Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **THURSDAY, 15 APRIL 2021**

TIME: **5:30 pm**

PLACE: **Zoom Meeting**

Members of the Commission

Councillor Kitterick (Chair)
Councillor Fonseca (Vice-Chair)

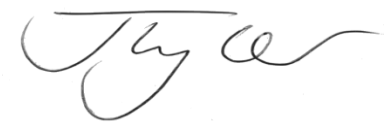
Councillors Aldred, Chamund, March, Dr Sangster and Westley

1 unallocated Non-Group place.

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester



For Monitoring Officer

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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Information for members of the public

PLEASE NOTE *that any member of the press and public may listen in to this 'virtual' meeting on Zoom through YouTube at the following link:*

https://www.youtube.com/channel/UCddTWo00_gs0cp-301XDbXA

Members of the press and public may tweet, blog etc. during the live broadcast as they would be able to during a regular Commission meeting at City Hall.

It is important, however, that Councillors can discuss and take decisions without disruption, so the only participants in this virtual meeting will be the Councillors concerned, the officers advising the Commission and any external partners invited to do so.

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Further information

If you have any queries about any of the above or the business to be discussed, please contact: Jason Tyler**,** Democratic Support Officer on (0116) 454 6359 or email jason.tyler@leicester.gov.uk

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USEFUL ACRONYMS RELATING TO
HEALTH AND WELLBEING SCRUTINY COMMISSION

Acronym	Meaning
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
BCF	Better Care Fund
BCT	Better Care Together
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
CCG LCCCG ELCCG WLCCG	Clinical Commissioning Group Leicester City Clinical Commissioning Group East Leicestershire Clinical Commissioning Group West Leicestershire Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DAFNE	Diabetes Adjusted Food and Nutrition Education
DES	Directly Enhanced Service
DMIRS	Digital Minor Illness Referral Service
DoSA	Diabetes for South Asians
DTOC	Delayed Transfers of Care
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EDEN	Effective Diabetes Education Now!
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
FBC	Full Business Case
FIT	Faecal Immunochemical Test
GPAU	General Practitioner Assessment Unit
GPFV	General Practice Forward View

HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HEEM	Health Education East Midlands
HWLL	Healthwatch Leicester and Leicestershire
ICS	Integrated Care System
IDT	Improved discharge pathways
ISHS	Integrated Sexual Health Service
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LTP	Long Term Plan
MECC	Making Every Contact Count
MDT	Multi-Disciplinary Team
NDPP	National Diabetes Prevention Pathway
NICE	National Institute for Health and Care Excellence
NHSE	NHS England
NQB	National Quality Board
OBC	Outline Business Case
OPEL	Operational Pressures Escalation Levels
PCN	Primary Care Network
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
QNIC	Quality Network for Inpatient CAMHS
RCR	Royal College of Radiologists
RN	Registered Nurses
RSE	Relationship and Sex Education
STI	Sexually Transmitted Infection
STP	Sustainability Transformation Plan
TasP	Treatment as Prevention
TASL	Thames Ambulance Services Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

LIVE STREAM OF MEETING:
A live stream of the meeting will be available on the link below:
https://www.youtube.com/channel/UCddTWo00_gs0cp-301XDbXA

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MINUTES OF PREVIOUS MEETING **Appendix A (Pages 1 - 6)**

The Minutes of the meeting held on 3 March 2021 are attached and the Commission will be asked to confirm them as a correct record.

4. UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT THE PREVIOUS MEETING

To receive any updates on the matters that were considered at the previous meeting of the Commission.

a) COVID HOSPITAL READMISSIONS & LONG COVID

5. CHAIR'S ANNOUNCEMENTS

6. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

7. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

8. COVID 19 UPDATE

The Director of Public Health will provide a verbal update on the latest position.

9. VACCINATIONS - FLU & COVID PROGRESS UPDATE

Appendix B (Pages 7 - 8)

The Leicester, Leicestershire and Rutland CCGs submit a report, which provides information on the uptake of the Leicester, Leicestershire and Rutland flu vaccination programme 2020/21.

10. HEALTH INEQUALITIES UPDATE - ACTION PLAN

Appendix C (Pages 9 - 24)

The Leicester, Leicestershire and Rutland (LLR) Health Inequalities Framework is attached. The Framework is intended to improve healthy life expectancy across LLR, by reducing health inequalities across the system.

11. OBESITY AND UNHEALTHY WEIGHT IN LEICESTER

Appendix D (Pages 25 - 38)

The Director of Public Health submits a report, which provides an update on Obesity and unhealthy weight in Leicester City, including Childhood Obesity.

12. WORK PROGRAMME

Appendix E (Pages 39 - 40)

The Commission's Work Programme is submitted for information and comment.

13. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: WEDNESDAY, 3 MARCH 2021 at 5:30 pm

P R E S E N T :

Councillor Kitterick (Chair)
Councillor Fonseca (Vice-Chair)

Councillor Chamund
Councillor March
Councillor Dr Sangster

In Attendance:

Councillor Dempster, Assistant City Mayor - Health

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32. APOLOGIES FOR ABSENCE

An apology for absence was received from Councillor Westley.

33. DECLARATIONS OF INTEREST

There were no Declarations of Interest.

34. MINUTES OF THE PREVIOUS MEETING

AGREED:

that the Minutes of the meeting of the Health and Wellbeing Scrutiny Commission held on 20 January 2021 be confirmed as a correct record.

35. UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT PREVIOUS MEETINGS

The Chair referred to updates and progress with matters considered at previous meetings and commented on the public question submitted by Sally Ruane in relation to the CCG's Hospitals Reconfiguration Plan. It was noted that the response had been received by email and could be published as an appendix to the Minutes of the meeting. It was further noted that recent positive publicity had demonstrated the important role of the Commission in being instrumental in recommending actions with the sale of Hospital Close (£10.5m) to bring 150 properties demonstrating the success of effective scrutiny.

The Chair then referred to the issue listed at the Agenda item relating to hospital readmission data and asked whether this had been considered as a cause for concern by UHL colleagues. It was reported that recent data had shown an increase in readmissions, both Covid and non-Covid related.

Mark Wightman (UHL - Director of Strategy and Communications) provided an update on benchmarked figures across the different trusts fighting the pandemic and advised that although Leicester's comparative data seemed positive, further information could be submitted in due course.

The Chair welcomed the offer of greater clarity and future monitoring of outcomes.

36. PETITIONS

The Monitoring Officer reported that no Petitions had been submitted, in accordance with the Council's procedures.

37. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no Questions, Representations or Statements of case had been submitted, in accordance with the Council's procedures.

38. COVID 19 UPDATE AND VACCINATIONS

The Director of Public Health gave a presentation, which provided an update on the statistical information concerning the impact of Covid-19.

It was reported that since the first laboratory test confirmed result of Covid 19 in Leicester on 11 March 2020 there had been 33,931 cases confirmed at February 2021. The recent data displayed a fall in the weekly numbers (on a seven-day moving average) from around 2000 cases per week to a current level of 726.

Data was submitted showing case numbers relative to comparable cities and the England average, including Birmingham, Bradford, Coventry, Luton and Nottingham together with age distribution figures and mortality rates in comparison to those areas.

In terms of the vaccination programme, data was provided on geographical areas across the city and the uptake of broad ethnic groups and age groups.

Concern was expressed that the figures indicated in areas such as St Matthews and St Peters and other small and densely populated areas, there had been a low take up of vaccinations. It was noted that in those areas there were alternative suitable buildings and locations, as the Peepul Centre seemed underused. The low take-up of doses by black South Asian and black British residents and healthcare workers had caused some concern. This was reflected nationally. There was also a lower percentage of uptake in the most deprived areas of the city.

Andy Williams, (Chief Executive of Leicester, Leicestershire and Rutland CCGs) provided greater details on the work undertaken on the vaccination program and the uptake including communications with the different communities, geographies, and age groups. It was noted that a detailed understanding of the reasons for vaccine hesitancy was being established.

The Chair commented that the vaccination program had been an impressive and positive piece of public health implementation but also noted the significant problem that there was an area of central Leicester which were clearly identified using the figures and mapping provided, detailing a poor record of vaccination uptake. It was accepted that further and enhanced communication would be key to the success of the vaccination programme in coming months.

Caroline Trevithick (CCGs) then provided enhanced data on the engagement programme and confirmed the evidence-based approach heavily supported by public health and the renewed focus on the approach on vaccine confidence.

It was accepted that community leaders together with clinical, non-clinical and public health partners were promoting the programme and public questions around confidence in vaccines.

Factsheets had been issued across the city and a myth busting webinar had been held which had reached out to thousands of residents through social media platforms.

The Director of Public Health was asked to comment, and he referred to the key work undertaken in the success of the vaccination programme and to the multi-cultural communities in Leicester stating the need to continue to support community confidence across the all communities.

Commission members welcomed the report and updates, however reference was made to the need to enhance communication with the groups that had shown a reluctance in taking up vaccinations, and also those living in more deprived areas of the city, to ensure that regular testing and confidence continued. The need to enhance contact with community leaders at a local level weas encouraged and highlighted.

In concluding the debate, the Commission discussed the impact of national policy on the roll-out of the vaccinations and health partners defended the approach being undertaken, although accepting that there were some areas that had been disadvantaged.

AGREED:

1. That enhanced engagement and community work be undertaken and a call for latitude to be delegated to areas of concern where vaccination uptake is low,

2. That arising from the above, data on vaccinations and testing and their availability across the city be presented to Commission members on a more regular basis, in order to show trends and levels of uptake.

39. UHL AUDIT UPDATE

The Chief Executive of the UHL submitted a report, which explained the events and background to the UHL Trust Board's decision not to agree the 2019/20 annual accounts as 'true and fair' and set out the action being taken to address the issue.

It was noted that the Trust's accounts for the financial year 2018/19 had received an unqualified, opinion, from the external auditors however the auditors did raise some concerns which although they were below the 'materiality' threshold, which had merited further investigation.

The concerns had been raised with the then Chief Executive and the Chairman who instructed the Interim Chief Financial Officer to look into the matters raised by the auditor. It was reported that the 2018/19 accounts had been significantly misstated to the tune of some £46m. As a consequence of this the Trust had to make a 'prior year adjustment' to the 2018/19 accounts correcting them.

This had been undertaken in January 2020 and stakeholders had received a briefing on that matter at the time. Further detailed and forensic work to accurately assess the Trust's financial position continued throughout 2020. Due to the scale and complexity of the task this work was still ongoing, but a huge amount of progress had already been made.

In terms of the steps taken, Commission members commented on the need to ensure that a cultural change was undertaken and with over a third of the original Board having resigned, questions were put as to how these vacancies and roles would be filled. It was clarified that the custom and practices that had been previously allowed to continue in the finance department would transform as the forthcoming cultural changes were put into place.

It was recommended that Health Partners involve the Commission into the committee selection process and also provide regular updates regarding the breakeven strategy, together with information on the Development Programme from Deloittes.

AGREED:

That the update and position be noted.

40. ADULT AND OLDER PEOPLE MENTAL HEALTH

The Leicestershire Partnership NHS Trust gave a presentation, which provided an update on the Adult and Older People Mental Health workstream.

The presentation detailed both the local and national context and advised of the progress into future years, including the new model for neighbourhood mental health services and areas suggested for support throughout that process.

In response to questions it was noted that regular updates could be submitted to individual Commission members on request, particularly concerning the links and engagement with vulnerable individuals and groups. This approach was welcomed in order to ensure that the support offered was aligned to need.

AGREED:

That the presentation and update be noted.

41. LPT IMPROVEMENT JOURNEY

The Leicestershire Partnership NHS Trust gave a presentation, which provided an update on the Improvement Journey from the 2018 CQC Inspection to the position in February 2021.

The three phases undertaken by the LPT and the governance improvements to support the changes were described in the presentation and were noted.

Commission members welcomed the details and requested an update at an appropriate time once further analysis had been undertaken.

AGREED:

That the presentation and update be noted.

42. WORK PROGRAMME

The Commission's Work Programme was submitted for information and comment.

AGREED:

That the Work Programme be noted.

43. CLOSE OF MEETING

The meeting closed at 8.55 pm.

Appendix B

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

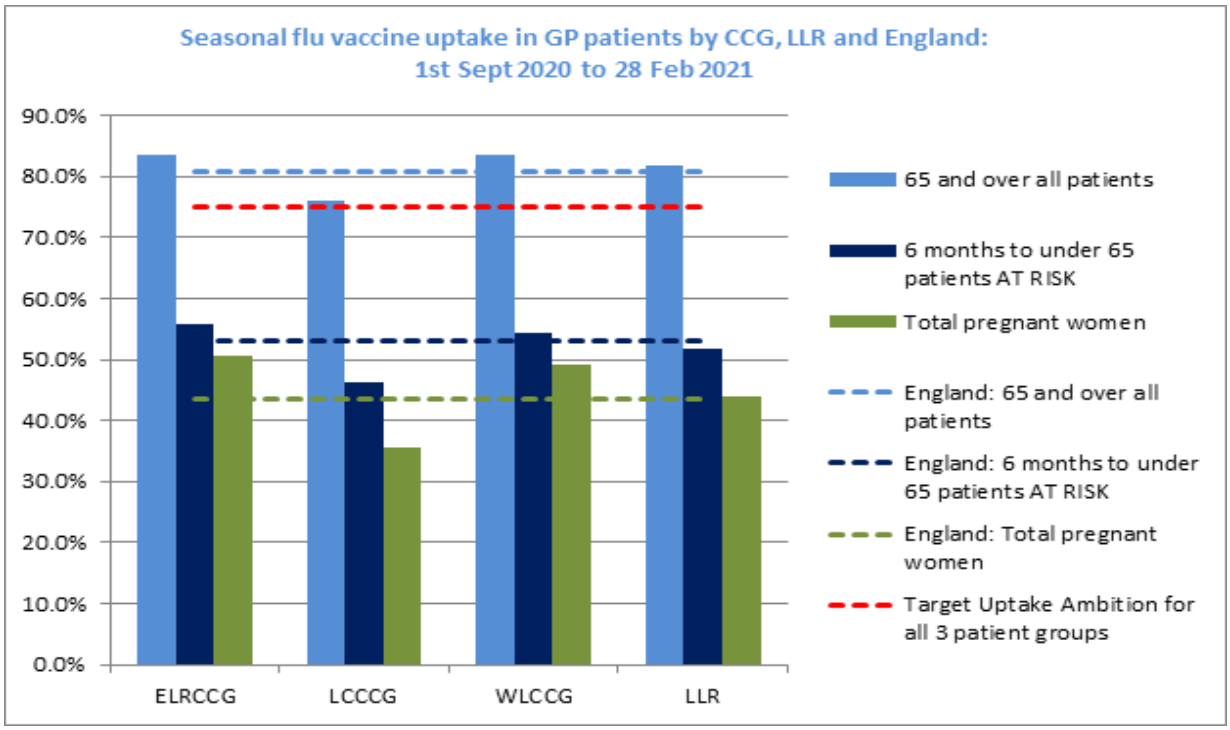
Flu Vaccination Programme Update
March 2021

1. The purpose of this paper is to provide information on the uptake of the Leicester Leicestershire and Rutland flu vaccination programme 2020/21. The data in this report provides the outturn position for the 2020/21 flu vaccination programme

2. Data is taken from the IMMFORM national database. It should be noted that practice level data from IMMFORM cannot be shared in the public domain due to licensing restrictions. The data in this report is limited to reporting at a CCG and system level.

Summary Update

3. The graph below shows vaccination rates in each of the three defined cohorts from 1st September 2020 to 28th February 2021.



Key areas to note from this year's Flu programme

- Despite the challenges faced with COVID-19 and infection prevention and control precautions the system wide effort from all organisations has meant we have vaccinated significantly more people than in previous years in each of the three cohorts. This is the result of the

considerable efforts within primary care and higher levels of public awareness of the importance of immunisations in the context of the Covid-19 pandemic;

- In Leicester City the change from 2019/20 is
  - Aged 65 and over: 10.34% (3705 more people vaccinated)
  - 6 months to 64 years at risk: 18% (6697 more people vaccinated)
  - Pregnant women: - 6% but this was based on a smaller list size of patients
- In particular we have been successful in vaccinating people over 65, a high risk cohort for both flu and Covid-19;
- There has been variation across general practices across the three 3 cohorts. We will be undertaking further analysis to inform next season's flu vaccination programme.
- There has been excellent collaboration with community pharmacy, faith groups, social care and healthcare to ensure a successful programme overall for Leicester, Leicestershire and Rutland.
- Our communications programme was more coordinated and focussed than in previous years. This has included:
  - Targeted checking – in with practices on what communications they have undertaken with patients and to determine what support they might need
  - Targeted public communications in the area of those practices with low uptake. This included media and hyperlocal social media channels.
  - Worked directly with voluntary and community organisations to send information to their networks e.g. Age concern for elderly, support groups for those with long – term conditions, faith communities
- Engaged the PPGs to cascade information wider through their networks

Conclusion

4. Despite the challenges faced more people across Leicester, Leicestershire and Rutland have received a Flu vaccination.
5. We are keen to ensure we apply the learnings from Covid-19 vaccinations to the flu immunisation programme this year. This will include looking at the evidence from new service delivery approaches e.g. pop-vaccination sites to determine if these will help us to further increase our flu uptake.

Wendy Hope
Head of Quality & Safety
LLR Clinical Commissioning Groups

Appendix C

LEICESTER, LEICESTERSHIRE AND RUTLAND

SYSTEM HEALTH INEQUALITIES FRAMEWORK

Version: Draft 10.1

Date: March 2021

Date	Version	Status	Author	Notes
December 2020	Initial	Early Draft	Mark Pierce and Steve McCue	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 11/12/20 LLR Population Health Management Advisory Group on 15/12/20
January 2021	Version 5	Draft	Mark Pierce and Steve McCue	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 07/01/21 LLR CCGs Governing Body meetings in common (confidential) on 12/01/21 Clinical Executive on 14/01/21 LLR NHS System Executive on 19/01/21
February 2021	Version 7	Draft	Mark Pierce, Steve McCue, Viv Robbins, Jo Atkinson, Aloma Onyemah and Lucy Wilson	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 04/02/21
February 2021	Version 9	Draft	Mark Pierce, Steve McCue, Viv Robbins, Jo Atkinson, Aloma Onyemah and Lucy Wilson	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 18/02/21
March 2021	Version 10.1	Draft	Mark Pierce, Steve McCue, Viv Robbins, Jo Atkinson, Aloma Onyemah and Lucy Wilson	For consideration: Reducing health inequalities across LLR – Task & Finish Group on 04/03/21 LLR CCGs Governing Body meetings in common (confidential) on 09/03/21

Leicester, Leicestershire and Rutland (LLR) System Health Inequalities Framework

Contents

Foreword to be included by ICS Chair

1. Purpose

The aim of the Leicester, Leicestershire and Rutland (LLR) Health Inequalities Framework is to improve healthy life expectancy across LLR, by reducing health inequalities across the system. The purpose of this Framework is therefore to:

1.1. Provide a system mandate for action to address health inequalities across LLR

1.2. Establish a collective understanding of the terms 'Inequality', 'Inequity' and 'Prevention' in relation to population health, across all parts of the LLR Integrated Care System (ICS)

1.3. Strengthen a whole system collaborative approach to reduce (and remove entirely where possible) avoidable unfairness in people's health and wellbeing in LLR

1.4. Establish the high-level principles of how LLR ICS partners will approach the work of reducing health inequity at system level

1.5. Recognise the framework will be implemented and agreed at system level, with much operational, political and community action taking place at 'place' and 'neighbourhood' level[1] . It is the systems' minimum ask of Place in relation to reducing health inequalities.

1.6. Set out some key actions that can be delivered at system level with support through the ICS, with recognition that some actions will be primarily for individual organisations e.g. the NHS or the Local Authority however many requiring partners to work together.

[1] LLR is divided into three "Places"; Leicester City, Leicestershire County and Rutland County, all of which align to upper tier local authority boundaries. Within each 'Place' smaller geographic areas known as 'Neighbourhoods' (also known by other terms such as 'districts' or 'communities') are used.

2. Introduction

2.1. Health and wellbeing is not just the concern of the NHS. The health and wellbeing of people is an asset to individuals, to communities, and to wider society. Good mental and physical health is a basic precondition for people to take an active role in family, community and work life. Although there is growing concern about stalling life expectancy, the existing wide inequalities in health outcomes tend to be overlooked. Improving healthy life expectancy enables people to live in better health for longer. Ensuring they can contribute to society. A workforce that remains fit, healthy and working for longer can contribute to a productive economy and decrease the costs of supporting an ageing society. However, health inequalities undermine these benefits.

2.2. Health inequalities can be found along a social gradient, with those living in the most deprived areas having the worst outcomes. Inequalities can be found even within areas that might be regarded as affluent. Therefore using a 'levelling up' approach will have an impact on the majority of the population. Evidence shows that having a more equitable society benefits the whole population, not just those living in the most deprived areas or currently experiencing the worst outcomes. [1] [2] [3] [4]

3. What are healthinequalities?

"*Health inequalities are the **preventable, unfair and unjust differences** in health status between groups, populations or individuals that **arise from the unequal distribution of social, environmental and economic** conditions within societies*" (NHS England) [5]

3.1. Those living in the most disadvantaged areas often have poorer health outcomes, as do some ethnic minority groups and vulnerable/socially excluded people. These inequalities are due to a combination of factors including income, education and the general conditions in which people are living. In addition, the most disadvantaged are not only more likely to get ill, but less likely to access services when they are ill. This is known as the inverse care law.

3.2. Health inequalities have been further exposed by the Covid-19 pandemic, which has taken a disproportionate toll on groups already facing the worst health outcomes. The mortality rate from the virus in the most deprived areas has been more than double that of the least deprived. In addition, some ethnic minority communities and people with disabilities have seen significantly higher Covid-19 mortality rates than the rest of the population. The economic and social consequences of measures to contain the virus have worsened these inequalities further, with people in crowded housing, on low wage, unstable and frontline work experiencing a greater burden and transmission of the virus.

3.3. There are always going to be differences in health, some are unavoidable e.g. as result of age or genetics but many differences in health are avoidable, unjust and unfair – it is these that we are concerned about and that this framework seeks to address. [2] [6] [7]

4. Inequalities vs equity

4.1 "Health inequalities" is the commonly used term, however we are actually referring to **health equity and inequities.** Therefore the terms are used interchangeably within this document and in the LLR system.

4.2. **Equality** means treating everyone the same/providing everyone with the same resource, whereas **Equity** means providing services relative to need. This will mean some *warranted* variation in services for different groups (see Figure 1).

4.3. It is important to note the difference in terminology between this work and those stated in the Equality Act 2010, although the terms relate to the same concept of equity. The Equality Act defines specific protected characteristics that require explicit consideration in any decision-making process, but this framework recognises the importance of identifying vulnerable groups that are not well reflected within these definitions (such as homeless people or those with caring responsibilities).

Figure 1: Representation of equality and equity using adapted bicycle example

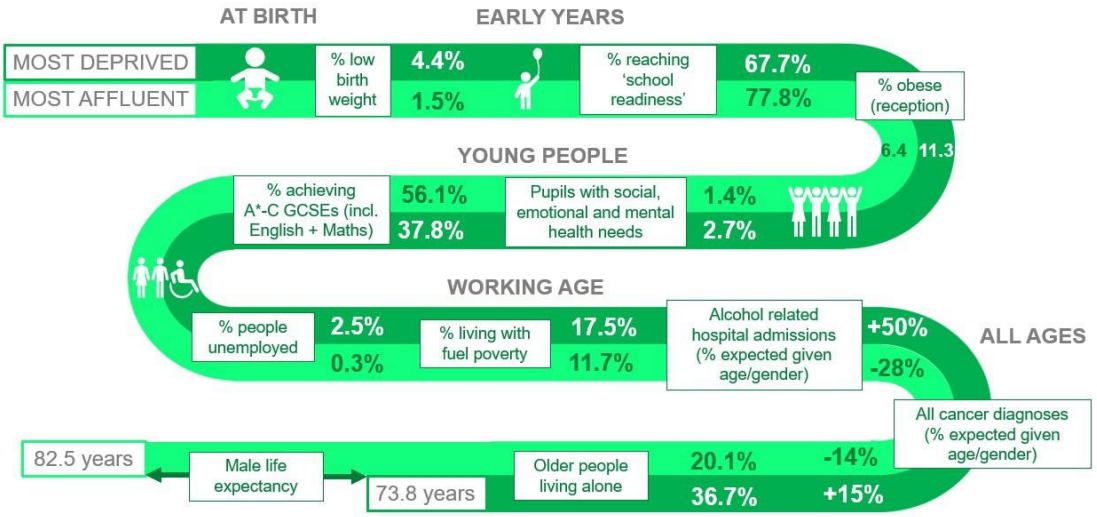
Source: Reproduced with authorisation from Robert Wood Johnson Foundation (Better Bike Share, 2017)

Need to add text description for people with visual impairments

A tale of two babies illustrates our story of inequalities in LLR (see Figure 2). It is vitally important to recognise that no outcome is set in stone. However the story aims to illustrate the potential variation in the opportunities and difficulties two babies might encounter throughout their life based on the circumstances into which they are born.

It highlights a demonstrable bias in the way our current systems are set up to benefit, to a greater extent, those in more affluent circumstances. With determination and collaborative effort we can reduce this injustice

Figure 2: Difference in health indicators between the most and least deprived local areas of LLR, over the life course



Source: PHE Fingertips [8]

Notes: Most deprived area data reflects inner City areas such as Braunston Park and Rowley Fields. Most affluent area data reflects areas such as Market Harborough-Logan and Market Harborough-Welland However there will be further hidden inequalities within each place for example within Rutland the most deprived ward is Greetham. Where small area data is not available local authority-level has been used.

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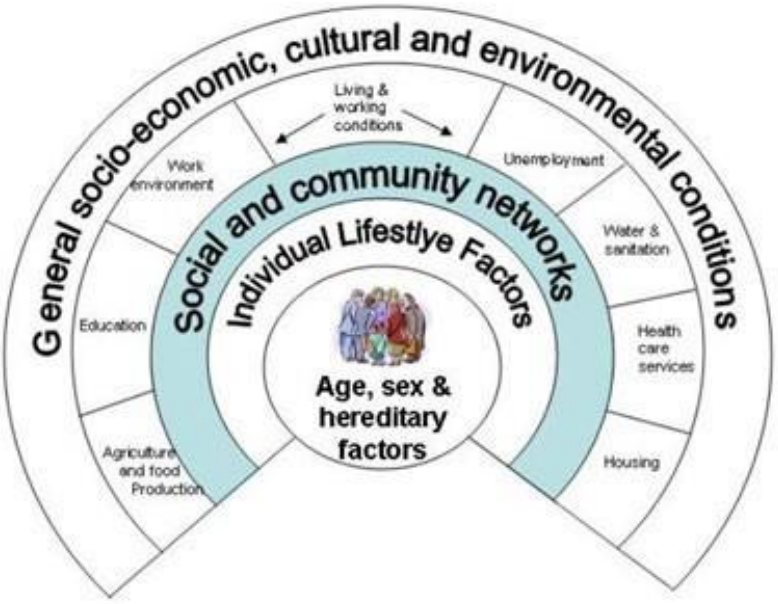
5. What is health?

5.1 Once we define health, we can understand why reducing health inequalities is a key piece of work for all partners within the ICS. Health is understood as;

"a state of wellbeing with physical, cultural, psychosocial, economic and spiritual attributes, not simply the absence of illness" (Marks, 2005) [9]

5.2 This framework recognises the above definition of health and the interconnected relationship between the elements of this definition. The work also adopts a social model of health influences, outlined in Figure 3 below. The social model of health identifies all but age, sex and hereditary factors as modifiable to change and therefore lying within the scope of this work, particularly in relation to primary prevention.

Figure 3: A Social Model of Health, Dahlgren & Whitehead (1991)



Source: The World Health Organisation. [6]

Need to add text description for people with visual impairments

5.3. The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. Systematic variation in these factors constitutes social inequality, an important driver of health inequalities. On a whole population level, the wider determinants of health (often known as the "causes of the causes") will have a much greater effect on reducing inequities in health compared to the NHS alone. Local Authorities, rather than the NHS, have influence and responsibility over some of the wider determinants such as education, housing, transport, clean air, licensing of food and alcohol outlets etc.

5.4. Local Authorities also have a key role in terms of fostering economic opportunity which is reflected in the supply and quality of jobs available in an area.

5.5. We can also see from Figure 3 that communities themselves are vital partners for the ICS members as they undertake this work – in terms of articulating lived experience of health inequalities and helping us co-produce solutions.

5.6. It's important to note that as an individual's health declines, the relative impact of NHS services on future health and life expectancy *increases.* By taking a preventative approach (working equally across primary, secondary and tertiary levels of intervention[2]) to delay and reduce the need for NHS treatment services the increasing demands on the health service can be managed appropriately. [1] [10] [11] [12]

[2] Primary prevention - Taking action to reduce the incidence of disease and health problems, through universal or targeted measures that reduce lifestyle risks and their causes

Secondary prevention - Systematically detecting the early stages of disease and intervening before full symptoms develop (e.g. taking measures to reduce high blood pressure).

Tertiary prevention - Helping people to manage the impact of ongoing illness or injury (e.g. chronic diseases, permanent impairments) to improve as much as possible their ability to function, their quality of life and their life expectancy. [12] [22]

6. How I can find out more about health inequalities in LLR?

6.1. A detailed analysis of local demographic and health data demonstrating the extent of inequality is available through local JSNA (Joint Strategic Needs Assessment) reports produced by each Public Health Team. Local JSNA's are available via the following organisational links:

Leicester City:

https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-health/data-reports-information/jsna/

Leicestershire:

https://www.lsr-online.org/leicestershire-2018-2021-jsna.html

Rutland:

https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/joint-strategic-needs-assessment/

Leicester, Leicestershire, and Rutland Integrated Care System Principles of Approach to Reducing Health Inequalities

7. Principles

As an ICS we are committed to taking action in order to reduce health inequalities across LLR. Our work in this area will be guided by the following set of principles.

Principle 1

Reducing Health inequalities is a key factor in all work conducted within the ICS – it is *everyone's* business. Reducing health inequalities and improving health equity should run through all work programmes at all levels as a "golden thread" from system to place to neighbourhood. Appropriate training and support will be given to enable people to think and act in ways that lead to reductions in health inequity.

Principle 2

The Integrated Care System (ICS) will adopt a Population Health Management[3] **and balanced approach to Prevention (across all three tiers**[2]**)** as core principles for their work together in order to reduce health inequalities. Prevention is key to managing future demand for health and care services. Prevention is also essential for improving health equity as the burden of disease is borne unfairly by those who are more deprived, marginalised or in a minority.

Principle 3

A focus on tackling the wider determinants of health. Primary prevention includes a focus on and increased investment in reducing inequalities in lifestyle risk factors (smoking, diet, exercise, alcohol consumption etc), mental wellbeing, housing, income, education, working conditions and the wider environment.

Principle 4

A focus on parity of esteem between mental and physical health - reducing inequalities in mental health will be prioritised to the same extent as reducing inequalities in physical health.

[3] Population Health Management approach involves the effective use of routinely collected data to provide meaningful insights on the population being served. This approach allows for proactive care planning by understanding the role of wider determinants of health and making best use of collective resources to improve the health of the population now and in the future. [3]

Principle 5

Public sector ICS partners will act as 'anchor institutions'[4] **in LLR** to promote health equity and reduce health inequalities through offering "social value". This approach includes supporting the system workforce to be more representative of the demography of the LLR population.

Principle 6

Investment in services will be proportionate to the needs (the ability to benefit) the people using those services (the principle of "proportionate universalism"). This means that although there will be a universal offer of services to all, there will be justifiable variation in services in response to differences in need within and between groups of people. Where we find variation in services that is not justified by the variation in need we will take action to "level up" the way the services are offered and outcomes achieved. While levelling up is generally a good thing, levelling down is not. So applying focus and resources in one area and targeting those resources to make them most effective will be appropriate, however, diverting those resources from somewhere they were also needed in order to improve health outcomes will not be.

Principle 7

We will use data – both qualitative and qualitative - to better understand the health inequalities that exist in LLR and how they affect people. We will draw upon the best evidence to select and implement effective action to reduce inequalities and to evaluate the impact of our services. Where services are failing to reduce inequity, or (by accident) are increasing it, the services will be adjusted or changed completely.

Principle 8

We will draw on the assets and strengths of communities and individuals to reduce health inequality and inequity. Our services will always try to listen to what really matters to people rather than focusing solely on "what is the matter" with them. We believe in the ability of people to develop effective solutions to challenges once the services we offer have been matched equitably to need.

Principle 9

The "**Health and Equity in all Policies**" approach[5] will help foster the process of ensuring the health and health equity perspectives are a core part of the ICS way of

[4] "Anchor institutions are large, public sector organisations that are called such because they are unlikely to relocate and have a significant stake in a geographical area – they are effectively 'anchored' in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land". [21]

[5] "Health in All Policies is an approach on health-related rights and obligations. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences

doing its business. This is particularly important on the wider determinants of health such as housing, education, employment etc.

Principle 10

We will take effective action at key points of the life course dependant on need ("from the cradle to the grave") to reduce health inequality and inequity. This means a specific focus on giving children the best start in life, prevention of ill health (including primary prevention), the promotion of wellbeing and resilience as key principles of our work. This approach will also address the intergenerational cycle of health inequalities across LLR.

Principle 11

Accountability for delivering on system wide health inequalities will be an ICS system accountability. However it is acknowledged that upper tier local authorities have a statutory duty to reduce health inequalities at the place level. Governance of system level principles and actions will be via the Health and Care Partnership.

Governance of place–based plans and strategies will be via Health and Wellbeing Boards. Governance of plans and actions at footprints beneath place level will be agreed between local partners using the most appropriate structures consistent with effective representation and oversight.

Much of the implementation of programmes to reduce health inequalities will occur at place. Within the requirements of system, places will be expected to influence the priorities for their populations. This is about understanding the population, how factors such as education, economy, housing, health etc are impacting on local communities and ensuring local engagement and co-production of any strategies or plans. The challenge is partners coming together to understand that impact, prioritising and developing programmes in collaboration with local communities (particularly communities who are most deprived and disadvantaged) is essential to strengthen community resilience and adverse social circumstances.

Principle 12

Actions will be undertaken at the most appropriate level of the ICS where they can be most effectively owned and delivered. Governance of different types of action will be determined in some cases by how statutory responsibility devolves from central government. Housing, education, and licensing rest with Local Authorities for example, while commissioning responsibility for most hospital services will lie with the local CCGs and their successors.

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of public policies on health systems, determinants of health, and well-being. It also contributes to sustainable development". [22] [12]

High level system actions to reduce health inequalities in Leicester, Leicestershire and Rutland

8. System actions

8.1. Introduction

We can see that health inequalities are the result of a complex range of interrelated causes – and "the causes of those causes". In some cases actions will be primarily in the hands of one partner. In other cases, reducing inequity will require close collaboration between several organisations across the system. The ICS partners are committed to taking action at all levels:

- System level – across the whole LLR area
- Place level – across the area covered by our Upper Tier Local Authorities (Leicester City Council, Leicestershire County Council, Rutland County Council) and led by Health and Wellbeing Boards
- Neighbourhood or locality level – smaller (though locally meaningful) populations within the wider Upper Tier boundaries.

At each of these levels the partners within the ICS – not just the NHS and the Local Authority, but the voluntary and community sectors too – will come together to plan in ever finer detail the actions they are going to take, individually and collectively, to reduce health inequity.

Priorities will be determined at place level and are likely to include;

1. A focus on the first 1,000 days of life as these determine outcomes across the whole life course. Action will be determined by the needs of each place.
2. Improving healthy life expectancy through early intervention and prevention including actions relating to the wider determinants of health. Actions will be determined by the needs of each place.
3. Using the lived experiences of people to inform our plans and actions.
4. Each organisation having an executive nominated lead for health inequalities who will be responsible for driving this agenda forward in their own organisation
5. A SMART approach to delivering actions at Place

The actions below are high level actions we will work on together because they will support effective work to increase health equity at all levels of the ICS or because they represent important health inequities faced to some degree in all parts of the system.

Below are the high-level system actions, detailed plans on action to reduce health inequity will be agreed at place level. The development, delivery and evaluation of place –based plans will be led by Directors of Public Health and Health and Wellbeing Boards. The plans will be based on local data and intelligence – qualitative and quantitative – derived from Public health, Local authority services, the NHS, other public sector partners, and communities themselves.

The most detailed implementation plans and actions will be developed by partners working together at a very local level (Neighbourhood or locality level). Multi-Disciplinary Team working, the sharing of information and engagement of individuals and communities around their assets and strengths will ensure that action is direct, person-centred and sensitive to feedback and revision from the integrated teams and the people those teams serve.

8.2. Strategic System Actions

Action 1

Places will be expected to translate the system level principles to their specific populations in the most appropriate way that meets their local needs. This is likely to take a wider determinants of health angle, acknowledging that much of this work happens at this level.

Action 2

We will agree a proportionate universalism approach to invest decisions across the ICS. This would allow actions to be universal, but with a scale and intensity that is proportionate to the level of disadvantage. ICS organisations will create a financial framework for addressing health inequalities with agreed investment in transformation of priority areas and investment based on need. NHS anticipates that any allocation of transformation and development funds being used to support the ICS will have reducing health inequalities as a high priority .

Specifically:

The NHS in LLR will develop and agree a new strategic long-term model of primary care funding distribution and investment to “level up” funding based on population need rather than historical allocation**.** This strategy will not destabilise local primary care.

Action 3

The ICS will establish a defined LLR resource to review health inequalities at the system level. This will be a virtual partnership between the NHS, the local authorities and local universities. It will aim to make available an enhanced capacity and capability for data processing and analysis to support a better understanding of inequity across LLR. It will gather and share best practice in effective interventions, it will provide teaching and training to all levels of staff in undertaking health equity audits. It will facilitate local research. It is acknowledged that Public Health teams

with partners will deliver the health inequalities support at a place and neighbourhood level.

Specifically:

a) Proposal for establishment of an LLR health inequalities specified resource to be presented to System Executive by 30.09.21

Action 4

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

Specifically:

a) Health Inequity and Inequality training will be mandatory for all executive decision makers in each organisation by 30.11 21
b) We will work locally and regionally to develop appropriate and robusttraining packages relevant to roles.

Action 5

System partners will work together to understand the full effect of the COVID-19 pandemic on health inequalities across LLR, to allow effective and equitable recovery after the pandemic. Whilst the specific programmes, metrics and evaluations will be agreed at place level for the most part, the LLR system will be looking to understand and encourage action around the following points:

- Identifying those communities and groups of all ages and across protected characteristics which have been most affected through the pandemic as a result of pre-existing vulnerabilities and disadvantages
- Undertake proportionate additional work to ensure vaccine uptake is equitable
- Ensuring a primary prevention focus to recovery that considers the wider determinants of health and causes of the causes including education, employment, housing and poverty
- Promote parity of esteem between the importance of both mental and physical health to those groups worst affected by the pandemic and the consequences of lockdown.

Action 6

All partners will work to improve the completeness and consistency of their data to enable a better understanding of health inequity both at all levels of the ICS. This predominantly relates to the collection of data on ‘protected characteristics’ under the Equality Act. The aim is to most appropriately reflect population need including levels of deprivation, vulnerability and the experience of different groups (including the use of qualitative methods).

Specifically:

(a) Key partner organisations to develop an action plan for having ethnicity, accessibility and communication needs of their population appropriately coded in records by 30.07.21
(b) We will risk stratify our population using combined data sets to identifyvulnerable groups and individuals in order to offer proactive, holistic care through Integrated Neighbourhood Teams involving a variety of system partners.

Action 7

The ICS will support the creation of health equity dashboards at place and system-level using agreed metrics to establish baseline information on health inequity and ensure systems are in place to measure progress appropriately. These dashboards at each level will help ensure accountability against our plans and targets to remove or reduce health inequity through all the work we do.

Specifically:

a) Each organisation will have adopted a standard health equity audit tool for completion at the planning phase of each project by 30.10.21
b) Training in undertaking these audits and common corrective actions that can be implemented to reduce inequity will be mandatory for relevant staff in each organisation – confirmation to System Executive by 30.10.21
c) Each Place in the LLR system will have a health equity dashboard with agreed metrics and benchmarked baseline performance by 30.10.21

Action 8

A form of Health Equity Audit (HEA) will be undertaken for projects delivered at all levels of commissioning, service redesign and evaluation within the ICS. These will occur at the planning stage of project work, at a scale that reflects a proportionate approach to work being conducted. Action to reduce health inequity will be taken based on audit findings (at a minimum considering the protected characteristics of the Equality Act 2010) will appropriate reviews planned where necessary.

Action 9

The ICS will develop an action plan, which develops the potential of the NHS and other partners to lead by example and act as an anchor institutions to drive change around a preventative approach and reducing health inequalities that focuses on what the collective LLR public sector can do in the areas of work opprotunities, use of buildings and purchasing by 1.7 2021

How will we know if this work is succeeding across LLR? If this framework is successful in driving effective action, we expect to see the following outcomes;

- A reduction in health inequities
- An increase in healthy life expectancy

- A reduction in premature mortality
- A workforce that is representative of the LLR population
- Population reported outcomes

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Appendix D

Obesity and Unhealthy Weight in Leicester

For consideration by: Health Scrutiny Commission

Date: 15th April 2021

Lead director: Ivan Browne

Useful information

■ Ward(s) All

■ Report author: Jo Atkinson, Consultant in Public Health; Etain McDermott, Public Health Programme Manager

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1. Purpose of report

1.1 To update Health Scrutiny on Obesity and unhealthy weight in Leicester City including Childhood Obesity

2. Report Summary

2.1 Introduction

Obesity is defined as an excess accumulation of body fat that presents a risk to health. The recommended measure of overweight and obesity is body mass index (BMI).

The National Institute for Health and Clinical Excellence (NICE, 2006) has recommended the classifications for defining weight in adults, as detailed in the table below.

Classification	BMI
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	30.0 – 39.9
Severely Obese	>40

It is important to note that as there is a high risk of type 2 diabetes and cardiovascular disease among Asian groups at a BMI lower than 25 using lower thresholds (23 to indicate increased risk and 27.5 to indicate high risk) for BMI to trigger action to prevent type 2 diabetes among Asian populations is recommended by NICE (2014).[i]

Weight gain can occur gradually over time when energy intake from food and drink is greater than energy used through the body's metabolism and physical activity. Obesity is a complex problem that is influenced by many different factors including excessive food intake and physical inactivity.

Research has identified a wide range of biological, psychological, environmental and economic determinants of obesity and the relationships between them, demonstrating the complexity of the issue.

Factors that cause obesity include;

- global factors – global food economy, multinational corporations
- local factors – health system, education system, socioeconomic, food economy
- community factors – support systems, built environment, culture and beliefs
- individual factors – food, psychology, physical activity, stress
- internal factors – genes, hormones

Obesity is a major public health issue. Among adults, obesity prevalence rose from 15% in 1993 to 29% in 2017. Health problems caused by obesity include type 2 diabetes, cardiovascular disease and cancer.

Diabetes is an on-going concern in Leicester, particularly type 2 diabetes which is often related to being overweight and physically inactive. In 2019-20 there were 31,242 people aged 17+ diagnosed with diabetes (type 1 or 2) on Leicester GP practice disease registers. Leicester City CCG has a diabetes QOF prevalence of 9.4% for those aged 17+. This is significantly higher than England, which is has a diabetes QOF prevalence of 7.1%. Around 95% of diabetes patients have Type 2 diabetes. In 2018/19 two thirds (66.9%) of those living with type two diabetes in Leicester were of a minority ethnic background. Losing weight and being physically active can improve the symptoms of diabetes in most cases. It is important to note that as a result of the covid-19 pandemic it is likely that many residents of Leicester have experienced weight gain, it is therefore likely that the prevalence of diabetes will increase furthermore.

The resulting NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year.

It is likely that the impact of covid will have a detrimental effect on healthy weight levels across the city due to the restrictions in the amount of exercise / activity people can do, closure of sports centres, clubs and gyms and the availability of fast food delivery. School closures will have affected the amount of activity children experience on a daily basis through the loss of PE lessons, daily mile and informal play through break times. In addition, throughout the covid-19 pandemic it has been found that being overweight or living with obesity increases the risk of dying from covid.

The Government have released a policy paper on tackling obesity in July 2020 that aims to empower children and adults to live healthy lives. Priorities of the plan include working to expand weight management services, introducing legislation

to add calorie labels to food, calorie labelling on alcohol and banning the advertising of foods high in fat, sugar or salt before 9pm.

As a result of the government call to action PHE have developed the Better Health campaign that urges people to take stock of how they live their lives in the wake of the covid-19 pandemic. It promotes evidence based tools and apps with advice on how to lose weight and keep it off.

Locally public health have also developed a healthy weight strategy through the implementation of the 1000 Tweaks to feeling great campaign. The campaign encourages everyone in the city to pledge to make a small tweak to their lifestyle to improve healthy lifestyle behaviours. It is targeted at everyone but particularly children, parents and grandparents, local businesses, communities, healthcare professionals, schools and teachers.

2.2 National Funding for Weight Management

On the 4th of March this year, the government announced an additional £100 million over 2021/22 to support people living with excess weight and obesity to lose weight and maintain healthier lifestyles.

The Parliamentary Under Secretary of State for Prevention, Public Health and Primary Care has confirmed that £34.9 million of this new funding will be dedicated to supporting the expansion of local authority weight management services for adults, children, and families. Funds will be allocated via two ringfenced grants under section 31 of the Local Government Act 2003 and will be available to Local Authorities for 12 months from the beginning of the 2021/22 financial year.

First, the Adult Weight Management Services Grant (No. 31/5540) will distribute £30.5 million among all local authorities in England, based on population size, obesity prevalence, and deprivation to commission adult behavioural weight management services. The funding is conditional on local authorities: commissioning new, or expanding existing, behavioural weight management services; providing information on current service provision at the start and end of the programme; and regularly sharing service user data (including demographics and outcomes) using a standardised dataset. It has been confirmed that Leicester will receive approximately £250,000 for 2021-22 expansion to adult weight management.

A further 5 million has been made available to support child weight management programmes. Public Health England (PHE) is seeking applications from local authorities with a high prevalence of childhood obesity and deprivation. Successful applicants will be allocated funding to support their work over the period 2021 to 2022.

2.3 Adult Obesity and Overweight in Leicester

The Active Lives Survey covers the whole of England and provides estimates for excess weight at a local authority level. In 2017/18 the Active Lives Survey estimated the level of excess weight (overweight or obese) in adults aged 18+ in Leicester at 55%, which is significantly lower than the England overall of 62%.

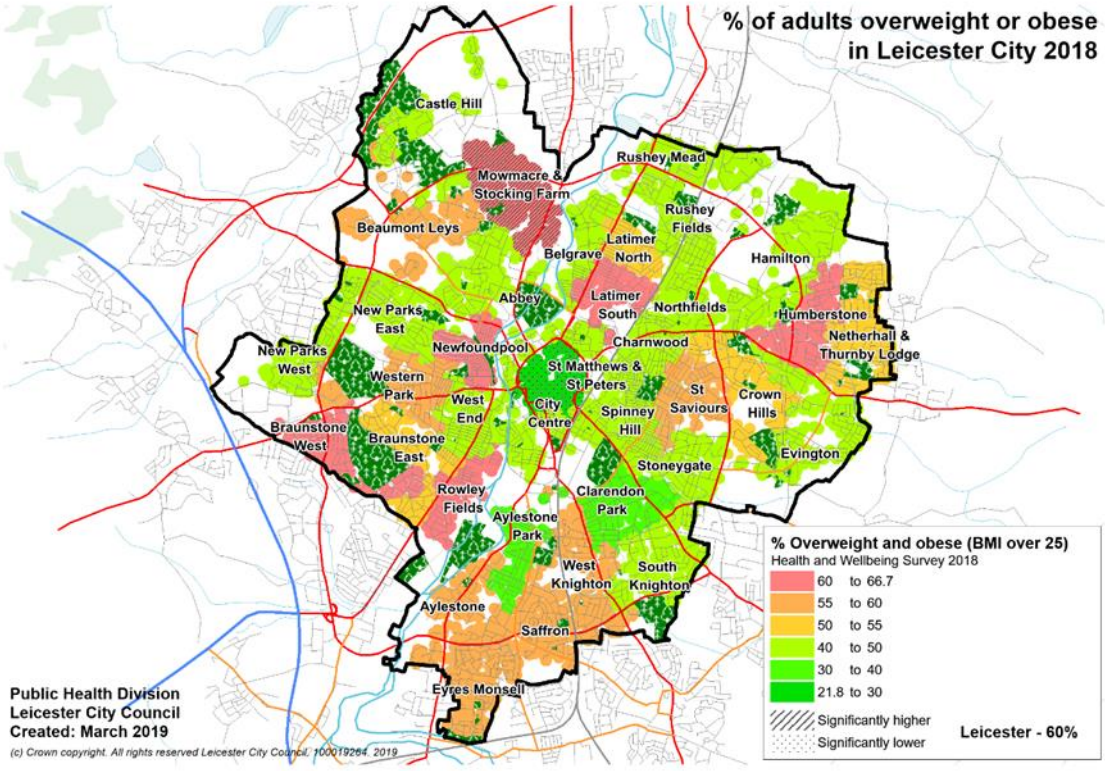
Local survey data estimates the levels of excess weight at 60% which is likely to be a more accurate estimate. (It is important to note that estimates of healthy weight are likely to be underestimates and they are based on self-reported height and weight measurements).

Leicester's relatively low excess weight prevalence can obscure the challenges posed by adult overweight and obesity in the city. A large proportion of Leicester's population are from ethnic backgrounds with a higher risk of chronic health conditions at a lower BMI threshold.

Small area estimates from the Leicester Health and Wellbeing Survey 2018 shows geographic variation within the city. Prevalence of overweight and obesity combined is generally higher in the south and west of the city (see figure below).

There is a strong relationship between socio-economic deprivation and being overweight/obese. Obesity prevalence increases with increasing levels of deprivation and there is a significant difference between the prevalence of obesity in those in the highest and lowest income and socioeconomic groups. Prevalence of type 2 diabetes is 40% more common among people in the most deprived quintile compared with those in the least deprived quintile.

It should be recognised that Leicester's Asian population is concentrated in the East of Leicester, so the geographical spread of risks associated with excess weight is likely to be more even than suggested by the geographical spread of overweight and obese BMI classifications.



2.4 Children's Overweight and Obesity

National Child Measurement Programme (NCMP)

The NCMP is a government-mandated activity. Every year, every child in reception year and year 6 has their height and weight measured.

The programme was established in school year 2005/06 and there is quality data available from 2007/8. It provides reliable data for monitoring changes in the weight of the 5/6-year-olds (reception) and 10/11-year-old (year 6) population over time and allows some comparison with England and other local authorities, as well as between demographic groups.

Data from the NCMP is used to support the commissioning and targeting of a range of local services and form part of the school health profiles public health provides to every school.

In Leicester, and most other local authorities, parents also receive a letter with feedback on their child's weight status and the offer of further advice and support on achieving a healthy weight for their child.

Leicester NCMP 2018/19 Key Messages:

- In reception year 10% of children were obese
- 23% of year 6 children were obese
- Boys were significantly less likely to be a healthy weight than girls in both age
- groups
- Reception year children in Leicester are just as likely to be a healthy weight as their peers in England
- Since 2007/8 there have been no statistically significant changes to levels of underweight, overweight and obesity in reception year .
- Since 2007/8 there has been a statistically significant increase in combined obesity and overweight prevalence among year 6s.
- overall.
- Leicester year 6 children are significantly more likely to be overweight or obese than their peers in England.
- In line with England, the highest levels of overweight and obesity were found in Black children in Leicester for both reception and year 6.
- White children in reception year were significantly more likely to be overweight or obese in Leicester than in England.
- Asian reception year children were significantly more likely to be underweight, and less likely to be overweight or obese compared with Asian children in England overall.
- In reception year, children in the West of the city were significantly more likely to be overweight or obese than England overall. Braunstone West (31%), New Parks East (30%), Newfoundpool (30%), and Mowmacre and Stocking Farm (27%) has the highest overweight and obesity rate.
- Children in 11 of Leicester's 37 MSOAS were significantly less likely to be overweight or obese compared to England. These areas were typically in the East, with high Asian populations. Charnwood (11%), Latimer South (14%), Hamilton (15%), and Rushey Mead (15%) had the lowest combined overweight and obesity prevalence.

2.5 Current Service Provision (Adults)

NICE (2006) recommend that any weight loss programmes fulfil the following criteria:

- Are based on a balanced healthy diet
- Encourage regular physical activity
- Expect people to lose no more than 0.5 – 1kg (1 – 2 lbs) a week

Weight management services are organised by tiers. The tier system of the ideal Obesity Service is outlined below:

Tier 1- Universal interventions for prevention and reinforcement of messages about physical activity and healthy eating. This is for all overweight individuals and includes local and national campaigns.

Tier 2- Lifestyle weight management programmes aimed at less complex cases, namely patients with lower BMI and/or without co-morbidities.

Tier 3- Specialist weight management service for obese individuals with complex needs and/or multiple co-morbidities who have not responded to intervention from other tiers. This service is aimed at those with BMI of ≥40kg/m^2 or ≥35kg/m^2 with co-morbidities.

Tier 4- Bariatric Surgery including pre-operative assessment and post-operative follow up. Must have participated in Tier 3 for 6-12 months prior to referral to Tier 4.

Based on national guidance, the commissioning of weight management services is shared across Local Authorities and CCGs. Local authority public health teams have the responsibility for commissioning tier 1 and 2 weight management services. CCGs have the responsibility for commissioning tier 3 (specialist weight management services) and tier 4 bariatric services.

Tier 1
Leicester promotes and signposts to open access universal services and opportunities, particularly those offered through leisure centres, sports clubs, parks and green spaces and active travel.

Tier 2
A Lifestyle services review took place and the decision was made to bring the majority of lifestyle services in house. As a result of this as of the 1st of July 2019 a new integrated lifestyle service called Live Well Leicester has been launched.

Currently there are three commissioned weight management programmes for adults with slightly different eligibility criteria. Live Well Leicester undertakes a holistic assessment with the referred client and then agrees which is the most appropriate service for them. GPs refer directly into the tier 3 service or for bariatric surgery.

Leicestershire Partnership Trust provide targeted weight management groups called LEAP (Lifestyle, Eating and Activity Programme) for people who are overweight or obese. LEAP is accessible for individuals who are overweight and obese and have

such as those with learning difficulties or mental health problems. The annual target is 218 per year.

Leicestershire Partnership Trust also provide enhanced programmes for people who are obese and have multiple comorbidities and so may need the specialist input of a dietician. This programme is known as DHAL, it is targeted at those with a South Asian diet but is open to anyone who is obese with multiple comorbidities. The annual target is 102 a year.

Tier 3
There is a gap with no local tier 3 provision of a specialist multidisciplinary team weight management service, although the DHAL and LEAP programmes described in tier 2 could be considered the dietetic component. There is a small team of dieticians based in the University Hospitals in Leicester (UHL) that provide Tier 3 dietetic support to less than 150 patients per year. Commissioning tier 3 is the responsibility of Clinical Commissioning Groups.

Tier 4
Leicester City CCG commission tier 4 bariatric surgery, however numbers of Leicester residents accessing bariatric surgery are low. Bariatric surgery is the option of choice (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m2 when other interventions have not been effective.

2.5.1 Other related services

Live Well Leicester undertakes a holistic assessment with clients referred from their GP or other health professional and some self-referrals. Subject to meeting the service specific referral criteria, the client will select which of the Lifestyle services to be referred to including weight management programmes, exercise on referral scheme, smoking cessation, alcohol support services and others.

Making Every Contact Count is available currently within UHL and Leicestershire Partnership Trust (LPT) with a training programme developed and implemented for all staff. This offer is due to be extended to the Local Authority with training for social care and leisure services staff a priority.

Midwifery
There is currently a limited amount of support available from a consultant midwife for pregnant women who are very obese at the time of booking. However, there is a lack of support available for women who are overweight or moderately obese apart from general support and advice from midwives.

Active Leicester
Leicester City has many assets to encourage and support greater participation in physical activity, from leisure centres and sports clubs, to, numerous parks and outdoor gyms to utilise for free.

Sport Services provide Nine sport and leisure facilities across the city, which consists of seven 7 leisure centres, an 18-hole golf course, 3G football pitches and an athletics track. The leisure centres offer a range of formal and informal sport and leisure opportunities including swimming, badminton, table tennis, climbing and football.

In addition, the service provides a portfolio of outdoor sport and physical activity opportunities across the council's parks and open spaces. These range from formal sport fixtures i.e. rugby and football pitches and tennis courts to a boating lake for leisure activities.

Outdoor Gyms (ODGs)
Leicester now has 32 ODG's spanning the City. These gyms are a valuable community asset as they provide a free, accessible form of exercise for members of the public. A mixture of resistance and cardiovascular equipment is available in each location ranging from 6 pieces of equipment in Netherhall park to 18 pieces of equipment in Spinney Hill park. The outdoor gym equipment states that it is appropriate for those 14+years, at any level of fitness and is free to use.

Park run
These are free, weekly, 5km timed runs around the world. They are open to everyone, free, and are safe and easy to take part in. These events take place in pleasant parkland surroundings and encourage people of every ability to take part; from those taking their first steps in running to Olympians; from juniors to those with more experience; Park Run welcomes everyone. There are 2 park runs in Leicester city Victoria Park and Braunstone Park. There is currently 1 junior park run in the city, public health, in partnership with Leicester City in the Community Trust and Beat the Street are looking to set up an additional junior park run once covid restrictions ease.

Parks and Open Spaces
There are 130 parks in Leicester 13 of which are considered large parks, all offering something different for everyone. Facilities include playgrounds, outdoor gyms, walking and cycling trails and meditation areas. Leicester City's parks, open spaces, community gardens and riverside corridor provide opportunities to participate in organised sport and fitness sessions along with space to enjoy informal recreational physical activity opportunities with friends and family.

Community Activities
There are large number of community sport and activity programmes and links to help individuals and families get out and about and active within their community and be as active as possible such as organised walks, tennis courts and community sports clubs.

Workplace Health
It is well documented that a sedentary lifestyle can prove harmful to health, however a number of occupations involve extended periods of sitting for employees. There are many workplace initiatives that aim to reduce the amount of sitting people do through encouraging short breaks at regular intervals, taking the stairs instead of the lift and provision of standing desks.
Leicester-shire and Rutland Sport (LRS) support workplaces to improve their health and wellbeing through:

- Workplace Health Needs Assessment - a tested tool to help businesses identify key priority areas of health and wellbeing.
- Opportunities for workplaces to get involved in competitions and Business Games, as well as training and workshops.
- Activity Tracker track your sport and physical activity levels, link to popular tracking apps and create workplace 'challenges'.
- Exercise, health, and wellbeing 'top tips' to support you to lead a healthy lifestyle in and out of work.

Walking in Leicester
There are many opportunities across Leicester to walk more including walking to school and health walks.

Choose How You Move (CHYM)
This website provides travel information for Leicester and Leicestershire, with a journey planner which allows residents and visitors to consider the different travel options available to them. The journey planner offers a variety of travel methods starting with the most active or sustainable travel options.

Cycling in Leicester
Increasing opportunities for people to cycle across Leicester City is a priority for the council. The level of change to the built environment and improvements for cyclists in Leicester has been unprecedented. The city has undergone much transformation with many new cycle routes and paths established. There has also been an increase in the availability of secure cycle parking, cycle training and guided rides.

Professional Sports Clubs
Leicester City benefits from 5 professional clubs all of which have extensive community programmes with a number of physical activity sessions on offer to local people who wish to improve their fitness, learn new skills, lose weight or socialise with likeminded people. Types of sessions include walking sports, educational sessions on a wide range of health topics, sporting camps and match day opportunities

Public Health have developed excellent partnerships with the professional sports clubs, establishing the Strategic Alliance for Sport and Physical Activity which is attended by all 5 clubs and other key partners incusing sports services and chaired by the Lead Member for Health. This has resulted in the development of a number of exciting initiatives including the sports club diabetes pledge and the formation of United Leicester. United Leicester is the umbrella brand for all 5 professional clubs work under to deliver public health initiatives to tackle unhealthy weight, physical inactivity and poor mental wellbeing.

2.6 Current Service Provision (Children)

Leicestershire Nutrition and Dietetic Service (LNDS)
Public Health commission LNDS to deliver a child weight management service called FLiC (a Family Lifestyle Club). FLiC is run by Dietitians and local Council Physical Activity leaders. It is an 8-week programme (meeting once each week) for children aged 8-13 years and their families, offering support and information about weight management. Each week will involve some fun active games for the children lead by the Physical Activity Co-ordinator. Whilst the children are involved in active games, there are topic based discussion for parents led by a Dietitian. At the end of each session children and parents get back together to take part in a fun, informative and tasting/food preparation session.

Food 4 Life – provided by the Soil Association, commissioned by Public Health

- A holistic, whole school evidence-based programme of tailored support that includes resources, training, cooking on the curriculum, food growing, the dining experience and the pupil voice. The programme has an accredited scheme for schools to achieve Bronze, Silver or Gold awards.

- Lunch box audits – sub-contract LNDS to conduct lunch box audits in FFL schools to see how healthy they are and educate children, staff and parents on how to improve them
- Currently 83 schools are enrolled on the FFL accreditation and are working towards achieving bronze or silver, 23 schools currently have bronze accreditation, 4 have achieved silver and 1 school has achieved gold.

Community Food Growing Support

- Develops and incentivises food growing to increase knowledge and skills in communities that may have limited access to food growing and its benefits. It focuses on sharing good practice by building a productive social media presence, providing a responsive and flexible service to support groups, building networks and widening opportunities for collaboration amongst community food growing groups, schools and early years settings to address diet related ill health. Public Health commissions The Conservation Volunteers (TCV) to provide this support. In addition, there re many wider initiatives in existence across the City ran by community groups, including allotments.
- 26 schools have been supported to develop a food growing area

2.7 Physical Activity Interventions for Children

The Daily Mile

Aims to improve physical, mental, emotional and social health and wellbeing of children, regardless of age or circumstances. Encourages children to walk, jog or run outside in the fresh air for 15 minutes every day. It is simple, free & sustainable. Led in partnership between Public Health and SSPAN there are currently 54 schools currently participating in TDM (as of Jan 2020).

School Sport & Physical Activity Network (SSPAN)

National School Games Programme

- A nationally funded offer free to schools including a limited competition programme, leadership opportunities, targeted health club resources and links to community opportunities.

Local SSPAN Membership enhanced offer

- A comprehensive offer to support schools developing the National School Games programme to offer more choice and opportunities relevant to Leicester City schools
- PE & Sport Premium advice and guidance – 5 Key Indicators plus Swimming

Enhanced health/well-being and physical activity offer

- Possible through additional funding for education-based interventions secured through partnership working with Leicester City Council Public Health.

Beat the Street

Beat the Street is an evidence-based intervention designed to increase physical activity levels across a community. It connects individuals with their local environment and supports long term behaviour change by making physical activity an enjoyable, integral part of everyday life.

Beat the Street encourages participation through game-based strategies and motivates positive behaviour that, over time, becomes the daily norm. Beat the Street

addresses some of the physical barriers to being active by using an inclusive, simplistic concept and combats emotional barriers by creating a community-wide social norm. Beat the Street ran very successfully in the north west of the city in 2019 and is planned to run city wide in 2021 dependant on covid restrictions,

Professional Sports Clubs – United Leicester
The city's 5 professional sports clubs offer a wide range of physical activity, healthy weight and wellbeing sessions to young people in schools and during the holidays.

Active Leicester – Leisure Centres
All of the city leisure centres offer range of formal and informal sport / leisure activities including Swimming/Badminton/Table Tennis /Climbing /Football. They offer access to gyms for 11 year olds and up. They also offer concessionary pricing available for children (Kids for a quid schemes) and Holiday camps

Other key professionals
There are many key partners who can and do play an important role in tackling childhood obesity including children's centres, health visitors, school nurses etc who have day to day interactions with children and their families.

2.8 City Council Vending Machines
A decision has been made to remove unhealthy snack foods from vending machines in council premises, starting with leisure centres. In regards to Leisure Services a contract currently exists with Selecta (vending company) and the centres take a commission of sales per year as income (£20k in 2019/20) across the leisure centres. However the contract currently rolls over annually so a procurement process is easily implemented.

There are 2 options going forward:

Option 1 – procurement of healthy vending externally managed, leisure services will receive a commission, but it is challenging to predict the impact on future finances. It would be natural to assume that a healthy vending product may reduce interest from external companies in the procurement, therefore the % commission that we receive may reduce slightly.

Option 2 – operating healthy vending internally, this is something that will deliver an improved financial return from vending, retaining all sales income. That said, the management becomes more intensive distracting from the core busines of leisure centre and outdoor sport with income of circa. £6 million.

A potential solution is that leisure services and public health develop a 2-year procurement for external healthy vending and accept a limited impact on income vs health benefits. During the 2-year period further work will be conducted to assess whether to then operate the healthy vending machines in-house.

2.9 Wider Determinants of Health
The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health.

Tackling the wider determinants of health in order to make a significant impact on reducing levels of obesity is vital as we will not see sustained improvements in healthy weight just by commissioning services.

There are a number of key areas that can influence and support the healthy weight agenda including;

The Food Plan – the plan offers the opportunity to improve the food environment across the City. It aims to make healthy choices the easy choices for residents, encourage breastfeeding and influence food businesses (retail and manufacturing) to improve their food offer.

The built environment – supporting planners and transport colleagues to consider the impact of the built environment on physical and mental will have a positive impact on healthy weight through the development of environments that encourage increased activity – better public transport systems, more cycle lanes, pedestrianised zones to encourage walking for example.

Making Every Contact Count - MECC is key to supporting the wider determinant of health in encouraging our own and other organisations to better consider health when planning and implementing services.

3. Recommendations

3.1 Scrutiny members are asked to note the contents of the report

3.2 Scrutiny members are asked to support the motion remove unhealthy snacks from leisure centre and other council premises vending machines

4. Financial, Legal and other implications

Financial implications

None associated with his paper.

Legal implications

None associated with his paper.

Climate Change and Carbon Reduction implications

None associated with his paper.

Equalities implications

None associated with his paper.

5. Is this a private report (If so, please indicated the reasons and state why it is not in the public interest to be dealt with publicly)?

No

6. Is this a "key decision"?

No

[i] NICE, BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups ,(2014). Available at: https://www.nice.org.uk/guidance/ph46/chapter/1-recommendations

Health and Wellbeing Scrutiny Commission

Work Programme (remaining meetings for 2019 – 2020)

Meeting Date	Topic	Actions arising	Progress
16th December 20	1. UHL Reconfiguration 2. COVID19 Update (including updates from partners) 3. Scoping Document for Scrutiny Review – BLM and Health	Reconfiguration update expected later (March or April meeting) to update on consultation findings. ACTION: chase CCG responses to public supplementary questions from public	Action Complete
20th January 21	1. COVID19 Update 2. Vaccinations - Flu & COVID Progress Update 3. Health Inequalities Update 4. Draft Revenue Budget 2021-22	Update on Young People's Council's Mental Health Report removed from proposed items and forward plan as no update available. 0-19 Commissioning deferred to next year due to need for extension (COVID)	
3rd March 21	1. COVID19 Update 2. Vaccinations - Flu & COVID Progress Update 3. UHL Financial Adjustment – Update 4. LPT Improvement Plan Update 5. Mental Health Workstream Update	Item 3 is based on the previous report presented in July 2020, with a need to update on auditor position.	
15th April 21	1. Matters Arising from the Last Meeting – COVID Hospital Readmissions 2. COVID19 Update 3. Vaccinations - Flu & COVID Progress Update 4. Health Inequalities Update – Action Plan 5. Updates on Obesity (including Childhood Obesity)	Item 1 will be a standing item until more clarity is provided on this matter. Item 4 added based on discussions from 20th January 2021 (Health Inequalities Item). Item 5 deferred to this meeting from March, due to length of the agenda above.	

Forward Plan Items

Topic	Detail	Proposed Date
Health & Care section of Forward Plan - **No decisions** due to be taken under this heading for the current period (on or after 1 Dec 2020)		
0-19 Commissioning Update	Planned for January 2021 but current contract extended by a year due to COVID	January 2022
Update on Sexual Health Services / Contraception	Requested as an item in the January 2021 meeting	Autumn 2021
Final Review Report – BLM and Health	First Task Group meeting in March 2021	May 2021
Manifesto Commitment Updates		Summer 2021
Impact of the Pre-exposure to HIV service and its funding		Summer 2021
Mental Health Update	Requested that an update be given in 6 months after the March 2021 update	September 2021
LPT Improvement Plan Update	Requested that an update be given in 6 months after the March 2021 update	September 2021
Updates on Obesity (including Childhood Obesity)		April 2021
Consultation Response to UHL Reconfiguration	Initial report was expected in early March 2021, but this could be as far as summer 2021.	May 2021
UHL Financial Adjustment - Update	Further information on the Development Programme from Deloitte and involvement in board selection processes.	September 2021
Review of contracts for vending machines and other food services at the Council's Leisure Centres	Requested as an item in the January 2021 meeting	Summer 2021
Matters Arising from the Last Meeting – COVID Hospital Readmissions	Standing item until further clarity is provided.	Spring 2021
Merger of CCGs		Summer 2021