LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 28 JULY 2022

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:

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

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

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

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

MEMBERS OF THE BOARD

Councillors:

Councillor 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 Mustafa Malik, Assistant City Mayor, Communities and Equalities

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

Sue Tilley, Head of Leicester, Leicestershire Enterprise Partnership

Kevin Routledge, Strategic Sports Alliance Group

Chief Superintendent, Jonny Starbuck, Head of Local Policing Directorate, Leicestershire Police

STANDING INVITEES: (Non-Voting Board Members)

Cathy Ellis – Chair of Leicestershire Partnership NHS Trust

Professor Andrew Fry – College Director of Research, Leicester University

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

John MacDonald, Chair of University Hospitals of Leicester NHS Trust

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

Information for members of the public

Attending meetings and access to information

You have the right to attend formal meetings such as full Council, committee meetings, City Mayor & Executive Public Briefing and Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

Dates of meetings and copies of public agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk, from the Council's Customer Service Centre or by contacting us using the details below.

Making meetings accessible to all

Wheelchair access – Public meeting rooms at the City Hall are accessible to wheelchair users. Wheelchair access to City Hall is from the middle entrance door on Charles Street - press the plate on the right hand side of the door to open the door automatically.

Braille/audio tape/translation - If you require this please contact the Democratic Support Officer (production times will depend upon equipment/facility availability).

Induction loops - There are induction loop facilities in City Hall meeting rooms. Please speak to the Democratic Support Officer using the details below.

Filming and Recording the Meeting - The Council is committed to transparency and supports efforts to record and share reports of proceedings of public meetings through a variety of means, including social media. In accordance with government regulations and the Council's policy, persons and press attending any meeting of the Council open to the public (except Licensing Sub Committees and where the public have been formally excluded) are allowed to record and/or report all or part of that meeting. Details of the Council's policy are available at www.leicester.gov.uk or from Democratic Support.

If you intend to film or make an audio recording of a meeting you are asked to notify the relevant Democratic Support Officer in advance of the meeting to ensure that participants can be notified in advance and consideration given to practicalities such as allocating appropriate space in the public gallery etc.

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

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

Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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

PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

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

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MEMBERSHIP OF THE BOARD

To note the membership of the Board for 2021/22 approved by the Annual Council on 19 May 2022:-

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 Mustafa Malik, Assistant City Mayor, Communities and Equalities

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)

Richard Mitchell, 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
Kevan Liles, Chief Executive, Voluntary Action Leicester
Rupert Matthews, Leicester, Leicestershire and Rutland Police and Crime Commissioner
Kevin Routledge, Strategic Sports Alliance Group
Chief Superintendent, Jonny Starbuck, Head of Local Policing Directorate, Leicestershire Police
Sue Tilley, Head of Leicester & Leicestershire Enterprise Partnership
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

4. TERMS OF REFERENCE

Appendix A (Pages 1 - 6)

To note the Board's Terms of Reference approved by the Annual Council on 19 April 2022.

5. MINUTES OF THE PREVIOUS MEETING

Appendix B (Pages 7 - 18)

The Minutes of the previous meeting of the Board held on 28 April 2022 are attached and the Board is asked to confirm them as a correct record.

6. PHARMACEUTICAL NEEDS ASSESSMENT **Appendix C (Pages 19 - 28)**

Dr Katherine Packham, Public Health Consultant, Leicester City Council to present a report providing an update on the progress of the Pharmaceutical Needs Assessment (PNA).

7. LEICESTER HEALTH CARE AND WELLBEING STRATEGY UPDATE **Appendix D (Pages 29 - 30)**

Dr Katherine Packham, Consultant in Public Health, Leicester City Council to present a report providing a summary of the current status of Leicester's Health, Care and Wellbeing Strategy and the next steps.

8. LLR/NHS COLLABORATIVE WORKING (MENTAL HEALTH FOCUS) **Appendix E (Pages 31 - 38)**

Tracie Rees. Director of Adult Social Care and Commissioning. Leicester City Council and Mark Roberts. Assistant Director. Leicestershire Partnership NHS Trust to present a report on work to improve the outcomes for people with a Learning Disability or Neuro developmental needs. As part of the Integrated Care System for Leicester, Leicestershire and Rutland there is the option to create formal collaboratives. These are commitments from organisations to work together and to build on the work already done, with a commitment that we continue working together to get the best outcomes for people.

9. INEQUALITIES PRESENT IN MATERNITY MORTALITY EXPERIENCED BY WOMEN OF DIFFERENT ETHNICITIES **Appendix F (Pages 39 - 54)**

Mel Thwaites, Head of Women and Children's Transformation, Dr Farah Siddiqui, Consultant Obstetrician and Gynaecologist and Robert Howard, Consultant in Public Health to present a report on the response to the LLR Local Maternity and Neonatal System (LMNS) and build on the plans outlined in Appendix 1 to address this disparity.

10. REDUCING HEALTH INEQUALITIES - CORE20PLUS5 **Appendix G (Pages 55 - 82)**

Steve McCue – Senior Strategic Development Manager, LLR ICB and Mark Pierce, Head of Population Health, LLR ICB to present a report informing the Board of the NHS requirement by NHS England and NHS Improvement to deliver against the CORE20Plus5 to support wider work to reduce health inequalities across Leicester, Leicestershire and Rutland (LLR).

11. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

12. DATES OF FUTURE MEETINGS

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

Thursday 13 October 2022 – 9.30 am
Thursday 2 February 2023 – 9.30am
Thursday 13 April 2023 – 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.

13. ANY OTHER URGENT BUSINESS

APPENDIX A

Leicester City Health and Wellbeing Board

Terms of Reference

Approved at Annual Council on 19 May 2022

Introduction

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

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

1 Aim

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

2 Objectives

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

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

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

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

3 Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 Membership

Members:

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

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

Up to seven representatives of the NHS (7)

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

Up to four Officers of Leicester City Council (4)

- The Strategic Director of Social Care and Education (Leicester City Council) (1)
- The Director of Public Health (Leicester City Council) (1)
- A Public Health Consultant leading on improving cross organisational initiatives and communication and developing links with the between system, place and neighbourhood within the Integrated Care System. (1)
- One Officer nominated by the Chief Operating Officer (1)

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

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

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

5 Quorum & Chair

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

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

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

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

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

6 Voting

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

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

6.3 All other members will have an equal vote.

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

7 Code of conduct and member responsibilities

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

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

7.1 Commit to attending the majority of meetings.

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

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

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

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

8 Agenda and Meetings

8.1 Administration support will be provided by Leicester City Council.

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

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

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

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 28 APRIL 2022 at 9:30 am

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Leicester City Council.
Ivan Browne	–	Director of Public Health, Leicester City Council.
Councillor Elly Cutkelvin	–	Assistant City Mayor, Education and Housing.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group.
Chief Inspector Rich Jackson	–	Local Policing Directorate, Leicestershire Constabulary.
Harsha Kotecha	–	Chair, Healthwatch Advisory Board, Leicester and Leicestershire.
Ruth Lake	–	Director of Adult Social Care and Safeguarding, Leicester City Council.
Rupert Matthews	–	Leicestershire and Rutland Police and Crime Commissioner.
Ellen Osbourne	–	Strategy And Partnerships Manager, University Hospitals of Leicester NHS Trust.
Dr Katherine Packham	–	Public Health Consultant, Leicester City Council.
Martin Samuels	–	Strategic Director Social Care and Education, Leicester City Council.
Councillor Piara Singh Clair	–	Deputy City Mayor, Culture, Leisure and Sport, Leicester City Council.
David Sissling	–	Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland.

Caroline Trevithick	–	Executive Director of Nursing, Quality and Performance, Leicester, Leicestershire and Rutland, Clinical Commissioning Groups.

Standing Invitees

Cathy Ellis	–	Chair of Leicestershire Partnership NHS Trust.
Graham Carey	–	Democratic Services, Leicester City Council.

*** ** ***

49. APPOINTMENT OF CHAIR

It was reported that the Chair Councillor Dempster would be arriving later in the meeting due to a previous Council engagement.

RESOLVED:-

That Councillor Singh Clair be appointed Chair of the meeting until such time as Councillor Dempster arrived at the meeting.

50. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:-

Councillor Sarah Russell	Deputy City Mayor Social Care and Anti-Poverty, Leicester City Council.
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.
Kevan Liles	Chief Executive, Voluntary Action Leicester.
Richard Mitchell	Chief Executive, University Hospitals of Leicester NHS Trust.
Kevin Routledge	Strategic Sports Alliance Group.
Chief Supt Jonny Starbuck	Head of Local Policing Directorate, Leicestershire Police.
Martin Samuels	Strategic Director of Social Care and Education.

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

51. 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.

52. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 28October 2021 be confirmed as a correct record.

53. SPOTLIGHT ON CASE STUDY

Consideration of the item was deferred until the Chair had arrived at the meeting.

54. THE LEICESTER HEALTH, CARE AND WELLBEING STRATEGY 2022-2027

Dr Katherine Packham, Consultant in Public Health, Leicester City Council presented the Leicester Health, Care and Wellbeing Strategy, 2022-2027 which had been updated since the Board considered the Draft Strategy on 28 October 2021.

The Board were asked to approve the final version of the overarching priority of the strategy outlined in the report and to approve the Leicester Health, Care and Wellbeing Strategy 2022-2027 and commit to the action plan development process to develop an action plan for implementation of the strategy.

It was noted that:-

- The Strategy combined the draft strategy together with the items which had emerged from the development sessions since then.
- The 19 priorities had been the subject of an online public engagement exercise from November 2021 to January 2022, as well as an extensive programme of discussion and engagement with a range of partnership boards and groups, and community groups and organisations.
- The Strategy aimed to tackle the Inverse Care Law where those who needed health care the most were least likely to receive it.
- It was intended to put all the priorities into the supporting Action Plan to form a list of issues which needed to be addressed during the 5-year period of the Strategy. A smaller manageable number (4-6 priorities) would be identified to be addressed in the in short term with the others being put into lower priority categories to be developed so everyone gets services proportionate to existing needs and circumstances. As the Action Plan progressed, and the initial priorities were achieved, the

Action Plan would be reviewed and priorities in the lower priority groups would be re-assessed to determine which should be considered to be addressed next. In this way, the Action Plan would be responsive to the changing health needs and circumstances prevalent at that time.

- Staff were working with the communications and engagement staff in the CCG.
- A rapid engagement group citizens panel had looked at the current wording of overarching priority of 'Working together to enable everyone in Leicester to have an equal opportunity for good health and wellbeing' and had preferred 'fair' to 'same' or 'equal' in relation to opportunity.
- It was hoped to get the final Strategy and collaborative Action Plan to the Board's next meeting.

Members of the Board commented that:-

- The Strategy did not comment upon the primary determinants of health such as employment and housing etc.
- 'Enable' in the overarching statement could mean that the opportunity was their there but 'fair' could mean that if people don't pick up the opportunity it was their fault.
- 'I statements' were supported in the Strategy together with the extensive engagement that had been carried out. Continued engagement could be addressed as part of the Action Plan.

Once the final version of the Strategy was available it would go through the Council's process for approval and scrutiny. The Strategy would also need to go to integrated boards and any other body or partners involved in the Strategy to get the Strategy into a wider audience and throughout the community.

It was emphasised that the Strategy was not an NHS and Local Authority document but was a strategic Health and Wellbeing Board document which needed to be owned and distributed in all the Board's organisations and partner organisations.

RESOLVED:-

1) That the Leicester Health, Care and Wellbeing Strategy be approved subject to amendments suggested in the meeting and that the Action Plan development processes to develop the Action Plan to implement the Strategy be supported.

2) That officers review and reword the overarching priority of the strategy based upon the comment made in the meeting.

3) That the final Strategy, as amended, be submitted to the Board's next meeting.

55. COUNCILLOR DEMPSTER IN THE CHAIR

Councillor Dempster arrived in the meeting and apologised for being delayed.

Councillor Dempster resumed her role as Chair for the remainder of the meeting

56. SPOTLIGHT ON CASE STUDY

The Chair introduced an anonymised case study of someone who was diagnosed with COPD and outlined his subsequent health issues.

The Chair commented that it was important to come back to issues to focus on what was done by all involved to provide best possible services to meet people's needs and to listen to concerns and to respond to them in a positive manner. The Chair felt that the case study showed what good was done, but also showed those things that did not go right. It was importance to address these issues and make sure they didn't happen again.

Members of the Board commented that:-

- The circumstances linked into the Health & Wellbeing Strategy. The person was likely to have been a smoker and smoking services funding had been decreased. If the person had lived in County, it was likely, statistically, that the COPD issues would have picked up earlier. Once COPD was diagnosed it was less likely the person would have got services as there were less in the City and the person was less likely to have received flu jabs as there were lower rates of these in the City
- This was a good study and it highlighted that the importance of wellbeing as well as care of wellbeing seemed to have fallen through the cracks.
- It was felt that the patient was a bystander in their care, and it was important to make sure patients were actively part of their care package and pathway.

RESOLVED:-

That the Case Study be received and all partners on the Board ensure that the lessons learned are addressed and included in the future care of patients.

57. PRIMARY CARE DEVELOPMENT

Yasmin Sidyot, Deputy Director Integration & Transformation, Leicester City Council submitted a report on the Identification of Unregistered Patients Programme and gave a presentation on primary care development plans in Leicester City which covered the context, key achievements, vision, focus areas and priorities.

During the presentation it was noted that:-

- The last 2 years had placed unprecedented demand on health and social care.
- LLR Primary Care Networks and practices had collaboratively

implemented a very successful Mass Covid Vaccination Programme, staffed by local primary care staff, wider health and social care teams and volunteers from local communities.

- The pandemic had significantly impacted on staffing levels due to sickness, self-isolation and the opportunity to recruit into vacancies.
- During the Covid period, practices had very quickly set up more telephony and virtual based contact with patients and this had been challenging for a number of reasons including the telephone systems that were in place were not equipped to deal with the call demands placed upon them. Although most practices had upgraded their systems to move to cloud-based telephony it had required retraining staff in the use of the new technology and having the right technology infrastructure in place that could support it.
- The aim to improve access to priority care included:-
    - Negating the need for patients to ring at 8.00am and ensure that same day access must be fit for purpose and needs based.
    - Where patients required additional services not offered by general practices, practices must have local services to book patients into where a GP is not appropriate for:-
        - 1. Pharmacy
        - 2. Optometrist
        - 3. Therapy services
        - 4. Mental health services
        - 5. Urgent treatment Centres / minor injury services
- Develop & implement service delivery models at neighbourhood / place level i.e. minor surgery etc.
- An understanding of the variation in access, outcomes and service utilisation would be co-designed and officers would work in partnership with practices and PCN's to understand how variations can be reduced.
- Where practices were struggling, officers would jointly agree a plan to tackle the issues and then work together with each PCN to implement working jointly with the LMC co produce a framework to support a Quality Improvement approach.
- Practice sustainability and business continuity plans would be part of the joint improvement programme at practice level, with support provided to practice managers / business managers to enable plans to be stress tested and regularly reviewed.
- The improvements planned for service delivery models were outlined.
- Workforce and leadership development proposals were explained in the presentation.
- The planned Primary Care trajectories were:-
    - Return to 2019 appointment levels across all general practice
    - Benchmarking of Practice appointments against locally agreed standard of minimum 75 appointments per 1000 population
    - 100% of completion of all Primary Care Backlog by Q3 2022/23
    - Improvement in prevalence targeted Long Term Conditions
    - 50% of GP appointments were face to face
    - 100% active participation of general practice in CPCS
    - Increase in FTE GPs

    - Balanced scorecard and benchmarking for all practices to be completed by the end of Q1 22/23
- Following funding awarded to the CCG, it had enabled them to meet part of the NHS's pledge to reduce health inequalities, working with areas of high deprivation and large BAME communities. The work had involved working with local communities, patient groups, identifying unregistered patients and supporting them through the process. Additionally, it had involved registering patients with 'No Legal Status' in the UK, informing them of all the healthcare and benefits provided by NHS. The target had been to register 5,000 new patients by January 2022. The success and effectiveness of the programme were measured regularly and by the end of December 2021, 51,545 new patients were registered within Leicester City which was an increase of 22,323 new patients than in year 2020. Full details of the methodology, engagement, communications and the learning outcomes were fully detailed in the report.
- In order to understand the depth and challenge of the problem of unregistered patients, 2 GP registration officers had made contact with organisations, religious sites, voluntary sector bodies and food banks to undertake outreach work and register patients with GPs. When the vaccination programme was launched it had enabled staff to utilise the programme to promote the benefits of registering with GPs as it enabled access to health services. A number of unregistered patients had underlying health issues and had not previously accessed services. The outreach model had resulted in more registrations as the community groups and representatives understood the barriers and challenges involved; and working with GPs enabled a 2 way dialogue to work across both sectors. The model to register Afghan and other refugees had been deployed quickly to get them registered and access health services. The feedback from GPs had indicated that they had found it useful to both themselves and for the individuals.
- Engagement with the community had been prepared in a language the patient could understand in the form of a conversation. The information was made available via a leaflet, Facebook, twitter and other communication methods.

Following the presentation members of the Board commented that:-

- The Strategy was considered to be good, but it hinged around staff supporting it and it would be useful to see how many CPCS and practice nurses per 100k were there, what was being done to increase numbers and how the City compared to surrounding areas.
- Different parts of the health and care system had access to patients records and hospital, social care and primary care staff should have the same access to patients' records, the current arrangements could be improved to be more effective.
- More diagnostics could be developed within the community diagnostic programme.
- More still needed to be done on equitable access to services and this should be at the fore and centre of the Strategy.

- The work on patient registration was welcomed but there were still challenges on capturing remaining numbers of unregistered patients before they attended A&E departments for treatment.
- Healthwatch commented that patients told them they had left hospital without a sick note and had been told to see their GP to obtain one. It was felt that patients should be advised not to see their doctor necessarily but to contact their medical practice to allow them to decide who followed up on issuing the certificate.
- Partners should support the changing ways to deliver primary care. For example, GPs used to see 50-60 patients per day and now new GPs didn't see more than 20-25 patients a day as the rest of the practice team was growing by the addition of qualified health practitioners/pharmacists etc so that the GP was not the only person patients needed to see in the practice for their health care.
- The early identification of patient issues and treatment not only benefited the patient but also patient care, UHL and LPT. An update in 6 months to provide an update on progress would be helpful.

The Chair commented that issues around primary care were crucial for the City and suggested that these be discussed at the next board meeting with particular focus on workforce and engagement. There should be more of joined up approach by the ICS, the Council, LPT and UHL working together on these issues.

RESOLVED:-

That officers be thanked for the report and the presentation and that partners on the Board actively support the work being taken forward to improve Primary Care Development.

58. TOBACCO CONTROL STRATEGY

Amy Endacott, Tobacco Control Lead, Public Health, Leicester City Council gave a presentation on the Tobacco Control Strategy.

During the presentation it was noted that:-

- In 2019 the Government laid out their ambition to achieve a smoke free generation (where prevalence of smoking is 5% or less) by 2030.
- Smoking rates had been in decline both nationally and locally over the last 20 years and were currently at their lowest ever rates of 13.9% nationally, and 15.4% locally.
- This trend has not translated across all groups, particularly those with mental health issues and those in routine and manual occupations, and smoking rates had remained unfairly high in these groups.
- A Tobacco Control Strategy for Leicester City was published in March 2021 which outlined how the Council intended to work towards the Government's 2030 ambition on a local level. It highlighted four key aims which will be integral to driving down smoking rates:
    - Partnership working to address tobacco control within Leicester

City
    - Achieving a smoke free generation
    - Smoke free pregnancy for all
    - Reducing the inequality gap for those with mental ill-health
- The interim target for a smoke free generation was to achieve 12% or less smoking and less than 3% of young people smoking and to reduce the levels of smoking in pregnancy before end of this year. Work was progressing with UHL in relation to anti-smoking in pregnancy and mental health.
- Smoking still had massive inequalities issues but had reduced over last 20 years – smoke free generation by 2030 (less than 5% of pop smoke).

The Board were asked to:-

1. Support the actions arising from the Tobacco Control Alliance (TCA) through promotion, sharing key communications, partnership working to achieve the goals and encouragement of staff to attend relevant training.
2. Provide representation on the TCA on an ongoing basis from the CCG, UHL and LPT.
3. Support the development of a robust approach to helping smokers who have mental health conditions to quit which was empathetic to their unique needs:
    - LPT had recruited a smoke free lead to progress this work within inpatient settings, but it was not funded to extend into the community
    - Ask the CCG to consider investing in the work proposed for the community?
4. Embed tobacco control in COVID recovery work – protecting the most vulnerable in our society from the impacts of COVID, keeping people out of hospitals etc.

RESOLVED:-

That the Board support the four actions requested as outlined above and partner organisations were requested to provide representatives on the Tobacco Control Alliance.

59. HEALTHY START - FIRST 1001 CRITICAL DAYS OF LIFE

Sue Welford (Principal Education Officer, Leicester City Council) Mel Thwaites (Head of Women's and Children's Transformation, CCG) and Clare Mills (Public Health Children's Commissioner) presented a report and gave a presentation on Healthy Start – First 1001 Critical Days of Life.

During the presentation the following was noted:-

- Leicester was a deprived city and 31% of children were in low-income families compared with 19% nationally.
- There were high numbers of homeless, or at risk of homelessness, families requiring protection.

- There were high levels of obesity in early pregnancy.
- The City had areas with high under-18 conception rates.
- Over a fifth of under 25-year-old mothers were smokers at the time of delivery.
- The breastfeeding prevalence at 6 to 8 weeks varies across the city
- Infant mortality rates were a significant concern; there were approximately 28 infant deaths (under 12 months) per year in Leicester and 5.9 deaths per 1,000 live births which was significantly higher than England (3.9).
- There were low MMR immunisation rates for 2 year olds
- Depravation leads to difficult engagement and outcomes for children.
- Asian heritage women were twice as likely to die in maternity, mixed heritage were 3 times more likely and black women were 4 times as likely compared to women of white heritage. Officers were working with health services to look at this.
- Postnatal depression affects the child's response at high levels for long periods and has an impact on its developing brain.
- New services commissioned by Public Health were:-
    - Building Communication Skills to support a reduction in the number of children who have below expected language levels at the 2 – 2 ½ year developmental review, and increasing children's school readiness.
    - Improving the mental and physical wellbeing of parents with vulnerabilities. In addition to mums and babies, the service also targeted fathers, male carers, and LGBT+ parents, ensuring their voices and needs were not overlooked.
- Schools were reporting children starting school were further behind following covid than before.
- The next steps for action were:-
    - A Start for Life offer, delivery plan and impact framework would be co-produced with families and created in partnership across health, education, social care, and the voluntary/community sector through the Readiness for School Steering Group by Autumn 2022.
    - A stakeholder engagement strategy, including a one-day workshop, would be held to shape the Equity and Equality work.
    - Following on from a successful online workforce development event held on 10th November 2021 on the importance of the First 1001 Critical Days, further engagement opportunities would be held in 2022 to encourage understanding and engagement with the Start for Life offer.
    - The development of Family Hubs and the Start for Life offer would be taken forward through funds from the Family Hubs and Start for Life programme from the Department for Education and Department for Health and Social Care (announced 2nd April 2022). Key learning exchange and impact frameworks would be developed with local, regional and national partners including the National Centre for Family

Hubs, Family Hubs Network, East Midlands Family Hubs Transformation Programme network and regional Early Years Strategic Leads network.

- The response to the First 1001 Critical Days benefited from a strong partnership between the Council, health services and community services.

Members of the Board commented that:-

- There were increasing numbers of children who were not vaccinated, and this led to later health issues.
- Childhood immunisation used to be good but there had been an on-going decline in recent years and the vaccination confidence was now impacting as well and further efforts were required to prevent further erosion in levels in vaccination and raise it to the previous levels and to promote immunisation to mothers.
- The higher rates of maternity deaths for black women should be linked to the broader health inequalities and service provision.
- There were links with the Action Plans involving groups and the Action Plan for the Health and Wellbeing Strategy and these needed to be linked to ensure issues incorporated into action plans enact with the whole strategy.

The Chair commented that the average case load was 200 per health visitor for city with our deprivation, the current rate in the city was over 500 cases and some had 600 cases per health visitors. The trial system that worked in County would not work in the City as it has different issues and levels of deprivation. A scheme should be tailored for the needs in the City and not the County. The issues of training and recruitment of health visitors required to be addressed urgently. The Chair would raise the issue of post-natal depression want to take up with Public Health. Neurodiversity also needed to be included to pick up these issues at a very early stage as it impacts significantly upon parenting and the family. An Action Plan on what was being done to reduce the levels of unvaccinated young people should be submitted to a future Board meeting.

RESOLVED:-

Officers were thanked for the report and the presentation and Board Members were requested to encourage partnership engagement in the development of the Start for Life offer.

60. PHARMACEUTICAL NEEDS ASSESSMENT

The Board received a report for noting on the Pharmaceutical Needs Assessment which needed to be prepared and published by 1 October 2022. The Board was asked to note the report and to approve the interagency LLR wide reference group and to receive further reports to future meetings.

RESOLVED:-

That the Pharmaceutical Needs Assessment be noted.

61. BETTER CARE FUND 2021-22

The Better Care Fund 2021-22 spending outline was submitted to the Board for noting.

RESOLVED:-

That the Better Care Fund 2021-22 spending outline be noted.

62. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions from members of the public had been received.

63. DATES OF FUTURE MEETINGS

The Board noted that future meetings of the Board would be agreed at the Annual Council Meeting on 19 May 2022 and would be published soon afterwards.

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.

64. ANY OTHER URGENT BUSINESS

There were no items of Any Other Business to be discussed.

65. CLOSE OF MEETING

The Chair declared the meeting closed at 11.52 am.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Pharmaceutical Needs Assessment
Presented to the Health and Wellbeing Board by:	Katherine Packham
Author:	Helen Reeve

SUMMARY:

Purpose

1. The purpose of this report is to update the Health and Wellbeing Board on the progress of the Pharmaceutical Needs Assessment (PNA).

2. The PNA is a statutory document that is used by NHS England to agree changes to the commissioning of local pharmaceutical services. As such, if NHS England receives a legal challenge to the services they commission based on the PNA, the local authority could also be part of that legal challenge. It is essential that the process that is followed meets the legislation that is set out and that the PNA is a robust document.

3. The purpose of the PNA is to:
    - Identify the pharmaceutical services currently available and assess the need for pharmaceutical services in the future;
    - inform the planning and commissioning of pharmacy services by identifying which services should be commissioned for local people, within available resources, and where these services should be;
    - inform decision making in response to applications made to NHS England by pharmacists and dispensing doctors to provide a new pharmacy. The organisation that will make these decisions is NHS England.

4. The Health and Wellbeing Board has a statutory responsibility to prepare a Pharmaceutical Needs Assessment (PNA) for Leicester City and publish it by 1st October 2022.

5. The PNA has been prepared according to:

    i. the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (amended) which sets out the minimum

information that must be contained within a PNA and outlines the process that must be followed in its development: https://www.legislation.gov.uk/uksi/2013/349/contents

ii. the Department of Health and Social Care PNA information pack for local authority health and wellbeing boards to support in the developing and updating of PNAs: https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

Governance

6. As many of the relationships required for the PNA are Leicester, Leicestershire and Rutland (LLR) wide – involving representation from NHS England, the Leicestershire Pharmaceutical Committee, Local Professional Network for Pharmacists and the Leicester, Leicestershire and Rutland Local Medical Committee - a PNA Reference Group was established. This Reference Group has supported PNA work across the three Health and Wellbeing Boards, identifying any economies of scale that can be delivered through joint work and ensure that there is an effective process for consultation on each of the PNAs for Leicester, Leicestershire and Rutland.

7. The principal resourcing for the development of the Leicester City PNA was provided by the Leicester Public Health Intelligence Team, with information and advice provided through the PNA Reference Group by NHS England, the LPC, CCGs and others.

Consultation

12. To gather additional intelligence for the PNA, two surveys ran throughout the spring:
    i. Public survey asking service users for their views on the current pharmaceutical provision in their local area
    ii. Survey for Pharmacies/pharmaceutical professionals to complete to collect information on pharmaceutical services they currently provide or may provide in the future, access facilities and languages spoken at the premises.

13. There was a low response from the professional pharmacy survey – only 19 of 85 Leicester pharmacies completed the survey. This means a gap in knowledge of services directly commissioned by pharmacies and any access facilities or languages spoken at community pharmacies. With support from public health colleagues, a phone round is planned to contact the pharmacies, explain the purpose and encourage completion of the survey. The results will be included in the final PNA.
14. The PNA is also subject to a 60-day statutory consultation period which was opened on 6th July 2022 and will close on 4th September 2022. An

email link to the draft PNA and the consultation questionnaire has been sent to the organisations below as required by Regulation 8 of the Pharmaceutical Services Regulations:

- the Local Pharmaceutical Committee
- the Local Medical Committee
- any persons on the pharmaceutical lists and any dispensing doctors list for its area
- any LPS chemist in its area with whom NHS England has made arrangements for the provision of any local pharmaceutical services
- Healthwatch, and any other patient, consumer or community group in its area which in the view of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in its area;
- any NHS trust or NHS foundation trust in its area
- NHS England
- any neighbouring HWB.

The consultation can be accessed via this link:
https://consultations.leicester.gov.uk/public-health/pna-2022

15. The consultation is also being promoted through internal networks and communications.

16. The results of the 60-day consultation will be collated and included in the final draft of the PNA for review by the Health and Wellbeing board in September 2022 and publication in October 2022.

17. An executive summary of the draft PNA is included in appendix 1

Equality Impact Assessment

18. The PNA will be subject to an EIA. This is currently underway and will use information collected from the pharmacy survey to inform any potential gaps in services or access barriers.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- to note this progress report;
- to receive the final PNA report for approval in September 2022.

APPENDIX 1

PHARMACEUTICAL NEEDS ASSESSMENT – EXECUTIVE SUMMARY

Purpose

The purpose of the Pharmaceutical Needs Assessment (PNA) is to:

- identify the pharmaceutical services currently available and assess the need for pharmaceutical services in the future
- inform the planning and commissioning of pharmacy services by identifying which services should be commissioned for local people, within available resources, and where these services should be; and
- inform decision making in response to applications made to NHS England and NHS Improvement by pharmacists and dispensing doctors to provide a new pharmacy. The organisation that will make these decisions is NHS England and NHS Improvement.

Content

The PNA has reviewed:

- Demographics of the relevant population shown as a whole and more specifically by locality with clear indication of needs specific to each area.

- Existing pharmacy provision and services (as at March 2022)

- Local area maps locating pharmacies and pharmaceutical services.

- Services available in neighbouring Health and Wellbeing Board areas that could affect the need for services.

- Gaps in the provision of services, taking into account future requirements that could be met by providing more pharmacies or pharmacy services.

- Impact of “The Community Pharmacy Contractual Framework for 2019/20 to 2023/24: supporting delivery for the NHS Long Term Plan” document.

The PNA does not include prison pharmaceutical services or hospital pharmacies.

Description of current services

1.1. Essential Services

- Dispensing
- Repeat Dispensing
- Disposal of Unwanted Medication
- Promotion of Healthy Lifestyles
- Sign Posting
- Support for Self Care
- Clinical Governance

1.2. Advanced Services – these are optional services that are commissioned nationally by NHS England through the core contract

- Medicine Use Review and Prescription Intervention Service (MUR) Activity
- New Medicines Services (NMS)
- Appliance use reviews (AUR)
- Stoma Appliance Customisation Service
- Community Pharmacist Consultation Service (CPCS) Activity
- Hepatitis C Antibody Testing Service Activity
- FLU Vaccinations
- Seasonal Influenza Vaccination Advances Service (FLU) Income
- Discharge Medicine Service Income
- Covid Vaccination Service Activity

1.3. Enhanced Services which are locally commissioned including

- C-Card (condom provision and sexual health advice)
- Emergency Hormonal Contraception (EHC)
- Child influenza vaccination service
- Needle Exchange
- Supervised Consumption
- Palliative Care

1.4. Pharmacies facilities – *to be informed by pharmacy survey*

- Wheelchair access
- Access to disabled car parking within 100m
- Private consultation rooms
- Customer toilets
- IT facilities
- Foreign languages spoken
- Electronic prescription service

1.5. Different types of pharmacy contract

- Internet/distance selling
- 100-hour dispensing
- Dispensing practices
- Dispensing appliance contractors
- Cross-border pharmacies affecting local population

2. Local Health Needs:

Leicester is a city characterised by rich diversity, with a younger population than England and around half of its residents from an ethnic group other than White British at the time of the 2011 census. Additionally, it experiences high levels of deprivation with around 35% of its 354,036 residents living in the 20% most deprived areas in the country. Health needs within the city are not evenly distributed, with the worst outcomes often concentrated in the most deprived areas. Life expectancy for men and women in Leicester is significantly lower than the England average.

Local health needs are also described across 6 locality areas (as used in Leicester City Health and Wellbeing survey) to indicate local variation in the population and health needs.

3. Location and access to pharmacies:

There are 85 pharmacies in Leicester (March 2022), equivalent to 2.4 pharmacies per 10,000 population (2.1 in England). All Leicester pharmacies are open for at least 40 hours per week, and 8 are open for 100 hours. The majority of 100-hour pharmacies are located in the west and central locality areas of Leicester, with one in the north, one in the east and one in the south; opening times are generally from 7am to 11pm Monday to Saturday, with some opening for reduced hours on Sunday.

There are more pharmacies concentrated in the centre and north of the city, and fewer in the east and north west of the city. Travel time analysis indicates that generally nearest pharmacies can be reached within 15 minutes of walking. There are a few areas of the city where walk times may be more than 15 minutes but these should be accessible by car or public transport within 15 minutes. Leicester residents can also make use of several pharmacies just into Leicestershire; 9 pharmacies within 0.5km and 15 between 0.5 and 1km of the city boundary.

4. Pharmaceutical service provision

All pharmacies are required to dispense medicines as part of their essential services contract with NHS England and NHS Improvement. In addition, they may be accredited to provide advanced services or locally commissioned services to provide for the needs of the local population.

Service provision is considered across Leicester by six locality areas. These have been defined by, and are consistent with, those used in the Health and Wellbeing Survey 2018. It is acknowledged that not everyone will choose their nearest pharmacy, however,

by providing rates for smaller locality areas this helps to show variation in provision of services for local populations across the city.

6 Projected future needs

By 2043, the population of Leicester is predicted to grow by around 37,400 to give a total population of around 391,400. Projections indicate that Leicester will have an increase of 18,600 people aged 65 and over, which represents an increase in the proportion of the population aged 65 and over from 12% in 2018 to 16% in 2043.

With the current provision of 85 pharmacies in Leicester, this would offer a rate of 2.2 pharmacies per 10,000 population. Nationally, there are 2.1 pharmacies per 10,000 population based on the number of pharmacies alone; it does not take into account variation in opening hours and services provided.

7 Consultation

There is a statutory requirement for each Health and Wellbeing Board to consult a number of bodies about the contents of the pharmaceutical needs assessment for a minimum of 60 days. The consultation period will take place between 6th July and 4th September 2022. The results will be incorporated into the revised PNA at the completion of the consultation period before submission to the Health and Wellbeing Board for approval.

8 Analysis of gaps in service

Pharmacies and local populations:

As of 31st March 2022, Leicester has 85 pharmacies located across the City, including 9 distance selling pharmacies, one Local Pharmaceutical Service pharmacy and one pharmacy eligible for the Pharmacy Access Scheme.

Overall Leicester has more pharmacies per head of the population than England (2.4 vs 2.1 pharmacies per 10,000 population).

Pharmacies are not evenly distributed throughout the city. There are more pharmacies in the north and centre of the city, with several closely located in Belgrave (around Belgrave Road) and another cluster around Spinney Hills towards Stoneygate. In the west of the city the pharmacies are more widely spread, although there are a number along the Narborough Road area in the West End.

Access and travel times:

Analysis of access and travel times suggests most residents will be able to access their nearest pharmacy within 15 minutes by walking, car or public transport. Travel times by car and public transport will be subject to traffic

variations during the day. Residents may have to travel further to reach a pharmacy outside of normal opening hours.

Opening hours:

All Leicester pharmacies are open for at least 40 hours per week; over half (47) are open up to 50 hours per week and Leicester has 8 pharmacies classified as 100-hour pharmacies. The 100-hour pharmacies are located in the west (3 pharmacies), central (2), east (1), north (1) and south (1) locality areas of the city. There is lower provision for extended opening hours in the north west of Leicester, however there are two 100-hour county pharmacies within 1km of the City border towards the north west of the city.

Essential Services:

It is concluded that there is adequate provision for the population of Leicester since essential services are provided by all pharmacies. Some residents may have further to travel where pharmacies are more sparsely distributed and opening hours are shorter (particularly in the north west of Leicester).

Advanced Services:

The majority of pharmacies provide the advanced services Community Pharmacist Consultation Service, Flu Vaccination Service and New Medicines Services. Few pharmacies offer Stoma Appliance Customisation and no pharmacies offer Appliance Use Reviews or Hepatitis C Testing Service.

Locally Commissioned Services:

Locally Commissioned Services are services commissioned by Local Authorities and Clinical Commissioning Groups (CCGs) which can be tailored towards the health needs of the local population. Pharmacies can be particularly effective in providing services to more hard-to-reach groups as they offer a walk-in service and do not require an appointment. They also offer valuable advice and support for people in making lifestyle choices and in managing their own health conditions.

Where data is available, the PNA presents maps showing the location of pharmacies providing each service by the six locality areas across the city. In order to provide an indication of variation across the city, rates are provided per 10,000 population within the locality area. It is recognised however, that residents will not always choose the pharmacy located nearest to them.

9 Conclusions and recommendations

This PNA has reviewed the provision of pharmaceutical services as of March 2022 (where available, otherwise at March 2021) and concludes that overall provision is

adequate for the population of Leicester. There are differences in local provision of services across the city and it may be that residents in some areas have to travel a little further to access a particular service or out of normal working hours.

The majority of pharmacies are accredited to carry out the advanced services of Community Pharmacist Consultation Service, Flu Vaccination Service and New Medicines Services (NMS).

Community based pharmacies offer a range of locally commissioned services to the local population that can be tailored by commissioners to meet specific local healthcare needs. Pharmacies can provide a valuable service to patients, particularly those more hard-to-reach groups who can take an advantage of a drop-in service at a time more convenient to themselves without the need for an appointment. It may also be more appealing to use a less formal environment within a pharmacy compared with the GP surgery.

Throughout the Covid-19 pandemic, the accessibility and provision of some pharmaceutical services changed. However, it is difficult to predict whether such changes will continue into the future or whether they will revert to pre-pandemic levels within the lifespan of this PNA. Given the potential benefits to patients, it is recommended that pharmacies are encouraged to maintain improved service provision.

Equity of service:

It is recommended that NHS England and NHS Improvement (and where relevant Leicester City Council and Leicester, Leicestershire and Rutland Integrated Care Board) should:

- Keep under review locations and opening times to assess whether access is equitable for all residents.
- Work with pharmacies and Local Pharmaceutical Committee to examine how equity issues can be addressed further
- Review cross-city and county-border service provision to ensure uniformity of access and quality of service
- Work closely with Integrated Care Board and Primary Care Networks to tackle health inequalities and address digital literacy
- Encourage pharmacies to offer discretionary services in relation to local need.

Promotion of health and healthcare management:

It is recommended that NHS England and NHS Improvement (and where relevant Leicester City Council and Leicester, Leicestershire and Rutland Integrated Care Board) should:

- Encourage the implementation of Healthy Living Pharmacy to promote healthier lifestyles through pharmacies so that individuals can gain advice and support in reducing unhealthy behaviours and adopting healthier ones.
- Ensure that the requirement for promotion of healthy lifestyles campaigns through pharmacies (Public Health) is fulfilled
- Consider and encourage the opportunity to include and develop the role of pharmacies in commissioning strategies and through the Integrated Care System - particularly in relation to providing services which deflect work out of primary care general practice.
- Assess levels of uptake of advanced and locally commissioned services and follow-up low or high performers in order to share best practice.
- Keep under review the appropriateness of monitoring and quality visits to pharmacies, in addition to pharmacy self- assessment, in order to provide assurance of effectiveness and to promote service improvement.

Community Pharmacies Policy:

It is recommended that NHS England and NHS Improvement (and where relevant Leicester City Council and Leicester, Leicestershire and Rutland Integrated Care Board) should:

- Review evidence of impact of policy and funding changes on services annually and report any findings to the Health and Wellbeing Board with appropriate advice.

LEICESTER CITY HEALTH AND WELLBEING BOARD
Thursday 28th July 2022

Subject:	Leicester Health, Care and Wellbeing Strategy 2022-2027
Presented to the Health and Wellbeing Board by:	Dr Katherine Packham, Consultant in Public Health
Author:	Dr Katherine Packham, Consultant in Public Health

EXECUTIVE SUMMARY:

This paper provides a summary of the current status of Leicester's Health, Care and Wellbeing Strategy and next steps.

Background

A refresh of Leicester's Health, Care and Wellbeing strategy has taken place over the last few months. This involved retaining the five themes of Healthy Start, Healthy Living, Healthy Ageing, Healthy Places and Healthy Minds from the previous strategy which was published in 2019. Health and Wellbeing Board approved a decision to refresh the strategy to reflect challenges that have been highlighted by the pandemic or where the need has increased as a result of the pandemic.

A Leicester Place-led Plan Core Working Group was set up to develop the strategy and priorities on behalf of the Health and Wellbeing Board. This is chaired by Katherine Packham. A set of suggested priorities was proposed. Subsequently, a series of engagement events, including working with a range of community groups and an online survey, were held between November 2021 and January 2022 with ongoing engagement with a number of partnership groups.

Health and Wellbeing Board approved the final draft in principle at the Health and Wellbeing Board in April 2022, with the following overarching priority:
"Working together to enable everyone in Leicester to have opportunities for good health and wellbeing."

Strategy governance processes

The strategy was taken to City Mayor's Briefing in early June and some minor amendments on the wording of the Healthy Ageing priorities were requested to ensure that they are holistic and person centred. Proposed changes for these will be made available to the board when they are completed. The strategy will be presented to Health Overview and Scrutiny committee in August 2022 where comments and feedback will be sought. The final strategy will be brought to Health and Wellbeing Board in October, along with a draft delivery plan.

Next steps

A delivery/implementation plan is in the early stages of development. Initially this will focus on the six 'do priorities i.e.:

- Healthy Places: Improving access to primary and community health/ care services
- Healthy Start: Mitigating the impacts of poverty on children and young people
- Healthy Living: Increasing early detection of heart & lung diseases and cancer in adults
- Healthy Minds: Improving access to primary & neighbourhood level Mental Health services for adults.
- Healthy Minds: Increasing access for children & young people to Mental Health & emotional wellbeing services.
- Healthy Ageing: Enabling Leicester's residents to age comfortably and confidently - *proposed focus on reducing health inequalities through a person-centred programme of frailty prevention.* PLEASE NOTE this wording is subject to change.

The draft delivery plan (2022-2024) is being developed in partnership across a range of boards, groups and organisations in conjunction with the Leicester Place-led plan core working group.

The draft delivery plan will be presented to Health and Wellbeing Board in October 2022.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: note the timelines and next steps for Leicester's Health, Care and Wellbeing Strategy.

LEICESTER CITY HEALTH AND WELLBEING BOARD
28th July 2022

Subject:	Learning Disability and Autism Collaborative
Presented to the Health and Wellbeing Board by:	Tracie Rees. Director of Adult Social Care and Commissioning. Leicester City Council. Mark Roberts. Assistant Director. Leicestershire Partnership NHS Trust.
Author:	Mark Roberts. Assistant Director. Leicestershire Partnership NHS Trust.

EXECUTIVE SUMMARY:

The City Council has been working in partnership with the NHS, and Leicestershire and Rutland County Councils to improve the outcomes for our people with a Learning Disability or Neuro developmental needs. Over recent years we have made significant improvements in the services we provide.

As part of the Integrated Care System for Leicester, Leicestershire and Rutland there is the option to create formal collaboratives. These are commitments from organisations to work together and to build on the work already done, with a commitment that we continue working together to get the best outcomes for our people.

The first collaborative to be launched will be the Learning Disability and Neurodisability Collaborative (LD&ND) on the 1st August 2022.

The LD&ND Collaborative will build on the successes in 2021 of all three Local Authorities and the local NHS to progress the Transforming Care Programme.

In early 2021 the LLR team's performance against the key indicators for this national programme was the third lowest in England; too many people with a Learning Disability and autistic people were being cared for in hospital, LeDeR reviews of the lives and deaths of people that died were significantly delayed, and insufficient numbers of people were accessing their Annual Health Checks (AHCs).

By April 2022 the local system had moved into the top 30% nationally and is continuing to improve. The number of people in hospital has reduced substantially; ensuring many more people are able to live in a less restrictive setting and experience more fulfilling lives, closer to family and friends in their own community. LeDeR reviews are undertaken more promptly and learning is actively shared across the local system; stimulating further improvement in services. In the financial year 2021/22 over 74% of people accessed an Annual Health Check with their GP and in

the twice as many people accessed an AHC in the first three months of this financial year than in the same period last year.

This work has been led by the LD&ND Design Group, a multiagency Delivery Group of operational and commissioning leads from all the partners, and co-ordinated through a comprehensive and structured three-year plan that is overseen by NHSEI. This integration of commissioning, delivery and improvement work has established the basis for the LD&ND Collaborative.

Our joint working as a collaborative provides the opportunity for the further development of joint solutions; workforce supply, increasing acuity and demand, inequality of access and outcomes, and timely access to specialist support.

This will mean we will be able to do more by working at scale, sharing data to create new insights, improving engagement with communities, and an increased focus on local neighbourhoods and places.

We believe the collaborative provides a framework for further joint working without changing any organisations' responsibilities or accountabilities. This joint working will lead to further improvements for our people. We should take pride in the support we provide together becoming the first collaborative in LLR, signalling a new way of working with the NHS.

RECOMMENDATIONS:

The Board is requested to:

1. Note the successes and challenges experienced by the local LD&ND system leaders that create the foundations for the LD&ND Collaborative
2. Support our plans to continue to work and establish a collaborative together
3. Continue to champion improving equity for our people in the city with a learning disability or neurodevelopmental need

LLR LEARNING DISABILITY AND NEURO-DISABILITY COLLABORATIVE

28.07.2022 Leicester City H&WBB

LEICESTER, LEICESTERSHIRE AND RUTLAND
INTEGRATED CARE SYSTEM

Learning Disabilities and Neuro-disability Collaborative:

a. To share successes of last year and the opportunities for the future

b. To update colleagues on progress to date with development of the *Collaborative*

c. To provide information about the next phase of the Collaborative's plans

A clear vision:

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

Collective Leadership

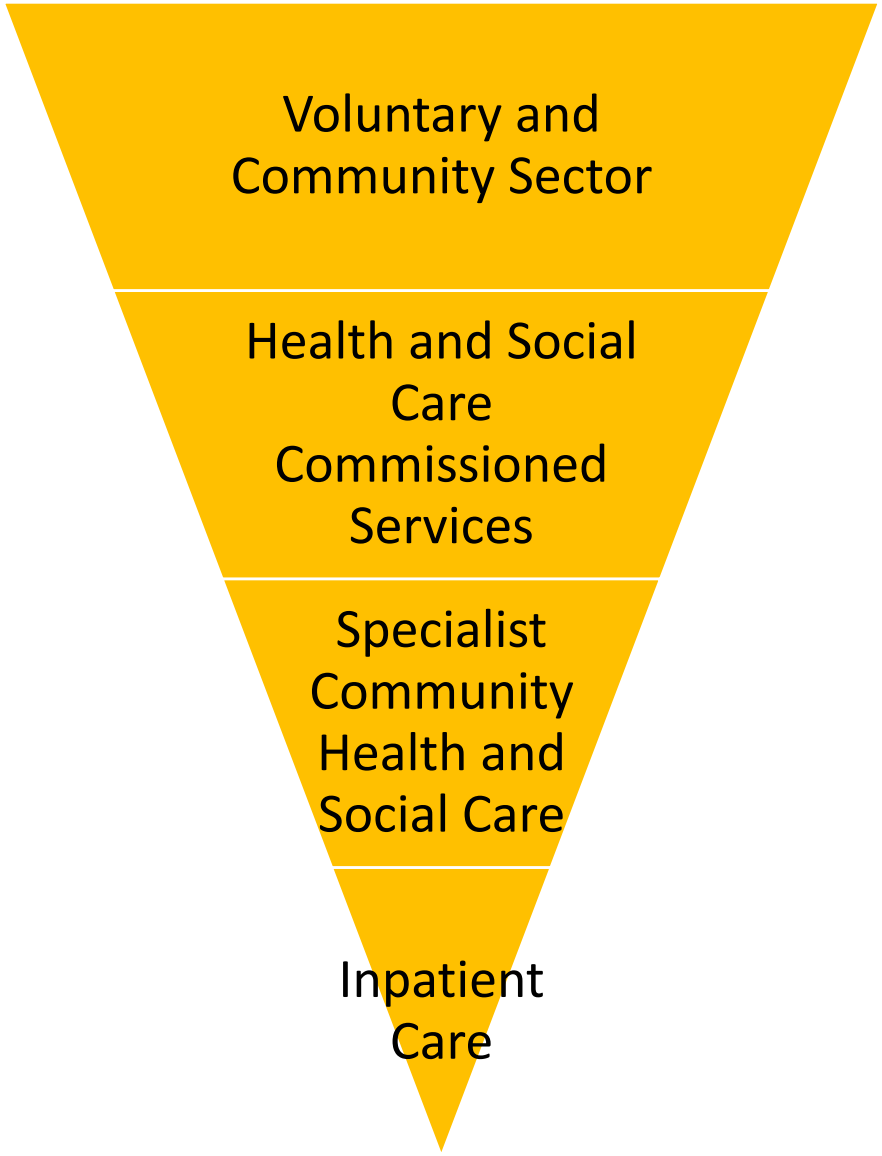
- Multiagency Hub - reducing admissions & improving discharge

Delivering:

- Annual Health Checks
- More people living in the community, less people living in hospital long term
- Sharing learning and working together

Opportunities

- The opportunity for health and social care organisations to come together to solve challenges such as unwarranted variation, inequality in access and outcomes/experience.
- Increased ability to work at scale, with effective decision-making and planning arrangements.
- Greater alignment of plans and mutual support in delivering them
- Improved stakeholder representation
- A culture of open and honest conversations reaching consensus
- A new culture and partnership to tackle ‘wicked issues’ that exist currently
- Increased focus on neighbourhood and place in planning and delivery models
- Sharing of skills across commissioning and provision, health, social care and the voluntary sector



We now work like this….

- We share joint leadership between local government and the NHS
- We meet together at least weekly to solve problems and deliver improved outcomes
- The new integrated care system provides us with an opportunity to formalise this way of working by stating we are a *collaborative*.
- It keeps our accountabilities exactly the same as they are now, whilst allowing us the space to work together more to deliver better outcomes.
- We have improved outcomes for people in hospital and in the community, working as a collaborative with others we know we can do more to support our communities.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE: Thursday 28th July 2022

Subject:	**Progress update on LLR LMNS's response to Black Maternal Mortality**
Presented to the Health and Wellbeing Board by:	**Mel Thwaites** - Head of Women and Childrens Transformation **Dr Farah Siddiqui** – Consultant Obstetrician and Gynaecologist **Robert Howard** – Consultant in Public Health
Author:	**Mina Bhavsar** - Maternity Transformation Programme Manager (1001 Critical Days) **Mel Thwaites** - Head of Women and Childrens Transformation
Contributions from:	**Rabina Ayaz** - CYP and Maternity Services Senior Officer **Monica Hingorani** - Senior Project Manager (Transformation) **Dr Farah Siddiqui** – Consultant Obstetrician and Gynaecologist

EXECUTIVE SUMMARY:

Purpose

The LLR Local Maternity and Neonatal System (LMNS) presented a paper on 'Black Maternal Healthcare and Mortality' to the LLR Joint Health Scrutiny Committee on the 16th November 2021.

The paper discussed the national and local argument for systems to recognise and address the continued gap between the mortality rates for women from Black, Asian and Mixed Heritage groups when compared to White ethnic groups.

The paper went on to provide an indication of the work undertaken and further plans in place to address this disparity. Due to the demographic makeup of the city of Leicester, where almost half of the city's residents classify themselves as belonging to an ethnic group that is not White (2011 census) this issue is poignant for the city. This paper is attached for information and referenced Appendix 1.

This report will focus on the response of our LMNS and build on the plans outlined in Appendix 1 to address this disparity. In addition, we will look at emerging findings coming through our maternity equity gap analysis and make a **strong recommendation for wider system support** to help us understand and address higher rates of maternal mortality in women of Black, Asian and Mixed Heritage ethnic background.

Our aims is:

- To achieve equity for mothers and babies from Black, Asian and Mixed ethnic groups, and those living in the most deprived areas.
- To achieve equality and experience for staff from minority ethnic groups.

However, it is important to note that no one organisation can address this on its own and acknowledge that we require a system response to make a real difference.

Background

The MBRRACE-UK - Saving Lives, Improving Mothers' Care 2020 reviewed maternal deaths from 2016-2018, and provided firm evidence that women from Black ethnic groups are four times more likely to die in pregnancy when compared to White women (Table 1). The table emphasis a real need to focus on actions to address these disparities.

Table 1 National - Black, Asian and Women of Mixed Heritage have a higher risk of dying in pregnancy when compared to White women:

White women		8/100,000
Asian women	2x	15/100,000
Mixed ethnicity women	3x	25/100,000
Black women	4x	34/100,000

Locally this picture mirrors the national picture described in Table 1 and over a 5-year period (2016- 2021) we have had 7 maternal deaths. All 7 women were from a Non-White ethnic background.

Emerging themes from the Maternity Equity Gap Analysis

As part of the maternity transformation programme all areas are required to undertake an equity analysis which will help inform co-produced action plans with service users and other key stake holders

Our LMNS recently undertook this exercise and has now started the process of engaging the wider community in efforts to produce a co-produced action plan.

What is the equity analysis telling us so far for LLR?

We are in the process of breaking down the information at place-based levels, however some of the key themes coming through are:

- 2017 - 59.7% were births to non-UK parents
- Antenatal complications - around 50% of Asian or Asian British: Bangladeshi

- Gestational diabetes and diabetes - higher in certain ethnic groups (Asian, African and Chinese)
- Postpartum haemorrhage - across LLR is generally higher than the Midlands position
- Premature births - higher within the Black or Black British: Caribbean ethnic group
- Low birthweight - higher proportions of low birthweights are seen in areas of Leicester with larger numbers of Asian mothers
- Smoking at the time of delivery - high prevalence seen in White: Irish mothers, with Mixed heritage: White and Black Caribbean mothers and Black or Black British: Caribbean mothers also being higher than the LLR average

The above information (although not exclusive) provides us with some insights into the complexity of factors that require further work to understand why maternal mortality rates are higher in women from Black and Minority groups. To make a difference we will require a whole system response.

What has the LMNS response been to date?

Whilst pregnancy remains very safe in the UK, one maternal death is still a death too many. In a three-year period given, there were 181 deaths nationally. For the same period in LLR we had 4 maternal deaths. Whilst we are not seen as an outlier, we recognise with our cities demographic make-up we have a real opportunity to make a difference to the maternal outcomes for women of Black, Asian, and Mixed heritage ethnic background.

We have continued to build on the actions outlined in Appendix 1 (pg. 5 & 6) and in addition we have put an additional five workstreams in place - Appendix 2:

- **Workstream 1:** Maternal and perinatal mortality and morbidity. This work entails robust perinatal mortality and morbidity reviews with multidisciplinary input and scrutiny of work to identify areas for improvement relating to health inequalities.
- **Workstream 2:** Creation of a LLR Perinatal Health Inequalities Dashboards.
- **Workstream 3:** Supporting Continuity of Carer and focussing on historically disadvantaged groups. (Due to current staffing levels this workstream is currently on hold and will re start once this is addressed).
- **Workstream 4:** Mental Health, Maternal and Family experiences: Understanding mental health issues and engagement with healthcare providers.
- **Workstream 5:** Infant mortality and the ICS Public Health agenda: An implementation strategy reducing risks for infant mortality.

Other key areas of work underway that contribute to this agenda include the following:

- As part of our drive to create a culturally competent workforce, we are developing cultural competency training and education for our staff.

- We have worked on specific areas of work to co-produce information with women and communities. For example, Leicester Mammas and LLR Maternity Voice Partnership (MVP).
- We continue to reach out to the community following our equity stakeholder event and have recently developed a questionnaire to roll out to specific groups in the community with an aim to understand how we can improve engagement and access.
- **1001 critical days -** we are working in collaboration with our public health and local authorities' colleagues at place and system level to improve preconceptual care for mothers and encourage early access.

East Midlands Maternal Medicine Hub - MBRRACE-UK 2021 reviewed all maternal deaths which identified that in about 37% of cases, early referral to a multidisciplinary team and improvements in care, may have made a difference to the outcome.

This information was backed up by the recent Ockenden Report which identified that there had been a lack of antenatal MDT planning for women with significant pre-existing co-morbidities and/or other medical risk factors.

To address this, NHSEI has commissioned a number of Maternal Medicine Hubs, to ensure women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy. LLR LMNS has been successful in its application to become the regional host for the East Midlands Medicine Network Service. The broad aim of the network is to develop and expand the existing maternal medicine services in the region to reduce health inequalities and give all women access to high quality maternal medicine care and advice accessible as close to home as possible and thereby improving maternal outcomes.

The need to provide maternal medicine services to areas of the community that may struggle to access the services is an area of work we are looking into.

Currently, at UHL we are delivering a series of lectures virtually on why some patients may find it difficult or feel less empowered to access our services, comply with management options and how this has led to disparities in obstetric and neonatal outcomes. We have held these sessions to the UHL consultants in the Quality and safety meeting, and the trainees within the regional teaching session, the next step is to reach out to the midwives both who lead the specialist services and within the community.

We also plan to meet with patients that represent those deemed most disadvantaged and start to collect stories and empower discussions through focus groups.

Perinatal Mental Health

Maternal suicide is the fifth most common cause of women's deaths during pregnancy and its immediate aftermath and is the leading cause of death over the first year after pregnancy. As an LMNS we are supporting the service to

work towards achieving key deliverables that will help us to improve access and extend support to women with a child of up to 2 years old, increase our offer that includes support for partners. We have a maternal mental health service in place for women who have suffered moderate to severe trauma for example due to losing their baby.

Next steps

The cause of poorer outcomes for women and babies from Black and ethnic communities are multi-factorial The LMNS has a programme of work underway to support improvements in maternal outcomes, but the LMNS will not make a difference on its own. This work needs to be part of a broader system response brought together and supported by the HWBB.

Key strategies and other key drivers that need to come together include:

- Place and system health inequality work
- Anti-poverty strategy
- Public health agenda with key focus on smoking, maternal obesity and screening
- 1001 critical days
- Health in All (HIA) Policies and use of Health Impact Assessment (HIA)
- LMNS - Maternity transformation programme

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

NOTE: The context of this report.
AGREE: To support our call for a wider system response in addressing the disparity noted for women from Black, Asian and women from Mixed Heritage ethnic background to improve maternal outcomes.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST,
Local Maternity and Neonatal System (LMNS)
LLR Integrated Care system (ICS)

REPORT TO: **Joint Health and Overview Scrutiny Committee**

DATE: **15th October 2021**

REPORT BY: **Elaine Broughton, Head of Midwifery**

SUBJECT: **Black maternal healthcare and mortality**

Introduction

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries), is a collaboration appointed by the Healthcare Quality Improvement Partnership to run the national Maternal, Newborn and Infant clinical Outcome Review Programme. The Infant Mortality and Morbidity studies for MBRRACE are led by the University of Leicester by two local Professors. MBRRACE carries out a national programme of work conducting surveillance and investigating the causes of maternal, stillbirths and neonatal deaths. A confidential enquiry is a systematic process of multi-disciplinary, anonymous review of all or a sample of defined cases occurring in a defined geographical area during a defined period of time, all demographics should remain anonymous to avoid identification of person or place.

What the MBRRACE reports continue to highlight are multiple and complex problems that affect women who die in pregnancy, these can be a combination of Social, physical and mental or just one of these factors alone. The women who live in deprived areas continue to be at greater risk of dying during or after pregnancy. MBRRACE also have highlighted before the disparities in outcomes for women from different ethnic minority groups. The coronavirus pandemic has brought this disparity even more starkly to the fore, and we must not lose sight of the actions that are required to address systemic biases that impact on the care we provide for ethnic minority women.

MBRRACE-UK - Saving Lives, Improving Mothers' Care 2020[1], which reviewed maternal deaths from 2016-2018, has shown little difference in outcomes of mortality rates for women of a black ethnic background since the previous report from 2013-2015. There remains a more than four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women, emphasising the need for a continued focus on action to address these disparities.

A petition presented to the house of Commons in April 2021 was part of a debate on healthcare disparities and black Women's experiences in maternity care, followed by a programme on Channel 4 dispatches, called the 'Black Maternity Scandal' has all raised the profile of the experience of maternity care in Britain today and although we recognise there are greater risks in this population of pregnant women, listening to the women and how they felt and the description of personal experiences is sad and disheartening.

[1] MBRRACE-UK: Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18. National Perinatal Epidemiology Unit, 2020

Background

The cause of poorer outcomes for women and babies from Black and ethnic communities are multi-factorial and more research is needed to better understand the contributory factors. Common issues which can exacerbate problems for this population include:

- low socio-economic status or social support
- lack of proficiency in English
- Multiple vulnerabilities such as FGM or recent migrant status
- Policy of charging undocumented migrants for maternity care
- A 'one size fits all' approach to maternity care which does not consider differences in women's abilities to understand or access care, or serve the most vulnerable appropriately, can result inequalities in healthcare provision, contributing to structural racism
- Cultural barriers combined with insufficient training of healthcare professionals in cultural sensitivity and knowledge

The National Requirement

The NHS Long Term Plan' (NHS England 2019)[2] set out that by 2024, 75% from Black and minority ethnic communities would receive continuity of care from the same midwife during pregnancy, birth and in the postnatal period. The benefits of this pathway of care are well researched and set out in Better Births (2016)[3]. It also documents the requirement to reduce health inequalities experienced by women of a Black and Minority ethnic background across England. Better Births (2016) set out a recommendation for personalised care for all women, which would address the contributory factor mentioned above 'the one size fits all approach' to maternity care. More recently the Ockenden report (2020)[4]

During the Covid Pandemic, MBRRACE published a rapid report, 'Learning from SARS-CoV-2-related and associated maternal deaths in the UK'[5] It reviewed maternal deaths over a 3 month period from 1st March 2020 to 31st May 2020 and reported a number of key messages, it is reported 10 women died in this period, the majority were from a minority ethnic background. This report identified existing guidance and some recommendations that had already been published that required improvement in implementation. These recommendations were for all pregnant women but highlighted in particular women of black or minority ethnic background (and women with other high risk health conditions) should be advised that they are at greater risk to seek help and advice as soon as possible if they have concerns about their health, either with a Covid Diagnosis or with symptoms

Following the report, the Local Maternity & Neonatal System (LMNS) received a letter advising all systems to ensure specific actions were taken in relation to the Black and minority ethnic women, during the ongoing pandemic, the response from the system is discussed below.

[2] NHS Longterm Plan, NHS England, 2019
[3] Better Births. Improving outcomes of maternity services in England. A Five Year Forward View for maternity care. National Maternity Review, 2016
[4] Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. Dec 2020
[5] MBRRACE-UK. Saving Lives, Improving Mothers' Care Rapid Report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK June 2020-March 2021. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2021

Public Health England made a number of recommendations in a report published in December 2020[6], they highlighted Maternity is a high impact area in achieving a universal approach to improving outcomes for mothers, babies and children and ensuring the best start in life. The report specifies six key topics that will impact outcomes based on research evidence, one of which is based on reducing the inequality of outcomes for women from a Black and minority ethnic background. All are based on improving outcomes for all women, there are large areas in England where there is social deprivation and these women are equally disadvantaged in terms of access to health care and achieving good outcomes.

In 2018 NICE[7] published guidance around Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups, this was not specific to pregnancy and childbirth but in particular the statement in relation to equality and diversity considerations is well evidenced in maternity specific publications. Due to language and communication difficulties and poor past experiences of racism and perhaps prejudice, some people from black, Asian and other minority ethnic groups may not engage with services and increase their risk of poor health outcomes, health professionals in maternity services must recognise and promote this when planning services, using a system wide approach.

There are specific recommendations published in September 2021 following the NHS 2021/22 Priorities and operational planning guidance produced in March 2021, called Equity and Equality: Guidance for local Maternity systems[8]. This document describes six interventions for the LMNS to take action on and shows which ethnic group will benefit most from the intervention, this also covers vulnerable groups and socially deprived groups of women. Plus the four pledges made by the NHS to improve equity for mothers and babies and race equality for NHS staff[9] in which they make four pledges. On the back of this each LMNS is required to complete and submit an equity analysis (covering health outcomes, community assets and staff experience) and a coproduction plan by 30th September 2021, and then Co-produce an Equity Action Plan by 31st December 2021

Current position in Leicester, Leicestershire and Rutland

This report is to describe what the local maternity & neonatal system is doing in relation to all the national evidence and guidance for health inequalities and poor outcomes for women of a black and minority ethnic background.

Below is a snapshot of the local population by ethnic group, the information describes by ethnic group the percentage of the population who fall in that group up to the age of 24 years. It is very reflective of the population of Leicester as a whole. The national statistics in terms of maternal deaths and ethnicity and the local data that UHL has collected in relation to maternal deaths up to 42 days of birth, all mothers were black Asian or mixed race.

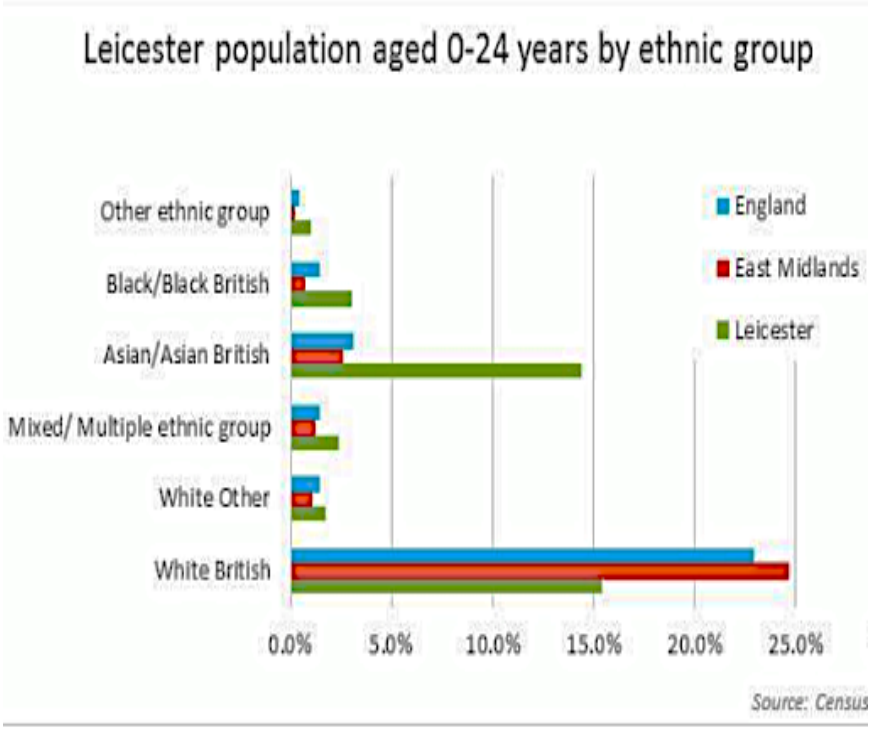
[6] Reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic (BAME) communities and their babies, 2020

[7] Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups. NICE(2018)

[8] NHS, Equity and Equality: Guidance for local Maternity Systems, 2021

[9] NHS pledges to improve equity for mothers and babies and race equality for staff , September 2021, NHS

What is clear when reviewing ethnicity that compared to the rest of the East Midlands and England, there is a significant difference to the national average, of Asian and Asian British group and also larger black and black British group. This suggests that LLR Local maternity system have the opportunity to make a difference in the lives of the women who receive maternity care with the UHL maternity service either in the provider Trust sites or in community. This is not just the responsibility of midwives and obstetricians but the system as a whole, to ensure robust implementation of guidance to improve outcomes.



National Statistics

	Ethnic group				Quintiles of deprivation	
	Black	Asian	Mixed	White	Most deprived	Least deprived
Maternal mortality rate per 100,000 maternities[4]	34.27	14.65	25.14	7.87	15.27	5.70
Number of maternal deaths 2016–18	28	28	8	117	74	15
Relative risk of maternal death	x4	x2	x3	Reference	x3	Reference

Local Data for the past 5 years of maternal Deaths (pregnancy-42 days)

Year	No of deaths	Ethnic group			
		Black	Asian	Mixed	White
2016	2	1	1		
2017	1			1	
2018	1		1		
2019	0	-	-	-	-
2020	1	1			
2021	2	1	1		

Over the past eighteen months these are the actions the maternity system has taken in response to the pandemic and national guidance, in relation to Black women's healthcare equity.

- Launched a continuity of carer team based at a city GP practices, the majority of women in this area are from an Asian or Indian background.
- Produced an informatics poster aimed at women whose first language is not English to encourage them to attend a health professional as soon as possible with any symptoms of Covid, working with members of the Maternity Voice Partnership (MVP)
- Produced a UHL Standard operating procedure to incorporate all the recommendations from the MBRRACE rapid report findings.
- A webinar to raising awareness and discussing health concerns and offering advice in relation to COVID-19 and other health concerns, encouraging women to attend for health and maternity care as soon as possible, this was run by a consultant obstetrician ,matron for community and midwives from the continuity team and discussed in 3 different languages
- Development of a Black and Minority dashboard. In conjunction with mental Health services' Public Health and Neonates, this group was started to identify and understand issues by analysing the local population, understanding the root cause of any disparity and then use the information and learning to design/target interventions accordingly. We believe LLR is the first in the region to undertake this work.
- Raised awareness of the use of interpreters throughout the service, reviewed many different ways of aiding communication with women whose first language is not English. There is now a midwife who is completing a chief nurse fellows programme, the project she is working on is improved communication and interpreting in maternity care
- The LMNS are completing the Equity and Equality analysis following the publication of the four pledges the NHS made to improve equity for mothers and babies and race equality for NHS staff in September 2021. This is to cover health outcomes, community assets and staff experience and set out how we will work in partnership with women and their families to draw up the plans to be completed by the end of November 202. Then submit an Equity and Equality action plan by February 2022
- Following the Channel 4 programme 'Despatches-Black Maternity Scandal' The community midwifery matron and An MVP member were interviewed on the radio to try and assure the local population of the maternity care in LLR and encourage them to seek maternity care early, discuss their concerns and seek interpreting help if needed.

- The Community midwifery matron recorded a video on the benefits of the Covid-19 vaccine with LPT which is on social media (U-Tube)
- The UHL maternity website is in the process of been upgraded, however the current one can be converted into other languages. The upgrade will ensure it is more accessible to all women
- As a system we are committed to delivering the governments ambition 'The Best Start in Life: The First 1001 Critical Days'-The importance of the conception to age two period' and plan to hold our first stakeholder event on the 10th November 2021.

Summary and next steps

A maternal death is a catastrophic event for the family, children are left without a mother and it has long reaching effects on families and also on health professionals, it is a rare event, the mortality rate been around 82 mortalities per 100,000 maternities. In a period of three years, 181 deaths occurred nationally. From the table above in that same 3 year period, there were 4 maternal deaths attributed to the LLR maternities. There is no indication LLR is an outlier for maternal death rates, given the local population.

It is not possible to pin point exactly why maternal mortality rates are higher in women from black and minority groups, there is no one factor that increases the risk. As shown above it is a complex combination of factors, social, physical and psychological. Women must have confidence in maternity services to access care earlier and maintain attendance, they must be facilitated to access health information and encouraged to seek advice.

How the Maternity system do this above and beyond what has been achieved so far, will be led by the results of the Equity and Equality analysis, we will work together to complete a comprehensive action plan and work as a system to implement the actions. When comparable data becomes meaningful from the ethnic Minority Dashboard we can incorporate findings and new indicators and measure results and review if LLR Maternity System is making a difference to the mortality and morbidity of Black and ethnic communities and to the lives and maternity care of vulnerable and socially disadvantaged women. The overall aim is to eliminate maternal deaths, improve the experience of Black and minority ethnic women in maternity services and continue to monitor and embed evidence based research in relation to this population of women

Appendix 2

Perinatal Health Inequalities within the Women's and Neonates Services at UHL/ LLR:

Driving changes for the future

A working document outlining the flow of information on work being undertaken on Perinatal Health Inequalities in UHL and the LLR, and Trust/LMNS support for this process

Overview

Perinatal health has been highlighted nationally for its substantial inequalities. Addressing ethnic diversity, social deprivation in this context is now an augmented focus within the Women's and Children's Clinical Management Group (W&C CMG) at UHL. Women's and neonatal teams are working towards developing a more robust appreciation of the challenges faced within our health sector, investigating, understanding and collaborating to promote changes that may over time contribute towards equality in health care delivery and utilisation for our diverse population, despite prevailing inequalities in societal and economic factors.

This working document brings together the work being done, and sets out the aims, objectives and aspirations for this within the W&C CMG at UHL.

Rider: It is acknowledged that health inequalities, brought about by social deprivation and its associations, including ethnicity, cannot solely be addressed through changes health care provision, but require in addition a wider economic and societal thrust. The work that will be described will be contextualised for UHL and LLR as proportionate universalism: provision of universal services at a scale and intensity proportionate to need.

Overarching Aim:

To provide an overview of the equality and diversity work within in perinatal health care at UHL and LLR that is supported by the W&C CMG, and with intention to harness further Trust support, going forward.

Objectives:

1. To outline work within 5 primary elements/workstreams of the Perinatal Health Inequalities Working Group (Appendix 1)
    - Workstream 1: Maternal and perinatal mortality and morbidity
    - Workstream 2: Perinatal Health Inequalities Dashboards
    - Workstream 3: Supporting Continuity of Carer and historically disadvantaged groups

- Workstream 4: Mental Health, Maternal and Family experiences of engaging with healthcare providers, information sharing and provision (including language/interpreters/App development/webinars)
- Workstream 5: Infant mortality and the ICS Public Health agenda

Its aspiration:

To inform, and to harness investigation, management, financial and implementation support for the W&C CMG, in the conduct of this work on behalf of the Trust, EQB and LMNS.

Structure:

Participants

- Multi-disciplinary, including individuals with an interest in perinatal health inequalities at UHL and the LLR: obstetricians, clinicians overseeing perinatal mortality and morbidity, the LLR Local Maternity and Neonatal Systems, Perinatal Mental Health services, Community/hospital-based Midwifery and Neonatal services.
- It is anticipated that over time the group will expand to include all aspects of the Women's and Children's directorate.

Organisational structure

- 6 monthly Trust, EQB and LMNS update involving an action-focussed report developed by each of Work streams and the Overview Group for the Trust, with LMNS, Trust, EQB feedback (on avenues of support) to the Perinatal Health Inequalities Overview Group.

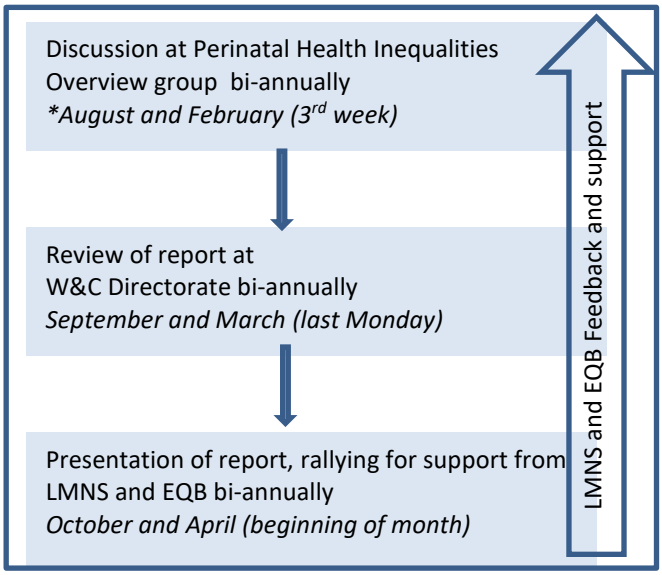


Figure 1: Intended Flow of Information and Trust Support for Perinatal Health Inequalities Overview Working Group, UHL W&C CMG

Appendix 1: A brief Outline of each Work Stream in the UHL LLR Perinatal Health Inequalities Overview Group

Workstream 1: Maternal and perinatal mortality and morbidity

This entails robust perinatal mortality and morbidity reviews with multidisciplinary input and scrutiny of work to identify areas for improvement relating to health inequalities.
The MBRRACE-UK: Mothers and Babies: Reducing the Risk through Audits and Confidential Enquiries across the UK, sets a platform for rigorous review, based on identification of substantial perinatal health inequalities around for example stillbirths in the UK.

Workstream 2: Perinatal Health Inequalities Dashboards

This working group is evaluating vulnerabilities through social deprivation, asylum seekers, poor mental health, complex co-morbidities, including those historically disadvantaged in the access, navigation and utilisation of health services. These vulnerabilities appear to be more prevalent in Black, Asian, and marginalised women in the region.
An innovative *Perinatal Health Inequalities Dashboard* combining demographic data on Race, Ethnicity, postcode, preferred language, with adverse pregnancy outcome data such as Stillbirths, early neonatal death, severe perineal trauma (3rd and 4th degree tear rates), major haemorrhage and perinatal maternal mental health is being trialled, to enable early, interactive, relevant, current information to be identified. The intention is that this over time enables us as a Trust to better address any inequity and to follow this in real time.

The W&C is *the first CMG to be employing a qualitative social scientist* CMG (housed in Neonatology) to study how best to incorporate measures of health inequalities, together with implementation, engaging both staff, families and community leaders. This is being done in conjunction with the University.

Workstream 3: Supporting Continuity of Carer and focussing on historically disadvantaged groups

A national midwifery programme providing continuous midwifery carer support, education, promoting engagement and empowerment for vulnerable women and families is currently underway. Research and implementation of novel strategies for engagement such as virtual antenatal sessions (including language/interpreters/App development/webinars), in this area is intended to identify areas for improvement going forwards.

Workstream 4: Mental Health, Maternal and Family experiences

Understanding mental health issues and engagement with healthcare providers, information sharing and provision (including language/interpreters/App development/webinars) is being explored through a variety of formats with intention to identify burden and seek avenues of improvement for the future.

Workstream 5: Infant mortality and the ICS Public Health agenda

An implementation strategy reducing risks for infant mortality (a key health inequality metric) in the form of parent education and empowerment is in place, together with research around a) how best to deliver key messages to vulnerable (socially impoverished, ethnic minority especially) families, but in the context of proportionate universalism, b) how best to understand what family and parent empowerment means and c) how to minimise the health inequality divide is underway. This work is integrated with the University of Wolverhampton, and part of a Midlands wide regional thrust to improve outcomes for the vulnerable. Included in this work, is implementation and qualitative research around education upstream of pregnancy, in schools, in conjunction with public health, city councils and relevant local maternity and neonatal systems.

Contributors: I Scudamore, F Siddiqui, P McParland, G O'Brady-Henry, M Bhavsar, A Doshani, E Broughton, K Williams, F Cox, L James, T Pillay. For the Womens' and Children's CMG, UHL, and LLR LMNS

Version 1: 3 May 2022
For comment reply to: tilly.pillay@uhl-tr.nhs.uk; Ian.Scudamore@uhl-tr.nhs.uk

LEICESTER CITY HEALTH AND WELLBEING BOARD
28 July 2022

Subject:	Report of the Chief Strategy Officer, LLR Integrated Care Board (ICB) Reducing Health Inequalities – Core20Plus5
Presented to the Health and Wellbeing Board by:	Steve McCue – Senior Strategic Development Manager, LLR ICB Mark Pierce – Head of Population Health, LLR ICB
Author:	Steve McCue - Senior Strategic Development Manager, LLR ICB

Purpose of report

1. The purpose of this report is to inform the Health and Wellbeing Board (HWB) of the NHS requirement by NHS England and NHS Improvement to deliver against the CORE20Plus5 to support wider work to reduce health inequalities across Leicester, Leicestershire and Rutland (LLR).

2. The HWB is required to 'Do' specific Leicester place-based work (such as work on the wider determinants of health) and 'Sponsor' wider LLR NHS initiatives that reduce health inequalities in Leicester.

RECOMMENDATIONS:

3. The Health and Wellbeing Board is requested to:

    a. Receive and Note the report

    b. Complete further work TO AGREE an initial focus on a Leicester population cohort(s) who already experience health inequities – a plus cohort of the Core20Plus5 approach

Policy Framework and Previous Decision

4. Previous reports on the Core20Plus 5 have been reported in the following meetings:

    a. Received for information by the LLR Integrated Care Board – 14 April 2022

    b. Received for information by the LLR Integrated Care Partnership - 29 March 2022

5. Improving population health and healthcare and tackling unequal outcomes and access are two of the four purposes of the LLR Integrated Care System (ICS)

6. Nationally, Core20Plus5 is the NHSs approach to tackling unequal outcomes and access

7. LLR Health Inequalities Framework – Better Care For All (Appendix 1) presented to the HWB on 25 March 2021

Background

8. NHS England define health inequalities as the preventable, unfair, and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental, and economic conditions within societies. Reducing health inequalities is a core priority for the LLR ICS and our programme of work to reduce health inequalities will be guided by the 12 principles within the LLR Health Inequalities Framework (see Appendix 1) with a focus on addressing the five priorities in the 21/22 & 22/23 NHS Operational Planning Guidance and the Core20Plus5 approach (Figure 1). The LLR ICS is aligned to the national vision of 'exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes. Health inequalities exist on a gradient throughout populations, and we are committed to using a proportionate universalism approach to reduce inequity wherever it exists across LLR.

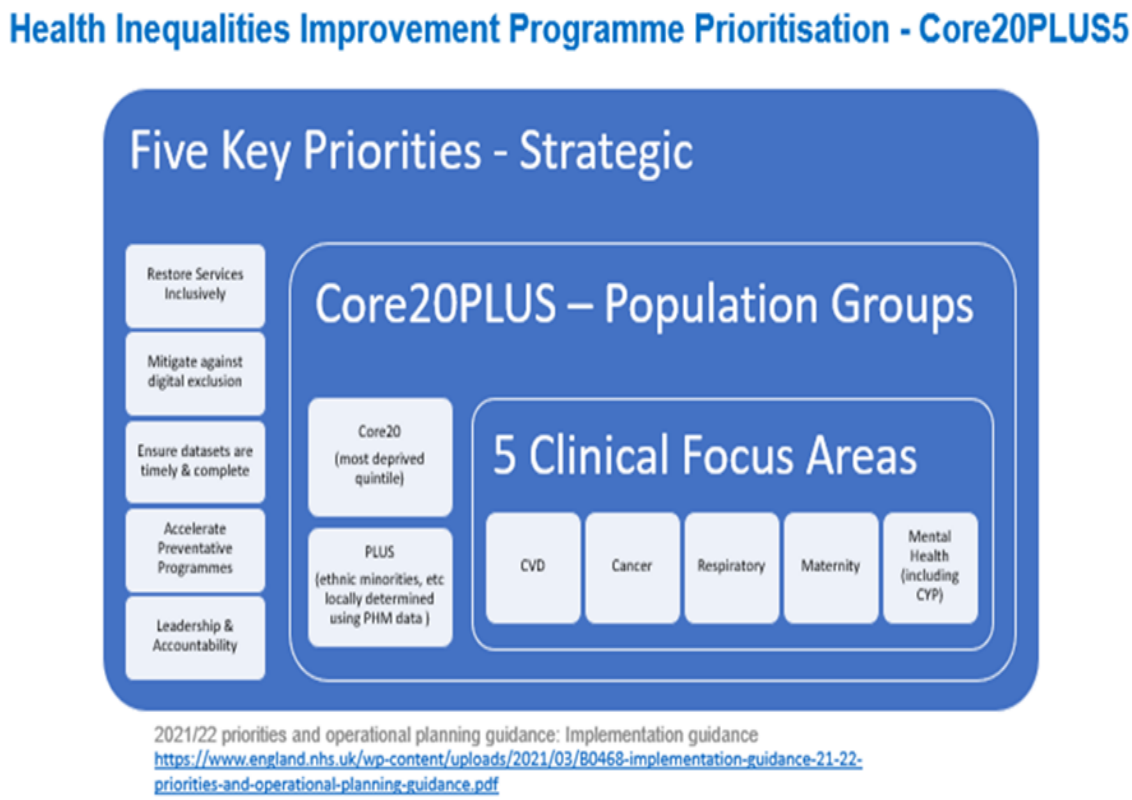


Figure 1: *The five priorities in the 21/22 & 22/23 NHS Operational Planning Guidance and the Core20Plus5 approach*

Core20Plus5 – An approach to reducing health inequalities

9. Core20Plus5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system (LLR) level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement (Figure 2).

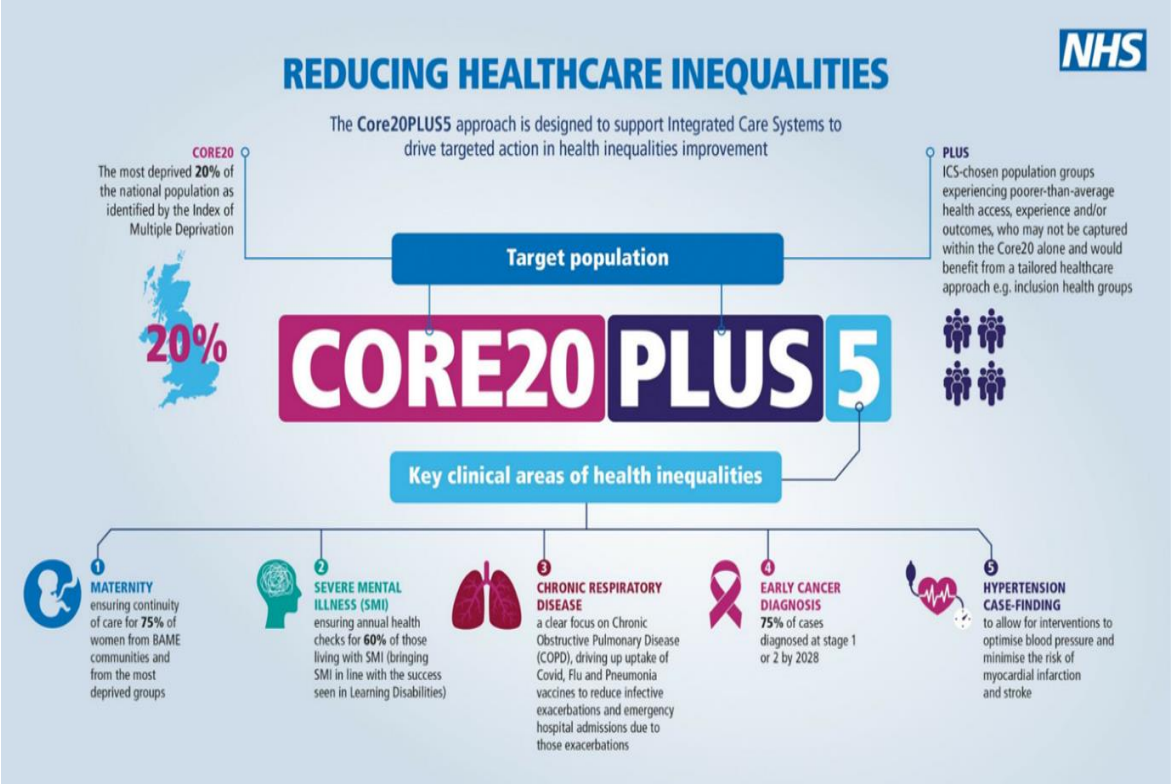


Figure 2: *The Core20Plus5 approach to reducing health inequalities*

Core20

10. The Core 20 refers to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

11. For Leicester, Leicestershire & Rutland (LLR), 153,284 registered patients live in the 20% most deprived neighbourhoods in England (Table1). Our Strategy and system, place and neighbourhood levels of service delivery will be to ensure that we invest resources to ensure that (1) access to services, (2) experience of services, and (3) health and care outcomes are fair and equitable for the people in this group compared to the rest of the population. This means that we will work with partners to make the necessary efforts and investments needed to "level the playing field" for everyone in terms of chances to live a long and healthy life.

Table1*: Summary of the number of registered patients across LLR and those that live in the 20% most deprived areas in England*

	Registered patients living in 20% most deprived areas in England	Total registered patients	%
Leicester	130,794	413,074	31.7%
Leicestershire	22,321	688,401	3.2%
Rutland	169	40,035	0.4%
LLR	153,284	1,141,510	13%

The "PLUS" populations

12. The Plus populations of the Core20Plus5 approach to reducing health inequalities are groups, not specifically covered in the "Core 20", who may need additional support from system partners in order to have an equitable chance of having the best health and care outcomes. The LLR partners will use national and local data to identify these groups. They may include ethnic minority communities, people with very poor mental health, protected characteristic groups, people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, military and veteran populations, sex workers, people in contact with the justice system, victims of modern slavery. It also considers those living in very rural areas/ those remote from certain services, and other socially excluded groups.

13. The emerging Leicester Health, Care & Wellbeing Strategy (2022-2027) has health inequalities as a cross cutting theme across all the life course stages. To ensure that additional work and resources are aligned to the specific 'place' priorities and populations, it is recommended that the 'Plus' population groups will be determined in each of our three 'places' by the relevant Health & Wellbeing Board.

"The 5"

14. The final part of the Core20Plus5 framework sets out five clinical areas of specific NHS focus. Governance for these five focus areas sits with national NHS programmes; national and regional teams coordinate local systems to achieve national aims. The five clinical areas include;

    a. Maternity: ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the Core 20 part of the population

b. **Severe mental illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities)

c. **Chronic respiratory disease**: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

d. **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028

e. **Hypertension case-finding**: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

Delivery & Governance

15. The local NHS will collaborate with partners to deliver against Core20Plus5 national targets. Successful programmes to improve access, experience and outcomes requires not just the NHS, but all system partners working together. At system level; reporting on, and governance of actions will be through the LLR Prevention & Health Inequalities Reduction Board and ICB/ICP. At place it will be through the Health and Wellbeing Boards and Directors of Public Health. At neighbourhood level, it will be through local neighbourhood Community Health and Wellbeing Plans which will include delivery partners such as Primary Care Networks, Integrated Neighbourhood Teams and local authority partners.

16. Reporting on Health Inequalities will be proportionate to the footprint at which action is taken, with neighbourhood reporting being the most detailed and localised, but aligned to place and system priorities, and overall progress against the NHSEI 5 priority areas and Core20Plus5 metrics for the five clinical areas.

17. The LLR ICS has placed a very high premium on identifying and strengthening leadership and accountability for tackling health inequity at all levels of the system. Health Inequality Leads are now in place at Board level in each large NHS providers, on the NHS system Board, and through formal clinical and management leader roles in different specialities. The LLR Prevention & Health Inequalities Board, chaired by the Director of Public Health for Leicestershire, will oversee the implementation of the LLR Health Inequalities Framework and support

action at place and neighbourhood level through a 'Do, Sponsor, Watch' approach to delivery.

18. A local LLR health inequalities dashboard has been developed in addition to the national reporting tool to help us measure local progress on reducing health inequalities through the Core20Plus5. Regular reporting against system, place and neighbourhood actions to reduce health inequalities will be presented to the Integrated Care Board, the Integrated Care Partnership and each of the three Health and Wellbeing Boards in LLR.

Consultation/Patient and Public Involvement

19. Health Watch has been a member of the Task and Finish Group for drafting the LLR Health Inequalities Framework. This framework is currently being updated to reflect the Core20Plus5 approach. We believe that meaningful engagement with public and patients on health inequalities needs to take place at place level and more locally to be effective in driving effective action.

Relevant Impact Assessments

Equality and Human Rights Implications

20. The CORE20Plus5 is a NHS national framework to reduce health inequalities, it takes into account protected characteristic's as part of it's 'Plus 5' groups.

Partnership Working and associated issues

21. The Core20Plus5 approach provides a framework for how we plan to act, both collectively and through specific organisations to positively impact not just the direct causes, but the "causes of the causes" of these differences. Some work, therefore, will fall to the NHS to do, some to other partners such as local authorities or other public sector bodies, and some as joint working at system, place or neighbourhood. Often this is not something one organisation can do on their own – it requires the system to work together to act as anchor institutions – using their collective resources and working with the voluntary and community sector to make a difference.

Background papers

https://www.england.nhs.uk/wp-content/uploads/2021/06/240621-board-meeting-item-9-tackling-inequalities-in-nhs-care.pdf

Appendices

LLR Health Inequalities Framework – Better Care For All

HIF - BETTER CARE FOR ALL - Final 03.0

Officer to contact

Sarah Prema, Chief Strategy Officer, LLR ICB

Telephone: 0116 2953413

Email: Sarah.Prema@nhs.net

Better care **for all**

A **framework** to reduce health inequalities in Leicester, Leicestershire and Rutland.

Contents

What are health inequalities?

Health inequalities are avoidable and unfair differences in health between different groups of people. Health inequalities concern not only people's health but the differences in care they receive and the opportunities they have to lead healthy lives.

Those living in the most disadvantaged areas often have poorer health, as do some ethnic minority groups and vulnerable/socially excluded people. These inequalities are due to many factors, such as income, education and the general conditions in which people are living. In addition, the most disadvantaged are not only more likely to get ill, but less likely to access services when they are ill.

Health inequalities have been made worse by the Covid-19 pandemic, which has hit hardest the groups who already do not have the best health. The rate of people dying from the virus has been higher in more deprived areas and among some ethnic minority communities and people with disabilities. People in crowded housing, on low wages, unstable or frontline work have experienced a greater impact from Covid-19.

There are always going to be differences in health, some are unavoidable, due to people's age or genetics, but many differences in health are avoidable, unjust and unfair – it is these that we are concerned about and that this framework seeks to address.

What does it mean for local people?

Health inequalities across Leicester, Leicestershire and Rutland (LLR) are stark.

A boy born today in our most deprived area could be expected to die up to nearly nine years earlier than a boy born in the least deprived area. Furthermore, people from less affluent areas will be spending a greater proportion of their (often shorter) lives in poor health compared to people from more affluent parts of our area.

What will this framework seek to achieve?

We want local people to be healthier, with everyone having a fair chance to live a long life in good health. This is why we will aim to 'level up' services and funding, rather than take anything away from areas where outcomes are already good.

This framework sets out how local organisations will plan to take action to not only affect the causes of these health inequalities but the 'causes of these causes'.

Health and wellbeing is not just the concern of the NHS. The health and wellbeing of people is an asset to individuals, to communities, and to wider society. Good mental and physical health is a basic precondition for people to take an active role in family, community and work life. The NHS, local authorities and other public bodies all have a part to play. Often, it will involve a number of different organisations working together to improve all the things that can affect someone's health.

Locally, we have set up an integrated care system (ICS) which brings organisations together to ensure better partnership working, and improvements in people's health and care. By listening and responding to local people, we will achieve a fairer and healthier future for us all.

> The health and wellbeing of people is an asset to individuals, to communities, and to wider society.

What does equity look like?

'Health inequalities' is the commonly used term, however we are actually referring to 'health equity and inequities'.

'Equality' means treating everyone the same or providing everyone with the same resource, whereas 'equity' means providing services relative to need.

We can show what this looks like in the illustration below. **Figure 01** shows, on the top line, four people of different sizes all trying to cycle the same size of bicycle. One person in a wheelchair cannot use the bicycle at all. The second line shows each person happily using a bicycle correctly sized or adapted for their needs.

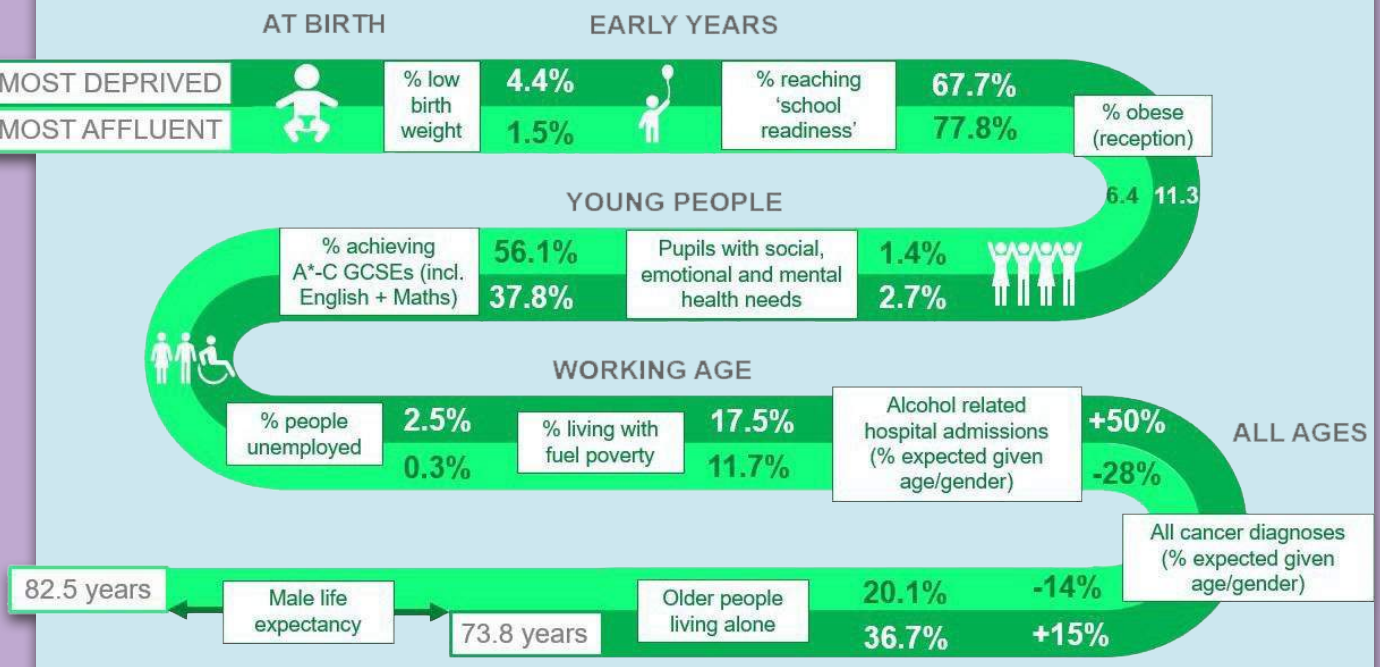
Figure 01 | Representation of equality and equity using adapted bicycle example

Source: Reproduced with authorisation from Robert Wood Johnson Foundation (Better Bike Share, 2017)

Inequalities can be seen as being present from birth, through someone's early years and into later life. At each stage this can result in relatively poorer mental and physical health.

This can be shown in a tale of two babies in **Figure 02** below. While we must recognise that no outcome is set in stone, the story aims to illustrate the different opportunities and difficulties that two babies might encounter throughout their life. The graphic shows two parallel curving lines. One showing outcomes for those from the most deprived areas of LLR and the other showing outcomes for those from the most affluent areas of LLR.

Figure 02 | Difference in health indicators between the most and least deprived local areas of LLR



Source: PHE Fingertips

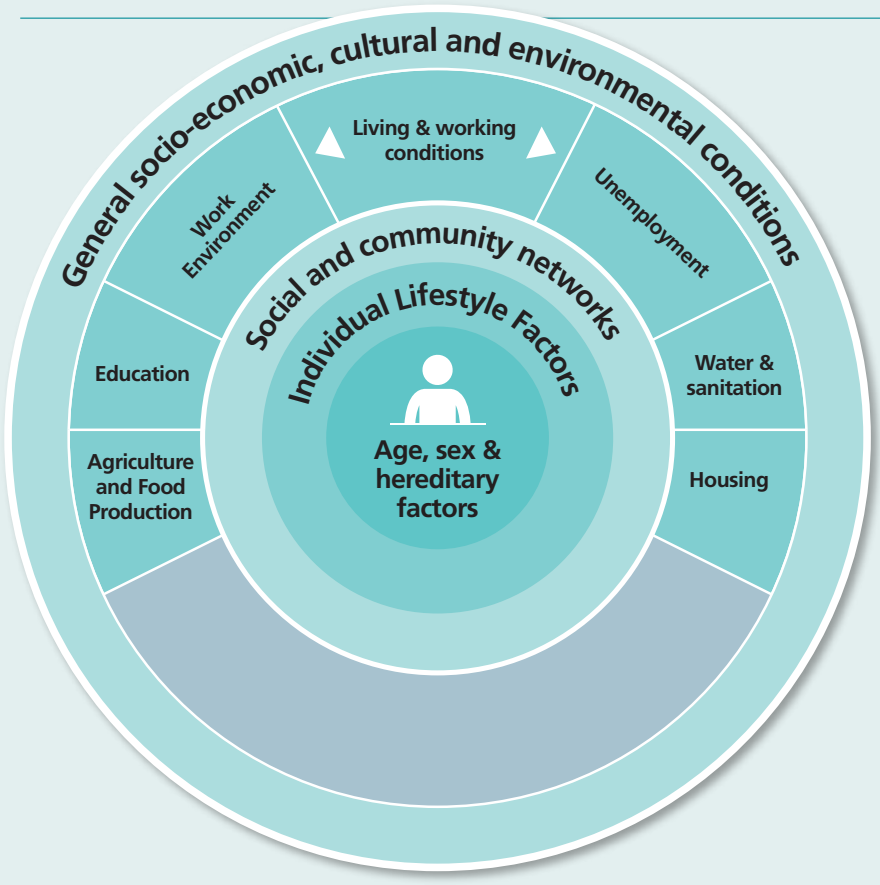
What is 'Health'?

Health has been defined as:
"A state of wellbeing with physical, cultural, psychosocial, economic and spiritual attributes, not simply the absence of illness."

We are using this definition of health in **assessing health inequalities.**

Our work is also based on a **'social model'** of the factors that can influence someone's health. This is shown in **Figure 03** below. It shows that everything but age, sex and hereditary factors can be modified in terms of factors that can influence an individual's health.

Figure 03 | A Social Model of Health



Things like education, housing, transport and clean air are often known as 'wider determinants of health'.

They can also be seen as the 'causes of causes' which we mentioned earlier. It shows the importance of the NHS working with local authorities and other organisations who can influence these factors.

Source: The World Health Organisation

Our Principles
for reducing health inequalities

> Reducing health inequalities is a key factor in all work carried out within the ICS – it is everyone's business.

Our work in this area will be guided by the following principles:

Principle 01

Reducing health inequalities

is a key factor in all work carried out within the ICS – it is everyone's business. Reducing health inequalities and improving health equity should run through all our work, at all levels, as a 'golden thread'. Appropriate training and support will be given to enable people to think and act in ways that reduce health inequity.

Principle 02

We will use data and insight

to better understand local health inequalities and how they affect people. We will draw upon the best evidence to take action to reduce inequalities and to evaluate the impact of our services. This is known as 'population health management'. Where services are failing to reduce inequity, or (by accident) are increasing it, the services will be adjusted or changed completely.

Principle 03

We will prioritise prevention,

helping prevent or lessen the impact of illness. This is important in improving health equity as the burden of disease is borne unfairly by those who are more deprived, marginalised or in a minority. Primary prevention includes a focus on and increased investment in reducing inequalities in lifestyle risk factors (such as smoking, diet, exercise or alcohol consumption), mental wellbeing, housing, income, education, working conditions and the wider environment. In these areas, it is critical that the NHS works effectively with local authority partners.

Principle 04

A focus on gaining a fair balance

between mental and physical health - reducing inequalities in mental health will be prioritised to the same extent as reducing inequalities in physical health.

Principle 05

Local public sector organisations

will seek to reduce health inequalities through offering 'social value'. This approach includes efforts to make the workforce more representative of the local population. We will use mentoring, reverse mentoring and apprenticeships to improve opportunities for under-represented groups, support people from less affluent backgrounds to establish a career in the public sector, and seek to tackle racism and prejudice in society. In addition, we will seek to maximise the value of our collective spending on the local economy.

Principle 06

Investment in services

will be proportionate to the needs of people using those services. This means that although there will be a universal offer of services to all, we will vary the provision of services in response to differences in need within, and between, groups of people. In this way we will look to 'level up' the way that services are offered and outcomes achieved.

Principle 07

We will draw on the strengths of communities and individuals

to reduce health inequality and inequity. Our services will aim to focus on 'what matters to people' rather than focusing on 'what is the matter' with them. We will listen to local people with lived experience to shape local priorities and redesign services. As part of strengthening resilience in communities we will work to improve health literacy – the skills, knowledge and understanding that people have to make use of available information and access local services.

Principle 08

We will ensure that all plans

and policies put forward by the ICS partners take into account issues of health equity. This is particularly important in relation to the wider factors that can affect people's health such as housing, education or employment.

Principle 09

We will take effective action

during the key points of a person's life to help reduce health inequality and inequity. This means a specific focus on giving children the best start in life, prevention of ill health and the promotion of wellbeing and resilience.

Principle 10

The ICS is accountable

for delivering on health inequalities across the local health and care system. We acknowledge that organisations within the ICS also have a statutory duty to reduce health inequalities. The work required to reduce health inequalities will tend to take place at a 'place' (or local neighbourhood) level. These places will need to be responsive to the particular needs of local people.

Principle 11

Actions will be undertaken

at the most appropriate level of the ICS where they can be most effectively owned and delivered. This will tend to be determined by the relevant statutory responsibilities of the partner organisations. Housing, education, and licensing rest with local authorities, for example, while commissioning responsibility for most health services sits with the local NHS clinical commissioning groups and their successors.

Principle 12

There is significant potential

to improve people's health through better and more widespread use of digital technologies. Digital technologies are integral to many of the changes envisaged in the NHS Long Term Plan. However, it will also be important to take steps to prevent digital technologies entrenching or widening health inequalities. This means understanding and addressing the issue of digital exclusion and ensuring that people can still receive face-to-face services where required.

Taking steps to reduce health inequalities

Actions to address health inequalities will need to take place at different levels:

System Level

Across the whole LLR area.

Place Level

Across the area covered by the upper tier local authorities (Leicester City Council, Leicestershire County Council, Rutland County Council) and led by Health and Wellbeing Boards.

Neighbourhood or Locality Level

Smaller (though locally meaningful) populations within the wider upper tier boundaries.

Medium to long term priorities will be determined at place level and are likely to include:

- A **focus on the first 1,001 days of life.** Events and people's health during this period often determine outcomes across the whole of someone's life
- **Improving healthy life expectancy** through early intervention and prevention. This will include actions relating to the other factors that can affect someone's health such as education or job opportunities
- **Using the lived experiences of people** to inform our plans and actions
- **Each organisation having their own executive lead for health inequalities** who will be responsible for driving this agenda forward
- An approach which is **Smart, Measurable, Achievable, Realistic and Timed (SMART).**

Shorter term goals are to:

- **Restore NHS services inclusively** (following the impact of Covid-19)
- **Mitigate** against digital exclusion
- Ensure that **our data is accurate** and **providing the necessary insights**
- **Accelerate preventative programmes** that engage those at greatest risk of poor health (management of long-term conditions, annual health checks for people with learning disabilities/serious mental illness, continuity of maternity care for BME women and those from deprived neighbourhoods)
- **Strengthen leadership and accountability.**

Strategic actions

to reduce health inequalities at the ICS level

All decision makers within the ICS will have expertise, skills, insight and understanding of health inequity and how to reduce it.

Action 01

Places will be expected

to apply the principles, outlined in this framework, to their specific populations, in the most appropriate way, that meets their local needs. This is likely to embrace the various factors that can affect people's health (as shown in figure three).

Action 02

The ICS will make investment decisions

for people across LLR that reflect the various needs of different communities. In this way, actions can be universal, but adjusted and made proportionate to the level of disadvantage. The aim of reducing health inequalities will be a high priority. Specifically, we will develop a new strategic long-term model of primary care (GP practice) funding, distribution and investment. This will 'level up' funding based on population need rather than historical allocation.

Action 03

We will establish a defined resource

to review health inequalities at this strategic level. This will be a virtual partnership between the NHS, local authorities and local universities. An enhanced ability to process and analyse data will support a better understanding of inequity across the area. We will gather and share best practice in effective interventions and provide teaching and training to all levels of staff in undertaking health equity audits. We will facilitate local research. Public health teams will deliver, with partners, the health inequalities support function at a place and neighbourhood level. Specifically, a proposal for the establishment of an LLR health inequality resource will be presented to the system executive.

Action 04

All decision makers

within the ICS will have expertise, skills, insight and understanding of health inequity and how to reduce it. Specifically, health inequity and inequality training will be mandatory for all executive decision makers in each organisation. We will work with local and regional partners to develop appropriate and robust training packages relevant to roles.

Action 05

Partner organisations will work together

to understand the impact of Covid-19 on health inequalities across LLR, to allow effective and equitable recovery after the pandemic. We will be looking to:

- Identify groups and communities, across all ages and across protected characteristics, which have been most affected by the pandemic as a result of pre-existing vulnerabilities and disadvantages
- Undertake proportionate additional work to ensure vaccine uptake is equitable
- Include consideration of the role of the wider determinants of health, such as education, employment, housing and poverty
- Promote equal support for mental and physical health to those groups worst affected by the pandemic and the consequences of lockdown.

Action 06

All partners will work

to improve the completeness and consistency of their data to enable a better understanding of health inequity. This mainly relates to data collection on people with 'protected characteristics' under the Equality Act. Specifically, partner organisations will develop an action plan for having ethnicity, accessibility and communication needs of their population appropriately coded in records. In addition, we will make better use of our data sets in order to identify vulnerable groups and individuals to offer proactive, holistic care through Integrated Neighbourhood Teams.

Action 07

At the ICS level,

we will obtain and use data to help us better understand where we can do more work to reduce health inequity. Each organisation will adopt a standard health equity audit tool and put training plans in place to use this tool, so that each 'place' area can compare their performance against other areas.

Action 08

We will undertake health equity audits

to identify health inequalities between different population groups. These will be carried out at the planning stage when we commission, redesign or evaluate services. Action to reduce health inequity will be taken based on audit findings (at a minimum considering the protected characteristics of the Equality Act 2010).

Action 09

The NHS

and public sector partner organisations within the ICS will seek to reduce health inequalities through seeing what we can do together, especially in the areas of work opportunities, use of buildings and purchasing.

How will we know if this work is succeeding?

If this framework is successful in driving effective action, we expect to see the following outcomes:

- A reduction in health inequities
- An increase in healthy life expectancy
- A reduction in premature mortality
- A workforce that is representative of the local population
- Better use of data

CASE STUDY 01:
Reducing health inequalities – COVID vaccine hesitancy in St Matthews

Our Approach

Our approach to tackling inequalities across LLR is based upon the NHS Race & Health Observatory Covid-19 working group recommendations for communications & engagement:

1. Build trust through community forums
2. Clear, simple and accessible messaging
3. Messages are repeated, consistent and culturally sensitive
4. Engages in proactive social media campaigns
5. Embed delivery within familiar and accessible locations – such as GP practices and community infrastructure
6. Use NHS professionals and other trusted community voices to promote and advocate the programme

What the issue was - i.e. rate prior to intervention

Data from SystmOne via Leicestershire Health Informatics Service includes counts of vaccines administered and population data by age band, sex, ethnic group and geographical area.
By showing vaccination uptake by ethnic group and geographical area, it is possible to see areas of the city with low vaccination uptake for different ethnic communities. Leicester's Somali population had 49% uptake in over 50s at 23/03/21 compared with 78% in the population overall. Over half of the Somali population live in 2 neighbouring areas in the city, St Matthews and St Peters.

Design of intervention in partnership with community

In Reach Pop Up Clinic

- To provide an agile response to the population, we facilitated a vaccination pop up clinic at a local Faith Centre in the City known to the community.

Community Engagement

- Zoom webinars - hosted by a local GP and proactive community leader with support from the Director for Public Health.
- YouTube video curated by a local GP highlighting the vaccination pop up clinic and key details/cascading amongst the local Community via whatsapp.
- Local Radio with BBC Radio Leicester to inform and discuss the vaccination pop up clinic, also interview with the local CCG.
- Communications material sent out to all shops, mosques, schools, and community organisations.
- Information sharing via the COVID helpline, managed by the Women 4 Change Community Organisation who can advocate for the population and signpost queries.
- Information sharing via NHS, LLR CCG websites and social media.

Rate after interventions

537 people attended the pop-up clinics for their vaccination. Overall, 44% of people that attended said that had this not been made available locally then they were not likely to have taken up the vaccine.

Data up to 23/3/21 shows uptake in over 50s Somali population was 49%. Following the In reach intervention with the community and a pop-up vaccination clinic increased vaccination uptake to 60% at 30/03/21.

Data up to 17/08/21 shows currently 78% of over 50s within the Somali population in Leicester have received dose 1 vaccination.

Data up to 23/3/21 in St Matthews & St Peters shows 69%. Data up to 30/3/21 shows an increase to 75%.

Feedback from staff and patients

- Volunteers and vaccinators alike stated they were **"proud to be part of this local initiative"**
- Many volunteers stated they **would like to join the mass vaccination efforts.**
- **The vaccinators felt it had an impact on changing hearts and minds** - individual interactions with the community members enabled them to breakdown a lot of the myths and allay their fears and concerns. Many community members who came to the clinics - partly out of curiosity and others who felt doubtful and came to ask questions - were able to have their vaccines there and then once they were able to have these conversations with the vaccinators.

How we have applied this learning elsewhere

The learning has been applied across various differing settings including Workplace in Reach Clinics. We were asked by Local Authority and Public Health colleagues to contact several large employers within the LLR footprint.

We set up an initial task and finish group with a large organisation where we discussed vaccine hesitancy, the use of the Healthy Conversations Toolkit, support for managers in using this toolkit and also asked for the demographics of the workforce this data showed us that 62% of the workforce were from ethnic minorities, including individuals from Eastern European communities and African communities.

As this large organisation uses a 24-hour shift pattern system. It was agreed that the best time to run the clinics was across the shift change times this gave all employees the opportunity to access the vaccination clinic.

A range of Comms was used for this clinic including internal comms through staff awareness sessions the Healthy Conversations toolkit was also used in these sessions.
The organisation also arranged for their staff to book into the clinics via an internal appointment system this was provided to us allowing us to book individuals into the clinic via the Swift Q system. Use of Swift Q ensured that a second dose trigger was set.

151 people were vaccinated over the two days of the clinic with 32% of those that attended advising that they would not have taken up the vaccine had it not been made available to them on site.

CASE STUDY 02:
Health inequalities - Introduction of new technology to improve care in diabetes

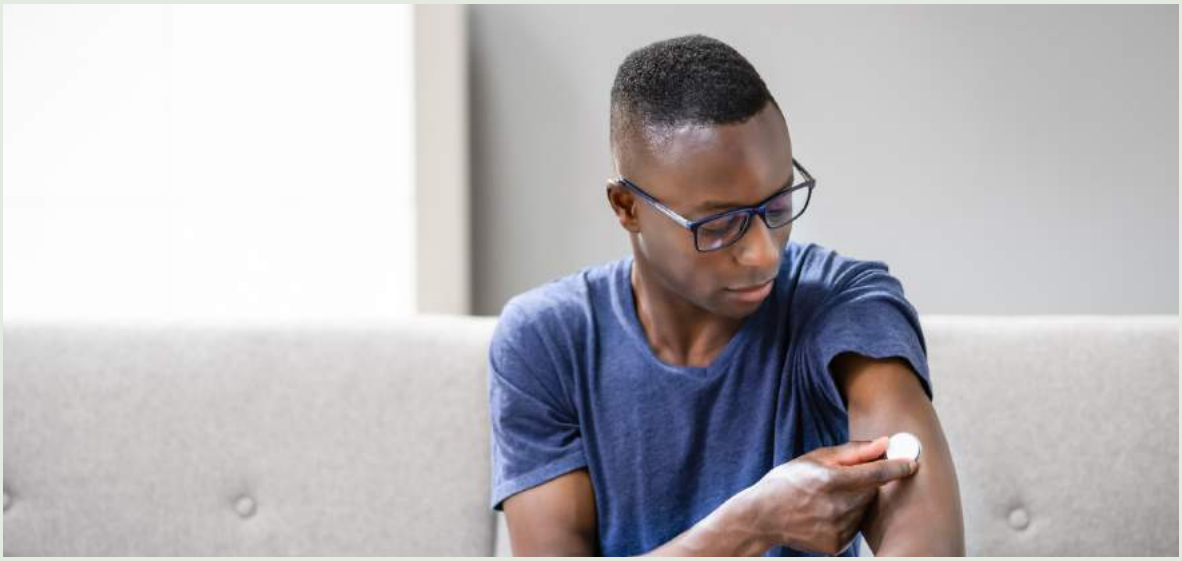
Case study by Professor Azhar Farooqi

Diabetes is one of the most common chronic disorders affecting nearly five million people in the UK. It is a significantly more common condition in people of low socio-economic status and in BME groups. Diabetes is a costly condition, not only in financial terms (more than 10% of the NHS budget), but also in terms of mortality and morbidity. Sufferers lose several years of life and the condition is the biggest cause of acquired blindness, renal failure and amputations.

The evidence that good control of blood glucose improves outcomes for patients and reduces NHS costs is overwhelming. Freestyle Libre (FSL) is a new technology, known as flash glucose monitoring, which allows patients to monitor in real time their blood glucose using a skin patch and a small handheld sensor. It avoids multiple lancet jabs and time-consuming use of glucose strips and machines.

The technology is approved by NICE for patients with type 1 diabetes who normally would test multiple times a day and is likely soon to be extended to patients with type 2 diabetes on insulin and other groups deemed at high risk of hypoglycaemia.

It costs about £500 per patient per year. The real-world impact of this technology has shown significant improvements in blood glucose levels, reduced hospital admissions and paramedic call-outs, less severe hypoglycaemia and improved overall blood glucose control.



How was this technology rolled out?

The prescribing of FSL has been via secondary (hospital) care to eligible patients who have an education session on how to use it. As with all new technologies and treatments, patients learn about the availability of this via media and friends and those most empowered tend to know about it first. The patient benefit is not only in improved diabetes control but also the avoidance of painful finger pricks. It was entirely predictable that the most articulate, informed and persuasive patients would be in a position to demand this technology and persuade their health care professional they are eligible and would benefit. The criteria of existing multiple testing and the education package also favours English speakers, literate patients and those already empowered in looking after their condition - all of which make it less likely that people form deprived backgrounds would either push for this technology or be prioritised for it.

What has been the health inequality?

Type 1 patients in the most deprived area of Leicester, Leicestershire and Rutland had a 29% chance of receiving this technology, compared to 39% in the least deprived area. Only 14% of type 1 patients received FSL in GP practices with the most BME people in their population, whereas this figure was 38% for the practices with fewest BME people.

Why has this happened?

This data was produced by a pharma company, who in effect, 'whistle blew' the problem. The local NHS service provider had no idea of this health inequality. There was no consideration of health inequalities in the introduction of this technology, nor monitoring of uptake by deprivation or socio-economic status. Despite the data, little has changed on the provision of this technology to date. Future provision requires a robust health equity audit to fully understand the potential impact on health inequalities.

Lessons to be learnt

It is important that a full equity impact assessment is carried out when all new technology (or therapies) are introduced. It is important that monitoring of uptake by socio-economic status and BME status, as well as other characteristics, is undertaken, and data reported and shared. It is important to consider if specialist-only provision will worsen health inequalities. Most type 1 patients (60%) and the vast majority of type 2 diabetics (95%) receive care only in general practice. It is likely that appropriate primary care provision will improve wider access to this intervention. Language is likely to be a significant barrier in addressing health inequalities, in particular, when a mandatory education package is only available in English. Specific thought, investment and planning needs to take place to reverse this inequality of provision of FSL.

Where can I find out more?

Public health experts routinely put together assessments of health and health inequalities for local areas. These are known as Joint Strategic Needs Assessments and are available for:

- **Leicester City**
- **Leicestershire**
- **Rutland**

Produced by

Leicester, Leicestershire and Rutland Integrated Care System

Concept & design by Fresh* Communications t: 0116 254 1351 e: alf@freshcom.co.uk