical cancer

X No cervical screening.
X No mental capacity act assessment.
X Delays in pain and symptom control.
X Stage 4 cancer diagnosis.
X No involvement of LD Specialist support

1. Reasonable Adjustments

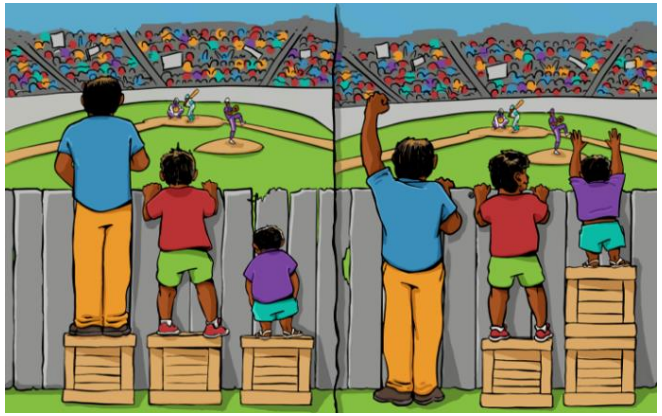
1. Make reasonable adjustments to improve access to care:

Each partnership and collaborative to establish reporting processes to evidence that:

A. The Reasonable Adjustment Digital Flag is fully implemented in their pathway and staff are accessing the RADF e-learning resource.

B. Improvement plans are in place across services to improve access through reasonable adjustment.

C. Inequality of access to care in their services for the LDA population is reducing.



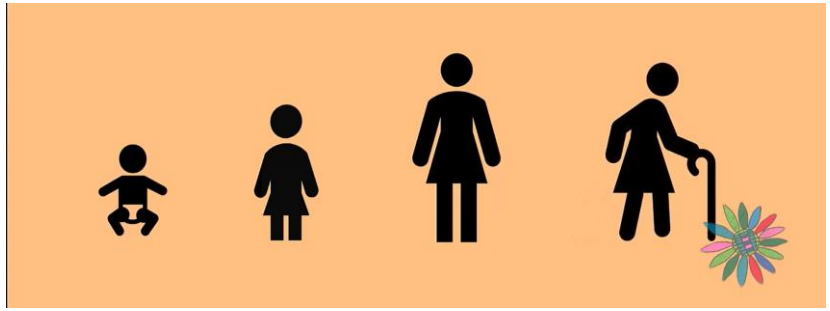
2. Preventing Avoidable Deaths

2. Intervene earlier to prevent premature death from cardiovascular and respiratory conditions.

Respiratory is the leading cause of death in people with a LD in LLR, nationally it is CVD for both the general population and people with a LD.

A. PCNs to implement improvement plans with the support of the LDA Collaborative to improve access to local early intervention and prevention offers for the LDA population and reduce premature deaths from cardiovascular and respiratory conditions, and cancer.

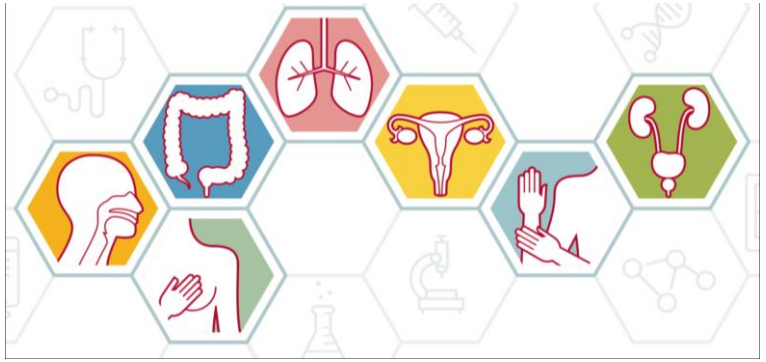
B. The ICB to add an LDA domain developed with the LDA Clinical Lead GP to the Primary Care Quality Assurance Tool used by 85% of practices.



3. Improve cancer screening and earlier diagnosis

3. Improve cancer screening and earlier diagnosis of cancer.

A. The ICB to agree an improvement plan to increase access to cancer screening for people with a learning disability and autistic people in readiness for transfer of the commissioning responsibility for screening from NHSE.



4. Immunisations and vaccinations

4. Improve uptake of immunisation and vaccination

A. The ICB to agree an improvement plan to increase access to immunisations and vaccinations for people with a learning disability and autistic people in readiness for transfer of the commissioning responsibility from NHSE.

5. Quality Assurance

5. Introduce quality assurance processes to stimulate, co-ordinate and monitor improvements in all partnerships/collaboratives and primary care (cross referenced to proposals 1 & 2).

A. The ICB Quality team and LDA Collaborative to co- design with partnership and collaborative clinical leads a single quality indicator and supporting plan to be adopted and reported against by all partnerships and collaboratives.

B. PCNs to agree with the ICB and LDA Collaborative LDA quality indicators and local improvement plans in response to the learning from LeDeR.

C. Scheduled review in July 2025.

LeDeR - Learning from the lives and deaths of people with a learning disability and autistic people

Top ten actions you can take to improve the lives and prevent the premature deaths of people with a learning disability and autistic people (aged 18 and over)

1

Inform us when an autistic person or a person with learning disabilities dies. You can do this online at https://leder.nhs.uk/report

2

Accurate recording of ethnicity is essential and should be a priority. Please ensure to report the deaths of those from the city and from diverse ethnic backgrounds.

3

Mental Capacity Act assessments really do make a difference - review your practices to ensure compliance and share your experiences.

4

Don't estimate weight - please measure, using appropriate equipment, and record accurately. List of scale locations: https://urlis.net/i4pw0fy2

5

Some people have behaviours that challenge which will also change as they grow older. Please put plans of care in place early to support people's behavioural and healthcare needs for life.

6

Have meaningful conversations about end-of-life in advance to ensure people are able to take an active part in discussions about their care.

7

Screening inequities exist, and every effort should be made to improve uptake. Speak to your Primary Care Liaison Nurse for support - lpt.pcln@nhs.net

8

Stop prescribing psychotropic medications unless they are necessary. For STOMP/STAMP enquiries please contact: lpt.ldstomp@nhs.net or lpt.camhs-stomp.stamp@nhs.net

9

Aspiration pneumonia happens as a consequence of a precipitating event. Early identification of risk factors and ongoing management saves lives.

10

Blood tests may sometimes needs to be done differently. Do not delay in using reasonable adjustments. Refer to specialist learning disability services if needed -

Use the following link to report to the LeDeR programme: https://leder.nhs.uk/report

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Two Important Statements from LeDeR

1. There remains a systemic culture of acceptance with the misuse of the **Mental Capacity Act (2005**) for People with a Learning Disability and Autistic people. LLR LeDeR urges our local system to act now and enforce the MCA and ensure it becomes intrinsic to our everyday care and support to people with a LD and Autistic people.

2. Secondly, people with a Learning Disability are at increased risk of communication and **pain** being misinterpreted or missed altogether and it is essential to safeguard this. There are communication tools/passports and a DISDAT (Disability distress assessment tool) that are readily available for people with a LD. Care providers, particularly those who are either not specialist in the field of LD or who do not know the person well and other services involved in their care must ensure that the communication needs and of upmost importance how pain is communicated by the person are known and prioritised. A priority must be with regard to those individuals who are moved away from their care setting into nursing care providers due to end of life care needs.

What is the ask to the Health and Well Being Board?

- Given that the life expectancy of people with a learning disability is 20yrs younger than the general population in LLR.
- How does the board ensure and that the needs of people with a learning disability and autistic people in LLR are included in every paper, presentation, pathway and service that is delivered?
- Key High Impact Areas:
  - Respiratory (leading cause of death)
  - Cardiovascular (national leading cause of death)
  - Cancer

It is not about a different service, but how we include people in the services we already have.

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

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T: 07500 993 864

LEICESTER CITY HEALTH AND WELLBEING BOARD
December 19 2024

Subject:	Healthy Weight – Amended KPI Review and Update
Presented to the Health and Wellbeing Board by:	Jo Atkinson
Author:	Amy Hathway

EXECUTIVE SUMMARY:

After attendance to the September 2024 Health and Wellbeing Board amendments have been made to the proposed KPIs. The four projects are described below.

Projects
Pilot brief intervention training – Understanding barriers to healthy weight and raising the conversation of healthy living.
Establishing local opportunity to improving healthy weight in pre, during and post-pregnancy
Increase number of schools doing The Daily Mile/daily activity
Social care (LD) focused work

The KPIs for each are within the slides.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Support the adoption of the Healthy Weight KPIs
- Support discussion around avenues to promote training pilot, particularly within workforces interacting with pregnant and post-partum women and for staff to undertake signposting included in that training
- Support promotion of Live Well walks in February 2025.
- Support discussion around opportunities to promote The Daily Mile within existing networks, including sports clubs, school nurses and wider contacts working with schools.
- Support review of contracts to support working age adults with learning disabilities with opportunities for good nutrition and physical activity

Healthy Weight

Objective: To create a system that enables at least 40% of our adult population and at least 70% of the Year 6 population to live at a healthy weight by 2034.

Rationale - Why is this important?	Projects reporting - Title and description of each project/ deliverable	Project KPIS - Clear and measurable	Subgroup/s responsible - Governance	Outcomes of workstream
Empowering workforces and communities sits as a key theme within the action plan and supports workforces to have conversations relating to healthy lifestyles.	**Pilot brief intervention training – Understanding barriers to healthy weight and raising the conversation of healthy living** Multi agency training will be offered on a quarterly basis for professionals working with any adults and families. This training will be open to a variety of workforces including teachers, VCS organisations, sports coaches, housing officers etc. This will build on the Healthy Conversation Skills offer and can be promoted through a variety of network. HWB Partners: Promote training to staff when contacted	• 80 staff trained from a variety of workforces annually. • Change in confidence, knowledge and awareness of assets/signposting locally pre and post training.	• Contract variation as part of S75 monitored through Amy Robinson (Commissioning Manager) via support meetings with commissioned provider LNDS. • Lead officer: Amy Hathway.	To support the creation of a system that is conducive to maintaining a healthy weight.
In Leicester, the percentage of pregnant women who were severely overweight at the time of booking an appointment with a midwife was 23.8% in 2018/19, which is significantly worse than the National average (22.1%).	**Establishing local opportunity to improving healthy weight in pre, during and post-pregnancy** A Health Needs Assessment is due to be completed by January 2025 to inform the promotion of healthy lifestyles more effectively within pre, during and post pregnancy. This work spans across a variety of avenues but aims to explore how we can use our existing services more effectively to promote healthy weight. Opportunities within midwifery, health visiting and physical buildings are being explored to promote movement and positive nutrition choices pre, during and post-pregnancy, empower women to understand how to maintain a healthy weight, and ensure that workforces are confident in raising the conversation compassionately. HWB Partners: UHL: support midwifery staff to undertake training and undertake signposting included in that training: promote Health for Under 5s website information, refer to Live Well LPT/VCS/sports: Ensure signposting at contacts to support mothers: promote Health for Under 5s website information, refer to Live Well	• Number of midwives and pre/post-natal workforces trained in raising conversation of weight during pregnancy and change in confidence, knowledge and awareness post training • Page views for healthy lifestyle sections of Health for Under 5s website • 8 Healthy Lifestyle Advisors within Live Well trained in Pre and Post Physical Activity course to support pregnant women accessing service. • Explore opportunities for referrals of pregnant women with long term conditions to be made in to Live Well service. • Number of mums attending Live Well Walk More mums walks. • Review leisure centre opportunities to promote themselves as breastfeeding friendly. • Antenatal physical activity classes at Aylestone Leisure Centre (March 2024)	• Specific maternal excess weight working group as part of healthy weight governance that feeds into Steering Group. • Lead reporting officer: Amy Hathway • Lead operational officer: Annie Kennedy.	

Rationale - Why is this important?	Projects reporting - Title and description of each project/ deliverable	Project KPIS - Clear and measurable	Subgroup/s responsible - Governance	Outcomes of workstream
Developing a positive relationship with physical activity during developmental years can support long term engagement. The Daily Mile aims to get children outside during their school day, outside of their Physical Education (PE) lessons, to participate in 15 minutes of daily exercise, contributing to improved social, emotional and physical wellbeing.	Increase number of schools doing The Daily Mile A recent survey (Nov 24, 52 responses) has shown us that now 14 schools are participating in the Daily Mile with a further 8 doing classroom/facilitated activity. HWB partners including public health nurses, sports clubs, VCS: promote the Daily Mile through contact with school senior leadership	• Support 15 schools to start/re-engage in participation of the Daily Mile or alternative daily activity	• To be monitored through the Childrens Healthy Weight working group (Chaired by Chirag Ruda) • Lead reporting officer: Claire Mellon / Inspire Together • Lead operational officer: Rhiannon Pritchard	To support the creation of a system that is conducive to maintaining a healthy weight.
Only 30% of people in LLR living with learning disability are a healthy weight with excess weight contributing to average 20-year shorter life expectancy. Social care are highly engaged within the approach and have prioritised healthy weight in line with their prevention and reducing inequalities agenda.	**Social care (LD) focused work** A focus on how to improve health and wellbeing messages throughout social care including for working age people with LD. This includes reviewing procurement opportunities to embed healthy living into provider contracts, creating resources to inform practitioners and providing training. HWB partners: LPT/LCC Review contracts to support working age adults with LD for opportunities for good nutrition and physical activity	• Front line adult social care staff trained in raising conversation of weight change in confidence, knowledge and awareness post training • Easy read information issued to all providers. • Contracts reviewed to embed healthy living more prominently.	• Social care working group. • Lead officer: Amy Hathway (with appropriate reps from LNDS/LPT and Social Care)	

Leicester City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD
19 12 2024

Subject:	Update from the Leicester Integrated Health and Care Group
Presented to the Health and Wellbeing Board by:	Diana Humphries, Programme Manager, Health and Wellbeing Board
Author:	Diana Humphries

EXECUTIVE SUMMARY:

The Leicester Integrated Health and Care Group is established to support the Health and Wellbeing Board in providing leadership, direction, delivery and assurance in fulfilling its aim to 'Achieve better health, wellbeing and social care outcomes for Leicester's population and a better quality of care for children, young people and adults using health and social services'.

In the responsibilities outlined within the Leicester Integrated Health and Care Group's TOR. The below is noted:

- To drive forward the work of the Health and Wellbeing Board, in supporting the implementation of Leicester's Health Care and Wellbeing Strategy.

This refers to providing updates on our strategic delivery plan. Furthermore, general updates on the ongoing work by the LIHCG are shared in this agenda item to ensure a close partnership between the two groups. Update below.

The LIHCG has now been active for a quarter. In this time the group has established partner reporting frameworks such as updates from PCNs, LPT, Healthwatch, UHL and has received Health, Care and Wellbeing Delivery plan updates. The group also received an in-depth dive into the Bringing People Together Programme and has requested the review of the Joy App programme. The Integrated Group Programme Manager attended a meeting for the review and has reported back that LPT will be leading on this work and will share outcomes in the new year.

The group is outcome focused with an active action log. Furthermore, a risk log with points that could be escalated to this group is being developed. A suggestion for the development of a risk log for Health and Wellbeing Board was also made.

The group continues to meet monthly and has recently recruited a Programme Manager who will take a strategic lead on projects and actions scoped out through the partnership. Updates will continue at each HWB meeting.

Delivery Plan updates in detail:

Date 15 10 2024

Title of workstream: Mental health and wellbeing related to social inclusion, and supportive networks

Objective: *Improving the mental health of our local population by promoting and facilitating community-based offers that support inclusion, connectedness and wellbeing*

Governance arrangements:

- Leicestershire Partnership NHS Trust
- Early Intervention & Prevention Board (Adult Social Care, Leicester City Council)
- Community Public Health Steering Group
- Leading Better Lives Steering Group (LCC)
- Mental Health Partnership Board
- Leicester City Council – Public Health

Reporting Project (*governance*)	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experienced young people	Risks and mitigations	RAG for period
Neighbourhood Mental Health Cafés *Leicestershire Partnership NHS*	Case studies demonstrating impact. Quality review of individual cafes	Monthly data and case studies collated. Reviews of individual cafes ongoing	Complete review of cafes by November.	n/a	Risk that individual cafes do not embed – mitigated through support from neighbourhood	

Trust					leads in LPT.	
Mental Health Wellbeing & Recovery Support Service *Early Intervention & Prevention Board (Adult Social Care, Leicester City Council)*	Undertake a quality review with a focus on impact of the service and how this offer fits within the wider mental health system.	Review ongoing in conjunction with County and Rutland.	Complete review of service by	n/a	Risk of non-collaboration with other services across the system Mitigation: monitoring and review asks for information on collaboration.	
Bringing People Together Programme *Community Public Health Steering Group*	Let's Get Together (LGT) • Maintain regular walks from the community locations • Warm Welcome to take place in all community locations Let's Get Digital • Enrol 240 people per term on the course • Maintain 60% of successful attendees accessing follow on	• Walks are well attended approx. 90 people a month attend • All libraries are offering Warm Welcome • 327 people successfully completed the course (Apr '23- June '24) • 60% of people continued digital	• Working with walk providers to maximise reach and resources • Support VCSE orgs to host warm welcome • Include a further module on travel training • Include outreach sessions e.g VCSE	• LGT activities are accessible, free and open to all. Possibility of targeted walks. • Increasing inclusivity by empowering organisations • Identifying and supporting people who are not digitally literate. • Increasing accessibility by working with VCSE		

	courses Let's Get Growing (Contracted) • Increase number of community food growing plots at allotment sites • Support educational settings to access food growing	learning after • 2 community plots have been allocated and work is ongoing with partners • Funding secured for one event this year	locations • Encourage community groups to take up community plots • Continue to support school-based initiatives	providing courses in familiar locations • Work with VCSE organisations to support more people from pus groups to access activities • Link with educational settings supporting people in plus groups to promote growing		
Leading Better Lives *Leading Better Lives Steering Group (LCC)*	Metrics to be developed in co-production as part of the project	Task groups have been established for each of the four projects	Establish parameters of individual projects.			

Prevention Concordat for Better Mental Health *Mental Health Partnership Board*	Partnership Board receives reports to address health inequalities Mental health in all policies, such as access to green space, transport, leisure, arts, and culture					
Joy app rollout *Leicestershire Partnership NHS Trust*	Quality Review of the impact of Joy including data, case studies and partner testimonies.	Work ongoing with social prescribers to collate data, case studies and testimonies.	Presentation to the Mental Health Partnership Board.	n/a		

Mental Health Friendly Places *Leicester City Council - Public Health*	Case studies demonstrating impact Survey collating feedback from the Mental Health Friendly places to measure positive impact	30 Orgs signed up in the city 329 people trained in MH first aid aware 20 MH first aiders 36 booked on to be trained Survey currently open closing end of October Pilot ongoing with FA around 'Mental Health Friendly Clubs' to train committee members and welfare leads of 5 clubs.	Close the survey end of October. Present outcome to a future Mental Health Partnership Board. Pilot of Mental Health Friendly Clubs to lead a football session	n/a	People's capacity to do the training although all training sessions for 2024 are fully booked.	
Getting Help in Neighbourhoods Projects *Leicestershire Partnership Trust*	Quality review taking place for individual projects	Monthly data / performance Priority themes have been established with funding available for initiatives that support themes. This includes Men's Mental Health with a Project being launched 9th Oct with webinar. Dementia, Transitions, Neurodiversity, Black Mental Health	Complete review and presentation to Mental Health Partnership Board			

Case study/ qualitative examples of progress:

Project	Example
Mental Health Friendly Places	**Saffron Acres:** "We have a small but dedicated staff team, who come from a variety of backgrounds and with different experiences. As a charity, it can sometimes be a little harder to find opportunities for funded training that is relevant to our job roles, and this is where the MHFP experience has really shined. Not only has the training enabled our team to gain uniform understandings so we are all on the same page, it has allowed us to become more confident when we are engaging people that visit us and access our services. It has been directly relevant in the mental health projects we run, but helps support all our other projects we engage people in."

Point for escalation relating to any of the projects:

Bibliography of Projects

Project	Description
Neighbourhood Mental Health Cafés	Drop-in sessions delivered by voluntary sector providers and located in areas with highest levels of mental health need where people can get mental health support and advice – no appointment needed.
Mental Health Wellbeing & Recovery Support Service	Preventative mental health service enabling people to improve and maintain their mental health & wellbeing, or recover from mental illness, through better use of community assets & resources.
Bringing People Together Programme	Free activity sessions at community centres and libraries encouraging people to learn new skills, get more active and get together with others. Projects include: • Let's Get Together (LGT) • Let's Get Growing (LGG) • Let's Get Digital (LGD) • Let's Get Walking LGW) • Let's Get Creative (LGC) • Warm Welcome

Leading Better Lives	Developing a coproduced council-wide approach to prevention and community wellbeing.
Prevention Concordat for Better Mental Health	Underpinned by a prevention-focused approach to improve mental health, which in turn contributes to a fairer and more equitable society.
Joy app rollout	Roll out of the Joy social prescribing app which promotes activities and support and allows people and professionals to make referrals
Mental Health Friendly Places	Encouraging local businesses & community organisations to take up training offer & accreditation to equip them with skills and knowledge to support people with mental health
Getting Help in Neighbourhoods Projects	Grant-funded projects allowing voluntary sector organisations to expand or enhance their existing offer in order to support mental health & wellbeing through activities and support.

Meeting date: 19 November 2024

Title of workstream: Childhood Immunisations

Objective: *To increase childhood vaccination uptake across Leicester.*

Governance arrangements: LLR Immunisations Board

Reporting Project	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experience young people	Risks and mitigations	RAG for period Please provide context for assesment
Antenatal Vaccinations	Pertussis: current LLR uptake 57%. National target: 60% Target TBC – further work needed to understand data sets and impact of proposed changes.	788 Maternity RSV vaccinations (23 October 2024) Roving Healthcare Units now offer Pertussis and RSV vaccines on a walk-in basis and are being widely promoted (73 community locations this autumn / winter). ICB website updated to show life course vaccinations with	Vaccination information in UHL maternity mama wallets (which secures patient notes) carried by pregnant women Meeting being arranged with DadPad lead to determine what vaccination information can be included for expectant fathers. Vaccination in pregnancy	Exploring joint working opportunities with UHL maternity diversity lead. Working with Inclusion Health to promote vaccinations amongst homeless cohort Vaccination training webinar planned for 30th	This service is commissioned by NHS England, not the ICB, until April 2026. UHL Maternity team delayed recruitment process has led to closures of the UHL antenatal clinics.	Off track

	RSV: New vaccine from 1.9.24, NHSE target is 50%.	comprehensive vaccinations in pregnancy information. Antenatal vaccination team staffing gaps are being addressed with 2 posts filled and a further 2 to be filled by December 2024. This has increased the number of available vaccination clinics offered to pregnant women alongside their FASP scans. This is expected to further improve in the next 2 months and will enable the opening of community hospital clinics. National pertussis campaign just launched, requiring GPs to call / recall pregnant women for vaccination. Oct 24 to Mar 25	promotional videos being developed for new TV Screens in UHL antenatal public areas. Continue monitoring of recruitment process for the antenatal vaccination team. Commence community hospital clinics December 2024.	October with Heads Up staff to promote vaccination to teenage mums-to-be and those with SMI. Specialist LD vaccination clinic for Covid and flu vaccinations opened 24 October and will continue twice per week to end November 2024.	Opening of UHL community hospital antenatal vaccination clinics pushed back from Sept to Dec due to delayed recruitment process. Unable to drill down to LSOA level for uptake information Uncertainly whether new national data system, RAVS, is pulling vaccination information through to System1	

Babies and Pre-school Children	MMR 2: current City uptake 69% (5 yrs). WHO target is 95% 2 doses at 5 years. Local target TBC – further work needed to understand data sets and impact of proposed changes.	Data group focussed on agreeing a single data source to use for performance reporting purposes. CHIS Improving Immunisation Uptake Team supported two practices for 6 months to clear 'ghost' patients and increase clinic capacity seeing a significant reduction in the waiting list. Super vaccinators delivered 87 clinics during August to support primary care increase access to childhood immunisation. 9 quality review meetings held with practices with low uptake to discuss uptake levels and explore barriers and areas for improvement.	Meeting with City PCNs to work through plans to increase childhood vaccinations/immunisations. MMR Core20 project continuing in the city with selected GP practices. Results awaited. CHIS Improving Immunisation Uptake Team to extend support offer to at least 2 more new practices with low childhood vaccination/immunisation and high waiting lists, in January 25. Set up LIST (Local Immunisation Street Team) - a new project launched through additional funding from NHSE - street teams with clinicians seeking to engage with traditionally underserved communities to understand and overcome barriers to vaccination (eg Pakastani, Bangladeshi, Eastern European, Caribbean communities, etc). Health Inequality Hub business case is progressing positively	Working with Inclusion Health to offer vaccinations to homeless cohort in the city.	Service providers are commissioned by NHS England, not the ICB. Not having a single data source. Unable to drill down to LSOA level for uptake information	On track

			through ICB approval process.			
School-age and Adolescents	HPV City 49% (male) 57% (female). WHO target is 90% in females by 2040. Local target TBC – further work needed to understand data sets and impact of proposed changes.	Current HPV uptake (23 October): • East Leics & Rutland: 82.8% • Leicester City: 57.2% • West Leicestershire: 81.8% Cervical Cancer Elimination Strategy in place, with sub section on HPV vaccine and gaol is to achieve 90% uptake by 2040.	In person workshop on 5th December to work on HPV implementation strategy with all relevant system partners to agree short- and long-term objectives and targets for uptake in males. Exploring opportunities to collaborate with East Midlands Cervical Cancer Alliance Working with SAIS team to look at support with vaccination consent as part of the mobilisation of the HPV campaign. HPV National HPV catch-up	LPT undergoing examination of patient data/records to establish if vaccination is low in patients registered with LD open to LPT.	Cohort of young adult males that miss out on vaccination due to the campaign start date as per national guidelines.	On Track

			campaign planned for 16–18-year-olds in January 2025. Scoping the addition of HPV vaccine to the RHU walk-in vaccination offer.			

Case study/ qualitative examples of progress:

Project	Example

Point for escalation relating to any of the projects:

UHL Maternity Vaccination Clinic cancellations due to lack of staff and failure to roll out community offer in original timeframe

Bibliography of Projects

Project	Description
Antenatal Vaccinations	Improve Pertussis (whooping cough) vaccination uptake through: • Raise awareness • Work with community groups e.g. *Leicester Mammas* to offer educational workshops • Increase accessibility via community clinics on board the Roving Healthcare Unit (RHU). • Continue to support antenatal clinics at UHL by utilising the super vaccinator workforce to cover gaps in staffing. Introduction of RSV (Respiratory Syncytial Virus) vaccine from 1 Sept. 2024: • Communications campaign to introduce vaccine and explain importance • Support midwives and vaccination nurses to confidently deliver the vaccine • Offering several pathways and opportunities for pregnant patients to access the vaccine i.e. antenatal clinics, GP, RHU and community locations
Babies and Pre-school Children	To support and provide vaccination and immunisation advice to parents of babies and pre-school children, reducing variation in uptake. • Support a shortlist of GP practices with lowest uptake and enabling CHIS service to target support • Raising awareness in primary care settings via regular clinical webinars. • Offering staffing support and additional capacity via the Super Vaccinators. • Offering childhood immunisations such as MMR and Pertussis on board the Roving Health Unit in areas where uptake is low. • MMR core 20 project to offer home visits to families without vaccination – catch up for all family members
School-age and Adolescents	To support the school aged immunisation service (SAIS) to deliver vaccinations to young people throughout their school years, with a specific focus on the HPV vaccine. • Work with schools to understand barriers to uptake. • Improve the self-consent process, empowering young people to better understand vaccinations and to make positive choices to support their health. • Targeted work with schools with the lowest uptake and learning from schools with higher uptake rates. • Developing an in-school programme and educational pack to support guidance and advice to young people, teaching staff and their parents/carers.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the update
- Raise any issues or concerns as a result of this
- Consider developing a risk log for Health and Wellbeing Board

LEICESTER CITY HEALTH AND WELLBEING BOARD
19 12 2024

Subject:	Health and Wellbeing Board Annual Report
Presented to the Health and Wellbeing Board by:	HWB Programme Manager
Author:	Diana Humphries- HWB Programme Manager

EXECUTIVE SUMMARY:

The Health and Wellbeing Board terms of reference outline that it is a requirement to provide an annual report of activity to the Leicester City Council Executive and to the Board of the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) to ensure that the HWB is publicly accountable for delivery.

The previous report was published in summer 2024 and features updates from July 2022-July 2023. The current report covers the August 2023-August 2024. This timeline is in line with the redesign of our Health, Care and Wellbeing Strategy delivery plan and will embed the annual reporting approach going forward.

This iteration of the annual report covers:

- An overview of how the Health and Wellbeing Board works
- A summary of the work of partnership boards who work with the Health and Wellbeing Board
- The statutory responsibilities it must enact
- An overview of key communications and engagement activity with stakeholders and local people, and how this is used to shape and influence their work
- An update on the Health Care and Wellbeing Delivery Plan progress and review of priorities
- Looking ahead to 24/25

A short and accessible newsletter featuring condensed information of the HWB annual report is being drafted and will be finalised for publication once the final report is approved.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- To receive the report and comment.
- To sign off the report for publication.
- To note the approach to the 24/25 annual report.

Health and Wellbeing Board Annual Report 2023-2024

HEALTH AND WELLBEING BOARD ANNUAL REPORT

August 2023 – August 2024

Chair's foreword

I would like to welcome you to our Health and Wellbeing Board's annual report for the past year ranging from August 2023-24. Having taken the role of Chair just a few months ahead of this reporting period I have been able to immerse myself in the work delivered by the Health and Wellbeing Board and can see its commitment to addressing local health inequalities. The past period focused on our six 'Do' priorities through which we were able to deliver a number of positive changes in the services available to our residents. Some examples of our achievements include:

- Boosted the use of social prescribing and non-clinical workforce, as well as healthcare professionals to direct patients to appropriate specialist support or to directly provide management of conditions. This has been achieved through the Additional Roles Reimbursement Scheme.
- Remodelled the Leicester, Leicestershire & Rutland Discharge to Assess Pathway 1 to increase reablement capacity to increase the numbers of older people who return to their usual home following a period of time in hospital.
- Delivered some Community Chill Out Zone workshops to support mental health and wellbeing of children and young people.
- Produced a video around cervical screening for patients with Learning Disability and another video focusing on Human Papilloma Virus (HPV) for the general population
- Continued to support Neighbourhood Mental Health Cafés which are delivered by local VCS organisations in order to adapt to local needs.
- Relaunched the Peer Support Programme to offer additional support to women and act as their advocate in experiencing perinatal mental health conditions.

Due to the changing nature of needs in the City, I was able to lead on the redevelopment of our delivery plan. This will now focus on four priorities most pertinent to our City's current picture. In addition to addressing inequalities, prevention is also a significant part of our focus and a Steering Group which feeds into the HWB has been developed to address this. With an ongoing focus on partnership work, we are going to deliver on our strategic commitments using a multidisciplinary approach.

As previously, I would like to thank: the Board members for their continued dedication; all of the staff who continue to provide high-quality health and care services care to our residents despite pressures experienced across the system; and give special thanks to the countless volunteers across Leicester who work tirelessly to support the health and wellbeing need.

Councillor Sarah Russell

Deputy City Mayor – Social Care, Health and Community Safety

Terminology and acronyms used in this report

Any words in **bold** throughout this report may require explanation or further detail. There is a 'glossary and links to further information' section at the end of this document to explain this terminology and to provide full details of websites or links to further information which have been referred to in this report.

1. Introduction

We, the Health and Wellbeing Board, represent and address health and wellbeing needs in Leicester by bringing together key partners from across the health and social care system to meet, in public, to discuss the issues which face Leicester's residents, and to identify and agree ways to address them collaboratively. Meeting agendas, minutes and webcasts of individual meetings are publicly available on the Leicester City Council website, but the purpose of this annual report is to provide an overview of our activity during the period being reported on (August 2023- August 2024) along with plans for the future.

2. Who we are and what we do.

2.1 What is the Health and Wellbeing Board?

Established under the **Health and Social Care Act 2012,** in April 2013, the Board became a formally constituted Committee of the council. The Board serves as a partnership forum which is made up of leaders from local health and care systems to enable them to understand the health and wellbeing of the local population, and to work together to improve it. Our primary purpose is to make sure that all residents of Leicester can live in good health to their full potential. We recognise that this will be different for every individual.

Notably, the Health and Wellbeing Board develops and oversees our Health, Care and Wellbeing strategy which is one of the tools for addressing local health inequalities.

2.2 Who represents the Health and Wellbeing Board?

We are a partnership forum which is made up of leaders from local health and social care systems who understand the health and wellbeing of the local population, and work together to improve it. Board membership aims to be representative of the organisations who support health, care and wellbeing needs across our city and the communities we serve. Membership of the Board is reviewed each municipal year (beginning in May). The membership for 23-24 was described in the previous annual report here. Current membership i.e. membership for 2024-25 comprises of:

Elected members of Leicester City Council
• Executive Lead Member for Health • Four further Elected Members (elected by the mayor)
NHS representatives
• Chief Executive plus three other representatives from the LLR ICB • Independent Chair of the Integrated Care System • Chief Executive of University Hospitals NHS Trust • Chief Executive of Leicestershire Partnership NHS Trust
Officers of Leicester City Council (4)
• Strategic Director of Social Care and Education • Director of Public Health • A Public Health Consultant leading on improving cross organisational initiatives and communication and developing links with the between system, place and neighbourhood within the Integrated Care System.

• One Officer nominated by the Chief Operating Officer (vacant)
Further representatives of the wider community (8)
• One representative of the Local Healthwatch organisation for Leicester City • Leicester City Local Policing Directorate, Leicestershire Police • The Leicester, Leicestershire and Rutland Police and Crime Commissioner • Chief Fire and Rescue Officer, Leicestershire Fire & Rescue Service • Two other people that the local authority thinks appropriate, after consultation with the Health and Wellbeing Board • A representative of the city's sports community • A representative of the private sector/business/employers

2.3 Health and Wellbeing Board Meetings

In the described period there have been six meetings of the Health and Wellbeing Board. This is in line with the Board's objective at the time. Full agenda, minutes and webcast of these meetings can be found on the **Leicester City Council Health and Wellbeing Board webpages**.

The meetings are mandated to be held in person. As well as the Board members and presenters attending the meeting, members of the public can attend and sit in the public gallery. The meetings are held in Leicester City Hall, time of meetings and room information can be found online here.

The meetings during this period were categorised as either Business as Usual (BAU) or relating to specific topics. For BAU the majority of the agenda was dedicated to matters relating directly to the Joint Health and Wellbeing Strategy or matters of the Board e.g. subgroup updates. Otherwise, themes relevant to pressing matters would be proposed such as 'winter pressures'. As well as the webpages, you can see appendix 2 of this report for detail of items discussed. The Chair decides on the agenda for each HWB meeting with the support of leading officers who maintain a forward plan of potential topics for the meetings.

The terms of reference for the Board were reviewed in May 2024 and going forward the Board will be meeting formally four times per year.

Development sessions

In addition to our standard meetings, a **development session** was held during the period. Development sessions provide an opportunity for Board members, along with wider partners, to collaborate strategically and in greater depth ahead of discussion being brought to a formal meeting. Development sessions are not broadcasted online and are limited to invitees rather than including the wider public.

The said development session focused on the review our Joint Health Care and Wellbeing delivery plan. The delivery plan is monitored monthly with reports submitted to Integrated Systems of Care Board and Joint Integrated Commissioning Board. The development session looked to review the priorities to ensure that the most pressing issues in the current moment are prioritised in our reporting. Four new priorities were agreed:

- Childhood immunisations
- Hypertension – prevention and case-finding
- Healthy weight
- Mental health and wellbeing related to social inclusion, and supportive networks

The reporting structure and frequency are to be agreed in an upcoming development session. After this, the new approach will be embedded.

Working as a Part of a Wider System

Leicester's Health and Wellbeing Board is part of the Integrated Care System (ICS). There are ICSs across the whole of England and this is nationally mandated. Our ICS features the Integrated Care Board and Integrated Partnership which is known as the Leicester, Leicestershire and Rutland Wellbeing Partnership (LLR HWP). Both subgroups aim to tackle inequalities in health and improve the health and wellbeing of our population across Leicester, Leicestershire and Rutland (LLR).

The ICS covers the whole of LLR, also known as **'system-level'**. This is important because many health and care services serve all three of those areas (for example, the hospitals). However, the uniquely different needs of each area within that system must also be considered if we are to be able to plan and deliver the right services to meet those needs and reduce health inequalities.

Feeding into the ICS, Leicester, Leicestershire and Rutland are individually referred to as '**places**' – each have their own Health and Wellbeing Board, which is the place Board for supporting health and wellbeing for that locality. The Health and Wellbeing Boards bring together partners from across the health and care system within the individual 'places' to ensure that decisions relating to health and care services meet the needs identified at place level, whilst also feeding into the wider ICS.

Leicester's Health and Wellbeing Board has a number of partnering Boards and subgroups which focus on more specific issues supporting HWB's oversights and assisting with strategic direction. These are outlined below together with updates on their progress in the last year.

The Mental Health Partnership Board

The Mental Health Partnership Board (MHPB) brings together various partners including health, social care, the voluntary sector, employment services, housing and the police. The board is also attended by people with lived experience of mental illness and by carers.

The Board has driven forward actions on the Leicester City Joint Integrated Commissioning Strategy for Adult Mental Health 2021-25. The strategy has three key priorities: Prevention, Accommodation and Education, Employment & Volunteering.

The Board continues to embed in its role as the place-based board for mental health in Leicester City, including taking ownership of the Healthy Minds priority under the Health, Care and Wellbeing Strategy. As part of the refresh of the strategy, the Board reviewed what should be a key focus under the Healthy Minds priority and decided that social isolation & loneliness should be taken forwards.

Over the past year, the Board has supported partnership working, the use of local evidence, and co-production across various pieces of work including:

- Communicating with the voluntary sector about pathways, processes and waiting lists for health and social care services.
- The management of DNAs (did not attends) for NHS appointments
- Support for younger people aged 16-25 and transitions from children's to adults' services

- Raising awareness of men's mental health and how best to support men to access support.

The Board has refreshed its terms of reference with the greatly appreciated input of people with lived experience and carers.

Learning Disability Programme Board

The main purpose of our Learning Disability Programme Board (LDPB) is to influence developments in the city that can make a difference to people with learning disabilities and their family carers. We organise our work around key priorities that people with learning disabilities and their families have told us are important. These priorities are captured in our coproduced joint health and social care strategy for Leicester City which we refer to as our Learning Disability Big Plan. This plan was introduced in 2020 and has just been extended for a further two years until 2026.

Some of the work we have done together, with people, their carers, our providers and the NHS since our Big Plan was introduced is captured in our You Said, We did report the-big-plan-report-2020-2023.pdf (leicester.gov.uk). This report explains what we have done to make things better for people with learning disabilities over the last three years. During the next couple of years the focus will be on three main themes which are: addressing health inequalities; support for our carers; and work, college and money, with an emphasis on supporting employment opportunities for people with a learning disability. The 'what we are doing' section of our website sets out the plan over the next two years to ensure we continue to make sure that people with a learning disability can stay safe, well and happy: What we are doing (leicester.gov.uk).

Some of the main highlights and achievements since this report was published include:

- Through my Eyes exhibition at Leicester's New Walk Museum which featured the photography, art and music of three local autistic artists, one of whom also had a learning disability. This ran from September 23 to March 2024 Showcase for autistic artists extended (leicester.gov.uk). Adult Social Care commissioners worked with Museum staff and three artists and a local charity to create the exhibition which was about smashing stigmas by showcasing the many and varied talents of the people we work with.

- A well-attended development day was held at City Hall in May 2024, to look at the operation of the board and whether there were things we could do to enhance and improve its operation. Lots of recommendations came from the day which will improve our connection and reach with other key strategic boards, how we work with our partners to integrate services and support and how we involve people through coproduction so that we work better together.

- People with learning disabilities and members of our LDPB are helping us create a coproduced preventative strategy for Leicester – this is part of our leading better lives project. Further work is also planned through Summer 2024 to understand how the We Think group, which is a group that helps ensure our board is well connected to the issues and has the advice of people with a learning disability in Leicester, can influence and inform our decision making in adult social care in Leicester.

The Joint Integrated Commissioning Board (JICB)

The Joint Integrated Commissioning Board (JICB) is an operational group reporting to the Health and Wellbeing Board. Membership of the JICB includes senior managers from Adult Social Care, Children and Young People's Services, Public Health and Housing within the local authority as well as senior managers and governing body members from Leicester, Leicestershire & Rutland Integrated Care Board (ICB).

The Health and Wellbeing Board has worked collaboratively with JICB throughout 2024 on the delivery of priorities within the Health Care & Wellbeing Delivery Plan for Leicester, following a refresh of the Leicester Health, Care and Wellbeing Strategy during 2022 with focused updates received on Healthy Minds provided during this time.

The JICB has provided an opportunity for senior leaders to gain a shared understanding of the pressures and responsibilities on each of the partners including updates at the start of 2024 on the financial position for both the City Council and the ICB. Other topic areas have ranged from the options for care home nursing, the hospital discharge grant for carers and the Learning Disability Strategy through to elective care and demand, capacity, and winter urgent care, as well as local work on tobacco control, and proposals for a local prevention and health inequalities group.

The JICB has continued to oversee the joint commissioning arrangements for both homecare and discharge to assess workstreams across adult social care and the ICB. JICB has also retained its governance role as part of the BCF. In partnership with the Integrated Systems of Care (ISOC) group, it continues to agree BCF funding allocations, monitor progress and approve statutory returns to central government.

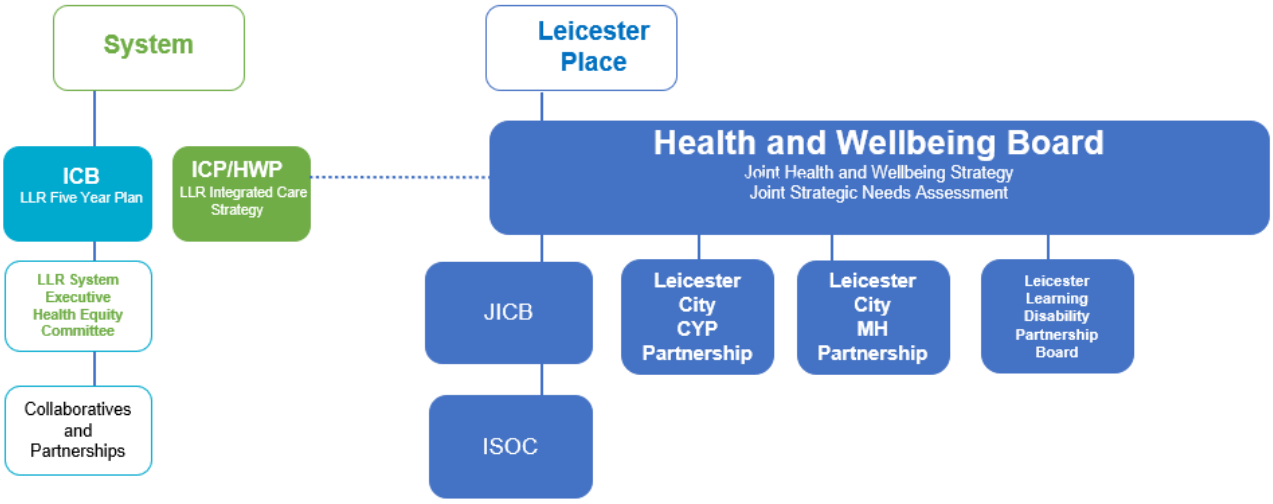
Integrated Systems of Care (ISoC)

The purpose of the Leicester City Integrated Systems of Care Group (ISoC) was to design and deliver a place-based system of care, contributing to the LLR system vision. ISoC brought system partners together to work collaboratively in the development of the place-based strategy and outcomes framework for Leicester City. The meetings were an opportunity to focus on all the key areas of work, highlighting the extensive work taking place on the ground and acknowledging the improvement of Leicester City's health outcomes.

From a governance perspective, ISoC has been instrumental in the oversight of the Better Care Fund (BCF) from an operational point of view. It provided the platform to service providers to report service delivery as well as share best practice and learning. Other topics of focus in 2024 were on Enhanced access, and Leicester's Heath, Care and Wellbeing delivery plan. ISoC supported the progress of these key areas over the year allowing health inequality to be central to all discussions. All members and service leads were then able to take that feedback back to their groups.

Utilising the vast expertise from colleagues, the meetings allowed for a space for open discussion and ensured that the BCF, and other place based services were looked at from all angles. Any risks were mitigated quickly as partners offered support and resources where possible. Ground level topics brought to ISOC included Healthy start and Healthy places, Care navigation, Integrated neighbourhood teams and the 6 do priorities.

Figure 1: Map of the Integrated Care System



Leicester Integrated Health and Care Group

To streamline the governance processes ISoC and JICB are being stood down in favour of the Leicester City Integrated Health and Care Group emerging. This new group will hold the function of both ISoC and JICB and will serve as a subgroup of HWB.

Leicester Integrated Health and Care Group will have a core business of:

- Oversight and delivery of the Joint Health and Wellbeing Strategy priorities
- Lead on work concerning joint commissioning/ transformation
- Oversee the city's Better Care Fund
- Influence, advocate and integrate the variety of projects within the system
- Explore and influence solutions for City specific challenges/ opportunities

Leicester Integrated Health and Care Group will directly feed into HWB. This group is due to commence in early Autumn 2024. An update on the action of the group will be provided in the following annual report.

2.3 Vision, aims and objectives of the Board

Our primary aim is to achieve better health, social care and wellbeing outcomes for Leicester City's population, and a better quality of care for patients and other people using health and social services. Our objectives are to:

- Provide strong local leadership for the improvement of the health and wellbeing of Leicester's population and work to reduce health inequalities.
- Lead on improving the strategic coordination of commissioning across NHS, adult social care, children's services and public health services.
- Maximise opportunities for joint working and integration of services using existing opportunities and processes, and prevent duplication or omission.
- Provide a key forum for public accountability of NHS, Public Health, Adult Social Care, Children's Services, and other commissioned services directly related to health and wellbeing.

2.4 Statutory responsibilities of the Board

We have some statutory duties which we must carry out. They are to:

Produce Joint Strategic Needs Assessments (JSNAs) which assess the health and wellbeing needs of Leicester's populations, and refresh them as needed.

The **Joint Strategic Needs Assessment (JSNA)** is a comprehensive document that evaluates the health profile of a population, identifying health inequalities and unmet needs. The JSNA also projects future health trends, providing recommendations for enhancing population health. JSNA's are an important tool in helping to develop local strategies and to inform decisions about the types of services which need to be commissioned to support local health and wellbeing. During the time period this report covers, the following JSNA's and **Joint Specific Needs Assessments (JSpNA's**) have been completed:

- Mental Health
- Living in Leicester
- Dementia
- Tobacco Use
- Healthy Weight
- Physical Activity
- Cardiovascular disease
- Adult social care
- Gambling

Produce a Pharmaceutical Needs Assessment (PNA) for Leicester

The **Pharmaceutical Needs Assessment** (PNA) is used to understand the current and future pharmaceutical needs of people in Leicester, and whether they are being met by the community pharmacies. This information is used to help to make decisions about the planning and commissioning of pharmaceutical services and new pharmacy applications made to NHS England and NHS Improvement. It is a statutory requirement to complete a PNA every three years to assess the demography of the area and needs of different localities, sufficient choice of pharmaceutical services; surrounding areas, and future need.

For information around the current PNA from the perspective of the HWB please refer to the 2022/23 annual report here. The current PNA is due to be refreshed for 2025. The work for this is due to start in the Autumn of 2024. The Health and Wellbeing Board will oversee the progress of this.

Agree the Better Care Fund (BCF) submissions.

The **Better Care Fund (BCF)** is a programme which supports partners across the local system to deliver the integration of health and social care in a way that supports person-centred care, sustainability, and better outcomes for people and carers. It allows the NHS and Local Authority to pool funding to spend in ways which join up care more effectively. The BCF supports a range of services and schemes that contribute to the overarching vision of the Health and Wellbeing Board and the strategic priorities set out in the Leicester Health, Care and Wellbeing Strategy and Delivery Plan. There is a well-established **place-based** infrastructure which supports the preparation and execution of the BCF plan. The Health and Wellbeing Board has a responsibility to approve the BCF submission to NHS England; the Joint Integrated Commissioning Board has delegated authority from Leicester City Health and Wellbeing Board to develop BCF strategy and to sign off BCF plans, pending HWB sign-off; the

Integrated Systems of Care board meets monthly to oversee operational delivery of BCF services and recommends any commissioning required to meet its objectives.

The BCF pooled budget for the period from April 2023 – March 2024 was £58,464,270, including the Improved BCF element (to support Local Authorities) and the Disabled Facilities Grant, which are received from central government via the BCF.

A substantial proportion of the BCF is used to support core health and care services, so that they are effective in enabling joint working on the national BCF priorities of reducing the use of acute care, reducing the use of residential and nursing care and improving people's independence.

The impact of this funding can be seen in the BCF metrics but more widely in the system resilience we have for services that support acute care flow (admission avoidance and discharge) and integrated community services.

In addition to supporting core social care, community health, therapy and adaptations activity, the BCF funded the following key place-based services in 2023/24:

- Leicester Mammas
- Dear Albert
- The Centre project
- Eye Clinical Liaison Service

The Leicester BCF was refreshed in April 2023 in accordance with national conditions and guidelines. Looking forward in to 24/25 the pooled budget has now been refreshed to support delivery of 24/25 national conditions and objectives.

BCF in action

Integrated Crisis Response Service

ICRS is a long-established BCF scheme, which delivers rapid support to people who have experienced a health or care crisis at home. In a 12-month period, over 6, 200 were supported at home, within 2 hours of contact. 80% of people did not require any ongoing extra support and only 1% of people were admitted to hospital of long-term care.

Care Navigators

Care Navigators have been a funded BCF project for over 10 years, with social care employed staff embedded in primary care to support people who present with underlying social and environmental needs. Care Navigators work holistically, with a skill set that crosses the health and care spectrum, enabling people to access support that reduces their inappropriate use of primary care and addresses issues as diverse as cold housing, loneliness, financial difficulties and mobility within the home.

Leicester Mammas

Is in receipt of £36,981 in 23/24. Baby Project sessions are held weekly for pregnant women and those with children under 3 years of age, with additional vulnerabilities, to access:

- Emotional support, antenatal and breastfeeding support
- Emergency supplies (including infant formula)
- Welfare advice and Healthy Start
- Support with housing applications and council tax, help with school/nursery applications

- Integration into existing services and parent and baby groups, and referrals to other organisations where appropriate

"Sometime just talking to someone helps. I miss my family and my home in India. But we are making new home here. I will restart my dissertation soon and I am feeling more positive. I feel I have friends here"

The Centre Project

Received £24,531 in 23/24. Delivers 6 core offers in city centre: open access welcoming space, social activity, food bank, advice and support, preventing homelessness, health support. Supported 750 individuals / 7, 580 contacts over the year. Targeted sessions – from cervical screening to gambling support. The Centre Project primarily provides services to those located in LE1 and LE2. LE1 and LE2 as a population contains the highest volume of those living in the lowest Indices of Multiple Deprivation.

Encourage integrated working between health and social care commissioners.

The Health and Wellbeing Board comprises of a multidisciplinary membership which featured health and social care representatives. Commissioners are encouraged to bring items to the attention of the Health and Wellbeing Board. MHPB and LDPB are managed by social care commissioners and both groups are subgroups of the HWB. ISOC and JICB are key to commissioning work and operational practice. Information that requires awareness of commissioners or directly relates to the commissioning of projects is also presented in the two Boards to ensure awareness and integration of work across relevant parties.

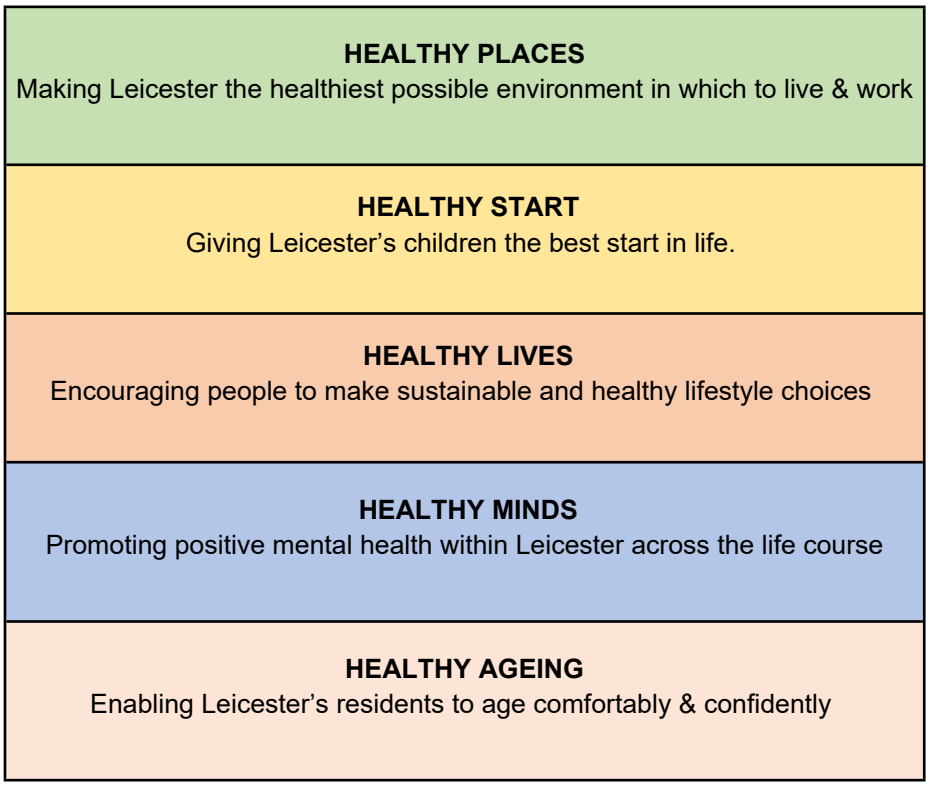
The Board has had direct updates around commissioning of services such as the recommissioning of sexual health services provision. Furthermore, items presented at the Board can impact commissioning practices and the shaping of strategic plans e.g. Black Mental Health and Me report has highlighted some issues around health inequalities experienced by Black communities and some suggestions for how this can be addressed. This has been brought to the attention of Mental Health commissioners and the report is being used in the development of our new Health, Care and Wellbeing Delivery Plan for the priority of 'Mental health and wellbeing related to social inclusion, and supportive networks'.

Develop and agree the priorities for improving the health and wellbeing of the people of Leicester and tackling health inequalities

A refreshed **Health, Care and Wellbeing Strategy 2022-2027** for Leicester was published in 2022, giving recognition to the impact of the COVID pandemic on health and wellbeing across our city and widening health inequalities. The strategy outlines the current and future heath, care and wellbeing needs of Leicester's residents and sets out 5 themes with their strategic ambitions and 19 fitting key priorities. These were agreed, through extensive consultation with residents, professionals, voluntary organisations and other stakeholders across Leicester, as being important to address in order to enable Leicester residents to live healthy and fulfilling lives. Alongside the strategy is a detailed delivery action plan which includes the specific actions and activities which are taking place to help us achieve our priorities. The plan brings together partners from across the health and care systems, as well as the voluntary and community sector, to work collaboratively to address these priorities.

The previous Health and Wellbeing Board's January 2022- July 2023 annual report was published describing the progress the Board made through general activity and the specific progress of the strategic delivery plan in that period. The delivery plan featured in the report

focused on 6 priorities which were labelled as '**do'**. These priorities were considered most pressing at the time:



Furthermore, the remaining 13 priorities were split between Sponsor and Watch. These priorities were not continuously monitored, nonetheless work in these areas continues as business as usual. Any issues regarding these priorities could be escalated to the HWB or its subgroups using their influence to resolve. To view the 2022-23 report please click here.

2023/24 saw the ongoing monthly collection of updates from the six 'do' priorities. These updates were shared with ISOC and JICB and the Health and Wellbeing Board itself. Business as usual continued with the remaining sponsor and watch priorities. The progress made within the last period across the priorities is noted below.

Healthy Places

Strategic Ambition: To make Leicester the healthiest possible environment in which to live and work.

Do

We will improve access to community health and care services

Developed Integrated Neighbourhood Teams to work in a more coordinated way with partners at a local level, through the evolution of PCNs.

- We have increased the number of patients diagnosed with Bowel Cancer in the City. Combined treatment (e.g., patients being seen and treated, consultation, medication etc) has increased by 77%. This will translate to long term benefits and improved outcomes for patients.
- Increased weight management and obesity coding (system code to record, audit and review clinical targets/ achievements) by practice. Referral to Obesity Programme has increased by 65%. This has supported people through early prevention and intervention support.
- Menopause diagnoses have increased by 93% and we continue to monitor Hormone Replacement Therapy (HRT) uptake in these patients. Additional support is offered to women from diverse backgrounds.
- Increase in CKD (chronic kidney disease) diagnosis by 88% in the city. Most referrals for CKD are done via LUCID (programme run in collaboration with UHL Chronic Kidney disease treatment and management supported in general practice). There was a significant increase in diagnosis and referral via LUCID programme, in collaboration with UHL.
- Increase in hypertension intervention/ coding by 75%. When we look at the age standardised rates for mortality rate for hypertensive diseases, we can see Leicester rates are higher than the national average. Early intervention and support are offered.

Boosted the use of social prescribing and the Additional Roles and Reimbursement Scheme (ARRS) to support primary care functions and ensure the right care is provided by the most appropriate provider.

- Increased access through allowing patients see non-GP direct care staff. PCNs use ARRS to support demand and often undertake home visits when required to do so / triage accordingly.
- Scheme bolsters staffing levels and enhance the capacity of primary care teams as outlined in the NHS Long Term Plan to increase the workforce in General Practice.
- 147.7 new ARRS roles from August 2023-March 2024.

Collaborated with a range of partners to train volunteers to support patients in medical practices with their use of the digital technologies which support management of their health needs.

- 6 sessions with 62 people in attendance which trained community members on how to use the NHS App and find trusted information online. This took place in collaboration with community groups in Leicester.
- Trained 30 health professionals to use the NHS App. 8 sessions held with 29 people attending.
- All surgeries in our contact list (58 surgeries) have been provided with information/posters on how to access NHS App YouTube videos, which they can also display to patients (including QR codes). These come in a variety of languages.

Delivered an Enhanced Access service in primary care to enable more people to receive appointments and care at a time and place which is accessible for them.

- PCN Extended Access Hub offers over the last 52 weeks: 23,637 appointments provided, averaging 600 per week.
- PCN Extended Access hub make up 7.6% of total appointments.

Sponsor

Creating Mental Health & Dementia friendly communities within Leicester

Alzheimer's Society stopped supporting dementia friendly communities on 31st December 2023.The former Leicester, Leicestershire and Rutland Dementia Friendly Community has converted into the Leicester, Leicestershire and Rutland Dementia Inclusive Network and we are working together to share best practice and highlight challenges to the Dementia Programme Board. We meet online once every 2 months, one week prior to the Dementia Programme Board and currently have 60 members, including organisations which successfully obtained funding from the Dementia Grants Programme in 2021.

The Dementia Inclusive Network are working on the following: -

- Proposed to the Dementia Programme Board that they organise regular information sessions to enable people in the dementia community to meet one another, find out what is available in their local community and try out a range of sessions.

- Investigating the possibility of establishing a network of people living with dementia from the members to ensure the network and dementia programme are more aware of what people diagnosed with dementia want to change and are finding successful in enabling and empowering them to live their best lives with dementia.

- Hosting a meeting with the Northamptonshire Dementia Inclusive network to share best practices in October 2024.

Furthermore, our Commissioned Dementia Support Service is supporting the development of Dementia friendly communities throughout Leicester and Leicestershire through:

- Supporting Glenfield Church and Fifty Five Café in Thurnby to create their own memory cafes. They have provided dementia awareness training and memory café facilitation training.
- Set up a dementia friendly gardening group (The Garden Gang) which is now self-managing.
- Set up Bright Sparks Social Café for pre / peri diagnostic individuals, which is mostly attended by individuals with mild cognitive impairment and those who support them.
- The Memory Advice and Dementia Support Service took part in a Virtual Reality workshop facilitated by Sekond Chance. Sekond Chance will be trialling some virtual reality experiences within our memory cafes and social groups over the next few months.

Mental Health Friendly Places are local organisations committed to challenging stigma linked to mental health problems. They contribute to our community capacity to raise awareness about poor mental health and signpost people to where they can get help to protect their mental health by staying connected, learning new skills, being active and productive.
17 Leicester organisations are signed up as Mental Health Friendly Places. They are in places like Leicester city centre, Evington, Highfields, Belgrave, Saffron, New Parks, Beaumont Leys, and Braunstone. These organisations work with community mental health cafes, voluntary sector, health, and social care organisations.
Through the Leicester Mental Health Partnership Board and the local Suicide Audit and Prevention more will be done to promote mental wellbeing and encourage local organisations to become Mental Health Friendly Places.

Sponsor

Improve the built environment to support people's long-term health and wellbeing

The Local Plan is one of the key factors to contribute to this target. It is an important planning document that once adopted will set out the vision and aims for growth of the city up to 2036. The plan will be used to allocate sites for development, deliver infrastructure, influence economic investment and make decisions on planning applications. Following previous consultations, the local plan has now been submitted to government. An independent examination is expected shortly which will review the plan. Following approval by government, it will be adopted as planning policy to guide planning decisions in Leicester.

The Leicester Local Plan has a health and wellbeing policy, including the need to assess major developments for their health impact. This will include how the development will contribute to improving health and reduce health inequalities. Where adverse impacts are identified, the development will be expected to demonstrate how it will address or mitigate these impacts. Work is underway to develop the process for this. Other work includes the development of the Leicester Streets Design Guide which includes the 'Healthy Streets' principles, the defibrillators project and a libraries and communities needs assessment which also includes a health and wellbeing section. Public health partners have regular meetings with representatives from planning to ensure that we work seamlessly together on this priority, and are planning to provide some training for their team on wider determinants and health impact assessments.

Watch
Supporting a move towards a carbon neutral city
An action plan has been developed within the public health team to incorporate environmental sustainability more strongly into public health work and through work with partners and communities to advocate for embedding environmental sustainability throughout the city. There are several themes within this work including commissioning and procurement, ways of working and processes, strategies and policies, specific areas of work, human resources, delivery of in-house services and quick wins. There are already several public health projects where outcomes align with improving health and environmental sustainability and more opportunities will continue to be sought. For example, 'Beat the Steet' and 'Let's Get Resourceful' projects aim to increase active travel or reduce energy consumption, respectively. The action plan also aims to improve the environmental sustainability of how public health work is delivered. For example, two upcoming contracts have been identified to trial building environmental sustainability more strongly into the commissioning cycle and strategies and policies are being identified where sustainability can be incorporated or strengthened.

Healthy Ageing

Strategic Ambition: To enable the people of Leicester to age comfortably and confidently.

Do

We will enable Leicester's residents to age comfortably and confidently through a person-centred programme to support self-care, build on strengths and reduce frailty.

Worked towards creating fully operational Integrated Neighbourhood Teams, by utilising Making Every Contact Count

- Making Every Contact Count is a low-cost intervention which is underpinned by the evidence-base for behaviour change approaches to prevention. Since August 2023, all care navigators have been using this approach with every new person they work with including those that are new to the role. This is fully embedded and is now considered business as usual.

Supported the commissioning of a range of services and opportunities to provide alternatives to residential care.

- The impact of the work that we have done in this area can be seen in the number of new admissions to residential and nursing care.
- Our year end outturn is confirmed as 275 new admissions to residential and nursing care (36 aged 18-64 and 239 aged 65 plus), a reduction on 2022/2023 admissions. This figure also includes 20 people who were not technically Adult Social Care (ASC) placements. They were self-funders who had elected to enter residential /nursing care and their funds had subsequently depleted to a level whereby ASC started to pick up the costs.
- The alternative arrangements that have been commissioned include community day opportunities. A new framework commenced on 1st April 2023 with 16 organisations within this. There are approximately 300 people in Adult Social Care accessing the service across this. Of that 37% are over 65 and the remaining 63% are working age adults.
- Since August 2023, our carer support service has been recommissioned. The revised model which seeks to support the early identification of carers across health and social care services intends to increase the reach of carers supported across the city and will go live in July 2024. The existing service has supported in excess of 2,500 carers and it is hoped that the emphasised focus on outreach, educating external health and social care services around the importance of identifying carers early and signposting to the service, will increase the numbers of carers that utilise the service particularly from those groups that are currently under-represented such as male carers, and carers aged 18-25 years. Performance will be monitored in the first 12 months of delivery to enable us to set appropriate targets.
- We continue to invest in dementia support services, which provides support in the community to people and their carers. During quarter 2 of 2023/24 (July – Sept), the service worked with 2,153 families of people living with dementia which was on track for exceeding the annual target of 2,534 by the end of the year. 97.7% of people were contacted by the service within 2 weeks of referral.
- We have a robust model of domiciliary care that provides timely support to people in their own homes. This year the service has been subject to a re-procurement, with new contracts due to go live in 2025. Despite responding to a tender and delivering services throughout the Winter months, the service provision is good and as of Q4 2023/24 (January-March) 91% of our contracted home care providers were rated as good or outstanding by the CQC.

Remodelled the Leicester, Leicestershire & Rutland Discharge to Assess Pathway 1 to increase reablement capacity in an attempt to increase the numbers of older people who return to their usual home following a period of time in hospital

- This work was a requirement set by NHS England whereby all ICB's have local plans in place which enable patients who have been medically optimised for discharge and require social care support to be discharged within 2 hours / same day. The City Council received £433,000 to assist with developing our approach, reducing the risk of deconditioning in hospital through a Reablement Service which actively promotes independence, with integrated care leading to better outcomes.
- The new Reablement Rehabilitation and Recovery (RRR) model went live on 1st November 2023, and more people are being seen within the service compared to the same time the previous year. For the period November 2022-January 2023, before the RRR model went live, 294 people were supported. For November 2023-January 2024, 401 people were supported.
- The ambition and next key objective of enabling everyone going home from hospital with new care needs to access the service will focus on people who usually have their care provided by more than one carer at each call. From June 2024, the service will start to support these people coming out of hospital via the Integrated Crisis Response Service, allowing them to access RRR support where appropriate. Where RRR isn't appropriate, the service will right size the support and move the care swiftly over to our homecare providers, whilst promoting as much independence as possible.
- In addition to this, the current therapy led offer for Pathway 2 has been transformed into one that provides a robust and effective RRR model for people stepping down from the acute with high dependency needs (a cohort characterised by dementia/delirium with significant behaviours that challenge). The work to adapt the bed base has included an enhanced GP offer commissioned with the local surgery, 24hr nursing with a dual registered nurse (Registered Mental Health Nurse & Registered General Nurse), 1:1 care and specialist therapy. This service was officially on 15 April 2024 and is now providing 15 beds for LLR patients triaged and identified as meeting the relevant criteria.

Sponsor and Watch

Reducing the number of falls for people aged 65+ & promoting independent living so that older people can live in their own home and communities.

ICRS (Integrated Crisis Response Service)

ICRS is part of the Home First offer of keeping people living at home for as long as possible with a specific remit of supporting those in a crisis situation whereby immediate social care intervention can help avoid a hospital or residential care home admission. Another key aspect is ICRS's ability to support with urgent hospital discharges whilst also being a key service responder to those who have fallen with a view of preventing further falls by working alongside its key partners. Shared below are the key outcomes achieved for everyone accessing the service alongside specific outcomes for those who had fallen.

ICRS outcomes from 1st April 2023 - 31st March 2024		
Total Referrals In	**5460**	
Residential placements	9	0.16%

Hospital admissions/Remained in hospital	248	4.54%
Reablement	179	3.28%
Remained at home with dom care	428	7.88%
Remained at home with no further intervention required	4506	82.49%
Deceased	90	1.65%

As noted, ICRS is also a responder to people who have fallen. The vast majority being people that use LeicesterCare alongside those referred in via ambulance crews (when no injury has been sustained) and homecare providers. When responding to fallers ICRS staff also proactively looks at the reason for the fall and the possibility of reducing any future falls too. Outcomes in relation to its falls response are shared below.

ICRS outcomes for fallers responded to between 1st April 2023 – 31st March 2024		
Total People That Have Fallen Supported	**1547**	
Remained at home with no further interventions (whilst equally assessing how a future fall could be avoided)	1440	93%
Residential placement	1	0.07%
Admitted to Hospital/EMAS called	77	4.98%
Support implemented by ICRS/increase in current support	29	1.86%

Reablement Service:
The Reablement Service has undergone key changes to help introduce an LLR vision called Reablement, Rehab and Recovery. The RRR Intake Service enables as many people being discharged home from hospital to access a period of Reablement. This new way of working went live 1st Nov 2023 and therefore outcomes for the last 7 months have been included below both in terms of the actual number of people supported alongside their outcomes.

Reablement Activity:

Month	**Referrals**	**Starts**	**Closures**	**Independent**	**Dom Care**	**Hospital**	**Residential**	**Deceased**
Nov 23	156	146	124	73	27	21	2	1
Dec 23	122	116	110	54	34	19	2	1
Jan 24	149	140	139	90	29	16	1	3
Feb 24	144	131	137	83	35	18	0	1
Mar 24	107	99	105	67	27	11	0	0
Apr 24	119	115	114	74	19	19	2	0

May 24	136	122	124	77	25	17	2	3
Total	**933**	**869**	**853**	**518**	**196**	**121**	**9**	**9**

Reablement Outcomes:

Month	Independent	Dom Care	Hospital	Residential	Deceased
Nov 23	59%	22%	17%	2%	1%
Dec 23	49%	31%	17%	2%	1%
Jan 24	65%	21%	12%	1%	2%
Feb 24	61%	26%	13%	0%	1%
Mar 24	64%	26%	10%	0%	0%
Apr 24	65%	17%	17%	2%	0%
May 24	62%	20%	14%	2%	2%
Total	**61%**	**23%**	**14%**	**1%**	**1%**

Healthy Lives

Strategic Objective: To encourage people to make sustainable and healthy lifestyle choices

Do
Increasing early detection of heart and lung disease and cancer in adults
Targeted Lung Checks Programme • The Targeted Lung Health Check (TLHC) Project is a new national service offered to those aged 55 to 74 who are at a greater risk of developing lung cancer. Recruitment to Clinical Director, Primary Care Clinician and UHL Project Manager role completed. Procurement timelines explored. Initial data modelling for rollout trajectory completed with caveats. Approx 145k people to be included in Leicester, Leicestershire and Rutland. **Awareness Campaigns** • Using national cancer awareness campaigns to promote cancer awareness in LLR. A video to support breast cancer awareness has been produced and launched. • The LLR ICB Cancer team attended Ashby Blue Light Event, ICB Women's event, Sunning safely event at East Midlands Airport to name a few. The team also works in collaboration with Patient Care Locally and their roving vehicle visits supporting the HPV vaccinations and promoting cancer awareness too. Events attended with

Patient Care Locally in Leicester City Centre, Thurmaston Health Centre and also at Beaumont Leys Shopping Centre. The scope is to provide information to patients regarding the HPV vaccination and also the signs and symptoms of cancer as well as screening opportunities to support the Early Diagnosis agenda.

FIT test Pilot

- Using the FIT (faecal immunochemical test) result in practices to decide whether a referral is appropriate. NHSE/I expect that at least 80% of lower gastrointestinal urgent cancer referrals should be accompanied by a FIT result carried out within last 21 days. IIF (Impact and investment Fund) Lower GI referrals which are accompanied by a FIT diagnostic test completed in the last 3 weeks was over the required 80% for 23/24. June 2024 data (cumulative from April 24) is at 84.6%.
- A City PCN undertook a pilot to directly provide patients with FIT (Faecal Immunochemical Test) and samples to be returned to the surgery (tests are usually issued via the post from Nottingham).
- Feedback on the pilot was positive from the surgeries. The pilot has now been completed and work is underway to roll this out across LLR. The pilot featured all patients within the PCN that require a FIT test, around 600 patients.

Cervical Screening and HPV Work

- A project to deliver on the WHO requirement to eliminate cervical cancer by 2040 has begun. To achieve this the NHS needs to ensure as many people as possible are being vaccinated against Human Papilloma Virus (HPV), while also coming forward for cervical screening. A cervical elimination strategy is being created with the partners and a delivery plan will be developed from this.
- A video around cervical screening was produced for patients with Learning Disability and another video focusing on HPV for the general population was produced.
- Project groups for HPV and cervical screening commence 26th June and will feed into a cervical elimination strategy and delivery plans.

Hypertension

- CVD Prevent data from quarter 3 for 2023/24, shows LLR reached 68.29% of patients with hypertension treated to NICE guidance. The goal was to increase to 77% by March 2024 and the target has increased to 80% by March 2024/25. In line with other ICBs, whilst more people with hypertension were diagnosed, the target was not met. Further work is planned in collaboration with Medicines Optimisation to relaunch the community pharmacy blood pressure check and hypertension case finding schemes and continue place based target work to support practices and PCNs. Oversight will be provided by the Long Term Conditions Partnership.
- At risk patients were identified and invited for a blood pressure check during enhanced hours clinics at GP practices or pharmacies. Over 4000 patients were tested over six weeks, identifying 545 new cases of hypertension, helping to prevent heart attacks or strokes. Tests are now being carried out in pharmacies with the relaunch of the blood pressure check service.

Watch
Promoting Independent Living for People with Long Term Conditions

RRR Intake: (Reablement, Rehab, Recovery Intake Service)
Launched in November 2023, the service has enabled the discharge of hospital patients medically optimised for discharge with a much more inclusive offer therefore increasing the number of people benefiting from this service (around 150 per month). Since June 2024 this now also includes those who need support from two people through the Integrated Crisis Response Service (ICRS). The outcomes remain equally very positive with the vast majority of people requiring no formal care or if so at a much more reduced level with 93.5% still being at home 3 months later. The service sits within Home First benefiting from community health services (nursing/therapy) alongside the OT Service, Care Technology/LeicesterCare, the Brokerage Team and the Reablement Social Work Team - all working as part of an integrated offer of support.

ICRS: (Integrated Crisis Response Service)
ICRS continues to support around 500 people per month facing a crisis and through its urgent step-up intervention helps avoid potential admissions into hospital. This is especially applicable with its long-standing work on people that have fallen whilst also pulling patients out of any pre-admission wards. Its pro-active work supporting the Frailty Wards has also been positively noted this year as has its offer of supporting patients with the need of support of two people coming out of hospital. The service sits at the heart of the Health and Social Care System and as the front door to Home First through integrated and co-ordinated care – with around 80% needing no ongoing formal care.

Sponsor

Reducing Levels of unhealthy weight across all ages.

The Whole System Approach to Healthy Weight continues to work towards creating a system that supports healthy weight in Leicester. A detailed action plan supports the approach and is divided into three themes: focusing on building a stronger system; changing environments to increase opportunity; and empowering workforces and communities. 15 actions spread across these three themes are in place across the next three years to contribute to reducing excess weight. Priority groups of those living in deprivation, with disability, children and families, and pregnant women with excess weight are identified within the action plan as a focus.

A variety of services exist that are already contributing to promoting a healthy weight across Leicester; the approach aims to build on these and use existing assets and services in a way that is more powerful to reducing excess weight. Existing services and themes already contributing to promoting healthy weight/living include but are not limited to: Live Well Leicester, Healthy Conversation Skills, United Leicester and Active Leicester. The approach as a whole aims to create a system that enables at least 40% of our adult population and at least 70% of the year 6 age group population to live at a healthy weight by 2034.

Sponsor

Improving support for carers

Since August 2023, the Leicester Carer Support Service that is commissioned by the City Council has also administered a hospital discharge grant for carers which was funded by the Adult Social Care Discharge Grant. The scheme ran from 1st October 2023 to 31st March 2024 with the aim of supporting carers by providing a one-off direct payment of up to £500 in recognition of the support they were providing to the cared for person on discharge.

Carers were provided with swift and simple access to a one-off payment of up to £500, to support the carer's wellbeing and any additional costs they might incur due to the cared for person being discharged from hospital, for example:

- Cleaning/housework in the carer's or cared for person's home.
- Short-term sitting service for the cared for person to provide the carer with a break from their caring duties.
- Carer's loss of income due to taking time of work to facilitate the discharge.
- Carer's additional expenditure associated with the hospital discharge, such as hospital parking, petrol/travel costs, bedding, clothing, incontinence products, extra washing/heating costs, extra childcare costs.
- Services that support the carers wellbeing such as attending fitness classes or relaxation activities.
- Small one-off items of equipment up to the value of £75 that will support the carer e.g. a microwave to make meal preparation easier and quicker.

63 referrals were made to the scheme from within hospitals, adult social care, voluntary sector organisations, GP's and other health organisations and 53 of those referrals resulted in carers receiving a grant with the average grant received being £341.00. 33 of the carers were new to the carer support service.

This scheme is currently being evaluated more widely to understand what a revised offer could look like and has been included as a project to be scoped out as part of the Accelerator Reforms Fund programme.

Do

Increasing access for children & young people to Mental Health & emotional wellbeing services

Children & Young People (C&YP) directory & QR code campaign

- This will contain a directory of services available for C&YP's MH and emotional wellbeing. It is being designed by C&YP to ensure it is C&YP friendly with an aim to improve access. The QR code will be displayed in various places so that C&YP can link straight onto the website. 2 directory pop ups held in Highcross and Haymarket in February to engage with CYP. Feedback was incorporated into final amends of the Directory. The feedback was mainly that this was something that C&YP wanted and would find useful. The launch of the directory will be over two weeks coinciding with A level results on the 15th August and GCSE results on the 22nd August.

Delivered Community Chill Out Zones

- Community Chill Out Zones (CCOZ) are workshops which take place in Relate's building on Aylestone Road, schools & community venues. There are two types of CCOZ: Core CCOZ which is a group service which can have between 6-20 CYP per group and Enhanced CCOZ which is 1:1. Both services offer the same support in terms or low-level preventative work to year 1-13 pupils. For example, they deliver work around anxiety getting the C&YP to recognise the physical symptoms of anxiety. Understanding what a normal response is e.g. anxiety around exams as well as when this may have become more problematic in their life. They provide them with coping strategies and the tools to manage their anxiety going forward. Feedback from Relate about the Enhanced CCOZ workshops: "It's been great to have the enhanced 1:1 workshops alongside the Core CCOZ workshops so that we can offer 1:1 option if a C&YP is feeling very anxious about accessing a MH service". For those living in the City who live in postcodes of LE1,2,3&4 - 61 C&YP have been supported through the Enhanced CCOZ. Core CCOZ has supported 3, 784 CYP across LLR since January 2024. Some of the feedback noted:

- 'I really enjoyed it, it was well presented by friendly people. I enjoyed the room search and have been doing it when I am upset as it makes me feel calmer. The stress balls were fun to play with'.
- 'It was good, I like the guard dog and wise owl way of managing things. It was easy to understand and explained well and we got to work in pairs.
- 'It helped by giving us stress balls, it gave us tactics of how to calm down'.
- 'I learnt that when my anxiety gets out of control that breathing techniques are very important. The sheets showed me that I need to put in more time to look after myself. I liked the stress ball, and the websites were useful'.

Commissioned Youth Workers

- Recruiting two Youth Workers: one in the City and one in North West Leicestershire. The role of the Youth Workers will be to support C&YP & their parent/carer to access self-help guidance by assisting them through identifying possible barriers/challenges and supporting them through these. This will also help with the pressure on the clinicians, so that the wait time to access the support is not increasing. The Youth Workers will also be aligned to joint work from the Emergency Department (ED) into the Community for NW Leicestershire for C&YP who leave hospital/self-discharge before being assessed by CAMHS services. This is a small pilot project currently to explore the efficacy of this for young people attending the Emergency Department due to self-harm. Numbers of people supported cannot yet be shared due to the early stage of this project.

Delivery of City Early Intervention Psychological Support (CEIPS).

- Work within schools in the City - not those that have Mental Health Support Teams. They deliver brief early intervention programme where C&YP can reflect on their emotional wellbeing with respect to anxiety, low self-esteem, worries, exam stress and everyday friendship skills with an assistant psychologist. CEIPS team has worked with 67 different schools in the primary and secondary school sector. It has delivered a combination of direct casework small group work interventions, and critical incident support (around loss and bereavement). The team is 2.5 full-time equivalent and supervised by clinical and educational psychologist. Since April 23-March 24: 39 Calm Young Persons Programmes (previously known as Calm Clinics) (an additional anxiety focused add on to CEIPS core service) have been delivered, 216 students have accessed this and there has been a total of 670 sessions. All students demonstrated increased wellbeing session by session and this was monitored throughout their engagement. Both the CEIPS Core and Calm Young Person Programme are contracted until March 2025.

Families, Young People and Children: Additional Roles Reimbursement Scheme (ARRS)

- 2 band 6 Mental Health Practitioner roles recruited, 1 for North West Leicestershire & 1 for Leicester City South PCN. The Mental health practitioners offers 6-8 targeted therapeutic interventions to YP (0-18yrs), presenting with a mild to moderate mental health presentation. On average each full-time practitioner will see between 75 -90 young people per year. Referrals into this service are from GPs/ practitioners in primary care within their designated PCN. This programme ensures that young people are given the tools they need to manage their symptoms before it requires an intervention by a more specialist CAMHS service. Initial feedback from GP's is really positive and they welcome the role in their PCNs. The feedback from C&YP is also positive as the appointments are longer and with an experienced C&YP Mental health Practitioner. Interestingly there have been no did not attend (DNA's) or did not bring as the C&YP is able to pick their appointment date and time with the practitioner.

Do

Improving access to primary& neighbourhood level Mental Health services for adults

Awareness Raising Roadshow

- The project (now 'business as usual') was focused on increasing local people's awareness and understanding of the various initiatives and schemes on offer for mental health & wellbeing. The project has worked in partnership with local GP practices and social prescribers to run events within surgeries for patients to pick up information and ask questions. The roadshow events have also been delivered in local community venues such as libraries. The project has also worked with local businesses who employ local people. Whilst online information is available, for some people they have limited online access and therefore this project provided physical resources and materials to ensure people could access the information.
- This was completed in a range of neighbourhood venues and local business enterprise inc. GP Practices, Tesco (Hamilton), Sainsburys, Walkers (PepsiCo), Hastings etc.
- c.250 people spoken to across 13 events (GP Practices, Libraries, supermarkets). Roadshow at Walkers Crisps (c.1,880 employees).Tesco's (est. c.900 footfall in hours roadshow took place).
- The success of this initiative has helped develop a blueprint for rolling out local small-scale stands in a community spaces (GP practices, libraries, local businesses) which provides information on all local offers and the opportunity to speak to an 'expert in the area'.

Mental Health Cafés

- Neighbourhood Mental Health Cafes are part of a national MH crisis alternatives scheme that intend to improve access to local support where someone who is experiencing mental or emotional distress can go to without the need for an appointment to speak to someone.
- The café scheme in Leicester is being delivered by VCS organisations in order to better meet local needs, by having organisations who understand the local population/community. The following organisations provide neighbourhood mental health cafes in Leicester;
    - Jamilla's Legacy (Highfields)
    - Team Hub (New Parks)
    - Peepul Health (Belgrave)
    - Turning Point (City Centre)
    - Saffron Neighbourhood Council (Saffron)
    - Eyres Monsell Children & Young Peoples Centre (Eyres Monsell)
    - ZamZam Unlimited Possibilities CIC (Beaumont Leys)
    - LLR MIND with Leicester City in the Community (Braunstone)
    - LLR MIND (Leicester Uni & DeMont Uni)
- These providers have received continuation funding for providing Neighbourhood Mental Health Cafes. Mental Health matters were previously delivering the University cafes and now this has switched to LLR MIND. The University cafes (DeMontfort & Leicester) and other neighbourhood cafes have gone back out to the market. VAL are supporting the application process. Specifications have been revised and a new University spec was developed as a result of the reviews. There have been 1,061 contacts at the City cafes since November 2023'.
- Estimated number of contacts per year in Leicester City are 2,500 – 3,500 based on recent data.
- Review is underway to track progress. Increased training across café providers to teach psychologically informed skills to individuals to increase ability to self-help.
- Analysis of data highlighting key groups not accessing the cafes and engagement work to commence with the aim of increasing café access.

The Decider skills (Psychological Skills)

- The Decider Skills use Cognitive Behaviour Therapy to teach people of all ages the skills to recognise their own thoughts, feelings and behaviours, enabling them to monitor and manage their own emotions and mental health. Complex psychological theory has been distilled into highly effective, evidence based skills for individuals and organisations to teach & learn.
- This was needed to increase accessibility of psychological support in Leicester and create a common language and framework across the system. The long waits for support were a driver to seek an alternative way of providing self-help skills to allow people to learn and support themselves when their mental and emotional help was becoming challenging. The ICB invested in 1,500 training spaces which has so far seen over 1,000 local practitioners complete across health and the VCS.
- Training to be rolled out to VCS sector. Talking therapies (through VitaMinds) are also to be offered to VCSE. Target is for 8-12 sessions over the year.
- A sleep session has been delivered in March with 31 people registered.
- A 'What is stress' session was delivered in April. 45 people attended this across the NHS (62%), Local Authority (13%), Police (2%), VCSE (20%) and other sectors (20%).
- When discussing the impact of stress on our day to day the main themes were finances, health, work, feeling overwhelmed, demands of balancing everything and caring for others.
- We received some great feedback in the chat with attendees stating that they'd found the session helpful and verbal feedback that practicing the breathing exercise during the session was useful.
- 12 VCS providers have been offered 3 Decider Skills training packages. The training allows recovery workers to teach individuals skills to support their mental health & well-being. 36 individuals will receive the training that will; increase their knowledge of psychologically informed skills to support people attending the café to recognise their own thoughts, feelings and behaviours, enabling them to monitor and manage their own emotions and mental health. This will also support the workers to manage their own mental health.
- Ongoing work by LPT to embed community mental health teams into eight neighbourhood teams across LLR and integration with primary care and other health and social care services. Positive introduction/pilot of the new community connector role in the secondary care MH team. Focused on speaking with newly referred individuals and supported organising appropriate additional help in the community where individuals did not meet the threshold for secondary care.
- A guidance document has been drafted describing the psychologically informed and person centred approach to treatment and care within community mental health services.

'3 Conversation' Project

- 3 Conversations is a strength-based approach to transform the way teams and services interact with individuals, moving away from traditional system referrals to a more person-centred interaction with individuals and organisations working together as opposed to bouncing people between services.
- A team of reablement workers are working with people in a 3-conversation way to implement the approach. There are two innovation sites in Leicester City.
- The Innovation sites have 1-2 reablement workers per site, each who can support up to 10-12 people over a 6-week period.
- City East– Supporting individuals who have been referred multiple times to Community Mental Health Services but not met the threshold. Reablement workers will engage the individuals and develop plan and actions to support their needs.
- Saffron & Eyres Monsell (Live) - which set out to support people initially who had PPNs (Police Protection Notices). Reablement workers engage with the individuals

and are there to support people to identify and reach the help they require. A drop in has also been developed at the Pork Pie Library.
- The projects should run until March 2025

Peer Support Workers

- This is linked to the transformation of the community mental health services and increasing the number of people with lived experience employed within secondary care mental health.
- A training pathway has been created for people to train to be able to work as Peer Support Workers. Predominantly the focus has been recruitment within secondary care community teams, however peer support is also a vital part of how Voluntary Community Sector organisations deliver support to people.
- Learning has centred around readiness to enter/re-enter the workforce and reasonable adjustments to ensure that peer support workers are treated in a person-centred manner in teams.
- 39 individuals with lived experience of poor mental health are in employment. Valuing the skills of people who live with or who have experienced mental ill health.
- Peer support workers have been recruited mainly as a result of attending the peer support worker training. The pathway tends to work on a train to recruit basis. MH services and teams have signposted individuals, the Recovery College and Patient Experience team have also signposted individuals to the training course.

Sponsor:

Reducing social isolation in older people and adults

Work to increase social inclusion in the city is delivered through a combination of commissioned services and collaborative programmes. The commissioned services are Community Connectors and Let's Get Growing. Community Connectors has been running for 9 months. They have established regular activities in four areas of the city, providing a buddying service for residents and are committed to setting up more Pprojects. Let's Get Growing offers courses and workshops covering different aspects of food growing, and support community-based food projects in the city, including at libraries and community centres. In addition, the Let's Get Together programme offers a variety of activities in the libraries and community centres, including chatty tables, health walks, sociable strolls, arts and crafts and growing activity.

Watch:

Work towards having no deaths by suicide in the city

The rate of death by suicide, based on a 3-year rolling average, shows that Leicester is not significantly different to England. When a person dies by suicide the impact is devastating and widespread, affecting families, friends, and the wider community. Our ambition, by working towards zero suicides in Leicester, is to make suicide everybody's business. We aim to do this by empowering, educating, and equipping individuals and organisations to support suicide awareness and prevention. In the period 2020-22 (latest data) 89 people died by suicide in Leicester.

The suicide prevention strategy for Leicester is shared with Leicestershire and Rutland and is currently being refreshed. The strategy is owned by the Leicester, Leicestershire and Rutland Suicide Audit and Prevention Group (SAPG). This group has several sub-groups, including high risk groups and locations, and latest data. It has worked with University Hospitals Leicester to improve our local response to mental health emergencies.
Leicester benefits from Real Time Suspected Suicide Surveillance data, collected by Leicestershire Police first responders. As a result, we know more about local deaths by suicide, and those who are impacted have access to specialist bereavement support at some

of the most difficult moments of their lives. Our improved knowledge has helped to bring together organisations to support communities in response to tragedies. The data have also been used to improve community resources by, for example, helping to inform decisions about where to place neighbourhood mental health cafes.
The public facing part of the SAPG is the Start a Conversation website. This has been recently redesigned to offer advice to people in distress and to highlight our work to empower local communities about mental wellbeing; a project called Mental Health Friendly Places (MHFPs).

At present there are 17 organisations signed up as MHFPs. These share an ethos to challenge stigma linked to mental health problems and to help people experiencing adversity. They have accessed our offer of free training (Mental Health First Aid Aware and First Aider, Samaritans Listening Skills). The organisations are based in areas across Leicester, including those of greatest need, such as the city centre, Evington, Highfields, Belgrave, Saffron, New Parks, Beaumont Leys, and Braunstone. Other training we've offered this year includes an online seminar on men's mental health, in conjunction with Leicestershire Partnership Trust, and suicide awareness and response training for Primary Care.
MHFPs do not stand alone, they are part of broader initiatives supportive of local mental health and wellbeing. These include, for example, action to promote mental wellbeing in the face of adversity, such as partnership working with the Mental Health Collaborative in response to local flood risk, and actions to promote mental wellbeing when tackling food and fuel poverty. MHFPs was an important theme and contributor to the Mental Health and Social Isolation Conference on Time to Talk Day, February 2024.

In coming months work on suicide prevention will continue with the refresh of the local strategy. In Leicester, MHFPs will build on current activity by working with Livewell, offering training to Central Library staff, work with LPT to deliver bereavement support training to Leicester organisations, and further develop the network of MHFPs into local areas where the need for support is greatest.

Healthy Start

Strategic ambition: To give Leicester's children the best start in life

Do
Mitigate against the impact of poverty on children and young people
Peer Support Programme • Relaunched the Peer Support Programme to offer additional support to women and act as their advocate in experiencing perinatal mental health conditions. This programme includes women/birthing people with lived experience and recovery of perinatal mental health conditions, who have then undertaken specialist training in peer support, supporting others who have gone through a similar journey. The aim of peer support is to promote hope, control and opportunity. This may take place on a 1:1 or group format but the main focus of the role is the lived experience of perinatal mental illness. The support is offered to women or birthing people experiencing moderate to severe mental health conditions, perinatal MH services support around 10% of parents experiencing moderate to severe mental health conditions during pregnancy and after having a baby. • The service has 1 peer support worker in post however it is now being reviewed due to issues around recruitment. The team have had preparation sessions which will help support and embed future Peer Support Workers. Peer Support Workers have both management supervision and peer supervision with their peers and are going to be supported internally and externally by the trust peer support wider services. There is no target around how many sessions are aimed to be delivered or how many PSW can be recruited. **STORK Programme**

- Parents and families at greatest need with babies in neonatal services across LLR, are offered the opportunity to take part in the training and education programme called STORK (Supportive Training Offering Knowledge and Reassurance). The aim is to expand this to all parent groups. The programme can be delivered in person or via an online app, covering topics including recognising signs of illness in babies, safe sleeping, and how to reduce the risk of sudden infant death. Other topics include healthy lifestyles, smoking cessation, coping with a crying baby, perinatal mental health support and breastfeeding support. There are also practical sessions on basic life support and responding to a choking baby. This programme links into multiple resources e.g. Lullaby Trust, healthy life styles, perinatal mental health services ICON and many others.
- In 2023 a total of 886 STORK programmes were delivered in hospital.. Half of the families were from an ethnic minority background and half of all of the families had no previous experience as it was their first born. One third of the families receiving the training were from the most deprived areas whilst for a fifth English was not their first language. A quarter of the families were taking their baby home to a passive smoking environment. The programme currently is only delivered in Neonates and has been selective delivered to those most in need. It is now in the process of optimising uptake through training more Band 4 nurses, so that it can be delivered across all families whose babies receive neonatal service support. The aim is to open it out to GP's and health visitors however due to lack of resources and not being able to secure funding, this project has not expanded any further.

Family Hubs

- Family Hubs are centres in communities which provide a more efficient service from a maternity perspective particularly in the provision of Primary Care Networks as more women and babies are able to be seen by one midwife. Women are also offered antenatal and postnatal care at the Hub. Glucose Tolerance blood Test clinics and infant feeding sessions are also offered. The hubs are across Leicester City and County. There are 32 weekly clinics in the city over 8 locations. The number of people attending each session varies from 9-21 per session depending on type of appointments.

Sponsor
Give every child the best start in life by focusing on the critical 1001 first days of life

- Recommissioned Leicester Partnership Trust (LPT) to deliver 0-19 Healthy Child Programme for 7 years (1st October 2023-2030), this includes Health Visiting which has a focus on the first 1,001 critical days. Leicester is a high performing provider, in the top 4 nationally and performing significantly better than the England average.
- Second year of Best Start for Life Workforce Pilot funding secured (£970,862) this money will be used by LPT, UHL, Heads Up Leicester and Leicester Mammas to

pilot innovative, collaborative solutions to supporting families during the first 1,001 critical days. National evaluations as part of a national pilot.
- Work continues on the re-fresh of the Healthy Pregnancy, Birth and Babies strategy (due in Autumn 2024).
- Seeking additional funding (£9,000 p/a) to ensure Baby Basics can continue to deliver at their current level when Lottery Funding ends. Baby Basics are a charity providing families with essential equipment such as cots, nappies and clothes. Baby Basics is a national charity and Leicester is the second busiest area in the Country after London.

Watch

Making sure children are able to Play and Learn

The LA has a duty to ensure there are sufficient places across the city to enable children and young people to access educational provision (Early Year Settings, schools, colleges) in order for them to learn. The LA works hard in partnership with education settings to ensure these places are available. Whilst there has been a decline in birth rate, in Leicester there has been a significant increase in inward migration over the past two years requiring the creation of additional school and college places. In addition, the government extended early years and wraparound care entitlements are requiring significant developments across the early years and primary school sector to ensure that the required places are available.
Our School Improvement team work in close partnership with the School Partnerships to ensure that a high education quality offer is in place for all CYP.
The LA has a strong Education Welfare Service who support children and young people to attend their statutory education placements and monitor closely those children who for a variety of reasons are missing education to ensure solutions are found to support them back into education. Our Early Years development team have worked hard to encourage the uptake of Early Years placements especially those more vulnerable families entitled to placements from 2Yrs olds. Equally our Connexions service work through programmes such as the Youth Hub to ensure our Post-16 Students are accessing employment or training.
The SEND Services continue to remove barriers to CYP accessing education, learning effectively and develop good well-being, by ensuring EHCPs re delivered in a timely manner, also by building knowledge and capacity in education settings through a large training and support offer.
Our CYP who are Looked After or Previously Looked After are supported in their Education by the Virtual School who not only offer academic support but many fantastic enrichment activities such as work with Curve Theatre and Bullfrogs Arts.

Empowering health self-care in families with young children

The LLR ICB Clinical Lead for CYP and the Head of Service of the Children's ED are working with the ICB comms and engagement team to provide information and advice for children with asthma and their families ahead of the start of the new academic school year. It is widely recognised that Emergency Departments experience a "September Surge" in cases of asthma exacerbation as children return to school. The ICB team are working on social media comms, including short videos to advise children and parents to ensure that they are taking their prescribed medication, that they have an asthma action plan and also that they have enough supply of their reliever medication. The aim of this communications and engagement work is to ensure that asthma management is optimised to prevent acute exacerbations and attendance at UEC services.

Core 20PLUS approach

Core20PLUS5[1] is the NHS framework for reducing healthcare inequalities by targeting services and support to those most at risk of experiencing healthcare inequalities. The Core20 refers to the 20% most deprived areas within a locality. '5' relates to five clinical areas which are linked to greater **health inequalities**. These are: Maternity; Severe mental illness (SMI); Chronic respiratory disease; Early cancer diagnosis; Hypertension case-finding and optimal management, and lipid optimal management. PLUS refers to groups identified locally as experiencing the poorest access, experience and outcomes with health and care services, regardless of their deprivation status or clinical needs.

In Leicester, the 'PLUS' groups which have been identified for initial focus are people experiencing homelessness, people with a learning disability, and people with severe mental illness. This is because these are the groups which are identified as having the lowest life expectancy, and poorer than average access to, and experience of, health and care services, and there is a clear need to address these issues. Across the health, care and wellbeing delivery plan, additional consideration is being given to how the unique needs of the identified plus groups can be considered and met to ensure that any activity is delivered adopting a proportionate universalism approach. The PLUS groups and the progress for these groups will be reviewed periodically.

During a development session this year, the future of our approach to providing additional attention to the PLUS groups was discussed. The PLUS groups will be highlighted in our future monitoring plan to ensure that each workstream is prompted to highlight any additional work that is being undertaken to support people in these groups. An additional inclusion of 'Children in Care' as a PLUS group to focus on in the city is being proposed. This is due to poor health outcomes experienced by the group and the importance of considering this when providing health interventions.

Community Engagement

Engagement with local communities is one of the core functions of the Health and Wellbeing Board, and there has been a range of communication and engagement activity over the period covered by this report, including:

Community Wellbeing Champions

The Community Wellbeing Champions (CWC) project was set up by Public Health in 2021 to help improve their reach into communities, especially underheard and underserved groups that experience poorer health access and outcomes. This is done by working with the CWC Network, a collective of VCSE and other local organisations and individuals that promote and support people's physical and mental health and wellbeing at a community level, and through direct engagement with residents themselves at public events. As well as reaching out with health messages and services, the project aims to gain quality insight through engagement with communities into the needs of different groups and the barriers they face in having those needs met, and to use this insight to inform how messages and services are shaped and delivered. Whilst initially developed in response to the Covid-19 pandemic, the CWC project works across the health inequality agenda as a whole and supports communication, information-sharing, networking, and collaboration across sectors and organisations for greater collective impact on strategic priorities and health inequalities in Leicester. Since August 2023, this has included holding two network conferences, one on the theme of Prevention (held October 2023) and the other on the theme of Mental Health and Social Isolation (held February

[1] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

2024), and eight online monthly network forums covering a range of health and wellbeing topics.

Case study

As part of the Whole Systems Approach to Healthy Weight in Leicester, a healthy eating survey was commissioned by Public Health in 2023 to gain insight into the barriers and enablers experienced by families wanting to maintain healthy diets. The first phase of this survey was undertaken with children and families in schools, and a second phase was then carried out to gain insight from other priority groups, including men and expectant and new mothers. The CWC Network was utilised to identify community organisations with a reach into these groups, and the CWC team then facilitated introductions between the Whole Systems Approach to Healthy Weight project manager and the key contacts at the selected organisations. The Whole Systems project manager then worked with the community organisations to co-produce and deliver focus groups and 1-1 interviews tailored to the needs and preferences of the people being engaged. This supported the project manager to gather additional quality insight into enablers and barriers to healthy eating from a range of perspectives that might not otherwise have been captured in the schools-based survey alone.

Healthwatch

Healthwatch are an organisation who are independent from the health and social care system, whose role is to represent the voice of local people to ensure that their experiences of health and social care services are both heard and used to shape future improvements.

Health and Wellbeing Boards have a statutory requirement to include Healthwatch in the membership, providing a unique opportunity for Healthwatch to ensure that the views of local people are built into the statutory functions carried out by the Health and Wellbeing Board.

During 2023-24 Healthwatch Leicester and Healthwatch Leicestershire published 12 reports, some of which are LLR-wide, relating to improvements that local people highlighted as being needed to improve their local health and care systems.

They engaged with people from across a range of different communities including asylum seekers and refugees, Sikh, Punjabi, Gujarati and Pakistani communities, LGBTQ+ communities, older people, Bangladeshi men, people living with support needs, Young people and women’s groups.

Case studies

Enhancing Healthcare Access for Asylum Seekers

In response to the growing concerns regarding the accessibility of healthcare services for asylum seekers, Healthwatch Leicester and Healthwatch Leicestershire decided to visit all the hotels in Leicester and Leicestershire housing asylum seekers. We published two reports (city and county) highlighting the experiences of asylum seekers with local health and care services.

The reports uncovered various barriers hindering asylum seekers' access to essential health and care services. These barriers include language barriers, lack of cultural competency among healthcare providers and inadequate awareness of available services.

Asylum seekers told us that they struggle to navigate the complicated healthcare system, which worsens their health problems.

Asylum seekers commonly faced heightened mental health stress attributable to the uncertainties surrounding their legal status. Improving the mental health of asylum seekers is crucial for their overall well-being. The reports highlight the importance of tailored mental health support within our local healthcare systems.

What difference did this make?

- The service provider (Serco) took our recommendations seriously, addressed the issues highlighted and made improvements to the services being provided.
- The Leicestershire Partnership NHS Trust (LPT) Neighbourhood Mental Health Teams meet regularly with Asylum seekers and provide mental health support to people at the hotels.
- Following this engagement, we supported the Leicester, Leicestershire & Rutland (LLR) Integrated Care Board (ICB) to gather patient views as part of their consultation on a new specialised GP service for asylum seekers. We were invited to support this because of our growing links with Asylum Seekers and our team has the skills to listen to people's experiences. We worked in partnership with ICB and LPT colleagues to deliver the focus group sessions.

<u>Bangladeshi men share their experiences</u>

From December 2023 to April 2024, Healthwatch conducted ten in-depth Coffee, Chai and Chat group sessions with six different groups and organisations in Leicester and Leicestershire.

Healthwatch collaborated with the Greater Sylhet Welfare Council UK (GSC) and the Diabetes Self-Help Group to deliver two focus group sessions to Bangladeshi men to raise awareness of Health and Social Care Services and gather feedback on what matters to them regarding these services, both positive and negative.

The participants in these sessions were primarily Bangladeshi men who had relocated from Italy to the UK. We identified several concerns and areas for improvement as most were unaware of the local NHS services available to them. This group faces multiple challenges, including low income and unemployment, poor housing conditions, social isolation and loneliness, mental health issues and language barriers.

As a result of what people shared, the focus group sessions have resulted in:

- Raising awareness among the men about the health and social care services available to them.
- The concerns and feedback collected are being shared with the local healthcare system to advocate for more inclusive and responsive services.
- The collaboration with GSC and the Self-Help Diabetic Group helped build trust within the community, encouraging more open and honest communication.

"The Chai, coffee and chat session gave our members a chance to voice their opinions and concerns about Health and Social Care Services. They were able to communicate confidently in their mother tongue and express their feelings. They felt that they were listened to while taking feedback. Diabetes Self-Help Group members found the session very useful and would like to stay in contact." Dr Sonal Bhavsar, Diabetes Self-Help Group.

Healthwatch will continue to fulfil their role in independently representing the views of the local population. Healthwatch publish outcomes from all of their engagement work, as well as their future planned activity on the Healthwatch Leicester and Healthwatch Leicestershire website – www.healthwatchll.com

Multi-morbidity focus groups

A collaborative project between Leicester City Council's Public Health team, two PCNs and four local VCSE organisations took place across winter 2023 and spring 2024 to engage with patients experiencing multi-morbidity using a focus groups approach. The aim of the project was to better understand patient experiences of living with multi-morbidity, self-care, and professional support with a view to considering how current and future services could be shaped to meet the needs of this patient group. The focus groups generated a range of valuable insights which enabled recommendations to be developed, collaboratively, for action. These will begin to be worked on during summer 2024 as part of an integrated neighbourhood team working approach. A wider benefit of this work was the valuable relationships the VCSE organisations were able to build with people who attended the focus groups, encouraging attendance at the activities offered by said organisations, and helping to reduce social isolation which patients expressed that they were experiencing.

24 participants were engaged with across four focus groups (in 3 different areas). There were 10 recommendations for further action which aligned with the overarching themes which emerged from the focus groups. An example is "Use asset-based approaches to raise awareness of existing local groups and offers in the community that could help alleviate isolation. This could involve working with, and leveraging, existing networks such as community organisations and pharmacy networks." In terms of actions, one of the PCNs involved is exploring how they currently work with community pharmacies and where there is scope to further strengthen this to support some of the needs identified through this project.

Looking Forward

The Health and Wellbeing Board intents to continue working on its primary aim of achieving better health, care and wellbeing outcomes for Leicester's population and a better quality of care for patients and other people using health and social services. The Joint Health Care and Wellbeing Strategy has been pivotal in establishing the business-as-usual priorities of the Board. The strategy will be reviewed in the upcoming years as a refresh will be necessary prior to its expiry in 2027.

The 19 priorities listed in the current strategy will be monitored by the Board annually as per this report. Furthermore, four new priorities have been established through development sessions with the Board. These are:

- Childhood immunisations
- Hypertension- prevention and case finding
- Mental health and wellbeing related to social inclusion, and supportive networks
- Healthy weight management

The Board will receive periodic updates on the progress of the four priorities listed. The priorities will be assigned to operational groups to ensure there is scope and accountability for progress.

The governance of the subgroups for the Health and Wellbeing Board is intended to change with a new Board being established in place of ISoC and JICB. This new subgroup, identified as 'Leicester Integrated Health and Care Group' will be reporting into the Health and Wellbeing Board accordingly.

The HWB intends to continue partnership working and strengthen community engagement. This is done through maintaining a diverse membership within the Board itself and through also promoting community engagement as well as participation of people with live experience, in the development of services. This is done through the subgroups of the HWB and partners such as Healthwatch and Community Wellbeing Champions.

The Chair of the Board together with responsible officers will shape and develop the agenda for Board meetings going forward. In the period August 2023-August 2024 six HWB meetings were held. This is to reduce to four meetings per year. The conditions for the meetings will remain the same with the papers and recordings uploaded onto our website. A robust forward plan is being maintained to ensure that the most relevant and influential topics are being brought forward to the meetings. Where further exploration of a topic is required, a development session can be undertaken at the request of the Chair, as was done previously with the delivery plan redesign.

The Board will continue to adopt a proportionate universalism approach to ensure that fair focus is able to be given to the issues which have the greatest impact on people's ability to remain in good health and wellbeing for as long as possible. To support this, a number of JSNA chapters are either in development or planned outlining key health and wellbeing issues affecting city residents.

Appendix 1: Glossary and links to further information

Anti-Poverty - Anti-poverty strategy (leicester.gov.uk)

Better Care Fund (BCF) – Supports local systems to deliver the integration of health and social care through collaborating with the Department of Health, Ministry of Housing Communities and Local Government, NHS England and Improvement, and the local government association. NHS England » Better Care Fund

Clinical Commissioning Groups (CCG's) – CCG's were clinically-led statutory NHS bodies who held responsibility for planning and commissioning of healthcare services in their local area. They were replaced by Integrated Care Systems in July 2022.

Core20PLUS5 – NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

Development sessions (of the Health and Wellbeing Board) – Development sessions are opportunities for members of the Health and Wellbeing Board and, where appropriate, wider partners to come together to consider an issue in detail before bringing to a formal board meeting. They are not held in public.

Do, sponsor, watch – An approach to addressing the priorities set out in the Joint Local Health and Wellbeing Strategy which recognises that the same level of resource and effort cannot be focussed on all 19 priorities simultaneously. This approach gives more intensive focus on a small number of 'Do' priorities (those agreed by the Health and Wellbeing Board as the most important to progress in initial years), whilst ensuring some level of focus on *all* priorities identified, with opportunity for any risk to progress of 'sponsor' and 'watch' priorities to be escalated through reporting to place-based groups.

Equity – this means "fairness" – in health and wellbeing it means that in order to achieve good outcomes for everyone recognising that not everyone is starting from the same place, and that adjustments need to be made to ensure that everyone can achieve their full potential for good health and wellbeing. We sometimes use the term **health equity**, which means the absence of unfair, avoidable, or remediable differences in health among population groups defined socially, economically, demographically, or geographically.

Fuel Poverty – a household is considered to be experiencing fuel poverty when they spend 10% or more of their income on energy. More information can be found at What is fuel poverty? - National Energy Action (NEA)

Health and Social Care Act 2012 – The Health and Social Care Act 2012 introduced a number of reforms to the NHS including the establishment of Health and Wellbeing Boards to bring together partners from across health and social care services to plan how to meet the health and care needs of their local populations.

Health and Wellbeing Board meetings – Health and Wellbeing Board (leicester.gov.uk)

Health inequalities – health inequalities are the unfair, avoidable and systematic differences in health and wellbeing between different populations or groups.

Healthwatch Leicester and Healthwatch Leicestershire - An independent watchdog which aims to make local health and social care services better for people by ensuring that their views and experiences are considered by those entrusted to design and run services. It is independent of the CQC/ NHS and is ran by and for local people. They have a statutory place on local Health and Wellbeing Boards and have the authority to enter and view health and social care services using their trained volunteers. HealthwatchLL - Healthwatch LL

Integrated Care Systems (ICS's) – Integrated Care Systems were established in 2022. They are Partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners. They collectively plan health and care services to meet the needs of their population. In the LLR region this is currently a system partnership between the three statutory organisations with their respective legislative roles. More information about how ICS's are structured and operate can be found at NHS England » What are integrated care systems?

Joint Local Health and Wellbeing Strategy (JLHWS)– Leicester's Care, Health and Wellbeing Strategy 2022-2027

Joint Strategic Needs Assessment/Joint Specific Needs Assessment (JSNA/JSpNA) – Analyse the health needs of populations. The purpose of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages. It should be viewed as a continuous process of strategic assessment and planning with the aim to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Joint Strategic Needs Assessment (leicester.gov.uk)

Learning Disability Partnership Board (LDPB) - Learning Disability Partnership Board (leicester.gov.uk)

Leicester City Joint Integrated Commissioning Strategy for Adult Mental Health 2021-25 - Mental Health BOOKLET8a (leicester.gov.uk)

Meetings held in public – these are meetings which members of the public are able to attend and observe. Members are the public are not permitted to join in any discussions at Health and Wellbeing Board meetings but are allowed to submit questions in advance of the meeting in line with statutory guidance, which will be asked and discussed during the meeting.

Person-centred care – this means making sure care is focussed on the needs of the individual.

Place-based/Place/System (and neighbourhood) – System, Place and Neighbourhood refer to geographical areas. **System** covers populations of around 500,000 – 3 million. In this report System means Leicester, Leicestershire and Rutland. **Place** covers populations of around 250,000-500,000. In this report, Place means Leicester city). **Neighbourhoods** cover smaller populations of around 30,000 to 50,000 people. In this report **Place-based** means thinking about the local need for Leicester. **Place-based** partnerships bring together a broad range of partners including local government, NHS providers, voluntary/community sector organisations, social care providers and others in order to integrate the planning and delivery of services through a multi-agency approach and address the social, economic and wider health needs of their population.

Pharmaceutical Needs Assessment (PNA) – A legal requirement for Health and Wellbeing Boards to produce every three years. It is a statement of needs from pharmacy services in the local area and is designed to ensure provision of local pharmaceutical services is effective for the needs of the local population. It can be used to direct commissioning decisions by CCGs and help NHS England in regulating new and existing pharmaceutical practice. Pharmaceutical Needs Assessment (PNA) (leicester.gov.uk)

Appendix 2 Full list of Health and Wellbeing Board meetings since September 2023

Meeting	Item	Description
21 September	Joint Health, Care and Wellbeing Delivery Plan progress update – February – July 2023	This update reflected progress highlights, next steps, and key risks against the six 'do' priorities outlined in the strategy which were selected, through a public consultation, for initial focus, and for which a full action plan has been developed to run from 2023-2025.
21 September	Acute CURE Tobacco Dependency Evaluation	Update on the delivery and progress of the Acute CURE Tobacco Dependency Service delivered across the University Hospitals of Leicester as part of the NHS Long Term Plan Prevention agenda for Tobacco Dependency. This programme requires joint efforts across the system to effectively address high smoking rates in Leicester.
21 September	Meeting the needs of Complex People	An update on positive progress since the original presentation in January 2023 to the Board that set out the significant health and service challenges of meeting the complex needs of people experiencing homelessness.
23 November	Winter Planning Update	Summarise planning to manage Winter pressures across LLR in 2023/ 2024 and provide an update on the COVID-19 and flu vaccination programme for the eligible population residents within Leicester, Leicestershire and Rutland.
23 November	Primary Care Capacity Planning over winter period	Overview of the NHSE Primary Care Recovery Plan (PCARP) and the commitments to patients therein, and provide assurance to Board that, through the development and implementation of LLR ICB's "System-level Access Improvement Plan", (SLAIP),
23 November	Vaccinations & Immunisations	An overview of the performance of the 2023/34 Covid-19 and flu vaccination programme covering the City of Leicester. An update on the new approach to shingles vaccination Measles NHSE as commissioners and transition to systems by 2025/26.

23 November	Winter Planning – Adult Social Care	Summary of the actions in place locally to support a resilient social care system that is able to provide people and their carers with the support they will get this Winter.
23 November	Public Health Initiatives and Winter Plans	Programmes and initiatives outlined to address critical winter issues. This ranged from health impacts of cold weather to food poverty etc.
18 January	Leicester Mammas HWB Update	Overview of the Leicester Mammas Service: Leicester Mammas is a city based First 1001 Critical Days organisation, that provides breastfeeding support to families across the city, with a focus on those experiencing any vulnerabilities or living in areas of social deprivation.
18 January	Community Wellbeing Champions Project	Introduction of the work by Community Wellbeing Champions (CWC) Project, which was set up by Public Health in light of Covid-19 to support community engagement efforts in relation to the pandemic and wider health and wellbeing needs.
18 January	Healthwatch LLR: Together: We are making care better report	An introduction into Healthwatch and an update of the work undertaken recently and plans for the upcoming year. Some exploration of where HWB can support and where engagement may be valuable in terms of the HWB strategy.
18 January	Active Leicester Strategy – Turning the Tide on Inactivity	A presentation on the Active Leicester Strategy, which was published in summer 2023. In response to the strategy action plan, the report will also shine a light on Active Leicester's response to the strategy, with a pilot approach that is being adopted at Aylestone Leisure centre.
18 January	Better Care Fund Q2 Update	Overview of BCF, its background and how it is currently managed. Position of BCF at Q2 is highlighted with some examples of achievements, challenges and case studies given.
18 January	AOB item St Johns Ambulance	Overview of St Johns ambulance which provides First Aid service for the Evening and Night Time Economy. Match funded by BID Leicester and OPCC / Community Safety Partnership.
7th March	Cardiovascular JSNA	The Joint Strategic Needs Assessment of Cardiovascular disease providing information on risk factors, impact on Leicester's population, current services, service gaps and recommendations
7th March	Tobacco Smoking Control JSNA	The Joint Strategic Needs Assessment of Tobacco Smoking provides a report of the risk factors associated with smoking, impact of tobacco smoking in Leicester, current services, service gaps and recommendations.
7th March	Tobacco Control Strategy	Presentation of the Tobacco Control Strategy. This strategy seeks to build on the local progress resulting from the previous 2020-2022 strategy by continuing to identify the need for ongoing tobacco control within Leicester City. Our vision is to achieve "A smoke free Leicester – to make Leicester smoke free by 2030".
7th March	Live Well	Overview of Live Well service and local population needs.

7th March	Early Detection of Heart Disease	This paper is a response to the request to update the H&WB about detection and management of Heart Disease in Leicester City. The paper provides brief overview of the profile of Cardiovascular Disease across LLR and summarises some of the initiatives being delivered by the ICB's Long Term Conditions team, with the focus on CVD in Leicester City.
7th March	Leicestershire's Targeted Lung Health Checks Programme Overview	The Targeted Lung Health Check (TLHC) Project is a new service offered to those aged 55 to 74 who are at a greater risk of developing lung cancer. The report provides an overview of the project and its outcomes thus far.
7th March	UHL's Prevention Report	The report aims to provide stakeholders an overview of UHL's progress in prevention and how this is being rooted into services. As well as summarise measures used by UHL to address health inequalities, detail the implementation of the MECC across the Trust and prepare recommendations for next steps.
18th April	Joint Care Health Wellbeing Strategy Delivery Plan Monitoring Update	Update of the delivery plan discussing strategy progress.
18th April	Making Every Contact Count	Presentation around using MECC as a means of upskilling the health and care workforces (and voluntary sector) in encouraging people to make positive changes to their health and wellbeing to prevent ill-health.
18th April	Learning Disability Programme Board Update: Learning Disability Big Plan (Strategy)	Background and context of the Learning Disability Board, focus on the 'Learning Disability Big Plan (strategy)' update.
18th April	Better Care Fund Q3 Update	Position at Q3
27th June	Sexual health needs assessment	Presenting recent findings and data from the review of local sexual health needs.
27th June	Recommissioning of sexual health services	A review of the process of recommissioning of sexual health services in Leicester and a review of a recent consultation exercise.
27th June	Tuberculosis in Leicester	A summary of the picture of Tuberculosis in Leicester and actions being taken.
27th June	Health and Wellbeing Board's Annual Report	A summary of the work of the Health and Wellbeing Board from January 2022 to July 2023.
27th June	Addressing racial disparities in maternal outcomes for the population of Leicester, Leicestershire and Rutland (LLR) -	This report intentionally focuses on key themes that should underpin work to address maternal inequalities, particularly for Black women and birthing people.

27th June	Black Mental Health and Me Report	Leicester City Council Division of Public Health worked with African Heritage Alliance to support an initiative to explore key areas related to black mental health in Leicester. The report is an overview of this.

HEALTH AND WELLBEING BOARD

Annual Report August 2023-24

Diana Humphries– Programme Manager, Health and Wellbeing Board

ANNUAL REPORT PURPOSE

Requirement outlined in our terms of reference to ensure public accountability

Progress against Health and Wellbeing Board's statutory duties

Health Care and Wellbeing Strategy Delivery Plan Updates	Case studies	Updates around the Better Care Fund	Updates from the subgroups of the Health and Wellbeing Board	Proposal for the next 12 months

REPORT HIGHLIGHTS

Joint Strategic Needs Assessments

- Mental Health
- Living in Leicester Dementia
- Tobacco Use
- Healthy Weight
- Physical Activity
- Cardiovascular disease
- Adult social care
- Gambling

Stakeholder Engagement

- Community Wellbeing Champions
- Healthwatch
- Multi morbidity focus group

Better Care Fund Spend

A range of core services supported such as the Integrated Crisis Response Service and Care navigators.

A portion of the fund was used to support smaller scale place-based services:

- Leicester Mammas
- Dear Albert
- The Centre project
- Eye Clinical Liaison Service

Updates from our subgroups

- Integrated Systems of Care
- Joint Integrated Commissioning Board
- Learning Disability Partnership Board
- Mental Health Partnership Board
- Leicester Integrated Health and Care Group

DELIVERY PLAN HIGHLIGHTS

Priority	Achievement	
HEALTHY PLACES Making Leicester the healthiest possible environment in which to live & work	Boosted the use of social prescribing and non-clinical workforce, as well as healthcare professionals to direct patients to appropriate specialist support or to directly provide management of conditions. This has been achieved through the Additional Roles Reimbursement Scheme.	
HEALTHY START Giving Leicester's children the best start in life.	Relaunched the Peer Support Programme to offer additional support to women and act as their advocate in experiencing perinatal mental health conditions.	
HEALTHY LIVES Encouraging people to make sustainable and healthy lifestyle choices	Produced a video around cervical screening for patients with Learning Disability and another video focusing on Human Papilloma Virus (HPV) for the general population	
HEALTHY MINDS Promoting positive mental health within Leicester across the life course	Delivered some Community Chill Out Zone workshops to support mental health and wellbeing of children and young people.	Continued to support Neighbourhood Mental Health Cafés which are delivered by local VCS organisations in order to adapt to local needs
HEALTHY AGEING Enabling Leicester's residents to age comfortably & confidently	Remodelled the Leicester, Leicestershire & Rutland Discharge to Assess Pathway 1 to increase reablement capacity in an attempt to increase the numbers of older people who return to their usual home following a period of time in hospital	

NEXT STEPS

- In the coming year, the Health and Wellbeing Board is focused on four priorities:

- Childhood immunisations
- Hypertension - prevention and case finding
- Mental health and wellbeing related to social inclusion and supportive networks
- Healthy weight

QUESTIONS?