LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 28 OCTOBER 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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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:

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

Richard Mitchell, Chief Executive, University Hospitals of Leicester NHS Trust

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

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- ✓ 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.

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PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

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

The Minutes of the previous meeting of the Board held on 29 July 2021 are attached and the Board is asked to confirm them as a correct record.

4. SUMMARY OF THE KEY POINTS AND NEXT STEPS HEALTH AND WELLBEING DEVELOPMENT SESSION 11 OCTOBER - VERBAL UPDATE

5. DRAFT HEALTH AND WELLBEING STRATEGY AND PRIORITIES **Appendix B (Pages 11 - 58)**

Dr Katherine Packham, Consultant in Public He Dr Katherine Packham, Consultant in Public Health, Leicester City Council will present the report.

6. LLR LEARNING DISABILITY AND AUTISM (LDA) - 3 YEAR PLAN PROGRESS REPORT **Appendices C1 and C2 (Pages 59 - 96)**

a) LLR Learning Disability and Autism (LDA) 3 Year Plan Progress Report.

Mark Roberts. Assistant Director. Leicestershire Partnership NHS Trust
Cheryl Bosworth. Senior Programme Manager - Transforming Care Programme. LLR CCGs will present the report.

b) Project Search Opportunities for Children, and Young People with SEND

Steph Beale will introduce the report

7. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

8. DATES OF FUTURE MEETINGS

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

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.

9. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 29 JULY 2021 at 9:30 am

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Leicester City Council.
Kash Bhayani	–	Healthwatch Advisory Board Member.
Councillor Elly Cutkelvin	–	Assistant City Mayor, Education and Housing.
Harsha Kotecha	–	Chair, Healthwatch Advisory Board, Leicester and Leicestershire.
Kevan Liles	–	Chief Executive, Voluntary Action Leicester.
Dr Sulaxni Nainani	–	GP Member of Leicester Clinical Commissioning Group.
Dr Katherine Packham	–	Public Health Consultant, Leicester City Council.
Mark Powell	–	Deputy Chief Executive, Leicester Partnership NHS Trust.
Martin Samuels	–	Strategic Director Social Care and Education, Leicester City Council.
David Sissling	–	Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland.
Councillor Sarah Russell	–	Deputy City Mayor, Social Care and Anti-Poverty, Leicester City Council.
Rachna Vyas	–	Leicester Clinical Commissioning Group.
Mark Wightman	–	Director of Strategy and Communications, University Hospitals of Leicester NHS Trust.
Andy Williams	–	Chief Executive, Leicester, Leicestershire and Rutland, Clinical Commissioning Groups.

Standing Invitees

Cathy Ellis – Chair of Leicestershire Partnership NHS Trust.

In Attendance

Graham Carey – Democratic Services, Leicester City Council.

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27. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:-

Councillor Rita Patel	Assistant City Mayor Communities, Equalities and Special Projects, Leicester City Council.
Ivan Browne	Director of Public Health, Leicester City Council.
Professor Azhar Farooqi	Co-Chair Leicester City Clinical Commissioning Group.
Andrew Fry	College Director of Research, University of Leicester.
Angela Hillery	Chief Executive, Leicestershire Partnership NHS Trust.
Haley Jackson	Deputy Director of Strategic Transformation, NHS England and NHS Improvement.
Harsha Koteca	Healthwatch Advisory Board, Leicester and Leicester.
Richard Lyne	General Manager, Leicestershire, East Midland Ambulance Service NHS Trust.
Rupert Matthews	Leicester, Leicestershire and Rutland, Police and Crime Commissioner.
John Macdonald	Chair of University Hospitals of Leicester NHS Trust.
Oliver Newbould	Director of Strategic Transformation, NHS England and NHS Improvement.

Dr Avi Prasad	Co-Chair Leicester City Clinical Commissioning Group.
Kevin Routledge	Strategic Sports Alliance.
Chief Supt Adam Streets	Head of Local Policing Directorate, Leicestershire Police.

28. 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.

29. MEMBERSHIP OF THE BOARD

The Board noted it's membership for 2021/22 approved by the Council on 29 April 2021 as follows:-

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 INVITEE: (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

30. TERMS OF REFERENCE

The Board noted the Terms of Reference approved by the Annual Council on 29 April 2021.

31. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 25 March 2021 be confirmed as a correct record.

32. SPOTLIGHT ON GOOD PRACTICE AND INNOVATION

Updates on good practice and innovation from organisations represented on the Board relating to a number of health and wellbeing issues were received. These included:-

Leicester Partnership NHS Trust

- 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 through providing Covid virtual wards for long term conditions management.

- Divert as many patients as possible from A&E to increase their capacity to deal with the start of the Covid-19 pandemic by establishing and developing a urgent mental health care hub.
- Improve the gap in the engagement of children and young people in reviewing and co-designing services through the application of 'youth proofing services' in the LPT Youth Advisory Board.

Police

- Throughout Covid, there have been an increased demand on Emergency and Mental Health services, with often first-time presentation of a Mental Health illness, through the Police and Mental Health Proactive Triage Car to ensure the correct pathfinder / service.
- Increase in Mental Health demand with limited referral pathways / reduction in face to face contact by other services during Covid-19 such as a transfer to telephone support. The Proactive Vulnerability Engagement Team (PAVE), however continued to complete face to face visits were this was considered necessary.
- 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.

University of Leicester

- Identification of those who might be at greatest risk of infection or adverse outcomes, particularly among healthcare workers from black and minority ethnic backgrounds through :-
    - A 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 health care records.
    - One of the outcomes was a new Risk Reduction Framework for NHS staff to better protect NHS workforce and maximise ability of NHS to deal with pandemic pressures.
    - Lack of easily accessible patient-focused information aimed at individuals who have had and were recovering from COVID-19 infection. Need for clear advice on how to manage the physical, emotional and psychological effects through an on-line service to support patients with ongoing symptoms in their recovery and one of the first websites in the world providing information on Covid-19, managing its effects and the road to recovery.

Voluntary Action Leicester

- Enabling effective support for vulnerable service users with Learning Disability during Covid restrictions through providing Covid safe support in person and via online connections through.
- Volunteer support for the Covid vaccination programme in recruiting 2,700 volunteers. VAL continued to recruit, co-ordinate and deploy volunteers across 36 sites which was likely to be for the remainder of the year.

Leicester City Clinical Commissioning Group

- GP's had fed back that the template itself was not helpful and with the pressures of COVID, the number of patients receiving a cancer care review had fell from 74% prior to Covid to 15% between September and December 2020, detrimentally impacting patient care. Clinical teams worked with management teams to rewrite the template in February 2020 and staff had on-line meetings with 80 clinician attendees. By March 31 2021 the patients having a cancer care review had risen to 67%.
- 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 had implemented a virtual ward model for 'front door' activity as well COVID admissions this had reduced patient readmission rates by 51%.
- 144 COVID-19 patients had been discharged after a hospital admission with remote monitoring at home. To date, only 5 of these patients had been readmitted.
- 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%. Changes to support and a funded post enabled the rate for people with a LD having an annual health check to be increased to 71% by March 2021.
- Approximately 4,500 patients across LLR had been offered but declined a COVID vaccination. Data analysis suggested that high proportion of were with BAME population or lived in deprived areas of LLR. A pilot initiative was developed with GP clinicians calling patients and this resulted in 69% booking a vaccine, 19% wanted more time ot consider and 9% still declined.
- Reducing the numbers of parents calling out of hours or presenting at A & E with children who have symptoms that could be managed at home through a Zoom call to schools and a webinar with parents.
- High ED attendance and variable admission behaviours for frail patients had been supported by providing Community Response Service (CRS) and the Integrated Crisis Response Service (ICRS) being present and staff from CRS and ICRS would work with the Therapy Team and with the Emergency Floor Discharge Practitioners (EFDP's) on ED. This had enabled to identify patients that could be diverted from the ED to other appropriate pathways as early as possible. It had also shared key

information in terms of the key interventions already in place for people and increase the knowledge awareness of community services especially around Home First offers across LLR.
- Introduction of the Community Pharmacy Consultation Service pathway to reduce appointments in GP practices to enable them to focus on patients most in need of GP services.
- Joint assessment and provision of assistive technology to prevent falls and keep people at home independently and safely to reduce the need for elderly acute care.

Healthwatch

- Working with UHL to reduce the time patients were waiting in discharge lounges to get their medication.
- 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.

The Chair welcomed the updates from member organisations and felt that this demonstrated the response to Covid issues across the whole of the system and that fully supported the approach to learning from each other and this item had clearly highlighted and demonstrated the good practice being delivered.

The Chair also commented that these updates reinforced both health and wellbeing and that it should be clearly seen in the City that there was parity for mental and physical health in service delivery and considerations. The updates also showed that services were making most differences to those less able.

RESOLVED: The reports from partner organisations were welcomed and future updates of good practices would be welcomed.

33. INTEGRATED CARE SYSTEM - PRINCIPLES, PRIORITIES AND PURPOSE

Sarah Prema (Executive Director of Strategy and Planning for Leicester, Leicestershire and Rutland CCGs) gave a presentation on the Integrated Care System – Principles, Priorities and Purpose.

During the presentation it was noted that:-

- Although Integrated Care was not new hand had been in existence for some time the responsibility for it would be put on a statutory footing from April 2022.
- It would enable transformation of health and care through joining up and co-ordination of services with a proactive and preventative focus and be responsive to the needs of local populations.
- Current guidance indicated that this would 80% for local determination and 20% mandated through legislation and government and national health bodies.

- It was expected that the current parliamentary Bill would be discussed by the House of Lords after the summer recess.
- Examples of what had already been done to integrate services was outlined the presentation. Co-locating social care and community services had been key in making improvements.
- There was flexibility to add others to the Health and Partnership Group above the statutory requirements.

During discussion, members commented that:-

- The proposals for memberships of the Health and Care Partnership Group to exclude elected members ahead of formal legislation being in place was unusual. There was a need to recognise the key differences democratically of the lead political and officer leaderships in the various organisations involved. The 3 lead Councils in the LLR were all different politically and were responsible for areas which had differing health needs and priorities and differing financial resources.
- This would be an evolving long term strategy as one solution would not fit all needs and the involvement of the respective Health and Wellbeing Boards would generate questions about the future sustainability and development issues.
- The Health & Wellbeing Boards needed to be involved in defining the partnership arrangements from a local government led perspective and not an NHS led viewpoint.
- The role and responsibilities of the Board and the officer led groups would need further discussion going forward to clarify priorities and feed in desired service provisions needs. This could be addressed through a development session.
- Though would need to be given on how the work and views of other interested groups such as the Safeguarding Children Partnership Boards and Learning Disability Boards etc are incorporated into the process for assessing service needs.
- The processes involved would need to constantly grow and evolve to respond to what was considered unsatisfactory, what needed ot be tackled next and what issues were still unresolved.
- One of the strengths of the Board is considering the wider determinants of health and wellbeing including education and housing etc and these are represented on the Board whereas the present system partnership group is predominately health and social care body and thought needs to be given to how the system partnership board does not end up being narrower in focus than the Health and Wellbeing Boards which are place. Police, Fire and Rescue and Universities footprints also need ot be incorporated.
- The new system brought in providers and social care employees which were greater in number that NHS staff. If barriers were being removed in commissioning etc then how the social care providers were involved needed to be considered.
- Going forward this would be a collective document with all organisation involved in putting it together and would need to be kept under constant

review so consideration could also be given to broader aspects about NHS delivery.

- LLR was unique and had special issues BAIME, poverty, rural and deprivation issues and it was hoped that something on these could be included on these.
- The priorities express were all NHS priorities and these could be change to reflect that the emphasis was not seen as statements about the services people would receive but about services the people wanted to see in order to lead the lives they wished to live. i.e. you asked for and we are providing etc.

RESOLVED:-

1) Officers were thanked for the presentation and discussion on the proposals and were asked to consider and incorporate the views express by members of the Board above, as it was important that work progressed in a. collaborative and transparent process.

2) Officers were asked ot present further updates as the process progressed and further guidance/legislation was received.

3) That a development session of the Board be arranged to discuss the role and responsibilities of the Board and the officer led groups further.

34. PLACE LED PLANS

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

The current Leicester Health & Wellbeing Strategy published in 2019 set out a strategy until 2024 and there was now a need to look at how this would fit into the arrangements being proposed for the Integrated Care System in the future. The core themes of the 2019 strategy (Healthy Places, Healthy Minds, Healthy Start, Healthy Lives, Healthy Ageing) were still relevant and the Coronavirus pandemic had accentuated pre-existing inequalities.

Three options for the current strategy were outlined together with their advantages and disadvantages:-

- Option 1: Keep existing Health and Wellbeing strategy.
- Option 2: Full rewrite of Health and Wellbeing Strategy.
- Option 3: Minor refresh of the current Health and Wellbeing
- Strategy.

The preference was for Option 3 to enable a small revision to update for Covid impact and mortality inequalities affecting communities and ethnic background etc by January 2022. It was proposed keep the existing strategy until 2024 and then refresh the whole plan. It would be a collaborative plan to do at 'place' with concordance rather than compliance on a strength-based approach to look at community-based assets. The suggested outline was contained in the presentation to be deliver through annual action plans.

It was suggested that the working group take into account the work of the Climate Emergency and Anti-Poverty Policies that would be in place by the time the strategy was revised and to take these into account.

RESOLVED:- Officers were thanked for the presentation and update and the Board supported the review of the strategy as outlined in Option 3 and asked officers to consider extending the strategy timeline from 2024 to 2030.

35. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions from members of the public had been received.

36. ANY OTHER URGENT BUSINESS

The Chair announced that the Council's Director of Public Health, Ivan Browne, had been honoured by receiving an Honorary Degree from Loughborough University in recognition of the outstanding contribution he had made throughout the Covid-19 pandemic to the City and the region in what had been one of the most challenging times in living memory. The Board congratulated Mr Browne for his achievements.

37. DATES OF FUTURE MEETINGS

The Board noted that the Annual Council on 29 April 2021 had approved future meetings of the Board would 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 were scheduled to be held in Meeting Rooms G01 and 2 at City Hall unless stated otherwise on the agenda for the meeting.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Draft Joint Health and Wellbeing Strategy refresh for 2022-2027 & proposed priorities for 'Leicester City Health, Care & Wellbeing Delivery Plan'
Presented to the Health and Wellbeing Board by:	Dr Katherine Packham, Consultant in Public Health
Author:	Dr Katherine Packham, Consultant in Public Health, John Singh, Senior Planning Manager, Strategy and Planning Directorate, LLR CCG's Colleagues from the Leicester Delivery Plan working group from Leicester City Council and the CCGs.

EXECUTIVE SUMMARY:
The production of a Joint Health and Wellbeing Strategy (JH+WBS) is a statutory duty of Leicester City Council and Leicester City Clinical Commissioning Group. The current JH+WBS was published in 2019 before the Covid pandemic. The draft revised JH+WBS that follows has been updated in light of the pandemic and other changes that have occurred in policy. A timeline of 2022-2027 is recommended for the JH+WBS.

As part of the development of the Integrated Care System, each 'place' needs to have a place-led plan. For Leicester the draft place-led plan consists of the draft JH+WBS and the draft priorities for the Leicester City Health, Care and Wellbeing Delivery Plan. A more detailed delivery plan will follow once the priorities have been through an engagement process and the final version approved by health and wellbeing board in January 2022.

The draft revised JH+WBS and the draft priorities have been developed through partnership working centred on a core working group, with members of this group collaborating with others.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- **APPROVE** the duration of the draft revised JH+WBS to be 2022-2027
- **COMMENT** on the draft revised JH+WBS
- **COMMENT** on the draft priorities for the Leicester City Health, Care and Wellbeing Delivery Plan
- **APPROVE** going out to engage on the draft priorities

Leicester's Joint Health and Wellbeing Strategy 2022-2027 (draft)

Foreword

I am pleased to introduce our Joint Health and Wellbeing Strategy for Leicester, which reflects the ambitions and priorities of the city's Health and Wellbeing Board.

Leicester is a vibrant and diverse city in which to live and work, but there are complex health challenges that need addressing. We aim to reduce health inequalities and improve the quality of life and life expectancy of residents, particularly those who are from lower socio-economic groups, and seldom heard communities.

This strategy was originally published in late 2019, before any of us had heard of COVID-19. Leicester has been hit particularly hard, being the first place to go into local lockdown in summer 2020 and having relatively high levels of coronavirus infection throughout. The coronavirus pandemic has affected people differently, with those with lower socio-economic status linked to housing and lower-paid jobs or unemployment showing higher rates of coronavirus infection, hospitalisation and deaths than the general population. These differences have been seen in levels of coronavirus infections, numbers of hospitalisations, and deaths as well as other impacts such as the economic effects. School bubbles having to close and children missing schooling has affected all children to an extent, but again children from more deprived areas have missed more school due to higher levels of coronavirus infection in the community and more frequent school bubble closures.

Many people in the city will have been personally affected by the grief of losing loved ones to coronavirus and we offer you our sincere condolences for your losses. We acknowledge that many people's lives will have been changed forever by the pandemic.

This strategy looks beyond the remit of healthcare alone and focusses on improving the health and wellbeing of Leicester's residents over the next five years. We are also looking to reduce the impact of unfair differences in health and wellbeing, known as health inequalities. These were already present in our city, as they are nationally and around the world. However the coronavirus pandemic has made many of these health inequalities more visible, and in some cases will have made these inequalities worse. In this strategy, we will set out our intention to use our local assets such as parks, waterways, leisure centres and museums and theatres to support health and wellbeing and reduce health inequalities. We will also work to make the city environment, including buildings and open spaces, as advantageous to good health and wellbeing as possible.

When this strategy was initially developed it was a time of financial pressure which was being felt across all sectors and organisations. We are now faced with the complex nature of a city and country trying to recover from the effects of a pandemic as well as restoring services.

Delivering this ambitious strategy will depend on a co-ordinated and collaborative approach between all partners, including the local authority, health and social care, local businesses and the voluntary and community sector. This approach may not be without its challenges, but we believe that working together is the best way to have a long-lasting, positive impact on the health of our city's residents as we all work to move into a recovery phase whilst the pandemic remains an ever present reality. During the pandemic, the people of Leicester demonstrated enormous community spirit to support one other. It is this drive and determination that will contribute to the delivery and success of the strategy.

I would like to thank everyone who has contributed to this strategy, a strategy which represents an important step in improving the health and wellbeing of Leicester's residents. Together, we can continue to make this city a great place to live, work and socialise as we continue the recovery from the coronavirus pandemic.

Councillor Vi Dempster, Assistant City Mayor - Health

Our approach

Our Joint Health and Wellbeing Strategy was originally published in 2019 and set out the health priorities for Leicester. This updated strategy provides details of the Health and Wellbeing Board's vision until 2027 and is supported by a set of priorities which will evolve further into a delivery plan.

When the strategy was first published none of us knew that the world was about to change dramatically. The coronavirus (Covid-19) pandemic was to affect our lives in ways that we could not have imagined.

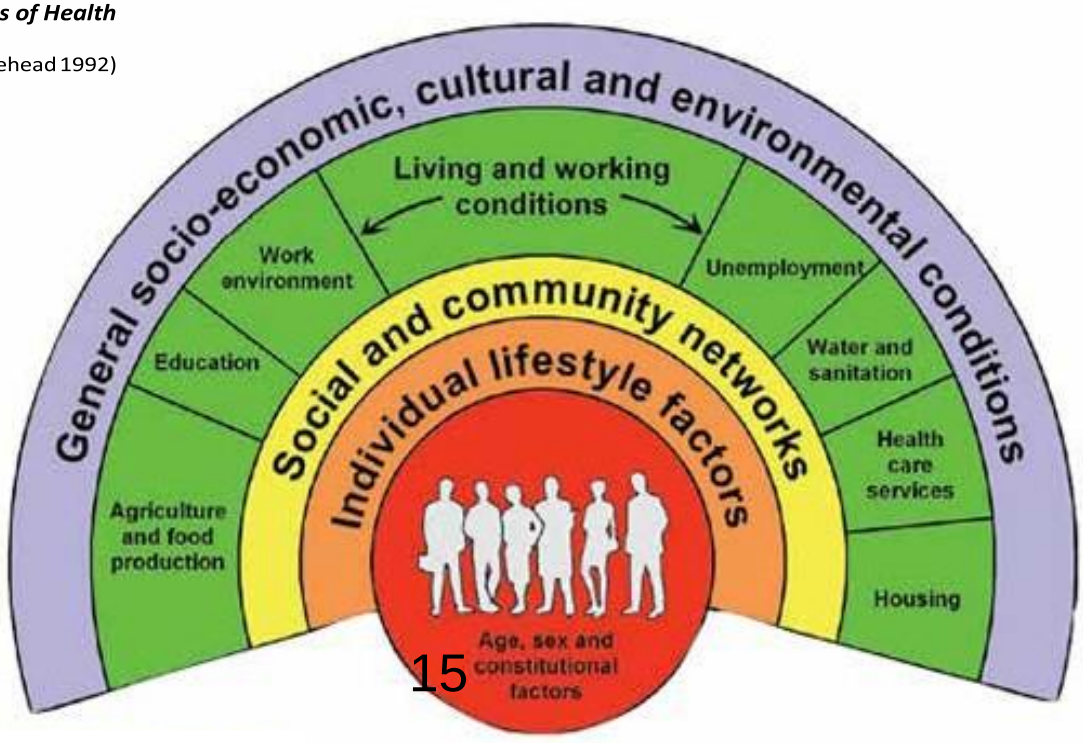
Leicester and its people have been subject to some form of coronavirus related restrictions since March 2020, with a considerable period under a local lockdown to try and curb coronavirus infection levels in the summer of 2020. The pandemic has affected people unequally, with differences seen in levels of infection, serious illness and death based on people's ethnicity, and living and working conditions. For example, some people with lower paid jobs were unable to work from home and therefore at greater risk of acquiring and dying from the infection. Another example of those disproportionately affected include those living in overcrowded and poor-quality housing. These factors are beyond people's individual control, and Covid has further exacerbated the struggled that people face due to them.

The issues identified as important by the people of Leicester in 2019 have not gone away. There will have been differences in people's experiences of life during the coronavirus pandemic. This updated strategy is a 'call to action' to tackle the origins of ill health in our city alongside our recovery from the coronavirus pandemic, by fostering a shared approach to protecting health and wellbeing with local organisations and communities.

Evidence shows that simply increasing access to health, care and wellbeing services will not adequately address health needs or improve the wellbeing of Leicester's residents. We need to have a more rounded approach to addressing health challenges, by considering the broad factors that determine a person's health and wellbeing, such as people's unique characteristics, their environment, communities and relationships. The image below illustrates how general socio-economic, cultural and environmental factors can interact to determine a person's health and wellbeing.

The Determinants of Health

(Dahlgren and Whitehead 1992)



A range of community and faith groups have been integral parts of Leicester's response to the pandemic, supporting local residents with practical support such as delivering food or medicines, and working to support vaccination pop-up clinics in community venues. By drawing on the existing resources of partners and communities and building on the relationships that have developed over the course of the pandemic, we can work together to provide innovative and wide-ranging solutions to the city's complex health and wellbeing needs.

Local organisations are working together on these solutions. We have a new Health Inequalities Framework, which sets out the ways that the NHS, local government and community and voluntary sector organisations will work together to reduce unfair and avoidable differences in wellbeing experienced by people in Leicester. There will be a new delivery plan that will be developed together with different communities across Leicester to come up with local solutions for issues that affect the physical, emotional and mental wellbeing of our residents.

Overview

Our vision: To give everyone in Leicester the opportunity to achieve and maintain good mental and physical health throughout their whole life.

Our joint health and wellbeing strategy sets out the plan of Leicester's Health and Wellbeing Board, which consists of a range of organisations working in partnership to improve the health and wellbeing of the people of Leicester. The health and wellbeing strategy is supported by a new delivery plan for Leicester. The strategy and delivery plan together make up the place-led plans for Leicester, which sit within Leicester, Leicestershire and Rutland's Integrated Care System. Integrated Care Systems are a partnership of health, care and wellbeing organisations working over a larger area. The delivery plan identifies priorities and actions to help achieve the overarching ambitions of Leicester's health and wellbeing strategy. Examples of actions are highlighted throughout the strategy. Other strategies and plans across the city have been considered within this process, with recognition given to their contributions to progressing specific objectives.

Why does Leicester need a Health and Wellbeing Strategy?

There are significant health inequalities between different areas within Leicester. The city has many areas of deprivation, and the difference in health outcomes between the most and least deprived areas of the city is stark. These differences have also been seen in the levels of coronavirus infection and deaths in different areas, as well as the wider impacts of the coronavirus pandemic.

There is a seven-year difference in life expectancy between men living in the most and least deprived areas of the city. Those living in the most deprived areas of Leicester will live more years in poor health than those in the least deprived. Reducing this inequality within our city can only be achieved by focusing on those in greatest need and working with them to reduce the many different factors that may have a negative influence on their health and wellbeing.

The coronavirus (Covid-19) pandemic has and continues to have a major impact on people. Food poverty increased in 2020. People in lower paid roles or with zero hours contracts were facing greater financial instability. Those whose employers could not fund time off work for self-isolation or those who were not eligible for financial support to isolate may have found themselves having to work regardless to be able to feed their family. Children from disadvantaged families, and children of black and minority ethnicities lost more learning time due to lockdowns and self-isolation than those

from wealthier areas. Carers of all ages will have found themselves under greater strain as a result of lockdowns.

One of the main aims of this strategy and its delivery plan is to reduce health inequalities. These are unfair and avoidable differences in health due to a range of factors as set out in the diagram on The Determinants of Health.

No matter where we live, our health behaviours are influenced by our wider environment. Behaviours such as smoking, excessive drinking, drug use, poor diet and inactivity are greater in many parts of our city than they should be. This leads to a poorer quality of life, a shorter life expectancy overall and to an increase in rates of heart disease, cancer and respiratory disease, the leading causes of death in the city.

Around 48,500 people in Leicester are living with more than one long term physical or mental health condition. In Leicester, 25% of people living with diabetes have five or more additional health conditions, and 35% of those living with depression have three or more additional health conditions.

There is a clear link between people's mental and physical health. When a person is struggling with poor mental health, their physical health is likely to suffer too, and vice versa. People with poor mental health are more likely to engage with unhealthy behaviours and poor lifestyle choices, contributing to premature death. In Leicester it is estimated that between 34,000 and 38,000 people live with a common mental health problem such as depression or anxiety, and around 3,400 people live with an enduring mental health condition, such as schizophrenia or bi-polar disorder.

Approximately 30,000 people are socially isolated in the city. Social isolation and loneliness have a direct negative impact on mental and physical health and can make existing health problems worse. This impacts on people of all ages, particularly older people, but this is becoming increasingly common amongst younger people aged 16 -24 years.

These key issues affecting the health of people in Leicester will be some of the core themes of this strategy.

Our ambition for Leicester

We have grouped our ambitions for Leicester under five themes, which are shown in the diagram below. For each theme, we describe the challenges and the work we are already doing to tackle the issues and set out what we are planning to do.

These themes align with the priorities of the wider Leicester, Leicestershire and Rutland Integrated Care System. Integrated care systems are partnerships that bring together the NHS services with local authorities (councils) and other local partners to collectively plan health and care services to meet the needs of their population.


Healthy
Healthy Places
to make Leicester the healthiest possible environment in which to live and work
Healthy Minds
to promote positive mental health within Leicester across the life course
Healthy Lives
to encourage people to make sustainable and healthy lifestyle choices
Healthy Start
to give Leicester's children the best start in life
Healthy Ageing
to enable Leicester's residents to age comfortably and confidently
Leicester

THEME 1: HEALTHY PLACES

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

A healthy place promotes good health and alleviates and prevents health inequalities. It has green and open spaces, leisure facilities, libraries and museums. The air is clean, fit to breathe, there are low levels of unemployment and insecure work, and homes are of a decent standard. There are good choices with easy access to healthy food and opportunities to exercise regularly and travel by bike or on food. A healthy place offers is a sense of community, safety and inclusiveness.

Our environment has an impact on our quality of life, our health and our life expectancy. People living in environments with increased air and noise pollution with little to no green space, or who are working in low-paid, insecure occupations with few opportunities for social mobility, are those who generally have poorer health and lower than average life expectancy.

Key issues affecting the local environment in Leicester:

Air quality and transport	Half of Leicester residents are concerned about air quality. Motor vehicles are the greatest contributor to air pollution in the city. With less people driving during the pandemic, the air quality in Leicester improved.
Health and Care Services	Leicester's people often have to tell their story more than once to different health and care agencies. Covid-19 has impacted access to health and care services, and waiting lists for diagnosis and treatment have increased.
Housing and the built environment	One in five households in Leicester are overcrowded, rising to two in five if they have children. With people spending more time working from home, it is even more important that housing is of good quality. Further, the fuel poverty rate in Leicester is among the highest in England
Mental Health	It is estimated that between 34,000-38,0000 people in Leicester live with a common mental health problem such as depression or anxiety. Covid-19 has further exacerbated mental health and wellbeing problems in our population.

Key things we are doing to make Leicester a healthy place:

Air quality

We are promoting the health benefits of sustainable transport, such as cycling and walking, and improving air quality by working with transport sectors to reduce their impact on the environment. We are endeavouring to keep the clean air levels that were reached when fewer vehicles on the road during the pandemic, through supporting work towards our city being carbon neutral.

Improving access to health and care services

We are improving digital access to care and optimising function through new models of integrated care.

Housing and the built environment

We are ensuring all local authority housing meets decent home standards. By maintaining and improving housing in the public and private sectors we are helping to ensure all properties are safe, healthy places to live in.

Creating mental health friendly communities

We are offering facilities where communities can come together to take part in a wide range of social and cultural activities to benefit their mental and physical wellbeing.

From our Delivery plan:

- Improve air quality by supporting the move towards Leicester becoming a Carbon Neutral city
- Develop shared records across health and social care providers
- Investment into reducing fuel poverty and reviewing housing adaptations for those with the most complex needs
- Create community touch points (businesses, clubs, societies, faith groups, schools and organisations) where local people can reach out for help

THEME 2: HEALTHY MINDS

Ambition: To promote positive mental health within Leicester across the life course

Good mental health and wellbeing is vital for quality of life and life expectancy. Many people in Leicester experience mental health problems which can contribute to problems loneliness, isolation, and poor physical health. Adverse life experiences such as relationship problems, debt, or bereavement can contribute to poor mental health.

Our mental wellbeing is shaped by childhood experiences. Learning to cope with problems from an early age can prevent mental health problems in later life. It's important to ensure children have emotional support at home and school.

People with poor mental health report the stigma they face from others can exacerbate their problems. In Leicester, we need to tackle mental health stigma and discrimination and work to ensure that mental health is viewed with the same importance as physical health.

Suicide is sometimes linked to poor mental health. It is for us to acknowledge and prevent suicide whenever possible. Deaths by suicide can trigger complex emotions in people who have been bereaved. Offering timely support to those who have been affected is key to our approach. Mental health services in Leicester are widely used. Sometimes people have difficulty accessing timely treatment. Our aim is to ensure wider approaches can be used to support the resilience of people in need.

Key issues affecting mental health in Leicester

Preventing deaths by suicide	Around 30 people die by suicide in Leicester each year. Suicide can be influenced by a complex mix of adverse life experiences, such as relationship breakdown, bereavement, debt, or unemployment
Mental health of children and young people	One in ten children report having a mental health problem; many more say they feel stressed or overwhelmed. Promoting resilience to the stresses of daily life is key to improving children's mental health, as well as having more honest conversations about mental health and wellbeing, free of stigma

Engagement with the local environment	People experiencing poor mental health are less satisfied with their local area and the green space in the city. This impacts on social isolation and happiness

Key things we are doing to encourage healthy minds:

Suicide prevention and support

We are working to prevent death by suicide and supporting people affected by suicide with our Start a Conversation: Suicide is Preventable campaign which focusses on how small actions can save lives.

Mental health of children and young people

We are supporting the mental health of children and young people in the city by providing emotional resilience training in Leicester.

Engagement with the local environment

We are encouraging people to use our parks, open spaces, leisure centres and waterways and supporting their mental wellbeing, by promoting outdoor gyms and encouraging walking and cycling.

Reducing stigmatising behaviour and attitudes around mental health

We are encouraging a wider awareness of mental health by encouraging people to speak out about their experiences of mental health problems.

Examples from our Delivery Plan:

- work with organisations who support young people in their families, schools, and communities to promote positive mental health and combat bullying and loneliness.
- Improve access to mental health and emotional wellbeing services for children and young people
- improve resilience to mental health problems among working age adults and reduce stigma and discrimination by encouraging people to speak out about their experiences of mental health problems.
- Improve access to neighbourhood level mental health services for adults
- promote zero suicides in Leicester through ongoing suicide prevention campaigns across the city.
- improve support for people bereaved or affected by a death by suicide.
- reducing social isolation in older people and adults

THEME 3: HEALTHY START

Ambition:

To give Leicester's children the best start in life.

Having the healthiest possible start in life increases the prospects of positive mental and physical health in the future. There are many factors that influence the health and wellbeing of our children and young people, from the health and lifestyle choices of mothers during pregnancy, the environment in which a child grows up and the education that child receives.

Actions that can be taken in the first few months and years of life to increase a child's likelihood of good health include supporting the mother to breastfeed, ensuring the child is immunised, and supporting the child to develop good communication skills and healthy behaviours such as practising good oral hygiene and exercising regularly. Activities that instil confidence and resilience in children are the key to supporting positive mental health. We also recognise the possible impact of emerging issues such as new technologies, including social media, on the mental health and wellbeing of children and young people.

Key issues affecting children and young people in Leicester:

Early years health	Infant mortality in Leicester is higher than the national average. Risk factors include poor maternal/family lifestyle choices, not breastfeeding and not immunising infants.
Mental health	One in ten children between five and 15 years suffers from poor mental health. This rate has increased through the Covid pandemic. One in four children has a parent at risk of developing a common mental health problem
Healthy eating and exercise	Childhood obesity in Leicester is higher than it is nationally, due to a number of different reasons
Communication	Many children across Leicester have poor communication skills compared to other areas of the country.
Oral health	Leicester has one of the worst rates of children's oral health in the country. This is particularly the case amongst under fives.

Key things we are doing to give children and young people a healthy start:

Reducing infant mortality

We are reducing the risk factors of infant mortality in the city by providing new mothers and families with information and support

Communication skills

Supporting families to improve early communication and use of home language. We are enabling professionals across the wider workforce and the community to promote good communication skills from 0-25.

Physical activity

We are encouraging more school-age children to be physically active by encouraging each school in Leicester to take part in the Daily Mile initiative.

Oral health

We are supporting children and families to develop good oral hygiene from an early age by signing up nurseries and other early year settings to the Healthy Teeth, Happy Smiles programme.

Mental health

We are working with education settings and workplaces to raise awareness and encourage early identification and support for mental health. This approach will support children to remain included within their education setting. Programmes from universal to specialist actively engage children and young people and those who work with them.

From our Delivery plan:

- Give every child the best start in life by focusing on the first 1001 days (from conception to 2 years of age), which is crucial in providing a strong foundation for longer term wellbeing
- Children being ready to play and learn, including supporting early language development
- Reducing the impacts of poverty on children and young people
- Empowering health self-care in families with young children

THEME 4: HEALTHY LIVES

Ambition:

To encourage people to make sustainable and healthy lifestyle choices

A healthy lifestyle reduces the risk factors linked to developing long term mental and physical health conditions. People with chronic health conditions can manage these risks and prevent their health from becoming worse by making healthy choices.

Some people experience unfair and unjust differences in health and wellbeing due to factors such as ethnicity, poverty, employment. People with a learning disability experience worse health than people without learning disabilities. People with mental health problems also tend to experience worse physical health. Many of these differences in health are avoidable, or things can be done to reduce the impact of these differences; this is something that we wish to work on together for the people of Leicester.

Lifestyle choices such as smoking, excess drinking of alcohol, poor diet and a lack of exercise contribute to around 40% of premature deaths in the city. Poor health choices made in adulthood may also have a negative impact on health in later life.

Environmental factors such as secure employment, a sense of purpose and having meaningful social connections also contribute towards positive health.

Having access to cultural activities, such as museums and theatre and opportunities for learning outside of work, helps overall health and wellbeing throughout our lives, as does feeling part of the local community by having strong relationships with friends, family and faith groups.

Key issues affecting people in Leicester

Chronic conditions	Rates of diabetes are significantly higher in Leicester compared to England, with an estimated 31,000 adults living with diabetes in the city. The number of people living with more than one chronic condition is increasing.
Lifestyle choices	Half of adults in Leicester are overweight or obese. One in ten adults drinks alcohol above the recommended weekly units. One in five adults in Leicester eats the recommended five fruit and vegetables a day and two in five do less than the recommended 150 minutes of exercise a week. Our most vulnerable groups, such as those living in the most deprived areas, are at risk of making poor lifestyle choices.

Mental and physical health	There is a clear link between mental and physical health. People with poor mental health may neglect their physical health and people who are physically unwell may develop poor mental health.

Key things we are doing to help people live healthy lives:

Reducing risk factors for heart disease, lung disease, chronic illnesses and cancer

We are encouraging more people to take up or increase their levels of physical activity through initiatives like Active Leicester and we are supporting people to walk and cycle more. We are encouraging people to eat more healthily through the delivery of the Food Plan and are supporting people to reduce smoking and alcohol consumption.

Reducing diabetes in the city

we are raising awareness of the condition and the importance of early diagnosis, and improving care and timely access to diagnosis, by working as part of Cities Changing Diabetes.

From our Delivery plan:

- Reduce levels of unhealthy weight across all ages
- Increase early detection of heart disease, lung disease and cancer in adults
- Promote independent living for people with long term conditions
- Improving support for carers

THEME 5: HEALTHY AGEING

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

In modern society 'age' can be less about years lived and more to do with subjective health and wellbeing - how we feel inside.

With people living longer, supporting people in retirement is even more important. Protecting our residents' continued health and wellbeing into older age requires them to have a continued sense of purpose. This may be through sharing their expertise, trying something new or giving back to society. Older residents at risk of poverty and those who are frail may need more practical support with healthcare and housing.

Healthy ageing is also about equality. As we age, discrimination can increase. Many older people in Leicester also suffer multiple discrimination, for example being both older and a woman, or older and a person from a minority group.

About 40% of people aged over 65 have a limiting long-term health condition and have a higher risk of developing sensory impairments such as loss of vision. There needs to be early diagnosis of, and effective support for, people with dementia. Older people need appropriate, timely access to the support they need to stay independent for as long as possible.

Supporting older people to manage their wellbeing can involve promoting good lifestyle choices such as a healthy diet, fluid intake exercise, oral health, flu (and other) vaccinations and regular NHS, or other, health checks. Maintaining good mental health in older age is also of key importance, particularly in helping people to cope with social isolation and loneliness.

Key Issues affecting older people in Leicester:

Lifestyle factors	The onset or progress of some health-related conditions can be influenced by lifestyle factors, with those aged 65+ being less likely to undertake the recommended amount of exercise, and more likely to be overweight or obese, and drink above recommendations.
Environmental factors	For some older people living in Leicester it is more difficult to travel independently and/ or access facilities. They are more likely to experience social isolation and loneliness, and may find online communication more difficult.

Mental health	An increasing number of people aged 65+ feel socially isolated and lonely. However, those aged 65+ generally report a higher state of mental wellbeing than people under 65.

Key things we are doing to promote healthy ageing

Managing dementia in the community

We are creating 'dementia friendly' public spaces throughout the city by working with public, private and voluntary sector age-friendly partners

Working towards managing the health of older people living with several long-term conditions

We are encouraging people to make positive changes that will improve their mental and physical health by working with partners to signpost and refer people to relevant lifestyle services.

Empowering older people to live independent lives for longer

We are encouraging older people to practice self-care and independence and improve their own wellbeing by working with partners to implement a model of support.

Examples from our Delivery Plan:

- Enabling the people of Leicester to age comfortably and confidently
- Promoting independence for frail older people
- Reducing the number of falls for people aged 65+ in Leicester City

Engagement and consultation

A variety of sources have informed our ambitions for Leicester's Joint Health and Wellbeing Strategy. Initial engagement, consultation and research for the strategy took place in 2019 when the original strategy was published. This was done in three ways:

1. We ran a series of workshops to inform the development of the strategy themes. Stakeholders, partners, and professionals from a range of organisations were invited to make suggestions for improving health and wellbeing in each area.
2. We consulted with authors of existing strategies and plans (including Leicester's Joint Specific Needs Assessments, Leicester's Health and Wellbeing Surveys and Health Needs Neighbourhood Profiles).
3. We carried out an engagement roadshow with several partners to raise the awareness of the strategy, and to give the opportunity for them to comment and input on this draft version.

This strategy has also been through an eight-week public consultation period in 2019, which has given organisations and members of the public a further opportunity to engage with the document and make comments. The revised delivery plan has also been the focus of an engagement process to ensure that our priorities reflect those of the people of Leicester. The delivery plan has been considered in a series of engagement events and opportunities in 2021.

Delivery and monitoring

Leicester's Health and Wellbeing Board is responsible for ensuring that there is a Joint Health and Wellbeing Strategy for the city. This strategy will provide focus and direction for the work of the board and of other boards and groups in Leicester. The details of how our objectives will be delivered and measured are set out in our delivery plan and progress will be reviewed and monitored by the Health and Wellbeing Board.

Monitoring and delivery of the strategy and delivery plan will be supported by subgroups reporting to the Health and Wellbeing Board.

Joint Health and Wellbeing Strategy refresh & proposed priorities for ‘Leicester City Health, Care & Wellbeing Delivery Plan’

JHWS refresh & proposed length

- Joint health and wellbeing strategy published late 2019
- Revised strategy approach approved at H+WBB July 2021
  - Agreed to update existing strategy in light of Covid pandemic and relevant policy
- Collaborative approach to review the H+WB strategy and update alongside draft priorities development
- Draft strategy included as part of the agenda pack
  - Online strategy proposed, with paper copies where required.
  - Formatting of final strategy will be as an online report.
- The delivery plan working group recommends strategy and delivery plan duration of 2022-2027
  - Gives 5 years to work on priorities and delivery of these priorities.
  - A new strategy in 2027 gives time for the long-term effects and subsequent population health needs resulting from the Covid pandemic to become clearer, without that date being too far into the future.
  - The priorities and delivery plan can be reviewed throughout the period 2022-2027.

Delivery Plan- Framework approach

Built on the 5 strategic strands of the Joint Health and Wellbeing Strategy:

Strand	Description
Healthy Places	Making Leicester the healthiest possible environment in which to live and work
Healthy Start	Giving Leicester's children the best start in life.
Healthy Lives	Encouraging people to make sustainable and healthy lifestyle choices
Healthy Minds	Promoting positive mental health within Leicester across the life course
Healthy Ageing	Enabling Leicester's residents to age comfortably and confidently

Guiding principles – identifying priorities:

We looked to identify priorities that multi- agency/partnership working can have a significant improvement impact in one or a number of the following areas:

- Reducing health inequalities.
- Improve equity of access to services.
- Address unwarranted variation within the city or against the England average.
- Strengthens integrated working between health, care and wellbeing services

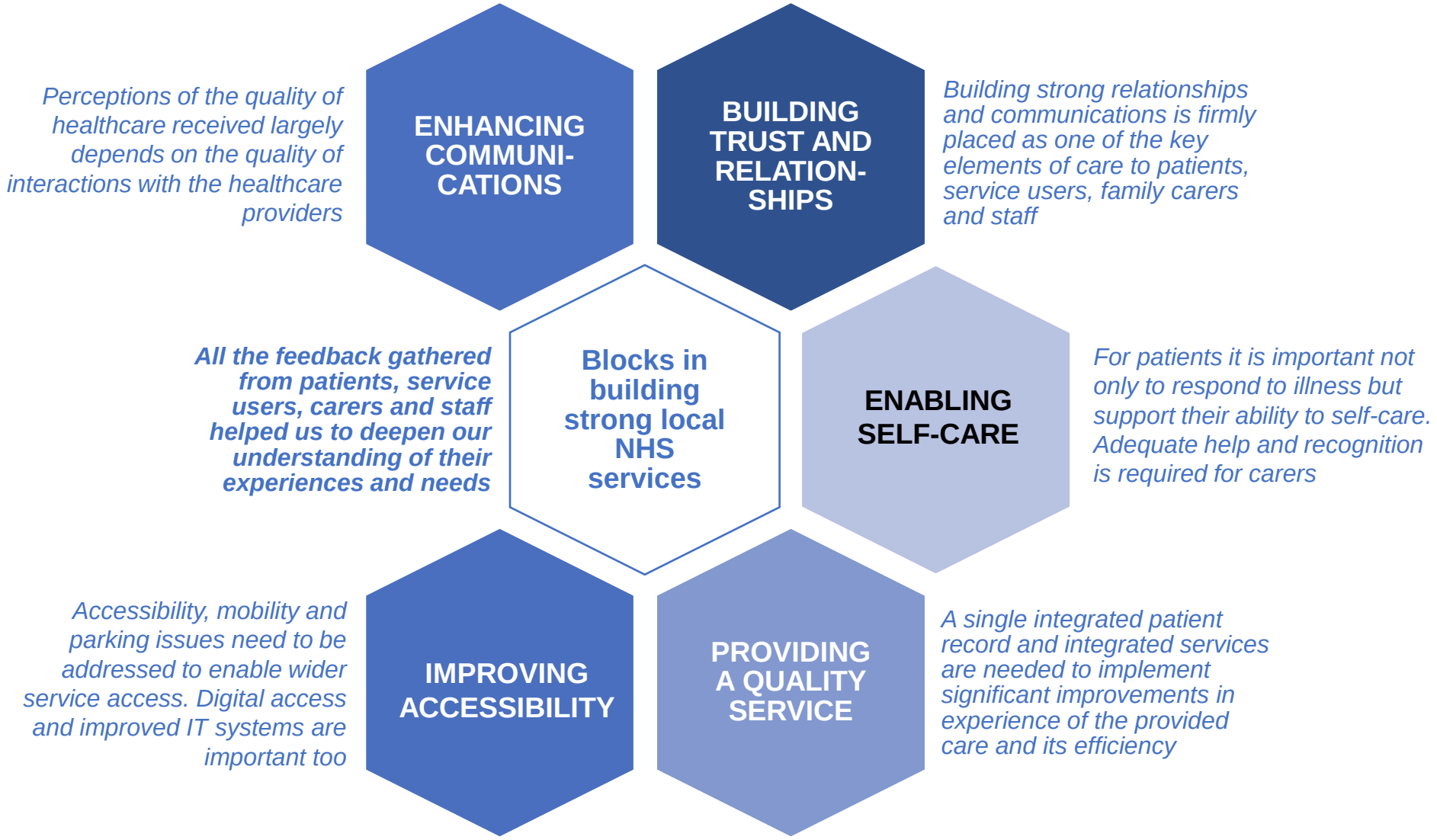
We have aimed to get a balance of health, care and wellbeing priorities.

Some priorities are for city wide action, some require more delivery at a neighbourhood level and some at both levels.

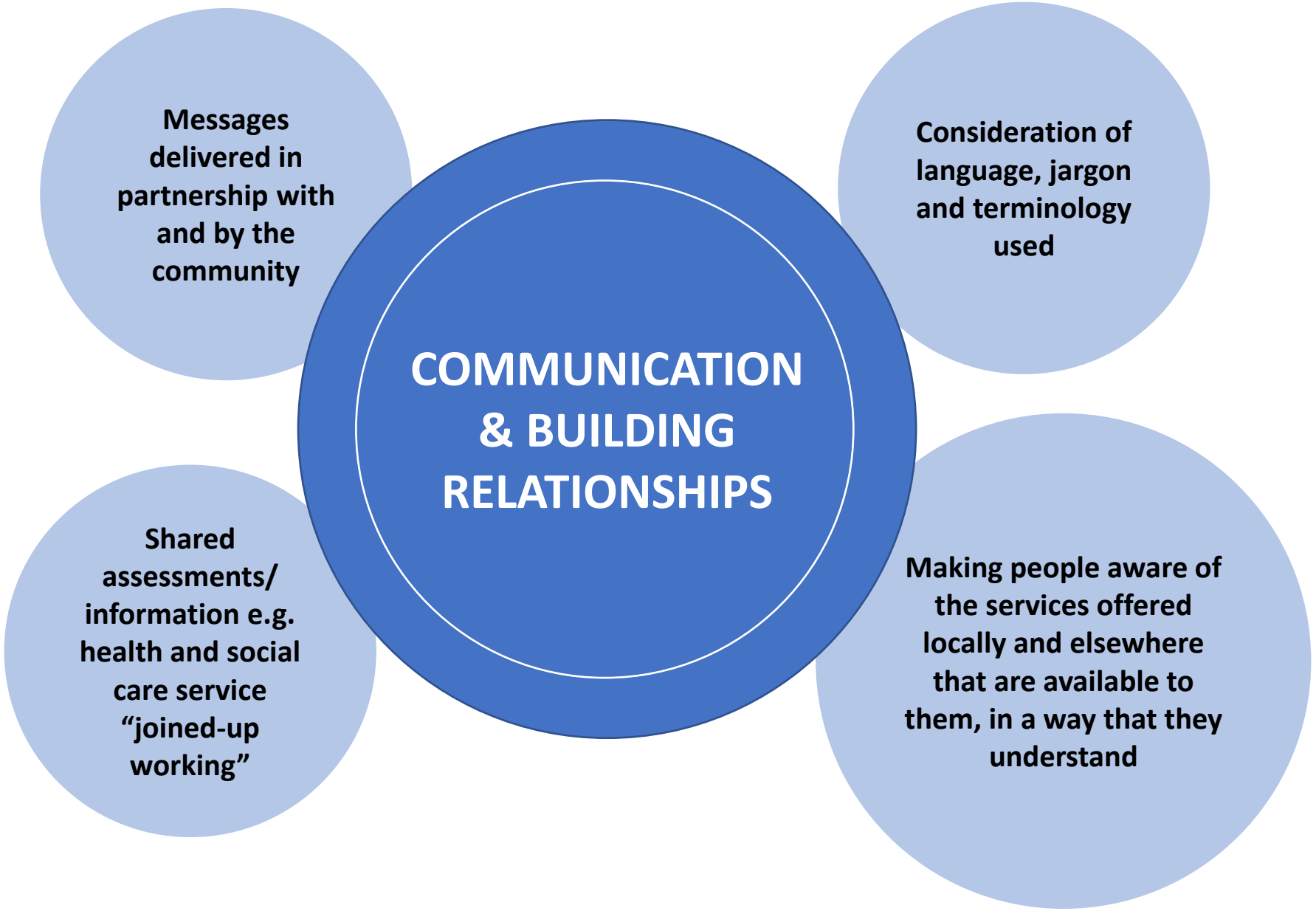
Guiding principles- progressing improvements on priorities:

- Ensure health and wellbeing equity is at the forefront. This includes an approach of ‘proportionate universalism’ in which interventions are targeted to enable a ‘levelling up’ of the gradient in health outcomes.
- Built on existing engagement insights of what people think is important in way services should be delivered (see next slide).
- Take a strengths based approach building on existing community services and assets
- Look at every opportunities for collaborative delivery of priorities with VCSE and community organisations at either a city wide or neighbourhood level.
- Are supported by clear measures of progress (i.e. SMART)

What people told us about their local NHS health and care – key themes



Leicester's needs in terms of communications



What can we do based on what we know now?

1

THE WAY WE COMMUNICATE

Because "the change is hard" for many, the language we use to communicate them is key. It needs to recognise a different nature (and therefore needs) and communicate this effective through communities. Residents ask for messages to be local and delivered by community leaders using methods which they use.

Look at more innovative ways to engage the community in designing and delivering local messages using terms and methods they understand and use. Consider small changes in the language we use to communicate with the community.

2

UNDERSTAND AND RESPOND TO THE NEEDS OF OUR COMMUNITIES

Communities are eager to share learning with service leads but ask that health professionals work with them in their surroundings and pay attention/adapt to their cultural beliefs and nuances

The development of ongoing engagement and partnerships with communities to build rapport, share 2 way learning and acting on insight

3

COLLABORATION IS KEY

Many of those from Leicester not only want to be involved in designing new care solutions but also have a confidence in the proposed changes. While some people share their views and opinions often, we may not be hearing from others, less engaged in the community life especially those with protected characteristics.

Engaging with the community at the very early stages of proposed projects to let them play a part in designing new solutions.

Summary of proposed priorities:

JHWS Strand	No.	Proposed Priority
Healthy Places Making Leicester the healthiest possible environment in which to live and work	1	Improving the built environment to support long term health and wellbeing
	2	Improving access to primary and community health and care services
	3	Supporting a move towards a carbon neutral city
	4	Creating Mental Health & Dementia friendly communities within Leicester
Healthy Start Giving Leicester's children the best start in life	5	'First 1001 Critical days'
	6	Mitigating the impacts of poverty on children and young people.
	7	Empowering health self-care in families with young children
Healthy Lives Encouraging people to make sustainable and healthy lifestyle choices	8	Reducing levels of unhealthy weight across all ages
	9	Increasing early detection of CVD, COPD and Cancer in adults
	10	Promoting independent living for people with long term conditions
	11	Improving support for Carers
Healthy Minds Promoting positive mental health within Leicester across the life course	12	Increasing access for CYP to Mental Health and emotional wellbeing services
	13	Improving access to primary & neighbourhood level Mental Health services for adults
	14	Reducing social isolation in older people and adults
Healthy Ageing Enabling Leicester's residents to age comfortably & confidently	15	Enabling Leicester's residents to age comfortably and confidently
	16	Promoting independence for frail older people
	17	Reducing the number of falls for people aged 65+ in Leicester City

Mapping to ICS priorities

Leicester H+WB strategy	ICS priorities
Healthy Places	No ICS equivalent
Healthy Minds	No ICS equivalent
Healthy Start	Best Start in Life
Healthy Living	Staying Healthy and Well
Healthy Ageing	Living and Supported Well Dying Well

Proposed Priority 1: Improving the built environment to support health and wellbeing

Healthy Places

Level: City wide

Why a Priority?

- Built environment is a wider determinant of peoples long term Health and Wellbeing.
- Fuel poverty and cold homes are linked to respiratory and circulatory problems among adults, as well as range of poor long-term health outcomes for children who grow up in them.
- Asthma is the most common long term medical condition in children and young people (CYP).
- The fuel poverty rate in Leicester is among the highest in England. 14% of households in Leicester are fuel poor (compared to 9% in the East Midlands and 11% in England.
- Leicester Health and Wellbeing Survey 2018 indicate that 20% of Leicester adults are living in overcrowded households across the city.

Key Partners: LA Planning Department, LA Adult Social Care, LPT, Public Health, CCG's, Local businesses, Landlords, Local People

Current improvement plans include:

- Develop greater links with Leicester City planning team around future health impact assessments and embedding of healthy places characteristics into local housing proposals.
- Increasing access to ' Green' grants for business and households
- Health Inequalities Grant allocation 2021-24 (£345k) for a number of initiatives to address the impact of poor housing on health. This includes funding:
  - Additional specialist Hoarding Social Worker
  - Occupational Therapist for attachment to Housing team to review needs of 200 people with most complex needs to support housing adaptations. (Managing backlog)
  - Reducing Fuel poverty – Investment in LCC Home Energy Team
  - 2 x Social workers for LCC Housing team to work with pre-eviction, ASB, intentionally homeless

Measuring progress:

*Improvement in Fuel Poverty indicators for Leicester

*Prevalence and incidence of Asthma, particularly in Children & Young People

Proposed Priority 2: Improving access to primary & community Health and Care services

Healthy Places

Level: City wide

Why a Priority?

- Insights from recent local NHS engagement and consultations indicate accessibility, mobility and parking issues need to be addressed to enable wider service access.
- Insights also indicate shared assessments/ information between health and social care service ("joined-up working") is important and people don't want to keep telling their story to different agencies, given over a 185 languages are spoken in the city.
- Local people think digital access and improved IT systems are important too but this need to ensure no groups are digitally excluded.
- Significant housing growth planned over next 15 years & there is a recognised lack of available space to meet growing demand and/or poor quality premisses across the City. In LLR city practices makes up half of those in greatest need of support due to unsuitable premises and insufficient space to meet current and projected demand.

Current improvement plans include:

- New models of care should focus in integrated health and care services to support quality and continuity of care. In particular:
  - Developing shared records across health and social care providers
  - Maximising opportunities for colocation of health and care services
- Maximising access to S106 development grants from housing developers
- Partnership work to inform local joint planning policy and support greater care integration and neighbourhood developments.
- Health Inequalities Grant allocation 2021-24 (£165k) to address the digital divide- Investment in programme of education and training, infrastructure development, and devices. This project plans to link closely with community connectors to recruit and train a network of digital champions across the city.

Key Partners: LA Planning Department, Primary Care/ PCNs , LA Adult Social care, CCG's, LPT, UHL

Measuring progress:

tbc

Proposed Priority 3: Supporting the move towards a carbon neutral city.

Healthy Places

Level: City wide

Why a Priority?

- Unabated climate change will disrupt care, with poor environmental health contributing to major diseases.
- Air pollution is associated with stroke, heart disease and lung cancer, along with breathing and circulatory problems. About 6% of all deaths in adults in Leicester is attributed to air pollution24 & deprived populations are more adversely impacted, as are those already in poor health.
- In recognition of this Leicester City Council declared a Climate Emergency in 2019, with a aim to become 'carbon neutral' by 2030 or sooner. To support this ambition it has developed at Leicester Climate Emergency Strategy 2020 – 2023.
- In October 2020, the Greener NHS National Programme published its new strategy, Delivering a net zero National Health Service. This set a target for the entire NHS to reach net zero carbon emissions by 2040 for the emissions it controls directly.

Key Partners: Local authority, All Healthcare providers and commissioners, VCSE sector, Local businesses, People of the city:

Current improvement plans include:

- Partners support the action plan from the Leicester Climate Emergency Strategy 2020 – 2023 focused on reducing carbon admissions through:
  - Homes
  - Travel and Transport
  - Consumer Choices and waste
  - At work
  - Land use, green space and development
- NHS partners lead the development of a ICS system ' Green Plan' by April 2022, setting out the carbon reduction initiatives that are already underway and their plans for the subsequent three years. This will include plans to:
  - Phase out coal and oil fuel as primary heating
  - Switching to lower carbon asthma inhalers
  - Reducing the carbon footprint from anaesthetic gases
  - Improve Air quality: including by cutting business mileages and fleet air pollutant emissions by 20%

Measuring progress:

- Ongoing reductions in in emissions of CO2) in city – the main greenhouse gas – from our transport, housing and other buildings.
- Reduction in carbon admissions from NHS organisations in line with national targets

Proposed Priority 4: Creating Mental Health & Dementia friendly communities within Leicester

Healthy Places

Level: City wide & through neighbourhood level initiatives

Why a Priority?

- In Leicester it is estimated that between 34,000 and 38,000 people live with a common mental health needs ,for example, depression or anxiety. Further around 3,400 people live with an enduring mental health condition, such as schizophrenia or bipolar disorder.
- Its is estimated just under 3000 people in the city are living with Dementia
- There is a recognised need to for continue work to:
  - Normalise conversations about Mental Health and Dementia
  - Encourage people to seek help and support locally, when they need it
  - Create community touch points (businesses, clubs, societies, faith groups, schools and organisations) where local people can reach out for help

Current improvement plans include:

- To build on the ' Time for Change Leicester' initiative, aimed at reducing mental health stigma and increasing the number of MH First Aid trained people within community and faith groups.
- To develop and promote the concept of Mental Friendly organisations which are .
  - Mental Health First Aid trained
  - Know about local support services and help available
  - Be able to show people how to self-refer to and access talking therapy services
  - Be able to signpost people to key access points for local *Mental Health services for children, young people, students, adults and older people
- Managing dementia in the community we are creating 'dementia friendly' public spaces throughout the city by working with public, private and voluntary sector age-friendly partners

Key Partners: Local authority, All Healthcare providers and commissioners, VCSE sector, Local businesses, People of the city:

Measuring progress:
tbc

Proposed Priority 5 : 'First 1001 Critical days'

Healthy Start

Level: Citywide

Why a Priority?

- Significant evidence indicates the first 1001 days (from conception through to 2 years of age) is critical in proving a strong foundation for longer term health outcomes and reducing health inequalities across the life course. It is recognised as a fundamental action in helping our population live healthy, happy lives and supporting individuals to fulfil their potential.
- Infant mortality in Leicester is higher than the national average. Risk factors include poor maternal/ family lifestyle choices, not breastfeeding and not immunising infants.
- In 2016/17 breast feeding initiation in the city was below the England average
- Central HNN is an outliner on the number of low weight babies

Key Partners : UHL (Maternity Transformation), LA Children's services, Public Health, LPT (Health Visitors & Perinatal MH access), VCSE sector, Primary care (Childhood imms)

Current improvement plans include:

- Effective implementation of 0-19 Healthy Child Programme in Leicester
- Maternity services transformation (Key aim includes improving continuity of maternity care plans for vulnerable and BAME groups).
- Increase access to perinatal Mental health support services
- Focus on early years language development through the Leicester City Speech, Language and Communication (SLC) Strategy 2021-2025. Supported by Health Inequalities Grant allocation 202-1-24 (£150k) to support language development Children who will grow up in families with more than one language.
- Additional health inequalities grant funding to ' Leicester Mammas'' peer support group to promote breastfeeding.
- Development of a high level of LLR Manifesto confirming organisations commitment to promoting the importance of the 'First 1001 Critical days'

Measuring progress:

- Increase in Childhood imms rates
- Increase in breast feeding rates
- improvement in the infant mortality rate
- Narrowing the gap at 2-2½ year health and development and early Years Foundation Stage Profile at expected levels in Communication and Language between Leicester and national average.

Proposed Priority 6: Mitigating the impacts of poverty on children and young people

Healthy Start

Level: Citywide but in particular in central, South & NW neighbourhoods

Why a Priority?

- Leicester has a higher than average number of low incomes families than the England average.
- Key stage 4 attainment score for Leicester is lower than national average. South and NW HNN are significant city outliners.
- South, NW and Central HNN's have a higher % of wards in the most deprived quintile in the UK. Poverty is recognised to impact negatively on all aspects of children's lives and their ability to thrive and achieve later in life. Health inequalities are exacerbated when poverty is also present.

Key Partners : All LA Departments, Health commissioners/ Providers, Schools, VCSE sector, Community organisations Private businesses

Current improvement plans include

- The city council is currently developing an anti-poverty strategy which will bring together up-to-date data on poverty trends across the city, with data at a neighbourhood level where it is available. It will also present the information obtained through extensive engagement across services which offers insight into the lived experience of poverty in the city.
- The strategy will enable council services and external partners to better understand the nature and impact of poverty on the people that use their services, thereby providing opportunities to make changes to services or develop new ones.

Measuring progress:

- Improvement in Leicester city and neighbourhood level Indices of Multiple Deprivation over the coming years.
- Additional local indicators to including employment levels, income levels, benefits claimed, etc.

Proposed Priority 7: Empowering health self-care in families with young children

Healthy Start

Level: Citywide

Why a Priority?

- Unprecedented demand in Children's Emergency Department with over 50% of attends deemed 'inappropriate'. Majority of attendance from Leicester city families.
- 50% of all presentation are from City families in last 6 months.
- Sure Start offered a 'one-stop-shop' for families with children under five. In 2010 it operated around 3,500 centres, but since then the programme has had its funding cut by two-thirds and the future of the programme is uncertain. Nuffield Foundation previous research has found that greater access to Sure Start significantly reduced hospitalisations among primary school children in disadvantaged areas.

Key Partners : CCG's, UHL, Primary Care/ PCN's, LA Children centres and services, Schools, Pharmacy, LPT, Public Health, Community organisations

Current improvement plans include:

- Developing education materials for the public and professionals around understanding common childhood illnesses and when to attend ED
- Expanding online webinars promoting management of minor illness e.g. Beat the Street Webinar –Beat the Street' sessions taking place regularly to communicate with public around managing minor illnesses in CYP and navigating the system.
- Developing online information on management of minor illness and promoting through children's services and schools.
- Expanding the role of pharmacies to promote self care in families.

Measuring progress:
Reduction in 'inappropriate' admissions to Children ED from Leicester city families.

Proposed Priority 8: Reducing levels of unhealthy weight across all ages

Healthy Lives

Level: Through City wide and neighbourhood level initiatives

Why a Priority?

- In Leicester over half of the adult population are overweight or obese. Obesity is a complex problem, influenced by many different factors including excessive food intake and physical inactivity
- Obesity is a high risk factor for Type 2 Diabetes, Stroke, heart disease and cancer.
- Leicester is a significant regional and England outliner for under 75 years or age death from CVD.
- Being overweight or obese is the main modifiable risk factor for type 2 diabetes.
- Prevalence of obesity in Year 6 on Leicester is higher than the national average
- Evidence from PHE of individuals self-reporting that they have put on weight directly as a result of the pandemic.
- Increased risk of worse outcomes due to being overweight/obese when contracting covid.

Key Partners :

Public Health. Primary care/PCN's, local authority, Community and secondary care health services, VCSE sector, community organisations

Current improvement Plans include:

- Leicester City Public Health have recently had approval to develop a whole system approach to obesity and a dedicated lead officer on this work now in post. This will include seeking to address known gaps in existing provision including a gap for people who require tier 3 specialist multidisciplinary teams.

- *Health Inequalities Grant allocation 202-1-24 (£180k) for additional investment in PH Live Well service to employ two additional Healthy Lifestyle Advisors focused on the most disadvantaged areas of the city- to develop healthy lifestyle sessions including physical activity, healthy eating advice and mental wellbeing support.

- Public Health England Guidance on 'Physical activity: understanding and addressing inequalities' will support addressing inequalities in physical activity locally.

Measuring progress:

- Weight management services at all 4 tiers in the city, line with best practice guidance
- Increase activity levels for Leicester in line with the national average
- *Reduction in prevalence of obesity including Year 6 levels
- Reduction in prevalence of diabetes

Proposed Priority 9: Increasing early detection of CVD, COPD and Cancer in adults

Healthy Lives

Level: Through City wide and neighbourhood level initiatives

Why a Priority?

- Cancers are the main cause of premature deaths (in the under 75s) in Leicester, accounting for over a third of early deaths, followed by heart disease and respiratory diseases.
- NHS 'RightCare Pack' indicates Leicester has the lowest colorectal cancers detected at any early stage compared to peer authorities.
- Leicester is a significant regional and England outliner for under 75 years or age death from CVD.
- Rates of diabetes are significantly higher in Leicester compared to England. Central and NE HNN are outliners in city for CHD and Diabetes Prevalence.
- Leicester is a significant regional and England outliner for under 75 years or age death from CVD.
- Central HNN-Outliner for CVD under 75 mortality.
- NW and South HNN outliner for early death from cancer and respiratory diseases

Key Partners :

Public Health, Primary care/PCN's, local authority, Community and secondary care health services, VCSE sector, Local community organisation

Current improvement plans include:

- Promote national cancer screening programmes on a city wide level and through work in neighbourhoods, particularly in NW and South HNN's
- Implementing high blood pressure through community pharmacies, in line with national guidelines
- Promote physical health checks for eligible adults under existing criteria and seek to expand provision
- Promoting Learning Disabilities and SMI annual physical Health checks
- Promote pre-diabetes checks particularly in in Central and NE HNN's
- Health Inequalities Grant allocation 2021-24 (£330k)to develop culturally competent comms strategy/ peer educators/ support to community groups in order to Promoting uptake of cancer and cardiac screening, health checks, and vaccinations in groups with lower uptake e.g. some BAME and disadvantaged groups..

Measuring progress:

- Improvements in health screening rates for adults including learning disabilities and SMI annual health checks rates.
- Reduction in early death from cancer and respiratory diseases, in particular in NW and South HNN's
- Reduction in under 75 years or age death from CVD
- Reduction in prevalence of diabetes

Proposed Priority 10: Promoting independent living for people with long term conditions.

Healthy Lives

Level: City wide & through Integrated neighbourhood working

Why a Priority?

- Nationally around one in four people have two or more long-term conditions or 'multimorbidity'. This rises to two thirds of people aged 65 years or over. Multimorbidity is associated with higher mortality, adverse drug events and greater use of unplanned care.
- According to Leicester's 2018 Health and Wellbeing Survey, almost three in ten residents (28%) have a long-standing illness or disability. Of these, two thirds (66%) say this limits their day to day activities in some way.
- As of September 21 Leicester City Council supports 1920 people aged between 18 and 64 years and 2268 people aged 65+ (totalling 4188) and number are expected to increase.
- It is expected that more people will be supported to live at home into the future and services will increasingly be focused on helping them to remain independent and to gain or retain life skills and links with their local community.

Key Partners :

Primary care/PCN's, local authority Adult Social , LPT, Community and secondary care health services, VCSE sector, community organisations

Current improvement plans include:

- Developing Population Health Management approaches and pro-active care through Integrated Neighbourhood multi-agency team working.
- PCNs to review LTC disease segmentation within own practice to identify local priorities for commissioning and care coordination
- Embedding a strengths-based model of support to promote wellbeing, self care, and independence
- Improve opportunities for those of working age to live independently in a home of their own, and continue to reduce our reliance on the use of residential care
- Improving the opportunities for those of working age to live independently in a home of their own including secure a steady and sustainable new supply of supported housing accommodation to support new care and support models
- Improve access to IAPT and other mental health and wellbeing services for people with long term conditions

Measuring progress:

- Quality of life feedback from people with Long term conditions.
- Increase in % of people in city with health & care personalised plans
- Increase in number of Adult Social care eligible people living in non residential care setting (e.g. extra care/ supported living).
- Increase in numbers of people with a long term condition in employment.

Proposed Priority 11: Improving support for carers

Healthy Lives

Level: City wide

Why a Priority?

- Census date indicated 9% of usual city residents were providing unpaid care (30,965). Of this group, over two-fifths (43%) were giving 20 or more hours care a week. This is estimated to have increased to 46,000 post COVID.
- Just over 10,000 carers are registered on the City GP registers and just over 1000 are accessing the Carer Support Service commissioned by the City Council.
- Many carers can be affected physically by caring through the night, repeatedly lifting, poor diet and lack of sleep. Stress, tiredness and mental ill-health are common issues for carers.
- Across LLR, numbers of carers reporting a feeling of depression and loss of appetite is significantly higher than the England average
- There is a recognised need to continue to improve support services for informal carers, including better access to primary care support, respite provision, financial/benefits advice and mental health support.

Key Partners :

LA Children's & Adult Social Care, Primary care/ PCN's, LPT, UHL, VCSE, * Community organisations

Current improvement plans include:

The current LLR wide Strategy 2018-21 identifies need for:

- Improving carers identification
- Increase health checks for carers are promoted as a means of supporting carers to maintain their own physical and mental health and wellbeing
- Promoting carers within our organisations and other employers
- Support carers through flexible policies
- Improving access to Information and Advice
- Improving Financial/ Benefits advice for carers
- Flexible and responsive carer respite
- Supporting young carers through awareness
- raising and early identification

Also need to:

- Improve access to GP appointments for carers
- Improving access to Mental Health support/ counselling services

Many of these improvements can be driven at a Place level

Measuring progress:

- Monitoring through carers related questions in the Adult Social Care Outcomes Framework: Carer reported Quality of Life,% of carers who felt they had sufficient social contact , overall satisfaction with social services etc.
- Increasing the number of carers flagged on GP Practice systems

Proposed Priority 12: Improving access for CYP to MH & emotional wellbeing services

Healthy Minds

Level: City wide

Why a Priority?

- In Leicester one in ten children aged 5-16 years has a mental health problem and, of adults with long-term mental health problems, half will have experienced their first symptoms before the age of 14.
- Failure to treat mental health disorders in children can have a devastating impact on their future, resulting in reduced job and life expectations.
- National target that 35% of CYP with CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service- In Leicester City current rates is 21% compared to 38% in Leicestershire County and a midland average of 33%. This lower access rate is indicated to be due to a combination of services capacity, need to promote services and ensuring data recording of people seen.

Key Partners :
LPT CYP services, LA children services, CCG's, Primary care/PCN's., VCSE & Third sector, Community organisations

Current improvement plans include:

CCG's /LPT/ City Council are working together to:

- Raise awareness of CYP MH services across the city
- Developing new and enhanced services including;
  - The City Early Intervention Psychology Support (CEIPS)- additional resources to deliver new 'Calm Clinics'.
  - Additional two mental health support teams in Leicester City schools
  - Community Chill Out Zone - 140 pop up Community Chill Out Zones covering more areas in Leicester City, including targeting faith.
  - Family Action Post Sexual Abuse Counselling Service – Additional resources allocated to increase referrals
  - Triage and Navigation Service – Additional resources to receive more referrals, including self-referral.
- Improving flow of data from services provided by the City Council and Third sector.

Measuring progress:
Improvement in NHSE national target that 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service. In 2021/22 this equates to 3,087 CYP in Leicester City.

Proposed Priority 13. Improving access to primary & neighbourhood mental health services for adults

Healthy Minds

Level: Delivered through Integrated Neighbourhood working

Why a Priority?

- Poor mental health is the most common condition affecting people in the UK. Local survey data shows 17% of Leicester's 16+ population report a poor mental wellbeing score. The unemployed, long term sick/disabled and social renters are all more likely to report poor mental health
- In Leicester it is estimated that between 34,000 and 38,000 people live with a common mental health problems & 3,400 people live with an enduring mental health condition, such as schizophrenia or bipolar disorder.
- Difficulty accessing support when needed can lead to poor outcomes. Further people with poor mental health are more likely to engage with unhealthy behaviours and poor lifestyle choices, contributing to premature death.
- Delivering community mental health services at a primary and neighbourhood level is a key NHSE transformation priority

Key Partners :

LPT, LA ASC Mental Health services, CCG's
Primary care/PCN's , VCSE sector, Housing

Current improvement plans include:

- Increasing the number of primary care based mental health roles
- Transforming existing LPT Community Mental Health Teams to be integrated teams working alongside GP's to support people with a Severe Mental Illness.
- Strengthening VCS mental health and wellbeing support services in neighbourhood and local communities
- Improving mental health support services for vulnerable group (homeless, offenders).
- Adopt, embrace and deliver through all services in system to be focused on individual 'recovery' and individuals to live well with their mental health

Measuring progress:

- Delivery of planned 4 week waiting time standards for CMHT's
- Increase in SMI health checks towards national 60.0% target
- Feedback from annual LPT community mental health surveys from patients.
- Feedback from independent evaluations of community mental health transformations
- Increasing number of individuals with SMI supported into employment

Proposed Priority 14: Reducing social isolation in older people & adults

Healthy Minds

Level: citywide

Why a Priority?

- There is increasing evidence of social isolation and loneliness increasing in both older people and younger adults.
- Social isolation and loneliness have a detrimental effect on health and wellbeing. Studies show that being lonely or isolated can impact on blood pressure, smoking prevalence, obesity levels, developing coronary heart disease and strokes and is a risk factor for developing depression or dementia in later life.
- Public Health Insight briefing on social isolation in 2019 found:
  - 8% of Leicester residents feel socially isolated from others often or all of the time.
  - There are no significant differences by gender or ethnicity.
  - Those aged 35-64 are reporting higher rates of isolation compared to other age groups.
  - One in five (19%) with a long term condition limiting daily life have feelings of social isolation

Key Partners :

Public Health, ASC Older persons services, CCG's, Primary care/ PCN's, VCSE sector, Local community organisations

Improvement Plans:

- To build on the work of Leicester Ageing Together Partnership October 2015 to reduce isolation and loneliness in older people in Leicester and expand approach to isolated adults.
- Develop initiatives that promote digital inclusion, including digital socialisation and cyber security, particularly for older people.
- Increase access to IAPT and other mental health and emotional wellbeing services for people older adults
- Health Inequalities Grant allocation 2021-24 (£330k) and Public Health funding (£120k) to employ six 'community connector's Reducing Social Isolation & Improving Health (Psychosocial and Physiological Impacts)

Measuring progress:

- Levels of depression in older people (GP QOF register).
- Level of access to IAPT and other mental health services by older people.
- Qualitative feedback from older people and adults from Public Health insight surveys on social isolation

Proposed Priority 15: Enabling Leicester's residents to age comfortably and confidently

Healthy Ageing

Level: City wide

Why a Priority?

- We have an ageing population: in the UK there are now half a million people in their 90s, more than two and half times the number in 1985.
- National evidence indicates years in poor health (the difference between life expectancy and healthy life expectancy) increased from 18.1 years to 19.1 year Having more than one condition increases with age.
- Healthy life expectancy in Leicester is around 60 years for men and 59 years for women in 2015 to 2017. This means men have on average 17 years and women have 22 years of their overall life expectancy where their health is not good. Compared with peer areas, Leicester men and women have the 3rd and 4th lowest rate of healthy life expectancy

Key Partners : Public Health, Primary care, LA ASC Older Persons services, LPT, UHL, VCSE sector, Housing

Current improvement plans include:

The Joint Health and Wellbeing Strategy recognises the need:

- Support older people to manage their wellbeing can involve promoting good lifestyle choices such as a healthy diet, fluid intake, exercise, oral health, flu (and other) vaccinations and regular NHS, or other, health checks.
- Making positive changes that will improve their mental and physical health by working with partners to signpost and refer people to relevant lifestyle services.
- Work with partners to make sure that older people feel safe and confident in their own homes and around the city
- Encourage older people to access leisure and cultural spaces in their local communities to improve mental and physical health.

Work will be supported by Health Inequalities Grant allocation 2021-24 (£330k) and Public Health funding (£120k) to employ six 'community connector's to help reducing social isolation & improving health

Measuring progress:

- Improvement the number of years Leicester city males and females spend in living in 'poor health'
- Qualitive feedback from older persons forums

Proposed Priority 16: Promoting independence in frail older people

Healthy Ageing

Level: City wide & through Integrated neighbourhood MDT working

Why a Priority?

- We have an ageing population and national evidence indicates years in poor health (the difference between life expectancy and healthy life expectancy) increased from 18.1 years to 19.1 year.
- Healthy life expectancy in Leicester is around 60 years for men and 59 years for women in 2015 to 2017. This means men have on average 17 years and women have 22 years of their overall life expectancy where their health is not good. Compared with peer areas, Leicester men and women have the 3rd and 4th lowest rate of healthy life expectancy
- Just 0.5% of the population in LCCCG accounted for over 20% of secondary costs in the previous year. Another 46% of secondary care costs were attributable to the next 4.5% of the population. Overall about 20% of the population accounts for over 90% of all secondary care costs in a given year

Key Partners : Primary care /PCN's, LA ASC Mental Health services, LPT, UHL, Housing, VCSE sector

Current improvement plans include:

Developing new models of care promoting independence including :

- Proactive/ anticipatory care building blocks through development of Integrated Neighbourhood Teams, adopting a population health management approach, co-ordinated care through Multi-disciplinary teams to identify people at risk of admission , primary care Anticipatory Care schemes.
- Responsive urgent and crisis response services , reablement and enhancing the Home First support offer.
- Adult Social care developing Extra Care and other independent living schemes on order to reducing reliance on residential care.
- Ensuring Dementia Support Service helps people from the point of diagnosis and prevents their needs escalating to the point they need residential care.

Measuring progress:

- Improvement the number of years Leicester city males and females spend in living in 'poor health'
- Reductions on unplanned admission for older people classed a frail or having co-morbidities.
- Reductions in the number of older people admitted to residential or nursing care homes.

Proposed Priority 17: Reducing the number of falls for people aged 65+ in Leicester City

Healthy Ageing

Level: City wide & through Integrated neighbourhood MDT working

Why a Priority?

- Leicester is a significant outliner in the number of hip fractures in people aged 65+.
- The City has historically had a higher rate of older people accessing acute care for frailty, including a higher rate of fallers
- There is a need to reduce both the incidence of falls, which can cause hip fractures.
- Further the prevalence of osteoarthritis in BME communities caused by a lack of bone density, in particular in women post menopause. This will be a particular issue for neighbourhood with high BAME population (Central and NE)

Current improvement plans include:

Reducing Incidence of Falls:

- One of the priorities of the LLR Frailty Collaborative and plans include ensuring a falls prevention service and rapid response service in is place equitably across LLR by October 2021.
- In addition specific City initiatives could include:
  - Supporting Frail people through Assistive Technology-Joint assessment and provision of assistive technology to prevent falls and keep people at home independently and safely.
  - Improving Falls information and advice e.g. Care navigators/ social prescribers/ housing staff all have a role when they see older people to look at obstacles & provide advice?

Reducing prevalence in BME communities:

- Developing culturally competent exercise programmes or funding local organisations to develop.
- Raising awareness of the importance of maintaining bone density within BME communities though the work of the 6 community connector roles funded through Health Inequalities grant funding.

Key Partners: : Primary care /PCN's, LA ASC Mental Health services, LPT, UHL, Housing, VCSE sector

Measuring progress:

- Reduction the number of hip fractures in people aged 65+.
- Reduction in number of unplanned hospital admissions in older people as result of a fall.

Planned next steps:

Action	When
Engagement on draft priorities	Nov. 2021 – early Jan. 2022
Agreement on final priorities by HWB	27th Jan 2022
Development of first year Action Plan and monitoring dashboard.	Feb.- early March 2022
Agreement on 1st year Action Plan by HWB	Late March 2022
Implementation & monitoring of Action Plan	April 2022 onwards

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	LLR Learning Disability and Autism (LDA) 3 Year Plan Progress Report
Presented to the Health and Wellbeing Board by:	Mark Roberts. Assistant Director. Leicestershire Partnership NHS Trust Cheryl Bosworth. Senior Programme Manager - Transforming Care Programme. LLR CCGs
Author:	Mark Roberts Cheryl Bosworth

EXECUTIVE SUMMARY:

The LLR Learning Disability and Autism 3 Year Plan was submitted to NHSEI in May 2021 and was favourably received. The plan seeks to address the health inequalities experienced by this population and is complimented by focused performance management of key outcomes detailed in the accompanying slides.

The plan contains within it a large number of projects pertaining to both adults, and children and young people's services for individuals with a learning disability, autism or both. It brings together multiple funding streams to ensure coordination of commissioning, provision and improvement work.

Funding streams include NHSEI Service Development Funding, NHSEI Spending Review Funding, DHSE Community Discharge Grant, East Midlands CAMHS Collaborative and the Mental Health Investment Standards

Robust governance arrangements are in place to monitor the progress and performance of these projects. New projects have been recently added to the initial plan following successful expressions of interest for additional funding.

Good progress is being made on all projects and progress is overseen by the multiagency Transforming Care Programme (TCP) Delivery Group. The Learning Disability and Neurodisability Design Group provide governance support.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

1. Be updated on the progress of the implementation of the projects included within the LDA 3 Year Plan.
2. Receive assurance that all projects are being monitored and reported upon in line with the agreed governance processes of this programme.
3. Be updated on advance planning for year 2 proposed projects

Transforming Care Programme

Leicester City Health and Wellbeing Board

29th October 2021

Title:	LLR Learning Disability and Autism (LDA) 3 Year Plan Progress Report	**Agenda Ref:**	Paper
Authors:	Mark Roberts Cheryl Bosworth Jenny Napier Dodd	**Contact No:**	07786171429
Email:	mark.roberts@leicspart.nhs.uk	**Presented by:**	Mark Roberts Cheryl Bosworth

Executive Summary

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- DHSE Community Discharge Grant
- East Midlands CAMHS Collaborative
- Mental Health Investment Standards

Robust governance arrangements are in place to monitor the progress and performance of these projects. New projects have been recently added to the initial plan following successful expressions of interest for additional funding.

Good progress is being made on all projects and progress is overseen by the multiagency Transforming Care Programme (TCP) Delivery Group. The Learning Disability and Neurodisability Design Group provide governance support.

Several new additional projects have gone live, project plans developed and project tasks begun. These include the development of a sensory friendly environment within the Bradgate Unit and the CYP ASD diagnostic waiting list reduction.

Potential projects for year 2 of the plan have been collated and are being evaluated, and initial prioritisation is on-going at the TCP Delivery Group meetings. Detailed costings and outcomes are now being requested for agreed priority projects. Funding arrangements for year 2 are being determined as several funding streams have

not been confirmed. Consequently year 2 schemes cannot yet be finalised. At a recent forum with NHSEI it was indicated that Spending Review Funding for LDA for 22/23 may not be available.

Recommendations

The Board is asked to:

1. Be updated on the progress of the implementation of the projects included within the LDA 3 Year Plan.
2. Receive assurance that all projects are being monitored and reported upon in line with the agreed governance processes of this programme.
3. Be updated on advance planning for year 2 proposed projects

Board Action Required (mark with X)			
	Approval/Decision		**For Review**
X	**For Assurance**	**X**	**For Update/Information**

Introduction

The three year plan outlines what good will look like for people with learning disability (LD), autism (ASD) or both who use community and inpatient services in Leicester, Leicestershire and Rutland (LLR), and focuses on addressing health inequalities for people living with a learning disability and/or autism.

Local and national data tells us that:

- The mean average life expectancy of a person with LD living in LLR is 59 [Leicester, Leicestershire and Rutland LeDeR Annual Report, June 2020]
- A person with LD is 10% more likely to be admitted to a hospital ward from ED [Leicester, Leicestershire and Rutland LeDeR Annual Report, June 2020]
- A person with LD is up to 6 times more likely to die from COVID-19 than someone without LD [Deaths of people identified as having learning disabilities with COVID-19 in England in the spring of 2020. Public Health England, November 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/933612/COVID-19__learning_disabilities_mortality_report.pdf]
- A person with ASD and no LD is more than twice as likely to have an anxiety disorder than someone without ASD [Nimmo-Smith V et al. Anxiety Disorders in Adults with Autism Spectrum Disorder: A Population-Based Study. J Autism Dev Disord. 2020 Jan;50(1):308-318. doi: 10.1007/s10803-019-04234-3. PMID: 31621020; PMCID: PMC6946757.]

We know this inequity is unacceptable and we are driven to reduce these fundamental health inequalities for this population. Our approach to delivering the key elements of the Transforming Care agenda (LeDeR, admission management and delivery of Annual Health Checks) focus on multi-organisational collaboration to deliver care individualised to patient need.

As a system, LLR completed a community mapping exercise to understand the local unmet needs, gaps in care and local health inequalities. This identified gaps in LD community forensics, post-diagnostic autism services, crisis wrap around services and urgent respite facilities. In addition:

- Community services for both adults and children & young people with LD and ASD were not fully joined up.
- Some services had received previous investment and were well developed, some were in development and some services and resources were not currently available at all.
- Some services were in place but without sufficient capacity and managing long waiting lists.

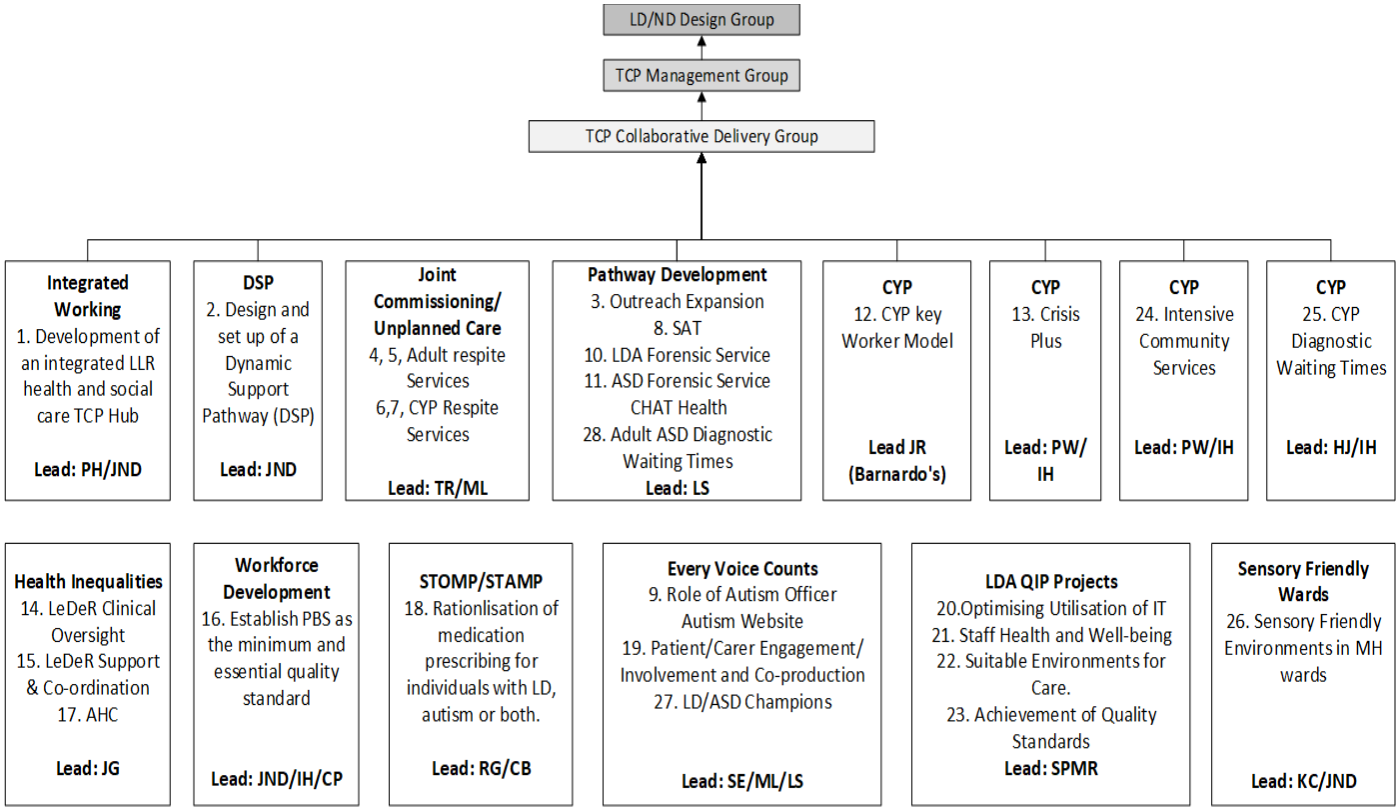
- Health, social care and education were all committed to delivering the right care but effective joint working processes were not always in place. This led to inconsistent approaches and outcomes. Communication and information flows between teams were inconsistent and this resulted in some duplication of work and wasted capacity.

The initiatives and services identified in this plan were designed to address these already identified gaps in service and concerns in process and ways of working. The plan sets out how we are ensuring local services work in partnership to make reasonable adjustments for people with learning disability, autism or both to achieve the best quality of care, support and treatment at the right time.

A key focus of the plan is working much more collaboratively as part of an integrated care system approach to prevent inappropriate mental health hospital admissions.

Governance Structure

Each Project has in place a Task & Finish Group with an appointed project lead. Each has developed their own project plan that includes key tasks, responsibilities, and timelines. In turn, each Task and Finish group is required to complete a monthly update/highlight report to be presented to the LLR TCP Collaborative Delivery group for discussion. This forum meets fortnightly to support timely progress.



Year 1 Project Updates

Project Title	Description	Outcome Description	Progress
TCP Integrated Hub	Development of an integrated LLR health and social care TCP Hub overseen by a dedicated Assistant Director including commissioners, social workers, CCG case managers, Housing Staff and discharge planning	Consistent approach in systems and processes. Obstacles to discharge anticipated and proactive measures in place to reduce. Process timelines reduced.	Hub in place and live. Weekly workshop in place and effectively evaluating and improving processes within the discharge pathway. Weekly patient level discharge planning meeting in

Project Title	Description	Outcome Description	Progress
	leads and dedicated project support.	Duplication of work removed. Gaps in processes causing delay identified and reduced. Clear roles and responsibilities of all stakeholders clearly identified. Role and task clarity for team members.	place to agree next steps, tasks and responsibilities.
Dynamic Support Pathway	Design and set up of a Dynamic Support Pathway (DSP) which includes the roll out of the Dynamic Support Register and more robust delivery of multi-agency meetings. Focus is on crisis avoidance.	All community services using a consistent approach/processes to deliver crisis avoidance and crisis management activities. Admission avoidance (crisis management) and crisis avoidance processes are more responsive and able to be deployed quickly.	Referral criteria agreed. Referral pathway agreed. DSP support officers recruited for both adult and CYP referral management. Communication and training/awareness
Adult LDASD Outreach	Extend LD Outreach working hours to include bank holidays. Increase capacity to become a more intensive support function.	Admission avoidance. Focussed support in the community for individuals requiring additional support than can be offered by community LDA services.	In place.
Unplanned Care (all age)	Development of crisis accommodation/emergency respite to prevent admission.	Individuals are no longer admitted to a hospital bed as a place of safety when behaviours that challenge increase and the family/carers/community placement providers are not able to manage the escalating risks. Alternatives to hospital admission during times of crisis are available.	Ongoing discussions with multiple potential providers. Costings now being received from several providers. Detailed option appraisal progressing.
Specialist Autism team (14+)	Mobilisation of a multi-disciplinary team to provide specialist support to those people (age 14+) with autism who are at risk of admission in the community and to provide in-reach to inpatient settings to ensure ASD needs are being met within assessment/treatment. Deliver post discharge support to prevent re-admission.	Individuals receive timely assessment and interventions within the community to prevent further deterioration. Crisis is avoided and risk of admission is significantly reduced. Timely discharge with appropriate length of stay.	Team now live and offering admission avoidance and in-reach discharge facilitation support.
LLR Autism Officer	Employment of an LLR Autism Officer to work with local services and businesses to improve autism access. To develop a dedicated Autism website for LLR containing links to relevant local support services.	Individuals/families and carers has 24/7 access to advice and support.	Autism officer in place and delivering project outcomes as described.
LD/ASD Community Forensic Service	Development of a dedicated team able to support individuals with a forensic need. Expansion of the LD Forensic Pilot to provide a complete team offering in-reach support to people with LD and/or Autism in secure hospitals and forensic support and training to community providers as part of	Patients (LD, LD &A) with a forensic need have a dedicated specialist team in place to support their discharge and to support them post discharge to enable them to return to life in the community. Dedicated team in place to offer support to prevent deterioration in well-being and to deliver a package of care that will reduce risk, manage	Team recruited, gone live and offering the support described. Responsible Clinician now also in place for this team.

Project Title	Description	Outcome Description	Progress
	discharge planning including supporting the development of risk assessments/risk management plans, etc.	behaviours and prevent crisis and the on-going risk of admission.	
Child and Young Parson (CYP) Keyworker Initiative	Development of an LLR Key worker service working as part of a multi-disciplinary team to improve early identification and tracking of CYP at risk of escalation through increased involvement in Early Help services, helping develop a clear risk stratification of the local area and dynamic risk register of children.	Timely access to the right personalised support is in place. Assessment, care and support are integrated across education, health, social care and voluntary, community services. CYP feel listened to, informed and involved. CYP feel involved in their plans, care and support Families experience a reduction in stress and uncertainty. Families experience an increase in stability. Families feel listened to, informed and involved	Team fully recruited and ready to go live. Awaiting final sign off of information sharing agreement.
CYP Crisis Plus	Provision of emergency crisis service (24/7) for CYP to enable crisis management and prevention of admission at a time of crisis. Alternative to hospital admission during times of crisis available. Step-down to 'hospital at home' like service to enable timely discharge (provided by CAMHS outreach & Beacon Unit staff)	Individuals are no longer admitted to a hospital bed as a place of safety when behaviours that challenge increase and the family/carers/community placement providers are not able to manage the escalating risks. Reduced LOS in in-patient Unit. Reduced number of CYP admitted to out of area hospitals away from family and carer support.	New initiative funded by Mental Health Investment Standard. Project plans in development.
LeDeR	Enhance the clinical oversight of local LeDeR reviews and take forward learning into action from previous LeDeR review outcomes.	Clear and concise reviews Clear understanding of cause and effect Clear understanding of lessons learnt Development and implementation of clear action plans to prevent recurrence of any identified concerns in the system. Dissemination of learning across the whole system.	LeDeR clinical leads and administrative support recruited. Findings from LeDeR reviews are being developed into SMART actions. Key areas of concern have been identified and primarily relate to respiratory illness (highest cause of LD death in LLR) and poor weight management (loss and weight gain). Actions will need to be agreed and taken forward across the whole of the system to address these concerns.
Annual health Checks	Working with Primary Care to increase attendance for annual health check	Increased attendance at AHC for individuals who have not previously engaged with this initiative. Early identification and treatment of physical health conditions.	Project live and on-going. Target trajectory set by NHSEI being achieved. However there remain some practices delivering very few health checks. Support now being put in place to address this inequality in access.
Workforce Development	PBS training at foundation level, practitioner level, basic functional behaviour Assessment and implementation of PBS for managers training package	A focus on PBS approach will result in the following desired outcomes: • Person centred approach in place • Improved CYP and family experience and outcomes.	Training plans in development with AMH and LDA in-patient Units. PBS practitioners recruited for community LD teams

Project Title	Description	Outcome Description	Progress
		• Risk reduction. • Early intervention. • Crisis avoidance. • Proactive care planning and management. • Person and family centred. • Reduced admissions.	
STOMP/STAMP	Initiatives include; delivery of training to all LPT staff, a primary care communication plan, the detailed review of the newly completed secondary care audit, business intelligence to identify additional information required (BAME data), set up of a STOMP/STAMP workshop and the development of an E-Learning package.	Rationalisation of medication prescribing for individuals with LD, autism or both. Ensure all individuals have a robust review of their medication and adjustments made in line with individual needs.	Project Plan in place. Task and Finish group in place and delivering in line with agreed priorities.
Every Voice Counts	To develop and implement a long term sustainable plan to embed service user and carer involvement and engagement into business as usual service improvement initiatives.	Sustainable and on-going commitment to including the voice of the patient/carer/family in all future service development. A culture of patient involvement in all decisions pertaining to their own care.	Project Plan in place. Task and Finish group in place and delivering in line with agreed priorities.
CYP Intensive Community Services	Community service for CYP who do not meet the CAMHS threshold but are struggling to cope in the community	Young people are no longer admitted to a hospital bed as a place of safety when behaviours that challenge increase and the family/carers/community placement providers are not able to manage the escalating risks.	Recent award of funding from East Midlands CAMHS Collaborative.
CYP Diagnostic Waiting Times	Project to reduce the number of children and young people waiting for a diagnostic assessment of autism.	System wide capability to manage the pathway internally with no requirement to outsource diagnostic assessments Robust MDT completion of diagnostic assessments completed without delay and without the input of an educational psychologist (a significant factor in system wide current inability to complete the diagnostic process) A NICE compliant pathway of care Improvements in parents / CYP satisfaction with the diagnostic process	Recent award of funding from NHSEI. Project plan in place. Agency teams now commissioned to complete assessments for young people waiting for assessment. Individual assessments on-going. Awaiting progress update on number of young people waiting and having received an assessment.
Development of Sensory Friendly Wards (Bradgate Unit)	Multi-faceted approach to creating a sensory friendly environment. The proposed changes will address concerns that are applicable to the majority of individuals with sensory needs and deliver a solution that can be tailored to meet the preferences and sensory needs of an individual and eliminate their dislikes and triggers.	Individual's sensory needs are understood – assessments would give rise to the creation of a bespoke in-patient environment conducive to enabling the in-patient treatment plan to be delivered and goals achieved. The individuals LOS would be appropriate and discharge timely. Re-admission rates will reduce as the sensory needs of the individual in the community home environment will be better understood and be in place in the commissioned community placement.	Recent award of funding from NHSEI. Project plan in place. Training plan in place. Furniture and equipment being purchased.

Project Title	Description	Outcome Description	Progress
LD/ASD Champions	Appointment of an all-age Learning Disability and Autism (LDA) Champion to provide the LLR ICS with expertise, advice and leadership to drive transformation of services for children, young people and adults with a learning disability and for autistic people	All services for people with LDA reflect, and are aligned, to, local and national priorities/requirements Ensure that health and care services collaborate actively and constructively with colleagues in CCGs, Local Authorities and other providers to ensure effective, seamless and responsive local services for individuals with LDA	Champion now in place.
Adult ASD Diagnostic Pathway	Development of revised screening tool Testing and monitoring the impact of the revised screening tool. Recruitment of additional clinical practitioner and administrative support to current AADs team able to deliver 1:1 support and psychoeducation workshops.	Reduction of inappropriate referrals and would reduce the numbers of pre-assessments that would need to be completed, thus reducing demand and increase the efficiency and responsiveness of the service Numbers of people waiting for autism assessments should decrease as people will be ruled out at a much earlier stage in the assessment process. People who are not autistic will be more quickly re-directed to more appropriate support through access to adult mental health, ADHD, IAPT services.	Recent project being funded by a successful expression of interest bid to NHSEI. Project plan now in place.

Summary

The Learning Disability and Autism 3 year plan was implemented in April 2021 through the development of the Transforming Care Collaborative, and with oversight from the Learning Disability and Neurodisability Design Group. these forums are supported by colleagues from NHS commissioning and provider organisations, the voluntary sector and all three local authorities.

Significant progress has been made in the last 12 months to improve the performance of the LLR Transforming Care Programme which is set out in the accompanying slides and was summarised in a previously published annual report. Rapid progress has been made in implementing new arrangements to support more local autistic people and people with a learning disability to live fulfilling lives in our community and further improvements are anticipated as more developments are fully mobilised.

Through the new partnership arrangements governance of planning, commissioning and improvement work is enabling co-ordination of investment in mental health, learning disability, autism, children and young peoples and adult services. This is minimising gaps in support and duplication, and improving the experience of staff and people accessing care and support.

Leicestershire Partnership NHS Trust

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Transforming Care in Leicester, Leicestershire and Rutland

3 Year Road Map 2021 to 2024

Leicester City Council

Leicestershire County Council

Rutland County Council

Leicestershire Partnership NHS Trust

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

LLR Vision

"All people with a learning disability and/or autism will have the fundamental right to live good fulfilling lives, within their communities with access to the right support from the right people at the right time".

Leicester City Council

Leicestershire County Council

Rutland County Council

A Unique Opportunity

- LLR performance has improved
- National funding in addition to local funding. NHS England has invested dedicated three year funding to transform services. This will enable long term planning for the first time
- National policy shifts Integration and innovation: working together to improve health and social care for all (White Paper 2021)
- Team LLR, we are all working together so much more than we were before, now a regional and national TCP leader of joint working

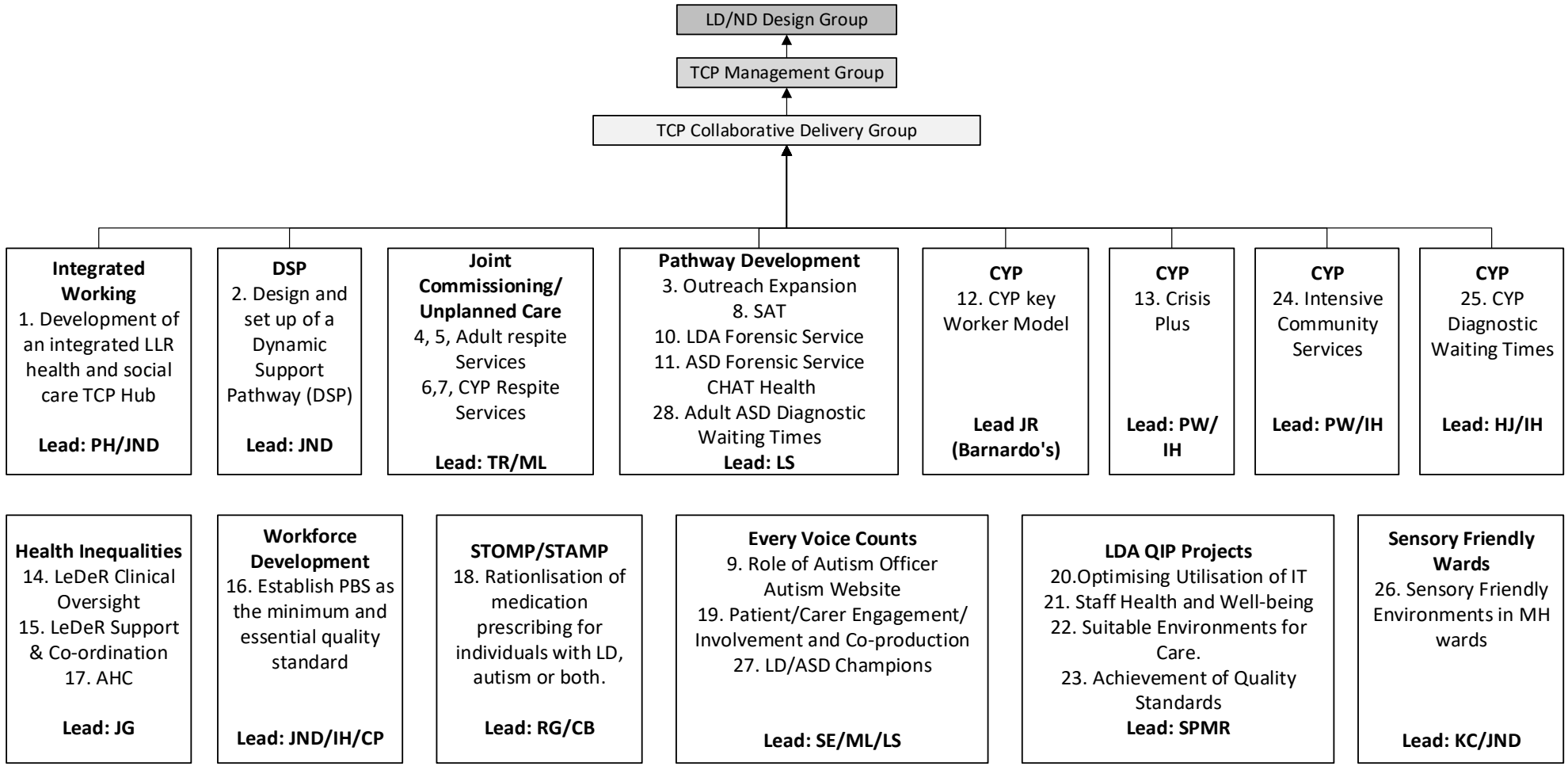
Aims and Objectives

Improve the wellbeing of people living with learning disabilities or autism or both across LLR
Person-centred, proactive and preventative approach
Reduce health inequalities
Improve quality
Increase the focus on autism especially 14+
Improve specific needs and pathways e.g. forensic, autism and transitions
Reduced admissions
Early intervention
Crisis avoidance

Key Priorities & pathways for Year 1

- Increased focus on co-production with people with LD and Autism
- Admission avoidance for CYP and adults
- Integrated team working – development of TCP Hub – joint working across LLR
- Continue to improve Annual Health Checks (AHC) completion rates – look to developing ASD AHCs
- Provide community and inpatient support for people with Autism without LD
- Learn from LeDeR (mortality review) – make service changes
- Provide better support for our LD forensic cohort

Governance Structure



Pathway Development

Specialist Autism Team (14+ community Service)

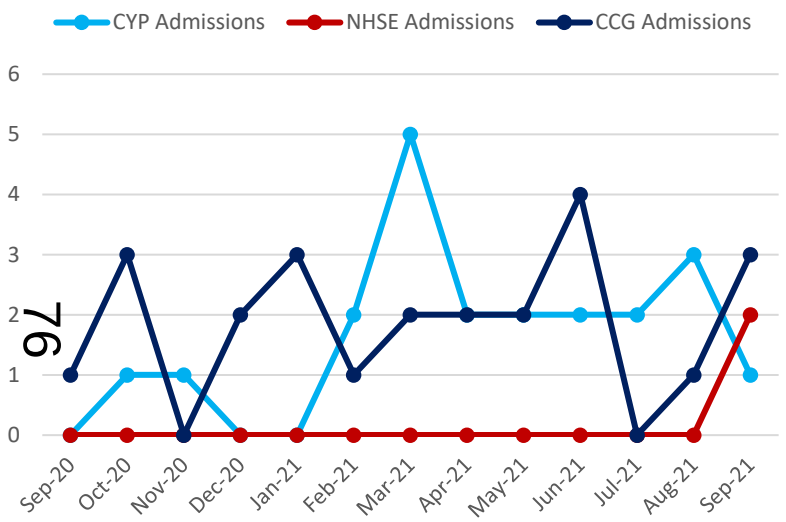
- Consultation & advice
- Positive Behaviour Support & early intervention
- Admission avoidance & support
- Inpatient discharge planning
- Post discharge support

LD & A Community Forensic service

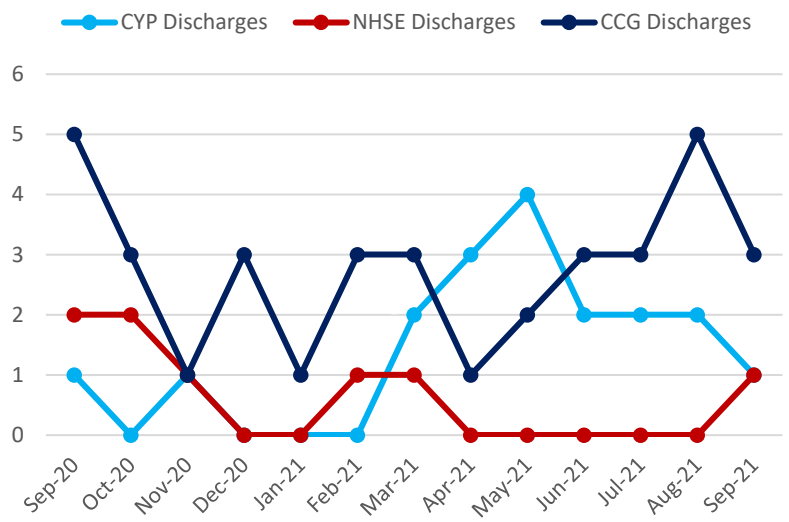
- Able to demonstrate effectiveness in reducing serious reoffending in individuals discharged from secure inpatient services.
- Dual emphasis on promoting and enabling individual recovery and independence, while also ensuring the protection of the public.

Improvements in Inpatient Data

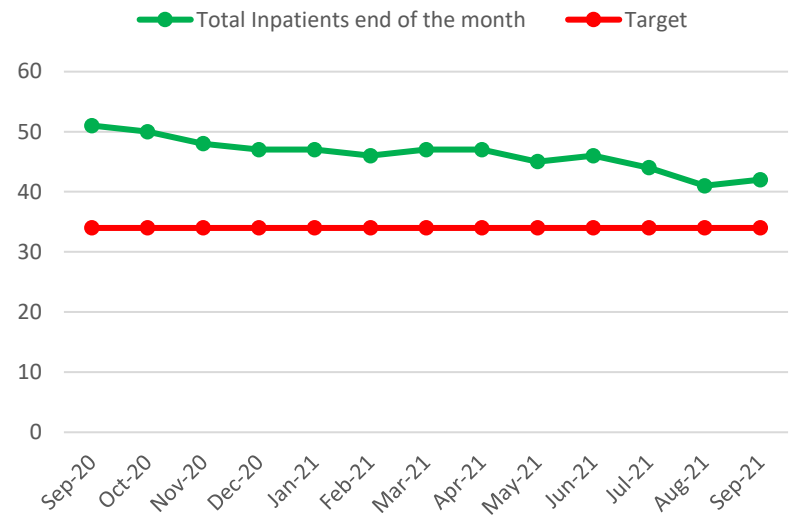
Number of Admissions each month



Number of Discharges each month



Total inpatients each month

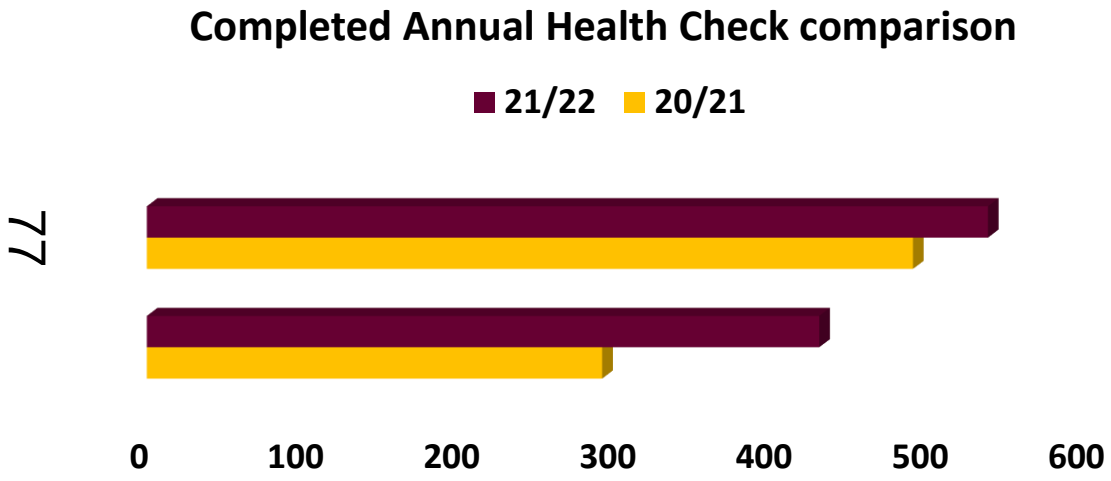


Since September 2020, there has been a total of 41 admissions, an average of 3 admissions each month across all patient types.

Since September 2020, there has been a total of 57 discharges an average of 5 discharges each month across all patient types.

Total inpatient figures have decreased but more discharges are needed to meet trajectory

Improvements in Learning Disability Annual health checks (AHCs)



Q2			
Jul-21	Aug-21	Sep-21	Total
153	119	266	538

2021/22 Total Completed	% of 14+ LD Register completed	2021/22 Not yet completed	Number yet to complete to reach 70%
968	17.98%	3712	2714

In the 1st and 2nd quarters of 2021 we have completed more health checks than the previous year. In total we have completed 968 checks, to reach the 70% target an additional 2,714 health checks need completing.

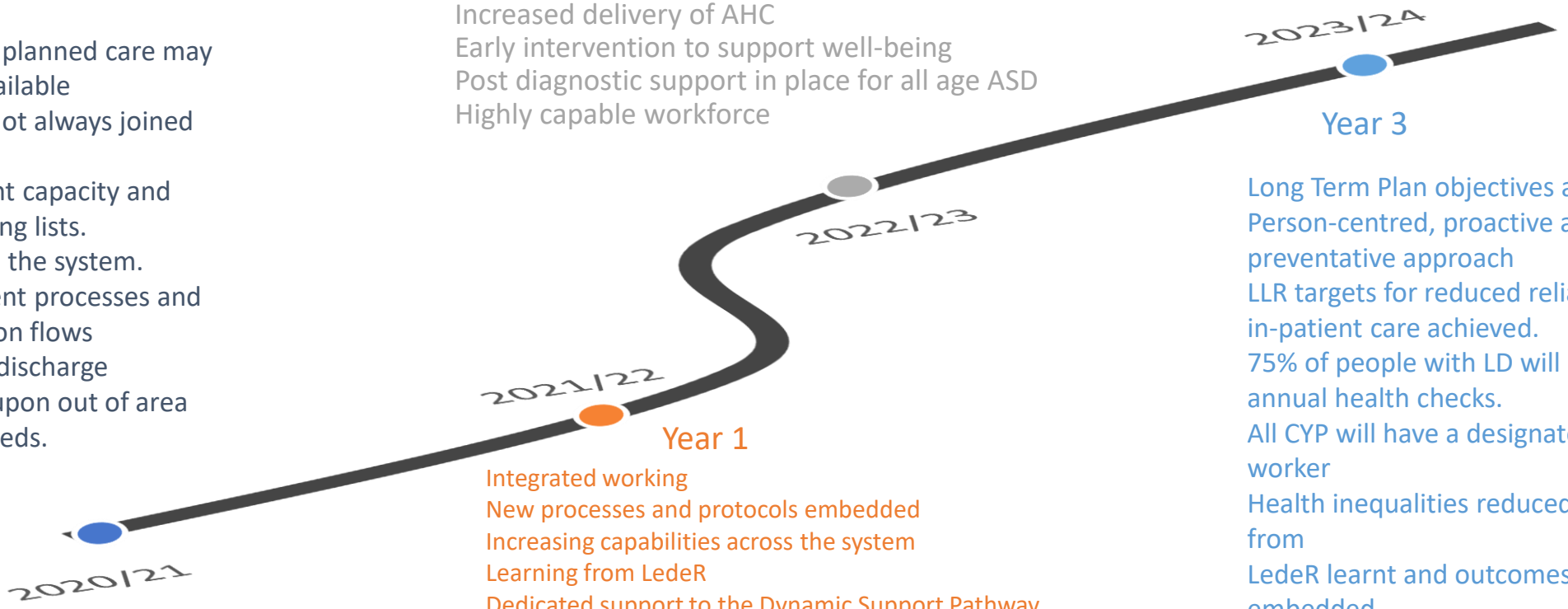
How things will look….

In year 1	Integrated working , New processes and protocols embedded, Learning from LedeR. Dedicated support to the Dynamic Support Pathway, Reduced number of admissions. New teams and new models of care for individuals with ASD and for those people with LD/ASD forensic needs.
In year 2	Timely discharges. No delays in Transfer of Care, Reduced reliance on in-patient care. Alternatives to admission available for all CYP and adults, Increased delivery of AHC. Early intervention to support well-being, Post diagnostic support in place for all age ASD Highly capable workforce.
In year 3	Person-centred, proactive and preventative approach, LLR targets for reduced reliance upon in-patient care achieved. 75% of people with LD will be having annual health checks. All CYP will have a designated key worker. Health inequalities reduced, lessons from LedeR learnt and outcomes embedded. Co-ordinated healthcare across the system. Long Term Plan objectives achieved. Interim Autism Strategy priorities embedded within the system.

Planned Outcomes

Current State

Some remaining gaps in service.
Urgent unplanned care may not be available
Services not always joined up.
Insufficient capacity and long waiting lists.
'Waste' in the system.
Inconsistent processes and information flows
Delays in discharge
Reliance upon out of area hospital beds.



Year 1

Integrated working
New processes and protocols embedded
Increasing capabilities across the system
Learning from LedeR
Dedicated support to the Dynamic Support Pathway
Reduced number of admissions
New teams and new models of care for individuals with ASD and for those people with LD/ASD forensic needs

Year 2

Timely discharges. No delays in Transfer of Care
Reduced reliance on in-patient care
Alternatives to admission available for all CYP and adults
Increased delivery of AHC
Early intervention to support well-being
Post diagnostic support in place for all age ASD
Highly capable workforce

Year 3

Long Term Plan objectives achieved
Person-centred, proactive and preventative approach
LLR targets for reduced reliance upon in-patient care achieved.
75% of people with LD will be having annual health checks.
All CYP will have a designated key worker
Health inequalities reduced, lessons from
LedeR learnt and outcomes embedded.
Co-ordinated healthcare across the system.

LOGIC MODEL – LLR Learning Disability & Autism Service

May 2021

Aim and Objectives

Aim
To improve the lives for people of all ages living with LD and/or autism (LDA) in LLR.

Objectives
Performance and Finance
NHSE/I trajectories met and surpassed. System wide savings as a result of reduced admissions and decreasing dependence on out of area independent sector hospital provision.

Systems and Processes
The LLR LDA system partners will design and deliver new processes which will result in new ways of working to increase efficiency, release capacity and improve response time and quality of care.

Patient, Family and Carer
Sustainable and on-going commitment to including the voice of the patient/carer/family in all future service development.

Service and Staffing
Teams have the capability to deliver the right interventions at the right time, in the right place and be delivered by the right person. Delivered right first time.

Estates
In-patient facilities are fit for purpose with highly capable staffing teams in place for all groups of patients with varying needs.

Inputs

Workforce
- Stakeholder capacity: Users and carers, independent sector providers (in-patient and community), adult mental health services, LD&A community services, ASD only services, CAMHS, Social care, voluntary sector providers
- Assistant Director level leadership.
- Dedicated staffing for project management.
- Deployment of dedicated existing substantive staff from both health and social care.
- Primary care
- On-going development of 'System 1' IT System to deliver required Business Intelligence.

Patient / Family / Carers
- Patient/carer involvement in all system wide workshops
- Co-production

Financial Investment:
- NHSEI Transformational funding allocation, existing staffing costs, CYP key worker funding allocation, LPT internal investment, East Midlands CAMH collaborative funding

Government Guidance
- National Guidance: Building the Right Support, NHS Long Term Plan Integrated care (2020).
- National Quality Standards
- NICE Guidance

Time.
- Meetings/workshops/task and finish groups
- Training sessions attended jointly by all system partners to facilitate a consistent approach and language.
- Completing Project Management Tools
- Evaluation support (data gathering, demand analysis, dashboard maintenance etc.)

Estates
- Allocation of required administrative and clinical space.

Activities

TCP integrated Hub
- Multiple team workshops to map all key processes within the patient journey.
- Mapping current procurement and communication processes.
- Clarification of roles and responsibilities

Dynamic Support Pathway (DSP) set up
- Liaison meetings with IT providers
- Documentation and register platform.
- DSP and Register training to all community services,

Workforce
- Focus on recruitment and retention activities
- Focus on capability. Skills gap analysis and development of training plan.
- Focus on staff well-being
- Focus on administrative support to support efficiency and capacity

Every Voice Counts
- Patients and carers involved in all workshops

Health Inequalities
- Enhance the clinical oversight of local LedeR reviews, clear action plans

Joint Commissioning
- Workshops/commissioning activities to procure components of unplanned care i.e. adult and CYP respite, 24/7 intensive support in the home

Pathway Development
- Workshops/activities to:
- Design and implement of new pathways of care, new ways of working, new roles and packages of care workshops
- Dedicated specialist team recruitment
- Agree competencies and training plans

Estates
- Detailed analysis of patient needs regarding in-patient facilities
- Current state mapping of current facilities

Outputs

TCP integrated Hub
- New processes and protocols in place for key functions of the team e.g. for crisis avoidance, crisis management, admission, discharge planning, transition and post discharge follow up.

Dynamic Support Pathway (DSP)
- Register and process for requesting and delivering more robust multi agency meetings completed.
- Dedicated project support officer to maintain register and support pathway in place.
- SOP completed and rolled out.

Workforce
- Training plan in place
- Staff well-being forums on-going.
- Successful recruitment
- Retention activities

Every Voice Counts
- Forums, focus groups, surveys, co-production of pathways and models of care

Health Inequalities
- LedeR - clear understanding of cause and effect, Clear understanding of lessons learnt
- Increased number and quality of AHC for all

Joint Commissioning
- Contracts as required
- Rapid response intensive home support available – Adults and CYP
- Short term respite beds available Adults and CYP

Pathway Development
- New care pathways for individuals with ASD and for individuals with LD/ASD with forensic service needs
- CYP key worker model of care in place

Outcomes

Integrated Hub Working
- Duplication of work removed. Gaps in processes causing delay identified and reduced. Role and task clarity
- Obstacles to discharge anticipated and proactive measures in place to reduce
- Process timelines reduced leading to faster admission to appropriate hospital, faster access to required treatment and more rapid and streamlined discharge.

Dynamic Support Pathway (DSP)
- Individuals in the community (all age) have their needs identified early and interventions provided quickly to reduce the risk of further deterioration in well-being.
- Reduced number of admissions for CYP and adults.

Workforce
- Highly capable workforce – capacity and competencies as required to deliver the right care when required

Every Voice Counts
- Sustainable and on-going commitment to including the voice of the patient/carer/family in all future service development.

Health Inequalities
- Improved quality of care for all individuals at all stages of their care and support

Joint Commissioning
- Alternatives to hospital admission during times of crisis are available.
- Prevention of carer breakdown.

Pathway Development
- Dedicated specialist teams in place and with the capability of meeting the needs of the individuals within their pathway.
- Reduced admissions, reduced LOS

Impacts

Identified aims and objectives are achieved.

LLR will have in place an inclusive, person-centred, proactive and preventative approach that supports the individual's needs and preferences.

When support is required all individuals will have access to the right support at the right time, in the right place and be delivered by the right person.

Adults, children and young people with a learning disability, autism or both are able to thrive in the community in their own homes in the least restrictive environment possible, develop independence, make their own choices, be able to integrate into society, maintain family and friend relationships, take part in hobbies and activities and lead a life of 'beautiful ordinariness'.
Families remain together.

Individuals are able to contribute to society through vocational activities and paid employment.
Individuals physical, emotional and mental well-being is maintained.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Project Search Opportunities for CYP with SEND
Presented to the Health and Wellbeing Board by:	Steph Beale
Author:	Steph Beale

EXECUTIVE SUMMARY:

Ellesmere College is the largest provider for SEND within the city of Leicester. We are keen for our young people to have realistic opportunities to join the workforce when they leave school. I believe that a Project Search supported internship programme within the NHS or other large organisation can help us to achieve this.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to support Ellesmere College in setting up a Project Search programme within the city.

Context

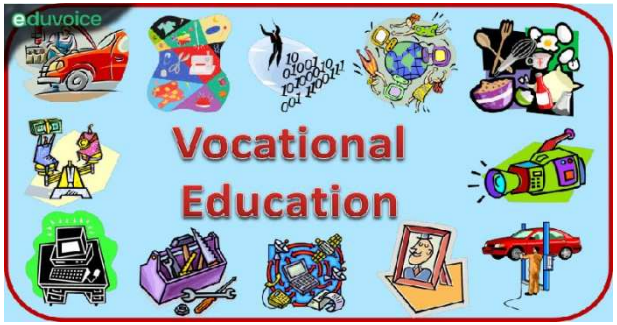
Ellesmere College is a large Special School in the heart of the city of Leicester catering for up to 426 young people aged 5-19 with a wide range of SEND. The above qualities underpin our curriculum and ethos. We train our young people to leave us with all of those qualities.

Ellesmere College

Post-16 Curriculum

Work Related Learning

Enterprise



Vocational Options

Maths & English

Be Your Best, Believe

We strive to build all of these skills, to prepare our students for the world of work.

But then what happens?

Ellesmere College

rcentage of adults with SEND in permanent sustained employment (16+ hrs

6.2%

3.8%

7.7%

Be Your Best, B

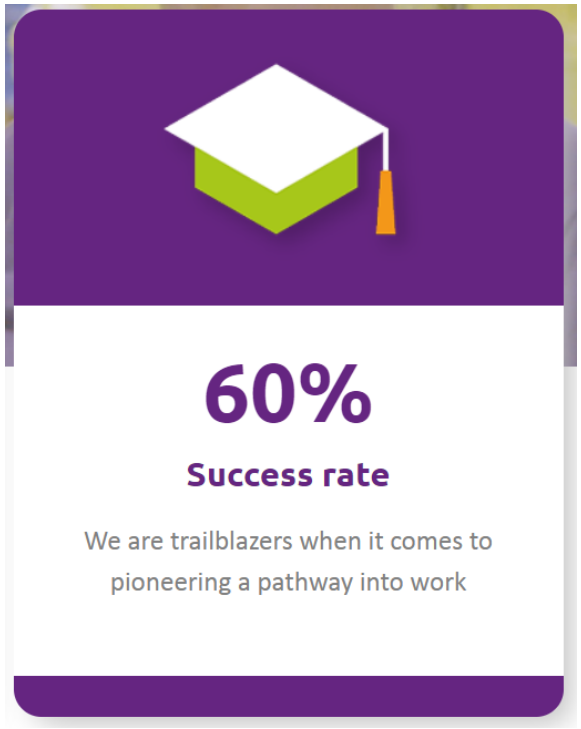
Believe

Ellesmere College

DFN Project | SEARCH

DFN Project SEARCH is a transition to work programme for students with learning disabilities and autism spectrum conditions, aimed at those motivated to achieve competitive employment.

Today Project Search are running over 69 schemes throughout the UK and Europe and have supported more than 1300 young people with SEND into paid work.



60% of supported internships continue into paid employment.

Social Value

Evidence shows that being in employment improves health and wellbeing and is central to individual identity, social roles, and social status.

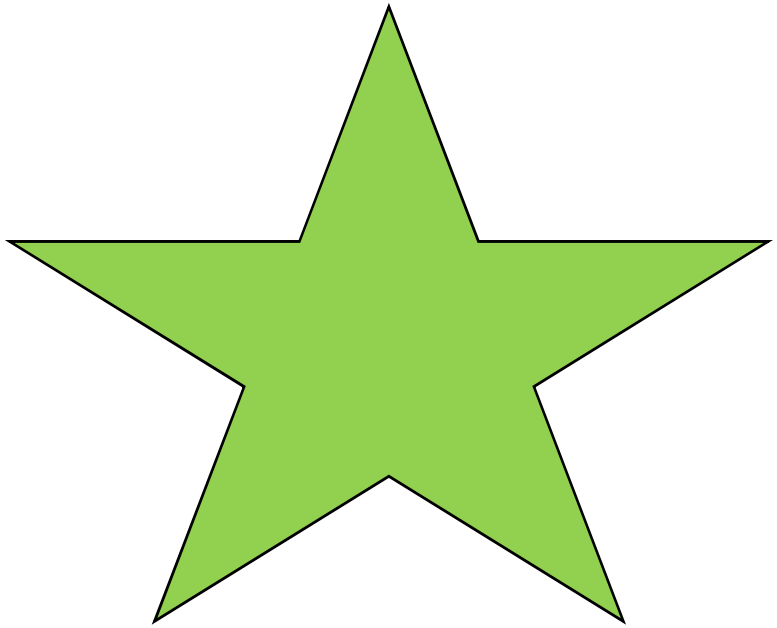
People in work tend to enjoy happier and healthier lives than those who are not in work. It is well documented that paid work has the potential to **improve health** and reduce **health** inequalities.

Transitioning people from education straight into competitive employment also saves money for health and social care by creating opportunities for people with learning disabilities to become **net contributors** rather than recipients of adult social care and health services.

A Five-pronged approach leads to success….

NHS Host Business:
Provides an on-site base and a variety of internships that teach core skills related to that business or organisation.

School or College:
Provides a teacher at the NHS site and student interns from the local area.

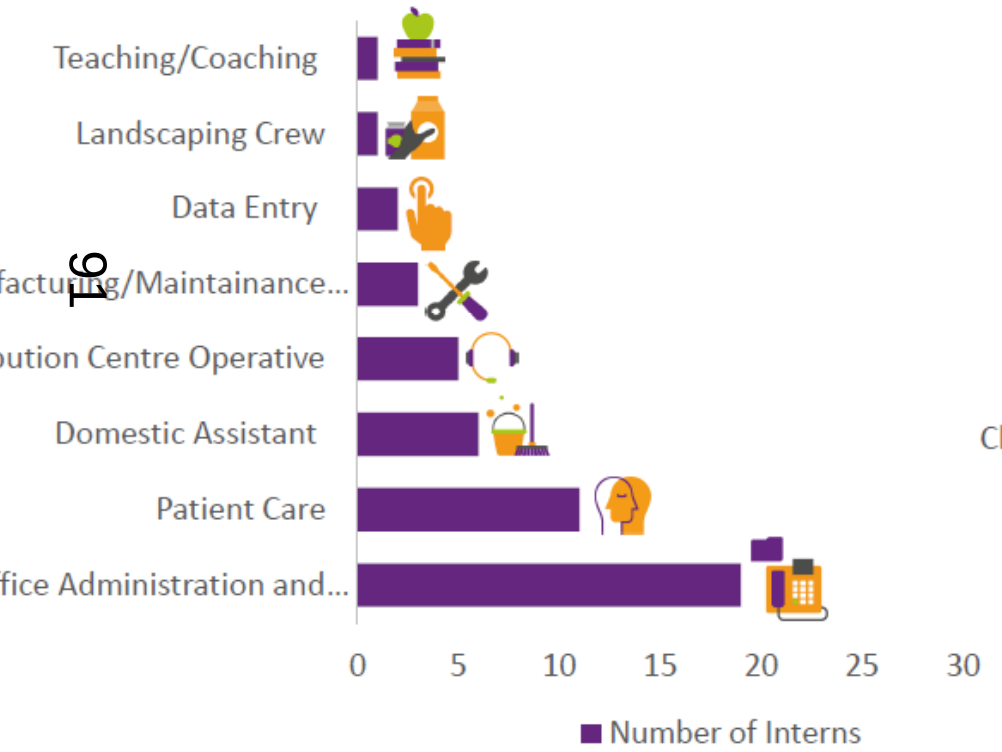


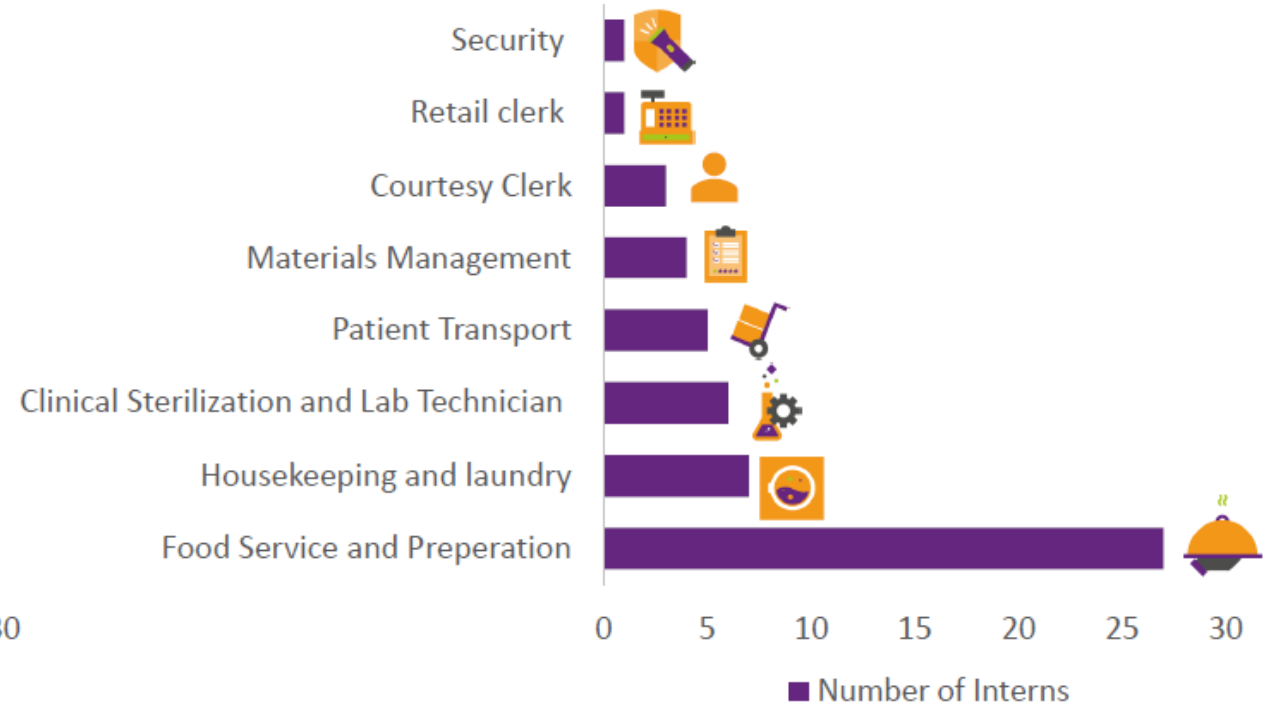
Local Authority:
Commissions appropriate partners an ensures access to the programme acr a community. They provide individual planning guidance, care management individual budgets for job coaching ar other support.

Supported Employment Agency:
Provides professional job coaching and job development for interns at the NHS site.

Department for Work and Pensions:
Provides 'Access to Work' funding for job coaching and other follow on support. Provides advice to the young person and their family about better off in work calculations.

NHS England Intern Employment Positions 2018/2019





Project Search have recently signed a contract with the NHS to run internships across 42 new sites in the UK.

Leicester was not included in this bid.

At Ellesmere we want to change this. Our students deserve to be part of the 60% who can successfully gain meaningful, paid employment not the 7% who currently do.

Benefits to NHS sites:

rovide an opportunity for one of the most isadvantaged groups in terms of health utcomes to transform their life chances y moving into employment and enjoying ll the benefits that come with being an mployee.

emonstrates a commitment to inclusion or one of the most disadvantaged groups of eople in the employment market.

practical way of demonstrating your ommitment to the NHS Learning Disability mployment Pledge.

- Gain access to a new, diverse, talent stream with skills that match labour ne
- Businesses experience increased local, regional, national and international recognition through marketing of this unique programme.
- Organisations dramatically improve performance and retention in some high-turnover or hard-to-fill posts.

What we can offer

- Amazing young people with the drive and enthusiasm to commit to employment.
- A commitment to Project Search.
- Provision of tutors throughout the programme.
- The ability and willingness to link with other special schools/mainstream colleges who may have a small number of young people who would like to be part of the project.
- A commitment not just from us as a school but from the LA as part of the P4A Strategy.

We need support to…

- Access a large employer (eg University Hospitals Trust)
- Bring Project Search to Leicester.
- Promote the superb abilities rather than limitations of our pupils.
- Identify and get on board a supported employment agency to provide job coaches.