LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 29 JULY 2021

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.

G. J. Carey
For Monitoring Officer

NOTE:

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

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

MEMBERS OF THE BOARD

Councillors:

Councillor Vi Dempster, Assistant City Mayor, Health (Chair)

Councillor Piara Singh Clair, Deputy City Mayor, Culture, Leisure and Sport

Councillor Sarah Russell, Deputy City Mayor, Social Care and Anti-Poverty

Councillor Elly Cutkelvin, Assistant City Mayor, Education and Housing

Councillor Rita Patel, Assistant City Mayor, Communities, Equalities & Special Projects

City Council Officers:

Martin Samuels, Strategic Director of Social Care and Education

Ivan Browne, Director Public Health

Dr Katherine Packham, Public Health Consultant

1 Vacancy

NHS Representatives:

Mark Wightman, Director of Strategy and Communications, University Hospitals of Leicester NHS Trust

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Angela Hillery, Chief Executive, Leicestershire Partnership NHS Trust

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

David Sissling – Independent Chair of Leicester, Leicestershire and Rutland Integrated Care System

Oliver Newbould, Director of Strategic Transformation, NHS England and NHS Improvement

Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Group

Healthwatch / Other Representatives:

Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service

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

Kevan Liles, Chief Executive, Voluntary Action Leicester

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

Mandip Rai, Director, Leicester, Leicestershire Enterprise Partnership

Kevin Routledge, Strategic Sports Alliance Group

Chief Superintendent, Adam Streets, Head of Local Policing Directorate, Leicestershire Police

STANDING INVITEES: (Non-Voting Board Members)

Cathy Ellis – Chair of Leicestershire Partnership NHS Trust

Professor Andrew Fry – College Director of Research, Leicester University

Richard Lyne, General Manager, Leicestershire, East Midlands Ambulance Service NHS Trust

John MacDonald, Chair of University Hospitals of Leicester NHS Trust

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

Information for members of the public

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Due to COVID restrictions, public access in person is limited to ensure social distancing. We would encourage you to view the meeting online but if you wish to attend in person, you are required to contact the Democratic Support Officer in advance of the meeting regarding arrangements for public attendance. A guide to attending public meetings can be found here on the Decisions, meetings and minutes page of the Council website.

Members of the public can follow a live stream of the meeting on the Council's website at this link: http://www.leicester.public-i.tv/core/portal/webcasts

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To hold this meeting in as Covid-safe a way as possible, all attendees are asked to follow current Government guidance and:

- maintain distancing while entering and leaving the room/building;
- remain seated and maintain distancing between seats during the meeting;
- wear face coverings throughout the meeting unless speaking or exempt;
- make use of the hand sanitiser available;
- when moving about the building to follow signs about traffic flows, lift capacities etc;
- comply with Test and Trace requirements by scanning the QR code at the entrance to the building and/or giving their name and contact details at reception prior to the meeting;
- if you are displaying Coronavirus symptoms: a high temperature; a new, continuous cough; or a loss or change to your sense of smell or taste, you should NOT attend the meeting, please stay at home, and get a PCR test.

Making meetings accessible to all

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If you intend to film or make an audio recording of a meeting you are asked to notify the relevant Democratic Support Officer in advance of the meeting to ensure that participants

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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 Graham Carey**, Democratic Support on (0116) 454 6356 or email** **graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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 Democratic 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. MEMBERSHIP OF THE BOARD

To note the membership of the Board for 2021/22 approved by the Council on 29 April 2020:-

City Councillors: (5 Places)

Councillor Vi Dempster, Assistant City Mayor, Health (Chair)
Councillor Piara Singh Clair, Deputy City Mayor, Culture, Leisure and Sport
Councillor Sarah Russell, Deputy City Mayor, Social Care and Anti-Poverty
Councillor Elly Cutkelvin, Assistant City Mayor, Education and Housing
Councillor Rita Patel, Assistant City Mayor, Communities, Equalities and Special Projects

City Council Officers: (4 Places)

Martin Samuels, Strategic Director of Social Care and Education
Ivan Browne, Director Public Health
Dr Katherine Packham, Public Health Consultant
1 Vacancy to be nominated by the Chief Operating Officer

NHS Representatives: (7 Places)

Chief Executive, University Hospitals of Leicester NHS Trust
Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group
Angela Hillery, Chief Executive, Leicestershire Partnership NHS Trust
Oliver Newbould, Director of Strategic Transformation, NHS England & NHS Improvement – Midlands
Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group
David Sissling, Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland
Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical

Commissioning Group

Healthwatch / Other Representatives: (8 Places)

Harsha Kotecha, Chair, Healthwatch Advisory Board, Leicester and Leicestershire
Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service
Rupert Harding, Leicester, Leicestershire and Rutland Police and Crime Commissioner
Kevan Liles, Chief Executive, Voluntary Action Leicester
Kevin Routledge, Strategic Sports Alliance Group
Mandip Rai, Director, Leicester & Leicestershire Enterprise Partnership
Chief Superintendent, Adam Streets, Head of Local Policing Directorate, Leicestershire Police
1 Unfilled Vacancy

STANDING INVITEES: (Not A Council Appointed Voting Board Member – Invited by the Chair of the Board. and no set number of places)

Cathy Ellis, Chair of Leicestershire Partnership NHS Trust
Professor Andrew Fry – College Director of Research, Leicester University
Richard Lyne, General Manager, Leicestershire, East Midlands Ambulance Service NHS Trust
John MacDonald, Chair of University Hospitals of Leicester NHS Trust,
Professor Bertha Ochieng – Integrated Health and Social Care, De Montfort University

4. TERMS OF REFERENCE

Appendix A (Pages 1 - 6)

To note the Board's Terms of Reference approved by the Annual Council on 29 April 2021.

5. MINUTES OF THE PREVIOUS MEETING

Appendix B (Pages 7 - 18)

The Minutes of the previous meeting of the Board held on 25 March 2021 are attached and the Board is asked to confirm them as a correct record.

6. SPOTLIGHT ON GOOD PRACTICE AND INNOVATION

Appendix C (Pages 19 - 44)

To consider updates on good practice and innovation from organisations represented on the Board relating to a number of health and wellbeing issues.

7. INTEGRATED CARE SYSTEM - PRINCIPLES, PRIORITIES AND PURPOSE

Appendix D (Pages 45 - 62)

Sara Prema (Executive Director of Strategy and Planning for Leicester, Leicestershire and Rutland CCGs) to give a presentation.

8. PLACE LED PLANS

Appendix E (Pages 63 - 78)

Sara Prema (Executive Director of Strategy and Planning for Leicester, Leicestershire and Rutland CCGs) and Katherine Packham (Public Health Consultant, Leicester City Council) to give a presentation outlining of the Health and Wellbeing Board at Place and the role of place within the integrated Care System. It also sets out the approach and options for rewriting /revising the Joint Health and Wellbeing Strategy and the delivery of place delivery plans and timelines.

9. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

10. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will be held on the following dates:-

Thursday 28 October 2021 – 9.30 am
Thursday 27 January 2022 – 9.30am
Thursday 28 April 2022 – 9.30 am

Meetings of the Board are scheduled to be held in Meeting Rooms G01 and 2 at City Hall unless stated otherwise on the agenda for the meeting.

11. ANY OTHER URGENT BUSINESS

Appendix A

Leicester City Health and Wellbeing Board

Terms of Reference

Approved at Annual Council on 29 April 2021

Introduction

In line with the Health and Social Care Act 2012, the Health & Wellbeing Board is established as a Committee of Leicester City Council.

The Health & Wellbeing Board operated in shadow form since August 2011. In April 2013, the Board became a formally constituted Committee of the Council with statutory functions and met for the first time on 11 April 2013.

1 Aim

To achieve better health, wellbeing and social care outcomes for Leicester City's population and a better quality of care for patients and other people using health and social services.

2 Objectives

2.1 To provide strong local leadership for the improvement of the health and wellbeing of Leicester's population and work to reduce health inequalities.

2.2 To lead on improving the strategic coordination of commissioning across NHS, adult social care, children's services and public health services.

2.3 To maximise opportunities for joint working and integration of services using existing opportunities and processes and prevent duplication or omission.

2.4 To provide a key forum for public accountability of NHS, Public Health, Adult Social Care and Children's Services and other commissioned services that the Health & Wellbeing Board agrees are directly related to health and wellbeing.

3 Responsibilities

3.1 Working jointly, to identify current and future health and wellbeing needs across Leicester City through revising the Joint Strategic Needs Assessment (JSNA) as and when required. Preparing the JSNA is a statutory duty of Leicester City Council and Leicester City Clinical Commissioning Group.

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

3.3 Prepare and publish a Joint Health and Wellbeing Strategy (JHWS) that is evidence based through the work of the Joint Strategic Needs Assessment (JSNA) and supported by all stakeholders. This will set out strategic objectives, ambitions for achievement and how we will be jointly held to account for delivery. Preparing the JHWS is a statutory duty of Leicester City Council and Leicester City Clinical Commissioning Group.

3.4 Save in relation to agreeing the JSNA, JHWS and any other function delegated to it from time to time, the Board will discharge its responsibilities by means of recommendation to the relevant partner organisations, who will act in accordance with their respective powers and duties.

3.5 Ensure that all commissioners of services relevant to health and wellbeing take appropriate account of the findings of the Joint Strategic Needs Assessment and demonstrate strategic alignment between the JHWS and each organisation's commissioning plans.

3.6 Ensure that all commissioners of services relevant to health and wellbeing demonstrate how the JHWS has been implemented in their commissioning decisions.

3.7 To monitor, evaluate and annually report on the Leicester City Clinical Commissioning Group performance as part of the Clinical Commissioning Groups annual assessment by the national Commissioning Board.

3.8 Review performance against key outcome indicators and be collectively accountable for outcomes and targets specific to performance frameworks within the NHS, Local Authority and Public Health.

3.9 Ensure that the work of the Board is aligned with policy developments both locally and nationally.

3.10 Provide an annual report from the Health and Wellbeing Board to the Leicester City Council Executive and to the Board of Leicester City Clinical Commissioning Group to ensure that the Board is publicly accountable for delivery.

3.11 Oversee progress against the Health and Wellbeing Strategy and other supporting plans and ensure action is taken to improve outcomes.

3.12 The Board will not exercise scrutiny duties around health and adult social care directly. This will remain the role of the relevant Scrutiny Commissions of Leicester City Council. Decisions taken and work progressed by the Health & Wellbeing Board will be subject to scrutiny by relevant Scrutiny Commissions of Leicester City Council.

3.13 The Board will need to be satisfied that all commissioning plans demonstrate compliance with the Equality Act 2010, improving health and social care services for groups within the population with protected characteristics and reducing health inequalities.

3.14 The Board will agree Better Care Fund submissions and have strategic oversight of the delivery of agreed programmes.

4 Membership

Members:

Up to five Elected Members of Leicester City Council (5)

- The Executive Lead Member for Health (1)
- Four Elected Members nominated by the City Mayor (4)

Up to seven representatives of the NHS (7)

- The Co -Chair of the Leicester City Clinical Commissioning Group (1)
- A further GP representative of the Leicester City Clinical Commissioning Group (1)
- The Chief Executive of the LLR Clinical Commissioning Groups (1)
- The Director of Strategic Transformation – NHS England & NHS Improvement – Midlands (1)
- The Independent Chair of the Integrated Care System (1)
- The Chief Executive of University Hospitals NHS Trust (1)
- The Chief Executive of Leicestershire Partnership NHS Trust (1)

Up to four Officers of Leicester City Council (4)

- The Strategic Director of Social Care and Education (Leicester City Council) (1)
- The Director of Public Health (Leicester City Council) (1)
- 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. (1)
- One Officer nominated by the Chief Operating Officer (1)

Up to eight further representatives including Healthwatch Leicester/Other Representatives (8)

- One representative of the Local Healthwatch organisation for Leicester City (1)
- Leicester City Local Policing Directorate, Leicestershire Police (1)
- The Leicester, Leicestershire and Rutland Police and Crime Commissioner (1)
- Chief Fire and Rescue Officer, Leicestershire Fire & Rescue Service (1)
- Two other people that the local authority thinks appropriate, after consultation with the Health and Wellbeing Board (2)

- A representative of the city's sports community (1)
- A representative of the private sector/business/employers (1)

5 Quorum & Chair

5.1 For a meeting to take place there must be at least six members of the Board present and at least one representative from each of the membership sections:

- Leicester City Council (Elected Member)
- LLR Clinical Commissioning Group or NHS England & NHS Improvement - Midlands
- One senior officer Board Member from Leicester City Council
- Local Healthwatch/Other Representatives

5.2 Where a meeting is inquorate those members in attendance may meet informally but any decisions shall require appropriate ratification at the next quorate meeting of the Board.

5.3 Where any member of the Board proposes to send a substitute to a meeting, that substitute's name shall be properly nominated by the relevant 'parent' person/body and submitted to the Chair in advance of the meeting. The substitute shall abide by the Code of Conduct.

5.4 The City Council has nominated the Executive Lead for Health to Chair the Board. Where the Executive Lead for Health is unable to chair the meeting, then one of the other Elected Members shall chair (noting that at least one Elected Member must be present in order for the meeting to be declared quorate).

6 Voting

6.1 The City Council at its meeting on 29 May 2014 resolved to disapply Section 13(1A) of the Local Government and Housing Act 1989 such that the four local authority officers on the Board will not exercise voting rights.

6.2 Any representatives of bodies asked to attend meetings of the Board as 'Standing Invitees' by the Board shall not have a vote.

6.3 All other members will have an equal vote.

6.4 Decision-making will be achieved through consensus reached amongst those members present. Where a vote is required decisions will be reached through a majority vote of voting members; where votes are equal the chair will have a second and casting vote.

7 Code of conduct and member responsibilities

All voting members are required to comply with Leicester City Council's Code of Conduct, including each submitting a Register of Interest.

In addition, all members of the Board will commit to the following roles, responsibilities and expectations:

7.1 Commit to attending the majority of meetings.

7.2 Uphold and support Board decisions and be prepared to follow though actions and decisions obtaining the necessary financial approval from their organisation for the Board proposals and declaring any conflict of interest.

7.3 Be prepared to represent the Board at stakeholder events and support the agreed consensus view of the Board when speaking on behalf of the Board to other parties. Champion the work of the Board in their wider networks and in community engagement activities.

7.4 To participate in Board discussion to reflect views of their partner organisations, being sufficiently briefed to be able to make recommendations about future policy developments and service delivery.

7.5 To ensure that are communication mechanisms in place within the partner organisations to enable information about the priorities and recommendation of the Board to be effectively disseminated.

8 Agenda and Meetings

8.1 Administration support will be provided by Leicester City Council.

8.2 There will be standing items on each agenda to include:

- Declarations of Interest
- Minutes of the Previous Meeting
- Matters Arising
- Updates from each of the working subgroups of the Health & Wellbeing Board.

8.3 Meetings will be held a minimum of four times a year and the Board will meet in public and comply with the Access to Information procedures as outlined in Part 4b of the Council's Constitution.

Version 9.7 April 2021

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 25 MARCH 2021 at 10:00 am

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Leicester City Council.
Ivan Browne	–	Director of Public Health, Leicester City Council.
Councillor Elly Cutkelvin	–	Assistant City Mayor, Education and Housing.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group.
Harsha Kotecha	–	Chair, Healthwatch Advisory Board, Leicester and Leicestershire.
Hayley Jackson	–	Assistant Director of Strategy and Integration NHS England & NHS Improvement
Gordon King		Director of Mental Health, Leicestershire Partnership NHS Trust
Kevan Liles	–	Chief Executive, Voluntary Action Leicester.
Richard Morris	–	Director of Operations and Corporate Affairs, Leicester, Leicestershire & Rutland Clinical Commissioning Groups
Councillor Rita Patel	–	Assistant City Mayor, Communities, Equalities and Special Projects, Leicester City Council.
Kevin Routledge	–	Strategic Sports Alliance Group.
Councillor Sarah Russell	–	Deputy City Mayor, Social Care and Anti-Poverty, Leicester City Council.
Martin Samuels	–	Strategic Director Social Care and Education,

		Leicester City Council.
Councillor Piara Singh Clair	–	Deputy City Mayor, Culture, Leisure and Sport, Leicester City Council.
Caroline Trevithick	–	Executive Director of Nursing Quality and Performance and Deputy Chief Executive, Leicester, Leicestershire & Rutland Clinical Commissioning Groups
Mark Wightman	–	Director of Strategy and Communications, University Hospitals of Leicester NHS Trust.

Standing Invitees

Cathy Ellis	–	Chair of Leicestershire Partnership NHS Trust.
David Sissling	–	Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland

In Attendance

Graham Carey	–	Democratic Services, Leicester City Council.

*** ** ***

17. WELCOME

The Chair welcomed Dr Katherine Packham, Mukesh Barot and David Sissling to their first meeting. Davis Sissling was the new Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland and Dr Katherine Packham was a Public Health Consultant specialising in integrated care. It was intended to appoint them as members of the Board at the Annual Council in May.

18. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Rebecca Browne	Acting Chief Executive University Hospitals Leicester
|Andrew Fry	College Director of Research, Leicester University
Oliver Newbould	Director of Strategic Transformation, NHS England & NHS Improvement - Midlands
Andy Williams	Chief Executive, Leicester, Leicestershire & Rutland Clinical Commissioning Groups

19. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business to be discussed at the meeting. No such declarations were received.

20. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 19 November 2020 be confirmed as a correct record.

21. LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH INEQUALITIES FRAMEWORK

Sarah Prema, Executive Director of Strategy and Planning for Leicester, Leicestershire and Rutland CCGs presented a report on the Leicester Leicestershire and Rutland System Health Inequalities Framework. The aim of the Framework was to improve healthy life expectancy across Leicester, Leicestershire & Rutland (LLR), by reducing health inequalities across the system.

The purpose of the Framework was to:-

- Provide a system mandate for action to address health inequalities from communities upwards through the whole life course from birth to death across LLR.
- Establish a collective understanding of the terms 'Inequality', 'Inequity' and 'Prevention' in relation to population health, across all parts of the LLR Integrated Care System (ICS).
- Strengthen a whole system collaborative approach to reduce or remove avoidable unfairness in people's health and wellbeing in LLR as the issues affecting health were complex and joint working was important as all the factors interacted.
- Establish the high-level principles of how LLR ICS partners will approach the work of reducing health inequity at system level.
- Recognise that the framework will be implemented and agreed at system level, with much operational, political and community action being undertaken at 'place' and 'neighbourhood' level. It is the systems' minimum ask of Place in relation to reducing health inequalities.
- Set out some key actions that can be delivered at system level with support through the ICS, with recognition that some actions will be primarily for individual organisations e.g. the NHS or the Local Authority with many others requiring partners to work together.
- As the ICS developed there would be a need to adopt proportionate realism to use resources better to bring service provision delivery together around health inequalities.
- The training and development of staff was important, and organisations would need to learn from Covid-19 experiences for service delivery.
- There would be a consistent approach to health equity audits when

commissioning and delivering services to ensure there was fair access to all; e.g. digital services did not disadvantage unintentionally.

It was noted that the principles of the approach would be:-

- Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies.
- The principles and actions outlined are deliberately high level – the framework is clear in identifying that it will be at place level and footprints below that specific action will be defined. Health and wellbeing Boards have a key role in leading and overseeing the work to establish local needs and action plans.
- Health outcomes are the result of a mixture of the wider determinants of health and the quality of the health service. It is estimated that non-medical factors influence as much as 80% of life expectancy.
- To optimise the health, wellbeing and safety of our population then all partners involved have to work together to impact all the factors that influence health inequalities.
- Reducing health inequalities will create a fairer society in which people are enabled to realise the best potential and contribute to our society in positive ways.
- The ICS will adopt a Population Health Management[3] and balanced approach to Prevention (across all three tiers**).**
- A focus on parity of esteem between mental and physical health.
- Public sector ICS partners will act as anchor institutions in LLR**.**
- Both qualitative and qualitative data would be used to better understand the health inequalities that exist in LLR.
- All the assets and strengths of communities and individuals would be used to reduce health inequality and inequity.
- Effective action would be taken at key points of the life course dependant on need.
- Accountability for delivering on system wide health inequalities will be an ICS system accountability.
- Actions will be undertaken at the most appropriate level of the ICS where they can be most effectively owned and delivered.
- There would be a proportionate universalism approach to invest decisions across the ICS. This would allow actions to be universal, but with a scale and intensity that is proportionate to the level of disadvantage.
- The ICS will establish a defined LLR resource to review health inequalities at the system level. This will be a virtual partnership between the NHS, the local authorities and local universities

Members of the Board supported the principle of the framework and commented that:-

- There has been a cyclical revisiting of health inequalities over the years and although there had been a data rich environment there had been no

follow up on quality of engagement and analysis.

- Training and sharing of resources to make a difference was supported.
- The challenge to address inequalities is to ensure a collaborative approach to improve healthy living conditions and education of issues. There still a need to build on the involvement of planning, transport and housing etc.
- The ICS supported the involvement of a wide range of organisations in developing the framework and the ICS would be really keen to see the framework put into action as a high priority to produce positive results.
- As the issue had been considered before communities needed to see real change and improvements. There are many people in the community that are wanting to do things to make improvements and they needed to be involved in the action to bring about improvements. There are many marginalised groups in the community, and they are not represented in the developing the proposals.
- The Board involvement in holding partners to account for actions was welcomed as discussing the actions and non-actions arising from the framework would lead to prioritising resources.
- Most of the inequality challenges were in the west of the city compared to the inequalities across the city as a whole.
- Proportional universalism was welcomed to directing resources to areas where there is an identified instead of everyone getting help regardless of their needs.
- Hospitals had traditionally treated those who turned up at hospitals and inbuilt inequalities had evolved within the system over time. There were inequalities in those not attending their first appointments. The average non-attendance rate was 7% but this could be as much as 50% from some ethnic groups. If patients did not attend the hospital appointment, then they were discharged back to their GP. If there were differential levels of discharge it could help to identify if there were underlying issues relating to non-attendance etc. There were also disparities in providing knee and hip operations depending on levels of wealth and ethnic origins. Those experiencing low levels of wealth might choose to work instead of having the operation until they were unable to work from the pain experienced. It would be important to bring consideration of ethnicity and inequalities into the health system.
- Experiences during Covid had provided information on which communities and sections of communities had been affected the most, those groups affected more by hospital admissions and which communities were reluctant to take up vaccines. Factors identified in these differences included access to open space spaces, communal living so not able to exercise social distancing, poverty, exercise and lack of active lifestyle and eating habits. Other comparable cities had been affected similarly with some more than others. It was important to use this information to look back and see how these factors can be address to bring about positive change and health improvements.
- It would be helpful to have simplified and easy to read versions of research projects to inform the work that would be needed going forward and also to inform on improvement engagement which those

experiences health inequalities.

- Research studies had linked deprivation to hospital outcomes eg planned and elective operations. The Michael Marmot 2020 Review examined a decade of data to understand the worsening situation of health inequality in the UK. Th report found funding cuts to be regressive and inequitable, suggesting that these financial decisions had harmed health and contributed to widening health inequalities.
- There was a need to level up services and ensure that when services are delivered, they do not create inequalities.
- Adult Social Care and Education Services had looked at data and carried out an internal to see if service delivery was equitable according to their context The department had introduced a participation model, based upon the Lundy model, which ensured staff listened and responded to the views of children and young people they work with. The adoption of this approach was getting Leicester national recognition.
- Work on Anti-smoking and Anti-Poverty had linked factors across a number of services and had shown that a change in one area helped to bring about change in other service areas and had identified the interaction of various factors affecting the outcomes. Getting the right advice at the right time can lead to people being less reluctant to open mail and missing appointments as they feel more engaged and helped.
- The existing Joint Health and Wellbeing Strategy Action Plan could be revised to incorporate and build on the work for the Framework. Officers intended to develop this and then engage partners in this work.
- The CCG had signed up to the Framework and NHS staff and GPs were also committed to it. It was useful to have good clear guidance of where to get the best evidence data or where to go to engage in services.

RESOLVED:

1) Officers were thanked for the work in producing the Framework which was supported and commented to all partners on the Board, together with the endorsement of the principles outlined in the Framework.

2) There should be a development session to discuss how the Framework can be moved forward by all participants in the Board and consider the issues of proportionate universalism and the factors affecting the inequalities of health.

22. ENGAGEMENT WORK

The Chair invited all organisations represented on the Board to present a verbal update on their engagement work during the last year.

The Chair commented that there was tendency to continually engage with the same people in the same way and partners should think about how engagement could be carried out differently. People's sense of place was often very different to officers. The recent example of the government establishing a vaccination centre at Peepuls Centre to improve vaccinations in

an area had low usage; but when it was suggested that it should be moved to a property within the community, the vaccination rates increased. Those living in the community intended to be vaccinated did not see the original location as part of their community area, but then moving it a relatively short distance into their recognised community area had achieve a better outcome.

Kevin Routledge (Strategic Sports Alliance Group) reported that professional sports clubs meet regularly in relation to the importance of physical activity as it was recognised it had a positive impact on health. Engagement was discussed together with the following :-

- How the clubs and participants had been impacted by Covid.
- Had it created opportunities and redefined how people interface with health, hospitals, health centres and GPs.
- Had there been transformation and demand changed and would that return to normal or would it be transformational.
- Was there room in this change from the normal and whether something should be done in the short term to recognise the total demand on the whole system has changed.

The Chair suggested that these issues could be picked up in a development session.

Martin Samuels (Adult and Children's Services) commented that:-

- Work had been undertaken with the Participation Strategy and the Professor Lundy Report and staff had embraced the exciting opportunities offered by a different approach to service delivery. A Rights Based Model had been embraced as recognising children had a right to a voice about the service they received for their needs and should not just be given the service determined by officers. It was an opportunity for an innovative engagement.
- There had been full consultation on the new approach during lockdown through active social media, daily polls, online consultation, webinars and topic groups to connect with young people in ways they chose and preferred.
- Children had been supported by having access to devices and they could meet in private.
- Valuable lessons had been learned and had brought out strongly the mental health of young people in a difficult year and an understanding of the pressures they had been under.
- Children did not want to use Teams and Zoom for meetings but preferred Facebook Live instead.
- Children could be far more resilient than often they were thought to be when facing pressure. They do respond well and, if officers used their preferred technology, they do engage positively.
- Professor Lundy had also said that Leicester's work was exemplary, and she uses it as a reference to others.

The Chair asked that information on the Participation Strategy be circulated to Board members as this would assist others to see how they could engage with

hard to reach groups.

Kevan Liles (Chief Executive, Voluntary Action Leicester) reported that they engaged with organised public groups through the website and newsletters. They also held a 3-day conference on-line and services users used Facebook portals to engage.

Cathy Ellis (Char of LPT NHS Trust) commented that they had set up in LPT People's Council in September 2020 chaired by Healthwatch which included diverse groups with protected characteristics and others. They came to a Board Meeting to report on mental health services. A Youth Advisory Board for 13-21 year olds had been set up to meeting weekly. They had engaged as mystery shoppers and taken a critical look at website and worked on 10 second tips on twitter to comply with social distancing and how to keep engaged. Participants were supported by training and developed by the Trust.

Mark Wightman (UHL Director of Strategy and Communications) indicated they had used Facebook Live to promote vaccines and address the resistance of people to have a vaccine for Covid. 6,000 people had taken part. The views of children and parents had been taken into account in relation to the building of the new children's hospital. There was merit in engaging with the public without already have an pre-determine agenda to implement in order to encourage the public to participate and find out the matters which were of importance to them.

Ivan Browne (Director of Public Health) stated that engagement had taken place though speaking to relevant people rather than issuing long consultation engagement documents. It had been beneficial to find that when the right people were engaged, they were able to pull together the right team rather than the usual group of people putting themselves forward. This had been particularly useful in relation to identified ethnic groups such as Somali and Black African Caribbean. Engagement could not be carried out without trust. Engagement work had started with Covid-19 and then developed into mental health, wellbeing and young people.

Richard Morris (Director of Operations and Corporate Affairs, LLR CCG) indicated that one size or model of engagement did not fit all situations. There was a need for a range of issues in a dynamic model as groups and communities were all different. The CCG had put in place a public involvement assurance group and had developed a citizen's panel. 1,000 people were used as a rapid testing method to give quick insight of public opinion. Engagement also took place on-line which enabled to the CCG to engage many with people who had not engaged before. It also resulted in seeing different people that would not normally come to face to face meetings. Going forward it would be important to engage through all different engagement methods to engage with as wide a base as possible. The CCG also engaged with faith and community leaders and groups to have dialogue about services with them. The engagement model had been radically changed so that engagement was not taken on issues when it was realistically too late to make a difference to one where having more open and place based discussions and consultation to

inform the development of the strategy model. There were direct benefits for engagement when it was possible to say these are the issues you said were of concern to you and this is what we are doing to address them. It would also allow better joint working with others.

Executive Members commented that:-

- It was important to build trust during engagement and the joint central resource for all to access the outcomes of engagement was welcomed. Learning outcomes should be pooled together so each organisation can draw from each other's learning outcomes and use them for future reference.
- It was important to understand that communities and geographical areas were very different and needs different aspects when undertaking engagement. For example, there's an old established Polish community in the City and also a newer more recent Polish community and each community generally lived in different areas of the City.
- It would be helpful to develop principles to draw together all the elements needed for engagement as had been done for the earlier item for health inequalities. This then would provide guidance for everyone to work to in the future. The Director of Public Health could lead on this and circulate to partners to add their contributions.

RESOLVED:-

That organisations be thanked for their updates and the items requested by the Chair above be actioned.

23. MENTAL HEALTH SERVICES

Paula Vaughan Head of Mental. Health and Learning. Disabilities and Gordon King from Leicester Partnership Trust gave a presentation on the co-design with service users of local mental health services.

During the presentation it was noted that:-

- Following new funding of £815k, there was a for a new piece of work on mental health and wellbeing and to do a piece of work in partnership with primary care networks as key partners. Initially groups within the networks would be asked to do the following 5 things
    - Have a real understanding and intelligence and narrative around the mental health needs of their local in neighbourhoods
    - Have a quantative assessment impact of Covid on mental health and wellbeing needs in each of the communities
    - Have conversations in the neighbourhood about what would make an impact in making lives better for them in the community.
    - Formalise the partnerships in the local community in a more formal way to enable those involved in the partnerships such as local voluntary sector, faith and youth groups etc to meet, talk and work together.
    - Think about the investment we have given them and what sort of

things would they want to put in place locally that would work specifically for their community and we will help them to measure the outcomes in a common format to see what the impact the community assets and investments have been.

- It would be launched in the next week or two. LPT and CCG some management capacity and resources to help with this piece of work.
- Poor mental health services had always tried to be at the heart of understanding how the inequalities and the wider determinants of poor mental health play through around poverty, race, trauma and discrimination. Chronic mental health was also strong driver for poverty. It also carried a lot of baggage around race and dangerousness and we will use that to inform specific work we will be doing around black mental health and the wider BAIME agenda.
- Undertaking a wider public engagement with service users on the wider transformation changes ready for public consultation. There is a legal duty and also a moral duty to do this address stigma etc.
- Targeted engagement to address historical lack of engagement from some groups around patient engagement on mental health.
- At the heart of delivery is daily engagement and co-production.
- It was important to ensure that everything done on a care plan, a care pathway people's medication plan, work with CPN and other organisation staff was how engagement was delivered in a way that was a genuine partnership to deliver high level mental health care and attain recovery for the patient. Recovery required agency in mental health and people having some hope and some control of what happens. If work was in partnership better outcomes were delivers for people.
- There was a recovery and collaborative care plan and cafe which was a 9-week programme shared space focusing on chine, connectivity, hope, opportunity and identity and meaning.
- Service users and carers were heavily involved in research. The psychologists team at Willows House and Stuart House engaged with service users on research on recovery on mental stress and recruitment panels to make sure we have the right representation of backgrounds of people when we recruit.
- Also doing work on self-assessments tools, central access points, and work around absconsion.
- Outcomes were only meaningful if they were developed by service users as they know how it feels to receive services and they know the outcomes they are looking for.

Board members commented:-

- Working at neighbourhood and community level was welcomed as targeted services were important including cultural specific services which should involve voluntary and community groups in providing them.
- When large contracts were awarded it could prevent small groups that were making local services and a vital contribution from being considered. There was a need to people who needed services a choice, so they could go to different groups to provide what they needed. Small

groups should not be excluded by organisations when going the tendering process as this could lead to
Part of the infrastructure being lost and depriving small groups of investment to continue to deliver their valuable services.

- It was desirable to embed genuine wellbeing and resilience within communities. It was also important to not just treat illnesses but to foster positive spirits and resilience. Mental health was not just about the absence of disease but also about positivity and hope.
- LPT had made and excellent way of making material available to people to focus on small habits and actions that foster wellbeing as opposed to dealing with poor mental health during the Covid restrictions. It was not just about addressing the consequences of not being well but using green spaces and access to transport were huge factors in promoting wellbeing to foster positive attitude and resilience in the future for people.

The Chair thanked Paula Vaughan and Gordon King for this important piece of work. Mental health was equally as important as physical health and needed to have equity of resources and parity of esteem. The changes being made were welcomed and a further update on these to a future meeting would be helpful. Numerous conversations with black ethnic communities all mentioned mental health issues as being important to the them. It would be desirable to have a symposium with members of the black community so that engagement can be taken forward on this issue and to learn lessons as engagement progressed from this piece of work. The Council's community, leisure and neighbourhood centres could be used help with this initiative.

24. DATES OF FUTURE MEETINGS

The Board noted that future meetings of the Board would be held on dates to be approved at the Annual Council Meeting in May 2021. These will be circulated when they were approved.

Meetings of the Board would currently continue to be held in a virtual format until such time as meetings are allowed to be held again in City Hall.

25. ANY OTHER URGENT BUSINESS

The Chair stated that no items of Any Other Urgent Business had been notified to be discussed.

26. CLOSE OF MEETING

The Chair declared the meeting closed at 12.05pm.

Appendix C

LPT

Leicester H+WB board SPOTLIGHT: LPT

Digital Pathways for the Management of Cardio-respiratory Conditions and Covid-19

Issue:

Supporting people with long term cardio-respiratory conditions through the Covid-19 period, within restricted face to face contact due to IPC guidance in healthcare settings.

Solution: Covid virtual wards for long term conditions management

- Community-based remote monitoring pathway for patients with chronic conditions and Covid 19 using digital technology
- New pathways of care were provided quickly and safely, using robust and rapid clinical governance across organisations to protect clinically vulnerable by reducing clinics and home visits
- Result: **1000 patients supported across four digital pathways;** Clear reduction in readmissions (C19); Reduce unplanned hospital admissions; Support patients with Covid 19 on discharge in the community; Alternative rehabilitation delivery methods

Learning and application for Leicester H+WB board:

- Rapidly responded to the needs of 'the system'
- New and innovative way of providing care through digital pathways/virtual wards
- Personalised patient support
- Patients cared for safely in their own homes
- Watch this film for more info

Leicester H+WB board SPOTLIGHT: LPT

Enhancing urgent mental health care during Covid

Issue:

Divert as many patients as possible from A&E to increase their capacity to deal with the start of the Covid-19 pandemic

Solution: Urgent mental health care hub

- LPT set up an urgent mental health care hub in 11 days to help divert patients from A&E, but it soon became much more than that.
- Put together a multidisciplinary team of staff to support the service from across other mental health teams
- Care for patients who would ordinarily have needed treatment from A&E staff, such as those who might have self-harmed or taken minor overdoses
- Based on the trust's acute mental health hospital site, creating a suitable and comfortable environment away from A&E for all ages, with system partners
- Working with colleagues in social care, housing and acute trusts, to get patients the right personalised care.

Learning and application for Leicester H+WB board:

- Create a shared vision with the team on set up
- Collate feedback from service users to build the model
- Act as a system for improving opportunities to signpost and get patients to the right place. System solution with ambulance service, A&E, and the acute trust through joint standard operating procedure
- An opportunity for future mental health models, be ambitious and empower staff to be leaders. Read the NHS Providers case study

Leicester H+WB board SPOTLIGHT: LPT

Youth Advisory Board

Issue:

Improve gap in the engagement of children and young people in reviewing and co-designing our services

YAB
Youth Advisory Board

Solution: LPT Youth Advisory Board to 'youth-proof' our services

- The YAB was set up in partnership with Leicester City Council Youth Team, and first met in November 2019 after several months of planning to ensure the structure and set up would be sustainable and safe
- Membership includes members of the youth council who have been nominated to be involved in health through their own experience and interest and service users aged between 13-25 years old supported by CAMHS Peer Support workers as a positive means for recovery.
- The group is supported by an LPT lead for patient experience and Involvement, Leicester City youthwork/children's rights manager and youth workers.
- The young people set the agendas. They review and support co-design of service developments and improvements, and have already made a significant contribution to improving services in LLR.

Learning and application for Leicester H+WB board:

- Co-design and involvement in partnership with young people, with them taking the lead on what they want to focus on that impacts them.
- A representative panel that staff across the system can access the group to 'youth-proof' future service developments.
- Read Page 62 of the LPT Book of Brilliance for more

Police

Leicester H+WB board SPOTLIGHT:

Police & LPT – Proactive Mental Health Triage Car

Issue:

Throughout Covid, we have seen increased demand on Emergency and MH services, with often first-time presentation of MH illness. Through Proactive triaging we ensured the correct pathfinder / service.

Solution:

Police & Mental Health Proactive Triage Car

- A PC and LPT Nurse out in a car attending live Police MH Incidents.
- Everyday 1700 – 0200. Ends 31st Aug 21
- First responding to MH incidents.
- Quicker triaging and passing Info to Police Crews.
- Ensuring the correct pathway / service for the service user.
- Reducing unnecessary demand on Emergency services / A&E.

Date / Result	Overall incidents	Taken / At Home	EMAS	Arrested	LRI	Hub	PSAU	MH Team / Care team	Not known	Monthly Diverted
January	53	6	3	0	3	1	1	2	0	16
February	103	1	3	0	11	1	3	2	1	22
March	119	2	5	0	8	2	0	5	0	22
April	118	12	10	1	8	1	2	4	0	38

Above is a snapshot of the results, as you can see we are attending around 100 incidents and ensuring the correct pathway is used.

We are ensuring service users enter the system at the correct point, receiving the right treatment. Which in turn reduces demand.

Leicester H+WB board SPOTLIGHT: Police

Pro-Active Vulnerability Engagement Team

Issue: Increase in Mental Health demand with limited referral pathways / reduction in face to face contact by other services during Covid-19

Solution:

- **Service provision** changed to a Monday – Friday 8am - 8pm. 7 day week was trialled initially however, did not identify significant demand over weekends.
- Several referrals during Covid-19 relating to service users whereby their mental health support in the community has been changed from face to face visits from their care team to telephone support. PAVE **continued to complete face to face visits** during Covid-19 where necessary, following relevant risk assessments – to reduce demand.
- **Proactive approach** taken towards service users in co-ordinating appropriate support and in identifying former service users with recent contact with services likely to present to police during the Covid-19 period.
- **Review of a number of high demand service** users to establish whether there was any role for our team to reduce demand. This continues to be embedded in current processes identifying repeat demand to the Mental Health Triage Car and Adult Referral Team.
- Implementing more **structured plans** for individuals open to PAVE including regular phone contact from the team to reduce the demand via Contact Management and to other emergency services where relevant.
- Utilisation of Microsoft Teams / Skype to chair professionals meetings
- **'Day of positive action'** – PAVE jointly visited vulnerable residents with one of the local police neighbourhood officers to identify individuals that may require additional support and referrals to look at alternative way to reduce demand and resolve some of the key neighbourhood concerns expeditiously with multiagency approach.

UoL

University of Leicester SPOTLIGHT

Title of project:

UK-REACH study into ethnicity and COVID-19 outcomes in healthcare workers

27

Issue:

Identification of those who might be at greatest risk of infection or adverse outcomes, particularly among healthcare workers from black and minority ethnic backgrounds.

Solution:

- Project led by Prof Kamlesh Khunti (Director of Centre for Ethnic Health Research and member of SAGE) and Dr Manish Pareek (Associate Clinical Professor in Infectious Diseases).
- Played pivotal role in bringing to light the disproportionate impact of COVID-19 on those from black, Asian and minority ethnic communities.
- £2.1M government funding (UKRI and NIHR) for **UK-REACH study into ethnicity and COVID-19 outcomes in healthcare workers**.
- Working with 30,000+ clinical and non-clinical members of NHS staff to determine their COVID risk based on analysis of healthcare records.
- One of the outcomes is a new Risk Reduction Framework for NHS staff to better protect NHS workforce and maximise ability of NHS to deal with pandemic pressures.

Learning and application for Leicester H+WB board:

- Adoption of new Risk Reduction Framework consensus document.
- NHS Trusts will require specialist occupational health support and advice to apply Framework guidance equitably.
- Consider where Framework can be reviewed and updated in light of new evidence.

University of Leicester SPOTLIGHT

Title of project:

Your COVID Recovery

Issue:

Lack of easily accessible patient-focused information aimed at individuals who have had and are recovering from COVID-19 infection.

Need for clear advice on how to manage the physical, emotional and psychological effects.

Solution:

- Project led by Prof Sally Singh, Professor of Pulmonary and Cardiac Rehabilitation (UoL) and Head of Pulmonary and Cardiac Rehabilitation (UHL).
- 'Your COVID Recovery' online service launched to support patients with ongoing symptoms from coronavirus in their recovery.
- One of the first public websites in the world providing information on:
  - *What is COVID-19?*
  - *Managing the effects*
  - *Your well-being*
  - *Your road to recovery*

Learning and application for Leicester H+WB board:

Ensure clear signposting for patients, their families and healthcare workers to the website:

https://www.yourcovidrecovery.nhs.uk

Your COVID Recovery

VAL

Leicester H+WB board SPOTLIGHT:

VALUES project at VAL

Issue: Enabling effective support for vulnerable service users with Learning Disability during Covid restrictions

Solution: Covid safe support in person and via online connections.

- Fundraised for Facebook Portals for clients
- Supported individuals to access support online – not suitable for all but some really took to it and improved communication skills.
- Limited number of home visits as welfare check on clients
- After initial 12 weeks lockdown reopened in person sessions by repurposing VAL building space.
- Throughout pandemic have maintained contact with all clients and families.
- Now moving back to service 'stretching' individuals to learn and develop skills for independence.

Learning and application for Leicester H+WB board:

- Helped by some commissioners being flexible about how support offered which has meant VALUES service has survived Covid

Leicester H+WB board SPOTLIGHT:

Vaccination Volunteers

Issue: Volunteer support for the Covid vaccination programme

Solution: Volunteer Support for the Covid Vaccination drive

- Massive ongoing volunteer deployment across LLR.
- Commenced in January 2021 – 2,700 volunteers recruited; 14,000 shifts completed to date (cash value £500,000)
- VAL continuing to recruit, co-ordinate, and deploy volunteers across LLR so far to 36 separate sites.
- Likely to be an ongoing exercise for rest of this year.

Learning and application for Leicester H+WB board:

- Volunteers are not free – but add enormous value to public service delivery.
- Volunteering works best where there is a 'common bond'.
- Volunteers effort is sustained if they are treated with respect and thanked.

Leicester City CCG

SPOTLIGHT:

Cancer care reviews

Issue:

Prior to COVID, 74% of LLR cancer patients had had a cancer care review with their GP.

GP's had fed back that the template itself was not helpful and with the pressures of COVID, this fell to 15% between Sept and Dec 20, detrimentally impacting patient care

- Clinical teams worked with management teams to rewrite the template in February 2020
- Further intel had shown that GP's were not confident in use of the template and had requested support from individual consultants at UHL.
- Changes were relayed to clinicians by clinicians at an online meeting with 80 attendees, with UHL / patient support.
- **As at March 31st 2021, the number of City patients having a cancer care review had increased from 15% to 67%**

SPOTLIGHT:

COVID Virtual Wards

Issue:

The increase in numbers of COVID patients had put the CDU at the Glenfield hospital under considerable pressure, with overcrowding, staff exhaustion and increasing admissions

- Both UHL and LPT have implemented a virtual ward model for 'front door' activity as well COVID admissions
- The services have seen over 900 patients combined and have been able to either discharge patients from CDU without admitting to a base or facilitated early supported discharge for admitted patients
- The integrated COVID Virtual ward mode for admitted patients has reduced readmission rates by 51%
- By month, 144 COVID-19 patients have been discharged after a hospital admission with remote monitoring at home. To date, only 5 of these patients have been readmitted

SPOTLIGHT:

Annual Health Checks (AHC) for 14+ People with LD

Issue:

NHSE expectation that at least 67% of 14+ LD patients with receive an AHC. 2019/20 LLR achieved 54%. As at Q1 2019/20, LLR had achieved just 5.1%

Solution:

- Focus the discussion and improvement strategy on addressing health inequalities for people with LD (e.g. life expectancy for a person with LD in LLR is only 59 years, people with LD more than 6 times more likely to die of Covid)
- Create a way of understanding where the areas of good practice and performance are. Introduce a weekly updated practice/PCN/CCG level dashboard indicating YTD performance, last week's activity and numbers of AHCs to go in year.
- Facilitated both focussed practice support from LD primary care liaison nurse team, executive level mandate to focus primary care capacity and a health inequalities focussed conversation with struggling practices.
- Exemplar bid funded post, focussed work on DNAs and non-engaging patients
- As at early March 2021, LLR has achieved 71% against the target of 67% of people with LD having an annual health check

SPOTLIGHT:

GP-led follow up with vaccine hesitant patients

Issue:

Approximately 4,500 patients across LLR have been offered a COVID vaccination but have declined.

Solution:

- Data analysis of patients who have been offered the vaccine but declined suggested that a high proportion were either of BAME population and / or live in deprived areas of LLR. Engagement with these communities had implied that much of the hesitancy was due to a lack of confidence in the vaccine or due to the information available not being in an accessible format / language.
- A pilot was developed across one practice in the City whereby a GP or clinician called those who had declined to ascertain the reasons for declining the vaccine. Analysis of the first day's data showed that many patients simply had unanswered questions or had seen / heard misinformation.
- Following a conversation with the clinician, 69% of patients booked in for vaccine, 19% of patients requested more time to think and 9% declined.

SPOTLIGHT: Rising numbers of non-acute attendances at Children's ED

Issue: reduce the numbers of parents calling out of hours or presenting at A & E with children who have symptoms that could be managed at home

Solution: Beat the Street Webinar – common childhood ailments

Beat the Street turns towns into giant games. Participants can earn points, win prizes and discover more about their local area by walking, running and cycling.

- Over 40,000 people played Beat the Street in Leicester between May and July 2021. 67% of all children in Leicester aged between 5-11yrs played the game
- It is this relationship and experience in communicating with this group that gave a great opportunity to talk to parents about dealing with common childhood symptoms (as well as Covid symptoms) that choke Out Of Hour GPs and A&E.
- Invited parents from the most engaged schools via a Zoom call to listen to a presentation from Dr William Bird (GP and Founder Intelligent Health), Dr Damian Roland (Consultant in Paediatric Emergency Medicine, UHL) and Dr Hanna Robbins (GP Partner, Long Lane Surgery & Clinical Lead, Children and Young People, Leicester, Leicestershire and Rutland CCGs)
- Webinar took place on the 30th June, 16 parents attended:
  - They all found it useful or very useful
  - Temperature and Covid were equally the most informative
  - Most found 7.00pm on a week day the best time
  - All but one wanted Mental Health in children covered next time (diet and physical activity were both chosen by one person)
  - How to use local resources was very popular as they feel GPs are hard to access.

Future webinars planned in partnership with Leicestershire Live, CCGs, UHL, and Public Health

SPOTLIGHT:

Home First front door presence

Issue:

High ED attendance and variable admission behaviours for frail patients

Solution:

- Over the last couple of weeks the ED department at the Leicester Royal Infirmary have seen between 659 to 925 attendees arrive at the front door daily
- City and County joint 4 week PDSA of social care crisis team presence in ED now live
- Community Response Service (CRS) and the Integrated Crisis Response Service (ICRS) both present initially 11am-2.30pm
- Staff from CRS and ICRS will work with the Therapy Team and with the Emergency Floor Discharge Practitioners (EFDP's) on ED.
- This work will help
  - Identify patients that can be diverted from ED on to the most appropriate pathway and at the earliest opportunity
  - Share key information in terms of the key interventions already in place for people (by accessing Liquid Logic/SystmOne)
  - Liaise with community teams (Health and Social Care) to restart existing packages of care and signpost to appropriate services
  - Participate in MDTs and board rounds (if needed)
  - Support CRS and ICRS to help enable collaborative learning, consistency in practice which also further strengthens their relationships as City/County providers
  - Increase the knowledge and awareness of community services, specifically around the Home First offer across LLR
- Evaluation will determine future need to maintain

SPOTLIGHT: Supporting surge in General Practice

Issue:

Between 6-8% of all appointments in General Practices can be safely and effectively managed in our community pharmacies, supporting GP's to focus on patients most in need of GP services

Solution: Introduction of the Community Pharmacy Consultation Service pathway

Mobilisation commenced in May 2021 and is ongoing

- 209 community pharmacies signed up across LLR
- 48 practices across LLR have made 2,424 referrals in first 6 weeks

- 100 of the engaged community pharmacies have an LE1 – LE5 postcode
- 17 Leicester City practices have made 1,020 referrals to date
- Leicester City South PCN and Leicester Health Focus PCN will be live by 31/07/2021

Getting this right will increase access to care whilst supporting our patients who require their GP

SPOTLIGHT:
Supporting Frail people through Assistive Technology

Issue: The City has historically had a higher rate of older people accessing acute care for frailty, including a higher rate of fallers

Solution: Joint assessment and provision of assistive technology to prevent falls and keep people at home independently and safely.

- This service is an important part of our integrated system of care supporting frail and older people to remain safe and independent at home – reducing the incidence of falls, improving medication compliance, helping those with dementia to remain orientated and safe
- The Assistive Technology service is joint-funded by contributions from the BCF and from the Local Authority.
- Between April 2021 and the end of June 2021, the service was provided to 621 people of whom 264 were new customers.
- 849 items of equipment were provided, including falls sensors, medication dispensers and lifeline alarms.

SPOTLIGHT:

Admission Avoidance – 24 hour call centre

Issue: The City has historically had a higher rate of older people accessing acute care for frailty, including a higher rate of fallers

- Leicester Care, the 24 hour call centre joint funded by BCF and the council, has 5,354 people on their database of whom 83% are over 65.
- They have taken 33,610 calls in the first three months of 2021-22, and 68% of these were for immediate needs/reassurance.
- The team dispatched ICRS to assess the person in their own home in c580 cases. It's very impressive that thanks to ICRS's ability to provide immediate care and to collaborative work with community health services, GPs, and pharmacies only 3% of these cases needed to go to hospital for further assessment.
- In over 700 cases a carer or neighbour was alerted to contact the caller and again, in over 95% of these cases the problem could be sorted out and the person kept safely at home.

Many of these patients would have used a significant amount of health and care resource and suffered poorer outcomes had this joint health and care response not been in place

Healthwatch

Leicester H+WB board SPOTLIGHT:

Improvements to discharge from Hospital

Issue: We visited the three UHL hospital discharge lounges in July 2019 and found that waiting for medication was a major cause of delays. In October 2020, we worked with the Matron at LRI to find out if any improvements or changes have been made.

Solution:

- UHL have introduced new Covid-19 pathways for all processes across the hospital including discharge
- The discharge lounges have been decorated and are more comfortable for patients
- We have raised the need for better communications on the wards
- There is still an ongoing issue for patients having to wait for both medication and transport
- UHL will be using this feedback within their safe and timely discharge quality improvement work stream to shape the discharge services going forward
- Nationally, the work is being used by NHS England and the Department for Health and Social Care to support the review of the discharge guidance and has highlighted the need for greater support for those with low level or short term needs leaving hospital

Leicester H+WB board SPOTLIGHT:

BME Connect

Issue: we established 'BME Connect' – a platform for communities to come together to talk about the issues that matter the most to them. This unique project began looking into mainstream methods of marketing and communication and its impact, influence, and connectivity to BME community settings.

Solution:

- Ensuring that there is an infrastructure in place to support BME communities.
- Establishing that the right people are represented in the right place, for the right reasons
- During the pandemic, BME Connect sought to address the most urgent issue, 'how are BME communities communicated with'
- Ensuring that BME people have the information they need to navigate the H&SC services / system, give them patient voice and representation
- The reference group is made up of people that are committed and want to see a difference

Leicester Health and Wellbeing Board

Leicester, Leicestershire and Rutland Integrated Care System Overview and Draft LLR ICS Purpose, Principles and Priorities

Appendix D

29th July 2021

Integrated Care Systems – What are they?

Enabling transformation of health and care:

- Joining up and co-ordination of health and care
- Proactive and preventative in focus
- Responsive to the needs of local populations

Grounded in the following:

- Planning for populations and population health outcomes and reducing inequalities and unwarranted variation
- Building on system and place based partnerships
- Subsidiarity and local flexibility
- Collaboration

Integrated Care Systems will:

- Improve outcomes in the population
- Tackle inequalities in outcomes, experience and access
- Support partners input into the broader social and economic development of the area through an anchor approach
- Enhance productivity and value for money

Our system

Integrated Care System: Leicester, Leicestershire and Rutland

Place

- Leicester
- Leicestershire
- Rutland

Neighbourhoods

Place	Local Integration Hubs
Leicester	Central; South; North West; North East
Leicestershire	North West Leicestershire; Hinckley; Blaby & Lutterworth; Charnwood; Melton & Rutland; Harborough, Oadby & Wigston
Rutland	Rutland

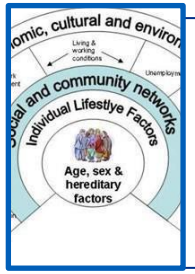
What does this mean for Leicestershire

This is not a new approach – it is a continuation of what we have been doing:

Understanding and working with communities

Population health management approach

Joining up and coordinating services



Addressing social and economic determinants of health and wellbeing and reducing health inequalities

Examples of what we have been doing in Leicester to integrate services

Home First: an integrated service to respond within 2 hours to people who are at risk of being admitted to hospital

Mental Health: integrated teams working alongside GP practices focused on patients with Long Term Conditions

Health Transfer Team: integrated work between social care and acute services to reduce discharge delays

Co-location: social care and community services co-located at the Neville Centre improving patients care through better co-ordination

Care Navigation: neighbourhood-based team working to support people in a range of areas – health; social care and wider services

Voluntary Sector: joint work with a number of voluntary sector organisations to provide support to particular groups

Priorities for Integration and Transformation in Leicester

Neighbourhood Teams: develop further the integrated team offer – primary care; social care; community care; voluntary sector

Health Inequalities: implement the local health inequalities investment fund

Joined Up Data: improve the sharing and quality of data across health and social care

Communities: build on the joint community based work undertaken during COVID to support health and wellbeing

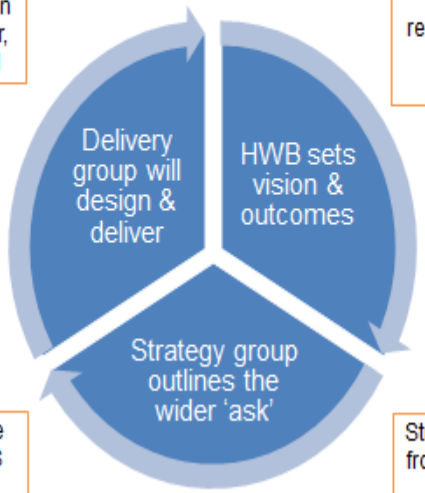
Mental Health: embed mental health services at a local level

Health and Wellbeing: refresh the Health and Wellbeing Strategy

Overview of ICS infrastructure

Place infrastructure

Governance at 'place'



52

"Integrating care" Nov 2020

The ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

1. Access clear advice on **staying well**;
2. Access a range of **preventative services**;
3. Access **simple, joined-up care and treatment** when they need it;
4. Access digital services (with non-digital alternatives) that put the citizen at the heart of their own care;
5. Access proactive support to keep as well as possible, where people have **additional needs or at high risk**; and
6. To expect the NHS, through its employment, training, procurement and volunteering activities, and as a major estate owner to play a full part in **social and economic development** and **environmental sustainability**

System infrastructure

Integrated Care System

Accountable for improving the health outcomes of the population

LLR ICS NHS Board

- Takes on CCG statutory responsibilities
- Lead integration within the NHS
- Bring together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population
- Joint working arrangements should be the norm
- Shared strategic priorities within the NHS
- Wider partnership working to tackle population health and enhance health and care services

LLR ICS Health and Care Partnership

- NHS and local government as equal partners
- Joint action to improve health and care services
- Influence the wider determinants of health and broader social and economic development
- Develop an integrated care strategy for whole population
- Support place and neighbourhood-level engagement

Membership

Health and Care Partnership Group

- Jointly appointed Chair
- Representatives from local authorities responsible for social care
- NHS Representation – at least one from the ICS
- Other membership is for local determination but could include wider representation from LAs and NHS; VCSE sector; HealthWatch; and other organisations that can contribute to the agenda of the group

LLR ICS NHS Board

- Independent Chair and minimum of 2 non-executive directors
- ICS Chief Executive; ICS Director Finance; ICS Nursing lead; ICS Medical Director; NHS Trust Representative; Primary Care Representation; Local Authority Representation
- Other membership is for local determination

Timeline

End of Q1
PREPARATION

- Understand guidance
- Develop plans to manage the change

End of Q2
IMPLEMENTATION

- Recruitment and selection processes for the ICS NHS body chair and chief executive
- Develop delivery model and governance model including system and place proposals
- Continue with delivering the plans for the change

End of Q3
IMPLEMENTATION

- Carry out the recruitment and selection processes senior management team
- ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form.
- Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership.
- Continue with delivering the plans for the change

End of Q4
TRANSITION

- Complete due diligence for staff and property transfers from CCGs and other NHS staff transfers to new ICS NHS body
- Submit any required documents for approval/agreement
- Undertake the close down of CCGs and establish ICS

55

The full Integrated Care Systems: design framework can be found at:

https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf

56

Draft LLR ICS Purpose, Principles and Priorities

Background

- The Leicester, Leicestershire and Rutland Integrated Care System Health and Care Partnership Group has developed its draft Purpose, Principles and Priorities through a series of workshops with partners.
- Each workshop built on the previous discussion to finalise proposals.
- Support was provided through a Task and Finish Group, of partners, between workshops to refine the proposals.
- At the final workshop on 17th May 2021 members were asked to provide any final comments before consideration by the Health and Care Partnership Group on 17th June 2021.
- The Health and Care Partnership Group asked for the Purpose, Principles and Priorities to be considered by Health and Wellbeing Boards before final approval was given by the Group.
- Therefore the Leicestershire Health and Wellbeing Board is asked for their comments and feedback on the proposed draft LLR ICS Purpose, Principals and Priorities.

Purpose

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

Principles

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

Transformational Priorities

Transformational Priorities
We will transform the following areas ensuring we take steps to improve the equity of access and outcomes

Best Start in Life We will focus on the first 1001 days of life to enable more equity in outcomes as we know this is critical to a child's life chances	**Staying Healthy and Well** We will support our residents to live a healthy life and make healthy choices to maintain wellbeing and independence within their communities
Living and Supported Well We will focus on supporting those with multiple conditions and who are frail to manage their health and care needs and live independently	**Dying Well** We will ensure people have a personalised, comfortable, and supported end of life with personalised support for carers and families

Operational Priorities

Operational Priorities – We will:	
Work together across health and local authorities to deliver the COVID vaccination programme and winter Flu programme ensuring maximum uptake	Recover services across all sectors of our partnership that have been affected during the pandemic improving our communication with our residents as we do this
Deliver changes to UHL hospitals and transform our mental health services ensuring appropriate local delivery	Work together across health and care to transform access to the health and care services we provide, with a focus on primary care, urgent care, chronic conditions and mental health services

Note: these priorities will be the focus of the LLR ICS NHS Board to deliver working with partners as necessary

DEVELOPING A LEICESTER CITY PLACE LED PLAN

Leicester City Health & Wellbeing Board

29th July 2021

Appendix E

Purpose

- To describe the role of place and the purpose of a place led plan within an Integrated Care System

- To invite discussion to shape our plans as a ‘place’ within the ICS

- To seek approval from Health and Wellbeing Board to:
  - Carry out a minor refresh of Leicester’s Joint Health and Wellbeing Strategy (2019-2024)
  - Develop a Leicester Health, Care & Wellbeing Delivery Plan based on the strategic aims of the Joint Health and Wellbeing Strategy

Context

- Integrated care systems (ICSs) are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population.

- All parts of England are now covered by one of 42 ICSs as of 1st April 2021.

- February 2021. White paper published on ICS

- 6th July 2021. The proposed Health and Care Bill 2021-2022 was introduced in Parliament; brings in statutory ICS organisations.

- It is hoped that they will be a vehicle for:
  - achieving greater integration of health and care services
  - improving population health and reducing inequalities
  - supporting productivity and sustainability of services
  - helping the NHS to support social and economic development

Context (continued)

The ‘ICS Design Framework’ released in June 2021 covers how Place led Plans will contribute towards the ICS aims and objectives:

‘We expect the ICS Partnership will have a specific responsibility to develop an ‘integrated care strategy’ for its whole population using best available evidence and data, covering health and social care (both children’s and adult’s social care), and addressing the wider determinants of health and wellbeing. This should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. We expect these plans to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities’.

https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/

Levels within Integrated Care Systems

Level	Purpose	Local approach
SYSTEM	Whole area's health and care partners in different sectors come together to set strategic direction at system level where appropriate (e.g. health inequalities framework)	One system: Leicester, Leicestershire and Rutland.
PLACE	A partnership of local health and care organisations setting place level vision, strategy and delivery (e.g. H+WBB, JICB, ISOC)	Three Places: • Leicester City • Leicestershire County • Rutland County
NEIGHBOURHOOD	GP practices, NHS community services, social care and other providers able to come together to provide locally based, integrated and proactive services.	Determined locally at each Place.

Place: an important building block for health and care integration

Aim is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

- access clear advice on **staying well**;
- access a range of **preventative services**;
- access **simple, joined-up care and treatment** when they need it;
- access digital services (with non-digital alternatives) that put the citizen at the heart of their own care;
- access proactive support to keep as well as possible, where they are **vulnerable or at high risk**; and to
- expect the NHS, through its employment, training, procurement and volunteering activities, and as a major estate owner to play a full part in **social and economic development** and **environmental sustainability**.

(Integrating care: Next steps to building strong and effective integrated care systems across England report Nov. 2020) https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/

Background: Leicester's Joint Health and Wellbeing Strategy

- Leicester's Health and Wellbeing Strategy (H+WBS) was published in late 2019
- Sets strategy until 2024
- Extensive communities and stakeholders focus groups, engagement and formal consultation
- Published pre-coronavirus pandemic
- Core themes of 2019 strategy (Healthy Places, Healthy Minds, Healthy Start, Healthy Lives, Healthy Ageing) still relevant
- Coronavirus pandemic has accentuated pre-existing inequalities

Option 1: Leicester's Joint Health and Wellbeing Strategy

- **Option 1: Keep existing Health and Wellbeing strategy (H+WBS)**
  - Advantages:
    - All of identified priorities likely to still be relevant in Leicester
    - Significant amount of focus group and engagement with communities and stakeholders went into the development of this strategy – avoids potential engagement fatigue
    - Significant time and resources went into developing the H+WBS; this work is kept
    - Can move straight to development of the delivery plan, with final plan aimed for approval by H+WBB in early 2022
  - Disadvantages:
    - Strategy does not mention the coronavirus pandemic, the direct or indirect impacts of it
    - Strategy does not refer to LLR health inequalities framework or the increased national focus on reducing inequalities

Option 2: Leicester's Joint Health and Wellbeing Strategy

- **Option 2: Full rewrite of Health and Wellbeing Strategy**
  - Advantages:
    - Can engage with local communities and stakeholders to ensure the strategy reflects people's current experiences of living in Leicester in and through a pandemic
  - Disadvantages:
    - Considerable amount of work for health, care and wellbeing partners at a time when staff are still responding to the pandemic, recovering services from the pandemic, and recovering themselves
    - Several major consultations and engagement exercises over the past year – risk of engagement fatigue
    - Delays development of the Leicester delivery plan into later 2022, with revised strategy likely ready in early 2022

Option 3: Leicester's Joint Health and Wellbeing Strategy

- **Option 3: Minor refresh of the current Health and Wellbeing strategy**
  - Keep all current themes and strategic aims
  - Update narrative to include impact of coronavirus pandemic on communities, including direct and indirect impacts
  - Refer to relevant local and national policies on reducing health inequalities

- Advantages:
  - Updates strategy to make it relevant in light of the significant impact that the coronavirus pandemic has had on our lives
  - Recognises and maintains the significant input from communities and stakeholders that went into the development of the strategy in 2019
  - Avoids risk of engagement fatigue
  - Aligns the timetable to the delivery plan, to make a combined place led plan which can run until 2024

- Disadvantages:
  - Possible that health and wellbeing challenges/priorities of Leicester people have changed as a result of the pandemic

Place led plans

Supporting Frameworks/ strategies:

- **Joint Strategic Needs Assessments (JSNA's)**
- **LLR system Health Inequalities Framework**
- **LLR system Population Health Framework**
- **LLR Healthcare system Operational Plan**
- **Leicester City Adult Social Care Strategy**
- **Leicester City Better Care Fund**

Developing a Leicester Health, Care & Wellbeing Delivery Plan (2021-24)

It is proposed the delivery plan will:

- Support delivery of the vision and priorities in the Leicester JH+WBS (2019-2024)

- Be a collaborative plan across key partners to
  - strengthen self care & wellbeing support
  - address wider determinants of health
  - reduce health inequalities – tailored to local circumstances
  - increase integration of health, care and wellbeing services
  - manage the impact of housing growth on services & estates

- Be delivered through annual action plans

- Take a strengths-based approach building on:
  - Existing health and wellbeing and community infrastructure
  - Integrated and joint working that has already been achieved

- Be informed by:
  - Local intelligence, key stakeholders & local communities through engagement

- Be aligned with existing Leicester City and LLR system plans/strategies

Key indicative milestones in place led plan development*

Agreement to approach from HWBB	**29th July 2021**
Profiling of Neighbourhood level needs	By 13th August 2021
Collation of planned priorities relating to: • Improving self-care & prevention • Addressing health inequalities • Addressing wider determinants of health • Improving access to health & care services • Integrating health and social care services • Future impact of housing growth	By 3rd September 2021
Intelligence/insights from recent engagement consultations	By 15th September 2021
Outline draft Delivery Plan developed	By 30th September 2021
Draft revised JH+WBS and draft delivery plan to H+WBB for discussion	28th October 2021
Wide stakeholder engagement on initial plan	1st Oct. - 17th Dec. 2021
Finalisation of Plan, including first year action plan	By 7th Jan 2022
Agreement of final revised JH+WBS and final Delivery Plan by HWBB	27th January 2022

*proposed timelines may be subject to change if COVID/other pressures on the health and care system change

Core working group

We have established a task and finish core working group to develop the Delivery Plan. It include representatives from:

- Public Health, Leicester City Council
- Adult Social Care, Leicester City Council
- CCG's Strategy and Planning Directorate
- CCG's Integration and Transformation Directorate
- Comms and Engagement leads from CCG and local authority (tbc)

The core working group is meeting monthly and membership will evolve as work progresses.

Recommendations

The Health and Wellbeing Board is asked to:

- APPROVE option 3, the minor refresh of the Joint Health and Wellbeing Strategy

- SUPPORT the approach outlined to the development of a Leicester City Health, Care & Wellbeing Delivery Plan

- APPROVE the proposed timeline for the revised JH+WBS and the delivery plan