Leicester Health and Wellbeing Board - Delivery Action Plan and Tracker 2023 - 2025 (Oct 2022)

1. Purpose of this Document

This Delivery Action Plan (DAP) document shares the Leicester Health and Wellbeing Board delivery priorities and corresponding actions that will be collectively focussed on initially for 2023-2025 . This plan has been informed by the views of Leicester people, local staff, partnership groups and health and care commissioners through various channels over the last 12-18 months. This plan includes our commitments to engaging and involving the local populations as part of a continual journey that will support planning, delivery and aid Health and Wellbeing Board decision making.

This document aims to give stakeholder visibility around the high priority actions identified during the development of the Leicester Joint Health and Wellbeing Strategy 2022-2027 . It provides a single focused strategic partnership portfolio overview with detail of the actions we will deliver to make improvement. It also includes key measures to enable us to check if we are seeing improvement through our collective efforts and includes information to help us to keep track of progress in one place.

2. Our Guiding Principles for Delivery

1. Help reduce health inequalities (key focus on Core20Plus5)	1a. Multi-agency/partnership working	1b. Strengthen collaborative/ integrated working between organisations/services	1c. Proportionate universalism
Building upon LLR HI framework with targeted interventions for the most deprived 20% noting deprivation prevalence in the City. Early intervention on the primary determinants of ill health – not necessarily starting with services by default.	*Continue Strategic partnership approach to collectively plan and commission care and services across the City Place*	*Ensure continued cohesive and coordinated approach at an Operational level*	*Allocate healthcare resources on a sliding scale; based on deprivation and need, with those with the greatest need provided with a greater share of resources.*

2. Improve equity of access (and experience) to services	3. Address unwarranted variation within the city and/or against the England average	4. Communicating and Engaging with people on the actions	5. Involvement of the voluntary community sectors and communities
Actions will be grounded in our collective efforts to address the inverse care law. "Peddle fastest for those in greatest need."	*Key to driving change and demonstrating tangible improvements in outcomes.*	*Building upon success of vaccination programme, harnessing community power and supporting citizen empowerment and education (health literacy). Exploring elements of plan which could be co-designed and re-reviewed where possible and appropriate.*	*Drawing upon expertise and experience of VCSE to support principle 4, utilising co-design and co-production methodology.*

3. Partnership Delivery Governance

It is anticipated that groups such as the Leicester Integrated Systems of Care (ISOC) partnership group will be a primary recipient / user of the detailed information contained within this document. This action plan will be a key partnership tool to enable all partners to see which activities are the highest priorities for Leicester's Health and Wellbeing Board, how these are progressing and support escalation of risks/issues during delivery for timeline mitigation. The tool will also provide ongoing opportunity for stakeholders/partners to reflect, using the guiding principles, on where their contributions can help deliver the aims of the partnership.

It is important to note that some of the actions within this tool have direct links to longer term major NHS strategic priorities for Leicester, Leicestershire, and Rutland (LLR) ICS. It has dependencies on other complex organisational partners and/or national programmes requiring closer working with local and national partners at all levels and our communities to ensure we successfully deliver this plan for the people of Leicester.

4. Guidance on RAG Status for partnership Delivery Leads:

Overall	What is overall status of Action / Project to deliver as per plan?
	Progressing as Planned nothing to escalate
	Progressing as planned but some challenges with risks or issues/Timeline / Finance that can or are being resolved
	Challenges / risks or issues that cant be resolved and require escalation as will not deliver as planned

Risk	What is the lowest rated risk for your Action / Project?
	Low Risk to delivery against plan
	Medium Risk to delivery against plan
	High Risk to delivery against plan

Improvement Trajectory	What is the status against the overall trajectory of improvement?
	There is evidence that this is heading in the right direction of travel and it is on track to make improvement from baseline
	There is some evidence of improvement but it is not yet clear to see through dashboard reporting mechanisms
	There is a risk to making improvement against the baseline as there is no evident improvement

Healthy Places: We will improve access to primary and community health and care services

AMBITION	WE WILL	BY	I WILL
To make Leicester the healthiest possible environment in which to live and work	**1. Develop integrated neighbourhood teams that work in a coordinated way with partners at a local level improving Primary Care**	Develop an agreed approach with our partners to align local integrated delivery models (INTs) with Primary Care in the community	I will receive the right support at the right time, at the right place from the right professional (s) to meet my health and care needs
		Recruit Additional Roles in Primary Care and develop these to optimise access for people in most need	
		Develop and optimise the use of Social Prescribing and other ARRS workforce in Leicester	
		Put in place the appropriate infrastructure and support for all neighbourhood teams through clinical and estate strategies for each PCN in Leicester and availability of Digital kit and digital services	
		Roll-out carer awareness training to staff working in INT's to ensure carers are identified, registered with GP's and signposted to sources of support	
	2. Enabling people to improve their literacy of local technology solutions	Explore and scope future opportunities to help people to learn and develop digital literacy through support from Leicester Adults Skills and Learning Group and Leicester practices	I will have the opportunity to use Digital technology equipment and services that are being locally offered to enable me to stay healthy and well
		Develop an Outreach approach to local communities to enable Digital Fluency/Literacy and Health literacy in using Health Technology (BPM for Hypertension)	
		Develop resources inc. Short videos in various languages to educate patient's around active sign posting and one stop shop approach	
		Run workshops/seminars to train communities such as the VCSE, community champions, social prescribers and Carers to learn about pathways and associated technology (Focus on Hypertension, Blood Pressure Monitoring and NHS App)	
	3. Deliver enhanced access in Primary Care	Increase health checks for people on our learning disability register	I will have the opportunity to receive the Health and Care that I need when I need it so that I can stay healthy and well
		Increase recording of ethnicity data in Primary Care Systems	
		Tackle unmet needs of specific populations at a Neighbourhood level	
		Identify further cohorts of unregistered residents (inc. family Carers) of Leicester and enable their registration with local GPs (Is there any localities) - Belgrave and Highfields	
		Ensure parity of access to services 6:30pm – 8:30pm and 9-5 Sat through each PCN delivering , we will feedback the findings of this into the development of INTs	
	4. Undertake a review of our current urgent care services for people in Leicester with minor injuries and illnesses	Review and define options of clinical model of Urgent Care at LRI and Merlyn Vaz (In and Out of Hours)	I will have access to the Urgent Care services I need to enable me to stay out of hospital and remain in the community
		Develop and seek agreement of Business Case with options for all LLR UTCs	
		Agreed Operational commissioning of LLR UEC services including offer at Merlyn Vaz and Leicester Royal Infirmary	

Healthy Minds (CYP): We will improve acess for children & young people to Mental Health & emotional wellbeing services

AMBITION	WE WILL	BY	I WILL
To promote positive mental health across the life course	**1. Develop a communication plan and clear map of Emotional Health and Wellbeing Service services for promoting access including the digital offer for schools, CYP and their families (inc. Family Carer)**	Explore options through development of a Business Case and obtain agreement of preferred option to implement and commission	TBC
		Promote EHW support and services available to CYP via school MHST's (whole school approach with low referrals schools)	TBC
	2. Focus city based CYP MH projects to areas of lowest uptake and high deprivation	Commission and Implement the plan Inc. actions for MHST	TBC
		Identify areas of low referral into MH services and increase the community services in the area to reach out	TBC
		Identify information needed to develop the demographic metric, ensure providers are submitting and develop this to demonstrate improvement on inequality	TBC
	3. Promote existing MH services to Primary Care Network and key children's workforce	Identify which GP practices and other workforces have low number of referrals to CYP mental health services in the city from the demographic matrix	TBC
		Target and support number of GP Practices by mental health practitioners offering advice, outreach and drop-in sessions	TBC
		Increase new roles in PCN with support of ARRS by be embedded as part of multi-disciplinary team	TBC

Healthy Minds (Adults): We will improve access to primary & neighbourhood level Mental Health services for adults.

AMBITION	WE WILL	BY	I WILL
To promote positive mental health across the life course	**1. Delivering increased Mental health focused voluntary sector offers**	Review and award grants for Getting Help in Neighbourhood round 2	TBC
		Review and award grants for Crisis café bids for City	TBC
	2. Tailor the workforce to local need in neighbourhoods	Launch recommissioned mental health and wellbeing services (10/22)	TBC
		Agreement on recruitment plan for City PCNs for 22/23 ARRS mental health workers	TBC
		Recruitment against 22/23 ARRS scheme completed	TBC
		Develop proposal for initial city neighbourhood mental health workforce reconfiguration from profiles	TBC
		Agree proposal and implementation plan	TBC
	3. Increase MH leadership and coordination through development of new ways of working	Set up project team and allocate resources for innovation site in south Leicester neighbourhood	TBC
		Evaluation of 13-week innovation site and establishing plan for other city neighbourhoods (????)	TBC
	4. Expand psychological offers in Leicester	Expansion of IAPT offer	TBC
		Develop Proposal Inc. implementation plan for expanding wider psychological offer to neighbourhoods	TBC

Healthy Lives: We will increase early detection of heart & lung diseases and Cancer in adults.

AMBITION	WE WILL	BY	I WILL
To encourage people to make sustainable and healthy lifestyle choices	**1. Implement a proactive care at home framework focussing on Hypertension**	Strengthen the use of the Community Pharmacy Hypertension Case-finding Service	TBC
		Explore the use of BP 'arm-machines" in practices identified as struggling with prevalence	TBC
		Recruit and develop LTC Champions to improve practice processes and reduce variation in Hypertension management/case-finding	TBC
		Enable Shamia Women's Centre, South Asian Health Action community delivery partners to be able to encourage better case finding in key City communities	TBC
		Work with Leicester City Council to support them in increasing the number of NHS Health Checks completed	TBC
		Implement the MECC Standard Operating Procedure for Blood Pressure checking in COVID-19 vaccination centres	TBC
	2. Increase early diagnosis in Cancer pathways through early detection and follow-on pathway developments	Review of prostate cancer identification in BAME groups with recommendations for improvement. Target men with familial history <60 and black men through targeted case findings and supported through the PCN Cancer DES	TBC
		Continuation in participation of the NHS Galleri clinical trial. Utilising opportunities to expand the trial where possible and indicated nationally	TBC
		Implementation of the Targeted Lung Health checks within LLR and primarily within the City. Notts is due to go live shortly with LLR the next priority site. This will be run in collaboration with the smoking cessation work by the LCC	TBC
		Improve colorectal cancer detection at early stage. Implementing the use of FIT as a diagnostic tool and with all 2WW to over 18 years (NICE requirements over 40).	TBC
		Targeted project within LC and in particular LE4 to increase the 1 year survival rate. Reduction of the screening age to 56 will be rolled out across LLR by the national programme.	TBC
		Review and agreed approach to identify patients at high risk of cancer in City – PCN Pilots targeted case finding	TBC
		Development of VCS HI connectors delivery plans with ongoing local monitoring (x3)	TBC
	3. Increase uptake of cervical screening	LD Screening programme being undertaken led by National Screening team	TBC
		Transformation within next 12 months to include self-testing HPV as piloted in London and risk stratified recall.	TBC
		Review of DNAs for Screening with PM to inform	TBC
		Pilot at PCN level using video texting to target patients who have not attended smears and appointments were provided outside of the core hours	TBC

Healthy Ageing: 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

AMBITION	WE WILL	BY	I WILL
To enable Leicester residents to age comfortably and confidently	**1. Create fully operational Integrated Neighbourhood Teams, focusing on Multi-Disciplinary Teams using anticipatory approaches with older people who may be at risk**	Making every contact count	TBC
		Develop a framework for local delivery of anticipatory care focusing on the role out of the MDT facilitator at PCN level	TBC
	2. Continue to develop MyChoice so that it is kept up to date with local VCS preventative services and community assets to reduce loneliness and isolation	Enable people who use MyChoice to have an easy way of feeding back their experiences of using it to inform improvements and work programme of steering group	TBC
		Work to improve useability so that people and professionals such as social prescribers have a positive experience and find what they are interested in	TBC
		a) Include personal assistants on MyChoice b) Develop 'social prescribing' add on to MyChoice which will encourage people to contact support agencies directly without a need for 'professional referral' c)As community connector programme develops, ensure services and groups set up to tackle isolation and loneliness feature on MyChoice	TBC
	3.Commission a range of services and opportunities that provide an alternative to residential care that support older people to self -care, build on strengths and reduce frailty wherever possible	Community Opportunities and short breaks	TBC
		Dementia Support Service	TBC
		Short term residential beds & D2A Pathway 2 review	TBC
		Homecare – new contracts to be in place 2024	TBC
		Hospital Bridging Service	TBC
		Respite review	TBC
		Supported living arrangements for older people	TBC
		Carer support services	TBC
	4.Delivery high quality Home-first services that are integrated, responsive and meet the Ageing Well ambition	LLR D2A P1 remodelling work to increase reablement capacity	TBC
		Continue to roll out Phase 2 of the ICRS EoL pilot !! 1.BLR D2A P1 remodelling work to increase reablement capacity 2.Continue to roll out Phase 2 of the ICRS EoL pilot Deliver and fully evaluate the ICRS Night Support Service offer	TBC

Healthy Start: We will mitigate against the impacts of poverty on children and young people.

AMBITION	WE WILL	BY	I WILL
To give Leicester's children the best start in life	**1. Tackling Poverty in Leicester**	Establishing an Anti-poverty partner network	TBC
		Anti-poverty board progress checks	TBC
	Set out actions and intentions for each themes in the framework: •Homes, furniture and utilities •Food and Clothing •Money debt and advice •Childcare & Schools •Jobs, skills & Transport •Health & wellbeing •Community	Review progress of intentions associated with the framework	TBC
		Monitor partner network activity and impact, and in areas most in need.	TBC
	3. Offer the Anti-poverty community grants scheme to more organisations	Grants of offered for local groups and organisations to develop and run projects that mitigate the impacts of poverty for residents across Leicester	TBC
	4. Deliver the Maternity and Neonates Equity and Quality Co produced action plans with a focus on the most deprived areas / most vulnerable/complex groups	Relaunch Peer Support Programme to support women and act as their advocate in perinatal mental health initially	TBC
		Expand the Stork Project for rollout to GP / Obstetrics / Health Visitors in Leicester and also offer Preconception education, support, and signposting through rolling out school education programmes, timing of pregnancy, smoking /drugs in pregnancy and breastfeeding	TBC
		To agree/develop how local Maternity services in Leicester can integrate with Family Hub "One Stop Shop" model developments	TBC
		Task and finish group commenced to look at Improving Maternity Access and Experience for Women from BAME Community	TBC

Healthy Places: We will improve access to primary and community health and care services

Ref	WE WILL	Delivery Stage	How will this demonstrate improvement?	No	Key Activities / Deliverables / Milestones	Will activities improve/increase equity at a local level? (Y/N)	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue RAG	Improvement Trajectory RAG
1	Develop integrated neighbourhood teams to work in a more coordinated way with partners at a local level through enabling the evolution of Primary Care	Delivery	•Reduction in unwarranted variation in access, experience, and outcomes (agree metrics with partners) •Increase referrals to Social Prescribers in areas of most need (Use IIF data to monitor referrals) •Evaluation of the Delivery of PCN Proactive social prescribing plans •Increase in referrals into promoted pathways (e.g. Long Covid, Sickle Cell) •Increase in the numbers of Carer identified and registering with their GP •Increase in the numbers of Carers identified and accessing commissioned services (Which ones?)	1.1	Develop an agreed approach with our partners to develop local integrated delivery models (INTs) with Primary Care in the community (East / West config??)	Y	Y (Existing)	Promotion of Social Prescribing and ARRS pathways to Leicester City PCNs	Primary Care Transformation Board	ICB/PCN (LA, LLR Leadership Academy, LPT CHS)	2023 - 2025	Mayur Patel / Jeremy Bennett	Green	Green	Green	Green
				1.2	Recruit Additional Roles in Primary Care and develop these to optimise access for people in most need											
				1.3	Develop and optimise the use of Social Prescribing and other ARRS workforce in Leicester											
				1.4	Put in place the appropriate infrastructure and support for all neighbourhood teams through clinical and estate strategies for each PCN in Leicester and availability of Digital kit and digital services											
				1.5	Roll out carer awareness training to staff working in INT's to ensure carers are identified, registered with GP's and signposted to sources of support											
2	Empower citizens to use technology where appropriate by enabling people to improve their literacy of local technology	Delivery	•Bring parity to Leicester residents for opportunity to access NHS App services through enabling an increase in registrations •Increase in use of Digital services •Patient feedback on use of Digital Services	2.1	Explore and scope future opportunities to help people to learn and develop digital literacy through support from Leicester Adults Skills and Learning Group and Leicester practices	Y	N		Primary Care Transformation Board	ICS (ICB,LA,VCS, PCNs)		???	**Not Started**	**Not Started**	**Not Started**	**Not Started**
				2.2	Develop an Outreach approach to local communities to enable Digital Fluency/Literacy and Health literacy in using Health Technology (BPM for Hypertension)											
				2.3	Develop resources Inc. Short videos in various languages to educate patient's around active sign posting and one stop shop approach											
				2.4	Run workshops/seminars to train communities such as the VCSE, community champions, social prescribers and Carers to learn about pathways and associated technology (Focus on Hypertension, Blood Pressure Monitoring and NHS App)											
3	Deliver the enhanced access in Primary Care	Delivery	•Evaluation of Hours of DES Delivery •Increase in Same day appointment (%) from overall •Increase in registered GP population in most deprived areas •No of hours-of-service enhanced access for PCNs	3.1	Increase health checks for people on our learning disability register	Y	Y (Existing)			PCN		Mayur Patel	Green	Green	Green	Green
				3.2	Increase recording of ethnicity data in Primary Care Systems											
				3.3	Tackle unmet needs of specific populations at a Neighbourhood level											
				3.4	Identify further cohorts of unregistered residents (Inc. family Carers) of Leicester and enable their registration with local GPs (Is there any localities) - Belgrave and Highfields											
				3.5	Ensure parity of access to services 6:30pm – 8:30pm and 9-5 Sat through each PCN delivering , we will feedback the findings of this into the development of INTs											
4	4. Undertake a strategic review of urgent care services for patients with minor injuries and illnesses (which will incorporate the Urgent Treatment Centres in Leicester (Merlyn Vaz and at Leicester Royal Infirmary)	Feasibility	Reduced ED Attendance and admissions of Leicester Residents 0-1 LOS impact metric (more so than reduced ED) Increase in positive Leicester resident feedback on experiences of access to UEC services	4.1	Review and define options of clinical model of Urgent Care at LRI and Merlyn Vaz (In and Out of Hours) (Dec 22)	Y	Y (Existing)	Formal Public Consultation Spring 23	LLR Access Strategic Review Group	ICB (DHU, PCNs,UHL)		Sarah Smith / Alex ?	Green	Green	Green	Green
				4.2	Develop and seek agreement of Business Case with options for all LLR UTCs (Apr 23)											
				4.3	Agreed Operational commissioning of LLR UEC services including offer at Merlyn Vaz and Leicester Royal Infirmary (Sept 24)											

Healthy Minds: We will improve access for children & young people to Mental Health & emotional wellbeing services

Ref	WE WILL	Delivery Stage	How will this demonstrate improvement?	No	Key Activities / Deliverables / Milestones	Will activities improve/increase equity at a local level? (Y/N)	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue RAG	Improvement Trajectory RAG
1	1. Develop a communication plan and clear map of Emotional Health and Wellbeing Service services for promoting access including the digital offer for schools, CYP and their families (Inc. Family Carer)	Delivery	Reduce prevalence in CYP Increase access to wider community Target uptake in the BAME Communities	1.1	Explore options through development of a Business Case and obtain agreement of preferred option to implement and commission	Y	Y	Undertake consultation and coproduction with young people to explore what works for them.	EHW CYP Delivery Group All Age Mental Health Delivery Group		Mar-23	Justin Hammond/John Edwards				
				1.2	Promote EHW support and services available to CYP via school MHST's (whole school approach with low referrals schools)											
				1.3	Commission and Implement the plan Inc. actions for MHST											
2	Focus city based CYP MH projects to areas of lowest uptake and high deprivation	Delivery	Improve access to CYP in the area of low referral and high deprivation	2.1	Identify areas of low referral into MH services and increase the community services in the area to reach out	Y		Some engagement has already taken place and further work will take place to develop a wide range of communication with CYP and their families group to implement the findings Involvement and engagement of faith and community leaders, faith, community and voluntary organisations resources and then target to promoting positive mental and support available e.g. Outreach project Ensure leaflets and TikTok, other leaflets are available to them	EHW CYP Delivery Group All Age Mental Health Delivery Group		Sep-23	Justin Hammond/John Edwards				
				2.2	Identify information needed to develop the demographic metric, ensure providers are submitting and develop this to demonstrate improvement on inequality											
3	Promote existing MH services to Primary Care Network and key children's workforce	Delivery	Increase local access to services Increased awareness of mental health support and how to access it across Primary care network and children's workforce in the city	3.1	Identify which GP practices and other workforces have low number of referrals to CYP mental health services in the city from the demographic matrix	Y	Y	Some engagement has already taken place and further work will take place to develop a wide range of communication with CYP and their families group to implement the findings Undertake presentation in Primary Care Network group and other workforce around low referrals linked to demographic matrix	EHW CYP Delivery Group All Age Mental Health Delivery Group		Mar-23	Justin Hammond/John Edwards				
				3.2	Target and support number of GP Practices by mental health practitioners offering advice, outreach and drop-in sessions											
				3.3	Increase new roles in PCN with support of ARRS by be embedded as part of multi-disciplinary team											

Healthy Minds (Adults): We will improve access to primary & neighbourhood level Mental Health

Ref	WE WILL	Delivery Stage	How will this demonstrate improvement?	No	Key Activities / Deliverables / Milestones	Will activities improve/increase equity at a local level? (Y/N)	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue RAG	Improvement Trajectory RAG
1	Delivering increased Mental health focused voluntary sector offers	Delivery		1.1	Review and award grants for Getting Help in Neighbourhood round 2	Y	Y (SDF, MHIS and LA (relating to 10% of MH and wellbeing service))		Task and finish group reporting through place based group	ICB		Justin Hammond/John Edwards				
				1.2	Review and award grants for Crisis café bids for City											
				1.3	Launch recommissioned mental health and wellbeing services (10/22)											
2	Tailor the workforce to local need in neighbourhoods	Delivery		2.2	Agreement on recruitment plan for City PCNs for 22/23 ARRS mental health workers	Y	Y (SDF and NHIS and ARRS)	Engagement and review of proposal	Task and Finish Group	ICB		Justin Hammond/John Edwards				
				2.3	Recruitment against 22/23 ARRS scheme completed											
				2.4	Develop proposal for initial city neighbourhood mental health workforce reconfiguration from profiles											
				2.5	Agree proposal and implementation plan											
3	Increase MH leadership and coordination through development of new ways of working	Delivery		3.1	Set up project team and allocate resources for innovation site in south Leicester neighbourhood	Y	Y (SDF and NHIS)		Making it happen task and finish group	Collab		Justin Hammond/John Edwards				
				3.2	Evaluation of 13-week innovation site and establishing plan for other city neighbourhoods (????)											
4	Expand psychological offers in Leicester	Delivery		4.1	Expansion of IAPT offer	Y	Y(MHIS)			ICB	Oct-23	Justin Hammond/John Edwards				
				4.2	Develop Proposal Inc. implementation plan for expanding wider psychological offer to neighbourhoods											
5	Continue to implement the Joint LLR Dementia Strategy which includes people who are diagnosed with early onset dementia (those between the ages of 30-65yrs)	Delivery		5.1	Continue to review and monitor the dementia grants scheme for grass roots organisations to support healthy ageing, brain health, exercise, and nutrition	Y	Y (ASC)		LLR Dementia Programme Board / MH Collaborative	ASC		Kate Galioppi / Bev White				
				5.2	Work to refresh dementia strategy	Y	Y(ASC)	Yes – timeline not yet available	LLR Dementia Programme Board / MH Collaborative	ASC		Kate Galioppi / Bev White				

Ref	WE WILL	Delivery Stage	How will this demonstrate	No	Key Activities / Deliverables / Milestones	Will activities improve/increase	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue RAG	Improvement Trajectory RAG
1	Tackling Poverty in Leicester	Delivery	Anti-poverty framework – tracking as below Anti-poverty partner network	1.1	Co-design of strategy and framework (at series of engagement events with over 500 people.	Y	Y (LCC)	Engagement for strategy development carried out Establishing an Anti-poverty partner network	Anti-poverty board	Leicester City Council with a developing anti-poverty partner network	Ongoing, anti-poverty microsite launched in May 2022					
				1.2	5 strategy objectives were agreed to cover: •Preventing fall into poverty •Crisis interventions •Short/medium term support •Long term infrastructure change •National lobbying											
				1.3	Anti-poverty board progress checks											
2	Set out actions and intentions for each themes in the framework: •Homes, furniture and utilities •Food and Clothing •Money debt and advice •Childcare & Schools •Jobs, skills & Transport •Health & wellbeing •Community	Delivery	There are a series of metrics associated with each of the existing actions and intentions	2.1	Review progress of intentions associated with the framework	Y	Y (LCC and partner network resource)	There are a series of engagement activities associated with each of the existing actions and intentions.	Anti-poverty Board	Leicester City Council with a developing anti-poverty partner network	Update provided at each Anti-poverty Board					
				2.2	Monitor partner network activity and impact, and in areas most in need.											
3	Offer the Anti-poverty community grants scheme to more organisations	Delivery	Assessing impact for each project Tracking of project progress and impact at Anti-poverty Board Assessing impact for each project Tracking of project progress and impact at Anti-poverty Board	3.1	Grants of offered for local groups and organisations to develop and run projects that mitigate the impacts of poverty for residents across Leicester	Y	Y (LCC & partners)	Offer to apply is open across the voluntary, private and public sector in Leicester.	Anti-poverty board	Leicester City Council	Launch of scheme planned for Nov 2022 Award of grants up to £10k in December 2022 Award of grants £10k+ in early 2023					
				3.2	Application rounds will be made to a panel											
4	Deliver the Maternity and Neonates Equity and Quality Co produced action plans with a focus on the most deprived areas / most vulnerable/complex groups	Delivery	Local women's feedback Workforce diversity trajectory Breastfeeding BFI/UNICEF Guidance compliance rates	4.1	Relaunch Peer Support Programme to support women and act as their advocate in perinatal mental health initially	Y	Y (Some existing transformation but new funds may be needed e.g. Family Hubs)	Local Schools Relaunch of MVP will link in with the developments Linking in with Leicester Mammas and Shama Women's Centre	Health Equity Committee / Anti-Poverty	Local Maternity System (H&WB Boards, ICS partnerships, PH, LHknown, LPT, Education	Start 2022 End 2024					
				4.2	Expand the Stork Project for rollout to GP / Obstetrics / Health Visitors in Leicester and also offer Preconception education, support, and signposting through rolling out school education programmes, timing of pregnancy, smoking /drugs in pregnancy and breastfeeding											
				4.3	To agree/develop how local Maternity services in Leicester can integrate with Family Hub "One Stop Shop" model developments											
				4.4	Task and finish group commenced to look at Improving Maternity Access and Experience for Women from BAME Community											

Healthy Lives: Increase early detection of heart & lung diseases and Cancer in adults

Ref	WE WILL	Delivery Stage	How will this demonstrate improvement?	No	Key Activities / Deliverables / Milestones	Will these activities improve/increase equity at a local level? (Y/N)	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue RAG	Improvement Trajectory RAG
1	Implement a proactive care at home framework focussing on Hypertension	Delivery	• Reduction in the number of strokes and heart attacks for City patients • Improved life expectancy at age 65 • Increase in competencies / knowledge in Primary Care • Increased use of Comm Pharmacy HTN service in the City • Reduce the number of high-risk patients with Hypertension • Increase in the % of City Health Checks completed •Progress Reporting of HI Connectors delivery of KPIs	1.1	Strengthen the use of the Community Pharmacy Hypertension Case-finding Service	Y	Y (Existing) e.g. QOF, DES and Core Connectors Project Funding	(Core Connectors) Workshops and core working group with community Delivery Partners Develop links with Community Wellbeing Champions Network (CWC) Promotion of Social Prescribing and ARRS pathways to Leicester City PCNs	Primary Care Transformation Board / LLR Health Equity Committee	ICB/PCNs/Community Delivery Partners	2023 - 2025	Mayur Patel / Jess Lucas	Green	Green	Green	Green
				1.2	Explore the use of BP 'arm-machines' in practices identified as struggling with prevalence											
				1.3	Recruit and develop LTC Champions to improve practice processes and reduce variation in Hypertension management/case-finding											
				1.4	Enable Shama Women's Centre, South Asian Health Action community delivery partners to be able to encourage better finding in key City communities											
				1.5	Work with Leicester City Council to support them in increasing the number of NHS Health Checks completed											
				1.6	Implement the MECC Standard Operating Procedure for Blood Pressure checking in COVID-19 vaccination centres											
2	Increase early diagnosis in Cancer pathways through early detection and follow-on pathway developments	Delivery	•Reduce prevalence in adults? •Increased uptake in South Asian Communities •Reduction in early death from cancer and respiratory diseases (NW and South HNN's) •Increased early-stage cancer diagnosis across key cancers •Progress Reporting of HI Connectors delivery of KPIs	2.1	Review of prostate cancer identification in BAME groups with recommendations for improvement. Target men with familial history <60 and black men through targeted case findings and supported through the PCN Cancer DES	Y	N	Lord Mayors Office meeting with Prostate and Genomics took place on 7/9/22. Focus campaign in March 2023 Work with local communities/ VCS to understand barriers to uptake Core20PLUS Cultural: Engagement with ethnic minority community organisations in the most deprived areas	Primary Care Transformation Board Cancer Transformation Group	ICS (ICB,LA,VCS, PCNs)	22/23 with review in line with ICB priorities to confirm 23/24	Vivek Varakantam/Pawan Randev/Helen Mather/Matt Archer	Amber	Amber	Amber	Amber
				2.2	Continuation in participation of the NHS Galleri clinical trial. Utilising opportunities to expand the trial where possible and indicated nationally											
				2.3	Implementation of the Targeted Lung Health checks within LLR and primarily within the City. Notts is due to go live shortly with LLR the next priority site. This will be run in collaboration with the smoking cessation work by the LCC											
				2.4	Improve colorectal cancer detection at early stage. Implementing the use of FIT as a diagnostic tool and with all 2WW to over 18 years (NICE requirements over 40).											
				2.5	Targeted project within LC and in particular LE4 to increase the 1 year survival rate. Reduction of the screening age to 56 will be rolled out across LLR by the national programme.											
				2.6	Review and agreed approach to identify patients at high risk of cancer in City – PCN Pilots targeted case finding											
				2.7	Development of VCS HI connectors delivery plans with ongoing local monitoring (x3)											
3	Increase uptake of cervical screening	Delivery	More working age women receiving screening Videos available in alternative languages and delivered by professionals and patients of different ages	3.1	LD Screening programme being undertaken led by National Screening team	Y		Engagement with communities – Macmillan EOI to be developed to engage Cancer Champions in communities.	Cancer Transformation Gtoup	ICS (ICB,LA, PCNs)	22/23 with review in line with ICB priorities to confirm 23/24	Pawan Randev/Helen Mather				
				3.2	Transformation within next 12 months to include self-testing HPV as piloted in London and risk stratified recall.											
				3.3	Review of DNAs for Screening with PH to inform											
				3.4	Pilot at PCN level using video texting to target patients who have not attended smears and appointments were provided outside of the core hours											

Healthy Ageing:

Ref	WE WILL	Delivery Stage	How will this demonstrate improvement?	No	Key Activities / Deliverables / Milestones	Will activities improve/increase equity at a local level? (Y/N)	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue RAG	Improvement Trajectory RAG
1	Create fully operational Integrated Neighbourhood Teams, focusing on Multi-Disciplinary Teams using anticipatory approaches with older people who may be at risk	Delivery	Power BI dashboard which monitors programme activity and outcomes – {in development} Ageing Well programme metrics	1.1 1.2	Making every contact count To develop a framework for local delivery of anticipatory care, which ensure consistency with the national operating model, but encourages flexibility at a place neigbourhood and pcn level focusing on the role out of the MDT facilitator at PCN level	Y	Y	Comms and engagement plan in place. Further details available from Paul Miles & Ibrahim Elias Co-design workshops planned for Oct/Nov 22	LLR Prevention & Inequalities Board (if still in operation) or LLR MECC Review Group LLR Anticipatory Care Project Group	ASC/ICB	2022 - 2024					
2	Continue to develop MyChoice so that it is kept up to date with local VCS preventative services and community assets to reduce loneliness and isolation	Delivery	Steering group performance measures in relation to most searched for terms, times that people are using mychoice, number of hits etc.	2.1 2.2 2.3	Enable people who use MyChoice to have an easy way of feeding back their experiences of using it to inform improvements and work programme of steering group Work to improve useability so that people and professionals such as social prescribers have a positive experience and find what they are interested in a) Include personal assistants on MyChoice b) Develop 'social prescribing' add on to MyChoice which will encourage people to contact support agencies directly without a need for 'professional referral' c)As community connector programme develops, ensure services and groups set up to tackle isolation and loneliness feature on MyChoice	Y	Yes ASC	None Planned	My Choice Steering Group meets 6 weekly. Reps from across the system attend that group. Escalation through ASC senior leaders	ASC	Started 2021, no planned end date as project is ongoing					
3	Commission a range of services and opportunities that provide an alternative to residential care that support older people to self -care, build on strengths and reduce frailty wherever possible	Delivery	Reduced permanent admissions to residential care	3.1 3.2 3.3 3.4 3.5 3.6 3.7 3.8	Community Opportunities and short breaks Dementia Support Service Short term residential beds & D2A Pathway 2 review Homecare – new contracts to be in place 2024 Hospital Bridging Service Respite review Supported living arrangements for older people Carer support services	Y	Y	Various	LA SCE Leadership & LA commissioning boards, project groups LLR Dementia Programme Board ISOC / JICB	ASC	Various for each commissic					
4	Delivery high quality Home-first services that are integrated, responsive and meet the Ageing Well ambition	Delivery	Increase numbers of older people who return to their usual home following time in hospital Increase numbers of people going through the reablement pathway Increase in the numbers of people who die in their place of choice	4.1 4.2	LLR D2A P1 remodelling work to increase reablement capacity Continue to roll out Phase 2 of the ICRS EoL pilot 1.LLR D2A P1 remodelling work to increase reablement capacity 2.Continue to roll out Phase 2 of the ICRS EoL pilot Deliver and fully evaluate the ICRS Night Support Service offer	Y	Y	None Planned	LLR Homefirst Collaborative End of Life Care Group	ASC	2022 - 2023					