LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 28 APRIL 2022

Time: 9:30 am

Location:
MEETING ROOM G.01/G02, GROUND FLOOR, CITY HALL, 115 CHARLES STREET, LEICESTER, LE1 1FZ

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

G. J. Carey
For Monitoring Officer

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MEMBERS OF THE BOARD

Councillors:

Councillor Vi Dempster, Assistant City Mayor, Health (Chair)

Councillor Piara Singh Clair, Deputy City Mayor, Culture, Leisure and Sport

Councillor Sarah Russell, Deputy City Mayor, Social Care and Anti-Poverty

Councillor Elly Cutkelvin, Assistant City Mayor, Education and Housing

Vacancy

City Council Officers:

Martin Samuels, Strategic Director of Social Care and Education

Ivan Browne, Director Public Health

Dr Katherine Packham, Public Health Consultant

1 Vacancy

NHS Representatives:

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Angela Hillery, Chief Executive, Leicestershire Partnership NHS Trust

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

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

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

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

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

Healthwatch / Other Representatives:

Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service

Harsha Kotecha, Chair, Healthwatch Advisory Board, Leicester and Leicestershire

Kevan Liles, Chief Executive, Voluntary Action Leicester

Rupert Matthews, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Mandip Rai, Director, Leicester, Leicestershire Enterprise Partnership

Kevin Routledge, Strategic Sports Alliance Group

Chief Superintendent, Adam Streets, Head of Local Policing Directorate, Leicestershire Police

STANDING INVITEES: (Non-Voting Board Members)

Cathy Ellis – Chair of Leicestershire Partnership NHS Trust

Professor Andrew Fry – College Director of Research, Leicester University

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

John MacDonald, Chair of University Hospitals of Leicester NHS Trust

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

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- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

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

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PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF THE PREVIOUS MEETING **Appendix A (Pages 1 - 12)**

The Minutes of the previous meeting of the Board held on 28 October 2021 are attached and the Board is asked to confirm them as a correct record.

4. SPOTLIGHT ON CASE STUDY **Appendix B (Pages 13 - 16)**

The Chair to introduce an anonymised case study of someone who was diagnosed with COPD and outlines his subsequent health issues.

5. THE LEICESTER HEALTH, CARE AND WELLBEING STRATEGY 2022-2027 **Appendix C (Pages 17 - 40)**

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

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

6. PRIMARY CARE DEVELOPMENT

Appendix D (Pages 41 - 72)

Yasmin Sidyot, Deputy Director Integration & Transformation, Leicester City Council to give a presentation on primary care development plans in Leicester City which covers the context, key achievements, vision, focus areas and priorities.

7. TOBACCO CONTROL STRATEGY

Appendix E (Pages 73 - 86)

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

8. HEALTHY START - FIRST 1001 CRITICAL DAYS OF LIFE

Appendix F (Pages 87 - 120)

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

9. PHARMACEUTICAL NEEDS ASSESSMENT

Appendix G (Pages 121 - 134)

To receive a report for noting on the Pharmaceutical Needs Assessment which needs to be prepared and published by 1 October 2022.

The Board is asked to note the report and to approve the interagency LLR wide reference group and to receive further reports to future meetings.

10. BETTER CARE FUND 2021-22

Appendix H (Pages 135 - 156)

To note the Better Care Fund 2021-22 spending outline.

11. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

12. DATES OF FUTURE MEETINGS

To note that the dates of future meetings of the Board will be agreed at the Annual Council Meeting on 19 May 2022and will be published soon afterwards.

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

13. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 28 OCTOBER 2021 at 9:30 am

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Leicester City Council.
Chief Inspector Manjit Atwal	–	Local Policing Directorate, Leicestershire Police.
Ivan Browne	–	Director of Public Health, Leicester City Council.
Councillor Elly Cutkelvin	–	Assistant City Mayor, Education and Housing.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group.
Harsha Kotecha	–	Chair, Healthwatch Advisory Board, Leicester and Leicestershire.
Richard Mitchell	–	Chief Executive, University Hospitals of Leicester NHS Trust.
Dr Katherine Packham	–	Public Health Consultant, Leicester City Council.
Councillor Rita Patel	–	Assistant City Mayor, Communities, Equalities and Special Projects, Leicester City Council.
Sarah Prema	–	Executive Director of Strategy and Planning. Leicester, Leicestershire and Rutland, Clinical Commissioning Groups.
Kevin Routledge	–	Strategic Sports Alliance Group.
Martin Samuels	–	Strategic Director Social Care and Education, Leicester City Council.
Councillor Piara Singh	–	Deputy City Mayor, Culture, Leisure and Sport,

Clair		Leicester City Council.
David Sissling	–	Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland.
Helen Thompson		Director of Families, Young People and Children's and LD Services, Leicestershire Partnership NHS Trust.
Mark Wightman	–	Director of Strategy and Communications, University Hospitals of Leicester NHS Trust.
Andy Williams	–	Chief Executive, Leicester, Leicestershire and Rutland, Clinical Commissioning Groups.

Standing Invitees

Cathy Ellis	–	Chair of Leicestershire Partnership NHS Trust

In Attendance

Graham Carey	–	Democratic Services, Leicester City Council.
Faisal Hussain	–	Deputy Chair of Leicestershire Partnership NHS Trust (As an observer).
Rachna Vyas	–	Executive Director for Integration and Transformation, Leicester, Leicestershire and Rutland, Clinical Commissioning Groups.

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38. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:-

Councillor Sarah Russell	Deputy City Mayor Social Care and Anti-Poverty, Leicester City Council.
Andrew Fry	College Director of Research, University of Leicester.
Angela Hillery	Chief Executive, Leicestershire Partnership NHS Trust.
Haley Jackson	Deputy Director of Strategic Transformation, NHS England and NHS Improvement.

Rupert Matthews	Leicester, Leicestershire and Rutland, Police and Crime Commissioner.
Oliver Newbould	Director of Strategic Transformation, NHS England and NHS Improvement.
Dr Avi Prasad	Co-Chair Leicester City Clinical Commissioning Group.
Mark Powell	Deputy Chief Executive, Leicestershire Partnership NHS Trust.
Chief Supt Adam Streets	Head of Local Policing Directorate, Leicestershire Police.

39. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business to be discussed at the meeting. No such declarations were received.

40. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 29 July 2021 be confirmed as a correct record.

41. CHAIR'S ANNOUNCEMENTS

The Chair paid tribute to Christine Jarvis of ADHD Solutions in Leicester who had retired and wished to thank her formally for her work in moving the support for families forward during her 25 years by making great achievements in improving the life chances of children and adults affected by ADHD through support, family coaching and resources for those with ADHD and their families.

The Chair also reported on 2 visits to GP practices to meet front line staff and GPs and praised the work they undertook under difficult circumstances arising from covid and the impacts this had on referrals to the NHS for elective operations and appointments etc. Both local authorities and the NHS had large numbers of health vacancies for which there were few applicants at present. The Chair encouraged a better understanding of the issues faced and for all to work in partnership to support patients and those waiting for operations and health services. Wherever possible enabling social subscribers should be used wherever possible to support patients until they received their operations etc. There was a need for everyone to show more restraint and respect for the pressures faced by primary care services and the NHS.

The Chair's comments were echoed and supported by Board Members and Healthwatch asked the Chair to share her visit experiences so they could put an article in their newsletter and publish it to share the story across the

networks.

It was recognised that the health services were aware of patients' frustrations and were working to reduce waiting times by taking action and investing time and money to improve experience of patients.

Andy Williams suggested that it would be helpful to have the PC development plans discussed at a future Board meeting so all partners could help to address the public's issues.

Martin Samuels welcomed the comments on how hard all sectors were working under the pressures they faced. He had been struck by the positive contribution to the interdependency of social care services which had changed positively in recent years. Social care generally employed more staff than the NHS, so their inclusion and acknowledgement of the working together was important and was considered to be a good strength of the Leicester system.

The Chair indicated that she would draw a letter together, for agreement, to be sent to social care and health staff summarising the Board's discussion and support for the work jointly undertaken in partnership to make a difference to the people of the City. The Chair also supported letting Healthwatch have details of the visits so they could add this to their newsletter.

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

Dr Katherine Packham, Consultant in Public Health gave a verbal summary on the outcome of the Health and Development Session held on 1 October.

- The aims of the Health & Wellbeing Board contained in its Terms of Reference were discussed, and some amendments were suggested which would be submitted to the Council for approval.
- The Board should set direction through the Health and Wellbeing Strategy and monitor progress and improvements through the Strategy's action plan.
- There should be a shared language and terms for initiatives used by all health partners. The Board should have a strong advocacy role in reducing health inequalities and the wider determinants of health and also ensure there was a focus on children and adults.
- Consideration was given to the Chairs of the Learning Disability Partnership Board and the Mental Health Partnership Boards having membership of the Board.
- Good discussion took place around housing and the wider determinates of health. These and other points discussed would need to be discussed further to consider how they could be progressed.
- The Board had an important role to link the Health and Wellbeing framework with the health system and determine how to implement and avoid duplications between health partners and also formalise links to other groups and committees in the integrated health system and integrated health care sectors to ensure they were aware of what the Board was working to achieve.

- There should be strong links with neighbourhoods in their different forms for community organisations and the differing natures of areas and GPs in the City etc.
- It was important for health providers to hear directly from communities on what they wanted from the health service due to their needs and lifestyles and not be just informed of the services health providers felt they should receive.
- There would be a need to provide funding and staff to progress the work forward.

The Chair stated that having arrived at these outcomes she didn't want to spend lengthy times in Board meetings sorting out the process. This would be for officers to undertake and submit revised Terms of Reference for circulation. The Chair supported having the Chairs of the 2 Partnership Boards taking part in Board meetings. The Board supported these views particularly working with carers differently and for the Board to focus on giving strong leadership of what Leicester's vision is about and to make Leicester a great place to live and work.

The Chair also felt that it was important to understand the responsibilities of the different Boards working in the health sector and how they fitted together in the system. Shared learning from each other and how they all undertook engagement could lead to joint engagement to avoid duplication and maximise public engagement.

Board members also felt that it was important not to be driven by a national dictates and agendas but what was considered to work locally to meet Leicester's health and wellbeing needs. Care should be taken that the Board did not unnecessarily rebadge or re-engineer what was already being done and it should be made clear what was not being done and why. The Board must be the driver around the concept of place. The focus should be on partnerships and recognise what can't be done together but recognise the influence of what can be done across the City. Police, universities and sports clubs should also play a part in the process.

The Chair thanked Board members for their contributions to the discussion.

RESOLVED:-

1) Officers were thanked for the update and asked to progress the amendments to the Terms of Reference.

2) The Board agreed with the Chair's suggestion that all future reports should be written and provided in an easy-to-read version and be implemented as soon as possible. Martin Samuels indicated that Adult Social Care staff could give advice on how this can be achieved.

3) That, as Ivan Browne and Dr Katherine Packham were already looking at what support should be available to the Board, they were asked to circulate these to all Board Members to see if they were fit for purpose and for Board Members to see what part their organise could play in

supporting the Board.

4) A further development session in 2-3 months' time would be helpful.

43. DRAFT HEALTH AND WELLBEING STRATEGY AND PRIORITIES

Dr Katherine Packham, Consultant in Public Health presented the report on the production of a Joint Health and Wellbeing Strategy (JH+WBS), a statutory duty of Leicester City Council and Leicester City Clinical Commissioning Group. The current JH+WBS was published in 2019 before the Covid pandemic. The draft revised JH+WBS has been updated in light of the pandemic and other changes that have occurred in policy. The report also outlined a recommended timeline for the 2022-2027 JH+WBS.

As part of the development of the Integrated Care System, each 'place' needed to have a place-led plan. The Leicester draft place-led plan consisted of the draft JH+WBS and the draft priorities for the Leicester City Health, Care and Wellbeing Delivery Plan. A more detailed delivery plan would follow once the priorities had been through an engagement process and the final version approved by Health and Wellbeing Board in January 2022.

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

During discussion on the report, it was noted that:-

- Members of the Board could comment on the draft priorities during the meeting or submit their views through the engagement process.
- The timescale of plan was considered to be the middle ground approach to give 5 years to deliver and achieve priorities and provide for a review not too far in the future as there had been many challenges through the impacts of Covid-19 which were not fully understood at the present, and these can be assessed in timely manner to review any new challenges.
- The Delivery Plan -Framework approach had been built upon the 5 strategic strands of the Joint Health and Wellbeing Strategy.
- In identifying the priorities, possible priorities that could have a significant impact through multi- agency/partnership working were selected. It was aimed to get a balance of health, care and wellbeing priorities. Some of the priorities required city wide action, whilst others required more delivery at a neighbourhood level and some required action at both levels.
- Health and wellbeing equity was at the forefront, and this included an approach of 'proportionate universalism' in which interventions were targeted to enable a 'levelling up' of the gradient in health outcomes.
- The priorities were built on existing engagement insights of what people thought was important in the way services should be delivered and took a strengths-based approach building upon existing community services and assets.
- Every opportunity for collaborative delivery of priorities with VCSE and

community organisations at either a city wide or neighbourhood level had been considered and they were supported by clear measures of progress (i.e. SMART).

- Since the agenda pack had been published, other priorities had come to light including a number of education related themes to young children affected by the pandemic and play development and others linked to deprivation. Also, healthy minds and other initiatives to be a zero suicide City had been identified. It would be helpful to have these extra priorities added to the summary of priorities and send to Board Members.

Members of the Board commented that:-

- More data was needed on outliers such as mental health in the city compared to the county. There were 20% more people with a mental health diagnosis in the in the city, a third were on care programmes and twice as many were in hospitals and 4 times the number of patients with Section 8 Notices. The City was a real outlier and this needed to be addressed through synergy and collaboration.
- The 5-year length of the Plan was supported and the 19 priorities could be standing priorities but with a focus this year on 3-4 priorities. There should be real community empowerment input into the priorities and the zero suicides ambition was supported as an ambitious and progressive aim to make improvements.
- The ability of staff in all organisations to develop should be recognised. UHL currently had 650 nurse vacancies and maybe there should be a reflection of how staff could be channelled from social care to nursing care etc. The biggest risk to the NHS was staff.
- Crime and Knife Crime were important and leisure centres and libraires could provide opportunities for healthy exercise through leisure facilities and GP referrals so people could stay fitter and not need to go to hospital.
- The focus on the whole city to make bigger impact on all people was supported. More information may be needed on racism and discrimination which impacted upon people. The strategy should support people to get the best impact for themselves with some support from services provided by organisations. The inclusion of people from a wider remit was needed to make a difference to what happens in the City. How the strategy connected with other strategies and schools and how opportunities were signposted would make a difference to the outcomes.
- Given the introduction of the ICS a possible challenge could be the proportion of funds spent on prevention services and how the Board's priorities could influence and be integrated with those of the ICS. The leverage provided by the whole system and its budgets could play a key role in maximising benefits for improvements in health and wellbeing.
- The working group was multi-disciplinary across the anchor institutions which should help to align priorities.
- There was support for the priorities to be bold and clearly indicate that they did not tolerate or support the inverse care law where less goes to

where it most needed. Leicester was a deprived multi-cultural city with complex needs that needed to be changed and to achieve improvements. It was important to focus on societal level changes and the priorities should hone in on genuine transformational issues.

The Chair thanked everyone for their supportive contributions and encouragement for the porposals.

RESOLVED:-

1) Officers were thanked for the presentation and update in the work carried out and endorsed the duration of the draft revised JH+WBS to be 2022-2027.

2) Officers were asked to take into account the comments made by Board Members and in preparing the draft priorities to be released for engagement.

44. LLR LEARNING DISABILITY AND AUTISM (LDA) - 3 YEAR PLAN PROGRESS REPORT

Helen Thompson, Director of Families, Young People and Children's and LD Services at Leicestershire Partnership NHS Trust and Chery Bosworth, Senior Programme Manager Transforming Care Programme, LLR CCG presented the LLR Learning Disability and Autism (LDA) 3 Year Plan Progress Report.

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

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

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

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

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

During the presentation it was noted that:-

- All people with a learning disability and/or autism would have the fundamental right to live good fulfilling lives, within their communities with access to the right support from the right people at the right time.
- The average age of death for adults with a learning disability was 59 years old and they were six times more likely to die from covid.
- NHS England had provided dedicated 3-year funding to transform services enabling long term planning to reduce numbers in hospital settings through a national policy shift around collaboration, integration and innovation to work together to improve social health for all.
- The Aims and Objectives of Transforming Care were outlined in the presentation which would improve early intervention and pathways, quality of service and reduce health inequalities, which would then help to reduce hospital admissions.
- Working as an integrated team across LLR was showing good benefits and outcomes. The aim was to enable 100% of people to have a health check to pick up issues earlier and to learn from assessing mortality reviews to make service changes.
- There was a clear defined governance structure for projects with co-ordination between service managers and the voluntary sector.
- Currently 77 70% had not had health checks but it was aimed to complete these before April 2022.
- 75% of people with a learning difficulty would have an annual health check by year 3 and, whilst this was an improvement over recent years, it was still not considered high enough.

Members of the Board commentated that:-

- There were high none attendance rates for primary care appointments and if care workers could be involved they could book appointments and help patients to attend. Both patients and carers should own the outcomes of checks.
- The work on collaborations was impressive and could be made into a case study of how services should work.
- Recent team efforts in getting people vaccination through a person accentuated approach had resulted in many vaccinations being carried out that would not otherwise have been done. This demonstrated that these things were best done at place level and system level and it was important to keep looking to ensure services were delivered at the most appropriate level in the most effective way.
- This work was important to share with the work done with SEND and the SEND Board.
- It was important for people to be supportive and take patients to appointments. The integrated approach was extremely welcome.

The Chair welcomed the work undertaken and was supportive with the strategy. She emphasised that families were struggling every day and don't always get the support and engagement they needed. They needed the

support to be available at the appropriate time and to be shown respect for their difficulties they were experiencing. The Chair also commented that neurodiversity should be promoted and adopted at this would provide services to a wider base than just those with ADHD.

Project Search Opportunities For CYP With Send

Steph Beale, Principal Ellesmere College, introduced Project Search Opportunities for CYP with SEND. Ellesmere College was the largest provider for SEND within the City of Leicester soon to provide 426 places for young people aged 5-19 with wide ranges of SEND. They were keen for their young people to have realistic opportunities to join the workforce when they left school. It was felt that a Project Search supported internship programme within the NHS or other large organisation could help us to achieve this. The Board received a presentation on the initiative.

During the presentation it was noted that:-

- The school trained pupils with the skills of respect, teamwork, responsibility, resilience, independence and confidence to prepare students for the world of work after leaving school and to be good citizens.
- The percentage of adults with SEND in permanent sustained employment (16 plus hours) was 6.2% nationally and it was currently 7.7% in Leicester which people wanted to improve.
- Project Search were running 69 schemes nationally supporting more than 1,300 young people with SEND into paid work. 60% of supported internships continued into paid employment and it hoped to improve this level in Leicester.
- Evidence showed that being in employment improved health and wellbeing and was central to individual identify, social roles and social status.
- People in work tended to enjoy happier and healthier lives and paid work had the potential to improve health and reduce health inequalities.
- Transitioning people from education straight into competitive employment also saved money for health and social care by creating opportunities for people with learning difficulties to become net contributors rather than recipients of adult social care and health services.
- Project Search had recently signed a contract with the NHS to run internships across 42 new sites in the UK, but Leicester was not included in the bid and Ellesmere wished to change this. The distribution of employment positions in the NHS was outlined.
- Ellesmere College were looking for support from a large employer in the City, UHL Trust for example, in order to bring the Project Search to Leicester.
- The Board's support for the initiative would be appreciated.

Mark Wightman (UHL NHS Trust), Helen Thompson (LPT NHS Trust) and Chief Inspector Manjit Atwal all indicated they would like to be involved in the

Project Search initiative and welcomed conversations with Steph Beale after the meeting. They all had employment opportunities which could provide opportunities to bring a young diverse range of people into their organisations to be part of their inclusive workforces.

Councillor Cutkelvin stated that she welcomed the proposal and wished to develop links with the work proposed by Ellesmere College and would welcome being involved as it supported work the Council wished to do with community colleges and SEND.

RESOLVED:-

1) Officers were thanked for the update on the progress of the implementation of the projects included in the LDA 3-year Plan and for the work to monitor the projects within the agreed governance arrangements.

2) The Board supported the Project Search initiative and encouraged representative of organisations on the Board to have discussions with Steph Beale to bring the initiative to Leicester and provide job opportunities for adult with learning difficulties as it was felt that the initiative could make a real difference in a short space of time.

45. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions from members of the public had been received.

46. DATES OF FUTURE MEETINGS

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

Thursday 27 January 2022 – 9.30am
Thursday 28 April 2022 – 9.30 am

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

47. ANY OTHER URGENT BUSINESS

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

48. CLOSE OF MEETING

The Chair declared the meeting closed at 11.38 am.

APPENDIX B

Spotlight – case study: Mr X

Mr X was diagnosed with COPD ten years ago and has managed his condition with medication for the ten years of being diagnosed. Before this he was quite active and enjoyed life and had many hobbies. But on the 2nd of February 2021 he was taken into hospital with swollen ankles and breathlessness. Whilst there he caught Covid 19. Fortunately he had his first vaccination and got mild symptoms. As the hospital started to investigate Mr X they found that he had heart failure and a hole in his heart. Consultants had many discussions about how to treat Mr X; they concluded that it would be to much of a risk to operate on Mr X. He was diagnosed with decompensated heart failure with reduced EF, cor pulmonale LRTI, pulmonary hypertension + advanced COPD, left leg cellulitis, Covid positive. He was hospitalised for 8 weeks and was put on oxygen. He was released from hospital and an oxygen concentrator was installed in his home; he was on 4 litres of oxygen. Mr X was admitted to hospital on numerous occasions with illness due to his previous diagnosis; this was a regular occurrence throughout the year. He couldn't leave the house at first because as he was reliant on receiving oxygen. After some time, after he had asked on numerous occasions if he could have portable oxygen tanks so he could at least leave the house, the NHS provided him this through BOC [oxygen provider]. He has support from the heart failure nurse and lung nurse weekly to check his condition and monitor him.

In October 2021 he was admitted again with an infection which was pneumonia and was there for many weeks but again he recovered. He was now on 8 litres of oxygen at home and was in recovery from his illness.

Throughout Mr X' admission to hospital he had numerous CT and MRI scans to identify what was going on inside his body.

On 24th February 2022 Mr X was admitted to hospital again with shortness of breath and swollen legs as he was retaining fluid. This was a regular occurrence with his condition. He had CT scans yet again and the results shown was a lung nodule that was likely to be cancer. As it had grown it was decided that due to frailty, he would not be suitable for any intervention, the best approach would be supportive care.

Whilst in hospital this time the consultant asked Mr X why he was on rivaroxaban, an anti-clot agent. He replied that on his first admission 2/02/21 to 19/03/21 that the doctor put him on them due to a blood clot. They reviewed the discharge letters, the letters states DOAC (direct-acting oral anticoagulants) was started during that admission. Another letter stated he had a PE. We have looked through the discharge letter it states no PE. They looked through the results of all CTPA results and no PE was seen. Mr X had had covid during that period; in view of this they stopped the DOAC.

Mr X was sent home he is currently still on 8 litres of oxygen but whilst in hospital he was on 15 litres then weaned down to 8 litres.

Mr X has the lung and heart failure nurse visit him alternative weeks; this is the only support Mr X gets. He was referred to LOROS. He had one session to talk about his last wishes. Mr X indicated that this was a lot to take in and wanted more support like counselling one to one. This was 8 months ago and still no support, so Mr X has to deal with all these changes with only his partner to support him. This has proved difficult for both of them as his partner is his primary carer and well as the closest person to him.

Mr X feels that he has been abandoned and sent home to die. His quality of life is so very limited now his mobility is very restricted due to breathlessness and other health issues. It is hard for him to speak to his partner because he doesn't want her to get upset and feels he needs to talk to someone non-related.

Now this section is how it as affected his partner Miss Y.

Obviously, the shock of Mr X's health deterioration has been hard to handle as before this they had a reasonably active life together. Miss Y feels that an assessment should have been carried out before he left the hospital the first time as she didn't know what to expect and didn't know how mobile Mr X would be. Nothing was done, so she had to predict what his needs would be so an adjustable bed was purchased and a commode as she predicted he would be able to get up the stairs. She was right, he couldn't. As Mr X's health has been deteriorating his needs have increased, so adaptions have been installed in the home bought by themselves, and a downstairs toilet and washroom has been installed paid for by themselves. It was only after all this was purchased that they were asked if adaptions were needed at this point; they said no as all adaptions had been purchased.

Also affecting them is the fact that the oxygen machine has made the energy bills in electric double, but it is needed so we have no choice. No help available for this. Miss Y works and can get no financial support.

Miss Y feels let down by everyone at this point. She feels deeply that Mr X is not supported in the way he should be and not knowing how much time they have together as Mr X will worsen and die. In August 2021 Mr X was told by doctors that he would be lucky if he seen his next birthday which is August. We have had to break the news to our grown-up children and Miss Y has been supporting them as well as it's been a very emotional journey.

What should have been done in Miss Y's eyes.

1. Mr X should have been assessed before he left the hospital the first time in February 2021 to see what adaptions and equipment, he would need to make his life easier especially with mobility issues.
2. He should have been offered counselling much sooner as it's a lot to take in especially when your life is going to be cut short and you have limited time left.
3. Consultants must make it much more understandable about diagnosis as patient don't always take on what they have been told and patients' partners

and relative closest should be spoken to about diagnosis and what to expect in the future.

4. Patients that are terminally ill should get better access to their GP and the GP should also be monitoring the patient's health which does not happen currently.
5. Carers of terminally ill relatives should get more support especially if they are the primary cares as their loved ones illness affects their own mental health and wellbeing.
6. Carers and patients to be made aware of what support they can get from different agencies and local government.

Final note from Miss Y:

I feel that each patient has different needs and that if you don't meet the criteria of the support on offer you don't get the support you need. Everyone is different and everyone's needs are different. if we don't start treating everyone's needs as different there will be vulnerable people who miss out on vital support they need.

Examples are

- Some people don't know that if you're a homeowner you can put in for adaptions grant from your local authority.
- If you are working and earn £19,000 plus you get little or no financial support with rising energy cost, mortgages and other household bill the amount above doesn't stretch far. It seems we have the working poor being more affected.
- Support information is not readily available to people.

In conclusion I praise the NHS services for what they provide but I feel more can be done as far as support after a patient leaves hospital from GP services, counselling services etc.
I would just like to say at this point that the NHS, ambulance services and community heart and lung nurses have been a lifeline for Mr X.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE: 28th April 2022

Subject:	The Leicester Health, Care and Wellbeing Strategy, 2022-2027
Presented to the Health and Wellbeing Board by:	Katherine Packham, Consultant in Public Health, Leicester City Council
Author:	Leicester Place-led Plan Core Working Group (a partnership group)

EXECUTIVE SUMMARY:

In 2019, 'Healthy Leicester. The Joint Health and Wellbeing Strategy, 2019-2024' was published. In 2021, the Health and Wellbeing Board approved a refresh of this strategy in light of the COVID-19 pandemic. A Place-led plan Core Working Group was established. This group is chaired by Katherine Packham, including representatives of children and young people and adult social care, NHS clinical commissioning groups colleagues from strategy and planning, Comms and engagement experts from LA and NHS, and GPs. This group developed a set of priorities based on extensive qualitative and quantitative data of health and wellbeing need. These priorities were then the subject of an online public engagement exercise from November 2021 to January 2022, as well as an extensive programme of discussion and engagement with a range of partnership boards and groups, and community groups and organisations. Further consideration and discussion took place in a health and wellbeing board development session. This strategy has been refined and updated in light of those discussions and feedback.

The overarching ambition will be the subject of a rapid engagement process to involve the people of Leicester in the phrasing of this ambition and vision.

Once the strategy is approved by Health and Wellbeing Board members, this will need to be formally ratified through the Council governance processes. It will then be taken to Integrated Care Partnership (LLR Health and Wellbeing Partnership) and the Integrated Care Board for information.

Ahead of the Health and Wellbeing Board in July 2022, members will be asked to contribute to an action plan to deliver the Health, Care and Wellbeing strategy priorities through partnership working as well as departmental and organisational specific inputs.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- **Consider** the rapid engagement feedback on the wording of the overarching priority.
- **Approve** the final version of the overarching priority of the strategy based on the feedback available.
  Current wording: **'Working together to enable everyone in Leicester to have an equal opportunity for good health and wellbeing'**
- **Approve** the Leicester Health, Care and Wellbeing Strategy 2022-2027.
- **Commit** to the action plan development process to develop an action plan for implementation of the strategy.

Leicester City Council

The Leicester Health, Care and Wellbeing Strategy

2022-27

Draft V4

April 2022

Foreword

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

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

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

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

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

When the previous strategy was initially developed it was a time of financial pressure which was being felt across all sectors and organisations. We are now faced with the complex nature of a city and country trying to recover from the effects of a pandemic as well as restoring services in the face of continuing financial pressures alongside the rising cost of living for us all.

Delivering this ambitious strategy will depend on a co-ordinated and collaborative approach between all partners, including the local authority, health and social care, local businesses and the voluntary and community sector. This approach may not be without its challenges, but we believe that working together is the best way to have a long-lasting, positive impact on the health of our city's residents as we all work

to move into a recovery phase whilst the pandemic remains a reality. During the pandemic, the people of Leicester demonstrated enormous community spirit to support one other. It is this drive and determination that will contribute to the delivery and success of the strategy.

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

Councillor Vi Dempster, Assistant City Mayor - Health

1. What is the purpose of this strategy?

The purpose of this strategy is to set out key priorities for the health and wellbeing of the people of Leicester over the next five years.

Our overall purpose and ambition is:

Working together to enable everyone in Leicester to have an equal opportunity for good health and wellbeing

We want to tackle the Inverse Care Law. This means that the people who most need health care are least likely to receive it. Unfortunately, this can also apply to other services and support. It is unfair and unjust. We recognise this will require greater collective partnership action to address the wider determinants of health and require targeted action to improve the lives of people in the city currently or are that are at risk of poor health outcomes. Leicester's Health and Wellbeing Board consists of a range of organisations working in partnership to improve the health and wellbeing of the people of Leicester. The board includes representatives from Leicester City Council (both elected members and officers), the NHS, a representative of the city's sports community, the Police, the universities, and Healthwatch. This strategy sets out the priorities of the Health and Wellbeing Board, and its member organisations, for the next five years, working in conjunction with a whole range of organisations, boards, groups and communities.

Further, this strategy is part of wider work to support of the Leicester, Leicestershire, and Rutland Integrated Care System (ICS) to create an offer to the local population of each place, to ensure that in that place everyone can:

- access clear advice on staying well.
- access a range of preventative services.
- access simple, joined-up care and treatment when they need it.
- access digital services (with non-digital alternatives) that put the citizen at the heart of their own care.
- access proactive support to keep as well as possible, where they are vulnerable or at high risk; and to
- through employment, training, procurement and volunteering activities, anchor institutions such as the NHS and local authorities, play a full part in social and economic development and environmental sustainability.[1]

2. Background

When the previous strategy was published in 2019, none of us knew that the world was about to change dramatically. The coronavirus (COVID-19) pandemic was to affect our lives in ways that we could not have imagined.

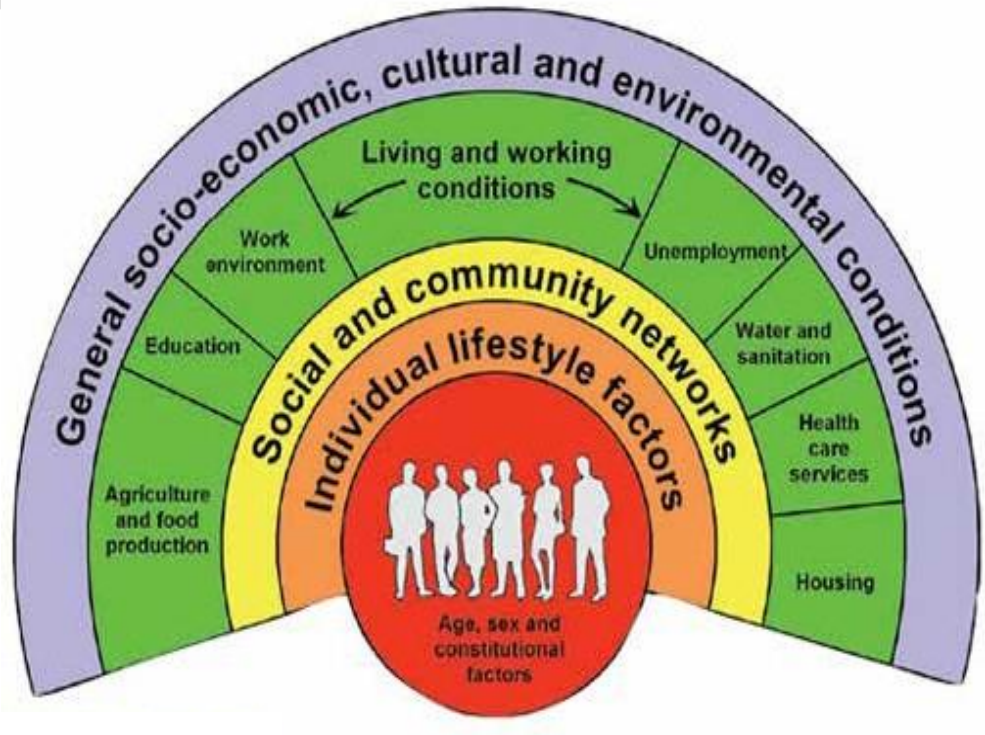
[1] https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf

Leicester and its people have been subject to some form of coronavirus related restrictions since March 2020. Leicester was the first place in the country to be placed into a local lockdown in summer 2020 to try and curb coronavirus infection levels in the summer of 2020. The pandemic has affected people unequally, with differences seen in levels of infection, serious illness and death based on people's ethnicity, and living and working conditions. For example, some people with lower paid jobs were unable to work from home and therefore at greater risk of acquiring and dying from the infection. Another example of those disproportionately affected include those living in overcrowded and poor-quality housing. These factors are beyond people's individual control, and the COVID-19 pandemic has further exacerbated the struggled that people face due to them.

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

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

Figure 1: The wider determinants of health, Dahlgren and Whitehead

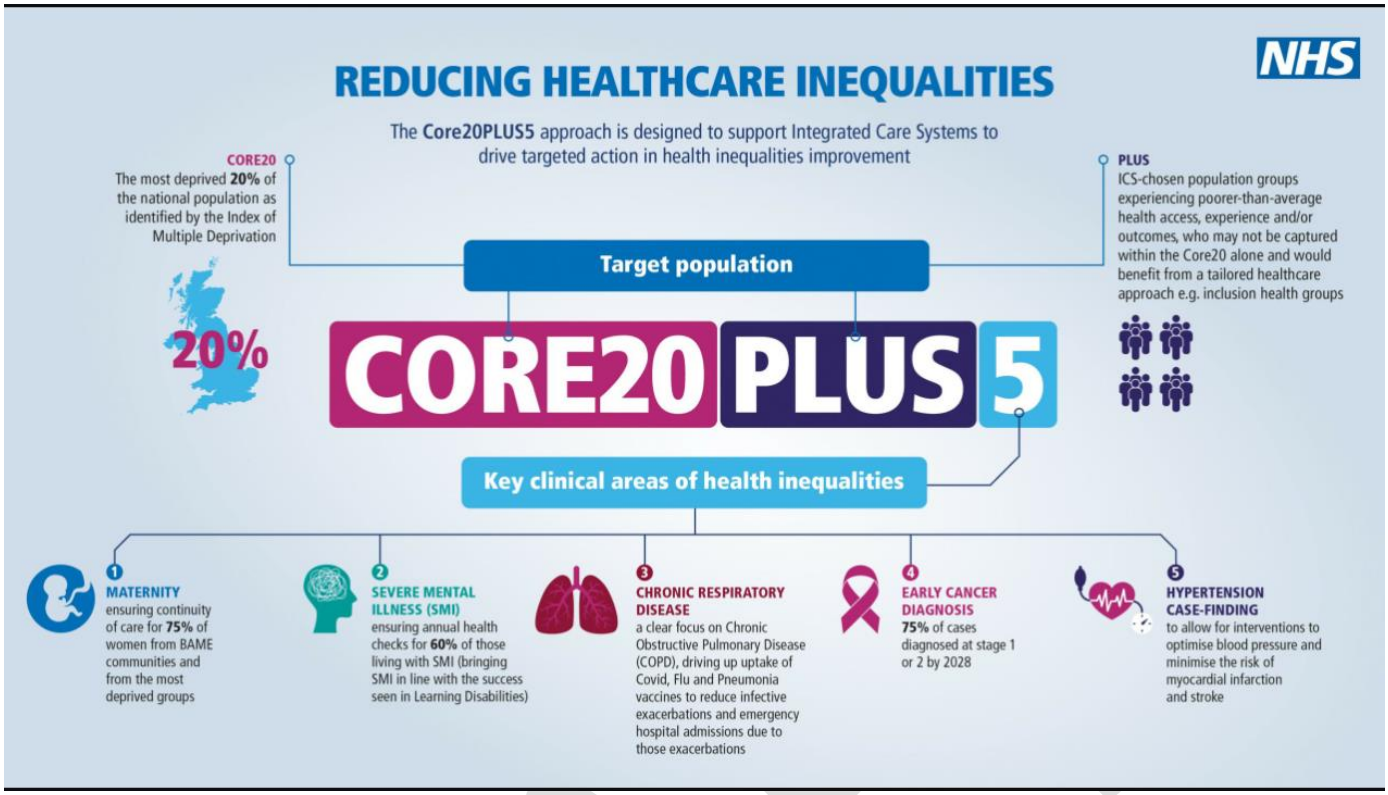


A range of community and faith groups have been integral parts of Leicester's response to the pandemic, supporting local residents with practical support such as delivering food or medicines, and working to support vaccination pop-up clinics in community venues. By drawing on the existing resources of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

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

NHS England also have a national framework for addressing health inequalities. This is called CORE20PLUS5. This approach defines target populations and 5 focus clinical areas. CORE20 is the people living in the 20% most deprived areas; PLUS incorporates groups that experience poorer than average access to services/experience of services and/or outcomes and inclusion groups; 5 includes specific targets within maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension. The CORE20PLUS5 approach is being used in Leicester and Health and Wellbeing board partners are working on reducing health inequalities in these groups alongside other initiatives.

Figure 2: CORE20PLUS5 www.england.nhs.uk/about/equality/equality-hub/core20plus5/



3. Why do we need a strategy?

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

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

The coronavirus (COVID-19) pandemic has and continues to have a major impact on people. Food poverty increased in 2020. People in lower paid roles or with zero hours contracts were facing greater financial instability. Those whose employers could not fund time off work for self-isolation or those who were not eligible for financial support to isolate may have found themselves having to work regardless to be able to feed their family. Children from disadvantaged families, and children of black and minority ethnicities lost more learning time due to lockdowns and self-isolation than those from wealthier areas. Carers of all ages will have found themselves under greater strain as a result of lockdowns. The cost of living is rising, with major increases in the cost of energy bills likely to increase the number of people living in fuel poverty over the coming months.

One of the main aims of this strategy is to reduce health inequalities. These are unfair and avoidable differences in health due to a range of factors as set out in the diagram on The Determinants of Health. No matter where we live, our health behaviours are influenced by our wider environment. Behaviours such as smoking, excessive drinking, drug use, poor diet and inactivity are greater in many parts of our city than they should be. This leads to a poorer quality of life, a shorter life expectancy overall and to an increase in rates of heart disease, cancer and respiratory disease, the leading causes of death in the city.

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

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

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

These key issues affecting the health of people in Leicester are the core themes of this strategy.

4. Themes for action

Our ambitions for Leicester are grouped under five themes, which are shown in the diagram below.

THEME 1: HEALTHY PLACES

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

A healthy Leicester promotes good health and alleviates and prevents health inequalities. It has green and open spaces, leisure facilities, libraries and museums. The air is clean, fit to breathe, there are low levels of unemployment and insecure work, and homes are of a decent standard. There are good choices with easy access to healthy food and opportunities to exercise regularly and travel by bike or on foot. A healthy place offers is a sense of community, safety and inclusiveness. Leicester has a number of parks and open spaces; work is going on to regenerate areas of the city and make these more pedestrian friendly; people continue to use our leisure centres, libraries and museums. However, these facilities are not necessarily equally accessible to all communities throughout the city.

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

Key issues that we know affect the local environment in Leicester with examples of what we are doing to improve people's opportunities of living a health life

Area	What we know about the City	Examples of work we are doing
Air quality and transport	Half of Leicester's residents are concerned about air quality. Motor vehicles are the greatest contributor to air pollution in the city. With less people driving during the pandemic, the air quality in Leicester improved.	We are promoting the health benefits of sustainable transport, such as cycling and walking, and improving air quality by working with transport sectors to reduce their impact on the environment. We are endeavouring to keep the clean air levels that were reached when fewer vehicles on the road during the pandemic, through supporting work towards our city being carbon neutral.
Health and Care Services	Leicester's people often have to tell their story more than once to different health and care agencies. COVID-19 has impacted access to health and care services and waiting lists for diagnosis and treatment have increased.	We are improving digital access to care and optimising function through new models of integrated care. We are also working in new partnership ways at a Neighbourhood Level to provide a seamless experience when residents are talking to partners
Housing and the built environment	One in five households in Leicester are overcrowded, rising to two in five if they have children. With people spending more time working from home, it is even more important that housing is of good quality. Further, the fuel poverty rate in Leicester is among the highest in England.	We are ensuring all local authority housing meets decent home standards. By maintaining and improving housing in the public and private sectors we are helping to ensure all properties are safe, healthy places to live in.
Mental Health	It is estimated that between 34,000-38,0000 people in Leicester live with a common mental health problem such as depression or anxiety. COVID-19 has further exacerbated mental health and wellbeing problems in our population.	We are offering facilities where communities can come together to take part in a wide range of social and cultural activities to benefit their mental and physical wellbeing.

THEME 2: HEALTHY MINDS

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

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

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

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

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

Key issues affecting mental health in Leicester with examples of what we are doing to improve people's opportunities to live a healthy life:

Area	What we know about the City	Examples of work we are doing
Preventing deaths by suicide	Around 30 people die by suicide in Leicester each year. Suicide can be influenced by a complex mix of adverse life experiences, such as relationship breakdown, bereavement, debt, or unemployment	We are working to prevent death by suicide and supporting people affected by suicide with our Start a Conversation: Suicide is Preventable campaign which focusses on how small actions can save lives.
Mental health of children and young people	One in ten children report having a mental health problem; many more say they feel stressed or overwhelmed. Promoting resilience to the stresses of daily life is key to improving children's mental health, as well as having more honest conversations about mental health and wellbeing, free of stigma.	We are supporting the mental health of children and young people in the city by providing emotional resilience training in Leicester.
Engagement with the local	People experiencing poor mental health are less satisfied with their local area and the green space in the city.	We are encouraging people to use our parks, open spaces, leisure centres and waterways and supporting their mental

environment of residents	This impacts on social isolation and happiness.	wellbeing, by promoting outdoor gyms and encouraging walking and cycling. We are encouraging a wider awareness of mental health by encouraging people to speak out about their experiences of mental health problems.

THEME 3: HEALTHY START

Ambition: To give Leicester's children the best start for life

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

For the best start for life for Leicester's children, we need to support the mother to breastfeed, ensuring the child is immunised, and supporting the child to develop good communication skills and healthy behaviours such as practising good oral hygiene and exercising regularly. Activities that instil confidence and resilience in children are the key to supporting positive mental health. We also recognise the possible impact of emerging issues such as new technologies, including social media, on the mental health and wellbeing of children and young people.

Key issues affecting children and young people in Leicester with examples of what we are doing to improve people's opportunities to living a healthy life:

Area	What we know about the City	Examples of work we are doing
Early years health	Infant mortality in Leicester is higher than the national average. Risk factors include poor maternal/family lifestyle choices, including smoking in pregnancy and in the house with babies and children, not breastfeeding and not immunising infants.	We are reducing the risk factors of infant mortality in the city by providing new mothers and families with information and support.
Mental health	One in ten children between five and 15 years suffers from poor mental health. This rate has increased through the COVID-19 pandemic. One in four children has a parent at risk of developing a common mental health problem.	Supporting families to improve early communication and use of home language. We are enabling professionals across the wider workforce and the community to promote good communication skills from 0-25.

Healthy eating and exercise	Childhood obesity in Leicester is higher than it is nationally, due to a number of different reasons.	We are encouraging more school-age children to be physically active by encouraging each school in Leicester to take part in the Daily Mile initiative.
Communication	Many children across Leicester have poor communication skills compared to other areas of the country.	We are working with education settings and workplaces to raise awareness and encourage early identification and support for mental health. This approach will support children to remain included within their education setting. Programmes from universal to specialist actively engage children and young people and those who work with them.
Oral health	Leicester has one of the worst rates of children's oral health in the country. This is particularly the case amongst under fives.	We are supporting children and families to develop good oral hygiene from an early age by signing up nurseries and other early year settings to the Healthy Teeth, Happy Smiles programme.

THEME 4: HEALTHY LIVES

Ambition: To encourage people to make sustainable and healthy lifestyle choices

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

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

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

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

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

Key issues affecting people in Leicester with examples of what we are doing to improve people's opportunities to live a healthy life:

Area	What we know about the City	Examples of work we are doing
Long-term conditions	Rates of diabetes are significantly higher in Leicester compared to England, with an estimated 31,000 adults living with diabetes in the city. The number of people living with more than one chronic condition is increasing.	We are encouraging more people to take up or increase their levels of physical activity through initiatives like Active Leicester and we are supporting people to walk and cycle more. We are encouraging people to eat more healthily through the delivery of the Food Plan and are supporting people to reduce smoking and alcohol consumption. We are raising awareness of the condition and the importance of early diagnosis, and improving care and timely access to diagnosis, by working as part of Cities Changing Diabetes.
Lifestyle choices	Half of adults in Leicester are overweight or obese. One in ten adults drinks alcohol above the recommended weekly units. One in five adults in Leicester eats the recommended five fruit and vegetables a day and two in five do less than the recommended 150 minutes of exercise a week. Our most vulnerable groups, such as those living in the most deprived areas, are at risk of making poor lifestyle choices.	
Mental and physical health	There is a clear link between mental and physical health. People with poor mental health may neglect their physical health and people who are physically unwell may develop poor mental health.	

THEME 5: HEALTHY AGEING

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

In modern society 'age' can be less about years lived and more to do with subjective health and wellbeing - how we feel inside. With people living longer, supporting people in retirement is even more important. Protecting our residents' continued health and wellbeing into older age requires them to have a continued sense of purpose. This may be through sharing their expertise, trying something new or giving back to society. Older residents at risk of poverty and those who are frail may need more practical support with healthcare and housing. Part of healthy ageing is about dying well. We will work to ensure people have a personalised, comfortable, and supported end of life with personalised support for carers and families.

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

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

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

Key Issues affecting older people in Leicester with examples of what we are doing to improve people's opportunities to experience healthy ageing:

Area	What we know about the City	Examples of work we are doing
Lifestyle factors	The onset or progress of some health-related conditions can be influenced by lifestyle factors, with those aged 65+ being less likely to undertake the recommended amount of exercise, and more likely to be overweight or obese, and drink above recommendations.	We are creating 'dementia friendly' public spaces throughout the city by working with public, private and voluntary sector age-friendly partners We are encouraging people to make positive changes that will improve their mental and physical health by working with partners to signpost and refer people to relevant lifestyle services.

Environmental factors	For some older people living in Leicester it is more difficult to travel independently and/ or access facilities. They are more likely to experience social isolation and loneliness, and may find online communication more difficult.	We are encouraging older people to practice self-care and independence and improve their own wellbeing by working with partners to implement a model of support.
Mental health	An increasing number of people aged 65+ feel socially isolated and lonely. However, those aged 65+ generally report a higher state of mental wellbeing than people under 65.	We are working to reduce social isolation and loneliness through a range of programmes and services in the city.

5. What are the key priorities?

We have identified a number of key priorities across the five overarching themes that we are and will continue to progress through an even more collaborative approach between health organisations, the local authority, voluntary and community sector organisations and with local communities:

Theme	Proposed Priority
A. HEALTHY PLACES Making Leicester the healthiest possible environment in which to live & work	1. We will improve the built environment to support people's long-term health and wellbeing.
	2. We will improve access to primary and community health and care services.
	3. We will move towards being a carbon neutral city.
	4. We will create Mental Health & Dementia friendly communities within Leicester.
B. HEALTHY START Giving Leicester's children the best start in life.	5. We will give every child the best start in life by focusing on the critical 1001 first days of life.
	6. We will make sure our children are able to Play and Learn.
	7. We will mitigate against the impacts of poverty on children and young people.
	8. We will empower health self-care in families with young children.
C. HEALTHY LIVES	9. We will take action to reduce levels of unhealthy weight across all ages.

Encouraging people to make sustainable and healthy lifestyle choices	
	10. We will increase early detection of heart & lung diseases and Cancer in adults.
	11. We will promoting independent living for people with long term health conditions.
	12. We will improve support for Carers.
D. HEALTHY MINDS Promoting positive mental health within Leicester across the life course	13. We will improve access for children & young people to Mental Health & emotional wellbeing services.
	14. We will improve access to primary & neighbourhood level Mental Health services for adults.
	15. We will reduce levels of social isolation in older people and adults.
	16. We will work towards having no deaths from suicide in the city.
E. HEALTHY AGEING Enabling Leicester's residents to age comfortably & confidently	17. We will enable Leicester's residents to age comfortably and confidently through a through a person-centred programme of frailty prevention.
	18. We will promote independent living for frail older people.
	19. We will reduce the number of falls for people aged 65+ in Leicester.

6. What will this mean for a resident of Leicester?

Progressing these key priorities should mean the following for a resident of Leicester:

I can access support and services when I need to, services will work together, and me and my family's needs will be the at the centre of the support that I receive.
I will live in a city with better air quality and a built environment that supports my health and wellbeing.
I will have more information of how to look after myself and my family's health.
I will have better and different ways (e.g. online) ways of accessing primary & community health services.

If I have children, I will get information, advice, and support to help them grow and develop.
I will get information, advice, and support on the importance of maintaining a healthy weight for myself and my family.
I will have better understanding of the early signs of health & lung diseases and cancers through more information advice and support.
If I have a long-term condition or illness, I will be supported to live as independently as possible.
If I am an unpaid carer I will get information, advice and support to help me manage this work.
If I am older person, I will get information advice and support to age comfortably and confidently as possible.
If I live in an area of the city or neighbourhood with poorer health outcomes, I will get targeted information, advice and support to improve my health & wellbeing.

7. How will work on these priorities be progressed?

The Health and Wellbeing Board recognises that we cannot focus the same level of resource and effort across all priorities simultaneously. For this reason we have therefore adopted a 'Do, Sponsor, Watch' approach as summarised below.

Approach	Supporting expectations	Number of priorities within each theme
DO	▪ Agreed by the Health and Wellbeing Board as the most important priorities to progress in initial years. ▪ Underpinned by detailed reference to plans & supporting metrics within an Action Plan. ▪ A member of the HWB will act as champion for each DO priority. ▪ Quarterly progress reporting to the Health and Wellbeing Board.	1-2
SPONSOR	▪ Plans & supporting metrics outlined within an Action Plan. ▪ Any risk to progress escalated through reporting to Place based groups.	1-2

WATCH	▪ Plans outlined within an Action Plan 22/24. ▪ Any risk to progress escalated through reporting to Place based groups.	1-2

The benefit of this approach is it gives focus on a small number of 'Do' priorities in initial years, whilst ensuring some level of focus on all priorities identified. The Health and Wellbeing Board can also review where each priority goes within the framework and regular intervals.

We also expect work on all priorities to be progressed using the guiding principles:

- Health and wellbeing equity in all we do, with support and services being provided and available at a scale and intensity that is proportionate to need.
- Using co-design and co-production of services and support with the people using the services, as well as using feedback we have already received from the people of Leicester on what is important to them on health and care services being delivered.
- Takes a strengths-based approach building on existing community and voluntary sector resources/ services in place.
- Look at new ways of building our local health and social care workforce.
- Are supported by clear measures of progress.

8. Engagement

A variety of partnership groups and boards, community organisations and groups, and other sources have informed our ambitions for Leicester's Joint Health and Wellbeing Strategy. Initial engagement, consultation and research for the strategy took place in 2019 when the previous version of the strategy was published. We have also incorporated what people have told us about their health and wellbeing in other engagement and consultation exercises such as: Building Better Hospitals, Step Up to Great Mental Health, primary care engagement and a range of COVID-19 pandemic and vaccination engagement and insights work.

More recently and to compliment what people have told us already, the strategy has also been the focus of an engagement process to ensure that our existing strategy and new priorities are aligned and continue to reflect views of the people of Leicester. The priorities were considered in a series of engagement events and opportunities in 2021 to 2022 including a public engagement event which collected views online from November 2021 to January 2022.

9. What are the next steps?

A series of action plans will support the strategy from 2022 to 2027. The initial action plan will run from 2022 to 2024, and will consider practical steps to convert the priorities into actions that can be implemented to achieve improvement and will include taking further some of the work that we have already started. Progress on these actions will be driven by and reported to a range of partnership groups as well as the Health and Wellbeing Board.

10. Acknowlegements

The Health and Wellbeing Board would like to thank the Leicester Place-led Plan core working group and all those who have worked in partnership to produce this strategy.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE 28th April 2022

Subject:	Primary Care Development
Presented to the Health and Wellbeing Board by:	Yasmin Sidyot Deputy Director Integration & Transformation (City)
Author:	Ian Potter Head of Transformation Sarah Smith Head of Transformation

EXECUTIVE SUMMARY:

The slides provide an update to the Health and Wellbeing Board on primary care development plans in Leicester City. The slides cover the context, key achievements, vision, focus areas and priorities.

The context outlines some of the challenges faced during the pandemic and the current structure of practices and Primary Care Networks (PCNs). Detail is provided on the vision for primary care and based on patient and staff feedback and the focus areas for the coming year including:

- Access
- Quality Improvement
- Service Delivery
- Workforce and Leadership
- PCN Development

Looking ahead, two all-member briefings have been planned through April and May, led by Cllr Dempster and our City GP's, to take members through the detail of the development plans and associated actions.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the paper.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE 28th April 2022

Subject:	Identification of Unregistered Patients Programme (GP Registration Programme)
Presented to the Health and Wellbeing Board by:	Yasmin Sidyot Deputy Director Integration & Transformation (City)
Author:	Mayur Patel Senior Integration & Transformation Manager

EXECUTIVE SUMMARY:

This report provides an update to the Health and Wellbeing Board on progress of the Identification of Unregistered Patient Programme, where patients reside within Leicester City but are not registered with a GP practice.

The investment of an additional £59,546 to Leicester City CCG to resource two additional band 4 staff for 12 months fixed term, enabled the CCG meet part of the NHS's pledge to reduce health inequalities, work with areas of high deprivation and large BAME communities. Aiming to work with local communities, patient groups, identifying unregistered patients and supporting them through the process. Additionally, registering patients with 'No Legal Status' in the UK, informing them of all the healthcare and benefits provided by NHS.

The report provides detailed information on the approach taken including:

- the aims and objectives
- methodology
- communication and engagement
- outcomes
- lessons learnt.

As summarised below, the GP Registration programme has delivered a significant increase in patient registrations across Leicester City during 2021 and a wealth of learning which has been used to inform current practice.

Date	New Patients Registered
January to December 2019	32,798
January to December 2020	29,222
January to November 2021	51,545

The programme was extended from January 2022 to March 2022 to expand across LLR, utilising the funding from NHS England on addressing health inequalities for Q4 of 2021/22.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- **Note** the paper.

Background

1. The NHS Constitution sets out the principles and values of the NHS in England, a key principle is that “access to NHS services is based on clinical need, not an individual’s ability to pay.” This is further explained in the following statement, “NHS services are free of charge, except in limited circumstances sanctioned by parliament”. This is applicable to all patients whether residing in the UK lawfully or not, including those that are within the area for more than 24 hours and less than 4 months. This applies to all patients including those who are an asylum seeker, refugee, homeless patients or overseas visitor, whether residing lawfully in the UK or not.

2. According to a Public Health England estimation, potentially 5,000-15,000 patients living within Leicester City have not registered with a general practice. To support and address these gaps, investment of £59,546 was given to Leicester City CCG. Leicester City CCG used the funds to recruit two GP Registration Officers to work with primary care providers, a range of statuary and voluntary care organization at a neighbourhood level to identify patients suitable for registration with a general practice to reduce health inequalities. GP Registration Officers also worked with large BAME communities as well as areas with high deprivation.

Aims & Objectives

3. The primary aim of this project was to ensure that all citizens in Leicester City have the knowledge, resources and information to make an informed choice on their rights to access primary care treatment provided by a GP and other primary care services.

4. The target was to register around 5,000 new patients in Leicester City by January 2022. The secondary objective was to ascertain, identify and acknowledge the issues faced within certain cohorts of patients in registering with primary care providers, and to generate a longer term, sustainable solution through co-production.

Methodology Identifying Areas / Communities to Target

5. A triangulation exercise was undertaken between CCG and Public Health teams, and potential gaps between the registered and resident population were identified with in the City. This enabled a strategic approach to target engagement on the areas most likely to be affected.

6. Vital work was undertaken in association with stakeholders to ensure development and delivery of communication and engagement strategies were co-designed. It was also crucial to build close relationships with the relevant local agencies and community groups with expertise in this area – such as the Immigration Enforcement team and groups supporting citizens with an illegal status where confirmation was provided that registering would not have an impact on their residency to remain in this country. Through this partnership approach, reassurances were provided by the Immigration Enforcement team to enable the GP registration officers to have an open and transparent dialogue with patients.

7. VCS organisations were invited to an online workshop to discuss the barriers their communities faced when registering with general practices and what mitigating solutions they would recommend for these barriers. Over 20 organisations attended and participated during the workshop, providing valuable feedback, feeding into the strategy developed to engage with patients and the communities they live in.

8. A strategic approach was taken to meet the aims and objectives of the project. A map (Appendix 1) was created to display all wards within Leicester City with a database showing the City geographically and targeting the population through a neighbourhood/locality approach.

9. The map identifies and highlights the type of engagement undertaken within each ward. This includes face to face engagements as well as places visited. The main focus of engagement remained through the hotspot areas of each ward including:

    - Places of Worship, Local Community Centres, Supermarkets, Pharmacies (as well as other primary care providers) and Walk in Covid-19 Vaccination clinics.
    - Once the national restrictions were eased, 21 neighbourhood areas were engaged across the City including Beaumont Leys, Frog Island & Abbey, Belgrave, Rushey Mead, Humberstone, Hamilton, North Evington, Evington, Thurncourt, Highfields, Spinney Hill, St Matthews, New Parks, Westcotes, City Centre, Stoneygate, Braunstone, Freeman, Knighton, Aylestone and Eyres Monsell.
    - To assure inclusion, the map also incorporated areas covered with the 9 protected characteristics, which was regularly reviewed throughout the year. Identifying communities within Leicester City, the engagement took place with 25 different communities and 'communities within communities' including Sikh, Muslim, Hindu, Somali, Bangladesh, Romanian, Polish, Gypsy, Traveller, Roma, Homeless, Refugees/Asylum Seeker, British Deaf Association, Elderly, LGBTQ+, Carers, Visually Impaired, South Asians Women's support groups, Children, Local families and communities, Mental Health, African/Caribbean, Afghans, Students, Chinese and Pregnant women etc. This partnership approach assured that patients of all ethnicities and protected characteristics were part of the programme mobilisation, aiming to reduce health inequalities for all and create better health outcomes.

Engagement and Working with Primary Care

10. Upon commencement of this programme, GP Registration Officers were introduced to practice managers and their teams. Individual MS team meetings were held with 25 practice managers covering 39 practices of the 56 in the city representing 75% take up. Also practice managers across Leicester City were engaged through weekly PM forums. A focused webinar for practice administration staff was also held. The progress and the success of the programme were also presented regularly at the Leicester City PLT as part of the Chair's address.

11. To improve registration and use of primary care, GP practice must ensure their policies and practice are in line with NHS England guidance and consider the needs of potentially excluded members of their local population.

12. A standard operating procedure was developed in partnership with Primary Care Contracting team. It includes the main principle for GP registrations which relates to:
    - Asking for identification
    - Different types of registration, including registering homeless / asylum seekers
    - And the reason for rejecting a patient registration.

13. The aim of this process was to ensure there was a standardized approach across Leicester City when GP practice registered new patients.

Communications Campaign

14. Communication campaign was created to promote the programme across the Leicester City consisting of:
    - A4 posters & A5 Leaflets in English, translated in top 7 Leicester City specific languages, both providing details of GP registration officers and information about service available to patient by registering with GP practice.
    - Banner pens were created with brief information and contact details, NHS "How to register with a GP" leaflet was also printed.
    - Posters were distributed to 204 outlets including pharmacies, local supermarket, shop, places of worship and VCS organisations.
    - Information was also posted on 11 Facebook spotted sites
    - Email was sent to 132 PPG groups
    - Workshop held with 20 VCS organisation
    - Regular engagement held at ED, large factory site visited, 31 Vaccine clinics attended engaging with 7800 patients, 36 face to face engagement event held engaging with approx. 2150 patients.

15. Covid-19 restrictions and government guidelines directly impacted the initial 2–3-month period, restricting the officers to non-face-to-face engagements. A wide range of digital methods were utilised to reach communities with message being relayed directly. A selection of the material used is in Appendix 2.

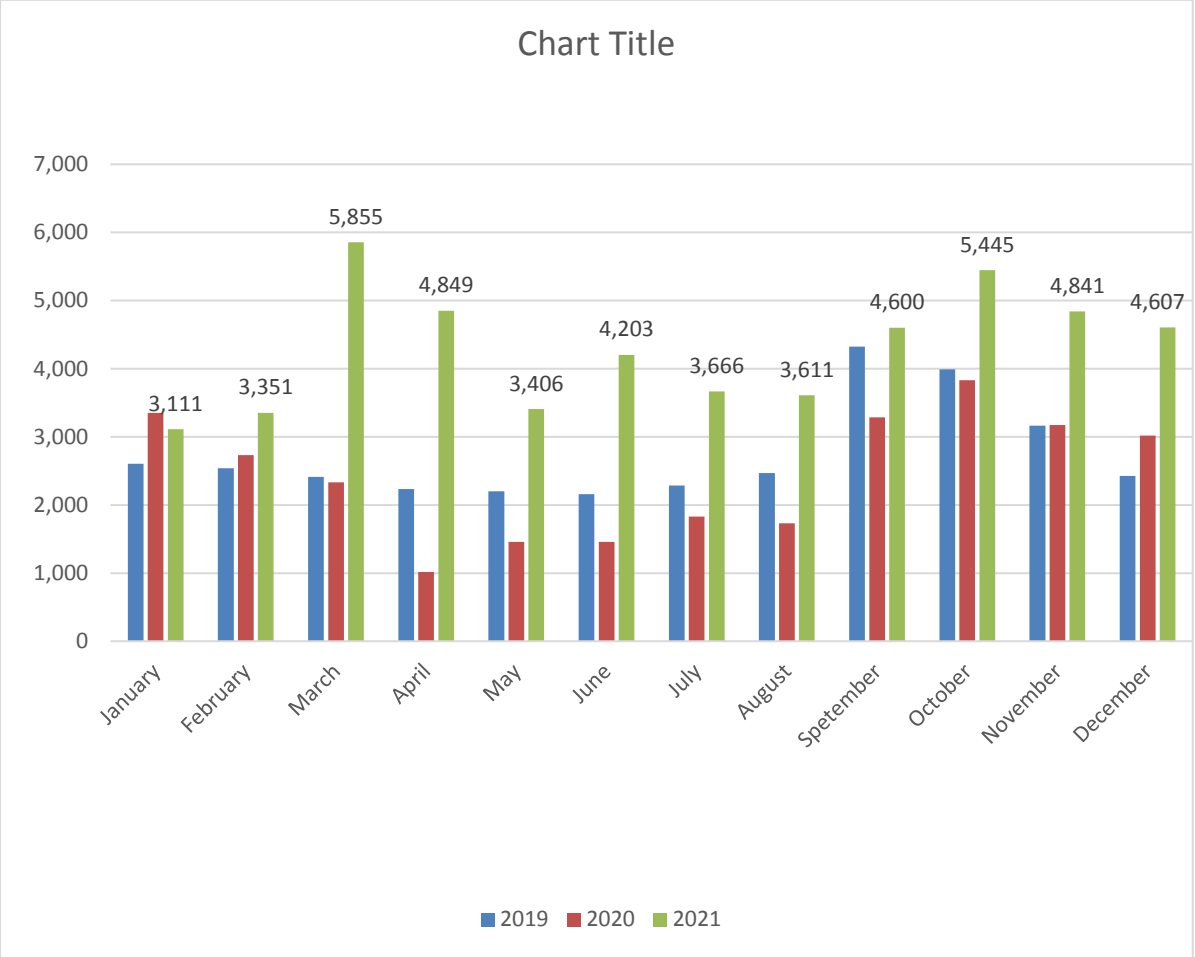
16. After the COVID-19 restrictions were lifted, officers attended 30+ walk in clinics as well as appointment based Covid-19 vaccine clinics held by GP Practices across Leicester City including: Community Health Centre - Highfields, St Peter's Health Centre - Highfields, Peepul Centre – Belgrave, Al Furquan Mosque - St Matthews, Merridale Medical Centre 6 - Westcotes, King Power Stadium - Aylestone, Barley Croft Community Centre - Beaumont Leys, De Montfort Hall - Clarendon Park, Afro Caribbean Centre - Highfields, Tudor Community Centre - Beaumont Leys, De Montfort University - City Centre etc.

Result

17. The target was to register 5,000 new patients by January 2022. The success and effectiveness of the programme were measured regularly and by the end of December 2021, 51,545 new patients were registered within Leicester City that an increase of 22,323 new patients then in year 2020.

Date	Patient Registered
January to December 2019	32,798
January to December 2020	29,222
January to December 2121	**51,545**

18. Data incorporates All new registrations (Which include newly born babies, patients moving into the area and patients registering from one practice to another) cannot be attributed directly to the project-however, a 76% increase in registrations compared to the three-year trend suggests that the additional engagement process put into place had an impact on registrations.



- January & February, early stages of the programme. Scoping / project plan completed to ensure requirements and objectives of the program were outlined with clear targets. Aiming to understand what communities to reach with tailored messages. Covid-19 restrictions and government guidelines had a direct impact on the first 2-3 months. Officers were unable to commence face-to-face engagements with the communities therefore messages were being relayed digitally.
- From March onwards demonstrates the full launch of this programme. Work to target potential patients, their carers and families through a range of communication channels including media, social media, websites, newsletter, stakeholder communications channels and by distributing communications materials.
- May / June indicates a slight decrease due to university students moving home and re-registering at their home residency. Similarly, September / October shows an increase to student moving into Leicester and registering.
- November & December showing slight reduction then previous Month as people are self isolating at home due to Covid19 Omicron variant.

- Promoting on local community radio stations; radio advertising across cultural and community specific radio stations.
- Key enablers in achieving the above target were robust communication and community engagement strategies, whilst working within the restrictions of the pandemic.

Learning from the Project

19. The GP Registration programme has gathered a wealth of information regarding barriers faced by the patients when registering with GP practices as well as issues faced by registration staff at practices. The table below outlines the exploratory approach to mitigate these barriers to ensure a positive patient experience and support to General Practice.

Barriers	Solutions
Patients and VCS' experiencing negative 'attitude' from reception staff when trying to register. Registration being refused in the absence of any identity documents (i.e. Passport or Utility bill)	Patients and VCS are assured through continuous engagement by the officers that when trying to register with a practice, the practice requests to see the relevant documentation to: 1. eliminate duplications if they were previously registered before with the NHS and 2. to check they are within the catchment area However, registration should not be refused in the absence of any identity documentation.
Language Barriers	Working with the wider I&T directorate, both officers were able to engage effectively with most communities in English, Hindi, and Gujarati. Interpretation and Translation services from UJALA are used on regular bases when holding engagement with other communities, such as Eastern European & Somali Communities.
Receptionist not accepting registration forms delivered by the officers	Working in partnership with Primary Care Contracting and GP Practices, solutions were identified to enable full patient registration.
Practices accepting but not processing the form	Working in partnership with Primary Care Contracting and GP Practices, solutions were identified to enable full patient registration.
Practice Managers / admin staff notified the officers that they were struggling to contact the patient with the numbers provided on the registration form.	When completing the GMS1 forms, the officers would check the number to confirm the details were correct and there were no discrepancies.
Lack of support from some places of worship to hold engagement events	Alternative sites; places of worship were identified to hold patient engagement. .

20. This learning has been shared with general practices to ensure that registration becomes easier for our communities, considering all the learning above.

21. The team is currently supporting county areas such as Loughborough with a similar exercise and growth has been noted in these PCN areas already.

Conclusion

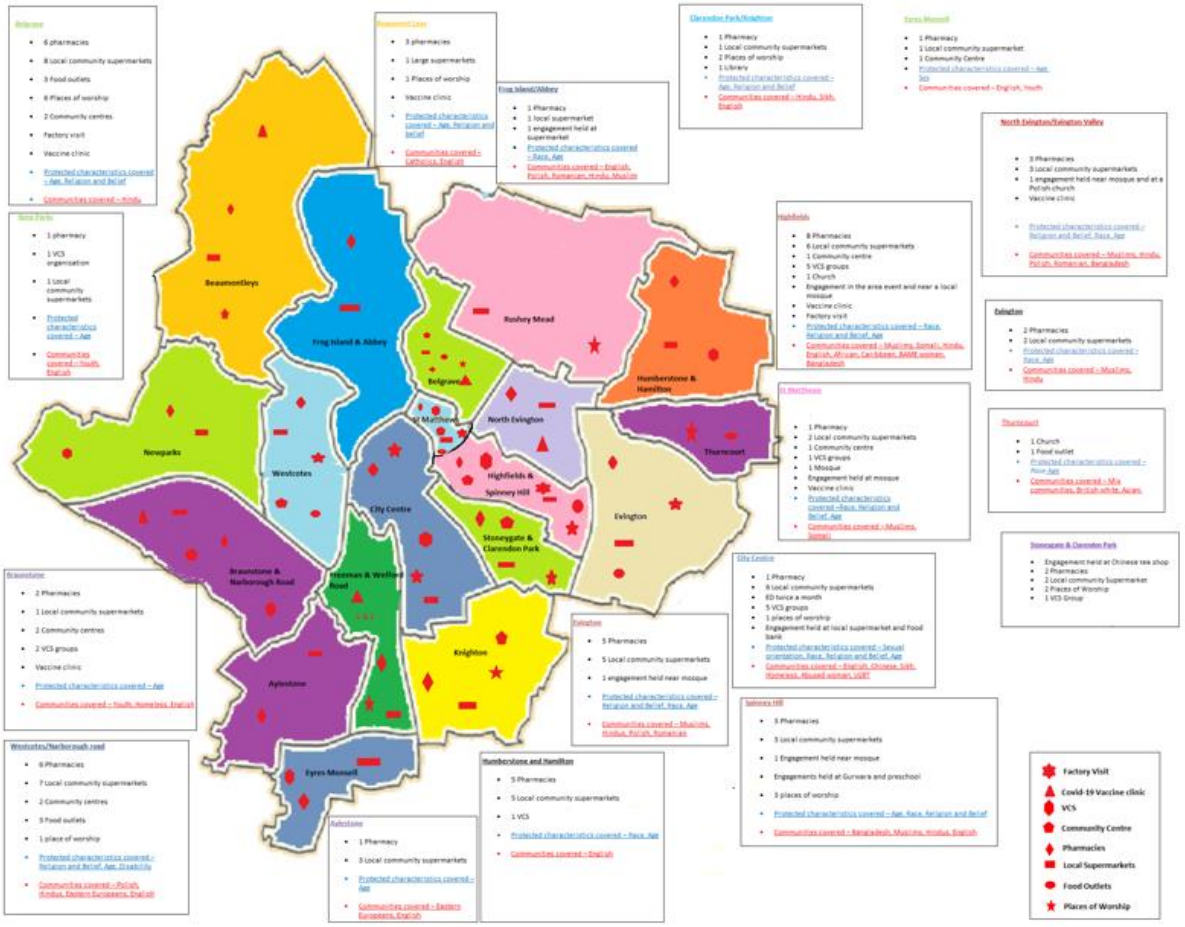
22. Despite the impact of COVID19 restrictions, and the acceptance that causality cannot be proven, the GP Registration programme has delivered in supporting Leicester City residents to register with a GP practice, where they were not registered before, enabling them to make an informed choice on their rights to access primary care treatment provided by a GP and other primary care services.

23. The programme has been an exemplar of integration between health and social care as well as working in partnership with Voluntary Care Sector, where the initial target of registering 5000 over the course of 12 month was exceed by registering over 22,323 by the end of December 2021. (Which equates to 76% increase from previous years).

24. The programme has succeeded in reducing the heath inequalities, as it aimed from the commencement, further evidenced by the case study outlined in Appendix 3.

25. Specific funding for 2022/23 has been sought from each of the City and County Better Care Funds, given that these citizens also require access to services from partner agencies. The expansion of the programme across Leicester, Leicestershire and Rutland for further 12 months will once again further support reduce the gap of health inequalities for those patients that have been residents in the area but are not registered with a GP practice.

Appendix 1 – Map displays all wards within Leicester City with a database showing the City geographically and targeting the population through a neighbourhood approach



Appendix 2 - GP Registration Poster

NHS

Did you know that treatment provided by a GP Practice is free of charge to all?

By registering with a GP Practice you will have access to a wide range of services such as:

- ✔ Tests
- ✔ Vaccinations
- ✔ Prescriptions
- ✔ Advice about your health
- ✔ Referrals to specialists

Everyone has the right to register

- You don't need to provide a fixed address
- Identification is not mandatory
- Anyone can see a GP even if you are visiting the country

For further information please visit:
www.leicestercityccg.nhs.uk/
you-and-your-gp-practice

For help and advice on registering, please contact your local **GP Registration Officers** Monday to Friday 9am to 5pm

Prakash Patel
07824 821101
Prakash.Patel@LeicesterCityCCG.nhs.uk

Dipa Mehta
07824 821047
Dipa.Mehta@LeicesterCityCCG.nhs.uk

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

Banner Pen Design

Appendix 3 - Case Study (with permission to share)

- The case study of Mr S reveals an excellent example and the success of this program. Mr S arrived in the UK in 2003 and overstayed his visa on permanent bases with no legal immigration status. He did not register with a GP as he believed this would have an impact on his residency to remain in this country. Mr S is an over stayer in UK and due to not having any valid documents he never approached a GP practice with the fear of being turned away.

- Mr S Said *" I was not registered with GP since I came to UK and was not aware that GP service is available free to all regardless of their status. Whenever I fell Ill, I was worried and I used to go to pharmacy to buy medication over the counter and if needed, used to go and see private doctor and end up paying £100's of pound. After speaking to GP registration officer, who provided me help to register with GP, I now have my own local GP where I can go and see when I need care and receive any relevant treatment free of charge. After registering with GP I have now received both of my COVID-19 Vaccine".*

- *After 18 years of not registering with a GP Practice, the officers were not only able to successfully register him, but also provide guidance on how services provided by the NHS should be used. Accessing primary care has provided him with services available free of charge which he previously paid. At times he would self-medicate as it would be significantly difficult for him to pay for his treatment with little income and in some instances his condition was made worse. Mr S is exceptionally grateful for the guidance and support provided. This is one of many case studies that has had a significant impact on patient's health and wellbeing.*

Leicester City Health and Wellbeing Board

April 2022

Primary Care Development Plans

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Context

- Last two years have seen an unprecedented demand on health an social care
- Primary care amongst others have had to adapt to respond to the Covid-19 pandemic
- LLR Primary Care Networks and practices collaboratively implemented a very successful Mass Covid Vaccination Programme, staffed by local primary care staff, wider health and social care teams and volunteers from local communities
- The pandemic significantly impacted on staffing levels due to sickness, self isolation and the opportunity to recruit into vacancies
- Social distancing and infection prevention and control guidelines that had to be implemented, limited the number of patients that could safely be in a practice premises and how they could be seen
- Very quickly practices had to set up more telephony and virtual based contact with patients – this was challenging for a number of reasons:
  - The telephone systems in place were not equipped to deal with the call demands placed upon them
  - Although most practices have upgraded their systems in response to this for example move to cloud-based telephony it has required retraining staff in the use of the new technology and having the right technology infrastructure in place that can support it

Context

The following set of slides provide an overview on the total number of practices and Primary Care Networks that exist in Leicester:

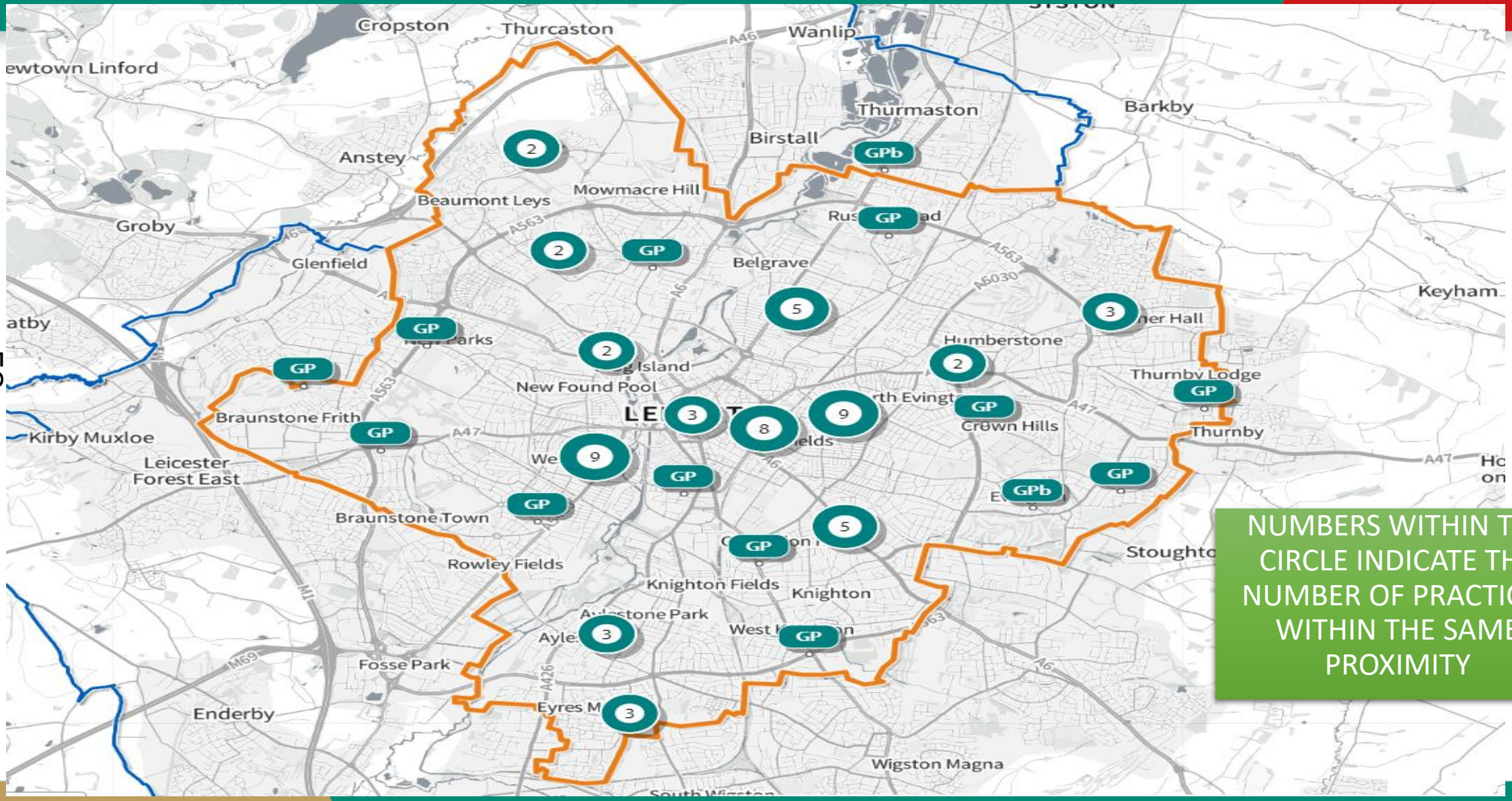
- Where they are
- What population it covers
- Names of the PCNs and the Practices

We have 56 practices (including branch surgeries) in Leicester

They are organised into 10 Primary Care Networks (PCNs)

Total Registered Population: 426,000

Leicester City Practices



General Practice in Leicester city

PCN NAME	PRACTICE NAME	CD	PCN List Size
AEGIS HEALTHCARE PCN	THE WILLOWS MEDICAL CENTRECLARENDON PARK ROAD HEALTH CENTRE HEATHERBROOK SURGERY (RP ARCHER) THE PRACTICE-SAYEED AR-RAZI MEDICAL CENTRE PASLEY ROAD HEALTH CENTRE (TK KHONG) WILLOWBROOK MEDICAL CENTRE (JG ASTLES)	Rishabh Prashad rishabh.prasad@nhs.net	36,593
BELGRAVE & SPINNEY HILL PCN	EAST PARK MEDICAL CENTRE SPINNEY HILL MEDICAL CENTRE THE CHARNWOOD PRACTICE BROADHURST ST MED PRACT DR B MODI	Prakash Pancholi prakash.pancholi1@nhs.net	47,027
CITY CARE ALLIANCE PCN	RUSHEY MEAD HEALTH CENTRE MERRIDALE MEDICAL CENTRE DR U K ROY ASQUITH SURGERY THE PARKS MEDICAL CENTRE THE PRACTICE BEAUMONT LEYS	Umesh Roy umesh.roy@nhs.net	39,767
LEICESTER CENTRAL PCN	HIGHFIELDS MEDICAL CENTRE HERON GP PRACTICE BOWLING GREEN STREET SURGERY SHEFA MEDICAL PRACTICE COMMUNITY HEALTH CENTRE HIGHFIELDS SURGERY	Rajiv Wadhwa rajiv.wadhwa@nhs.net	47,548
LEICESTER CITY SOUTH PCN	SAFFRON GROUP PRACTICE STURDEE ROAD HEALTH AND WELLBEING CENTRE THE HEDGES MEDICAL CENTRE INCLUSION HEALTHCARE LEICESTER CITY ASSIST PRACTICE	Amit Rastogi amit.rastogi2@nhs.net	31,081

General Practice in Leicester city

PCN NAME	PRACTICE NAME	CD	PCN List Size
SALUTEM PCN	ST ELIZABETH'S MEDICAL CENTRE DOWNING DRIVE SURGERY JOHNSON MEDICAL PRACTICE HUMBERSTONE MEDICAL CENTRE EAST LEICESTER MED PRACTICE	Aileen Tincello aileen.tincello@nhs.net	50,812
LEICESTER CITY & UNIVERSITY PCN	VICTORIA PARK HEALTH CENTRE OAKMEADOW SURGERY HOCKLEY FARM MED PRACT	Aruna Garcea aruna.garcea@nhs.net	42,919
MILLENNIUM PCN	FOSSE MEDICAL CENTRE PARKER DRIVE SURGERY/ MANOR MC BEAUMONT LODGE MEDICAL PRACTICE WALNUT ST MED CTR	Moses Bandrapalli moses.bandrapalli1@nhs.net	37,806
ORION PCN	DE MONTFORT SURGERY WESTCOTES GP SURGERY (ONE) DR S SHAFI COSSINGTON PARK SURGERY AYLESTONE HEALTH CENTRE WESTCOTES GP SURGERY (TWO) WESTCOTES HEALTH CENTRE	Gopi Boora gopi.boora@nhs.net	46,978
THE LEICESTER FOXES PCN	HORIZON HEALTHCARE ST PETER'S MED CENTRE DR GANDECHA & PARTNER AL-WAQAS MEDICAL CENTRE THE SURGERY @ AYLESTONE DR R KAPUR & PARTNERS NARBOROUGH ROAD SURGERY	Khalid Choudhry khalid.choudhry2@nhs.net	35,939

High level summary of what has been delivered over past 2 years in Primary Care

- Vaccinations – delivery of a COVID vaccination programme from multiple sites across the city. Delivered a multi-partnership and agency approach working with our communities to provide accessible clinics in areas such St Matthews, Highfields, Beaumont Leys, Braunstone
- Mobilisation of vaccination and outreach health support to homeless, refugees and vulnerable people during the pandemic – led by Inclusion Health who provide our City based Homeless and Assist Services
- Mobilising Primary Care services for the Afghan Refugees – accessing General practice and education on using the healthcare services locally
- GP Registration of unregistered patients – detailed paper on the agenda from Mayur Patel
- During Winter 2021/22 City Primary Care Networks delivered 19,384 additional appointments (up to Feb 22)
- 11 GP practices identified as a priority through the Winter Access Fund and supported to develop access improvement plans actions taken include: provision of additional appointments, training for staff on active signposting to improve patient journey, work with patient groups to increase awareness around access routes.
- Primary Care Estates Strategy approved to invest an addition £2.5 million in GP practice premises over 5 years to increase access for patients. 17 City practices prioritised as part of this process and programme underway to improve and develop their premises with a workshop planned for May

Our Vision for Primary Care moving forwards

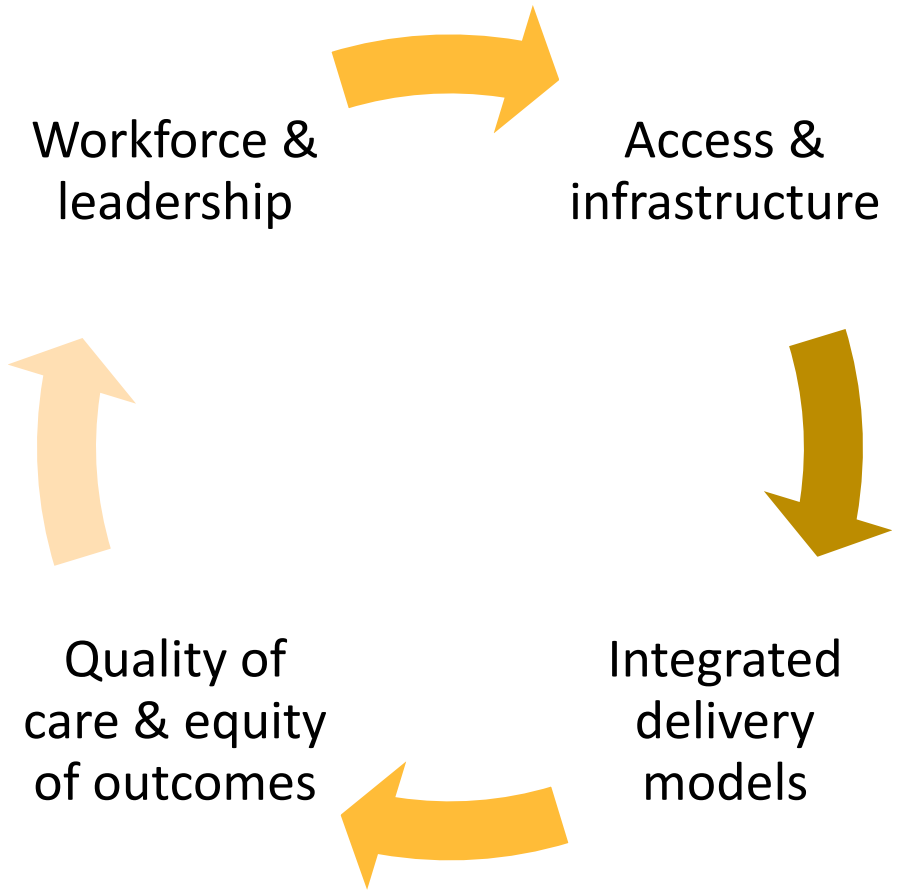
- LLR Model of Care with a place and neighbourhood focus
- Clear Primary Care Strategy in the Integrated Care System – Focus on tackling some key issues relating to Access, Capacity and Workforce
- Place and neighbourhood Based approach to transformation – for example reducing the complexity and variation in access to healthcare services including primary care
- Developing the Primary Care Networks – in order to deliver at network and neighbourhood – improvement in health outcomes related to long term conditions, frailty and care home residents and improving use of medications – enabling the better use of digital solutions where appropriate
- Supporting General Practice Quality Improvement, Resilience and Sustainability

Focus areas

- Based on patient and staff feedback, it's clear that there are four areas of focus for primary care

- This is based on triangulation of data sources across:
  - Patient feedback
  - Staff feedback
  - GP feedback
  - CQC reports
  - Quality dashboards
  - Soft intelligence

- Many of these are historical issues but some have occurred / been compounded as a result of the pandemic



Primary Care Priorities

Our goal: Deliver PC Strategy in the ICS in order to improve access, quality, outcomes, transform service delivery and workforce

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Primary Care Priority – Access

1. Negate the ‘ring at 8am’ model
2. Same day access must be fit for purpose and needs based
3. Where patients require additional services not offered by general practices, practices must have local services to book patients into where a GP is not appropriate
    1. Pharmacy
    2. Optometrist
    3. Therapy services
    4. Mental health services
    5. Urgent treatment Centres / minor injury services
4. Develop & implement service delivery models at neighbourhood / place level i.e. minor surgery etc

Primary Care Priority - Quality Improvement

- Understanding of variation in access, outcomes and service utilisation will be co-designed and we will work in partnership with practices and PCN's to understand how variation can be reduced

- Where practices are struggling, we will jointly agree a plan to tackle the issues and then work together with each PCN to implement – working jointly with the LMC co-produce a framework to support a QI approach

- Practice sustainability and business continuity plans will be part of our joint improvement programme at practice level, with support provided to practice managers / business managers to enable plans to be stress-tested and regularly reviewed

Primary Care Priority – Service Delivery Models

- Implement & embed the full ‘integrated neighbourhood team’ model, working in partnership with local partners across health and social care
- Improving proactive care support to patients with complex needs/multimorbidity, including proactive care planning, crisis services including a 2 hour in-home health and care response and a post-discharge wellness service
- Supporting primary care to complete the remaining backlog of patients with long term conditions and further roll out the proactive care model
- Develop and test new models of digital care for specific populations i.e. young children / care homes etc

Primary Care Priority – Workforce and Leadership

- Maximise the use of the additional roles such as clinical pharmacists, physio, paramedics and MH Practitioners in every PCN by linking this to data from population health management along with forming ‘communities of practice’
- Further develop portfolio careers for GP’s to attract/retain them locally
- Develop and implement a practice nurse leadership programme.
- Enhance our ability to link in with communities to grow our workforce i.e. colleges, universities, job centres in addition to growing our refugee employment offers.
- Embed career pathways for our Health Care Assistants across health and care.
- Develop and embed Practice Manager and admin workforce.
- Develop our PCN leadership across each of the 10 PCN’s in the City
- Continue to support workforce resilience o and encourage Practices/ PCN to access these as an when required.

Primary Care Collaborative PCN Development

In line with 5 national priorities for PCNs the LLR PCN Development Steering Group will focus on the following 3 areas:

- Development of the LLR strategy and vision for PCN development
- Strong engagement with Clinical Directors/ PCNs and their wider partners to drive the programme and to identify and agree their role in the ICS
- Service delivery grip on the requirements set out in the Network Contract Directed Enhanced Service

To achieve the three priority areas, a work programme has been developed which focusses on strategic and operational domains as follows:

- Strategic: governance, PCN Development maturity, PCN Risks and building resilience in PCNs, tackling neighbourhood health inequalities,
- Operational: Service delivery, PCN development fund, ARRs, IIF.

Primary Care Trajectories

- Return to 2019 appointment levels across all general practice
- Benchmarking of Practice appointments – against locally agreed standard of minimum 75 appointments per 1000 population
- 100% of completion of all Primary Care Backlog by Q3 2022/23
- Improvement in prevalence – targeted Long Term Conditions
- 50% of GP appointments are face to face
- 100% active participation of general practice in CPCS
- Increase in FTE GPs
- Balanced scorecard and benchmarking for all practices completed be end of Q1 22/23

Questions, Discussion & Next Steps

- Thanks for opportunity to share the work
- 2 x all-member briefings have been planned through April and May, led by Cllr Dempster and our City GP's, to take members through the detail in this pack
- Welcome feedback and discussion on how we can continue to work together

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE: 28th April 2022

Subject:	Tobacco Control Strategy
Presented to the Health and Wellbeing Board by:	Amy Endacott – Tobacco Control Lead, Public Health
Author:	Amy Endacott

EXECUTIVE SUMMARY:

In 2019 the Government laid out their ambition to achieve a smoke free generation (where prevalence of smoking is 5% or less) by 2030. Smoking rates have been in decline both nationally and locally over the last 20 years and are currently at their lowest ever rates of 13.9% nationally, and 15.4% locally (although local survey data would indicate that the Leicester rate is higher than this). However, this trend has not translated across all groups, particularly those with mental health issues and those in routine and manual occupations, and smoking rates have remained unfairly high in these groups. A Tobacco Control Strategy for Leicester City was published in March 2021 which outlines how the Council intends to work towards the Government's 2030 ambition on a local level. It highlights four key aims which will be integral to driving down smoking rates:

- Partnership working to address tobacco control within Leicester City
- Achieving a smoke free generation
- Smoke free pregnancy for all
- Reducing the inequality gap for those with mental ill-health

The attached presentation will be used to highlight the contents of the Tobacco Control Strategy, including the local imperative to act, current efforts to tackle tobacco use, and future intentions.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Support the actions arising from the Tobacco Control Alliance through: promotion, sharing key communications, partnership working to achieve the goals, and encouragement of staff to attend relevant training.
- Provide representation on the Tobacco Control Alliance on an ongoing basis
- Support the development of a robust approach to helping smokers who have mental health conditions to quit which is empathetic to their unique needs:
    - Consider whether the CCG could invest into this area of work
- Embed tobacco control in COVID recovery work – protecting the most vulnerable in our society from the impacts of COVID, keeping people out of hospitals etc

Tobacco Control Strategy

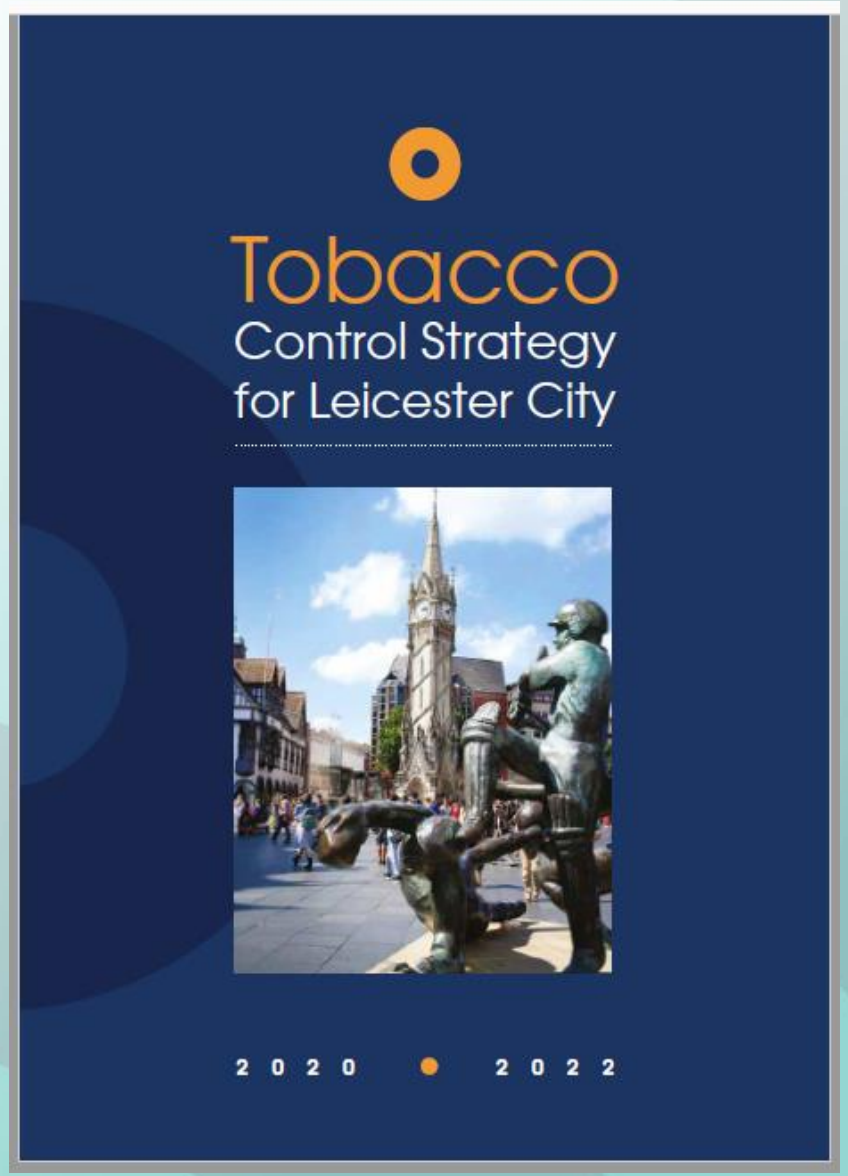
Amy Endacott – Tobacco Control Lead

Public Health Team – Leicester City Council

Leicester City Council

Tobacco Control Strategy for Leicester City – 2022-2022

- Published in March 2021
- Initially developed for 2020-2022 to align with the National Tobacco Control Strategy for England 2017-2022.
- Reflective of the 4 key ambitions laid out in the national plan, with a focus on our local priorities.



Summary of contents

Local data to support a need for tobacco control

Achievements to date

Alignment with national policy and other local policies

Governance and partnership working

Vision and aims, and current progress against these

Action plan to inform future TC progress

Local data

Local survey data shows that the following groups are more likely to smoke; males, those aged 20-34, White British and Other White communities, the unemployed and long term sick.

Children are three times more likely to smoke if they have a parent who smokes. A third of young people surveyed in the Leicester young people's health and wellbeing survey (2018) reported having a parent or carer who smokes,

Rates of smoking differ across the city with those living in the west of the city and those in our most deprived areas more likely to smoke.

Smoking in pregnancy is still a major concern in Leicester with 10.2% of women still recorded as smoking at time of delivery (SATOD) in 2020/21. Being exposed to tobacco smoke in the womb is responsible for a range of serious health and behavioural issues.

Approximately 400 lives are lost each year through smoking related illness and many more Leicester City residents spend years of their life in poor health from smoking attributable illness.

The number of Leicester City residents who have a poor mental health and wellbeing score has increased since 2015. Nearly a third of adults with poor mental wellbeing report being a smoker.

Vision

"To make Leicester a smoke free city by the end of 2030"

- Aligns with the national ambition set out in the Government's Prevention Green Paper (2019).
- In working towards this ambition consideration should be given to the wide disparity in smoking rates across different populations of our city, so efforts will need to be proportionate to those in greatest need, particularly those in routine and manual occupations, and those with mental health conditions.

Key aims

- **Partnership working to address tobacco control within Leicester City**
- **Achieving a smoke free generation**
- **Smoke free pregnancy for all**
- **Reducing the inequality gap for those with mental ill-health**

Why is mental health a key focus area?

- MH is so widespread in the UK – 1 in 4 adults
- MH accounts for 1/3 of all cigarettes smoked in the UK
- Prevalence is significantly higher in this group
- Average life expectancy of people with poor mental health is 10-20 years earlier than the general population – **smoking** is the single largest contributor to this life expectancy gap.
- MH smokers smoke more, and have greater nicotine dependence than other smokers

Smokers with mental health conditions are no less likely to express a desire to stop – and they have an equal right to be supported with this

What is happening currently:

- CURE/NHS Long Term Plan implementation –
  - Acute
  - Maternity
  - LPT all included in this.
- Community mental health support proposals
- Live Well smoking cessation provision to all smokers wishing to quit – innovation
- Tobacco Control Alliance

Governance and key partners

- Overseen by the joint City/County Tobacco Control Alliance to ensure no opportunity to address tobacco control is missed.
- Governed by the Leicester City Health and Wellbeing board.
- Clear links with each area of the existing HWB strategy.

What are we anticipating from the new national tobacco control strategy?

The All Party Parliamentary Group published a report in June 2021 which provides recommendations to the Government and hints at what the new strategy should include.

It is likely to focus on how to achieve the 2030 ‘smoke free generation’ target.

- Recommendation 4: Deliver anti-smoking behaviour change campaigns targeted at routine and manual and unemployed smokers.
- Recommendation 5: Ensure all smokers are advised to quit at least annually and given opt-out referral to Stop Smoking Services.
- Recommendation 6: Target support to give additional help to those living in social housing or with mental health conditions, who have high rates of smoking.
- Recommendation 7: Ensure all pregnant smokers are given financial incentives to quit in addition to smoking cessation support.

“Asks” from the Health and Wellbeing Board

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

Questions?

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE: 28th April 2022

Subject:	Healthy Start – First 1001 Critical Days of Life
Presented to the Health and Wellbeing Board by:	Sue Welford – Principal Education Officer Mel Thwaites – Head of Women's and Children's Transformation, CCG Clare Mills – Public Health Children's Commissioner
Author:	Monica Hingorani – Senior Project Manager (Transformation)

1 EXECUTIVE SUMMARY:

1.1 The first 1001 critical days – from the start of pregnancy to a child's second birthday is a time of rapid brain development and is recognised as significant for a child's life long physical, social, emotional and cognitive development.

1.2 A healthy start in life is a priority for families in the city and for partners in the Joint Health, Care and Wellbeing Delivery Plan. The Best Start for Life: a vision for the 1001 critical days was published by the government in March 2021, and announcements were made in the Budget 2021 on taking this priority forward through Family Hubs and the Best Start for Life Vision (referred to as Start for Life). On 2nd April 2022 it was announced that Leicester City is one of the 75 LAs that have been pre-selected for access to government funds as part of the roll out of Family Hubs and Start for Life.

1.3 This report covers why the First 1001 Critical Days matter; what we know about the First 1001 Critical Days in Leicester and how the wider social determinants of health including poverty impact on outcomes; how we already support families with young children in Leicester; and how we will work with partners in responding to the First 1001 Critical Days through 'Start for Life'.

2 Why the First 1001 Critical Days Matter

2.1 During this time babies' brains are shaped by their experiences and interactions with parents and other caregivers. Children's resilience can

be developed by providing supportive adult-child relationships; scaffolding learning so that the child builds a sense of self and agency; supporting the development of skills to use in new situations; using faith and cultural traditions as a foundation for hope and stability.

3 The First 1001 Critical Days in Leicester

3.1 The Joint Strategic Needs Assessment for the city identifies significant health challenges for families in the First 1001 Critical Days including high maternal mortality, increased demand for perinatal mental health support, low birth-weight and low immunisation take-up in early childhood. (See Appendix 1 for data). Evidence shows that the wider social determinants of family health inequities, including poverty and social isolation, have been exacerbated through COVID-19 Lockdown which has disproportionately impacted upon women, Black and minority ethnic and deprived communities.

4 How we already support families with young children in Leicester

4.1 There is currently a mix of formal and informal support that is vital for families with young children such as universal services available to all families such as Stay and Play sessions, Rhyme Time for babies in libraries. There is targeted and specialist provision for vulnerable families or those with specific needs including children with special educational needs and/or disabilities. For example, Leicester Mammas and the Centre for Fun and Families voluntary and community sector partners have jointly received Starting Well Funding (DHSC) to support vulnerable families from diverse and deprived backgrounds in the First 1001 Critical Days.

4.2 The overarching deliverables of the Maternity and Neonatal Transformation Programme are improving experiences during pregnancy including personalised care plans and at birth including skin-to-skin contact with baby, breastfeeding support and assessment of physical and emotional wellbeing,

4.3 The multiagency Readiness for School group chaired by the Principal Education Officer coordinates support activity from the first 1001 critical days throughout the early years to school age. It brings together health, education and social care services and wider community support such as schools, early years settings, libraries, Speech and Language Therapy and early years settings. Members of this group contribute to the City Mayor's manifesto on School Readiness and Supporting Early Language through a Speech Language & Communication Pathway for staff/families (including bilingual resources/support), the SLC strategy

and action plan 2021-2025 – supporting children's voice, agency and wellbeing from the First 1001 Critical Days onwards.

4.4 The wider social determinants of health and the disproportionate impact of COVID 19 on deprived and minority communities are being addressed through

- the Anti-Poverty Strategy
- Black Lives Matter Action Plan and
- Joint Health, Care and Wellbeing Delivery Plan.

The Women Talking, City Listening (leicester.gov.uk) project report is influencing local responses to the diverse experiences of women (and mothers) across the city.

A stakeholder engagement event is planned for Summer 2022 to identify what is working well to support equity and equality in maternity services and areas for co-produced improvements in service delivery to improve outcomes for all families.

5 Responding to the First 1001 Days: *Build Back Better* through *Start for Life*

5.1 Nationally the Leadsom Review (March 2021) set out a vision for the Best Start in Life. Announcements were made in the Budget (2021) HMT Shared Outcomes Fund and Department for Education's Build Back Better Fund for local areas to develop 'Start for Life' offers as part of service transformation towards Family Hubs, through the development of seamless support for families from the first 1001 critical days to early adulthood.

5.2 The local Start for Life offer will bring together midwifery, public health nursing (health visiting) services, support for mental health and wellbeing, infant feeding and specialist breastfeeding support, safeguarding and SEND support for all families across the city, taken up by need. Targeted and specialist support will help those families experiencing the toughest times and improve health, wellbeing and learning outcomes as we recover from COVID-19.

5.3 The Start for Life offer will develop support that is:

- **Accessible** - with public health messages co-produced with families available through online portals, telephone/text, and face-to-face in Family Hubs and community venues. Information will be relevant and understood by audiences including those with protected characteristics. We work together with members of the community to foster resilience and become ambassadors in their communities. An example of this approach is the use of the Better Care Fund to commission evidence-informed interventions with families who speak more than one language and those on the perinatal mental health pathway to support communication development in early childhood. Outcomes will include

more children who are curious and confident communicators ready to play and learn, and improved family wellbeing.

- **Connected** – through a strategic vision and delivered through an integrated care system. A culturally competent and confident Start for Life workforce will collaborate (avoiding duplication of services), use a strengths-based approach and share and analyse data and evidence to inform practice.
- **Relational** – in recognition that new parents access support and advice primarily from their wider family and friends, community networks and mutual aid groups will also be supported. Peer support e.g. through volunteer-led Breastfeeding Support Groups and Family and Young Champions (including Augmented Reality Avatars) will be strengthened through community development approaches.

5.4 Resourceful and collaborative leadership will support the development of the Start for Life offer including through the Health and Wellbeing Board, Children's Trust Board, Family Hubs Transformation Board and Readiness for School Steering Group partnership.

5.5 Potential Benefits of the Start for Life offer will include:

- Relevant advice and support is co-produced with families and local communities who are empowered through self-care and mutual aid
- Take-up of universal support increases, particularly by BME and deprived families
- Demand is reduced on specialist services as families access help early or when needs first arise
- Duplication in services is reduced and resources are invested in outreach and early intervention
- Improved family health outcomes include increased levels of mental wellbeing for parents and young children
- Families are increasingly confident to support their young children's holistic development through warm, playful interactions

6 Next steps for action

6.1 A Start for Life offer, delivery plan and impact framework will be co-produced with families and created in partnership across health, education, social care, and the voluntary/community sector through the Readiness for School Steering Group by Autumn 2022.

6.2 A stakeholder engagement strategy – including a one-day workshop – will be held to shape the Equity and Equality work.

6.3 Following on from a successful online workforce development event held on 10th November 2021 on the importance of the First 1001 Critical

Days, further engagement opportunities will be held in 2022 to encourage understanding and engagement with the *Start for Life* offer.

6.4 The development of Family Hubs and the *Start for Life* offer will be taken forward through funds from the Family Hubs and Start for Life programme from the Department for Education and Department for Health and Social Care (announced 2nd April 2022). Key learning exchange and impact frameworks will be developed with local, regional and national partners including the National Centre for Family Hubs, Family Hubs Network, East Midlands Family Hubs Transformation Programme network and regional Early Years Strategic Leads network.

7 RECOMMENDATIONS:

7.1 The Health and Wellbeing Board is requested to encourage partnership engagement in the development of the *Start for Life* offer.

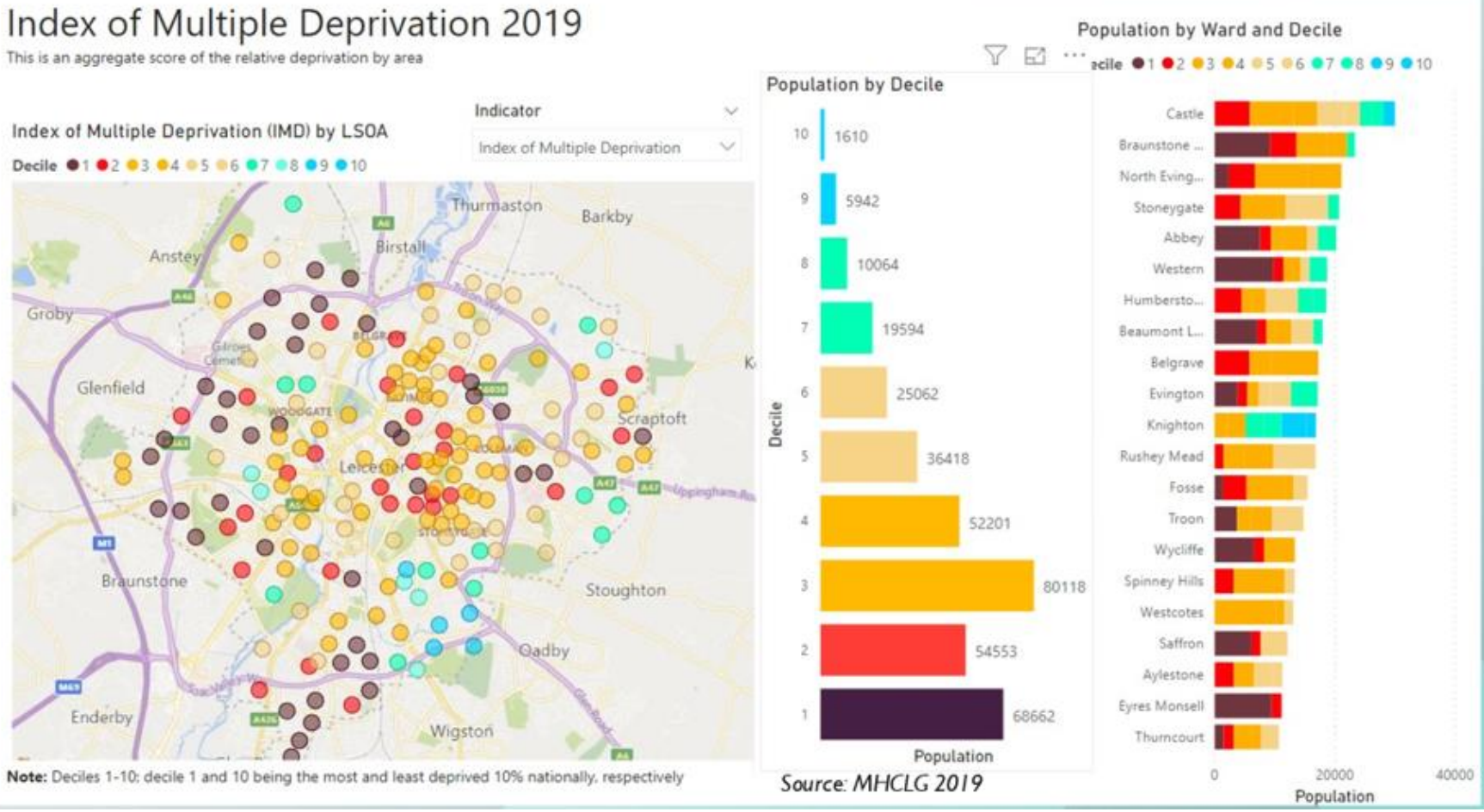
8 References

- Health and Wellbeing Board (leicester.gov.uk)
- Children and young people's JSNA (leicester.gov.uk)
- The best start for life: a vision for the 1,001 critical days - GOV.UK (www.gov.uk)
- Speech, Language and Communication (SLC) Strategy 2021-2025 (leicester.gov.uk)
- Family Information | Speech, language and communication pathway (leicester.gov.uk)
- Welcome (leicestermaternity.nhs.uk)
- Maternity Archives - Leicester City Clinical Commissioning Group Leicester City Clinical Commissioning Group (leicestercityccg.nhs.uk)
- STARTING WELL LEICESTER – Home
- FIVEXMORE
- Parent-Infant Foundation (parentinfantfoundation.org.uk)
- InBrief: The Science of Resilience (harvard.edu)
- Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK | BMJ Open
- A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe (plos.org)
- STRICTLY-EMBARGOED-UNTIL-0001-HRS-FRIDAY-27-NOVEMBER-2020-IPSOS-MORI-ROYAL-FOUNDATION-EXECUTIVE-SUMMARY.pdf (kinstacdn.com)
- Build Back fairer - the COVID-19 Marmot review (health.org.uk)
- Babies in Lockdown - Parent-Infant Foundation (parentinfantfoundation.org.uk)

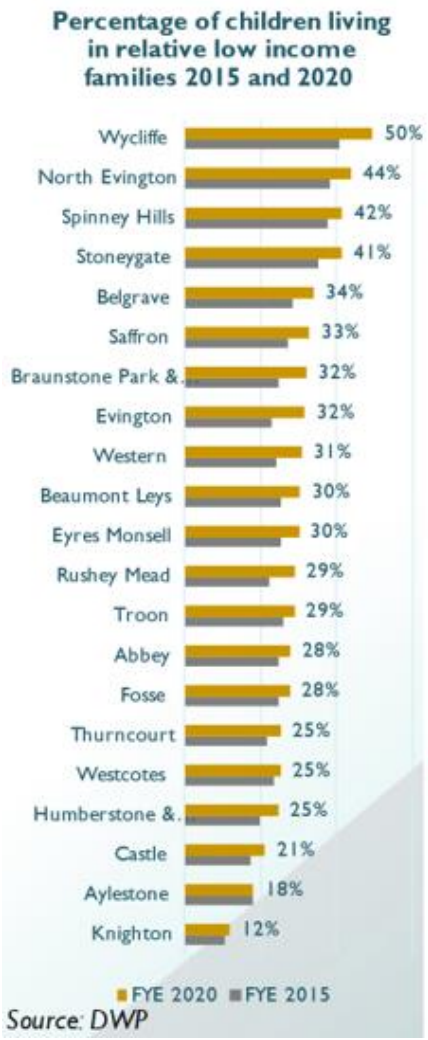
9 Appendix 1

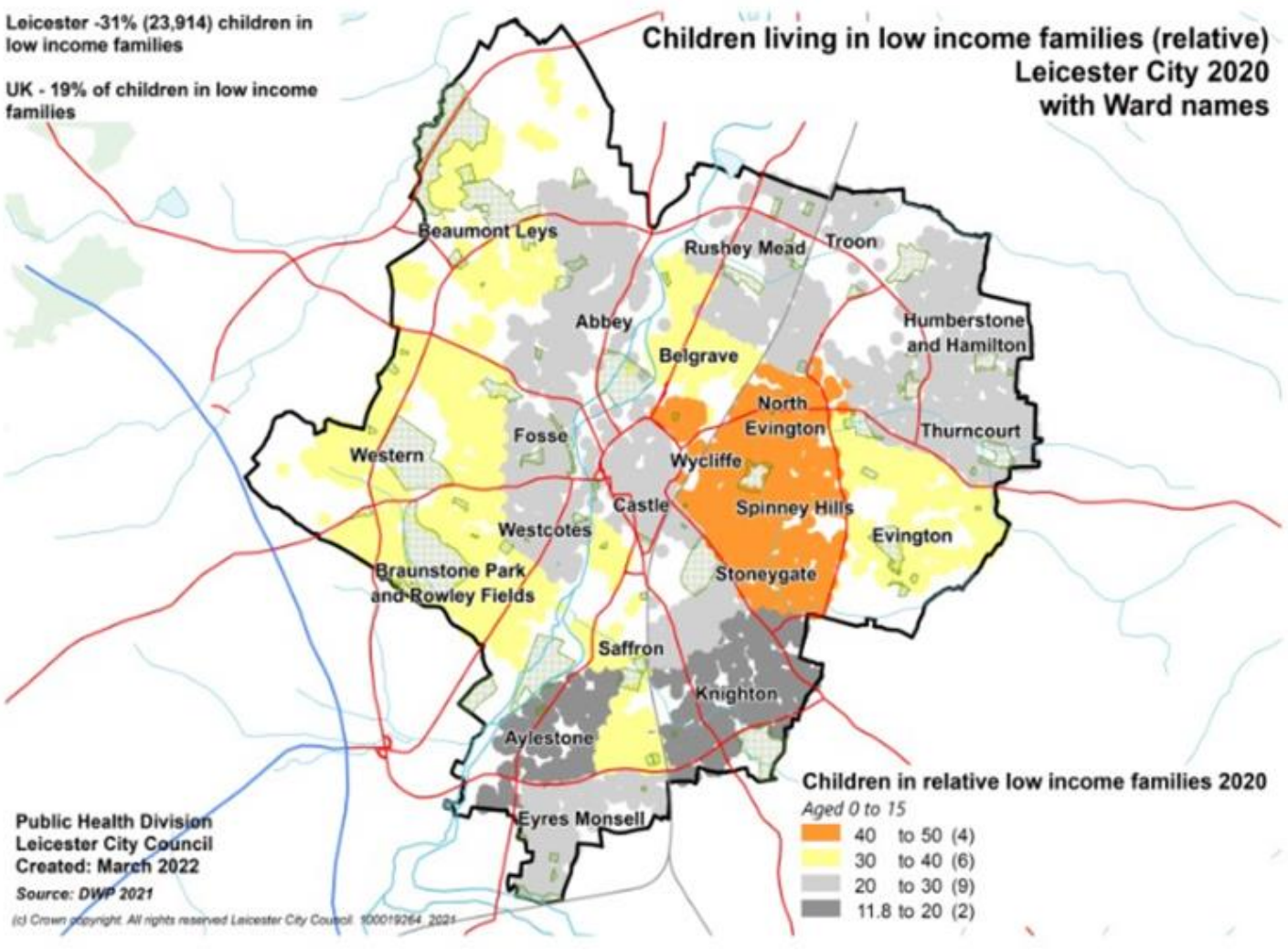
These slides illustrate Deprivation in Leicester City and how this impacts on a child's first 1001 Critical Days

Leicester is a deprived city: Over a third of the population are resident in the most deprived 20% areas. Life expectancy analysis shows that the gap in life expectancy for our most deprived and least deprived residents is 8 years for males and 6 years forfemales.

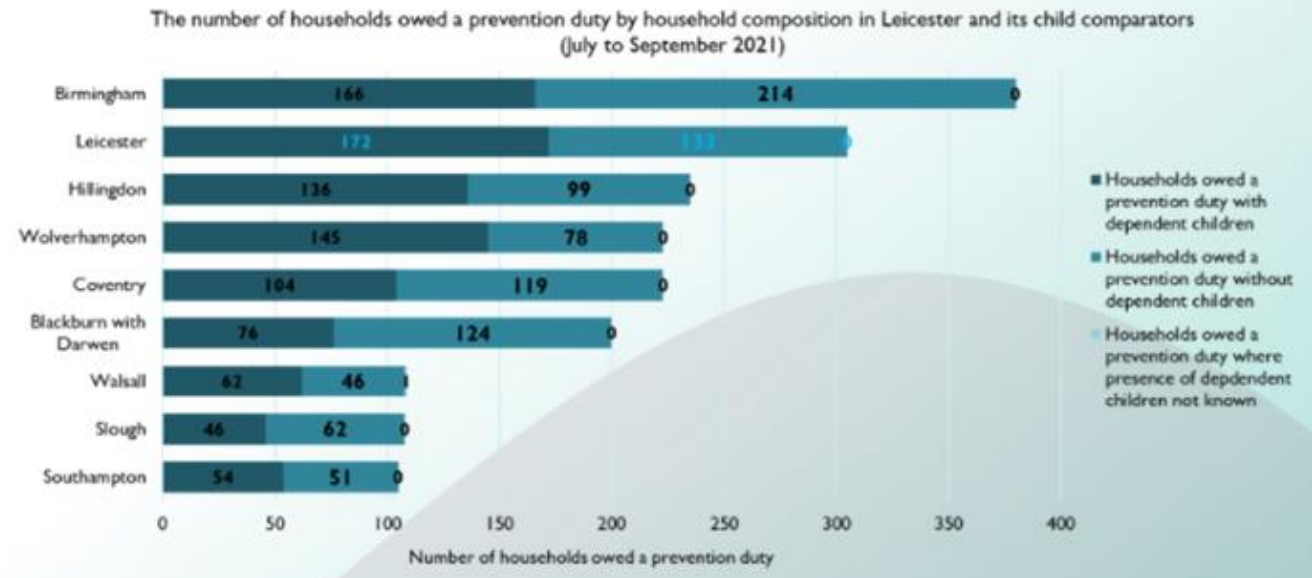


Note: Deciles 1-10: decile 1 and 10 being the most and least deprived 10% nationally, respectively


Percentage of children living in relative low income families 2015 and 2020
Wycliffe 50%
North Evington 44%
Spinney Hills 42%
Stoneygate 41%
Belgrave 34%
Saffron 33%
Braunstone Park &. 32%
Evington 32%
Western 31%
Beaumont Leys 30%
Eyres Monsell 30%
Rushey Mead 29%
Troon 29%
Abbey 28%
Fosse 28%
Thurncourt 25%
Westcotes 25%
Humberstone &. 25%
Castle 21%
Aylestone 18%
Knighton 12%
FYE 2020 FYE 2015
Source: DWP


Leicester -31% (23,914) children in low income families
UK - 19% of children in low income families
Children living in low income families (relative)
Leicester City 2020
with Ward names
Beaumont Leys
Rushey Mead
Troon
Abbey
Humberstone and Hamilton
Belgrave
North Evington
Thurncourt
Fosse
Western
Wycliffe
Castle
Spinney Hills
Westcotes
Evington
Braunstone Park and Rowley Fields
Stoneygate
Saffron
Knighton
Aylestone
Eyres Monsell
Public Health Division
Leicester City Council
Created: March 2022
Source: DWP 2021
(c) Crown copyright. All rights reserved Leicester City Council 100019264 2021
Children in relative low income families 2020
Aged 0 to 15
40 to 50 (4)
30 to 40 (6)
20 to 30 (9)
11.8 to 20 (2)

Homelessness with dependent children (July to September 2021): Prevention duties include any activities aimed at preventing a household threatened with homelessness within 56 days from becoming homeless.

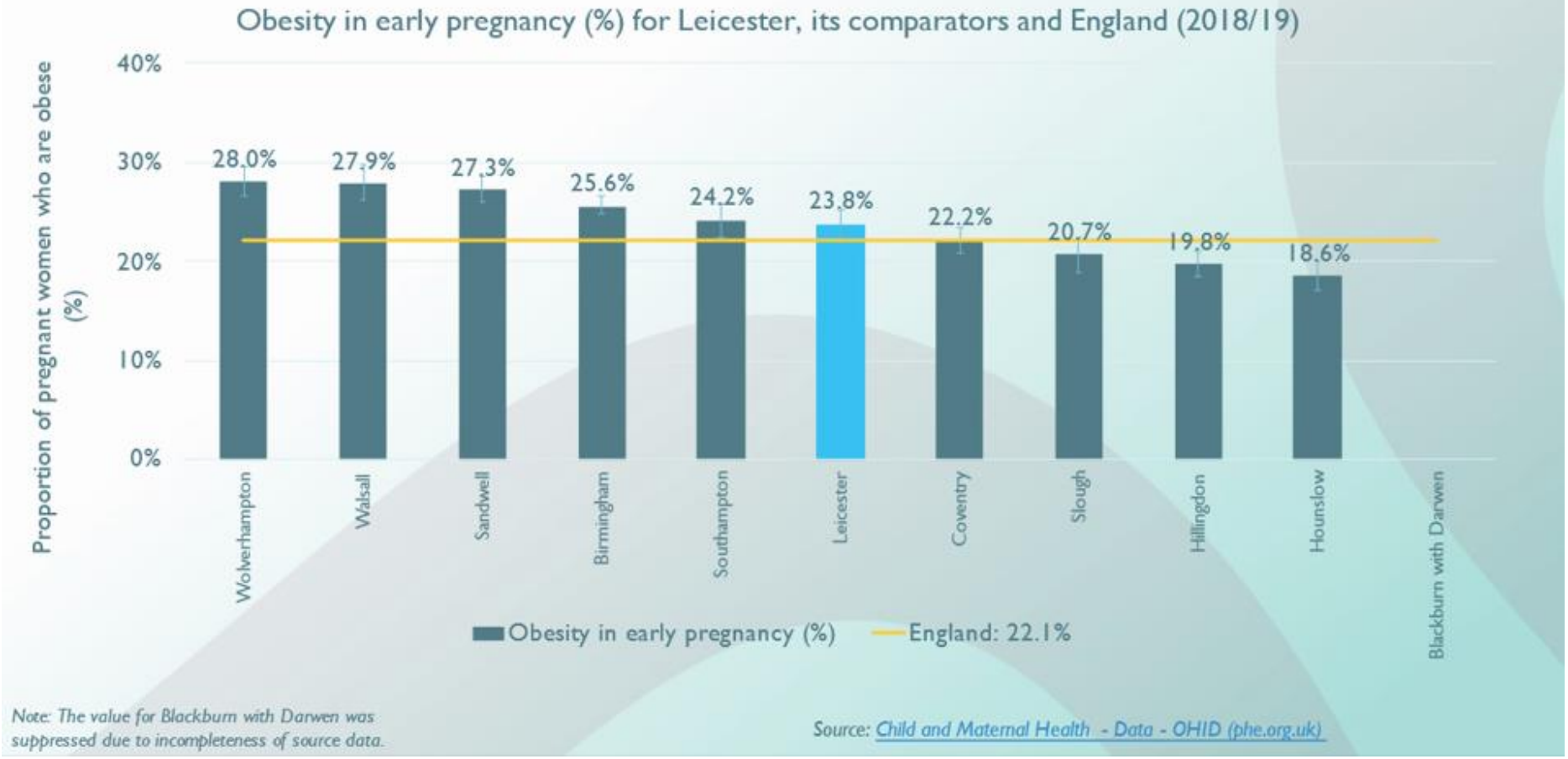


- Households owed a prevention duty with dependent children include single parent, couple/two adult and three or more adult households with dependent children.
- Leicester had the 2nd highest number of households owed a prevention duty and the highest number of households owed a prevention duty with dependent children when compared to its child comparators.

Notes:
-The data for Hounslow and Sandwell was incomplete or no data was received from the local authority.
-The total number of households owed a prevention duty includes estimates for all local authorities where there was no accurate data this quarter but where there had been in the previous quarters. The data from previous quarters was used to derive estimates for inclusion in this total.
-Totals may not equal the sum of components because of rounding.

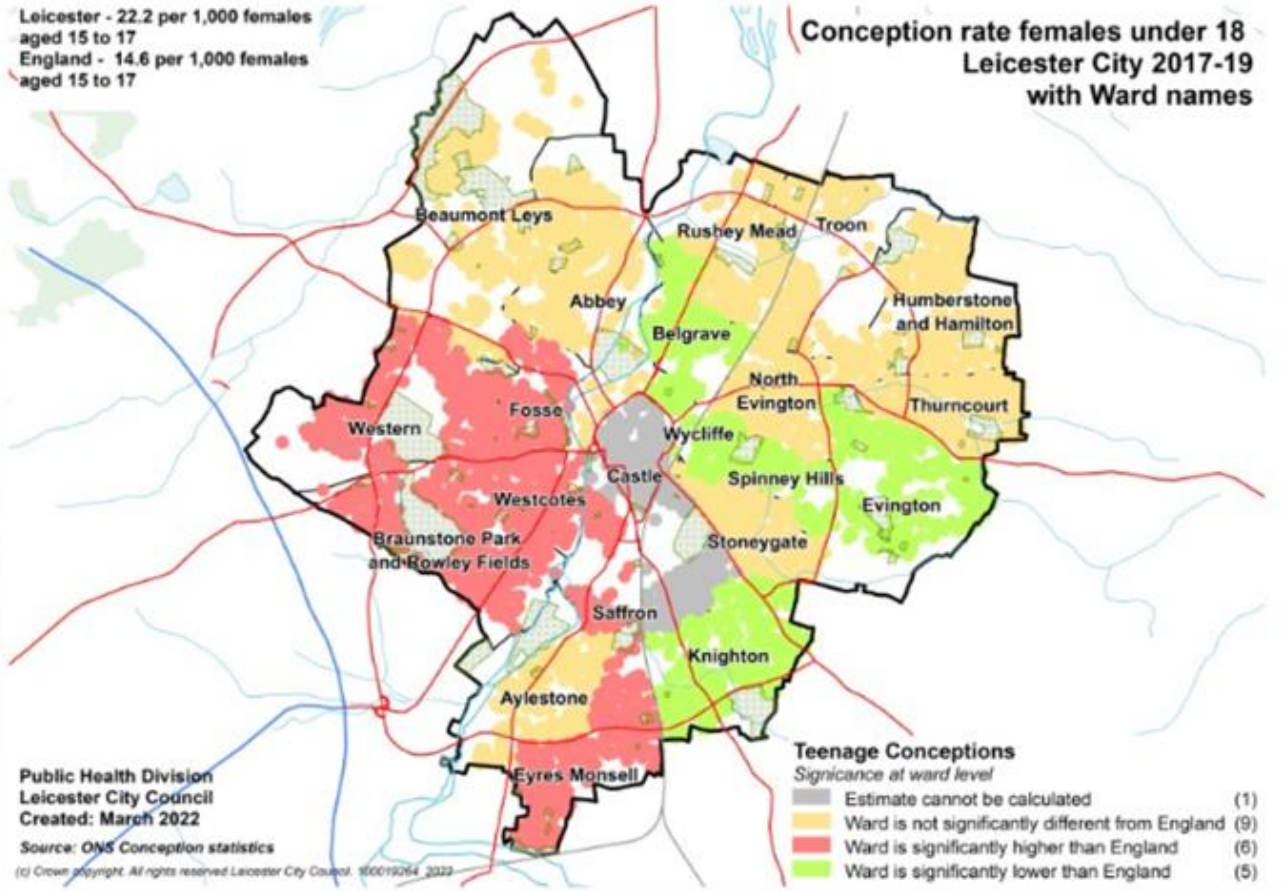
Source: Statutory homelessness in England: July to September 2021- GOV.UK (www.gov.uk)

Obesity in early pregnancy: The percentage of pregnant women who were obese (BMI>=30kg/m2) at the time of booking an appointment with the midwife in Leicester was 23.8% in 2018/19, this is significantly worse than the value for England (22.1%) Leicester had the 6th highest percentage of pregnant women who were obese in early pregnancy when compared to its 10 child comparators.

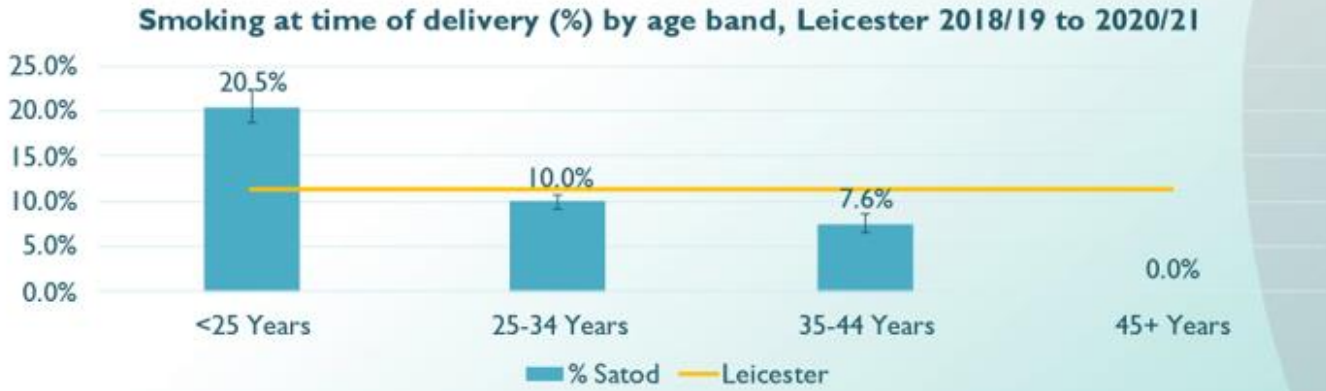


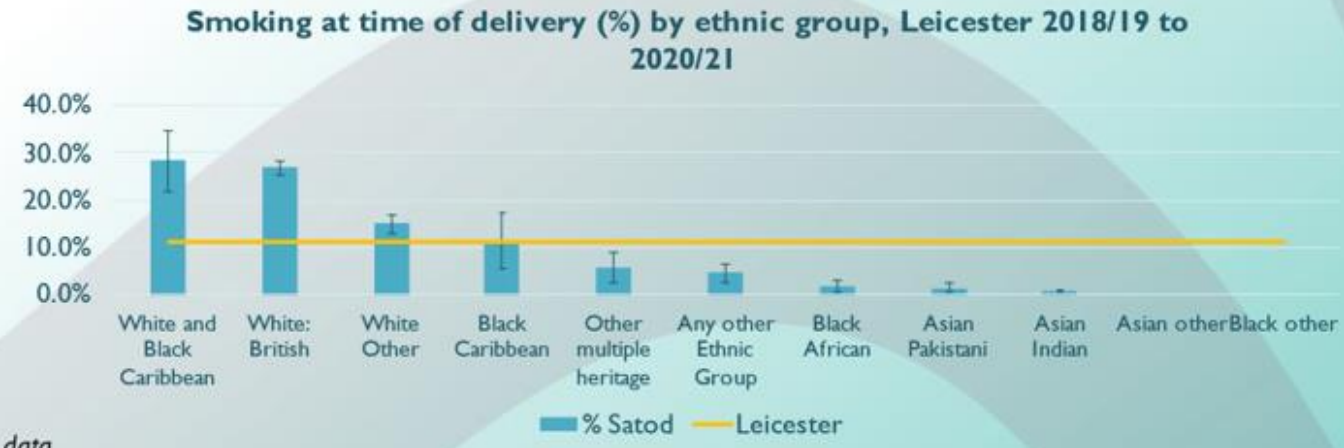
Mothers who are overweight or obese have increased risk of complications during pregnancy and birth and including diabetes, thromboembolism, miscarriage and maternal death. Babies born to obese women have a higher risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity.

Under 18 conceptions: The rate of under 18 conceptions (per 1,000 15 to 17 year old females) continues to fall locally and nationally. However, there are areas in the city where the conception rate is significantly higher than the national rate.



Smoking at time of delivery: Local data reveals the under 25's and white and some mixed heritage communities report significantly higher rates.





Source: UHL SATOD data

8

Smoking in pregnancy: smoking rates in early pregnancy are higher (18%) than nationally (13%), smoking status at time of delivery (10.4%) is similar to nationally

About 69% of babies in Leicester 2020/21 continued to be breastfed at 6-8 weeks.

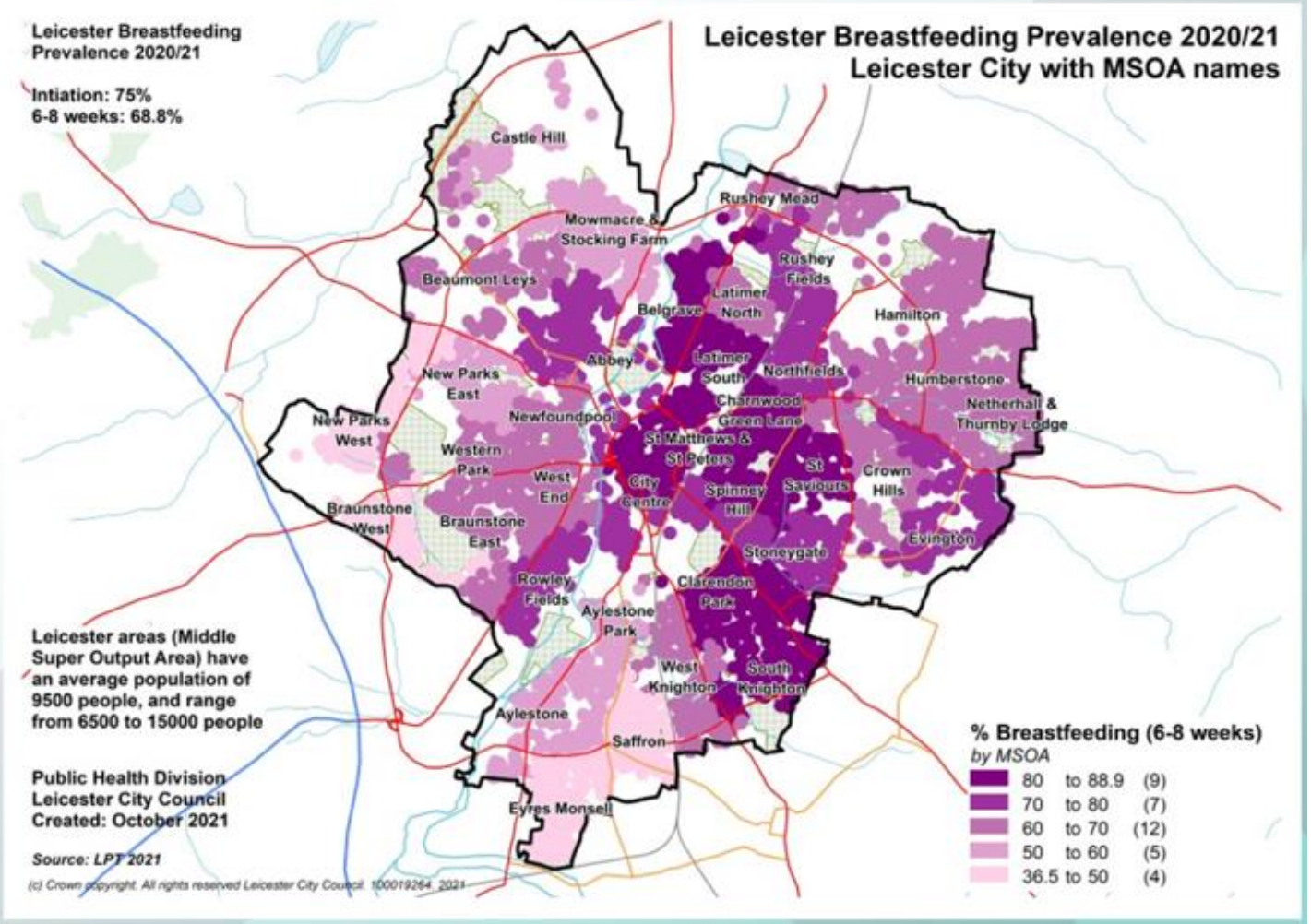
Breastfeeding is higher in the centre and east of the city.

The west and parts of the south report much lower breastfeeding.

Continued breastfeeding at 6-8 weeks post-birth is consistent with the initiation period and directly proportional to a mother's age.

There are also clear differences in breastfeeding by ethnicity with White British reporting the lower rate.

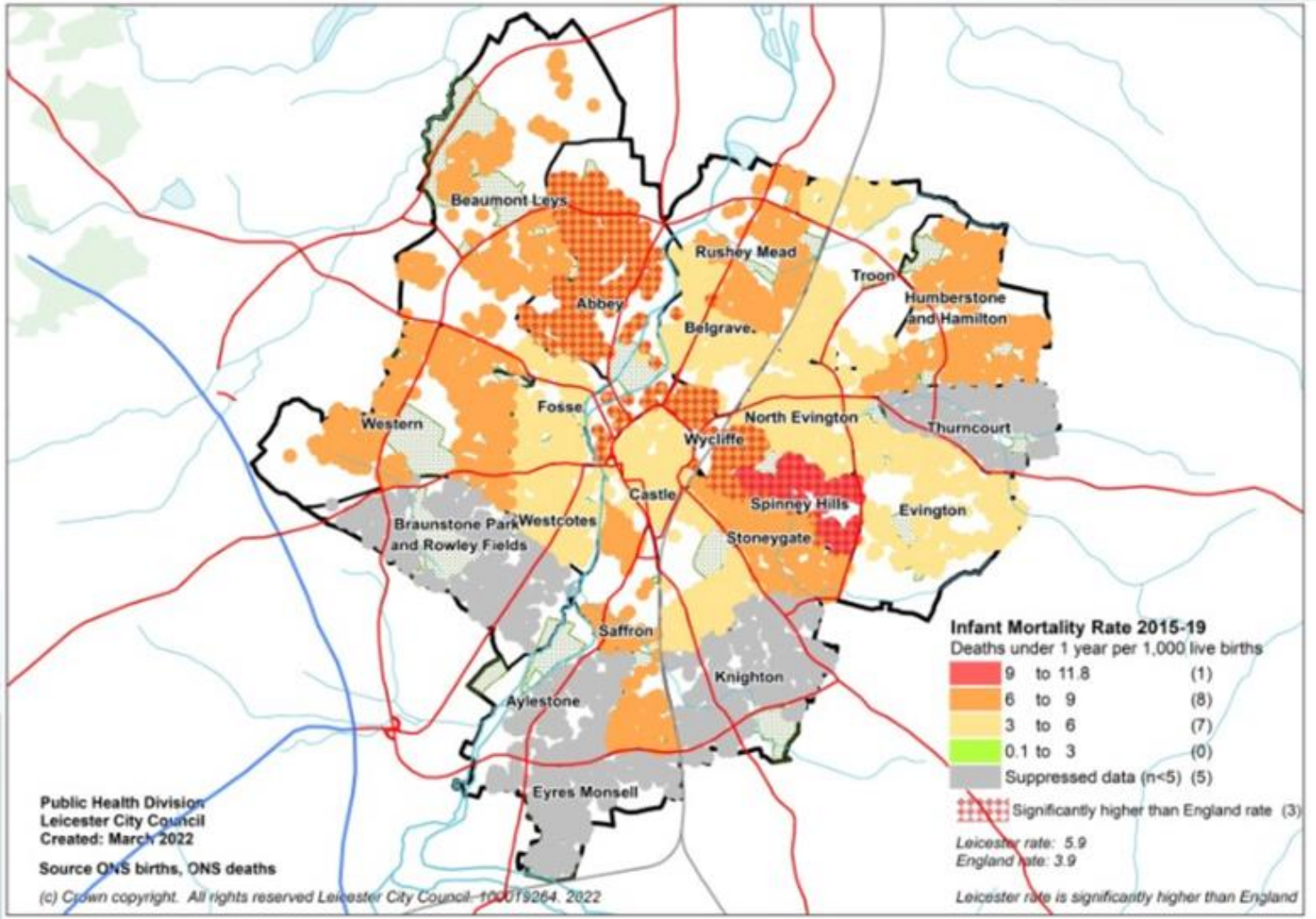
Source: LPT Health visitor data



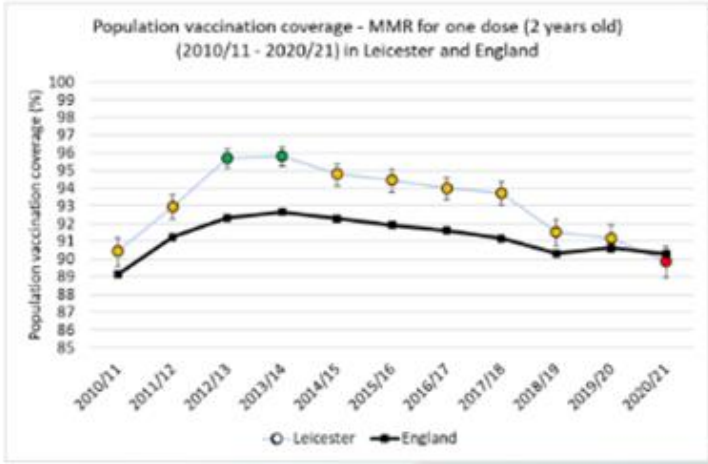
Infant Mortality Rate (IMR) by wards, 2015 2019

- Approx 28 infant deaths (under 12 months) per year in Leicester
- IMR in Leicester (5.9 deaths per 1,000 live births) is significantly higher than England (3.9)
- 3 wards have a significantly higher rate than England (Abbey, Wycliffe, Spinney Hills)
- Data suppressed for 5 wards where number of deaths <5

Source: ONS Mortality data



Population vaccination coverage (%)– MMR for one dose (2 years old)– Recent Trend



Recent trend: ⬇ Decreasing & getting worse

Benchmarking against goal: <90% | 90% to 95% | ≥95%

Period		Leicester Count	Leicester Value	Leicester 95% Lower CI	Leicester 95% Upper CI	East Midlands	England
2010/11		4,554	90.4%	89.6%	91.2%	90.6%*	89.1%*
2011/12		4,703	93.0%	92.2%	93.6%	92.9%*	91.2%*
2012/13		4,997	95.7%	95.1%	96.2%	94.1%*	92.3%*
2013/14		5,034	95.8%	95.2%	96.3%	94.9%*	92.7%*
2014/15		4,894	94.8%*	94.1%	95.4%	94.3%	92.3%
2015/16		4,757	94.5%	93.8%	95.1%	94.1%	91.9%
2016/17		4,836	94.0%	93.3%	94.6%	93.6%	91.6%
2017/18		4,617	93.7%	93.0%	94.4%	93.1%	91.2%
2018/19		4,685	91.5%	90.7%	92.3%	92.0%	90.3%
2019/20		4,511	91.2%	90.4%	91.9%	92.3%	90.6%
2020/21		4,112	89.8%	88.9%	90.7%	92.4%	90.3%

Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Office for Health Improvement and Disparities (OHID). Available from NHS Digital

Please Note: The scale on this graph starts at 85% to show the variation in the population vaccination coverage more clearly.

- The population vaccination coverage for the MMR dose one vaccination (2 years old) in Leicester was significantly worse than the benchmark goal of 95% in 2020/21, before 2020/21 Leicester had performed similarly to the benchmark goal of 95% since 2014/15.
- Over the last five time periods, Leicester's performance for this indicator has been decreasing and getting worse.

Source: Child and Maternal Health - Data - OHID (phe.org.uk)

First 1001 Critical Days in Leicester City

Sue Welford, Social Care and Education
Monica Hingorani, Social Care and Education
Mel Thwaites, Clinical Commissioning Group
Clare Mills, Public Health

Leicester City Council

NHS
Leicester City
Clinical Commissioning Group

This presentation will cover:

- Why the First 1001 Critical Days matter
- What we know about the First 1001 Critical Days in Leicester
- How we already support families with young children in Leicester
- How we will work with partners in responding to the First 1001 Critical Days in recovery from Lockdown through '*Start for Life*' and Family Hubs

Giving every child the best start in life

A loving, secure and reliable relationship with a parent or carer supports a child's:

- emotional wellbeing
- brain development
- language development and ability to learn
- capacity to form and maintain positive relationships with others

Deprivation impact on First 1001 Critical Days in Leicester City

- Leicester is a deprived city
- 31% children in low income families compared with 19% nationally
- High numbers of homeless, or at risk of homelessness, families requiring protection
- High levels of obesity in early pregnancy
- Areas with high under-18 conception rates
- Over a fifth of under 25 mothers are smokers at the time of delivery
- Breastfeeding prevalence at 6 to 8 weeks varies across the city
- Infant mortality rates are a significant concern - approx 28 infant deaths (under 12 months) per year in Leicester and 5.9 deaths per 1,000 live births which is significantly higher than England (3.9)
- Low MMR immunisation rates for 2 year olds

Encouraging a healthy pregnancy

Addressing Postnatal Depression

Postnatal depression affects more than 1 in every 10 women within a year of giving birth

Health professionals should be alert to the increased risk of experiencing mental health problems among teenage mothers and women who have experienced:

previous history of mental illness

a traumatic birth

a history of stillbirth or miscarriage

relationship difficulties

social isolation

Best Start for Life in Leicester

Define

Vision for First 1001 Critical Days in Leicester
Building Back Fairer in recovery from COVID 19

Discover

What's working well?
Areas for improvement?
Theory of Change and economic case

Develop

Access, connection, relationships
Engage and empower families and staff

Deliver

Improvement through a shared outcomes framework and resourceful leadership

Co-production

Learning practical skills and importance of interaction with baby and connecting with other mums at Leicester Mammas.

Never thought it was critical.. the information given was very wishy washy.

'Lets Talk' – talking and dealing with emotions really helped.

Postnatal support with my baby was amazing it was a 'slick system'.

I had to negotiate with the services to prevent separation between me and my son when he was admitted to hospital.

My child was given free books and finger puppets which I thought were really good and I could involve my elder daughter in the interaction with my baby.

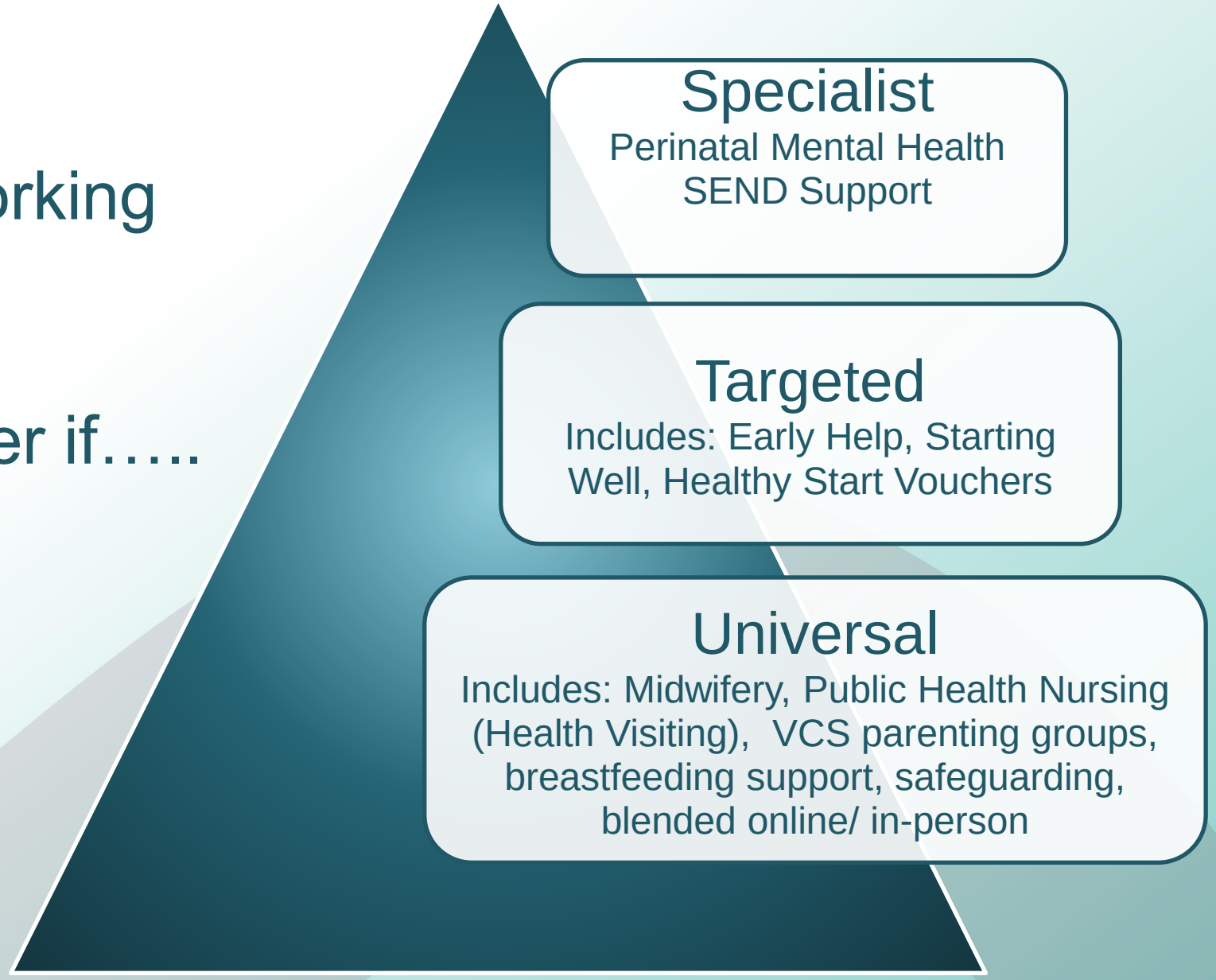
I knew the importance of the bonding and interaction …always thought it was 0-5 years not 0-2.

Views from Mammas' Focus Group for First 1001 Critical Days event (10 Nov 2021)

Discover: current support

What's working well?

Even better if…..



Develop: Maternity and Neonatal Transformation Programme

- Delivery of Saving Baby Lives Care Bundle version 2 (SBLCBv2)
- Personalisation and Choice: Every woman will have an enhanced experience of their care
- Continuity of Carer (CofC): Improving quality and safety of maternity care
- Delivering Perinatal Mental Health Service (PMHS) and Maternal Mental Health Services
- Delivery of Neonatal Critical Care Review: To reduce mortality and morbidly to babies by offering them the right form of care and treatment; right place and at the right time
- Equity and Equality workstream and stakeholder engagement

First 1,001 Critical Days New Services commissioned by Public Health

Building Communication Skills

The ambition of the service is to support a reduction in the number of children who have below expected language levels at the 2 – 2 ½ year developmental review, and increasing children's school readiness.

Improve the mental and physical wellbeing of parents with vulnerabilities

As well as mums and babies, this service targets fathers, male carers, and LGBT+ parents, ensuring their voices and needs are not overlooked

Leicester City Council

Action Areas

Ensuring families have access to services they need	
1.	Seamless support for all families
2.	A welcoming hub for families
3.	The information families need when they need it
Ensuring the *Start for Life* system supports families	
4.	An empowered *Start for Life* workforce
5.	Continually improving the *Start for Life* offer
6.	Leadership for change

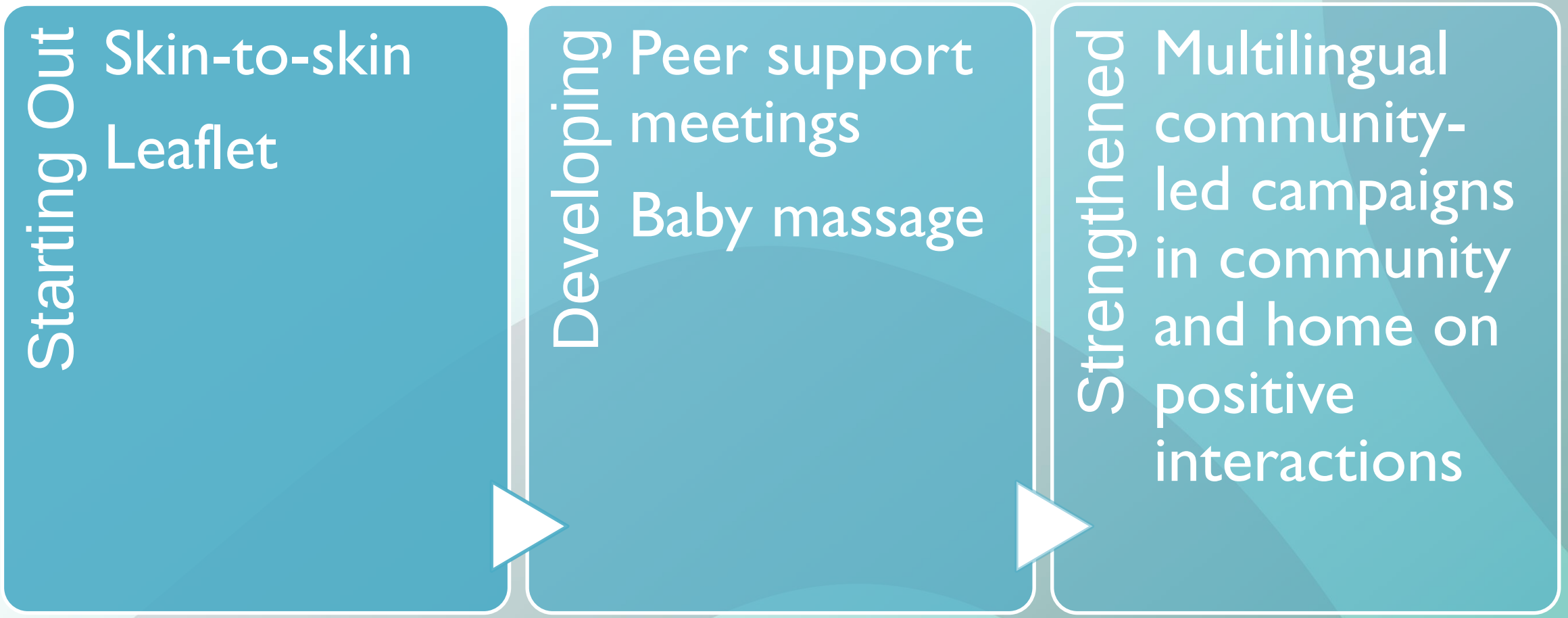
Develop: Start for Life Local Plan

Area for change	Access Digital, in-person, outreach	Connection Seamless, single-front door, data sharing	Relationships Strengths-based, culturally relevant
Maternal/midwifery			
Public Health Nurses (health visiting)			
Perinatal and infant mental health and wellbeing			
Breastfeeding and infant feeding			
Safeguarding			
SEND			

	Starting		Developing		Strong

Develop: Start for Life Plan

Action on perinatal and infant mental health



Family Hubs – a way forward

Integrated family services – central access point

Families with children and young people 0-19 (25 SEND)to receive early help services. Prevention and whole family help

Effective early intervention- education, health and social care – improved outcomes.

Key principles in its design include…

- Clear way for families to access help
- Single access point
- Outreach
- Family friendly culture
- Accessibility and equality
- Going beyond start for life and 0-5 offer

Family Hubs

Aim to create a system where families with children aged 0 to 19 (or up to 25 with SEND) can engage with seamless personalised support at the right time in the right way to improve learning, health and wellbeing outcomes.

Regional/National

- Working across the East Midlands to develop feasibility plans for the roll out of the Family Hubs model
- Utilising frameworks developed by the Department for Education, National Centre for Family Hubs, Family Hubs Network and Early Intervention Foundation to support efficient and effective Family Hubs Transformation.

Local

Multi-agency partnership board

- Develop shared vision and drive change
- Oversight and scrutiny of the development and implementation of Family Hubs
- Monitor the impact and outcomes of the Family Hubs approach

Project

Development of Family Hubs in Leicester, including a city centre 'super hub' and four spoke hubs

- Digital virtual front door
- Coproduction
- Data sharing, analytics and impact
- Property design/renovation
- Workforce development and culture change

Links to fundamental savings review

A number of projects scoped in the fundamental savings review have interdependencies with the Family Hubs model.

Start for Life Local Offer – First 1001 Critical Days

- Co-production with families and Readiness for School Group partners of First 1001 Critical Days: *Start for Life* vision and delivery plan for support in early childhood (from conception to a child's second birthday).
- Linking to the Joint Health and Wellbeing Strategy in supporting the best start in life and addressing the wider social determinants of health.

Responding to the First 1001 Critical Days

- A Start for Life offer, delivery plan and impact framework to be co-produced with families and created in partnership by Autumn 2022.
- Closely linked and integral to the development of Family Hubs
- Members of the Health and Wellbeing Board are asked to encourage partnership engagement in the development of the Start for Life offer
- Health and Wellbeing draft plan approach

DO: mitigate the impact of poverty,
SPONSOR: the Start for Life focus on the First 1001 Critical Days
WATCH: making sure children are able to play and learn, and empowering health self-care in families with young children

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE 28th April 2022

Subject:	Primary Care Development
Presented to the Health and Wellbeing Board by:	Yasmin Sidyot Deputy Director Integration & Transformation (City)
Author:	Ian Potter Head of Transformation Sarah Smith Head of Transformation

EXECUTIVE SUMMARY:

The slides provide an update to the Health and Wellbeing Board on primary care development plans in Leicester City. The slides cover the context, key achievements, vision, focus areas and priorities.

The context outlines some of the challenges faced during the pandemic and the current structure of practices and Primary Care Networks (PCNs). Detail is provided on the vision for primary care and based on patient and staff feedback and the focus areas for the coming year including:

- Access
- Quality Improvement
- Service Delivery
- Workforce and Leadership
- PCN Development

Looking ahead, two all-member briefings have been planned through April and May, led by Cllr Dempster and our City GP's, to take members through the detail of the development plans and associated actions.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the paper.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Pharmaceutical Needs Assessment
Presented to the Health and Wellbeing Board by:	Paper submitted for note
Author:	Helen Reeve

EXECUTIVE SUMMARY:

1. The purpose of this report is to highlight the responsibility of the Health and Wellbeing Board to publish a Pharmaceutical Needs Assessment (PNA), the timescale to do so, and the proposed governance structure to enable production of the PNA.

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

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

4. The last PNA for Leicester was produced in 2018 and can be accessed at: https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-health/data-reports-and-strategies/pharmaceutical-needs-assessment-pna/

5. The responsibility for producing the PNA rests with Health and Wellbeing Boards in the general reforms embodied in the Health and Social Care Act (2012). The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (amended) sets out the minimum information that must be contained within a PNA and outlines

the process that must be followed in its development and can be found at: https://www.legislation.gov.uk/uksi/2013/349/contents

6. In October 2021, the Department of Health and Social Care published a pharmaceutical needs assessment information pack for local authority health and wellbeing boards to support in the developing and updating of PNAs. The PNA guidance can be accessed via the following link:

   https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

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

Governance

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

9. Terms of reference and membership for the PNA Reference Group are attached as Appendix A.

10. It is proposed that the Health and Wellbeing Board will approve the pre-consultation draft version and the final version of the Leicester City PNA. The PNA reference group will submit the pre-consultation draft PNA for approval in July 2022. The final draft of the PNA will be submitted for approval in September 2022, allowing publication towards the beginning of October 2022. The PNA Reference Group will also provide assurance to the Health and Wellbeing Board that the final PNA is an accurate reflection of the pharmaceutical needs of the population and has been developed using robust processes.

11. The principal resourcing for the development of the Leicester City PNA is provided by the Leicester Public Health Intelligence Team, with

information and advice provided through the PNA Reference Group by NHS England, the LPC, CCGs and others.

Consultation

12. To gather additional intelligence for the PNA, it is proposed that two surveys will run throughout the spring. One survey will ask service users for their views on the current pharmaceutical provision and the second will gather data on services provided, opening times etc from pharmaceutical professionals. The findings from these two survey exercises will be incorporated into the main PNA document. The surveys are currently live and will be open until 14/04/2022. The professional survey has been circulated to pharmacies via the chief operating officer for LLR Local Pharmaceutical Committee (LPC) and the public survey can be accessed via: https://bit.ly/3hWX9pY

13. The PNA is subject to a 60-day statutory consultation period which will start at the beginning of Summer 2022. Regulation 8 of the Pharmaceutical Services Regulations specifies that the Health and Wellbeing Board must consult with the following:-

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

14. Health and Wellbeing Boards must consult the above at least once during the process of developing the PNA. Those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

15. The draft PNA will be published on the Leicester City Council website and we will be proactive in seeking views from the statutory consultees and other stakeholders.

Content and Timescales

16. The regulations and guidance documents provide information on the PNA content. This has been reflected in the overview of proposed

content of the PNA provided in Appendix B. We propose a similar approach to that taken in the 2018 PNA but may seek more innovative ways to present and visualise the data which might also facilitate updating.

17. Since the last PNA the Government's policy document of "Community pharmacy in 2016/17 and beyond" has been implemented. The impact of these changes and an assessment of the new and emergent system should be examined to understand the implications for the PNA 2022.

18. The project plan is tight with respect to delivering a signed off PNA by the 1st October 2022. The impact of the COVID-19 pandemic could also impact on timescales. The PNA Reference Group will monitor this and report any issues of concern to the Health and Wellbeing Board.

Equality Impact Assessment

19. The PNA will be subject to an EIA.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- to note this report;
- approve the interagency LLR wide reference group;
- to receive further reports on progress and the final PNA report for approval in September 2022.

Appendix 1:

LEICESTERSHIRE COUNTY COUNCIL, RUTLAND COUNTY COUNCIL AND LEICESTER CITY COUNCIL

PHARMACEUTICAL NEEDS ASSESSMENT REFERENCE GROUP

TERMS OF REFERENCE

Purpose:

The Pharmaceutical Needs Assessment (PNA) is a legal duty of the Health and Wellbeing Board (HWB) and each HWB will need to publish its own revised PNA for its area by 01st October 2022.

The purpose of this reference group is to develop the PNA for Leicestershire, the PNA for Rutland and the PNA for Leicester City.

The team will set the timetable for the development of the PNA, agree the format and content of the PNA and ensure that each PNA fulfils statutory duties around consultation for the PNA.

The team will be a task and finish group, meeting between December 2021 and September 2022.

Key responsibilities:

- To oversee the PNA process
- To ensure that the development of the PNA meets the statutory duties of the HWBs
- To ensure active engagement from all stakeholders
- To communicate to a wider audience how the PNA is being developed
- To ensure that the PNA addresses issues of provision and identifies need
- To map current provision of pharmaceutical services
- To identify any gaps in pharmaceutical provision
- To map any future provision

Governance:

- Leicester City Council – the Health and Wellbeing Board will ensure the PNA is conducted according to the legislation.

- The reference group will be chaired by the Public Health Director, Mike Sandys.

PNA Reference Group membership:

Local Authority PNA Leads

- Mike Sandys, Leicestershire County Council, Chair
- Caroline Boucher/Andy Brown, Business Intelligence, Leicestershire County Council
- Vivienne Robbins, Rutland County Council
- Julie OBoyle, Leicester City Council

Local Pharmaceutical Committee

- Chief Officer and Secretary, Rajshri Owen

Clinical Commissioning Group

- Gillian Stead, Medicines Management lead, LLR CCG
- Amit Sammi, Head of Strategy and Planning, LLR CCG

HealthWatch

- Mukesh Barot, Leicester, Leicestershire and Rutland

NHS England

- Dianne Wells, Commissioning Manager

UHL

- Claire Ellwood, Chief Pharmacist, UHL and ICS

Public Health Intelligence Leads

- Kajal Lad, Leicestershire County Council
- Victoria Rice, Rutland County Council
- Helen Reeve, Leicester City Council

Local Medical Committee

- Charlotte Woods

Voluntary Action LeicesterShire

- Paul Akroyd/Kevin Allen-Khimani

Leicestershire Equalities Challenge Group

- Matthew Hulbert

NB: Membership will be reviewed regularly and may be extended by agreement of the Reference Group members

Frequency of meetings: five meetings have been arranged – December 2021, February 2022, March 2022, May 2022, August 2022.
Additional meetings may be required between January 2022 and May 2022 as this will be the main development phase of the PNA.

Support arrangements:
The meetings will be minuted by Leicestershire County Council.

Confidentiality
An undertaking of confidentiality will be signed by non-Local Authority employed group members.
During the period of membership of the Reference Group, members may have access to information designated by the Local Authorities or other members as being of a confidential nature and which must not be divulged, published or disclosed without prior written consent. Improper use of or disclosure of confidential information will be regarded as a serious disciplinary matter and will be referred back to the employing organisation. For the avoidance of doubt as to whether an agenda item is confidential all papers will be marked as confidential before circulation to the group members.

Declarations of Interest
Where there is an item to be discussed, where a member could have a commercial or financial interest, the interest is to be declared and formally recorded in the minutes of the meeting.

APPENDIX B

PHARMACEUTICAL NEEDS ASSESSMENT – WORKING OUTLINE

Purpose

1. To support local commissioners in deciding on the provision of NHS funded services through community pharmacies in Leicester, Leicestershire and Rutland. These services are part of the local healthcare provision and affect NHS and Local Authority budgets.

2. To support NHS England in the determination of market entry decisions.

3. To provide a robust governance framework should a market entry decision are contested or challenged legally by an applicant or by existing NHS contractors.

4. To provide a source of relevant reference to Leicester, Leicestershire and Rutland local authorities, clinical commissioning groups and NHS England for the commissioning of any future of local pharmaceutical services.

Publication Outline

The PNA will review and include:

- Existing pharmacy provision and services including dispensing, health care and lifestyle advice, medicines reviews and information and implementation of public health messages and services.

- Dispensing by GP surgeries.

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

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

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

- Local area maps locating pharmacies and pharmaceutical services.

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

The PNA will not include:

- Prison pharmaceutical services;

- Hospital pharmacies.

The published document will cover the following key areas of review (this list is a guide and will evolve alongside the development of the report and subject to advice from the wider Reference Group):

1. Context for the Pharmaceutical Needs Assessment

2. Description of current services
    2.1. Essential Services
        - Dispensing
        - Repeat Dispensing
        - Disposal of Unwanted Medication
        - Promotion of Healthy Lifestyles
        - Sign Posting
        - Support for Self Care
        - Clinical Governance

    2.2. Advanced Services – these are optional services that are commissioned nationally by NHS England through the core contract
        - Medicine Use Review and Prescription Intervention Service (MUR) Activity
        - New Medicines Services (NMS)
        - Appliance use reviews (AUR)
        - Stoma Appliance Customisation Service
        - Community Pharmacist Consultation Service (CPCS) Activity
        - Hepatitis C Antibody Testing Service Activity
        - FLU Vaccinations
        - Seasonal Influenza Vaccination Advances Service (FLU) Income
        - Discharge Medicine Service Income
        - Covid Vaccination Service Activity

    2.3. Enhanced Services which are locally commissioned (list is an example)
        - Out of Hours Services
        - Supply of Palliative Care Drugs
        - Minor Ailment Scheme
        - Advice and Support to Care Homes
        - Emergency Hormonal Contraception (EHC)
        - Chlamydia Screening
        - Stop Smoking Services
        - Alcohol Brief Interventions
        - NHS Health Checks

- Supervised Consumption
- Needle Exchange
- Healthy living pharmacies

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

2.5. Different types of pharmacy contract
- Internet/distance selling
- 100 hour dispensing
- Dispensing practices
- Dispensing appliance contractors
- One-Stop primary care centres
- Cross-border pharmacies affecting local population
- Hospital pharmacy discharge medication arrangements
- Prison pharmacy arrangements
- Rurality

3. Each local authority will produce an overarching health needs document as part of their JSNA process which will inform the PNA.

3.1. Local Health Needs
- This will be the section that identifies the health needs that need to inform the commissioning of the pharmaceutical needs assessment – so the interpretation of the health needs document into the services that can be commissioned through community pharmacy
- For example, mapping of teenage pregnancy hotspot wards to EHC provision.
- Include a review of patients that are not within a 10-minute drive time or a 20 minute walk time of a pharmacy

4. Changes to demography, services, etc. that will affect pharmaceutical needs
   - Demographic changes
   - Planning intentions and housing developments
   - Care homes and retirement villages
   - Issues such as the impact of the co-operative pharmacy plans
5. Key Strategic Priorities
   - Local Authority JHWS
   - NHS England Primary Care Strategy

- NHS Long Term Plan

6. Neighbouring and Regional Services
7. Engagement
8. Conclusions
9. Recommendations
10. Equality Impact Assessment
11. Table of Abbreviations/Glossary
12. Appendices

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.
7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

HM Government

NHS

Version 1.0

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist: Complete:
Health and Wellbeing Board:	Leicester	Yes
Completed by:	Mark Pierce	Yes
E-mail:		No
Contact number:		No

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chair of Leicester City Health & Wellbeing Board	Yes
Name:	Councillor Vi Dempster	Yes
Has this plan been signed off by the HWB at the time of submission?	Yes	Yes
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:		Yes

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair		Vi	Dempster		No
	Clinical Commissioning Group Accountable Officer (Lead)		Andy	Williams		No
	Additional Clinical Commissioning Group(s) Accountable Officers		Rachna	Vyas		No
	Local Authority Chief Executive		Alison	Greenhill		No
	Local Authority Director of Adult Social Services (or equivalent)		Ruth	Lake		No
	Better Care Fund Lead Official		Ruth	Lake		No
	LA Section 151 Officer		Colin	Sharpe		No
Please add further area contacts that you would wish to be included in official correspondence -->						Yes
						Yes
						Yes

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	No
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Leicester

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,714,004	£2,714,004	£0
Minimum CCG Contribution	£26,627,780	£26,627,780	£0
iBCF	£17,040,259	£17,040,259	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£46,382,043**	**£46,382,043**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£7,566,860
Planned spend	£7,567,313

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£17,144,028
Planned spend	£17,229,099

Scheme Types

Assistive Technologies and Equipment	£300,963	(0.6%)
Care Act Implementation Related Duties	£0	(0.0%)
Carers Services	£723,098	(1.6%)
Community Based Schemes	£2,878,889	(6.2%)

DFG Related Schemes	£2,714,004	(5.9%)
Enablers for Integration	£127,189	(0.3%)
High Impact Change Model for Managing Transfer of C	£3,551,165	(7.7%)
Home Care or Domiciliary Care	£30,107,069	(64.9%)
Housing Related Schemes	£222,574	(0.5%)
Integrated Care Planning and Navigation	£1,064,380	(2.3%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£4,183,666	(9.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£115,000	(0.2%)
Prevention / Early Intervention	£358,227	(0.8%)
Residential Placements	£0	(0.0%)
Other	£35,819	(0.1%)
Total	**£46,382,043**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	875.6	1,197.7

Length of Stay

21-22 Q3 Plan	21-22 Q4 Plan

Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	27.3%	32.7%
	LOS 21+	20.3%	23.9%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	94.4%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	411	557

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	92.1%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Leicester

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Leicester	£2,714,004
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,714,004**

iBCF Contribution	Contribution
Leicester	£17,040,259
Total iBCF Contribution	**£17,040,259**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

Checklist

Complete:

Yes

Yes

CCG Minimum Contribution	Contribution
NHS Leicester City CCG	£26,627,780
Total Minimum CCG Contribution	**£26,627,780**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£26,627,780**	

	2021-22
Total BCF Pooled Budget	**£46,382,043**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

Yes

Yes

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Leicester

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,714,004	£2,714,004	£0
Minimum CCG Contribution	£26,627,780	£26,627,780	£0
iBCF	£17,040,259	£17,040,259	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£46,382,043**	**£46,382,043**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£7,566,860	£7,567,313	£0
Adult Social Care services spend from the minimum CCG allocations	£17,144,028	£17,229,099	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Existing ASC Transfer	Resource for ASC provision	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum CCG Contribution	£13,066,810	Existing
3	Carers Funding	Statutory Support for carers	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum CCG Contribution	£723,098	Existing
4	Reablement funds - LA	In House ASC reablement service	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum CCG Contribution	£917,778	Existing
5	Lifestyle Hub	Culturally competent primary & secondary prevention of LTCs & Health promotion.	Prevention / Early Intervention	Other	Exercise/weight Mx/Smoking support	Community Health		CCG			Local Authority	Minimum CCG Contribution	£113,237	Existing
6	Assistive technologies	Assistive technology to support independence & reduce social isolation	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£300,963	Existing

7	Strengthening ICRS - LA	ASC 2 hr response 24/7 step up/down	Reablement in a persons own home	Rapid/Crisis Response - step up (2 hr response)		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,254,390	Existing
8	Health Transfers Team - in hospital social workers	on-site social work team to facilitate timely Acute hospital discharge	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£207,579	Existing
9	MH Discharge Team - Health Transfers Team - individual based in	on-site social work team to facilitate timely MH in-patient discharge	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£70,965	Existing
10	IT System Integration	RA card support/ Help Desk support for ICRS/Care Navigators to	Enablers for Integration	Data Integration		Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£28,606	Existing
11	Services for Complex Patients (Care Navigators)	6x Care Navigators to case-manage prevention interventions for frail & older people	Integrated Care Planning and Navigation	Care navigation and planning		Primary Care		CCG			Local Authority	Minimum CCG Contribution	£334,380	Existing
12	Discharge Home to Assess staff costs	ASC Case Managers to facilitate hospital discharge home	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	Minimum CCG Contribution	£337,753	Existing
13	H&SC Protocols - training	Training for ASC and dom care providers to undertake delegated health tasks safely	Enablers for Integration	Workforce development		Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£72,996	Existing
16	Social worker for alcohol dependent people/hoarders	Specialist dedicated case management, support and service coordination for those with a hoarding disorder	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£53,574	Existing
17	6m funding for change manager to support JICB	Joint funding of admin support for range of integration activities	Enablers for Integration	Joint commissioning infrastructure		Social Care		CCG			Local Authority	Minimum CCG Contribution	£25,587	New
18	The Centre Project	Day Centre and outreach support for vulnerable adults	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£23,200	Existing
19	Training for Falls Prevention	CIC provider of community strength & balance programmes for those at risk of falls	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Private Sector	Minimum CCG Contribution	£101,790	Existing

20	Hospital Housing Enablement Team	Specialist housing support to enable timely hospital discharge and NRPF cases	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£169,000	Existing
21	Risk stratification	Licensing and data processing fees for risk strat programme. Sessional fees for clinical lead	Prevention / Early Intervention	Risk Stratification		Other	Licence cost for risk strat product. Additional data processing costs to CSU. GP technical lead time	CCG			Private Sector	Minimum CCG Contribution	£70,000	Existing
22	Services for Complex Patients (GP PIC/Training)	Enhanced programme of primary, community/VCS support to high-risk LTC patients	Integrated Care Planning and Navigation	Care navigation and planning		Primary Care		CCG			Private Sector	Minimum CCG Contribution	£730,000	Existing
23	Action on Deafness – Audiology and	Specialist support for those with hearing loss and Deafness	Personalised Care at Home	Mental health /wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£35,000	Existing
24	Eye Clinic Liaison Service	Specialist support for those with sight loss & blindness	Personalised Care at Home	Physical health/wellbeing		Other	Specialist Vol Sector Support to those w/ sight loss (includes registration)	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£50,000	Existing
25	Royal Voluntary Service	Post-discharge offer of 6 weeks of support to regain skills and confidence	Personalised Care at Home	Mental health /wellbeing		Other	Reducing readmissions through Vol Sector support to recently discharged patients	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£30,000	Existing
26	Leicester Mammas	Voluntary sector support for breast feeding, budget management and cooking skills	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£35,000	New
27	Home Visiting Service	Skill mixed home visiting service to assess frail & older people at home	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			Private Sector	Minimum CCG Contribution	£1,352,996	Existing
28	Unscheduled Care Team	Home First	Reablement in a persons own home	Rapid/Crisis Response - step up (2 hr response)		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£555,710	Existing
29	MH Planned Care Team	Dedicated specialist MH assessment and treatment for those whose LTC management is complicated by functional MH issues	Community Based Schemes	Integrated neighbourhood services		Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£415,063	Existing
30	Care Home Therapies Team	Proactive in-reach to care homes residents to reduce risk of falls	Reablement in a persons own home	Preventing admissions to acute setting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£155,008	Existing

31	Intensive Community Support Beds	Home First	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,019,910	Existing
32	Reablement	Home First	Reablement in a persons own home	Reablement to support discharge - step down		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,300,780	Existing
33	Additonal Community therapy	Home First	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,110,830	Existing
34	IBCF	Meeting ASC needs/Reducing NHS pressures/Supporting local ASC market	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	iBCF	£17,040,259	Existing
35	Disabled Facilities Grant	Adaptations to support independence for those who meet eligibility criteria	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Local Authority	DFG	£2,714,004	Existing
36	UHL fund	Hospital discharge specialist team	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£1,856,955	Existing
37	Fund Care Package costs relating to hospital discharge activity	Additional discharge coordinator in Health Transfers team	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		Community Health		CCG			Local Authority	Minimum CCG Contribution	£58,003	New
38	Stop Smoking app developed by Public Health	Mobile phone app to support stop smoking efforts	Other		Digital support for stop smoking attempts	Community Health		CCG			Local Authority	Minimum CCG Contribution	£15,819	New
39	Dear Albert	Lived experience worker to support inclusion population	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£15,000	New
40	Leicester Counselling Centre	Provision of counselling services including bereavement	Other		Responding to increased MH needs related to pandemic, lock down and their consequences	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£20,000	New

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Leicester

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative		Checklist Complete:
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	875.6	1,197.7	Our planned figure for 21-22 represents a 9% reduction from 19/20. Key schemes that are expected to impact as follows: •Step up Home First and ICRS response (Mostly BCF-Funded). Current demand and capacity figures show that the ICRS service could respond to an estimated 550	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**	Yes

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments		
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	27.3%	32.7%	Q3 and Q4 figures are based on previous averages with the trend on current data for Q1 and Q2 being taken into consideration. Overall we aim to reduce our overall annual figure from 19/20 by 0.41% for 14+ days (29.29%) and 0.88% reduction on our overall annual figure for 21+ days (21.58%) Key schemes that are expected to impact as follows: BCF-funded ICRS and Reablement teams supporting patients discharge home (Inc. bridging care for ASC)	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**	Yes
	Proportion of inpatients resident for 21 days or more	20.3%	23.9%			Yes

8.3 Discharge to normal place of residence

	21-22 Plan	Comments		
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.4%	This ambition has been reached via analysis of actual in year performance, projected performance and known service developments which should impact positively on the outcomes for people. The primary strategic approach is our Home First offer across social care and community services, supported via	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**	Yes

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	586	696	411	557	Leicester continues to focus on activity that supports people to remain in their own homes. This includes: Responsive crisis services Effective reablement services Increasing use of risk stratification and data to support targeted interventions within primary / community
	Numerator	254	300	179	250	
	Denominator	43,358	43,121	43,602	44,865	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Yes

Yes

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	93.0%	90.0%	92.1%	The plan for this metric is based on a range of factors including in year activity to date, forecast activity, covid recovery plans and the development of other, supporting services. We anticipate a small improvement in the number of people still at home, due to increased capacity to accept referrals, enhanced support via
	Numerator	214	207	198	
	Denominator	230	230	215	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Yes

Yes

Yes

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Leicester

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Checklist Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes				Yes
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes				Yes
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes				Yes

NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes				Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes				Yes
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes				Yes