LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 21 SEPTEMBER 2023

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.

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 Sarah Russell, Deputy City Mayor, Social Care, Health and Community Safety (Chair)

Councillor Adam Clarke, Deputy City Mayor, Climate, Economy and Culture

Councillor Elly Cutkelvin, Deputy City Mayor, Housing and Neighbourhoods

Councillor Vi Dempster, Assistant City Mayor, Education, Libraries and Community Centres

1Vacancy

City Council Officers:

Martin Samuels, Strategic Director of Social Care and Education

Rob Howard, Director Public Health

Dr Katherine Packham, Public Health Consultant

1 Vacancy

NHS Representatives:

Jean Knight, Deputy Chief Executive, Leicestershire Partnership NHS Trust

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

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

Dr Avi Prasad, Place Board Clinical Lead, Integrated Care Board

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

Rachna Vyas, Chief Operating Officer, Leicester, Leicestershire and Rutland Integrated Care Board

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

Healthwatch / Other Representatives:

Benjamin Bee, Area Manager Community Risk, 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

Kevin Routledge, Strategic Sports Alliance Group

Sue Tilley, Head of Leicester, Leicestershire Enterprise Partnership

Barney Thorne, Mental Health Manager, Local Policing Directorate, Leicestershire Police

1 vacancy

<u>STANDING INVITEES</u>: (Non-Voting Board Members)

Cathy Ellis – Chair of Leicestershire Partnership NHS Trust

Professor Andrew Fry – College Director of Research, Leicester University

Susannah Ashton, Divisional Manager for Leicester, Leicestershire and Rutland, East Midlands Ambulance Service

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

The Minutes of the previous meeting of the Board held on 29 June 2023 are attached and the Board is asked to confirm them as a correct record.

4. CHAIR'S ANNOUNCEMENTS

5. LEICESTER JOINT HEALTH, CARE AND WELLBEING STRATEGY DELIVERY PLAN QUARTERLY UPDATE — **Appendix B (Pages 11 - 22)**

Dr Katherine Packham (Consultant in Public Health, Leicester City Council) will present a highlight report summarising key progress against actions to address the six priorities selected for initial focus outlined within the Joint Health, Care and Wellbeing Strategy, outlining proposed next steps, and highlighting any significant risks to the Board.

This update will cover a six-month period from February to July 2023.

6. CURE EVALUATION — **Appendix C (Pages 23 - 34)**

Jo Atkinson (Consultant in Public Health, Leicester City Council) and Andrea Thorne (Public Health Project Manager, Leicester City Council) will present a report on the evaluation of the CURE programme, which is a tobacco dependency treatment service within acute, mental health and maternity hospital settings, since it's implementation.

7. MEETING THE NEEDS OF COMPLEX PEOPLE — **Appendix D (Pages 35 - 42)**

Chris Burgin (Director of Housing, Leicester City Council) will present an update on the positive progress which has been made towards addressing the significant health and service challenges which are faced by complex tenants, and the development of a cross-agency working group, since bringing this issue to the Health and Wellbeing Board in January 2023.

8. HEALTHWATCH ANNUAL REPORT

Appendix E
(Pages 43 - 60)

Kevin Allen-Khimani (Head of Operations and Services, Voluntary Action Leicester) will present an overview of the scope and remit of Healthwatch Leicester, which will include achievements over the last financial year and an outline of the priorities for the current year under the new contract with Voluntary Action LeicesterShire (VAL).

9. BETTER CARE FUND

Appendix F
(Pages 61 - 63)

Board members are asked to note that the numbers in tab 4 (Capacity and Demand) are amended from the version published in the Health and Wellbeing Board agenda for June 2023.

10. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

11. DATES OF FUTURE MEETINGS

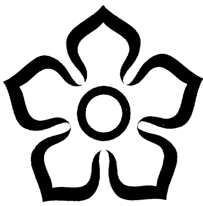
To note that meetings have been arranged for the following dates in 2023/2024 which were submitted to the Annual Council in May 2023. Please add these dates to your diaries. Diary appointments will be sent to Board Members.

Thursday 23 November 2023 – 9.30am
Thursday 18 January 2024 – 9.30am
Thursday 22 February 2024 – 9.30am
Thursday 18 April 2024 – 9.30am

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.

12. ANY OTHER URGENT BUSINESS

APPENDIX A



Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 29 JUNE 2023 at 9:30 am

Present:

Councillor Russell (Chair)	Deputy City Mayor, Social Care, Health, and Community Safety
Councillor Clarke	Deputy City Mayor, Climate, Economy, and Culture
Caroline Gregory	Interim Chief Finance Officer, Leicester, Leicestershire, and Rutland integrated Care Board
Rob Howard	Public Health Consultant, Leicester City Council
Jean Knight	Deputy Chief Executive, Leicestershire Partnership NHS Trust
Harsha Kotecha	Chair, Healthwatch Advisory Board, Leicester and Leicestershire
Kevin Lilies	Chief Executive, Voluntary Action Leicester
Rani Mahal	Deputy Police and Crime Commissioner, Leicester, Leicestershire, and Rutland
Richard Mitchell	Chief Executive, University Partnership NHS Trust
Dr Avi Prassad	Clinical Place Leader, Leicester, Leicestershire, and Rutland Integrated Care Board
Kevin Routledge	Strategic Sports Alliance Group
Martin Samuels	Strategic Director of Social Care and Education, Leicester City Council
David Sissling	Independent Chair, Leicester, Leicestershire, and Rutland Integrated Care Board
Sue Tilly	Head of the Leicester and Leicestershire Enterprise Partnership
Barney Thorne	Mental Health Partnership Manager, Leicestershire Police .

Standing Invitees

Cathy Ellis – Chair of Leicestershire Partnership NHS Trust.

In Attendance

Jacob Mann – Democratic Services, Leicester City Council.

* * * * * * * *

1. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:

- Councillor Cutkelvin - Deputy City Mayor
- Councillor Dempster - Assistant City Mayor
- Andy Williams - Chief Executive, LLR Integrated Care Board
- Rachna Vyas - Chief Operating Officer, LLR Integrated Care Board
- Sarah Prema – Chief Strategy Officer, LLR Integrated Care Board
- Oliver Newbould – Director of Strategic Transformation, NHS England and NHS Improvement
- Susannah Ashton – Divisional Manager for LLR, East Midlands Ambulance NHS Trust
- John MacDonald – Chair of University Hospitals of Leicester NHS Trust

2. 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.

3. MEMBERSHIP OF THE BOARD

The Membership of the Board for 2023/24 was noted.

4. TERMS OF REFERENCE

The Terms of Reference were noted.

5. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 16 March 2023 be confirmed as a correct record.

6. LEICESTER CHILDREN'S HEALTH AND WELLBEING SURVEY 2021/22

Gurjeet Rajania (Public Health Intelligence Analyst, Leicester City Council),

gave a presentation on the key findings of the recent Children and Young People's Health and Wellbeing Survey, it was noted that:

- The survey was completed in the academic year 2021/22, this followed up from a previous survey in 2016/17. The survey was completed by a national organisation (School Health Education Unit) specialising in surveys of children and young people.
- This was a sample survey of children Leicester City as schools aged 10-15. A fair spread of primary, secondary, and special schools across the city were represented in the survey and a quarter of the eligible target group participated in the survey. Each participating school got its own bespoke report.
- Around 2 in 5 children reported skipping at least 1 meal the day before, with the most common skipped meal being breakfast. 1 in 5 reported having 5 fruit and veg portions a day.
- Around 1 in 5 reported worrying about having enough food to eat.
- Around a third of participants reported having read a book for pleasure.
- 1 in 5 reported having some kind of caring responsibility after school, a significant increase from pre-pandemic.
- 39% reported going to bed later than recommended, it was found that this group were significantly less likely to have breakfast.
- 73% reported being happy in their local area, 95% reported feeling safe in their local area.
- 17% reported having tried alcohol at some point, and 9% reported having tried drugs at some point. Those who had parents or carers who smoked were much more likely to have tried smoking themselves.
- The most common worry participants reported having was around school work. Those with caring responsibilities were found to have higher rates of worrying about most issues listed.
- Those with no adult confidant reported being significantly worse at dealing emotionally with things going wrong.
- Those with SEN were found to be in a good mood significantly less of the time.
- 1 in 10 participants were found to have poor mental health based on the Stirling Children's Wellbeing Scale. This group was far more likely to not have all 3 meals in a day, not have a trusted adult, and have worse sleep habits.
- The aim of the survey was to use the findings to inform as wide range of services as possible across various relevant bodies.

Members of the Board commented that:

- While there was concerning information in the findings related to issues like mental health and trusted adults, there was cause to be optimistic as the findings would help to target intervention.
- With regard to allowing children and young people to build relationships with trusted adults. It was suggested that there should be more stability in terms of the adults that were around in those settings and that this should be considered when staff rotas were planned.

- A more easily publicly accessible version of the findings should be available. The Chair asked Officers to consider this.
- The drop in the level of sports take up from 14 onwards was concerning.
- The concerns about challenges in the west of the city were felt across services.
- There was concern that despite good intentions, young people could be overexposed to mental health issues through awareness work which could make it worse. It was suggested that more nuance was required in conversations around mental health with young people.
- It was important when considering implementing changes based on these findings that a top-down approach was avoided, and that work should be undertaken to produce organic change.

In response to questions from Members of the Board it was noted that:

- The caring responsibility question in this survey covered broader caring responsibilities such as babysitting. School census data showed a much smaller number had formal caring responsibilities. Members of the Board stated that it was positive that those wider responsibilities were captured in this survey.
- An example of actions that arose from the previous survey in 2016/17 was the Holiday Hunger Programme which arose from concerns about food sufficiency from the survey findings. It was hoped that this set of data would be circulated much wider across various organisations to lead to system-wide change.

RESOLVED:

1. That the Board thanks Officers for the presentation and asks them to take Members comments into account.
2. That the Board requests that Officers consider ways to make the data from the survey more available to the public.
3. That the Board requests that Officers from all services and partners consider the findings of the survey and how to adjust services accordingly.

7. LLR CHILD DEATH OVERVIEW PANEL ANNUAL REPORT FOR 2021-2022

Rob Howard (Public Health Consultant, Leicester City Council), and Dr Suzi Armitage (LLR Designated Doctor for Child Deaths), gave a presentation on the annual report for 2021/22 for the LLR Child Death Overview Panel (CDOP). It was noted that:

- CDOP was a statutory duty to review the deaths of all children in LLR.
- CDOP produced an annual report, a new report would be released before the end of the calendar year.
- Death notifications were more closely aligned with the actual date of death. The reviews typically took place months and sometimes years later after a long process of other investigations for example Coroner's,

Serious Incident, and Police investigations.

- The aim of the review was to consider which factors contributed to the vulnerability or death of the child and which were modifiable by national or local means.
- There had been a significant increase in the number of notifications in 2021/22 compared to previous years. This could have been due to delayed deaths from those in lockdown who weren't exposed to infections they were vulnerable to until after. A small increase had also come from now recording deaths in all those who showed signs of life in any the gestation period.
- Infant mortality in Leicester was higher than in the rest of LLR and England. Infant mortality was seen as a strong general indicator of the health of the community and was linked strongly to poverty.
- Due to the time to complete reviews, some reviews included in this report were from as far back as 2017/18. In 2021/22 71 cases had been reviewed.
- Underlying causes of death were broadly very similar to the national picture, with the largest category being neonatal events.
- The majority of child deaths were within the first year of life.
- When the narrative of a death was being considered, factors that may have contributed to the death were considered and those which were potentially modifiable were determined. Modifiable factors had been identified om 37% of cases. There was found to be a clear link between risk of death and deprivation across almost all categories.
- It had been found that suicide cases were not correlated to any demographic group, 62% has suffered a major personal loss, over a third had never been in contact with mental health services, 16% had a confirmed neurodevelopmental condition, and almost a quarter had experienced bullying. Suicide deaths were reviewed every 2 years.
- Alongside CDOP there was another process for reviewing deaths of those over 4 years old with learning disabilities (LEDER). Of 16 of these cases modifiable factors had been found in 3. The key learning area from this work was that communication between different organisations and processes was key.
- A function of CDOP was to collate the learning processes from each body for each death together. Learning had been identified across al categories.
- Key learning points were on the need for more integrated IT systems, need for early recognition of vulnerability, and better safer sleep conversations.
- Recommendations from the report included a digital solutions to improve communication, a refreshed strategy on infant mortality, and working with stakeholders to produce a thematic report on suicide and self-harm.

Members of the Board commented that it would be helpful to be able to determine how the work ongoing in this area was having an impact on data.

In response to a question from the Chair, it was noted that the messages from

this work on topics such as safer sleep had not changed in 7 years of work, however increased evidence and understanding had led to a better understanding of vulnerability and where to target conversations. Working practices had been proving throughout the period of using these factors. It was also noted that work on smoking cessation was available to partner organisations.

RESOLVED:

That the Board thanks Officers for the report.

8. 0-19 HEALTHY CHILD PROGRAMME

Claire Mills (Public Health Lead Commissioner, Leicester City Council) and Alex Yeomanson (Family Services Manager for School Nursing, LPT) gave a presentation on the work the 0-19 Healthy Child Programme is delivering to address children's health and wellbeing in the city. It was noted that:

- There was a small team in Leicester of Public Health Nurses and other staff who delivered a clinical service within school settings.
- The team was split into 2 sections, 1 of which focused of public health and the other which focused on safeguarding. This was because historically Safeguarding work took priority over public health work.
- The service was open for all children and young people in Leicester but was a targeted service with a public health overview.
- A school agreement laid out to the schools what services could and could not be provided and how to refer.
- The service also worked with schools to determine if workshops on particular subjects were needed.
- Another area of work was the statutory National Childhood Measurement Programme which was focused on recording the height and weight of those in reception and year 6.
- A referral to school nursing could be made from any agency, or by a parent or the young person themselves.
- Staff had been trained on how to capture the voice of the child appropriately based on national guidance.
- Additional support was needed in 15% of referrals. When it was found that support was needed then who was best to deliver that was considered. A scaling tool was used to monitor progress for those with emotional health needs.
- Chat Health was a free and confidential text service for parents and for teens. The digital team had developed 3 websites for different age groups which contained local information and available support.
- Safeguarding nurses needed parental permission to do a health assessment which would be fed back into the safeguarding process. These disclosures could lead to changes in safeguarding outcomes.

Members of the Board commented that:

- Access into other agencies including CAHMS was very positive.
- With regard to previous concerns around the need for those who could

be trusted adults. School Nurses were a good example of those who were in a position to be a trusted adult. It was noted that there was increasing uptake of the drop-in nursing service.

RESOLVED:

That the Board thanks Officers for the presentation and asks that the role of School Nurses as a trusted adult be considered.

9. MATERNAL MORTALITY IN ETHNIC MINORITY GROUPS

Rob Howard (Public Health Consultant, Leicester City Council) gave an update on work taking place to address health inequalities experience by Black and Asian women in terms of access to, and experience of maternity services, and the significant differences in maternal mortality between white British women and women from Black Asian and Minority ethnic backgrounds. It was noted that:

- A task and finish group had been established in October 2022 looking at this area after data had shown that Black women were 3.7 times more likely to die in pregnancy and childbirth, and Asian women 1.8 times more likely than White British women. The group had met bi-weekly and had senior representation from UHL, ICB, LCC and LPT.
- Risks for those in deprived communities were also considered.
- National data and research had been considered, including research into attitudes and assumptions from health professionals.
- Local data reflected the national picture.
- A significant maternal equity action plan was ongoing.
- A large event had been held last week bringing together the national picture and the local picture alongside hearing lived experience. A separate event would be held specifically focusing on hearing from those communities most affected.
- Progress was ongoing to establish a framework of all the different issues to consider.

In response to a question from the Member of the Board, it was noted that international data comparisons had not yet been considered. It was suggested that international data could reveal the larger picture to find accurate conclusions.

Members of the Board commented that disparities had been found in every single service examined however the nature of the disparities was often different.

The Chair noted that it was positive that women were more likely to talk in detail about their experiences in this area than other medical topics, giving much more qualitative data.

RESOLVED:

That the Board thanks Officers for the update and requests further updates on this work to later meetings.

In response to a question from the Member of the Board, it was noted that international data comparisons had not yet been considered. It was suggested that international data could reveal the larger picture to find accurate conclusions.

Members of the Board commented that disparities had been found in every single service examined however the nature of the disparities was often different.

The Chair noted that it was positive that women were more likely to talk in detail about their experiences in this area than other medical topics, giving much more qualitative data.

RESOLVED:

That the Board thanks Officers for the update and requests further updates on this work to later meetings.

10. COLORECTAL CANCER 1 YEAR SURVIVAL RATES

Julia Emery (Consultant in Public Health, NHS England) and Dr Pawan Randev (Cancer Lead, LLR ICB) gave a presentation on a programme of work which had taken place to address the poor one-year survival rate for colorectal cancer which was experienced in Leicester, and to highlight the importance of retaining focus on this following a period of 12 months intensive work across the system to address the issue. It was noted that:

- Leicester had the lowest 1-year survival rate for colorectal cancer in the country. With the situation getting worse over a 20-year period. However, the number of incidence of colorectal cancer and the death rate had been in decline for decades.
- It was thought that the decrease in incidence was due to the change of demographics in the city, with colorectal cancer being much rarer in the South Asian community.
- It was thought that the cohort of older white men form more deprived areas of the city were the ones experiencing poorer outcomes. Therefore, the priority was bringing in earlier stage detection and diagnosis for this group.
- A detailed audit of all patients over the last 5 years over LLR was ongoing to establish a complete picture of demographics and nature of diagnosis.
- There were now improved tools for detection including superior Stoll testing which was now being rolled out in Leicester. A programme of clinical education was ongoing to support this.
- A novel risk stratification tool had been brought in to prioritise those patients at higher risk.
- At the community level, a local cancer awareness campaign was being considered to discover the populations understanding of the symptoms and attitudes towards screenings. As part of similar work, a targeted video had been created for those who had not taken up the screening offer.

- The next step was to explore data more in-depth and establish the right cohort to target.

Members of the Board commented that:

- It was positive to see recognition that something was going on in the city that required targeted work. Targeted messaging work directly to communities was praised.
- This group was hard to reach so it needed to be considered where to target initiatives to educate this group on the need for screenings. Breaking down the stigma around the topic was a major area of focus.

In response to questions from Members of the Board it was noted that the screening levels of those receiving ASC services was being considered as part of the primary care audit. Education packages for social care recipients was part of longer-term work.

RESOLVED:

That the Board notes the update.

11. LEICESTER'S JOINT HEALTH, CARE AND WELLBEING STRATEGY DELIVERY PLAN QUARTERLY UPDATE

The Chair noted that due to time constraints there was not time to appropriately consider this update and therefore the update would be deferred to another meeting.

RESOLVED:

That the update be deferred to a future meeting of the Board.

12. BETTER CARE FUND END OF YEAR APPROVAL

The Chair asked the Board to provide formal approval of the Better Care Fund end of year submission to NHS England.

Martin Samuels (Strategic Director of Social Care and Education) presented an update on the Better Care Fund. It was noted that for a number of years the Better Care Fund had been seeking to bring ASC and NHS services closer together through an integrated approach. The national processes for the Fund meant that each year the local plan was officially signed off by NHS England only towards the end of the year to which it referred. However, this year planning had included next year as well as this year meaning this was a 2-year fund being signed off. The plan for 23/24-24/25 would be submitted shortly and go through a rigorous assurance process. The Board was therefore asked to formally approve the submission of the 2-year plan.

RESOLVED:

That the Board approves the Better Care Fund end of year submission to NHS England and the submission of the plan for 23/24-24/25.

13. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions from members of the public had been received.

14. DATES OF FUTURE MEETINGS

The Board noted that future meetings of the Board would be held on the following dates:-

Thursday 21 September 2023 – 9.30 am
Thursday 23 November 2023 – 9.30am
Thursday 18 January 2024 – 9 30 am
Thursday 22 February 2024 – 9.30am
Thursday 18 April 20234– 9.30 am

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

15. ANY OTHER URGENT BUSINESS

Dr A Farooqi (GP, East Leicester Medical Practice) gave an update on the present situation at East Leicester Medical Practice. It was noted that following torrential downpours the previous week, serious flooding had occurred in the Practice which severely damaged the facilities, including making electrics unusable and destroying paper records. The building was not unusable and would likely be out of action for several months. This meant that thousands of patients were now without GP services. Work was ongoing with the ICB to get services up and running again and it was hoped that next week phones would be up and running. It was felt that the facility had been badly maintained and not fit for purpose and that this would present an opportunity to bring the facility up to date.

The Chair stated that she would be interested to see the contingency plans for GPs and the wider learning form this incident.

There being no other business the meeting closed at 12.02pm.

APPENDIX B

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Joint Health, Care and Wellbeing Delivery Plan progress update – February – July 2023
Presented to the Health and Wellbeing Board by:	Dr Katherine Packham
Author:	Amy Endacott

EXECUTIVE SUMMARY:

Leicester's Joint Health, Care and Wellbeing strategy (JHCWS) outlines the health and wellbeing needs of Leicester's population, and highlights 19 priorities for action. These are categorised into 'do,' 'sponsor,' and 'watch' in recognition that equal resource and focus cannot be given to all 19 priorities simultaneously. This update reflects progress highlights, next steps, and key risks against the six 'do' priorities which were selected, through a public consultation, for initial focus, and for which a full action plan has been developed to run from 2023-2025. The period covered by this update is February – July (inclusive) 2023.

The action plan is a collaborative plan which encompasses activity across the Local Authority, NHS, Integrated Care Board, and the Voluntary and Community Enterprise Sector (VCSE).

The following pages provide a summary of each of the five 'Healthy' theme areas, and a summary of communications and engagement activity to support the delivery of individual actions.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Review the detail of the report.
- Provide feedback on any topics or matters arising from updates where more detailed discussions would facilitate delivery.
- Provide feedback on opportunities for strategic leadership to enhance progress against individual priority areas.
- Provide any feedback on mitigation of risks and issues that are included within the report.

Healthy Start

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

Progress to date:

- An anti-poverty strategy and framework has been developed through a co-design approach, engaging with more than 500 people. Leicester's approach has been recognised as good practice by Greater Manchester Poverty Action[1].
- Anti-poverty community grants have been awarded to a number of organisations to develop and run projects which mitigate against the impacts of poverty for residents across Leicester with currently 13 organisations in receipt of just over £102k supporting projects across the themes of food, clothing, digital exclusion, welfare support and community spaces.
- The Adult Learning/Public Health collaboration to extend the 'Let's Get Resourceful' programme has been agreed and is being worked up at present for launch in September. The previous programme provided 54 slow cookers to participants that attended the 2-day course and positive feedback was received by those attending.
- The offer of vouchers to carpet the living room in new Leicester City Council (LCC) lets for those eligible for Community Support Grants has been well-received, with around £100k of vouchers distributed.
- In collaboration with the Public Health fuel poverty programme with National Energy Action (NEA), funding for 8 further places on the 3-day Energy Awareness course to train advisors within community groups has been agreed by the anti-poverty board.
- Developments have been made against Maternity and Neonates Equity and Quality co-produced actions plans, which focus on areas of deprivation and vulnerable/complex groups. Preparatory work has taken place to support the relaunch of a Peer Support Programme to ensure women accessing perinatal mental health support have access to someone who can act as an advocate for them.
- A task and finish group meet monthly to address the impacts on service accessibility and experience of women from the Black and Asian ethnic minority (BAME) community. This has included reviewing national and local data, carrying out focus groups with key community groups, and planning events to increase engagement and awareness within the community. Learning from these activities has helped to shape further discussions and events to address the issue.
- An event aimed at raising awareness of the significant disparities in equity related to maternity care experienced by BAME women, and other factors specific to the city population, was well-attended and brought together partners from across the system to facilitate joined up working. This focussed on multiple determinants of health, co-production with patients, eliminating unconscious bias, mitigating against digital exclusion, and making health equity a strategic priority.
- Additional work to address this priority is being supported by the Public Health team, and colleagues are working to embed this activity into the delivery action plan. Public Health are working with:
  [1] Baby Basics and Healthy Together (LPT) to deliver essential equipment such as cots, nappies and clothing to families who do not have them.

[1] GMPA-Local-anti-poverty-strategies-report-2023-final.pdf (gmpovertyaction.org)

[2] Leicester Mammas and the ICB to deliver breastfeeding advice and support, and vouchers for formula milk to families with children under 12 months who are experiencing food insecurity.

Next steps:

- A peer supporter programme for perinatal mental health is being developed and will be progressed through a training offer and promotions of the course to women with lived experience.
- A second awareness-raising/engagement event is being planned for Autumn/Winter 2023.

Risks:
None raised.

Healthy Places

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

Progress to date:

- Work to develop Integrated Neighbourhood Teams (INTs) to work in a more coordinated way with partners at local level through enabling the evolution of Primary Care Networks (PCNs) is progressing. Five key priorities for this workstream have been identified (bowel cancer screening, women's health, obesity, Integrated Chronic Kidney Disease (ICKD) and hypertension). PCN's have recruited 202 Additional Roles and Responsibilities Scheme (ARRS) staff across Leicester, Leicestershire and Rutland (as of October 2022). The Integrated Care Board (ICB) continue to develop and optimise the use of social prescribing and other ARRS workforce across Leicester City. Training events and network sessions have been held monthly for social prescribers to share learning, with active signposting facilitated by the training team. PCNs are required to meet the Investment and Impact fund (IIF) indicator focussed on social prescribing referrals.
- Training has been delivered via Reaching People to volunteers around the NHS app, online GP services and a range of other digital skills, to enable them to support patients in medical practices. This aims to empower citizens to use technology where appropriate by enabling people to improve their literacy of local technology. Reaching People have also developed a range of communications materials to support this project. This includes hyperlocal support for the Accident and Emergency department (A&E) through the ICBs Voluntary, Community and Social Enterprise (VCSE) Alliance funding individual organisations to support signposting to appropriate or alternative services.
- Delivery of the Enhanced Access (EA) service in Primary Care – dashboard data is indicating an improvement in learning disability (LD) health checks compared to previous months, as well as achievement of increased recording of ethnicity data by PCNs. Monthly EA returns indicate that PCNS are offering appointments/hours above their contracted hours.
- As part of a strategic review of urgent care services (UCS's) for patients with minor illness and injuries, streaming off-site from the emergency department front desk to 4 urgent treatment centres and 10 urgent care centres and EA hubs has been agreed for 2023/24.

Next steps:

- Clinical directors will continue to meet monthly to progress city INT working delivering on the identified priorities. Workshops designed and tailored to address priorities and links with INTs will be held to support progress. Work will take place to develop a dashboard to report on individual practice support for engagement.
- Development of the social prescribers network and active signposting training will take place to align with the direction of travel for 2023/24, focussing on alleviating access pressures and increased INT working.
- There will be ongoing monitoring of EA and a review of the benefits, with feedback from patients and PCNS. Proposals for improvement will be the subject of a public engagement consultation, currently planned for summer 2023.
- Emergency department and urgent treatment centre off-site streaming will continue to be monitored.

- Communications and engagement support will be provided to practices, including reviewing GP website content, actioning Google reviews, developing targeted text messages and developing relationships with the VCSE..

Risks:
None raised.

Healthy Minds

Priority 1: We will improve access for children & young people to Mental Health & emotional wellbeing services.
Priority 2: We will improve access to primary & neighbourhood level Mental Health services for adults.

Progress to date:

Children and young people (CYP)

- A pathway review of CYP mental health and Emotional Health and Wellbeing Services took place at the end of 2022, leading to contracts being extended for two years with possible 24-month extensions for four of the high-performing services. An up-to-date CYP directory of services is in development to support promotion of services. A CYP online self-referral to the Triage and Navigation service went live on May 23rd, removing the requirement to see a GP first, with the aim of improving access and removing barriers to services. Roll-out of Mental Health Support Teams (MHSTs) in schools has continued, with Wave 9 recruitment underway, which will lead to an additional three teams in the City in areas of deprivation to help with improved access and focus on addressing inequality.
- Data has been used to identify areas within the City where health inequalities and deprivation exist, and where there are low referrals, with a view to better understanding whether there are barriers to access and how these can be addressed.
- Additional work to address this priority is being supported by the Public Health team, and colleagues are working to embed this activity into the delivery action plan. Public Health are working with:
  [1] Children's Services to deliver:
  - Restorative approaches to promote anti-bullying initiatives in Leicester schools
  - Mental health mentorship in Further Education colleges
  - Relationship education

  [2] Neighbourhood Services to deliver:
  - Targeted after school support to help children do their homework, promote inclusion and a warm space to go after school in the winter months.

  [3]ADHD Solutions to:
  - Promote best practice in ADHD in local schools.
  - Increase knowledge of ADHA in local minority ethnic communities
  - Improve support for siblings of people with ADHD
  - Support people waiting for a diagnosis of ADHD

  [4] Harmless and the ICB to:
  - Promote support for people who self-harm in Leicester

Adults

- 13 city organisations have been awarded grants for Getting Help in Neighbourhoods in round 2 of the grant awards scheme, and all schemes have now been mobilised. Five additional crisis cafes have been awarded during round 2, bringing the total to 11. Five out of nine Primary Care Networks (PCNs) have a Mental Health Practitioner and an additional Peer Support Worker working alongside them. Three Mental Health Leads are in place in the City, facilitating new ways of working, organising local mental health networks and facilitating improvement projects in line with the LCC strategy and local needs. The newly rebranded NHS Talking Therapies Service (previously known as Improving

Access to Psychological Therapies (IAPT)), provided by VITA MIND, have provided promotional information to pharmacies, and communications activity is taking place via the local lead.

- Recruitment of all Additional Roles and Reimbursement Scheme (ARRS) has been completed for 23/24.
- 800 staff have completed Decider Skills training, supporting activity to expand a wider psychological offer to neighbourhoods.
- A draft of the refreshed Dementia Strategy has been completed and has been shared with relevant governance boards. A public consultation on the strategy went live in July for a period of ten weeks. A Voluntary and Community Sector (VCS) dementia forum hosted by Leicester City Council has been well attended and has offered opportunities to strengthen relationships between the VCS and other relevant services to better support people experiencing dementia.
- Additional work to address this priority is being supported by the Public Health team, and colleagues are working to embed this activity into the delivery action plan. Public Health are working with:

[1] Neighbourhood services to deliver:

- Volunteer co-ordination and support for people dealing with adversity and mental health challenges such as anxiety.

[2] Community Advice and Law Service:

- Promoting low level advice and support for people accessing a foodbank, with mental health problems linked to debt.

[3] Living without abuse:

- Mental health mentorship for women whose mental health has been affected by domestic abuse.

These projects have been evaluated by De Montfort University.

Next steps:

<u>CYP</u>

- Recruitment for Wave 9 will identify specific schools where the new MHSTs will be based. Key areas in the city for work to address low referrals into mental health services will be agreed.
- Work will begin to progress increasing new roles in PCNs with support of adult Additional Roles and Reimbursement Scheme (ARRS) teams to share learning and best practice from the work they have done in implementing these roles.

<u>Adults</u>

- There will be increased local communications and engagement activity with GPs and the developing Integrated Neighbourhood Teams to promote the NHS Talking Therapies service, including local promotional events hosted by VITA MIND to raise their profile and circulate information on the psychological offers. A primary care engagement plan will be developed and VITA MIND will work towards reporting NHS Talking Therapy activity at neighbourhood/GP practice level.
- A review of the Getting Help in Neighbourhoods round two grant awards will take place by September 2023, as well as a progress review for the launch of the recommissioned mental health and wellbeing services.

Risks:
None raised.

Healthy Lives

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

Progress to date:

Hypertension

- A pilot scheme to identify undiagnosed hypertension has concluded and is being evaluated to provide information on the demographics of people with undiagnosed hypertension, and demographics of those who responded to invitations.
- A project to recruit and develop long term conditions (LTCs) champions which was funded until March 2023 has concluded, with no further funding secured. Across the duration of the project three champions engaged with nine practices, and developed specific action plans. An evaluation of this programme is underway as of May 2023, with indications that practices who had a LTCs champion attached to them demonstrated improved LTCs process.

Cancer pathways

- A range of activity has taken place to increase early diagnosis in cancer pathways through early detection and follow-on pathway developments:
- Prostate cancer identification in Black and Asian minority ethnic (BAME) men is being supported through the use of a video text message to raise awareness, targeted at black men, and men with a family history. A Health Inequalities manager is now in post to progress this work.
- Year one of the NHS Galleri clinical trial (a blood test aimed at fit and healthy people aged over 50 to detect cancer markers) was considered successful, and year 2 blood tests have now been completed. The focus was on retention, rather than recruitment, of clients, with a retention rate of 93% achieved. This was above other local areas.
- Work to improve colorectal cancer detection at an early stage has resulted in significant changes to the faecal immunochemical test (FIT) pathway, including a reduction in screening age to 56, and intentions to provide more GP surgeries with access to testing kits to reduce postal delays. A multi-partner task and finish group have led on a targeted project to increase the 1-year survival rate in the LE4 area of Leicester.
- Work continues to implement a pathway to address ‘did not attend’ rates for breast cancer screening amongst Black African/Black Caribbean women.
- A cervical cancer text project has been launched, using video texting to target patients who have not attended cervical screening. This will be developed into a range of languages.
- Cancer screening and symptom events were held in July via LLR ICB-recruited community organisations, collaboratively with Macmillan, Cancer Research, Healthwatch and UHL.
- There has been agreement to purchase a colposcopy chair to support cervical screening for patients with learning disabilities.

Next steps:

Hypertension

- Learning from the PCN based pilot will be used to look for associations with inequalities gaps and recommend methods to address them.

- A project to enable better case-finding and management for hypertension within specific communities (Sharma Women's Centre and South Asian Health Action are key delivery partners) will be developed in the coming months.
- Exploratory work will take place with the Public Health team to identify what work can be done within current resources to support the long-term conditions work.

Cancer pathways

- Future awareness campaigns in early diagnosis of lung and skin cancers are planned – with production of videos to support skin cancer and breast cancer screening.
- Evaluation of the Galleri trial year 2 will continue, to review lessons learnt ahead of year 3.
- Further scoping activity to explore mobile cervical screening will continue to take place.
- Development and delivery of training, in collaboration with primary and secondary care colleagues, to support the significant changes to the FIT pathway.

Risks:
None raised.

Healthy Ageing

Priority: We will enable Leicester's residents to age comfortably and confidently through a through a person-centred programme to support self-care, build on strengths and reduce frailty.

Progress to date:

- There has been a range of activity to support development of a framework for local delivery of anticipatory care (now proactive care). A proactive care project group were mobilised and were meeting regularly to progress this work. Early adopter sites have been identified and Care Navigators are taking part in multi-disciplinary teams (MDT's). There is active pursual of confidentiality agreement from PCN's for the MDT facilitator. Training needs for staff have been identified and training costs agreed via LOROS. Care Navigators have also received MECC training and are using this approach with any new people they start to work with. However, as of July 2023 proactive care is on hold due to the departure of the MDT facilitator.
- Development of the MyChoice directory is progressing to include local voluntary sector preventative services and community assets to reduce loneliness and isolation. A feedback function has been identified, and Personal Assistants listed. Community Connectors are now part of the MyChoice steering group to enable actions relating to community connectors to move forward. A business case has been created to develop a 'social prescribing' add-on, which will enable people to contact support agencies directly without the need for a referral.
- There has been activity to support commissioning of a range of services and opportunities to provide alternatives to residential care. The hospital bridging service has been brought in-house within the Homefirst suite of service provided by Leicester City Council, offering greater ability to meet the demand for this service. A commissioning review for Homecare is in progress, with a model of delivery agreed by the project board, and is on target for new contracts to be in place for 2024. A review of respite services is underway to establish demand and use. A commissioning review has begun into carer support services and is at the 'soft market test' stage, with planned engagement activity with carers during National Carers week.
- An Operational Project Lead has been appointed to lead a project team working to increase reablement capacity, and to make a transformative change whereby all hospital discharges (unless there are specific reasons) will be supported by the reablement service, with £500k initially released by the Integrated Care Board to fund this work.

Next steps:

- Proactive care – The MDT role will be reviewed, and options explored for offering MDT assistance through alternative roles and recruitment.
- Commissioning – Proposals will be drafted to pilot a short breaks service with the care home market which will inform the design and scope of the longer-term model.
- Remodelling work to increase reablement capacity – The project lead will commence in post at the start of June to drive this project forward, and five sub-groups will commence to drive this work forward.
- Integrated Crisis Response Service (ICRS) night service offer – funding has been set aside for an 18-month pilot to go live in January 2024. ICRS will continue to support the frailty virtual wards.

Risks:

Funding to increase reablement capacity will not exceed the £500k allocated as part of the Discharge Grant. There are concerns that this will fall short of the funding required to help make this transformative change possible. More budget planning work is due to take place to map out risks and mitigations.

Communications and engagement activity

Communications and engagement is embedded within the delivery plan as a critical component of delivery of the outlined activities. A range of communications and engagement activity has taken place across the ICB and through the local authority and community wellbeing champions to facilitate progress against the identified actions. This has included:

- Supporting delivery of the new Maternity and Neonatal Voices Partnership contract.
- A volunteering campaign for individual at practice level to support development of integrated neighbourhood team working.
- Supporting activity to empower citizens to use technology where appropriate.
- Planned engagement and consultation with the public on options for urgent care services.
- Cancer screening.
- Implementation of the joint LLR Dementia Strategy, and planning the Dementia Strategy consultation.
- Promotion of the emotional health and wellbeing service, including the digital offer for schools for CYP and their families.
- CYP engagement over a 6-month period to gather insight and experiences as part of the development of Integrated Neighbourhood Team working.

Sponsor and watch priorities

The working group who have developed and implemented the initial ‘do’ priorities delivery action plan are due to reconvene in July to consider approaches for reviewing and monitoring progress against the ‘sponsor’ and ‘watch’ priorities, and to identify the governance structure, reporting frequency and level of detail in which updates against these priorities should be provided.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Acute CURE Tobacco Dependency Evaluation
Presented to the Health and Wellbeing Board by:	Jo Atkinson/ Andrea Thorne
Author:	Andrea Thorne/ Dr Shilpa Sisodia

EXECUTIVE SUMMARY:

The purpose of this report is to update key boards on the delivery and progress of the Acute CURE Tobacco Dependency Service delivered across the University Hospitals of Leicester as part of the NHS Long Term Plan Prevention agenda for Tobacco Dependency. This programme requires joint efforts across the system to effectively address high smoking rates in Leicester.

Leicester City Council Public Health hold the NHS Prevention funding and employ the delivery team for this programme. In order to deliver on the national programme requirements the ICB, UHL and Local Authority Public Health teams are working together across the system to develop streamlined pathways from hospital to community.

The NHS Long Term Plan outlines a clear requirement to provide all people admitted to hospital who smoke with an NHS-funded in-house tobacco treatment service by 2023/24. Guidance and delivery models have been issued by NHS England and Improvement (NHSEI) to improve care for patients who smoke across various settings; these are acute inpatients, mental health inpatients and pregnant women. The Acute inpatient project (otherwise known as The CURE Project) was the first model to start implementation in March 2020 and has now reached full implementation, operating at Glenfield Hospital, Leicester Royal Infirmary and The General Hospital as of April 2023.

An evaluation has recently been conducted using RE-AIM methodology to gain a better understanding of service delivery and outcomes through quantitative and qualitative data collections. Two papers have been produced 1) An Acute CURE internal Evaluation report for service level use 2) An Acute CURE Evaluation research paper, submitted to Journal of Public Health to contribute to academic research in the field and share with national networks, if accepted. The lead author of these reports is Dr Shilpa Sisodia in collaboration with the CURE project team.

In summary, the evaluation of the service demonstrates that an in-reach tobacco dependency treatment service model which systematically identifies and treats inpatients on an ‘opt-out’ basis can be implemented successfully and effectively in a large tertiary hospital.

Key facilitators to implementation have been noted as strong leadership, joint working, a national mandate for delivery, and seed funding from East Midland Cancer Alliance (EMCA) to mobilise the service quicker. Key challenges are noted as lack of integrated systems for transfer of care and national data collection requirements, as well as, difficulty navigating Trust governance to request or approve actions, and accessing operational facilities such as office space and IT equipment on sites. Funding to sustain and meet the national expectations for the service has also been highlighted as a risk due to increasing referrals, pharmacotherapy costs, as well as increased pressure on our community stop smoking services, which are all key parts of the patient's pathway.

Next steps and considerations have been made to share the successful delivery and outcomes of the acute tobacco dependency pathway and respond to evaluation recommendations, as well as continue to monitor and evaluated the service as it improves and expands.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- To acknowledge the successful implementation of the NHS Long Term Plan Tobacco Dependency Programme; specifically, the Acute CURE service launched across UHL in partnership with local government public health and the ICB.
- To acknowledge and support the challenges and facilitators noted in implementing a programme across the ICS.
- Acknowledge the risk noted regarding the Long Term Plan funding and the resource required across the system to uphold and improve programme delivery.

1. Background and options with supporting evidence

1.1. Context

The NHS Long Term Plan (LTP) outlines a clear requirement to provide all people admitted to hospital who smoke with an NHS-funded in-house tobacco treatment service by 2023/24.

The NHS Long Term Plan was published in 2019:

"2.9. First, the NHS will therefore make a significant new contribution to making England a smoke-free society, by supporting people in contact with NHS services to quit based on a proven model implemented in Canada and Manchester [26]. By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services." (NHS Long Term Plan, 2019)

Gradual funding, guidance and delivery models have been issued by NHSEI across various settings; these are, acute inpatients, mental health inpatients and pregnant women. LLR have initiated delivery for all three models of care, along with a bespoke staff tobacco dependency offer via a digital smokefree app service.

The CURE model was named as an example of an inpatient smoking cessation model by the NHS and Trusts around the UK have begun to implement various models against national requirements within their Integrated Care System (ICS).

Manchester was the first area of the UK to adapt and implement to the Ottawa Model for Smoking Cessation (OMSC). They developed the CURE programme, based on the OMSC but adapted and branded it for the UK.

CURE stands for Conversation, Understand, Replace, Experts and Evidence-based treatments (CURE).

This model aims "to change healthcare practices so that smoking cessation treatment is provided as part of routine care to all patients who are tobacco users". This model is evidence based, validated, and has shown favourable outcomes.

Figure 1: CURE acronym

1.1.2. Need

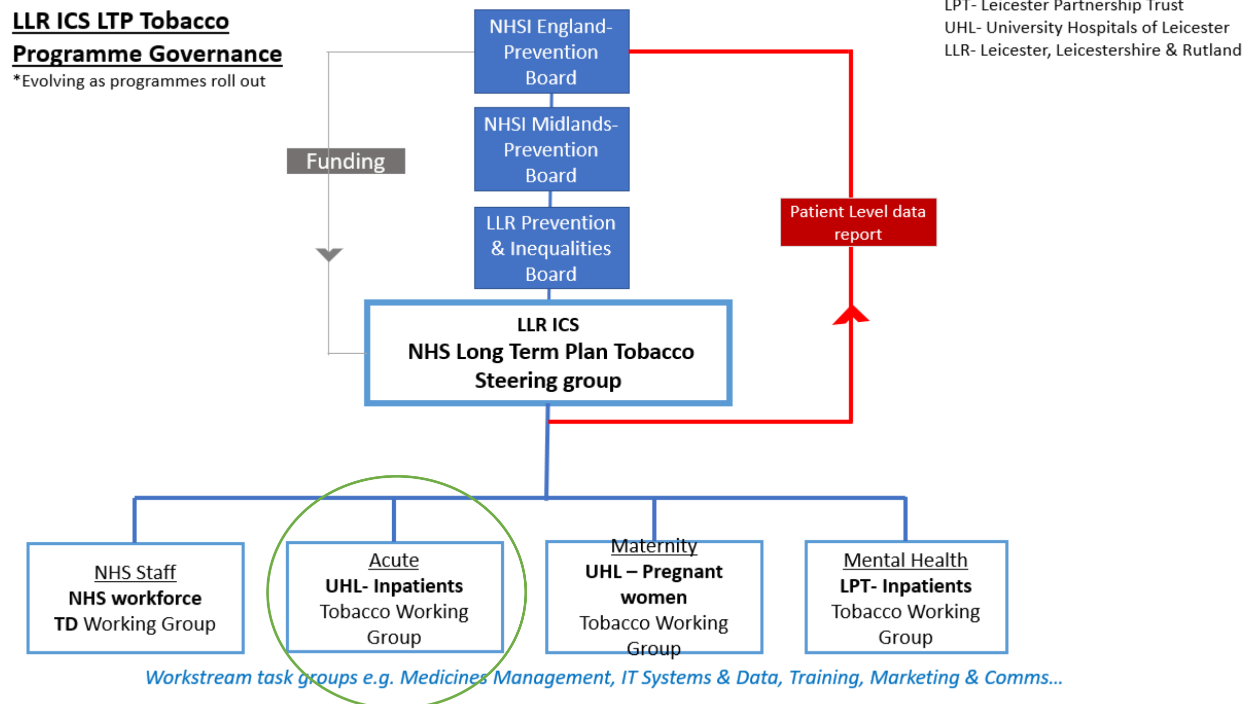
Smoking tobacco and the use of other tobacco products is intrinsically linked with health inequalities. Smoking is widely accepted as having significant disparity across socio-economic and geographical communities with those in the more deprived areas having higher smoking rates and poorer health outcomes.

The national average for smoking prevalence in adults in 2021 was reported 13% in 2021 with Leicester at 12.8% and Leicestershire at 11.2%. Leicester has around 346 deaths annually attributed to smoking. The majority of deaths attributable to smoking are due to lung cancer, chronic airway obstruction and ischaemic (coronary) heart disease. In addition, the rate of smoking attributable hospital admissions in Leicester is significantly higher than the national rate and is equivalent to over 2,800 admissions per year.

Addressing Tobacco addiction in our population is inarguable, recognising its health and economic benefits. Therefore, LLR took the initiative in 2019 to start the implementation of an Acute inpatient

Tobacco Dependency service through East Midlands Cancer Alliance funding. This enabled a faster and more co-ordinated approach to delivering the Tobacco Dependency programme models which were issued with mandatory reporting requirements in 2021.

Figure 2: Tobacco Programme Governance



1.2. LLR Acute CURE Service Model

Following disruption from Covid 19, the Acute CURE service has now reached full implementation, operating at Glenfield Hospital, Leicester Royal Infirmary and The General Hospital as of April 2023.

LLR's CURE model of delivery is defined as an in-reach model where a transfer of care takes place from one organisation to another. TDA's are employed by Leicester City Council and inpatients are referred to the community stop smoking services; Livewell (for City patients), Quit Ready (for County patients) and recently local pharmacies, post discharge for 12 weeks support to quit.

The in-reach service has advantages and disadvantages. Advantages include the ability to spread the workload and resource of implementation across specialist organisations, capitalising on existing infrastructure, experience, and expertise of community services, as well as establishing strong partnerships within the ICS.

Disadvantages include the need for exceptional team working, difficulties with co-ordinating data and integration of systems across organisations as well as increased challenges to influencing change in Hospitals and ensuring ownership from all organisations involved with care.

The Acute CURE inpatient pathway is shown in figure 3. Each stage of the patient's journey is pivotal in treating tobacco addiction; from identification on hospital admission to quitting within community care. This model is dependent on the community stop smoking services being able to provide ongoing care within the community setting and providing patient outcomes for national reporting.

This service operates 5 days Mon-Fri, with 4 full time TDA's. The LTP advises a 7-day service however further funding and capacity would be required to implement weekend working.

The Acute CURE Tobacco Dependency team sits in Public Health and consist of:

Figure 3: Acute CURE inpatient pathway

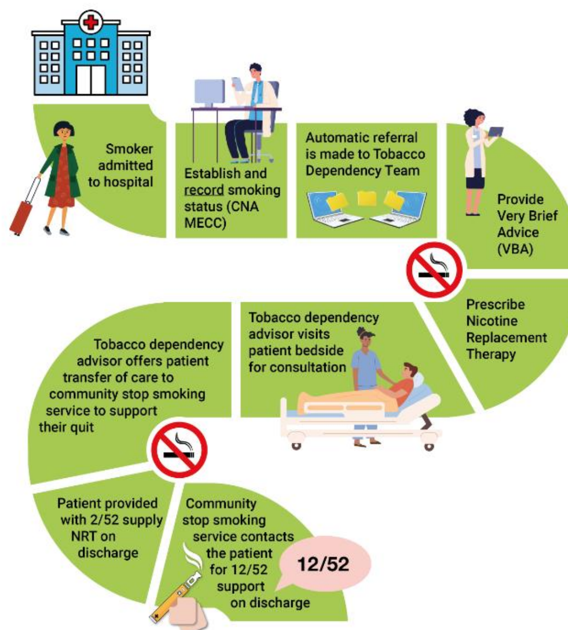


Table 1: Acute CURE Team:

1 x Project Manager	Fixed Term, Full Time
1 x CURE Co-ordinator	Permanent, Full Time
4 x FTE Tobacco Dependency Advisors (TDA's)	Permanent, Full Time
1 x CURE Admin & Business Support	Fixed Term, Full time

1.3 Acute CURE Tobacco Dependency Evaluation

A REAIM mixed methods evaluation of the Acute CURE service has recently been conducted by a Public Health Speciality Registrar to evaluate the implementation of Acute CURE and its early outcomes, using qualitative and quantitative analysis. A summary of finding using REAIM framework is presented below, and the full internal report including methods used is available on request.

1.3.1. Brief findings:

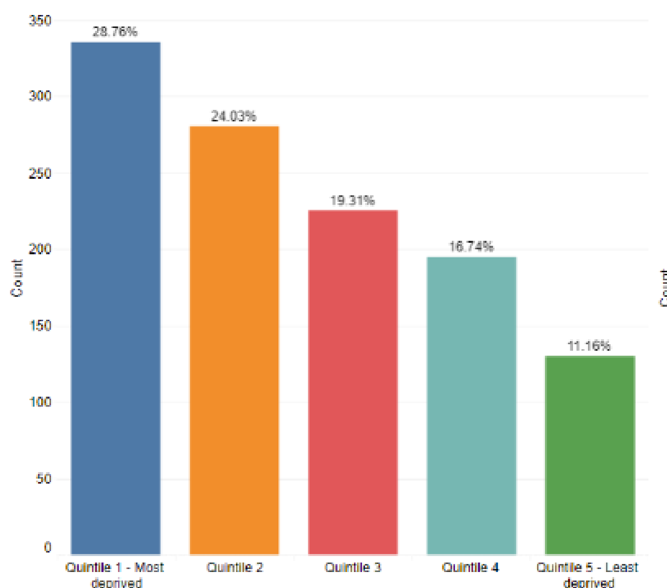
Reach: Between April 2021 and August 2022 (using initial pilot data collection metrics), 4965 smokers were referred to CURE, 3621 (73%) were contacted by the CURE team, of whom 1992 (55%) accepted NRT and 1986 (55%) accepted transfer of care to community services.

Between October 2022 and February 2023 (using new national data collection metrics), 3615 smokers were referred to the CURE service, 1140 (31%) were seen by the CURE team (the CURE team were short staffed during period of analysis and seen rates are gradually increasing,

indicating 49% in June). Stakeholders stated that they could see more patients by increasing TDA capacity and increasing the completion of the screening assessment for smoking status, which is currently 75.91% on average across UHL. A breakdown of the smoking assessment across UHL for 30.05.23 can be found in appendix 1.

An acute hospital-based intervention provided a prime opportunity to capture smokers with greater need and who may not know how to refer themselves. Over half (53%) of patients ‘seen’ by the CURE team were from deprivation quintiles 1 and 2, quintile 1 being most deprived areas of LLR.

Graph 1: IMD score for count of patients by the Acute CURE team in UHL from Oct-Feb 23.



Effectiveness: There were early data issues in data extraction of 4 week quit data from community settings due to multiple reasons, but the latest figures of those that set a quit date with the community from October 2022- March 2023 indicated a 4-week quit rate of 65.6% with 57.9%% of these individuals going on to quit at 12 weeks. This is similar to or higher than community 4 week quit rates of 56% for City and 63% for County, with acute inpatients potentially being a harder to engage group due to referrals being opt out and not self-referred. TDAs suggested better access to Trust computer systems; the ability to prescribe and a more efficient and integrated IT system to process referrals and outcomes would allow them to see more patients and thus improve the effectiveness of the intervention.

Adoption: Adoption was both shown quantitatively and perceived qualitatively to be higher at Leicester Glenfield Hospital (GH) compared to Leicester Royal Infirmary (LRI). The reasons for this included GH being the original launch site for CURE, GH housing the cardiorespiratory unit, more clinical champions on site and GH being a smaller hospital, making visibility a quicker process. Adoption overall was viewed positively, with a main facilitator being leadership and training.

Implementation: IT was the main barrier to implementation alongside staff retention, recruitment processes and access to Nicotine Replacement Therapy. The main facilitator was the CURE team (including TDAs, clinical leads, project manager, project co-ordinator, administrator, and members of the steering group). Many clinical staff received tobacco dependency training and showed increases in confidence and knowledge related to treating tobacco dependency.

Maintenance: An increasing number of smokers were seen over time in hospital. To ensure CURE continues running in the long term, stakeholders felt sustainable funding was required.

1.3.2. CURE feedback quotes:

CURE Patient feedback:

“can I shake your hand/ I want to tell you that you have influenced me to make this change to my lifestyle and can’t tell you how grateful I am”

"I had no idea there was support available for smokers to quit. I have been trying to quit on my own and really needed some help. Thank you so much for coming to see me. I really appreciate it"

“It’s not usual that smokers get offered this support or understanding- usually taboo”

“I cannot believe that Nicotine patches are being offered in hospital -it is amazing”

UHL Staff feedback:

“I saw a man in PA today who you saw in July 40-60 cigarettes per day. Since you saw him he has not smoked one cigarette and has had no side effects other than feeling so much better in himself can taste things again. Thank you for all your support you are making a huge difference”. – CRM Sister.

“It is an ESSENTIAL service, especially to the Glenfield Respiratory Team as we deal with a lot of smoking-related diseases. It sees patients in a timely manner and offers gives such a positive impact on their inpatient stay” – Respiratory SHO

“I think the CURE team is doing an excellent job of projecting their aims and message to the Respiratory team. Their teaching is clear and effective, and they are always available to speak to you when you need to clarify something”. - Respiratory Dr GH

Patient case studies have also been produced and can be shared on request.

1.3.3. Evaluation recommendations:

Some key recommendations have been presented from the quantitative and qualitative findings of the evaluation. These will be reviewed and addressed, with some recommendations already completed or underway since research was conducted.

Long Term	
Evaluation: Evaluate the long term outcomes of CURE. Based on the logic model, long term outcomes are: (1) Reduced readmissions (2) Reduced smoking related morbidity and mortality (3) Reduced smoking rates in patients being admitted.	Ongoing – National Tobacco Dashboard is now able to present consistent data. The impact on re-admission and mortality will be more complicated and take time to demonstrate and will be sought from national evaluation work.
Culture change: Continue a culture change to embed “tobacco dependency as everyone’s business” in the Trust. In the long term, this means ensuring all decision-makers see treating tobacco dependence as a key prevention activity.	Ongoing – Raise and share impact of the service through national and local boards to support priority status.
Medium Term	
IT and data: Prioritise improving LLR IT infrastructure to streamline patient	Underway – Partial data

care pathways and support efficient case management. Fulfil local and national data requirements for systematic reporting. Improve data submission to the NHS, particularly focusing on 28 day quit data.	submission are being made. A case management system is in development and community services are amending new/current systems to support full data submission requirements.
Treating all smokers: Improve screening and identification by making the Making Every Contact Count Core (MECC) Nursing Assessment a mandatory field on admission. Address the large number of patients lost between referral to community services and setting a quit dates with services through improving the transfer of care pathway.	Take forward – MECC assessment has not yet been made mandatory but has been raised. Further work is required to address community lost to follow up once IT systems are set up to extract accurate data.
Nicotine Replacement Therapy (NRT): Improve NRT accessibility and continuity of medication into community stop smoking services whilst considering sustainability and affordability of provision.	Completed/Underway- a significant improvement has been made to prescribing NRT and further work is underway to enable TDA's to prescribe inhouse. Continuity of medication is a risk with reduced budgets in community and pharmacy protocol. e.g. Quit ready have reduced NRT products and community pharmacy are unable to prescribe E-cigarettes.
Evaluation: Use the newly available tobacco dependency service dashboard to set and monitor service targets and report to key governance groups. Evaluate, audit and review delivery and outcomes on a regular basis to improve quality of service using NICE guidance and Patient and Public Involvement (PPI). Conduct an economic analysis of the service to assess sustainability of the full programme model and resource with a focus on NRT funding.	Underway- Further analysis work is being done to ascertain targets and are regularly monitored through the steering group. A Quality improvement task group is being set up to review and improve delivery and outcomes.
Short Term	
Translation: Ensure all TDAs are aware of translation services.	Underway – Working with comms to develop relevant resources.
Treating all smokers: Continue promotion of the CURE programme through training for clinical staff. Further encourage all staff to provide VBA and early NRT to patients who smoke.	Ongoing- CURE will continue to deliver training and seek all opportunities available to access different staff group to upskill them in VBA and prescribing.
Nicotine Replacement Therapy (NRT): Further work to ensure that patients receive NRT as quickly as possible. This could include messages through UHL staff training, continued clinical staff training sessions and ensuring NRT is accessible.	Underway – Quality Improvement projects have already focused on and improved NRT prescribing and accessibility and will be continued.
Wider support: Support TDAs to engage with conversations with patients about health improvement topics such as mental health and stress management, including signposting to support. This in turn may facilitate a patient's quit journey.	Underway/take forward- CURE TDA's all receive Healthy Conversation Skills and mental health first aid training. Further work can be taken forward to equip

	staff further for wider conversations.

1.4. Implementation Facilitators and Challenges

Facilitators	
Clinical leadership and project management:	The support of a clinical lead in UHL was raised from all stakeholder levels as a key facilitator to an in-reach integrated service to help navigate the Trust and escalate issues and change, this includes a consultant lead and also clinical leads in pharmacy and admitting teams etc. Project management was pivotal to co-ordinating the number of workstreams and aspects to launching a new integrated service across organisations.
Seed Funding:	Funding for this programme has been released gradually and the recurrent amount is unknown until year end for the following year. This makes forward planning challenging in securing staff and planning for increasing pharmacotherapy costs within Trust and community settings. Seed funding from EMCA allowed quicker roll out for LLR in comparison to other areas and enabled us to recruit permanent staff.
Leadership and Joint working	Strong leadership and an early active steering group with key leads from UHL, ICB and LA supported the project to launch and overcome many barriers and obstacles to delivery. Proactive support from pharmacy enabled significant improvement to prescribing protocols.
CURE Training and champions	A large number of clinical staff received Tobacco dependency training and showed increases in confidence and knowledge to deliver VBA and prescribe pharmacotherapy to the patient. Recruiting champions also improved delivery in clinical areas, particularly in admission departments to improve screening and prescribing. CURE training has made a huge impact on the delivery of the service.
National Mandates	Aspects of the tobacco dependency programme came in phases and big changes in engagement was notice post covid when Trusts were given responsibility to submit data returns. Progress in IT and data workstreams significantly improved by raising the profile and mandating delivery.
Challenges	
Governance	Navigating the Trust and finding the right person to initiate change to support aspects of work was a challenge with many high priority areas in the Trust to compete with, particularly in a time of a pandemic. It has been noted whether this was made more challenging as an in-reach model rather than an inhouse model which may improve ownership.
Recurrent Funding	Recurrent funding for the programme is unknown and there is a real concern that LLR's allocation will not cover the required resource for a sustainable and effective service for all acute inpatients.
IT Systems	IT systems requirements for LLR's pathway were seen as the main barrier from all stakeholders and has impacted systems across the ICS to meet national data returns. Request for change in IT systems are a lengthy process slowing down delivery or not meeting national requirement.
Data Collections	Data has been a challenge as definitions and data fields for this programme were not streamlined with existing smoking cessation data collections. Large changes and additional asks had to be

	considered and requested to multiple systems to deliver an in-reach model.
Pharmacotherapy provision	NRT provision is a key aspect of patient care though the pathway. Funding pharmacotherapy is being approached in different ways, with many Trusts and community services absorbing NRT costs. LLR are funding the programme's NRT cost through LTP which will not be sustainable long term with expansion and improved prescribing.
Operational facilities	Working across local authority and UHL created many operational challenges for staff such as gaining their honorary contracts and getting appropriate IT access to systems and application on all devices. Significant delays were also experienced in trying to obtain office space at each site.

1.5. <u>Next steps & Considerations</u>

- Address learning and remaining recommendations from the main internal acute CURE evaluation to improve service delivery for users including the CURE team, clinical staff and patients.

- Share the experience of implementing and delivering an integrated patient pathway across organisations with key local and national stakeholders and boards.

- Assess sustainability of the Acute CURE Service within the current ICS funding allocation for LTP Tobacco Dependency, noting increased numbers of patients, costs of pharmacotherapy and increased resource required by community services.

2. Detailed report

The detailed internal Acute CURE Evaluation Report is available on request.

3. Appendices

Appendix 1:

Current Inpatient MECC Assessment Stats as at 30/05/2023

Current Inpatients, aged 18 and over, exlcuding maternity

Hospital Code	N. of Current Inpatients	N With MECC Assessment Recorded	N With NO MECC Assessment Recorded	% MECC	Count of Smokers	% Smoke
GH	533	453	80	84.99%	61	11.44%
LGH	285	169	116	59.30%	14	4.91%
LRI	913	692	221	75.79%	88	9.64%
UHL Total	**1731**	**1314**	**417**	**75.91%**	**163**	**9.42%**

Clinical Management Group	N. of Current Inpatients	N With MECC Assessment Recorded	N With NO MECC Assessment Recorded	% MECC	Count of Smokers	% Smoke
CHUGGS	395	219	176	55.44%	34	8.61%
CSI	6		6			
Emergency and Specialist Medicine	660	567	93	85.91%	59	8.94%
ITAPS	10	4	6	40.00%	2	20.00%
Musculoskeletal and Specialist Surgery	171	100	71	58.48%	15	8.77%
Renal, Respiratory and Cardiovascular	464	417	47	89.87%	53	11.42%

GH = Glenfield Hospital
LGH = Leicester General Hospital
LRI = Leicester Royal Infirmary
CHUGGS = Cancer, Haematology, Urology, Gastroenterology, General Surgery
CSI = Clinical Support imaging
ITAPS = Intensive Care Theatres, anaesthesia, Pain, and Sleep

APPENDIX D

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	**Meeting the needs of Complex People**
Presented to the Health and Wellbeing Board by:	Chris Burgin
Author:	Chris Burgin

EXECUTIVE SUMMARY:

An update on positive progress since the original presentation in January 2023 to the Board that set out the significant health and service challenges of this complex client group.

The agreed actions and steps taken as part of the working group which include a Health needs assessment for this group and also utilisation of the changing futures system change model will provide a solid evidence base to drive forward necessary change and improvement collaboratively.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

Note the progress made by the cross agency Working Group

Support the ongoing actions identified by the cross agency working party set out in the presentation by ensuring workstreams have owners in your Organisation with sufficient authority to deliver the identified areas and changes that will be required to strengthen services to this client group.

Support the need for ongoing collaboration across agencies involving complex Homelessness client group involving external bids for funding around such aspects as Housing and interventions around drugs, alcohol and mental health services.

Health & Wellbeing Board
Meeting the needs of Complex People

Leicester
City Council

Homelessness & Complex people

- Presented to H&WB 26th January 2023
- Setting out the current Homelessness challenges involving Complex Homeless people & the Housing crisis we face in Leicester
- It was agreed that a cross Agency Working Group should be set up to tackle the challenges

Leicester City Council

Homelessness & Complex people

Since the Board;

- the Working group has set up and concluded
- Held 3 successful meeting with robust discussions around the matter
- The outcomes and output have been positive (covered in a later slide)
- Most of the agreed outputs are work in progress
- These outputs will generate actions that will continue to need joined up commitment and working

Leicester City Council

Agreed outputs from the Board

- Changing Futures arrangements and platform to be used for the central coordination of complex cases driving system change
- Identification of complex cases not currently in the mainstream system to be taken forward as part of CF
- Public Health Joint Service Needs Assessment (JSNA) is being undertaken
- Distinct work in Social Care and Health that is feeding in to the JSNA to strengthen it
- Work around reducing outpatient DNA's for this client group being progressed
- Primary care provision promotion in conjunction with Inclusion Healthcare to wider service area to enhance knowledge around access

Leicester
City Council

Next Steps

- Ongoing joined up working
- The CF case management work will drive system change which will be overseen and delivered by that Board
- The completed JSNA evidence base will identify other gaps and issues in this group
- These gaps and issues will be added to the Homelessness Strategy Action plan.
- Use of the outputs from all these areas to review the pathways for complex Homeless people
- Shape LCC's Housing acquisitions & newbuild offer to meet this group
- Public Health to coordinate work around early prevention with partners

Leicester City Council

Thank you

- Thank you to the Board for setting this work in motion
- Thank you to all those that have attended the Working Groups

Ruth Lake – Social Care
Rakesh Ramphul – Social Care
Helen Manning – Social Care
Rob Howard – Public Health
Wane Henderson – Inclusion Healthcare
Sarah Hancock Smith – Turning Point
Andrea Knowles – Turning Point
Ruw Abeyratne – University Hospitals Leicester
Mark Pierce – NHS LLR
Seema Gaj – NHS LLR
Hannah Stammers – Public Health
Gurjinder Bans - Public Health
Mark Grant – Action Homeless
Caroline Tote – Childrens
Caroline Green – Neighbourhoods
Caroline Carpendale – Housing
Justin Haywood – Housing

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Presentation on Healthwatch and current priorities
Presented to the Health and Wellbeing Board by:	Gemma Barrow and Kevin Allen-Khimani
Author:	Gemma Barrow

EXECUTIVE SUMMARY:

Presentation and supporting paper outlining the remit of Healthwatch, what has been achieved last financial year and what the current priorities are for this year under the new contract with Voluntary Action LeicesterShire (VAL)

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

Note the presentation and paper for information

healthwatch Leicester

healthwatch Leicestershire

Brief report -

Healthwatch Leicester and Healthwatch Leicestershire

September 2023

Role and Remit

Healthwatch Leicester and Healthwatch Leicestershire (HWLL) is your local health and social care champion. If you use GPs and hospitals, dentists, pharmacies, care homes or other support services in your area, we want to hear about your experiences.

As an independent statutory body, we have the power to make sure NHS leaders and other decision makers listen to local feedback and improve standards of care. We can also help you to find reliable and trustworthy information and advice. Last year, the Healthwatch network helped nearly a million people like you to have your say and get the support you need.

Healthwatch Leicester and Healthwatch Leicestershire is part of a network of 150 local Healthwatch across the country. We're here to listen to the issues that really matter to people in Leicester and Leicestershire and to hear about your experiences of using local health and social care services.

We're entirely independent and impartial, and anything you share with us is confidential. Healthwatch uses your feedback to better understand the challenges facing the NHS and other care providers and we make sure your experiences improve health and care for everyone - locally and nationally.

The legal foundations of Healthwatch Leicester and Healthwatch Leicestershire are set out in the Health and Social Care Act 2012.

Engagement and Communication

We are committed to improving communications across all channels and increasing public engagement participation across all our work streams and projects.

We have established working relationships with strategic partners, local councils, the Integrated Care Board (ICB) and voluntary and community organisations.

Leicester City is recognised as one of the most diverse cities in the country. Traditional standards and approaches to communications as well as engagement require thinking beyond the norm. By working with our local partners, we want to improve our reach to local people and ensure that they are informed and involved in activities.

Workplan 2023-24

The table highlights our activities for 2023-24 as well as core work.

Quarter	Activities	Core work
Q1 Apr - June	Transition Recruitment Drive Volunteers week	Stakeholder engagement and management Board meetings and representation Governance Volunteers Enter & View Programme Young People's Healthwatch Training Community network Signposting and Information service Social media and communications
Q2 July - Sept	'Summer Tour' Enter & View Access and communication Diversity and inclusion sessions	
Q3 Oct - Dec	'Autumn Tour' World mental health day activities Social care project	
Q4 Jan – March	'What matters most' – reflections from communities Social care project	

Our Board members have a lead area of work and sit on Boards and Committees relating to these work areas.

Healthwatch Advisory Board Member	Lead areas
Harsha Kotecha	Children and Young People Acute & tertiary care
Mark Farmer	Mental Health
Joe Johal	Primary Care and Community
Kash Bhayani	Carers
Alexandra Partner	Learning Disabilities

Projects

Examples of projects undertaken this year.

Living with Dementia

Local people shared their views and experiences of Dementia services in our new report 'Living with Dementia in Leicester, Leicestershire and Rutland'.

In the report we have identified wide inconsistencies across Leicester, Leicestershire and Rutland (LLR) in the way diagnoses are made and what services are available and accessible for people living with dementia from the first suspicions of memory problems onwards.

We heard from more than 350 people living with Dementia, their carers and families. Thanks to people sharing their experiences we have identified wide inconsistencies in the way in which services are available and accessible for people living with dementia.

Supporting and helping those living with dementia and their carers remains a priority for LLR's health and social care organisations which includes the Dementia Programme Board. The LLR Dementia Programme Board aims to address all the recommendations and the report findings will inform the development of the revised Dementia Strategy in 2024.

Dentistry

Change takes time. We often work behind the scenes with services to consistently raise issues and bring about change. Over the years, we have been raising the issue of access to dentistry. We have continued to work with the NHS Local Dental Committee (LDC) and provide concerns from patients. We have advocated for clear advice for patients and details of local NHS provision. We have produced up to date advice which has meant people who need urgent treatment know their options and have clear information.

Lipoedema

We worked with a local Lipoedema support group to help raise awareness of the condition amongst the medical profession and other women who may have the condition misdiagnosed or undiagnosed.

Working with medical students from Keele University, we undertook surveys to assess awareness of the condition. One was with medical students at Keele and St George's (London) universities, and one was aimed at healthcare allied healthcare professionals to gauge their knowledge and understanding of the condition.

35 medical students and 102 allied health professionals responded to the surveys and as a result of their responses two information posters were developed and distributed to the universities, GP surgeries and clinics across Leicestershire. In addition, a survey focused at identifying people with symptoms resulted in Healthwatch signposting people to the Lipoedema support group.

Details of future work and projects planned in Leicester

East Midlands Healthwatch Regional Mental Health Enter and View

In partnership with IMPACT and supporting NHS England to conduct an in-depth look at the care provided and experiences of those who are present within Mental Health Inpatient wards across the

East Midlands region. The opportunity to work across the midlands region to listen to inpatients in the 48 low and medium secure Mental Health Inpatient (MHI) wards within the localities of Lincolnshire, Nottinghamshire, Derbyshire, Rutland, Northamptonshire, Leicester and Leicestershire.

Healthwatch Diversity Inclusion Health Network

Exclusion continues to impact on some communities leading to access issues, negative experience and more importantly, higher prevalence of health inequalities.

Our aim is to develop a platform for marginalised voices to be heard and empower people through regular and ongoing engagement and involvement.

We held our first NHS complaints event at the Highfields centre on 17 August. We were joined by representatives from University Hospitals of Leicester NHS Trust (UHL), Leicestershire Partnership Trust (LPT) and PoHWER Advocacy.

We had 20 attendees and feedback was positive from the participants and partners.

We will be continuing these sessions with different communities across the city.

What Matters Most

In February 2024, we will be consulting with the people of Leicester and Leicestershire to give them the opportunity to share their views about what key themes they would like to see us focus on in the next 12 months. Following these events, we will compile our list of city projects for 2024-25.

Together

We’re making health and social care better
September 2023

healthwatch Leicester

healthwatch Leicestershire

What is healthwatch?

A national and local patient champion to give people and communities a stronger voice to influence

An independent body with statutory functions

Set up by the Health & Social Care Act 2012

Challenges how health and social care services are provided

Healthwatch England (influences national policy & guidance and provides leadership, guidance & support to local Healthwatch)

Local Healthwatch (currently over 150 throughout England)

Statutory functions

Enter and View

Gathering the views and understanding experiences of patients and the public

Making people's views known

Promoting and supporting the involvement of people in the commissioning and provision of local health and social services and how they are scrutinised

Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC)

Information and signposting

Our mission

To make sure people's experiences help make health and care better in Leicester City and Leicestershire.

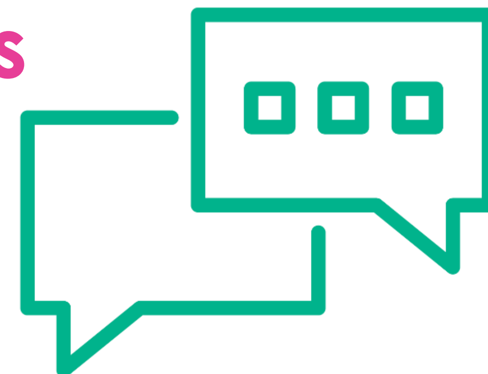
Our vision

To champion and empower local people to drive excellence in quality, inclusion and access to Health and Care Services.

Our approach

- Understanding what matters to most to local people.
- Developing and sharing evidence based local intelligence.
- Influencing those with power to change service design and delivery.
- Involving everyone, reaching out to diverse communities by embracing equality and diversity in all our work.
- Partnering with local health and care services and the voluntary and community sector to make care better whilst retaining our independence.

How we carry out our functions



- Enter and View Programme
- Information and signposting
- Community outreach events at local services
- Public engagement and Community Partnerships
- Referrals to Independent NHS Complaints Advocacy
- Research projects on local priorities
- Have a seat on the local Health and Wellbeing board to influence commissioning decisions by representing the views of local stakeholders

2022-23: What we did

Over 30000 people came to us last year to seek information or to share their story with us.

- We published **20** reports about the improvements people would like to see to health and social care services.
- We attended **45** events and engaged directly with **2165** people during our summer tour. People told us about challenges of accessing GP Practices, NHS dentists and hospital services.
- Our Chair went on local radio to highlight the concerns around 'delays in emergency care at A&E'. We then visited the Adults Emergency Department at Leicester Royal Infirmary in September and heard from **139** people.

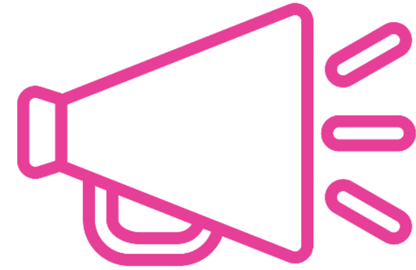
2022-23: What people told us

- Carers Week gave us an opportunity to reach carers to hear their views on services. We partnered with the team at Voluntary Action South Leicestershire (VASL) to attend carer events across the county and listened to **165** carers.
- With the COVID-19 pandemic disproportionately impacting Bangladeshi and Pakistani communities and vaccination uptake remaining consistently low, we reached out to these communities to hear their stories.
- Over **200** young people have shared with us their views on mental health services. We have raised concerns with the service provider about young people's services.
- We spoke to over **350** people about local Dementia Services and the impact that COVID-19 has had on local service provision.

NHS Dentistry

- Dentistry access was one of the top issues reported by the public to Healthwatch.
- Thousands of people have spoken up about their struggles accessing an NHS dentist over the last few years.
- Dentistry continues to be the key issue for a lot of patients across Leicester and Leicestershire as they are still not able to access NHS Dental Services.
- People are telling us that they are unable to register with an NHS Dentist in Leicester or Leicestershire.
- People are concerned about where this is all moving to and the cost implications. People are finding private dentistry but there are considerable costs attached which some people are unable to afford.

Our plans for 2023-24



Access and communication

We will explore if people's needs of health and care services are being met in Leicester and Leicestershire. We have identified groups and we will seek to listen and outline what the specific issues are for those communities.

Supported Living

We want to engage with people who are in receipt of supported living to hear their experiences of the services provided.

Enter and View

Enter and observe health and social care services as they are being delivered. We have a programme of visits to GP Practices, care homes, hospital services and Mental Health units.

Community engagement

World mental health day event, diversity and inclusion networking sessions and autumn tour.

Get involved

Volunteer
Join the community network
sign up to our newsletter

For more information

Healthwatch Leicester and Healthwatch Leicestershire
9 Newarke Street
Leicester
LE1 5SN

www.healthwatchll.com

t: 0116 257 4999

e: enquiries@healthwatchll.com

@HealthwatchLeics

Facebook.com/HealthwatchLL

healthwatch

APPENDIX F

61

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Leicester

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month.
The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.
Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	
	The template asks for pathway 1 and 2 to be split down into 'rehabilitation' and 'reablement'- we do not record data in this way and only have overall pathway 1 and pathway 2 numbers, so the data added is for all of City data into the 'reablement' headings. There is also no data broken down by UHL/LPT to I have added it all to the UHL lines only For VCS demand 22/23 data has been used for estimates of demand. The data already shows increased demand through winter period. Demand for reablement in a bedded setting includes numbers requiring discharge into temp res care and block booked reablement and therapy beds Discharge into rehabilitation beds is the number of people requiring a community hospital bed Community demand is proactive demand into Care Co-ordination Capacity rejection data for unmet demand is not available for some areas of data Short term domiciliary care capacity is not populated for hospital discharge: although we can calculate demand for this type of support, our capacity is contained within our long term domiciiary framework contracts so is not distinguishable by type. If preferred, we can present capacity as the same as demand: there is no capacity constraint for short term domiciliary care Short term residential capacity is spot purchased from the whole market so capacity has been mapped to predicted demand Rehab at home capacity is covered within reablement at home - our home first offer is a continuim within a single delivery approach Where we have gaps between capacity and demand, there are plans for this, such as wrok to incraese therapy for home based reablement / reahabilitation. There is also further work required to ensure our modelling assumptions are accurate as data has been challenging to extract from systems in place and our service delivery approaches don't lend themselves to disaggregation along the servoice lines in this template.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	Social support (including VCS) (pathway 0)	99	100	106	119	102	102	106	140	147	139	160	120
LEICESTERSHIRE PARTNERSHIP NHS TRUST	Reablement at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST		88	113	89	80	89	73	126	129	146	140	115	120
LEICESTERSHIRE PARTNERSHIP NHS TRUST	Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST		166	174	164	182	174	161	168	184	176	196	186	169
LEICESTERSHIRE PARTNERSHIP NHS TRUST	Short term domiciliary care (pathway 1)	55	80	63	68	88	64	84	71	65	88	79	97
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
LEICESTERSHIRE PARTNERSHIP NHS TRUST	Reablement in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST		77	91	77	61	72	73	62	81	62	66	51	62
LEICESTERSHIRE PARTNERSHIP NHS TRUST	Rehabilitation in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST		91	91	94	100	103	98	117	112	120	121	100	116
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	6	8	7	6	8	6	6	8	9	7	6	8
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST													
Totals	Total:	2784.79661	1801.37288	1652.08475	1731.79661	1802.37288	1653.79661	1819.44068	1888.37288	1862.01695	2003.08475	1801.44068	1877.72881

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	442	410	450	430	430	430	450	470	470	470	470	450
Reablement at home	13	27	21	15	13	10	13	18	12	25	28	20
Rehabilitation at home	424	488	497	468	456	400	381	427	420	533	421	420
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	9	7	6	6	5	4	9	4	5	7	4	5

3.3 Capacity - Hospital Discharge

Service Area	Capacity - Hospital Discharge Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.???	56	56	56	56	56	56	56	56	56	56	56	56
Reablement at Home	Monthly capacity. Number of new clients.	104	104	104	104	104	104	104	120	120	120	120	120
Rehabilitation at home	Monthly capacity. Number of new clients.	153	157	154	166	158	149	156	172	168	184	171	157
Short term domiciliary care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Reablement in a bedded setting	Monthly capacity. Number of new clients.	4	4	4	4	4	4	4	4	4	4	4	4
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	91	91	94	100	98	117	112	120	121	100	116	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	6	8	7	6	8	6	6	8	9	7	6	8

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
		100%
	100%	
100%		
	100%	
		100%
100%		
		100%

3.4 Capacity - Community

Capacity - Community																	
														Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients???	0	0	0	0	0	0	0	0	0	0	0	0			100%
Urgent Community Response	Monthly capacity. Number of new clients.	480	480	480	480	480	480	480	480	480	480	480	480			100%
Reablement at Home	Monthly capacity. Number of new clients.	26	26	26	26	26	26	26	30	30	30	30	30		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	377	434	440	440	440	440	440	440	440	440	440	440	100%		
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			100%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	100%		
Other short-term social care	Monthly capacity. Number of new clients.	10	10	10	10	10	10	10	10	10	10	10	10		100%	