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Core 20 Plus 5

Why the need for a strategy?

Themes for Action

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Key Priorities

What

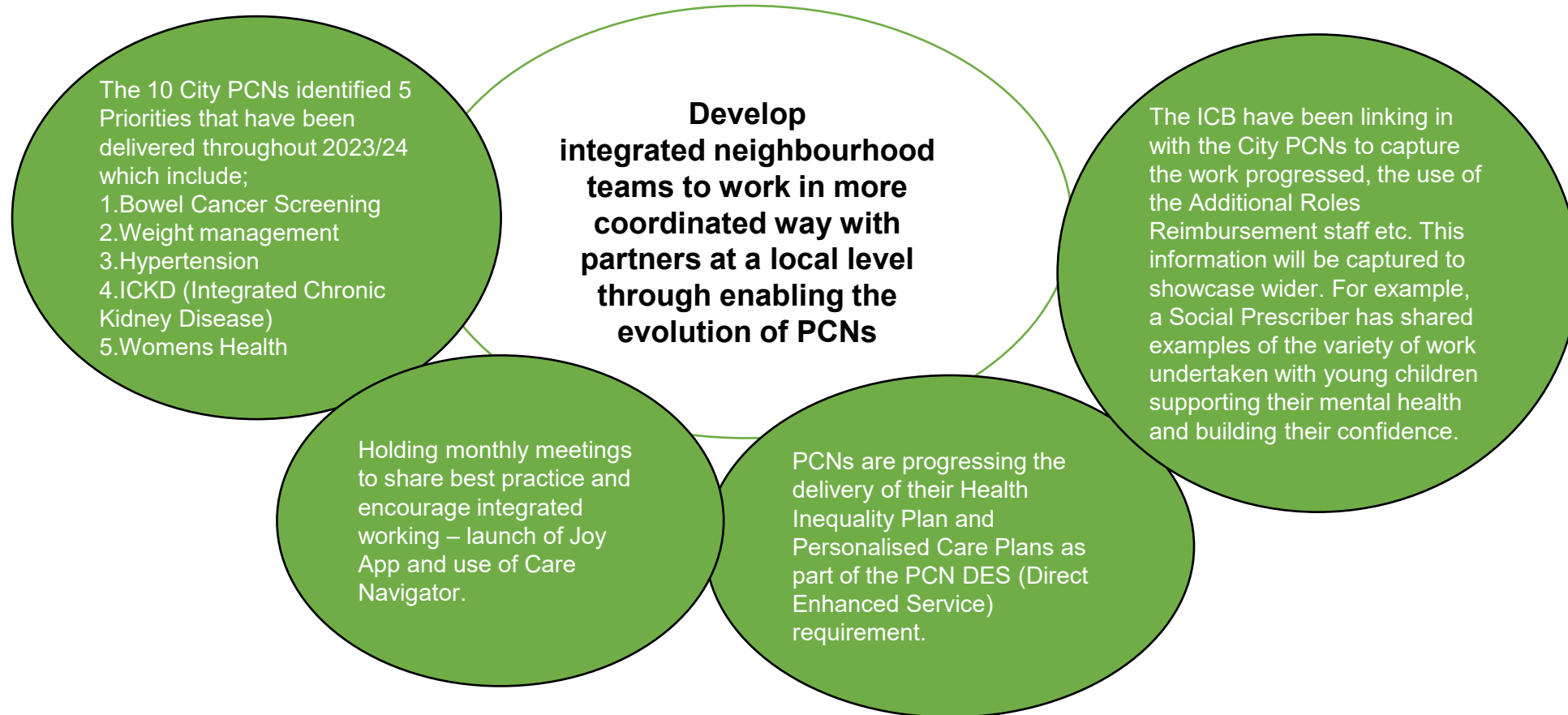
Leicester's Care, Health and Wellbeing Strategy 2022-2027

Delivery Plan Update
August- March 2024

Theme	Proposed Priority
<p>A. HEALTHY PLACES Making Leicester the healthiest possible environment in which to live & work</p>	1. We will improve the built environment to support people’s long-term health and wellbeing.
	2. We will improve access to primary and community health and care services.
	3. We will move towards being a carbon neutral city.
	4. We will create Mental Health & Dementia friendly communities within Leicester.
<p>B. HEALTHY START Giving Leicester’s children the best start in life.</p>	5. We will give every child the best start in life by focusing on the critical 1001 first days of life.
	6. We will make sure our children are able to Play and Learn.
	7. We will mitigate against the impacts of poverty on children and young people.
	8. We will empower health self-care in families with young children.
<p>C. HEALTHY LIVES Encouraging people to make sustainable and healthy lifestyle choices</p>	9. We will take action to reduce levels of unhealthy weight across all ages.
	10. We will increase early detection of heart & lung diseases and Cancer in adults.
	11. We will promoting independent living for people with long term health conditions.
	12. We will improve support for Carers.
<p>D. HEALTHY MINDS Promoting positive mental health within Leicester across the life course</p>	13. We will improve access for children & young people to Mental Health & emotional wellbeing services.
	14. We will improve access to primary & neighbourhood level Mental Health services for adults.
	15. We will reduce levels of social isolation in older people and adults.
	16. We will work towards having no deaths from suicide in the city.
<p>E. HEALTHY AGEING Enabling Leicester’s residents to age comfortably & confidently</p>	17. We will enable Leicester’s residents to age comfortably and confidently through a through a person-centred programme to support self-care, build on strengths and reduce frailty.
	18. We will promote independent living, so that older people can live in their own homes and communities.
	19. We will reduce the number of falls for people aged 65+ in Leicester.

Healthy Places

DO: We will improve access to primary and community health and care services.



Next Steps

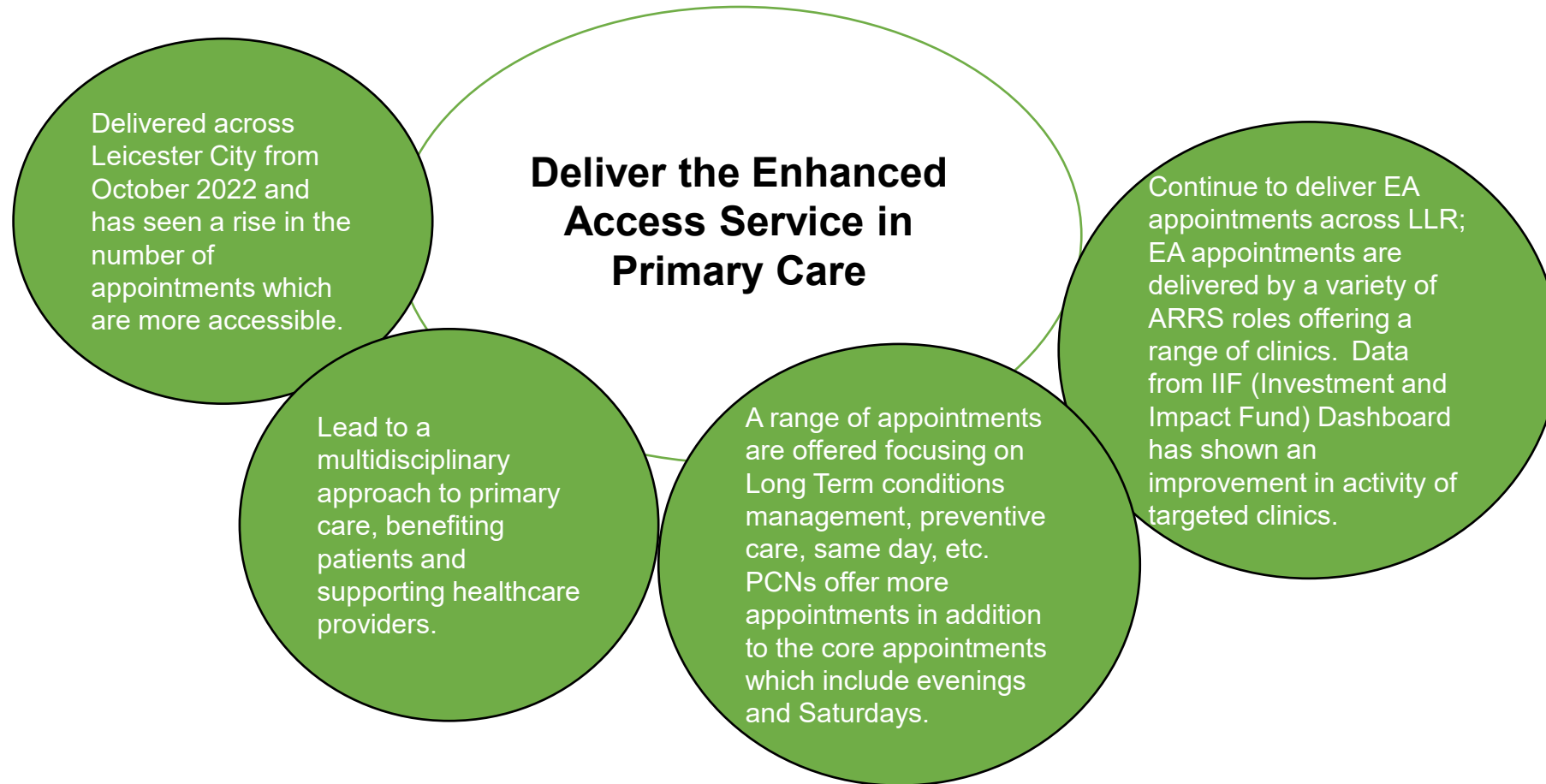
Undertake further deep dive and sharing of best practice.

Enable PCNs to co-design plans with their partners on addressing health inequality.

Support PCNs to progress in their Maturity Matrix.- which outlines components that underpin the successful development of networks.

Healthy Places

DO: We will improve access to primary and community health and care services.



Next Steps

NHSE will publish the Primary Care Network Direct Enhanced Access guidance / specification which will outline the delivery of Enhanced Access from April 2024/25. Next steps will then be designed on how PCNs continue to delivery EA and improve care and access offered to patients across the City.

Healthy Start

DO: We will mitigate against the impacts of poverty on children and young people

Peer Support Programme

The perinatal team have received a team preparation session which provides information about peer support, the evidence base, provides the opportunity to dispel myths, ask questions, talk about fears and worries about the peer support role.

Currently there is 1 peer support worker in the service but plans for the development of a lived experience network which will provide the opportunity for women with lived experience to find out more about peer support opportunities.

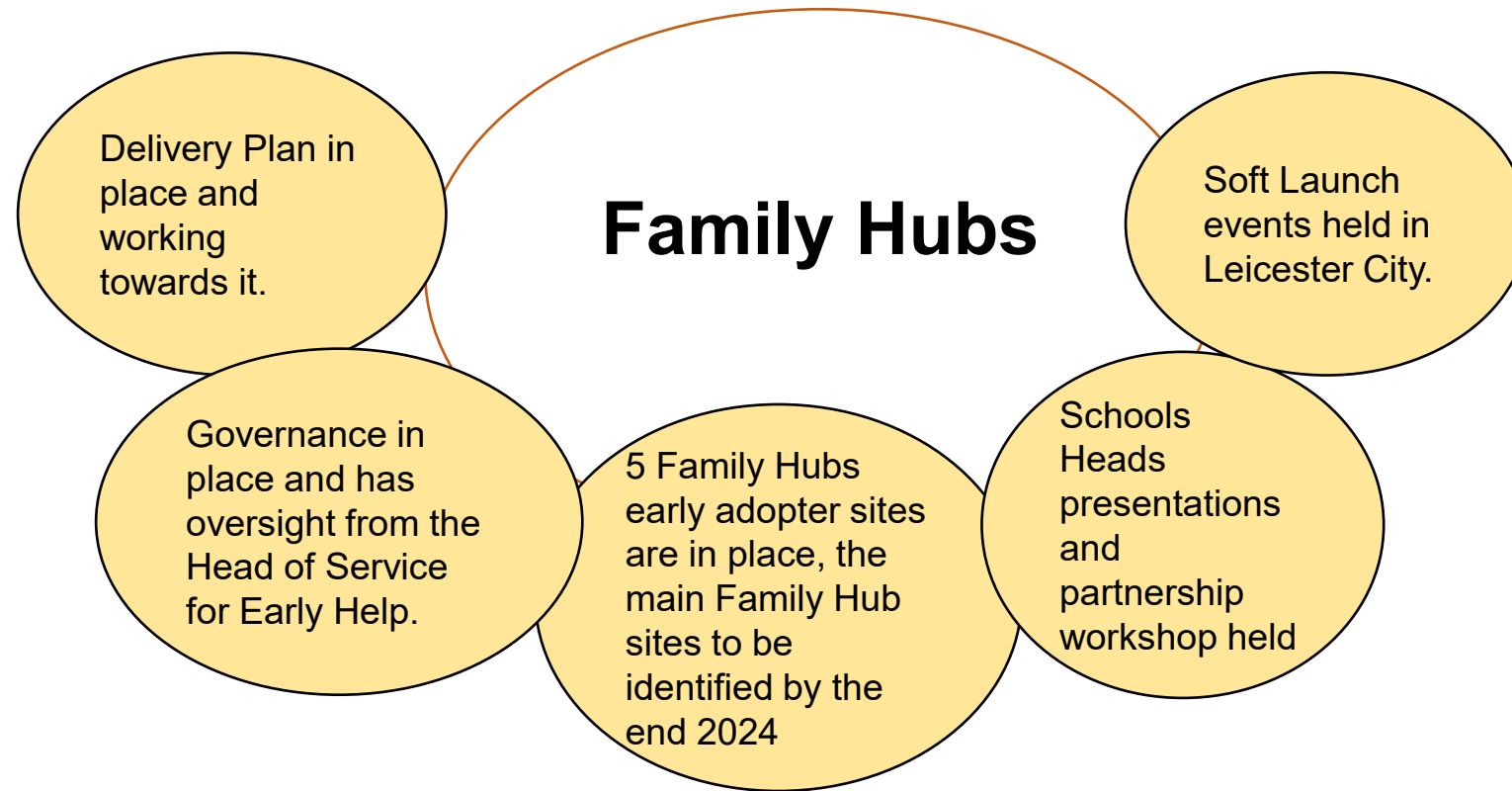
Risk: Not being able to recruit enough peer supporters with the appropriate lived experience.

Next Steps

Also linking in with other VCSE organisations such as blossom and bloom, Leicester Mamas, Heads up Leicester and Home Start, who have volunteers with lived experience who may be looking for development opportunities.

Healthy Start

DO: We will mitigate against the impacts of poverty on children and young people



Next Steps

Roadshow engagement events to be held; Digital website in development; Needs Analysis taking place and due to be completed May 24

Healthy Lives

DO: We will increase early detection of heart & lung diseases and cancer in adults

Hypertension Optimisation

Reviewed the PCN/Practice data up to Jan 2024 for LLR and identified the 20 practices with the lowest rates of optimisation (treatment to target) in the City.

The data set identified the optimisation gap for each practice – this gap is the number of patients that needs to be recorded as 'optimised' by 31/03/24 to meet the ambition of having 77% of their Hypertensives optimised.

Practices may not act consistently on the information shared.

Next Steps

Met with City Place group to share the data at both PCN and practice level identifying which age group to target, recommendation from this exercise is that they focus their activities on the 79 yrs. and under band. There is a much wider gap in achievement of this indicator. Discussing the data openly will provide an opportunity for practices to share and learn from those practices who are already meeting this target.

Healthy Lives

DO: We will increase early detection of heart & lung diseases and cancer in adults

FIT Test Pilot

A City PCN is undertaking a pilot to directly provide patients with FIT (Faecal Immunochemical Test) and samples to be returned to the surgery – Feedback is positive

IIF (Impact and investment Fund) January 24 data has been released and LLR have achieved 81.9% of Lower GI (Gastrointestinal) referrals which are accompanied by a FIT diagnostic test completed in the last 3 weeks.. This is over the required 80%.

In April, the % will reset as the data collected next to targets is cumulated annually. Because of information governance, they are unable to be provided with the data from practices with 6 or less patients either having been referred or tested by LHS (LeicestershireHealth Informatics Service).

Next Steps

Carry out a review of the PCN FIT pilot and work with County to extend the pilot to another PCN.

Healthy Minds

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

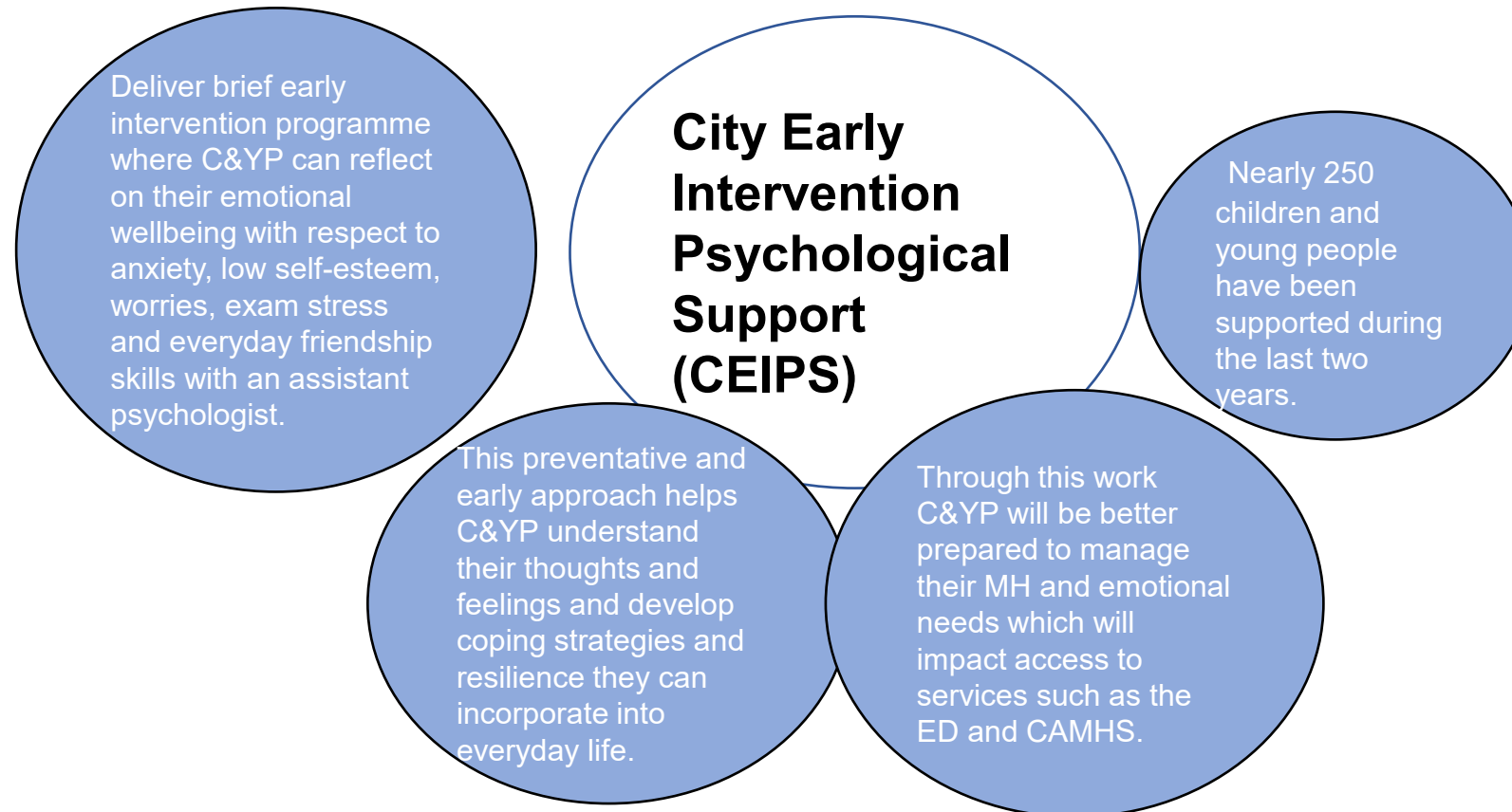


Next Steps

MHST Led C&YP workshops for C&YP MH Week 5th – 11th Feb. The data is still being extracted, they were held across LLR secondary schools that have an MHST – initial numbers indicated 7,700 C&YP were reached in this week through 1:1, workshops, activities, assemblies (although this is LLR wide, not just the City).

Healthy Minds

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

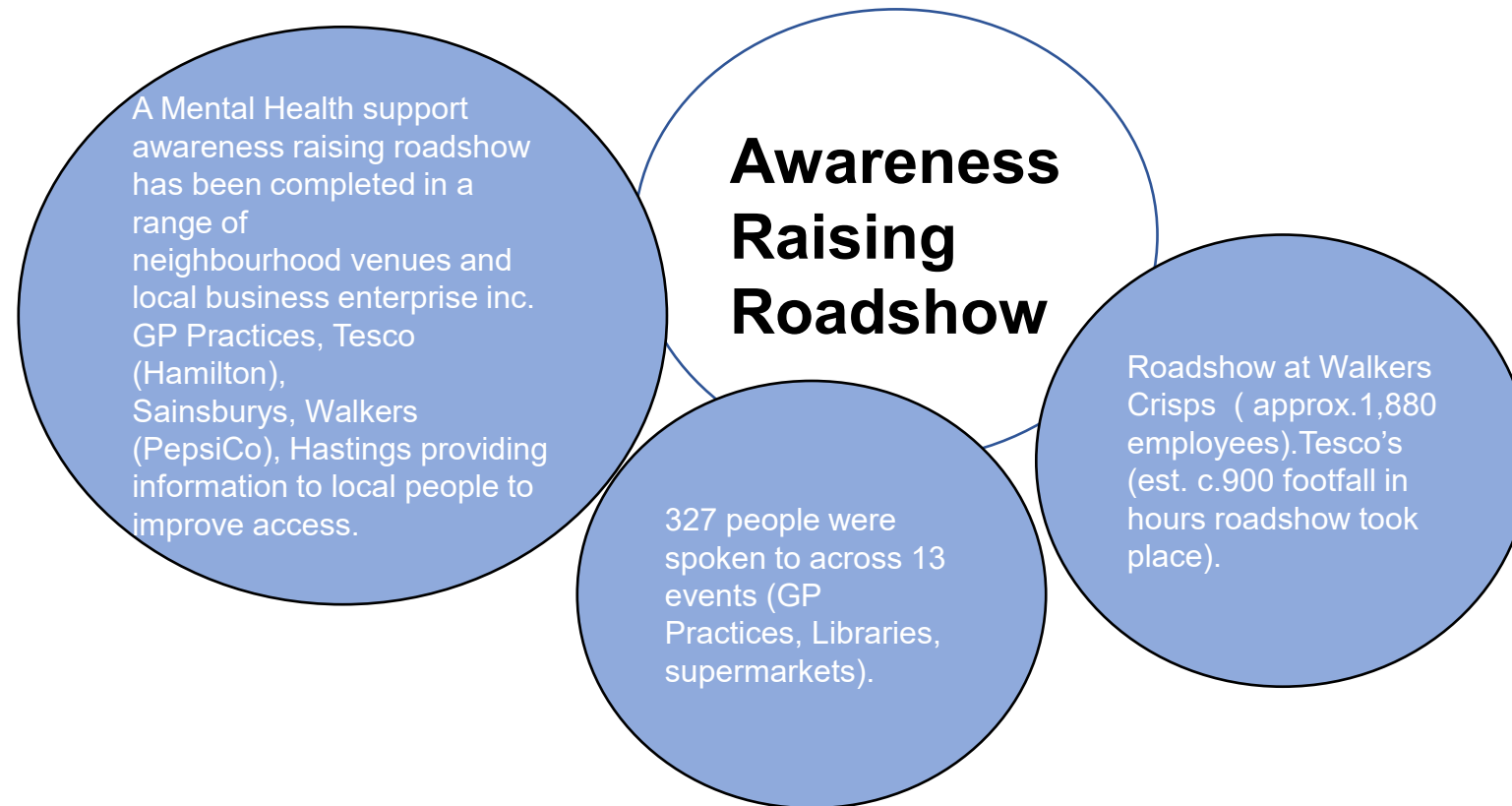


Next Steps

CEIPS core service contract has been extended until March 2025

Healthy Minds

DO: We will improve access to primary & neighbourhood level Mental Health services for adults.

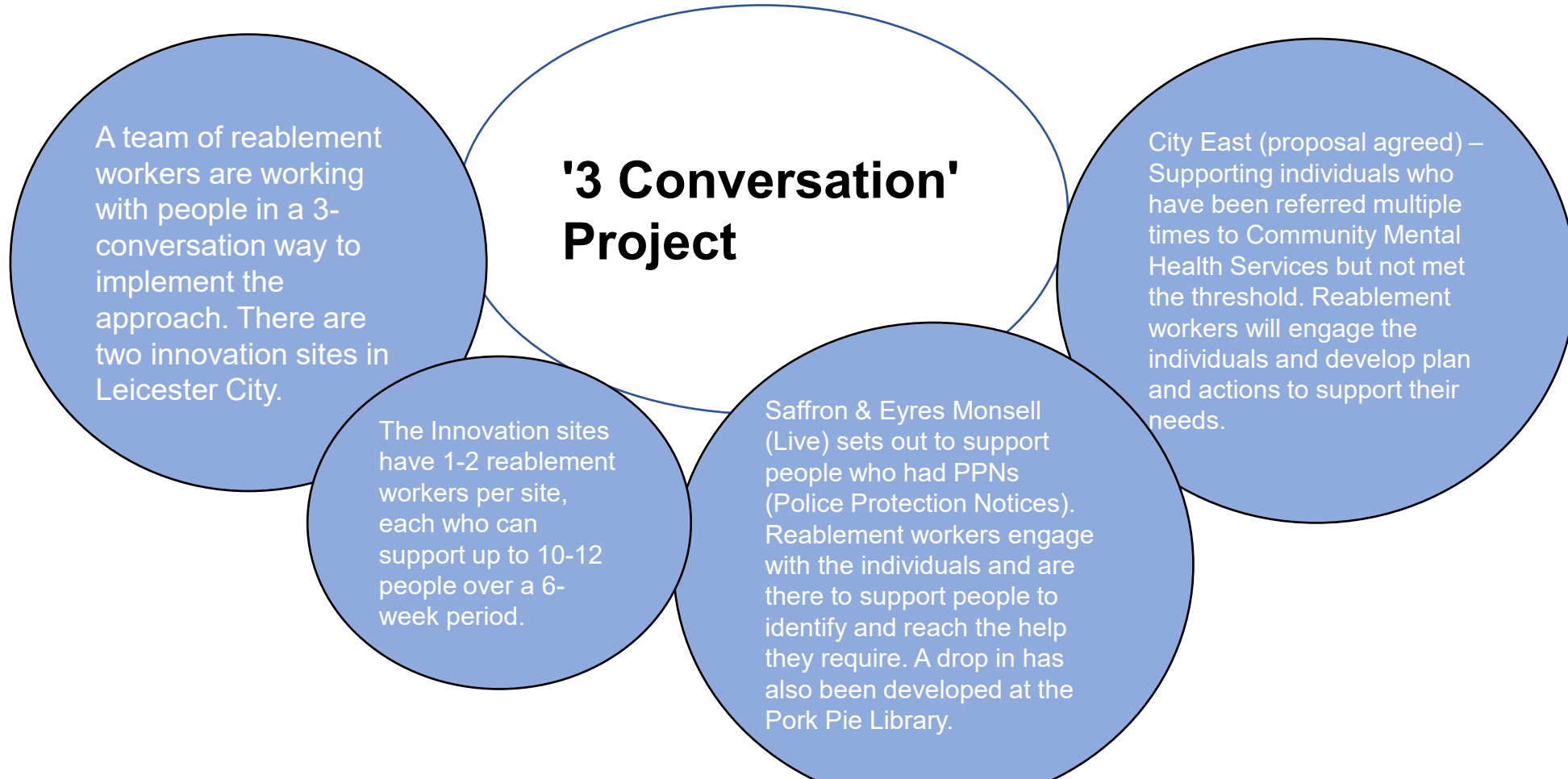


Next Steps

Blueprint developed 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'.

Healthy Minds

DO: We will improve access to primary & neighbourhood level Mental Health services for adults.



Next Steps

Progress on establishing a local Step 3 plus (NHS Psychological Therapies LLR) service to strengthen the overall LLR psychological therapies support offer. The projects should run until March 2025.

Healthy Ageing

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.

This work is 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 who require social care support being discharged within 2 hours / same day.

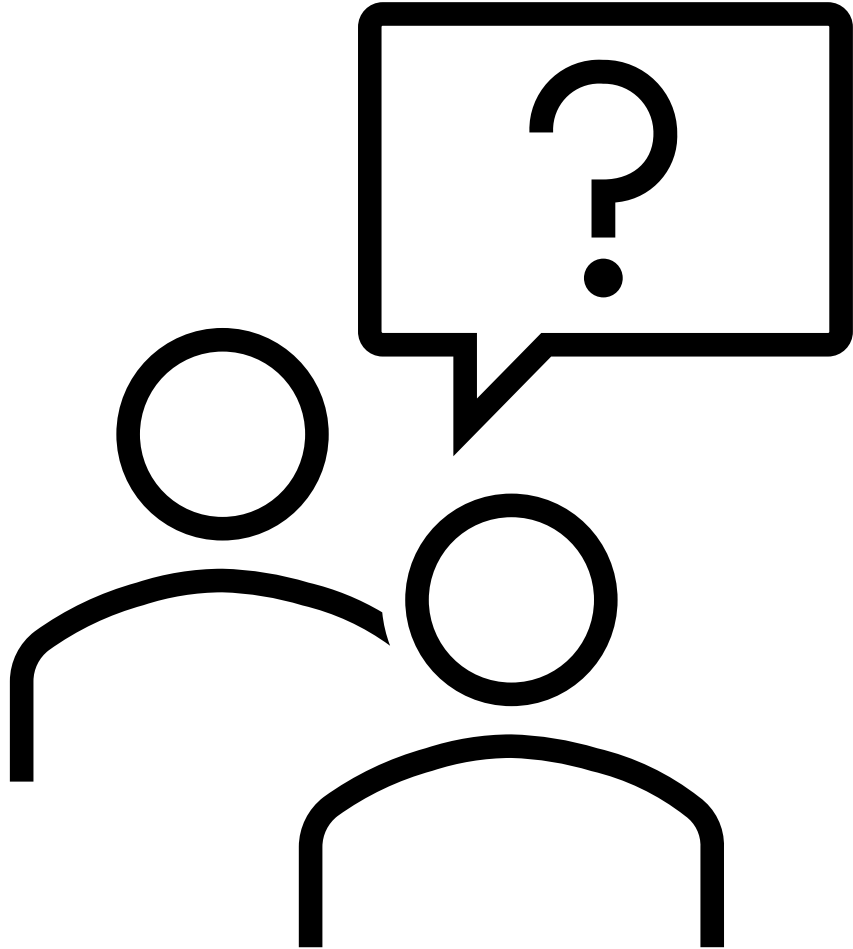
Discharge to Assess Project

401 people benefited from this service in its first 3 months of go live (Nov 1st 23 to Jan 31st 24) with 58% becoming fully independent with no ongoing care needs.

Ensuring people with double-handed care needs are also discharged through this pathway. The service has revisited its staffing rotas and processes to ensure capacity and flow is sufficient to help sustain this.

Next Steps

Key developments are around transforming our current therapy led offer into one that can support our high dependency cohort.



Any questions?

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