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

JHWS refresh & proposed length

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

Delivery Plan- Framework approach

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

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

Guiding principles – identifying priorities:

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

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

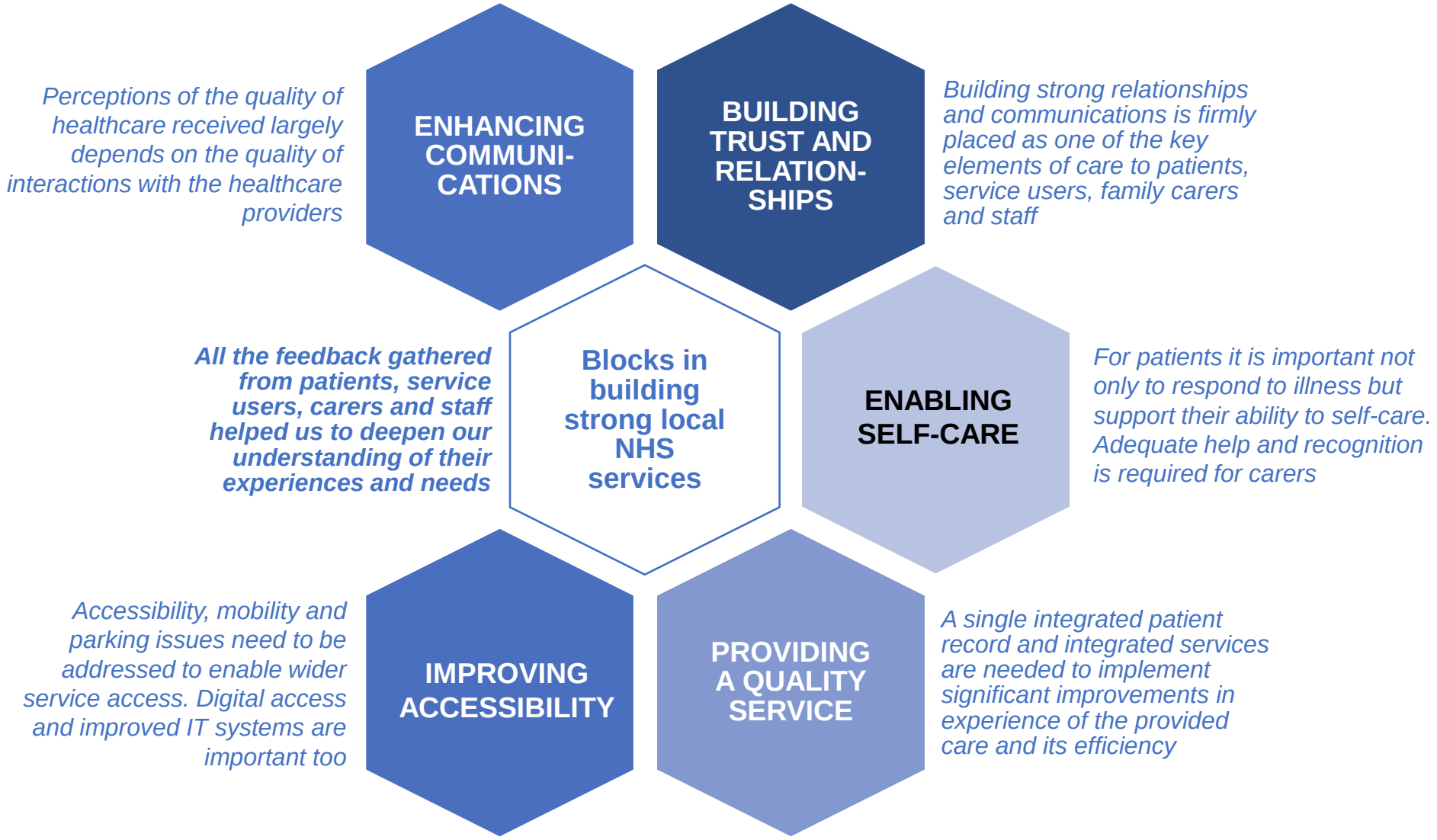
We have aimed to get a balance of health, care and wellbeing priorities.

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

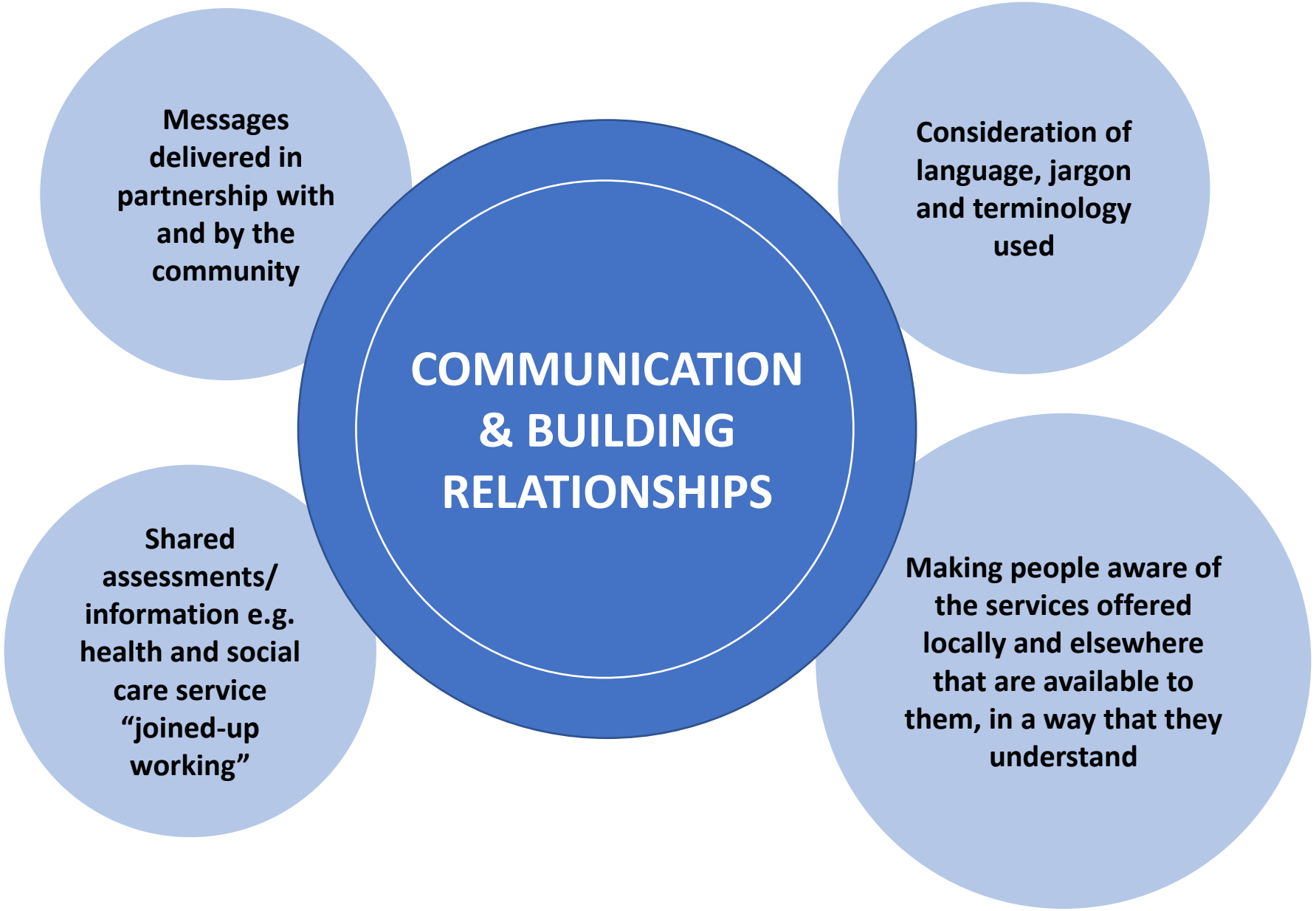
Guiding principles- progressing improvements on priorities:

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

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



Leicester's needs in terms of communications



What can we do based on what we know now?

1

THE WAY WE COMMUNICATE

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

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

2

UNDERSTAND AND RESPOND TO THE NEEDS OF OUR COMMUNITIES

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

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

3

COLLABORATION IS KEY

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

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

Summary of proposed priorities:

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

Mapping to ICS priorities

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

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

Healthy Places

Level: City wide

Why a Priority?

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

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

Current improvement plans include:

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

Measuring progress:

*Improvement in Fuel Poverty indicators for Leicester

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

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

Healthy Places

Level: City wide

Why a Priority?

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

Current improvement plans include:

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

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

Measuring progress:

tbc

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

Healthy Places

Level: City wide

Why a Priority?

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

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

Current improvement plans include:

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

Measuring progress:

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

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

Healthy Places

Level: City wide & through neighbourhood level initiatives

Why a Priority?

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

Current improvement plans include:

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

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

Measuring progress:
tbc

Proposed Priority 5 : 'First 1001 Critical days'

Healthy Start

Level: Citywide

Why a Priority?

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

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

Current improvement plans include:

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

Measuring progress:

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

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

Healthy Start

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

Why a Priority?

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

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

Current improvement plans include

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

Measuring progress:

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

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

Healthy Start

Level: Citywide

Why a Priority?

- Unprecedented demand in Children's Emergency Department with over 50% of attends deemed 'inappropriate'. Majority of attendance from Leicester city families.

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

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

Current improvement plans include:

- Developing education materials for the public and professionals around understanding common childhood illnesses and when to attend ED

- Expanding online webinars promoting management of minor illness e.g. Beat the Street Webinar –Beat the Street' sessions taking place regularly to communicate with public around managing minor illnesses in CYP and navigating the system.

- Developing online information on management of minor illness and promoting through children's services and schools.

- Expanding the role of pharmacies to promote self care in families**.**

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

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

Healthy Lives

Level: Through City wide and neighbourhood level initiatives

Why a Priority?

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

Key Partners :

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

Current improvement Plans include:

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

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

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

Measuring progress:

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

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

Healthy Lives

Level: Through City wide and neighbourhood level initiatives

Why a Priority?

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

Key Partners :

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

Current improvement plans include:

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

Measuring progress:

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

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

Healthy Lives

Level: City wide & through Integrated neighbourhood working

Why a Priority?

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

Key Partners :

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

Current improvement plans include:

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

Measuring progress:

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

Proposed Priority 11: Improving support for carers

Healthy Lives

Level: City wide

Why a Priority?

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

Key Partners :

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

Current improvement plans include:

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

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

Also need to:

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

Many of these improvements can be driven at a Place level

Measuring progress:

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

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

Healthy Minds

Level: City wide

Why a Priority?

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

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

Current improvement plans include:

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

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

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

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

Healthy Minds

Level: Delivered through Integrated Neighbourhood working

Why a Priority?

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

Key Partners :

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

Current improvement plans include:

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

Measuring progress:

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

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

Healthy Minds

Level: citywide

Why a Priority?

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

Key Partners :

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

Improvement Plans:

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

Measuring progress:

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

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

Healthy Ageing

Level: City wide

Why a Priority?

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

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

Current improvement plans include:

The Joint Health and Wellbeing Strategy recognises the need:

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

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

Measuring progress:

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

Proposed Priority 16: Promoting independence in frail older people

Healthy Ageing

Level: City wide & through Integrated neighbourhood MDT working

Why a Priority?

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

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

Current improvement plans include:

Developing new models of care promoting independence including :

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

Measuring progress:

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

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

Healthy Ageing

Level: City wide & through Integrated neighbourhood MDT working

Why a Priority?

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

Current improvement plans include:

Reducing Incidence of Falls:

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

Reducing prevalence in BME communities:

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

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

Measuring progress:

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

Planned next steps:

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