LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 26 JANUARY 2023

Time: 9:30 am

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

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

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

G. J. Carey
For Monitoring Officer

NOTE:

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

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

MEMBERS OF THE BOARD

Councillors:

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

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

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

Councillor Elly Cutkelvin, Assistant City Mayor, Education and Housing

Councillor Mustafa Malik, Assistant City Mayor, Communities and Equalities

City Council Officers:

Martin Samuels, Strategic Director of Social Care and Education

Ivan Browne, Director Public Health

Dr Katherine Packham, Public Health Consultant

1 Vacancy

NHS Representatives:

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

Angela Hillery, Chief Executive, Leicestershire Partnership NHS Trust

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

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

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

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

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

Healthwatch / Other Representatives:

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

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

Kevan Liles, Chief Executive, Voluntary Action Leicester

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

Sue Tilley, Head of Leicester, Leicestershire Enterprise Partnership

Kevin Routledge, Strategic Sports Alliance Group

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

STANDING INVITEES: (Non-Voting Board Members)

Cathy Ellis – Chair of Leicestershire Partnership NHS Trust

Professor Andrew Fry – College Director of Research, Leicester University

Richard Lyne, East Midlands Ambulance Service, Divisional Director LLR

John MacDonald, Chair of University Hospitals of Leicester NHS Trust

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

Information for members of the public

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

Further information

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

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

PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

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

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF THE PREVIOUS MEETING **APPENDIX A (Pages 1 - 10)**

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

4. CHAIR'S INTRODUCTION

The Chair will:

- Highlight some excellent work University Hospitals Leicester have delivered with Ellesmere.
- Give future notice that colorectal cancer survival will be on a future agenda of the Health & Wellbeing Board in relation to rates of survival one year after diagnosis in Leicester being the lowest in England, and ask members to liaise with their organisations regarding this work with a view to bringing actions to the relevant Health & Wellbeing Board that their organisation is able to commit to in order to improve colorectal cancer survival rates.

5. BETTER CARE FUND **APPENDIX B (Pages 11 - 86)**

The Chair will ask the Board to provide a formal approval of the Better Care Fund (BCF) – noting that the plan was circulated in January 2022 and recirculated in December 2022, and members of the Board have had opportunity to make contact with the report authors with any questions in advance of this meeting.

6. DELIVERY AND ACTION PLAN (2023-2025) FOR LEICESTER'S HEALTH CARE AND WELLBEING STRATEGY

APPENDIX C (Pages 87 - 122)

Katherine Packham, Consultant in Public Health, Leicester City Council, to present a report and a presentation which summarise the development of the Leicester Health Care and Wellbeing Strategy Delivery Plan (2023 2025), which was last considered by the Board on 28 July 2022. The Board are asked to formally approve the Delivery action plan (2023 – 2025) for the six 'do' priorities of the Leicester's Health, Care and Wellbeing Strategy.

7. INEQUALITIES PRESENT IN MATERNITY MORTALITY EXPERIENCED BY WOMEN OF DIFFERENT ETHNICITIES

Rob Howard (Consultant in Public Health, Leicester City Council) and Dr Ruw Abeyratne (Director of Health Equality and Inclusion – University Hospitals of Leicester NHS Trust) will provide a verbal update on the progress being made to tackle inequalities in maternal mortality faced by Black and Asian women in the City.

8. CHILDREN AND YOUNG PEOPLE IN THE CONSIDERATIONS OF THE HEALTH AND WELLBEING BOARD

APPENDIX D (Pages 123 - 132)

Martin Samuels, Strategic Director for Social Care & Education, Leicester City Council, will introduce a report on the formation of the Children & Young People's Collaborative involving the senior leaders for children's services from the LLR. The group has identified a number of key priorities for shared work in this area to ensure the needs of children and young people in the City are given equitable focus as the needs of adults in relation to their health and wellbeing needs.

9. MEETING THE NEEDS OF COMPLEX PEOPLE

APPENDIX E (Pages 133 - 144)

Chris Burgin, Director of Housing, Leicester City Council, will give a presentation setting out the increasing challenges of helping complex housing applicants and tenants, housing them and the need for Housing services and Health services to work together to ensure Health services pathways are accessible and timely for those people going through Homelessness and those complex and vulnerable people in Housing.

10. INTEGRATED CARE BOARD ROLES AND RESPONSIBILITIES

APPENDIX F (Pages 145 - 148)

Sarah Prema, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board to present a report setting out the roles and responsibilities of the Integrated Care Boards which replaced Clinical Commissioning groups in July 2022.

11. PHARMACEUTICAL NEEDS ASSESSMENT (PNA) **APPENDIX G (Pages 149 - 272)**

Helen Reeve, Senior Intelligence Manager, Public Health, Leicester City Council to present a report which summarises the Pharmaceutical Needs Assessment following its development since it was last discussed at the Board on 28 July 2022.

12. LLR HEALTH AND WELLBEING PARTNERSHIP DRAFT INTEGRATED STRATEGY **APPENDIX H (Pages 273 - 308)**

Sarah Prema, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board, to present a report on the draft Integrated Care Strategy which has been developed by the LLR Health and Wellbeing Partnership and outlines the engagement process with Health and Wellbeing Boards.

13. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

14. DATES OF FUTURE MEETINGS

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

Thursday 16 March 2023 – 9.30 am

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

Thursday 29 June 2023 – 9.30am
Thursday 21 September 2023 – 9.30 am
Thursday 18 January 2024 – 9.30am
Thursday 18 April 2024 – 9.30 am

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

15. ANY OTHER URGENT BUSINESS

APPENDIX A

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

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

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Leicester City Council.
Kash Bhayani	–	Healthwatch Advisory Board, Leicester and Leicestershire.
Councillor Elly Cutkelvin	–	Assistant City Mayor, Education and Housing.
Richard Mitchell	–	Chief Executive, University Hospitals of Leicester NHS Trust.
Dr Katherine Packham	–	Public Health Consultant, Leicester City Council.
Dr Avi Prasad	–	Co-Chair, Leicester City Clinical Commissioning Group.
Mark Powell	–	Deputy Chief Executive, Leicestershire Partnership NHS Trust
Kevin Routledge	–	Strategic Sports Alliance Group.
Sue Tilley	–	Director, Leicester, Leicestershire Enterprise Partnership.
Councillor Piara Singh Clair	–	Deputy City Mayor, Culture, Leisure and Sport, Leicester City Council.
Chief Supt Jonny Starbuck	–	Head of Local Policing Directorate, Leicestershire Police.
Caroline Trevithick	–	Executive Director of Nursing, Quality and Performance, Leicester, Leicestershire and Rutland Clinical Commissioning Group

Standing Invitees

Cathy Ellis	–	Chair of Leicestershire Partnership NHS Trust.
John MacDonald	–	Chair of University Hospitals Leicester NHS Trust.
Professor Bertha Ochieng	–	Integrated Health and Social Care, DeMontfort University.

In Attendance

Graham Carey	–	Democratic Services, Leicester City Council.

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66. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:-

Councillor Sarah Russell	Deputy City Mayor Social Care and Anti-Poverty, Leicester City Council.
Ivan Browne	Director of Public Heath, Leicester City Council
Professor Azhar Farooqi	Co-Chair, Leicester City Clinical Commissioning Group
Andrew Fry	College Director of Research, University of Leicester.
Angela Hillery	Chief Executive, Leicestershire Partnership NHS Trust
Harsha Kotecha	Chair, Healthwatch Advisory Board, Leicester and Leicestershire
Kevan Liles	Chief Executive, Voluntary Action Leicester
Martin Samuels	Strategic Director of Social Care and Education
David Sissling	Independent Chair, Leicester, Leicestershire and Rutland Integrated Care System
Andy Williams	Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Group

67. 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.

68. MEMBERSHIP OF THE BOARD

The Board noted the membership for 2022/23 approved by the Council on 19 May 2022 as follows:-

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

City Councillors: (5 Places)

Councillor Vi Dempster, Assistant City Mayor, Health (Chair)
Councillor Piara Singh Clair, Deputy City Mayor, Culture, Leisure and Sport
Councillor Sarah Russell, Deputy City Mayor, Social Care and Anti-Poverty
Councillor Elly Cutkelvin, Assistant City Mayor, Education and Housing
Councillor Mustafa Malik, Assistant City Mayor, Communities and Equalities

City Council Officers: (4 Places)

Martin Samuels, Strategic Director of Social Care and Education
Ivan Browne, Director Public Health
Dr Katherine Packham, Public Health Consultant
1 Vacancy to be nominated by the Chief Operating Officer

NHS Representatives: (7 Places)

Richard Mitchell, Chief Executive, University Hospitals of Leicester NHS Trust
Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group
Angela Hillery, Chief Executive, Leicestershire Partnership NHS Trust
Oliver Newbould, Director of Strategic Transformation, NHS England & NHS Improvement – Midlands
Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group
David Sissling, Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland
Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Group

Healthwatch / Other Representatives: (8 Places)

Harsha Kotecha, Chair, Healthwatch Advisory Board, Leicester and Leicestershire
Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service
Kevan Liles, Chief Executive, Voluntary Action Leicester

Rupert Matthews, Leicester, Leicestershire and Rutland Police and Crime Commissioner
Kevin Routledge, Strategic Sports Alliance Group
Chief Supt, Jonny Starbuck, Head of Local Policing Directorate, Leicestershire Police
Sue Tilley, Head of Leicester & Leicestershire Enterprise Partnership
1 Unfilled Vacancy

STANDING INVITEE: (Not A Council Appointed Voting Board Member – Invited by the Chair of the Board. and no set number of places)

Cathy Ellis, Chair of Leicestershire Partnership NHS Trust
Professor Andrew Fry – College Director of Research, Leicester University
Richard Lyne, General Manager, Leicestershire, East Midlands Ambulance Service NHS Trust
John MacDonald, Chair of University Hospitals of Leicester NHS Trust,
Professor Bertha Ochieng – Integrated Health and Social Care, De Montfort University

69. TERMS OF REFERENCE

The Board noted the Terms of Reference approved by the Annual Council on 19 May 2022.

70. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 28 April 2022 be confirmed as a correct record.

71. PHARMACEUTICAL NEEDS ASSESSMENT

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

It was noted that:-

- 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.
- The PNA was subject to a 60-day statutory consultation period which opened on 6th July 2022 and would close on 4th September 2022.
- The PNA looked at current, projected and future needs and made recommendations on what could be done differently.

In response to questions from Board Members, officers stated

- Thew PNA took into account population projections for the next 10-30 years to assess the number of pharmacies per 10,000 population and

address any issues. Currently there were 85 pharmacies across the City and overall Leicester had more pharmacies per 10,000 population at 2.4 than the 2.1 average for England.

- There was a move away from hard to reach groups to a focus on making service more accessible. Those communities which were deemed to underserved by pharmacies tended to be the same groups who experienced, homelessness, language barriers and physical barriers to accessing premises. There was a need to make people aware of how to contact or when to contact services. The officer groups dealing with this would pick these issues up.
- Work was progressing with developing the support role in pharmacies to dealt with minor injuries, covid and lifestyle issues. The issue was providing incentives to pharmacy committees to increase the supply of community pharmacies and take on these additional roles.
- The increase in electronic prescribing reduced the impact on travelling distance but could give rise to the impact on overall needs if pharmacies were in the wrong locations. Customers with transport could also be disadvantaged if there were no pharmacies in a convenient location to them. Pharmacies were also competing with internet style delivery services.
- The Integrated Care Board design group engaged with pharmacies and were looking at a number of th issues commented upon especially the issues around the workforce changing and moving around facilities which could leave big gaps in service provision and were seeing how this issue could be supported.

The Chair commented that moving pharmacies to engage in primary care was crucial and the cornerstone to going forward. All Board partners were engaged in this and asked that they asked questions in their own organisations on how to engage and respond and what can be done in each organisation to help in promoting the messages to the public.

RESOLVED:- That officers be thanked for the progress made on the development of the Pharmaceutical Needs Assessment and were asked to submit the final Pharmaceutical Needs Assessment after it had been completed taking into account the comments made by the Board Members.

72. LEICESTER HEALTH CARE AND WELLBEING STRATEGY UPDATE

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

It was noted that:-

- A refresh of Leicester's Health, Care and Wellbeing strategy had taken place over the last few months. This involved retaining the five themes of Healthy Start, Healthy Living, Healthy Ageing, Healthy Places and Healthy Minds from the previous strategy which was published in 2019.

- The Board has previously approved a decision to refresh the strategy to reflect challenges that had been highlighted by the pandemic or where the need had increased as a result of the pandemic.
- A Leicester Place-led Plan Core Working Group was set up to develop the strategy and priorities on behalf of the Board.
- A series of engagement events, including working with a range of community groups and an online survey, were held between November 2021 and January 2022 with ongoing engagement with a number of partnership groups.
- The strategy would be presented to Health and Overview and Scrutiny committee in August 2022 where comments and feedback would be sought, before the final strategy was brough back to the Board together with a draft delivery plan.
- The delivery/implementation plan was in the early stages of development and focused on the six 'do' priorities of:-
    - Healthy Places: Improving access to primary and community health/ care services
    - Healthy Start: Mitigating the impacts of poverty on children and young people
    - Healthy Living: Increasing early detection of heart & lung diseases and cancer in adults
    - Healthy Minds: Improving access to primary & neighbourhood level Mental Health services for adults.
    - Healthy Minds: Increasing access for children & young people to Mental Health & emotional wellbeing services.
    - Healthy Ageing: Enabling Leicester's residents to age comfortably and confidently - proposed focus on reducing health inequalities through a person-centred programme of frailty prevention. (this wording was subject to change).

Members of the Board commented:-

- That a good majority of GP practices in east and south of the City had patients from different ethnicity and languages and it would be helpful to look at a mix and match of language skills and to see if these can moved around to have a robust system to improve language access to service to overcome the barriers.
- Sports clubs would welcome a meeting with the Council as they were keen to contribute to Healthy Minds through sport and physical activity but were unsure how this could be developed and wanted to understand how to capture synergy, avoid duplication with other initiatives and add value as well as ensuring they were delivering initiatives to the right people in the right circumstances.
- The strategy should influence how services were enabled in the future. The strategy should have elements of skilling within it, so it not only built services but also taught people how to drive changes and improvements.

In response to Members comments, officers commented that:-

- Three items in the delivery plan related to language and how access to services could be improved.

- The priorities were refreshed rather than started again from scratch. There were likely to be impacts of the pandemic but these were not fully understood yet on health, employment, reduced income and cost of living crisis. The priorities would be reviewed in 5 years. The previous strategy did not have a dashboard reporting element, but this would be built into the delivery plan. Most of the priorities were still largely the same as in the last strategy
- It was recognised that a lot of public data had a time lag in their accuracy, but other current data sources were also used and monitored.
- It would be helpful if different organisations with funds available for accessing mental health services could be aligned to ensure the best outcomes based upon need. The challenge with the implementation was to make sure it happened, and partners needed to know what was needed and to work together to deliver and use resources differently based on what was identified in strategy
- The was a huge role to be played for a range of organisations. Voluntary and community sector organisations and other large employers such as the universities, police and sports groups should contact officers working on mental health issues in Public Health for assistance.
- There was merit in getting all major employers to align activities and initiatives so it improved Leicester as a good place to work and improve wellbeing.

The Chair commented that the issues in developing the delivery plan would be a major focus in a private development session of the Board which would enable a focused approach to the delivery plan

RESOLVED:- That the timelines and next steps for Leicester's Health, Care and Wellbeing Strategy be noted and the delivery plan be discussed at a private development session of the Board.

73. LLR/NHS COLLABORATIVE WORKING (MENTAL HEALTH FOCUS)

The Chair stated that consideration of the report would be deferred to a future meeting as it required further details to be added.

74. INEQUALITIES PRESENT IN MATERNITY MORTALITY EXPERIENCED BY WOMEN OF DIFFERENT ETHNICITIES

The Chair stated that consideration of the report would be deferred to a future meeting as it required further details to be added.

75. REDUCING HEALTH INEQUALITIES - CORE20PLUS5

Steve McCue – Senior Strategic Development Manager, LLR ICB and Mark Pierce, Head of Population Health, LLR ICB submitted a report informing the Board of the NHS requirement by NHS England and NHS Improvement to

deliver against the CORE20Plus5 to support wider work to reduce health inequalities across Leicester, Leicestershire and Rutland (LLR).

It was noted that:-

- NHS England defined health inequalities as the preventable, unfair, and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental, and economic conditions within societies.

- The LLR ICS was aligned to the national vision of 'exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes. Health inequalities exist on a gradient throughout populations, and they were committed to using a proportionate universalism approach to reduce inequity wherever it existed across LLR.

- Core20Plus5 was a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system (LLR) level. The approach defined a target population cohort – the 'Core20PLUS' – and identified '5' focus clinical areas requiring accelerated improvement.
- The Core 20 referred to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health. In Leicester, Leicestershire & Rutland (LLR), 153,284 registered patients lived in the 20% most deprived neighbourhoods in England. In Leicester this was 31.7% of the total number of registered patients compared to 3.2% for Leicestershire and 0.4% for Rutland.

- The Core20Plus5 framework set out five clinical areas of specific NHS focus. Governance for these five focus areas sat with national NHS programmes and national and regional teams coordinate local systems to achieve national aims. The five clinical areas included;
    - Maternity: ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the Core 20 part of the population
    - Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities)
    - Chronic respiratory disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
    - Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
    - Hypertension case-finding: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and

stroke

- Using this framework would not tackle all health issues, but it was still a good tool to improve Health and Wellbeing. There were also elements that are locally determined, and officers will be working on those and bring a report to a future meeting to see which specific needs to be involved or where services were not serving groups very well e.g. communities that experienced vaccination issues during covid etc.

During discussion Members of the Board commented that:-

- The approach was a good opportunity to have a forensic look about talking about deprivation in providing health care. There needed to be clarity on governance and what would be done if there were differences on place level and system based levels.

- It was positive that there were local decisions to be made and everyone needed to understand what these were and then take them through the ICB to make the right decision. When this was considered again it should have more details on public engagement

- There was a need to understand health inequalities in Core 20 plus 5; but health inequalities have been known for some time. There was a need to be focused on what was being done now to address inequalities and have evidence for it and, if this was not possible there was a need to ask why it can't be provided.

- The County Council were making approaches to the ICB to protect the county hospitals so it was important that the City needed to make representations about deprivation, otherwise it would lose out again.

- Proportionate universalism was supported where the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services were, therefore, universally available, not only for the most disadvantaged, and were able to respond to the level of presenting need. It would be difficult to make inroads in improving health and wellbeing if the focus on the need was not paramount.

- Whilst this initiative was supported it did not engage with the remaining 80% to look at and underpin good health outcomes in education and housing. It was somewhat unfortunate that this had come through a health route and not a wider route for consideration. The aim should be on how the focus was prioritised for all and not get overshadowed by concentrating on the 20% in deprivation.

The Chair commented that there was a concern that the Board had its own strategy and priorities and there was a risk that the same thing could be created elsewhere with different name. Governance issues were important, and place was about the City and our health inequalities. Engagement of the public was crucial, and each organisation did it differently. If possible, there should be a tie up and it would be helpful to have a paper on engagement with the public looking at co-production of engagement by partners as a way

forward as there was a need for a much more joined up approach and have a system in place to consult for all partners organisations to consult together and provide feedback to the ICB as well.

RESOLVED:- That the report be received and all partner organisations work together to on an initial focus on Leicester population cohorts who already experience health inequalities and that a further report on progress of the initiative be submitted in the future taking into account the comments made by Board Members.

76. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions from members of the public had been received.

77. DATES OF FUTURE MEETINGS

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

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

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

It was noted that the meetings for October and February would be re-arranged as there were NHS meetings on those days involving a number of the Board Members.

78. ANY OTHER URGENT BUSINESS

There were no items of Any Other Business.

79. CLOSE OF MEETING

The Chair declared the meeting closed at 10.57am.

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

BCF narrative plan template

Cover

Health and Wellbeing Board(s)

Leicester City

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

Leicester City Council – Adult Social Care
Leicester City Council – Public Health Department
Leicester City CCG (now LLR ICB)
University Hospitals of Leicester Trust
Leicestershire Partnership Trust
Derbyshire Health United – provider of out of hours, emergency home visiting and Urgent Care Centre services

The BCF plan is co-developed with stakeholders and forms part of the wider Joint Health and Wellbeing Strategy delivery. Bodies involved in the preparation of this plan have been through a well-established, place-based infrastructure:

1. **Leicester City Integrated System of Care Group (ISOC).** This groups brings together representatives from the University Hospitals of Leicester, Leicester City Public Health Team, Leicester City Adult Social Care, Leicester City Place (ICB), Leicestershire Partnership Trust (MH and Community Health Services Provider), Derbyshire Health United (provider of out of hours medical services, out of hospital hubs and home visiting services), Health Watch, The City Primary Care Network Strategic Clinical Directors, Leicester City GP Lead for Population Health, Dr Raj Than, Leicester City Place clinical leads Dr Avi Prasad and Dr Fahad Rizvi. Voluntary Sector providers also attend to update on elements of BCF-funded provision. A sub-group of this Group drafted the initial 2022-23 City BCF budget. ISOC meets monthly to oversee operational delivery of BCF services and recommends any commissioning required to meet our objectives.
2. **Leicester City Joint Integrated Commissioning Board (JICB).** This monthly Board meeting is chaired alternately by the Director of Social Care, Education and Housing from Leicester City Council and the Chief Operating Officer for the ICB. It includes senior representatives from ICB, UHL, Public Health, Adult Social Care, Children's Services and Community Health Services. JICB has delegated authority from Leicester City Health and Wellbeing Board to develop BCF strategy and to sign off BCF plans pending HWB sign-off.

3. **Leicester City Health and Wellbeing Board:** Formal approval of the City 2022/23 BCF plans is expected at the scheduled meeting on 13th October. The chair of the Health and Wellbeing Board, is a member of the ISOC group, which has developed the 2022/23 plans.

Executive summary

Leicester City has adopted the Making it Real Framework. This ambition for this plan reflects our key 'I' and 'We' statements:

"I have care and support that is coordinated and everyone works well together and with me"

"We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services"

The BCF plan for Leicester City for 2022/23 reflects the established framework already in place for delivery of integrated working across the LLR system, whilst reflecting a high degree of continuity of strategic intent with our plans from previous years.

1. We will be focusing on delivery of the national metrics identified in the BCF Framework published in July 2022. (See Excel Template tabs 4,5,6,7)

2. We will continue to use the BCF monies and the partnerships and relationships to advance a broader range of culture, service improvement and quality-related agendas across the city health and care landscape as a whole:

    - Integration of services into an Integrated System of Care for people and their carers living with frailty or multimorbidity.
    - Reducing inequity of outcomes across health and care
    - Making Every Contact Count (MECC)
    - Promoting personalisation of care
    - Promoting parity of esteem for those with mental ill-health or neurodiversity
    - Improving the experience of care
    - Improving the experience of work for all our staff
    - Mobilising the voluntary sector as partners in a health and care system
    - Improving value (value for money and social value) for people and partners in our system
    - Embedding a population health approach to Improving health and care outcomes for the people of Leicester City (the Core20Plus5 approach)

The BCF pooled budget will fund the following key areas of place-based services in 2022/23:

- Care Navigation and coordination
- Home First Community Response Service including Integrated Hospital Discharge and Reablement Pathways
- Integrated Crisis Response Service
- Transforming Care and Learning Disability priorities
- Health and care data integration solutions
- Assistive technology developments (including community alarm call centre),
- Key services to support and sustain adult social care, (e.g. Care Act requirements
- residential respite, assessment and review teams, quality assurance team for care and nursing homes, mitigation of demographic growth and winter pressures).

Key changes in the 2022-23 plan

A tabletop review of City BCF investment in 2021/22 resulted in the following changes in the 2022/23 investment plan. These changes were made on the bases of emerging population need, strategic priorities at Place, and in some cases the identification of alternative (non-BCF) sources of funding for some services. For the 2022/23 plan, alternative funding sources (in full or part) were identified for some services, e.g. Dear Albert, Leicester Counselling Centre, VISTA and Warm Homes Services. This enabled new investments to be made in the GP Registration programme and the MDT Leader's post, as well as increases in other services as outlined below.

Iterations of 2022/23 BCF plans were debated at ISOC at which the chair of the Health and Wellbeing Board represents the views of the elected HWB members

- Additional investment in Care Co-ordination for Discharge to Assess
- Additional investment in Integrated Crisis Response Services
- Additional investment in Care Navigation
- Additional investment in Reablement and in digital inclusion for those with sight loss
- Additional investment in Breast feeding support for women from less advantaged groups
- New investment in support for those who are resident within Leicester City but are not registered with a GP practice
- New investment for support to day care for those with alcohol and other substance misuse issues

- For 2022/23, joint priorities and projected spend were planned and approved by partners and stakeholders during the planning phase which began in February 2022. This included alignment to the newly refreshed Joint Health and Wellbeing Strategy (JHWS) priorities for Leicester City. The strategy focuses on the life course approach, with specific integration focus on Living and Supported Well, and Dying Well priorities.

Metric targets have been jointly produced with each BCF "Place" in Leicester, Leicestershire, and Rutland (LLR) using the same methodology. This has been through a collaboration of representation from Midlands and Lancashire Commissioning Support Unit, the ICB and Local Authorities. These have been added to the performance framework across LLR for joint delivery of outcomes related to activity to support timely discharge.

Governance

Overall responsibility for sign-off of the BCF plan sits with Leicester City's Health and Wellbeing Board, to ensure that the plan is supporting the delivery of the (newly refreshed in 2022) Health and Wellbeing strategy for Leicester. The next meeting of the Health and Wellbeing Board will take place on 13th October 2022, at which the plan will be formally approved. The Chair of the Health and Wellbeing Board has approved submission of this current plan following a Lead Member briefing.

Strategic oversight of the development of the plan is delegated to the Joint integrated Commissioning Board (JICB), which includes senior representatives of the Local Authority and ICB across adults and children's services, housing, and Public Health. Earlier drafts of this plan were developed by a sub-group of The Integrated Systems of Care group (ISOC, see below), were revised in line with comments from JICB and ISOC, and the final plan approved by JICB and by the CCG Executive Management Team.

The operational delivery of the BCF plan in Leicester City is managed each year by the Integrated Systems of Care Group (ISOC). ISOC includes representatives from a range of organisations including healthcare providers, the ICB, Health and Wellbeing Board, Public Health, Adult Social Care, Strategic Clinical Leadership and Health Watch. This group meets every month under the chairmanship of Deputy Director of Integration and Transformation (previously a CCG Independent Lay Vice Chair) to review progress and performance of BCF-funded services in relation to national BCF metrics and the wider agenda of integration, personalisation of care and reduction of inequity.

Leicester's BCF investment plan is mutually supportive with those of its ICS partners in Leicestershire and Rutland. Given its focus on improving outcomes and experiences of care for adults living in Leicester, its strategic development is also influenced by LLR system-wide groups including the LLR Prevention and Health Inequalities Reduction Board, the LLR Population Health Management Advisory Group and the LLR Frailty collaborative.

Overall BCF plan and approach to integration

Leicester's vision for health and care integration is '*Working together to enable everyone in Leicester to have opportunities for good health and wellbeing' (Leicester Health, Care and Wellbeing Strategy 2022-27)* Our jointly agreed priorities for delivering models of care are to:

- Access a range of preventative and proactive services
- Deliver more care outside of hospital and closer to home
- Provide integrated, personalised, and holistic services.
- Help citizens, carers and professionals work together to maintain health, wellbeing and independence, for as long as possible.

Our approach to joint commissioning for 2022/23 has been to re-align the BCF into key sections of delivery against emerging priorities in order to make it clear how BCF investment aligns to person-centred care and maintaining independence wherever possible

Many chronic conditions are preventable, yet the NHS remains, at heart, a treatment service for people when they become ill, and lacks a comprehensive approach to keeping people well. To address this, there is a need to move away from a system focused on diagnosing and treating illness towards a partnership that is based on promoting wellbeing and preventing ill health. To do this, our ICS will reach beyond the NHS to work alongside local authorities and other partners to address social, economic, and environmental determinants of health within an integrated system of care.

Evidence consistently shows that it is the wider conditions of people's lives – their homes, financial resources, opportunities for education and employment, access to public services, and the environments in which they live that exert the greatest impact on health and wellbeing. These 'wider determinants of health' require partners to work together to consider how they all combine to affect our wellbeing and health.

Our LLR 'Home First' Collaborative brings together clinical and managerial leadership across the system and aims to deliver optimal outcomes for our complex/ frailty patients through design and delivery of an integrated system of complex care across the Leicester, Leicestershire & Rutland health and care system. Over the years many great services have been developed through BCF funding to support people to remain at home as independently, and as safely, as possible. We are now looking

to opportunities to ensure our offer fits together without gaps in provision for all frail and complex patient groups.

These are: Home First, Discharge to Assess, Transforming Care, Mental Health, and Health and Social Care protected services. Within these spheres, schemes are funded to deliver outcomes around proactive care, place-based models of care, personalised care, Dementia Strategy, Learning Disability pooled budget arrangements and "preablement" preparation for elective surgery. This has made it easier to determine overall commissioning activity within each key section. A desktop review of all BCF schemes by the Subgroup of ISOC helped to re-align BCF priorities for partners to new emerging models of care.

Summarised below are the some of the new key Home First programme priority schemes and developments that aim to meet the above priorities in addition to existing services described in previous years' plans, including any changes and additional investment to our Better Care Fund planning or spend.

For each scheme described in brief below, the appendix attached details key features, desired, outcomes, overall impact, challenges and mitigations to these areas of work.

Overall BCF Plan and approach

Transforming and building community services capacity through growing the LLR virtual ward model: £2.6 million initial investment – Start April 22 – completion Dec 23

A virtual ward is a team of professionals working to manage a group of patients in the community. It allows patients to get the care they need at home, safely and conveniently, rather than being in hospital. Using a combination of remote monitoring by healthcare professionals and home visits, virtual wards can help prevent hospital admissions or allow for an earlier, supported discharge. It has been shown that people make a better recovery in their own surroundings and that staying in hospital longer than necessary can have a detrimental effect on their condition and their independence.

By Winter it is hoped that 275 patients across LLR will be able to be looked after simultaneously across nine virtual wards including frailty, cardiology, acute respiratory and diabetes. The number of beds will increase to more than 440 by December 2023. (Leicester's population represents approximately 40% of the LLR population and would be using these services in a broadly proportionate way.)

The virtual ward service has been arranged by NHS LLR and will be provided by a collaborative of local organisations, including University Hospitals of Leicester NHS Trust, Leicestershire Partnership NHS Trust, Local Authorities and the local hospice, LOROS.

Among the priorities will be: to increase utilisation of existing virtual ward beds, ensuring appropriate use to avoid admission (where appropriate)/ facilitate earlier discharge; and to enhance our step up and step-down access to virtual ward beds through growing the development of the LLR unscheduled care coordination hub.

Impacts on equality and access to asset-based community approaches will be detailed for each ward in the EHIRA attached below. Phase 2 stages for the EHIRA are in development and further work is

underway to assess the ongoing requirements for this. E.g. whether impact assessments are required for each protected characteristic.

Paper D - Stage 1 EHIIRA questions MS '

Pathway 1: supporting reablement, rehabilitation and recovery intake model – initial health investment across LLR of circa £2.3 million recurrent funding (including non-BCF funding such as Ageing Well) – start implementation September 2022 – ongoing until September 2023

One of the major ambitions in our approach to integrated care has been the development of an overarching health and social care service that aims to support timely discharge and also to provide a step-up crisis model of care.

This will support the previous ambitions of the Ageing Well Programme by further integrating community models of care, to maximise independence, support people to remain in their own homes and reduce inequality of ability to remain at home particularly those with protected characteristics within the Equality and Diversity strategy. This will further ensure that Leicester City residents are receiving the right level of care in the right place at the right time, supporting delivery of recommendations received in the LLR system-wide review conducted by Dr Ian Sturgess, Urgent and Emergency Care Improvement Expert, during July and August 2022. The recommendations relating to this piece of work are being fed into a programme plan (currently in development) which will include risks to delivery and a breakdown of individual task-related timescales.

Changes from 2021/22 -

- Further investment in recruitment (recurrent) of staff to support the model
- Aligning the locality model of delivery to LPT hubs to incorporate community nursing and therapy
- Re-assessment (post-pandemic) of demand and capacity modelling
- Incorporating community response services with reablement

Embedding integrated neighbourhood working and delivering anticipatory care: **Additional £200k investment across LLR– this phase of implementation to last until April 2023**

Integrated Neighbourhood Teams aim to provide proactive and integrated care to communities of 30,000-50,000. They aim to keep local people well and out of hospital and are built on the base of primary care networks. They bring all parts of the workforce together and put the people at the centre of the care they receive. The cornerstone of each Integrated Neighbourhood is a Primary Care Network.

Our Making it Real model of care is shown in the diagram below:

Model-of-care-Leicestershire.pdf

Some of the key deliverables include:

- Embedding operational Multi-Disciplinary Teams (MDTs) and an anticipatory care/population health management (PHM) approach to jointly manage frail, complex and high-risk patients, ensuring that all neighbourhood teams have well-functioning MDTs in place by October 2022 ;

- Ensuring consistent use of care co-ordinators, care navigators and social prescribers to maximise use of the Voluntary and Community Sector and other wellbeing offers in order to ensure the issues related to the wider determinants of health as well as purely clinical or functional capacity issues are addressed;
- Developing high-performing Integrated neighbourhood leadership teams consistently across LLR with full engagement, clear governance and shared purpose, underpinned by a local PHM plan by March 2023.
- Increasing the identification of carers enabling support to be offered;
- Developing an Integrated Neighbourhood Team maturity matrix;
- Increasing care planning to 95% of vulnerable patients;
- Recruiting additional care co-ordinators and finalising an MDT draft framework; and
- Recruiting MDT Facilitator roles through LAs (underway).
- community services, care homes and acute; and, planning and delivering a public awareness campaign.

Transforming and building community services through Home First Urgent Crisis Response and reablement

The aim of this priority is to deliver an urgent community response within two hours for more patients than in 2021-22 and achieve this target at least 80% (we are exceeding our target) of the time for the system.

Urgent crisis response referrals will be increased through: Emergency Department front door diversion; expanding pendant alarm referral routes; diverting appropriate calls from EMAS alignment to other local offers; continuation of the falls crisis response offer; and maintaining delivery of rehabilitation and reablement within two days of referral to at least 80% of cases across LLR. (Again a target that is being achieved)

Strengthening the community palliative and end-of-life care response

LLR partners will support more people to die in their place of choice through:

- Increased identification of people in their last year of life via increased use of risk predictive modelling markers within the ACG system (MRS) and ReSPECT planning;
- Improved access to end-of-life care provision through the design and mobilisation of a 24/7 advice line for patients, carers and professionals;
- Enhancing the end-of-life discharge pathway by testing an integrated end of life social care bridging and co-ordination offer and undertaking quality and co-production reviews of patient and carer experiences at the end of life.
- Ensuring end-of-life care remains everyone's business through appropriate training and support to staff of all disciplines
- Refreshing place-level JSNAs and the LLR all-age end of life strategy

Implementing the enhanced health in care homes (EHCH) model

- Ensuring full and consistent delivery of all parts of the EHCH PCN Direct Enhanced Service, including allocating named GPs for all care homes and residents;

- Piloting the use of a care home virtual ward with remote monitoring for patients with a frailty score of seven or above or a higher risk of admission, and developing a plan for further roll out by September 2022;
- Embedding comprehensive geriatric assessments and effective MDTs across all care homes by August 2022;
- Determining the ongoing model of care for bed based reablement care;
- Implementing the National Early Warning Score (NEWS) which is a tool for identifying and responding to acute illness. When used in care homes, staff measure residents' vital signs and record them on a tablet computer, which calculates a NEWS to share with health partners; and
- Complementing this by piloting WHZAN and Spirit digital technologies in care homes to support the identification of deterioration using NEWS2. The Whzan Blue Box is an all-in-one telehealth case. It measures vital signs, records photos, and performs multiple assessments and questionnaires including NEWS2. Signs of deterioration or illness are identified earlier, for a clinical response or carer support.

Implementing equitable falls prevention and management across LLR

- Evaluating and developing longer term plans for the falls crisis response model to maintain an equitable response across LLR by August 2022;
- Developing a plan for early identification and support for people at risk of falls by October 2022; and
- Embedding a consistent falls management offer across LLR.

Implementing an integrated therapy model that maximises shared resources

The Integrated Therapies Vision is to best utilise LLR therapy resources across LLR where services provided are similar or across patient pathways where there are key therapy interfaces. This will support seamless and effective patient care, efficiencies, flow, admission avoidance, and a single model of care within certain pathways with agreed standards and ways of working. This needs to be underpinned by a robust LLR Therapy workforce plan. Among the changes are:

- Maximising the use of LLR's integrated therapy workforce across ICS shared roles, a single leadership model, a single clinical model and shared waiting lists across each pathway;
- Development of a single clinical model and pathway for stroke therapy;
- Development of an integrated therapy model for community health and social care.

Growing community capacity through the workforce

- Engaging with independent providers of care home and domiciliary care, through provider forums, to support system resilience and the integration agenda;

- Co-design of a responsive system-wide Home First career pathway encouraging more effective integration and sharing of future workforce capacity by collectively developing a pipeline by championing of new roles and shared training and development; and
- Further exploration of Multi-Professional Teams/ co-location/ collaborative working to ensure consistent working practices and to promote better integration of the LLR workforce as well as care pathway delivery improvements.

Implementing the BCF Policy Objectives (national condition four)

Below are examples of investment in schemes to support enable people to stay well, safe and independent at home for longer and to provide the right care in the right place at the right time. All schemes are jointly agreed and approved with partners including Hospital Trusts and joint processes and resources are agreed in all cases. This is done both formally through the agreed governance structure and also through joint forums such as the Strategic Discharge Cell. We believe that these services which are funded through both BCF and national and local funding streams will help us deliver successfully against the high-impact change metrics and the other national BCF metrics.

As in the previous section, for each scheme described in brief below, the appendix attached details key features, desired, outcomes, overall impact, challenges and mitigations to these.

Implementing BCF Policy Objectives ap|

Unscheduled Care Hub – pilot phase from April 2022. Ongoing development until April 2023
Our local health and care services will be taking responsibility for managing the needs of sub-acute patients who present to the Unscheduled Care Coordination Hub (UCCH). These are residents who are not seriously ill but are at immediate risk of unscheduled attendance at hospital or having an ambulance response.

The UCCH will co-locate a multidisciplinary team made of representatives from DHU Health Care, East Midlands Ambulance Service (EMAS), Adult Social Care (ASC), Leicestershire Partnership Trust (LPT), Integrated Care Board (ICB) and the Emergency Care Improvement Support Team (ECIST).

The UCCH can continue to take referrals from the Emergency Operations Centre (EOC) for EMAS calls waiting, however there will be a dedicated (Clinical Advice Team (CAT) clinician on site for a complete overview of LLR EMAS calls waiting (on EMAS stack), along with UCCH reviewing the Clinical Navigation Hub (CNH) and Home Visiting Service (HVS) calls waiting and EDs bed stack. This will provide UCCH with oversight of a substantial proportion of LLR's unscheduled care demand providing the ability to safely navigate patients to the most appropriate care setting for their needs.

Referrals from community teams in LPT and ASC will also be able to phone the UCCH to discuss patients presenting with non-emergency clinical presentations. This will be to guide a decision on whether an ambulance should be requested, or if the patient can be safely supported in their home environment.

Referrals to the UCCH from EMAS crews on scene is advised where a patient is at risk of admission and there is a view that a community-based alternative could be safely offered. This can be where there is no existing appropriate pathway, or the crew are not aware of an existing pathway. Where there is an community existing pathway, this should be utilised.

All patients referred or reviewed will receive a multi-disciplinary team discussion. This will support decisions being made within 15 minutes to ensure patients are placed into the most appropriate health or care setting and safely transferred into alternative pathways. Further considerations will include proactive support at home. The UCCH will take ownership of patients moved from all patient lists and the UCCH team will inform patients of any alternative plan/pathway identified.

The multidisciplinary unscheduled care team will have real time visibility of EMAS, DHU and LPT caseloads and the ability to interact with healthcare professionals on scene to provide viable alternatives to hospital admission and enabling appropriate support within the home environment.

The unscheduled care coordination hub will be supported by health and care colleagues ensuring the right skill set, experience and knowledge is in place to support the diverse needs of the patients being referred in. There will be clinical oversight by DHU throughout the hub's operation to ensure risks are monitored and patient safety is adhered to.

Integrated Discharge Hub and Case Management for Discharge - £313k – Completion October 2022
In 2020/21 Leicester, Leicestershire, and Rutland established an Integrated Discharge Hub with Hospital Trusts to streamline, coordinate and facilitate discharges for patients requiring ongoing support post discharge on pathways 1-3. In 22/23 this will be further developed and enhanced.

We have developed an electronic LLR Discharge Tracker that serves to provide system-wide assurance, across our single bed-base, of acute and community hospital inpatient beds, on key quality and performance metrics aligned to the national discharge guidance.

Multi-agency staff have access to all SystmOne electronic health records and can update and track patient activity in real-time.

Re-Commissioning of step-down D2A beds to support the 3 R model of care – commissioning to start October 2022 – completion for "go-live" July 2023
The introduction of the national discharge model to deal with COVID, and with it a more explicit onus on rehabilitation, reablement and recovery (RRR) as a core offer within the discharge process, is supporting a move to recovery and therapeutic interventions within a pathway 2 model. These services give our local system an opportunity to embed strength-based, outcome-focused care for people 'stepping down' from an acute care episode and, ideally, as a way of also avoiding admissions (step up) where a safe and effective alternative is available.

Previously commissioned bed-based models proved that 77% of patients returned to their usual place of residence with only a small percentage of people discharged into longer term residential care. The Care Co-ordination service has been enhanced to support this and offers links to ongoing community support and care. They work as part of the MDT alongside therapists to ensure that patients are effectively case managed and discharged with the appropriate levels of ongoing care for residual needs (if any).

The clear importance of a dynamic and comprehensive "RRR" offer in the LLR out-of-hospital landscape recognises that a shift from the provision of traditional care after discharge to one that is based on the principles of effective RRR, can maximise independence and wellbeing and potentially reduce the long-term costs of care. These services ensure dedicated capacity is available for people who would benefit from a RRR intervention as part of our Home First approach This supports the LLR vision for Home First and the key BCF priorities of the last several years relating to length of acute hospital stay, timely discharge and promoting independence for older people and those with disabilities.

These services have at their core, the principles and values of personalisation and community-based support, this is central to improving outcomes for people transferring from hospital into these settings. This specification borrows from Think Local Act Personal's "Making it Real" framework which is a set of 'I' and 'We' statements that describes what good care and support looks like from a person's perspective.

Integrated Personalised Care Framework - £81k for training packages – go live Nov 22

A review of the LLR Health and Social Care Protocol (2014) began in 2019 in a context of growing demand, with increasing complexity of need across all health and social care partners and against a backdrop of ongoing budgetary pressures and significant challenge in relation to capacity across all parts of the system.

The protocol listed and enabled partners to have a mandate for health and care providers to deliver a set of shared tasks on behalf of each other linked to the personalisation of deliveries of care models. The Integrated Personalised Care Framework aims to:

- Identifies the Principles, Statutory duties and National guidance that underpin and inform decision making around the delegation of support tasks between Health and Social Care.
- Identifies the elements required to support appropriate delegation and aims to help registered practitioners and commissioning workers understand the decision-making process involved in safe and effective delegation of a task from one provider /organisation to another.

In addition to this, there has been an ongoing drive towards integration across Health and Social Care, including the development of Primary Care Networks, Integrated Neighbourhood Teams, Home First and the effective utilisation of the voluntary sector and wider community assets.

Training and launch events are scheduled for September to roll out the new framework to the health and care workforce within Leicestershire.

Demand and Capacity modelling

The Demand Capacity modelling template has been completed in line with the guidance issued. The pattern of BCF investments in the range of services included in the 'intermediate care' descriptions is a continuation of the approach which has proved successful in Leicester City in previous years and which we believe best ensures that City capacity matches demand. (Still at home after 91 days after discharge = 93%. 60% requiring no package of care, 25% requiring same package of care as before) The BCF investment in this sphere on non-bed based services is £5,203,519. The sum of £494,077 spent on the city bed based services comes from a non-BCF source.

High Impact Change Model – self-assessment

Leicester City has undertaken a self-assessment against the high impact change model of care for 22/23. Attached is the summary of the assessment conducted and the work to progress through the levels of maturity.

High Impact Model

Supporting unpaid carers.

Leicester has a comprehensive offer that supports carers within our community. There are various schemes and services for unpaid carers and ways for them to access funds and short-breaks.

Details of the BCF finances used to support carers is detailed below. The last two bullets points represents the investment by the NHS in the delivery of the care act duties in relation to supporting unpaid carers (total = £764,025) (see row 2 in the Expenditure tab of the template):

- Provision for enhanced carer support services - £223k
- LD Short Breaks - £929k
- Residential Respite Service - £874k
- Care Act Enablers - £158k
- Care Act Support Pathway - £522k

Help is available through the customer service centre in Adult Social Care, with the BCF funding two carer champions to help carers access support initiatives shown below. In addition, Leicestershire has worked with the community and voluntary sector to commission VASL to support carers in the following ways:

- a dedicated telephone advice line Monday to Friday
- a telephone befriending service specifically for carers
- local carers groups and events
- support to complete Leicestershire County Council's online carer's assessment form

Carers support grants of £250 and personal budgets for carers are accessed through a carer assessment. This looks at existing support networks for example, family or friends. It considers the things a carer wants or need to achieve outside of your caring role and the impact this has on their ability to carry out those activities and affects their wellbeing.

Support to young carers is also included in the support offer and includes:

- help with school and college work
- training to get a job
- help to get a job
- activities
- spending time away from your caring responsibilities

In 2020 we signed up to become a partner organisation to Carefree which offers al breaks away listed on Carefree's Breaks Hub. Unpaid carers can browse available options and submit a request for a specific hotel on specific dates.

Respite at home (sitting service / time with)
Carers can find providers by using our online information and support directory and the Leicester, Leicestershire and Rutland Care Directory. The website also informs carers on NICE guidance on what to expect from a good service.

Short term care
This is available for carers to take a short break or holiday, this can be arranged by contacting any residential home and asking for availability and pricing for respite care.

Disabled Facilities Grant (DFG) and wider services

The Council administers a programme of DFGs with OT and housing staff working in partnership. A range of initiatives are deployed to create flexible and creative solutions for people requiring major adaptations, including a cost equivalent scheme, stair lift scheme, and bespoke solutions for people using the exceptional circumstances flexibility in the DFG policy. A funding pool is being explored to

support adaptations beyond the DFG cap, where this will maintain people living within their own home.

The BCF supports a wider range of housing needs including warm homes, small adaptations and equipment, additional capacity in the 24/7 community alarm scheme with direct access to UCR services. Work has taken place to explore how building links between the alarm scheme and CNS services might increase safe triage into non-acute services.

There are plans to increase OT capacity to support a review of people who are awaiting adapted rehousing, to inform the Housing Department's capital investment, creating suitable properties for people who have noy been able to secure suitable accommodation to date. This is challenging presently, as OT staff are proving difficult to recruit, which is a known national issue.

Housing Enablement Team

The Hospital Housing Enablement Team (HET) who provide a bedside service to patients and support flow through the UHL hospitals and the Bradgate Mental Health Unit continue to support the Integrated Discharge Hub.

A high volume of the work involves cases that fall outside of statutory duty for Local Authority Housing Options teams but fulfil the hospitals requirement to have a legal route for referral of homeless patients to the Local Authority. In addition, HET also supports patients with preventing evictions, accessing refuges, moving into new tenancies, provision of essential furniture items/white goods, support with adequate heating of homes, housing applications and benefit applications as just some of the work undertaken by HET that is outside the remit of statutory services but is otherwise necessary to secure safe, effective discharges for patients.

The additional support provided includes housing support for TB patients that access the TB centre for the East Midlands located in the Leicester hospitals, as well as extending support to patients with No Recourse to Public Funds but who are otherwise unable to be discharged from hospital safely. Most recently Lightbulb services and HET have been supporting therapy service patients with housing related issues by providing measures such as creating a downstairs-existences where possible and by undertaking small-scale cleans and clearances to make properties safe and accessible for discharges for patients and carers. In this way, patients are more likely to be able to return home in the first instance, rather than require interim placements or other high-cost interventions. Within mental health services, HET continues to work alongside Action Homeless to manage the Community Transitions Project, a step-down facility where patients who are ready to leave hospital can stay whilst they await long-term accommodation but who would otherwise be unsuitable for other temporary accommodation. This partnership allows vulnerable patients to be discharged safely from acute mental health beds, whilst still preventing readmissions as a result of unsafe discharges.

The team has expanded in a number of pilots to support the wider services and flow in the Mental Health Rehabilitation units and in all Community Hospitals. This is currently on a temporary basis to monitor demand. A similar pilot in MHSOP is also in discussion.

In 2021/22 the HET service undertook:

- 698 referrals from the UHL hospitals
- 173 referrals from the Bradgate Mental Health Unit
- 30 referrals from the MH Rehab units
- Managed 5 long-term TB cases in the community
- Achieved average resolutions times of just 2.61 days for UHL cases and 15.21 days for BMHU cases

Equality and health inequalities

The Leicester BCF plan is an enabler to all statutory organisations in our integration partnership in discharging their duties with respect to tackling and reducing inequalities. Reduction in health inequalities is informed by socio-economic data and woven into the design and prioritisation of interventions.

In this year's BCF, once again, we have further developed our approach to population health management particularly in light of inequalities highlighted during the covid pandemic. Partners have been provided with integrated sets of data to examine these issues which supported the development of the Joint Health and Wellbeing Strategy. One of the main aims of the strategy is to pinpoint health inequalities in order to design effective services to reduce these. This will be fed into current and future BCF planning.

Reducing health inequalities is a core priority for the LLR Integrated Care System (ICS) and its programme of work to reduce health inequalities will be guided by the 12 principles within the LLR Health Inequalities Framework with a focus on addressing the five priorities in the 21/22 & 22/23 NHS Operational Planning Guidance and the Core20Plus5 approach.
Attached is a report that was presented to the HWBB in July 2022, for Leicester and includes further details on the LLR approach to delivery of the core principles of the Core20Plus5.

LC HWBB CORE20PLUS5

Examples of continuous investment to reduce health inequalities in the city through the 2022-23 BCF investments, once again, include:

- The Centre Project
- VISTA
- Dear Albert
- Leicester Mammas
- Integrated Mental Health Team
- Royal National Institute for the Deaf (formerly known as Action on Deafness)
- Care Navigators
- Specialist support for those with Hoarding Disorder
- Live Well
- Smoke Free App
- GP registration team – New investment for 2022/23

All newly commissioned schemes, including those funded through the BCF, are subject to EHIRA's which form part of the overall development of business cases and presented throughout the corresponding governance structure. Work is underway to ensure that timescales for the development of EHIRA's is consistent within the development of schemes.

Current (2022/23) strategic actions to reduce health inequalities at the Integrated Care System level and local level following systemwide adoption of principles and actions contained within the LLR

Health Inequalities framework, further progress is planned or has already been made in the following areas:

Action 1
Places will be expected to apply the principles, outlined in the LLR Health Inequality Framework, to their specific populations in the most appropriate way that meets their local needs. This is likely to embrace the various factors that can affect people's health – including the wider determinants of health. For example in 2022 the ICB has agreed to a £1.1m investment in Leicester City Public Health to help mitigate the impact of current fuel poverty crises, on the basis of the impact of fuel poverty on physical and mental ill health.

Action 2
The ICS will make investment decisions for people across LLR that reflect the various needs of different communities - following the principle of proportionate universalism outlined in the Marmot reports. In this way, actions can be universal, but adjusted and made proportionate to the level of disadvantage. The aim of reducing health inequalities will be a high priority. Delivery of actions to reduce health inequalities locally, will be the responsibility of the Health and Wellbeing Board and the Leicester City Joint Integrated Commissioning Board. At system level across LLR, ensuring health and care equity through proportionately universal investment policies will be the responsibility of the LLR Prevention and Health Inequality Board, and of the ICB's Health Equity Committee. In 2022, Leicester City's BCF funded locally enhanced primary care scheme 'Planning for Integrated Care in General Practice' (PIC GP) allocated funding for a programme of enhanced primary and community care (including social care) on the basis of population health-based case mixed adjusted formula rather than simply on weighted list size. This model allocated larger sums of money to population with greater health inequalities and health care needs. This represents a proportionately universal approach to service provision.

Action 3
We will establish a defined resource to review health inequalities at this strategic level. This Health Inequalities Support Unit will be a virtual partnership between the NHS, local authorities and local universities. An enhanced ability to process and analyse data will support a better understanding of inequity across the area. We will gather and share best practice on effective interventions and provide teaching and training to all levels of staff in undertaking health equity audits. We will facilitate local research. Public health teams will deliver, with partners, the health inequalities support function at a place and neighbourhood level as part of the delivery of the Health and Wellbeing Strategy. The Health Inequalities Support Unit will be inaugurated during 2022-23. The directors of Public Health in Leicester, Leicestershire and Rutland have agreed the allocation of some Public Health analytical resource to commence an initial project on Cancer inequalities in Leicester City.

Action 4
All decision makers within the ICS will have expertise, skills, insight and understanding of health inequity and how to reduce it. Specifically, health inequity and inequality training will be mandatory for all executive decision makers in each organisation. In 2022 a sum of £20k was secured to fund the running of an initial health inequalities training course for LLR leaders, provided through the LLR Academy. The first cohort is expected to start in January 2023.

Action 5
Partner organisations continue to work together to understand the impact of Covid-19 on health inequalities across LLR, to allow effective and equitable recovery after the pandemic. We will be looking to:

- Identify groups and communities, across all ages and across protected characteristics, which have been most affected by the pandemic as a result of pre-existing vulnerabilities and disadvantages. In 2022 City BCF has funded GP Registration Programme to ensure marginalised groups, often the worst affected by Covid, has access to routine primary care and other public services.
- Undertake proportionate additional work to ensure vaccine uptake is equitable. LLR has been successful in applying to participate in the national Core20 Connectors Programme. The South Asian Health Alliance, SHAMA Women Centre and Equality Action Charnwood will be undertaking vaccine promotion activities this Autumn, specifically focusing on vaccine hesitant communities.
- Include consideration of the role of the wider determinants of health, such as education, employment, housing and poverty. For 2022/23 see comment on fuel poverty above.

Action 6

All partners will work to improve the completeness and consistency of their data to enable a better understanding of health inequity. This mainly relates to data collection on people with 'protected characteristics' under the Equality Act. Specifically, partner organisations will develop an action plan for having ethnicity, accessibility and communication needs of their population appropriately coded in records. In addition, we will make better use of our data sets in order to identify vulnerable groups and individuals to offer proactive, holistic care through Integrated Neighbourhood Teams. The BCF funded Care Co-ordination model is an example of how this will be addressed. In 2022, the GP IM&T Strategy group is developing a business case for funding access to the ARDENS electronic clinical software to support more consistent clinical coding in the primary care records.

Action 7

At the ICS level, we will obtain and use data to help us better understand where we can do more work to reduce health inequity. Specifically, each organisation will adopt a standard health equity audit tool and put training plans in place to use this tool, so that each 'place' area can compare their performance against other areas. In light of significant system pressures in other areas, action on rolling out this training is being deferred until the new year 2023.

Action 8

The NHS and public sector partner organisations within the ICS will seek to reduce health inequalities in respect of work opportunities, use of buildings and purchasing acting as "anchor institutions". The aim of doing this collaboratively, will increase purchasing power and commercial viability. From a workforce perspective in 2022/23, partner organisations across the LLR ICP have implemented a number of reverse mentoring programmes. Currently there are 25 participants across ICB, LPT, UHL and Local Authorities across LLR.

Scheme	Key features	Desired outcomes	Overall impact	Challenges	Mitigations
Pathway 1 intake model **Initial demand and capacity modelling Aug 22** **Further modelling to increase to pathway 2 impact Sept – Oct 22** **Initial recruitment phase Oct – Dec 22** **LPT therapies capacity modelling Oct – Dec 22**	• Integrated teams supporting people in the community aligned to the 3 R model of care; Reablement, Recovery and Rehabilitation • Supporting people to step down care after a stay in hospital or step-up care at home, (when needs change and/or in a crisis) into a therapy-led model • Joint planning, oversight and review of packages of care at home after an initial period of recovery • Incorporating Crisis response • Development of the case management function to support the rapid assessment of any ongoing needs • Additional brokerage function to improve flow into longer term domiciliary care	• Assessment of people in their own homes to gain better insight into their requirements – both maximising reablement potential and right-sizing pathway 1 domiciliary care commissioning • Helping people to remain in their own home particularly through use of therapy-led services • Partnership led service that can adapt to meet increased needs in the community • Singular case management function improving links to VCS and community services to provide additional / ongoing support • Development and delivery of the Integrated Personalised Care framework	• Reduce the number of unplanned admissions for chronic ambulatory care-sensitive conditions. • Maximising opportunities for reablement and rehabilitation to increase the number of people at home 91 days after discharge into reablement services • Maximising the number of people discharged to their usual place of residence • Reduce the demand on domiciliary care • Preventing admissions to long-term residential care	• Recruitment – Additional funding is contributing to this for 2022/23 and a joint LLR workforce strategy has been produced with health and LA partners for long-term recruitment, retention and workforce development. • Capacity within community nursing and therapy services requires audit and possible re-design in order to support this function. • Realignment of current BCF budgets and spend to accommodate this model • Not realising the reduction in care costs due to unprecedented increase in demands not decreasing.	• Recruitment planning and system-wide retention policy to expand and maintain the existing workforce. • Assessing the current contract provision for therapy and nursing • Demand and capacity modelling taking place with Newton Europe to test initial assumptions on savings

Scheme	Key features	Desired outcomes	Overall impact	Challenges	Mitigations
Growing our virtual wards **SOP development May – Oct 22** **Recruitment phase – May 22 – Mar 23** **Roll-out finishes Dec 23**	• A virtual ward is a team of professionals working to manage a group of patients in the community • It allows patients to get the care they need at home, safely and conveniently, rather than being in hospital • Using a combination of remote monitoring by healthcare professionals and home visits, virtual wards can help prevent hospital admissions or allow for an earlier, supported discharge. • People make a better recovery in their own surroundings and staying in hospital longer than necessary can have a detrimental effect on their condition and their independence. • The virtual ward service has been arranged by NHS Leicester, Leicestershire and Rutland and will be provided by a collaborative of local organisations, including	• By Winter it is hoped that 275 patients will be able to be looked after simultaneously across nine virtual wards including frailty, cardiology, acute respiratory and diabetes. • The number of beds will increase to more than 440 by December 2023. • Increase utilisation of existing virtual ward beds, ensuring appropriate use to avoid admission/ facilitate earlier discharge • Enhance step up and step-down access to virtual ward beds through growing the unscheduled care hub	• Provide safe and optimal care those presenting with urgent or emergent care needs due to intercurrent illness and/ or to manage an exacerbation in an underlying pre-existing long-term condition in their usual place of residence. • Reduce demand for inpatient beds and pressure on Emergency Departments. • Identify patients who are showing signs of early deterioration in the community and with medical oversight to maintain the patient safely at home where the presenting condition is amenable to treatment in usual home environment and/or it is the persons preference to receive management at home. • To enable patients to receive management and to recover within their own familiar surroundings	• Recruitment to 75 new posts, delayed recruitment and unsuccessful recruitment • NHSE funding for 2022/23 not in plan, no longer available including system match funding for 2023/24 cost pressure • Digital technologies not funded for 2023/24 • Revised bed modelling forecasts not meeting NHSE target • Delays to pathways planned start date • Low bed utilisation on some of the existing pathways • Virtual Ward work may impact on other services particularly those within the community • VW will create additional capacity which will create	• Possible delay to timescales for delivery to allow for geriatrician resource recruitment • Ensuring robust plans for when resource is in place • Working with ASC as part of the delivery group to ensure community capacity is well-placed to support

Scheme	Key features	Desired outcomes	Overall impact	Challenges	Mitigations
	University Hospitals of Leicester NHS Trust, Leicestershire Partnership NHS Trust, Local Authorities and LOROS		– for improved experience of care, plus improved person and population health and wellbeing outcomes	additional cost pressures.	
Embedding Integrated neighbourhood working **Population Health Management risk strat Oct 22** **MDT embedding and fully functional – Oct 22** **Leadership team development Mar 23**	• There will be a focus on the four building blocks of integrated care. • Adopting a Population Health Management approach including risk stratification • Delivering co-ordinated care at a local level • Multi-disciplinary teams (MDT) working to deliver better outcomes facilitated by ASC business support team with health investment to support development and recruitment of additional staffing • Delivering a preventative approach to care, with access to a local prevention offer including social prescribing	• Embed operational MDTs and anticipatory care/ population health management approach to jointly manage frail, complex and high-risk patients, ensuring that all neighbourhood teams have well-functioning MDTs in place by October 2022 • Ensure consistent use of care co-ordinators, care navigators and social prescribers to maximise use of VCSE, community and other wellbeing offers • Develop high performing Integrated neighbourhood leadership teams consistently across LLR with full engagement, clear governance, shared purpose and	• INT maturity matrix being developed following discussions at each INT meeting. • Care planning increased to 55% vulnerable patients • Care planning incentive (to 31/3/22) launched across LLR. Training webinar delivered to 260 attendees and considerable dialogue with practices and PCNs around care planning	• Recruitment causes delays to further implementation including within the care co-ordination expansion. • PCN development can be inconsistent depending on area and population density and cohorts • Changes to PCN zones and ongoing associated changes to GP engagement	• Developing a joined-up recruitment strategy • Work to develop common approaches to neighbourhood development for PCN's to apply when ready • Re-aligning and working with City partners to ensure patient needs are met

Scheme	Key features	Desired outcomes	Overall impact	Challenges	Mitigations
		underpinned by a local PHM plan by March 23. • Increase identification of carers enabling support to be offered • Additional care co-ordinators recruited, ongoing work to standardise approach. IG signed off enabling LLR spread • MDT draft framework to be finalised following agreement with IG. • Recruitment of MDT Facilitator role through LAs has started.			

Midlands and Lancashire
Commissioning Support Unit

Stage 1 Equality, Health Inequality Impact and Risk Assessment

- Title of Assessment:
- Person Responsible (please insert name, email address and contact number):
- Service Area:
- Overview of proposal, policy, service etc:

Equality, Health Inequality Impact and Risk Assessment

Section one: equality impact

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

1. Will this (decision / proposal / change) affect / impact on people in any way? (e.g. population, patients, carers, staff)?
2. Is this decision or change part of a transformation programme or commissioning / decommissioning review?
3. Is this a decision that may change or potentially change the delivery of a service / activity or introduce a charge?
4. Will this (decision / proposal / change) potentially reduce the availability of a service or activity or product (e.g. prescriptions)?
5. Is this a review of a policy, procedure, protocol or strategy?
6. Is this (decision / proposal / change) about improving access or delivery of a service?
7. Will this (decision / proposal / change) potentially negatively impact groups covered by the Equality Act and other vulnerable groups?
8. Will this (decision / proposal / change) affect Employees or levels of training for those who will be delivering the service?

9. Will this (decision / proposal / change) have any **positive** effect / impact in reducing health inequalities?

10. Will this (decision / proposal / change) have any **negative** effect / impact on health inequalities?

Section two: equality risk

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

11. To reach your (decision / proposal / change) have you considered any information / supporting documents?

12. Have you engaged or consulted with people or stakeholders / staff that may be affected by the (decision / proposal / change)?

13. Have you taken specialist advice in regard to impacts of the (decision / proposal / change)?

14. Have you considered how this can address and eliminate discrimination, harassment and victimisation?

15. Have you considered how this can help to address inequality issues to enable all groups to access services?

16. Have you considered how this can help foster good relations and community cohesion within communities?

17. Can you address or minimise any negative impacts that may represent an equality risk?

18. Will your decision reports be available to the public?

Section three: human rights impact

For each question, please answer **Yes** or **No**, and provide a brief rationale for your answer.

19. Is there any concern that Article 2: Right to life may be breached?

20. Is there any concern that Article 3: Right not to be treated in an inhuman or degrading way may be breached?

21. Is there any concern that Article 5: Right to liberty may be breached?

22. Is there any concern that Article 6: Right to a fair trial or hearing (this includes right to fair assessment, interview or investigation) may be breached?

23. Is there any concern that Article 8: Right to respect for private and family life may be breached?

24. Is there any concern that Article 9: Right to freedom of thought, conscience and religion may be breached? E.g. right to participate (individually or as a group) religion / belief

25. Is there any concern that Article 10: Right to freedom of expression may be breached? E.g. concern that people won't be able to have opinions and express their views on their own or in a group

26. Is there any concern that Article 14: Right not to be discriminated against in relation to any human rights, may be breached?

27. Is there any concern the obligation to protect human rights may be breached? E.g. concern that systems, processes and monitoring will not identify human rights breaches.

Section four: Assessment Comments

28. Further comments from individual / team drafting this assessment:

- Stage 1 Assessment / Approval comments from MLCSU Equality and Inclusion Business Partner:

Our Model of Care

Individuals empowered to live a healthy life in resilient communities

- Supported to stay and age well via preventative interventions
- Supported self-management
- Active social prescribing and signposting
- Communities supported to develop a vibrant third sector volunteer opportunities supporting health and care

Primary Care

Where the majority of patient care takes place working as individual practices or in networks (Primary Care Networks) using digital and total triage first, including:

- Advice, information, diagnosis, treatment and prescribing
- Active Long Term Condition management
- Signposting and referral to other services including specialist services
- Screening and immunisation

Integrated Neighbourhood Teams

Multi-disciplinary teams of general practice staff, community nurses and therapists, social care staff and the voluntary sector providing:

- Enhanced Long Term Condition Management
- Active case management of at risk patients including specialist treatment in the community
- Rapid assessment and support in crisis including step down in care setting when patient is ready
- Community rehabilitation and discharge support
- Nursing and care home support
- End of life care

Care for acutely unwell people

- Care will be provided using digital and total triage approaches in local care settings wherever possible and in an acute setting when not
- Discharged when medically fit
- Teaching, research and innovation at the heart of acute care
- Growing our specialist care sector where it makes sense to do so

I am able to proactively manage my own health

I receive easy to access and tailored support in the community

I find it easy to access specialist care in the community

I have the best quality and most innovative care available to me

Pathways of care

Population Health Management

Wellness ← → **Acute Illness**

Our 10 Expectations

1. Safety first
2. Equitable care for all
3. Involve our patients and public
4. A virtual by default approach
5. Care in local settings
6. Provide excellent care
7. Enhanced care in the community
8. Enabling culture
9. Drive technology, innovation and sustainability
10. Work as one system with a system workforce

Implementing BCF Policy Objectives

Scheme and key milestones	Key features	Desired outcomes	Overall impact	Challenges	Mitigations
Unscheduled Care Hub **Pilot phase Oct 22** **Business case development Dec 22** **Continuation of pilot into BAU Dec 22 - Apr 22**	• All patients referred or reviewed will receive a multiple disciplinary team evaluation. • This model aims to deliver an asset-based approach to care within a person's community by pathways including access to: - Same day Urgent Community Response (UCR) service - Remote consultations with advanced practitioners - Urgent Treatment Centres (UTC) - Hot clinics - Same Day Emergency Care (SDEC) - Community mental health - Local authority • In the future this will also include: - Outpatient diagnostics - Virtual wards - Community step up beds - Consultant geriatrician/GPs	• Increase the utilisation of UCR as the first point of call and reduce reliance on 999. Supporting Right Care, Right Time, Right Place • Improve patient outcomes by implementing contingency planning and care plans as part of their "crisis" episode to avoid future crisis from occurring or reoccurring • Opportunity and time to look at future alignment of our UCR offer to host the unscheduled care hub instead of it being a separate operating model • Improve outcomes (with 85% remaining at home) for an increased	• Review our multiple access points with the intent to reduce these significantly across LLR • Identify gaps in our service provision and redesign how our model of care operates in the future • Develop a wider clinical understanding of inappropriate 999 call outs and hospital admissions and those who can be managed appropriately in UCR, over time this will support education and a culture change towards more home-based response	• Maintaining resource and focus on diverting away from A and E • Longer-term costs and sustainability for the function • Not impacting on overall ambulance handover times sufficiently.	• Robust performance reporting on outcomes that decrease pressure on the system • Complete cost-benefit analysis to show benefits of reducing pressure elsewhere in the LLR system • Measure impact against handover times via regular monitoring

Scheme and key milestones	Key features	Desired outcomes	Overall impact	Challenges	Mitigations
	• Referring clinicians will have trusted assessor status with no secondary triage or referral process • We will aim for the transfer of care to be complete within 15 minutes. The	number of patients across 7 days • Initial outcomes and return on investment show that over the initial 10 week period, the hub diverted 418 cases from the EMAS stack with the outcome of the intervention enabling 252 of these cases to remain at home and avoided 340 EMAS attendances.			
Integrated Discharge Hub **ASC staff part of triage Apr 22 onwards** **HART staff recruitment June – July 22** **HART workers form part of triage Aug 22 onwards**	• We have developed an electronic LLR Discharge Tracker that serves to provide system-wide assurance of acute and community hospital inpatient beds • Multi-agency staff have access to all Systm1 health records and can update and track patient activity in real-time • Adult social care staff are supported to return to triaging patients alongside	• Timely discharge for all patients to their usual place of residence • Maximising recovery, rehabilitation and reablement potential • Right-sizing pathway 1 • Correct level of care on discharge, reducing over-prescription • Increasing flow through hospitals • One data set to enable real-time information	• To meet the national D2A guidance for discharging patients within 24 hours of medical optimisation and meet the local target of 75% • To increase the number of residents discharged to their usual place of residence • Reduce length of stay	• Increased overall admissions has been observed nationally due to many people not seeking healthcare support during the covid pandemic. • Greater healthcare needs overall and has created higher demand for services both within health and social care.	• Ensure that pathways and processes are designed effectively to intake any increases and ensure ongoing care is right-sized • Work to increase community therapy capacity for more complex needs

Scheme and key milestones	Key features	Desired outcomes	Overall impact	Challenges	Mitigations
	clinical and ward staff to establish appropriate level of care needs with approx 10 staff members available on a daily basis to support ward rounds at 3 UHL sites • 8 HART reablement workers to begin triaging cases to maximise potential reablement referrals. 5 out of 6 referrals on the first day were re-directed to HART instead of home care or pathway 2 beds.	• Increase description of care needs not prescription			including health needs
Re-Commissioning of step-down D2A beds **Commissioning business case developed Apr – July 22** **Agreement for Lot 1 commissioning to begin Aug 22**	• The LLR system is aiming to secure up to 25 beds on a block contract in residential care home/s. • Primary function and purpose of these beds to provide effective reablement opportunities • people who would benefit from a period of rehabilitation, reablement and recovery before moving on to the place they call home.	• Enhancing quality of life for people with care and support needs • Delaying and reducing the need for care and support • Ensuring that people have a positive experience of care and support • Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.	• People are citizens first and foremost and are at the centre -this ensures people are given choice and control over the support they receive. • Conversations with people are based on what matters to them and support is built around their strengths. • People are treated fairly and with dignity	• Unclear and lengthy processes for continuation of funding • No decrease in reablement • Ongoing costs to care and people not returning to their usual place of residence • Insufficient therapy resource to support the model	• Phased approach to implementation • Health funding model for reablement beds • MDT arrangements and process reviewed to ensure timely assessments

Scheme and key milestones	Key features	Desired outcomes	Overall impact	Challenges	Mitigations
Additional system discussions on commissioning Lot 2 – Sept – Oct 22 **Further commissioning activity to begin Oct 22 – Apr 23**		• Preventing people from dying prematurely • Enhancing the quality of Life for people with long term conditions • Helping people to recover from episodes of ill health or following injury • Ensuring that people have a positive experience of care • Treating and caring for people in a safe environment and protecting them from avoidable harm.	and their feedback is sought and used to bring about improvements in the way these Services are delivered. • Avoiding readmission • Maximising independence by timely provision of RRR principles		

High Impact Model – Action planning Template

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Change 1: Early discharge planning	**Established** • Information given as soon as possible after admission • System leaflet tracker in place	• Additional training so all staff understand their role to play in discharge planning • Electronic notifications for elective admission to social care with needs described • Increased MDT working for emergency admissions that involve families and carers further speeding up discharges	**May 2023**	• Quicker discharges – days waiting for discharge will decrease • Reduced waiting times when MOFD
Change 2: Monitoring and responding to system demand and capacity	**Established/Mature** • Data analysis to understand system trends for long and medium term strategies. • Key blockages identified, high impact change models such as Home First D2A being scoped for improvement. • Currently have a daily reporting system between partners to view capacity and flow	• A system-wide emphasis on impacting and reducing ambulance hand over times • Introducing virtual ward rounds to manage flow. • Increased integrated training to give all front-line staff the same message ensuring they understand service capacity, pathways enabling best decision making for individuals. • Increased working with VCSE sector to develop step down facilities	**Feb 2023**	• Increased patient feedback with increased positive outcomes • Less waiting days once MOFD • Improved ambulance hand over times • Better information sharing with less time spent trying to contact each organization. • Better engagement from VCSE services. Attending delivery groups more frequently.
Change 3: Multi-disciplinary working	**Mature** • We have established MDT working across the system, through the IDT hub and our co-located HomeFirst services • Support in place for Clinical Navigation Hub but yet to be recurrently funded	• Capturing continuous feedback and evaluation to improve the experience of staff and people accessing care. • Build on successful pilots started via Ageing Well and embed capacity needed to contribute to the Unscheduled Care Hub	**Dec 2022**	• Joint training across the system implemented • Improved experience for staff and people accessing care • Increased MDT working
Change 4: Home first	**Mature** • Established Home First Service	• Look at costs to system rather than each organisation for a truly integrated home first service. • Increase re-ablement and	**April 2023**	• Increased numbers of people going to their home after discharge • Decrease in social care services

		rehabilitation in the community to Increase capacity to address 85 / 95% discharge time targets • Better data reporting to track people 6 months after discharge to monitor progress of Home first services. • Streamlined pathways working towards a single point of access.		when more people are given re-ablement and rehabilitation after discharge • People are still at home 6 months after discharge • Better understanding of discharge pathways
Change 5: Flexible working patterns	**Mature** • ICRS and Reablement – 7 days per week, with 24 hours crisis cover and less than 2 hour response	• Consult with medical staff to provide more weekend cover • Consider brokerage needs if P1 is extended to take all discharges	**Jan 2023**	• UHL to look at 7 day staffing to further support discharges particularly consultant decision making and pharmacy
Change 6: Trusted assessment	**Established** • Trusted assessors in place across UHL and LPT for specific community services	• Looking to expand the role / realign it to the IDT in UHL and allow it to be more flexible with other roles within the IDT function	**March 2023**	• Quicker assessments resulting in quicker discharges
Change 7: Engagement and choice	**Established** • Many leaflets given out on admission	• Further engage with VCSE sector to be more involved in discharge planning and support • Update system wide leaflets on who funds care now D2A has reverted to 7 day funding • Clearer message to families on discharge routes and funding • Better streamlined choice protocol • Further involve group feedback i.e. patient groups when developing information leaflets • Be more creative when communicating this information i.e. talks on TV screens explaining in simple language	**Nov 2023**	• Families and people accessing care feel better informed on their choices • Better engagement with patient groups giving a voice to people accessing care • Regular representation with Healthwatch across the system • Housing Discharge enabler team linking to vol sector for earlier discharges
Change 8: Improved discharge to care homes	**Established** • NHS emails provided to care homes	• For out of hours care/urgent care, look at care homes having Ipads with GPs/professionals on the end of a video call which will reduce conveyances in the first place.	**March 2023**	• Reduced conveyances from carehomes who care for some of Leicestershire's most vulnerable people.

	• Trusted assessor role	• Attend local care home forums to establish what providers feel our challenges and working well on discharge process. • Better/faster communication between wards and care homes • Actively involve ambulance service when planning		• Decreased waiting days once MOFD • Use of TA's to reduce reliance on care home assessment requirements • Improved brokerage function
Change 9: Housing and related services	**Mature** • Established service/roles (housing enablers) to allow for early planning before discharge	• Use technology creatively within the home to enable safer discharges • Communication campaign to allow all involved in discharge to know technology available and a clear pathway for referral • Use an approved temporary housing whilst adaptations/changes are being made to peoples homes	**Jan 2023**	• Increased use of technology within peoples homes allowing for quicker discharges. • Less waiting time from referral to completion for adaptations to be made in a persons home • Improved access and use of extra care facilities • Use of DFG top-slicing for additional housing related initiatives

LEICESTER CITY HEALTH AND WELLBEING BOARD
28 July 2022

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

Purpose of report

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

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

RECOMMENDATIONS:

3. The Health and Wellbeing Board is requested to:

    a. Receive and Note the report

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

Policy Framework and Previous Decision

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

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

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

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

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

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

Background

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

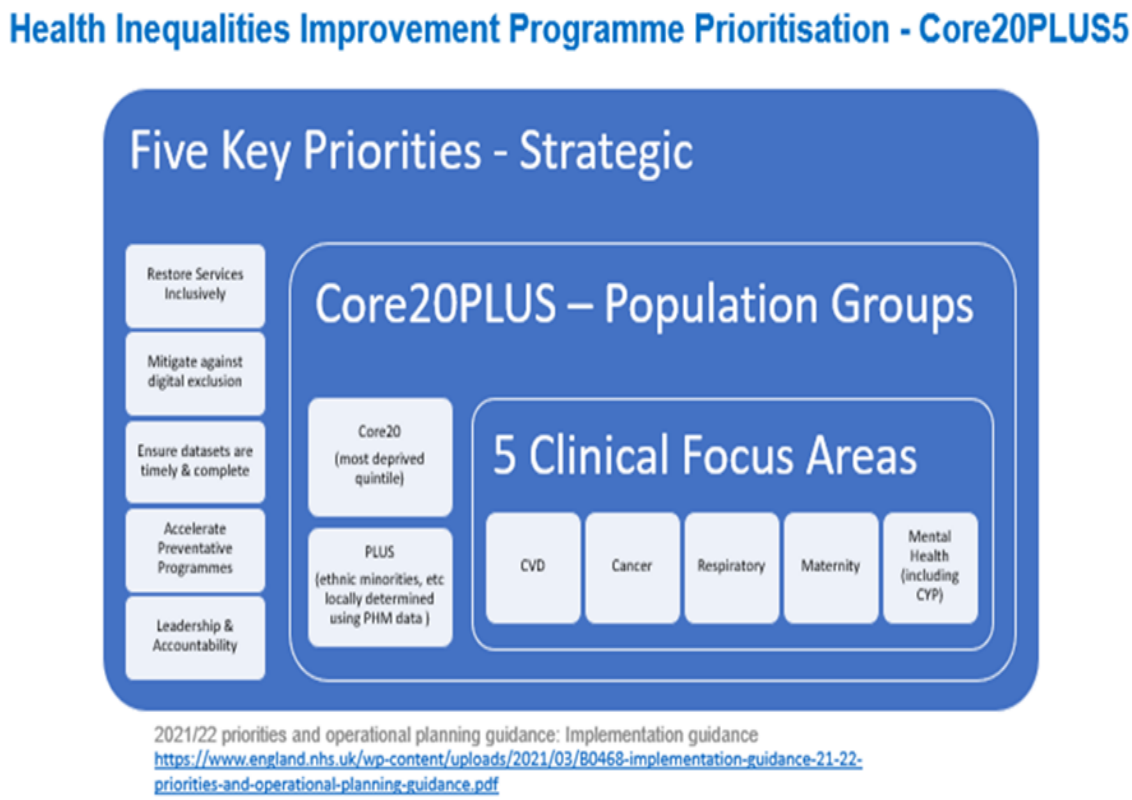

Figure 1: *The five priorities in the 21/22 & 22/23 NHS Operational Planning Guidance and the Core20Plus5 approach*

Core20Plus5 – An approach to reducing health inequalities

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

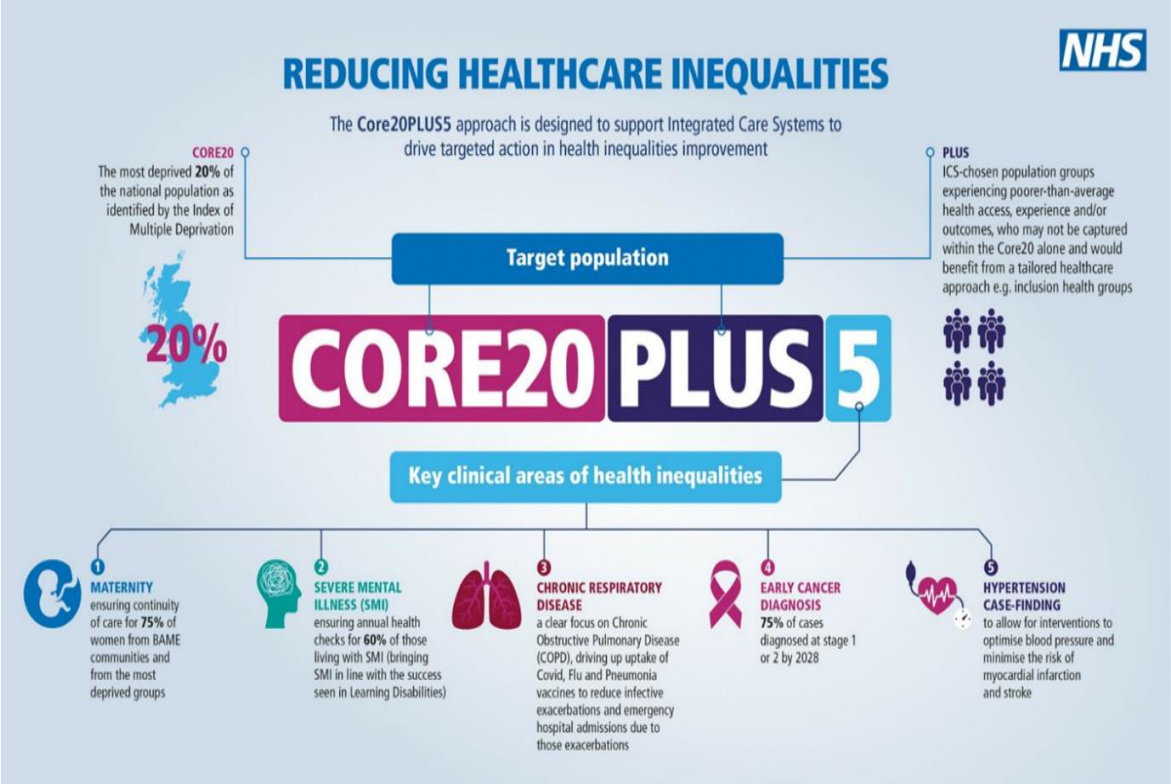

Figure 2: *The Core20Plus5 approach to reducing health inequalities*

Core20

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

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

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

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

The "PLUS" populations

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

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

"The 5"

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

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

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

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

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

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

Delivery & Governance

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

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

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

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

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

Consultation/Patient and Public Involvement

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

Relevant Impact Assessments

Equality and Human Rights Implications

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

Partnership Working and associated issues

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

Background papers

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

Appendices

LLR Health Inequalities Framework – Better Care For All

HIF - BETTER CARE FOR ALL - Final 03.0

Officer to contact

Sarah Prema, Chief Strategy Officer, LLR ICB

Telephone: 0116 2953413

Email: Sarah.Prema@nhs.net

Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme. The programme is jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans,

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to

- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
Data for capacity and demand should be provided on a month by month basis for the third and fourth

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care services as defined in appendix 4 of the BCF Planning Requirements.

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 grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists in the relevant sheet or in

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

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, cont
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

england.bettercarefundteam@nhs.net

(please also each copy in your respective Better Care Manager)
If you have any queries on the template then please direct these to the above email inbox or reach out via

3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital
We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

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

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

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

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- VCS services to support someone to remain at home
- Urgent Community Response (2 hr response)

- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

:acts a

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Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	Leicester
Completed by:	Mayur Patel / Mark Pierce
E-mail:	mayur.patel@nhs.net / mark.pierce2@nhs.net
Contact number:	7788338758

Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No, subject to sign-off	
If no, please indicate when the report is expected to be signed off:	Thu 13/10/2022	<< Please enter using the format, DD/MM/YYYY

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

Job Title:	Chief Operating Officer
Name:	Rachna Vyas

How could this template be improved?	Greater clarity in the guidance on which services are to be included in the calculations. Careful checking of the template to ensure no inappropriate error messages are seen.

Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: Leicester

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

Totals Summary (autopopulated)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	56	56	56	56	56	56
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	148	163	163	163	163	148
2: Step down beds (D2A pathway 2)	25	28	28	28	28	25
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	5	5	5	5	5	5

Any assumptions made:	
	Most recent 8 weeks data utilised (from 16th July to 16th Sep) from Systm1 daily weekday sitrep. Sitrep is not published during weekend and bank holidays, therefore weekend referrals are assumed to be a quarter of weekday referrals. This 8 weeks data has been multiplied to provide projection for the H2 of 2022/23.

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

Trust Referral Source (Select as many as you need)	Demand - Discharge Pathway	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	0: Low level support for simple hospital discharges - e.g. Voluntary or Community	56	56	56	56	56	56
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	1: Reablement in a persons own home to support discharge (D2A Pathway 1)	148	163	163	163	163	148
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	2: Step down beds (D2A pathway 2)	25	28	28	28	28	25
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	3: Discharge from hospital (with reablement) to long term residential care (Discharge	5	5	5	5	5	5

Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: Leicester

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

Any assumptions made:	Most recent 8 weeks data utilised (from 16th July to 16th Sep) from Systm1 daily weekday sitrep. Sitrep is not published during weekend and bank holidays, therefore weekend referrals are assumed to be a quarter of weekday referrals. This 8 weeks data has been multiplied to provide projection for the H2 of 2022/23.

Demand - Intermediate Care

Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	0	0	0	0	0	0
Urgent community response	420	420	420	420	420	420
Reablement/support someone to remain at home	30	30	30	30	30	30
Bed based intermediate care (Step up)	0	0	0	0	0	0

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: Leicester

4.1 Capacity - discharge

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

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	Royal Voluntary Service provides six week follow-up 'Home from Hospital' service, to provide support and confidence raising to frail older people recently discharged. The capacity is 50-60 patients a month. Readmission rate within 28 days is significantly lower for patients accessing this service. Integrated Crisis Response service (ICRS) bridges out aprox 40 patients a month to allow timely discharge start of dom care package

Capacity - Hospital Discharge							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
VCS services to support discharge	Monthly capacity. Number of new clients.	56	56	56	56	56	56
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.	40	40	40	40	40	40
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	80	80	80	80	80	80
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.	10	10	10	10	10	10
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.	0	0	0	0	0	0

Better Care Fund 2022-23 Capacity & Demand Template

4.2 Capacity - Community

Selected Health and Wellbeing Board: Leicester

4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	Bed based Intermediate Care: City patients at Sovereign Unit, a bedded unit and Therapy led beds amounts to 40% of the total utilisation. June 2021 to June 22 data used to project Oct to March capacity

Capacity - Community							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.	0	0	0	0	0	0
Urgent Community Response	Monthly capacity. Number of new clients.	450	450	450	450	450	450
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.	30	30	30	30	30	30
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.	10	10	10	10	10	10

Better Care Fund 2022-23 Capacity & Demand Template

5.0 Spend

Selected Health and Wellbeing Board: Leicester

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	£7,587,596
BCF related spend	£5,203,519

Comments if applicable	Overall Spend includes: Integrated Crisis Response Service (ICRS) Leicester Care Call centre and assistive technology Case management for bed-based offer

BCF Planning Template 2022-23

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 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 2022-23. It will be pre-populated with the minimum NHS 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 ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.

6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these 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 NHS 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. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

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 in assurance and to our understanding of how BCF funding is being used nationally.
- 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 “NHS 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. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of 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 ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- 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 2022-23 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 ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. 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. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board 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 percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- 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)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- 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.

4. 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 expected 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.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- 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 and 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 2022-23 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 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

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 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Leicester
Completed by:	Mark Pierce
E-mail:	mark.pierce2@nhs.net
Contact number:	07545 761012
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	No
If no please indicate when the HWB is expected to sign off the plan:	Thu 13/10/2022 << Please enter using the format, DD/MM/YYYY
If using a delegated authority, please state who is signing off the BCF plan:	Councillor Vi Dempster

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

Job Title:	Chair of the Health and Wellbeing Board
Name:	Councillor Vi Dempster

	Role:	**Professional Title (e.g. Dr, Cllr, Prof)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Vi	Dempster	Vi.Dempster@leicester.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Ms	Rachna	Vyas	Rachna.Vyas@nhs.net
	Additional ICB(s) contacts if relevant	Mr	Mayur	Patel	Mayur.Patel@nhs.net
	Local Authority Chief Executive	Ms	Alison	Greenhill	Alison.Greenhill@leicester.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Ms	Ruth	Lake	Ruth.Lake@leicester.gov.uk
	Better Care Fund Lead Official	Ms	Rachna	Vyas	Ruth.Lake@leicester.gov.uk
	LA Section 151 Officer	Mr	Colin	Sharpe	colin.sharpe@leicester.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

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	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 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 NHS Contribution	£28,134,913	£28,134,913	£0
iBCF	£17,556,473	£17,556,473	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£48,405,390**	**£48,405,390**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£7,995,144
Planned spend	£8,018,149

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£18,114,380
Planned spend	£18,265,488

Scheme Types

Assistive Technologies and Equipment	£365,545	(0.8%)
Care Act Implementation Related Duties	£0	(0.0%)
Carers Services	£764,025	(1.6%)
Community Based Schemes	£3,262,386	(6.7%)
DFG Related Schemes	£2,714,004	(5.6%)
Enablers for Integration	£134,388	(0.3%)
High Impact Change Model for Managing Transfer of	£3,561,127	(7.4%)
Home Care or Domiciliary Care	£17,556,473	(36.3%)
Housing Related Schemes	£225,606	(0.5%)
Integrated Care Planning and Navigation	£1,138,306	(2.4%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£4,352,983	(9.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£13,900,071	(28.7%)
Prevention / Early Intervention	£430,475	(0.9%)
Residential Placements	£0	(0.0%)
Other	£0	(0.0%)
Total	**£48,405,389**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	0.0	0.0	0.0	0.0

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
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)	93.3%	93.7%	93.0%	93.2%

Residential Admissions

		2020-21 Actual	2022-23 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	433	569

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.3%

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: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Leicester

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

iBCF Contribution	Contribution
Leicester	£17,556,473
Total iBCF Contribution	**£17,556,473**

Are any additional LA Contributions being made in 2022-23? 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**	

NHS Minimum Contribution	Contribution
NHS Leicester, Leicestershire and Rutland ICB	£28,134,913
Total NHS Minimum Contribution	**£28,134,913**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	No

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£28,134,913**	

	2021-22
Total BCF Pooled Budget	**£48,405,390**

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

Better Care Fund 2022-23 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 NHS Contribution	£28,134,913	£28,134,913	£0
iBCF	£17,556,473	£17,556,473	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Total	**£48,405,390**	**£48,405,390**	**£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 ICB allocation	£7,995,144	£8,018,149	£0
Adult Social Care services spend from the minimum ICB allocations	£18,114,380	£18,265,488	£0

>> Link to further guidance

Checklist

Column complete:

Yes	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	Personalised Care at Home	Physical health/wellbeing		Social Care		LA			Local Authority	Minimum NHS Contribution	£13,806,392	Existing
2	Carers Funding	Statutory Support for carers	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£764,025	Existing
3	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 NHS Contribution	£969,724	Existing
4	Lifestyle Hub	Culturally competent primary & secondary prevention of LTCs &	Prevention / Early Intervention	Other	Exercise/weight Mx/Smoking support	Community Health		CCG			Local Authority	Minimum NHS Contribution	£119,646	Existing
5	Assistive technologies	Assistive technology to support independence & reduce social isolation	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£365,545	Existing
6	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 NHS Contribution	£1,348,629	Existing
7	Health Transfers Team - in hospital social workers	on-site social work team to facilitate timely Acute hospital discharge	High Impact Change Model for Managing	Early Discharge Planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£219,328	Existing

8	MH Discharge Team - Health Transfers Team -	on-site social work team to facilitate timely MH in-patient discharge	High Impact Change Model for Managing	Early Discharge Planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£74,982	Existing
9	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 NHS Contribution	£30,225	Existing
10	Services for Complex Patients (Care Navigators)	6x Care Navigators to case-manage prevention interventions for frail &	Integrated Care Planning and Navigation	Care navigation and planning		Primary Care		CCG			Local Authority	Minimum NHS Contribution	£353,306	Existing
11	Discharge Home to Assess staff costs	ASC Case Managers to facilitate hospital discharge home	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	Minimum NHS Contribution	£356,868	Existing
12	H&SC Protocols - training	Training for ASC and dom care providers to undertake delegated	Enablers for Integration	Workforce development		Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£77,128	Existing
13	Social worker for alcohol dependent	Specialist dedicated case management, support and service coordination	Housing Related Schemes			Social Care		LA			Local Authority	Minimum NHS Contribution	£56,606	Existing
14	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 NHS Contribution	£27,035	Existing
15	The Centre Project	Day Centre and outreach support for vulnerable adults	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£24,513	Existing
16	Training for Falls Prevention	CIC provider of community strength & balance programmes for	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Private Sector	Minimum NHS Contribution	£107,551	Existing
17	Hospital Housing Enablement Team	Specialist housing support to enable timely hospital discharge and	Housing Related Schemes			Social Care		LA			Local Authority	Minimum NHS Contribution	£169,000	Existing
18	Risk stratification	Licensing and data processing fees for risk strat programme.	Prevention / Early Intervention	Risk Stratification		Other	Licence cost for risk strat product.	CCG			Private Sector	Minimum NHS Contribution	£79,245	Existing
19	Services for Complex Patients (GP PIC/Training)	Enhanced programme of primary, community/VCS support	Integrated Care Planning and Navigation	Care navigation and planning		Primary Care		CCG			Private Sector	Minimum NHS Contribution	£730,000	Existing
20	(Royal National Institute for the Deaf) Action on	Specialist support for those with hearing loss and Deafness	Personalised Care at Home	Mental health /wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£36,981	Existing
21	VISTA - 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	CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£25,000	Existing
22	Royal Voluntary Service	Post-discharge offer of 6 weeks of support to regain skills and	Personalised Care at Home	Mental health /wellbeing		Other	Reducing readmissions through Vol	CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£31,698	Existing
23	Leicester Mammas	Voluntary sector support for breast feeding, budget	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£36,981	Existing
24	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 NHS Contribution	£1,368,556	Existing
25	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 NHS Contribution	£562,100	Existing
26	MH Planned Care Team	Dedicated specialist MH assessment and treatment for those	Community Based Schemes	Integrated neighbourhood services		Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£419,836	Existing

27	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 NHS Contribution	£156,791	Existing
28	Intensive Community Support Beds	Home First	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,031,639	Existing
29	Reablement	Home First	Reablement in a persons own home	Reablement to support discharge - step down		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,315,739	Existing
30	Additonal Community therapy	Home First	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,473,994	Existing
31	IBCF	Meeting ASC needs/Reducing NHS pressures/Supporting	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	iBCF	£17,556,473	Existing
32	Disabled Facilities Grant	Adaptations to support independence for those who meet eligibility	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Local Authority	DFG	£2,714,004	Existing
33	UHL fund	Hospital discharge specialist team	High Impact Change Model for Managing	Early Discharge Planning		Acute		CCG			NHS Acute Provider	Minimum NHS Contribution	£1,878,310	Existing
34	Stop Smoking app developed by Public Health	Mobile phone app to support stop smoking efforts	Prevention / Early Intervention	Other	Digital support for stop smoking attempts	Community Health		CCG			Local Authority	Minimum NHS Contribution	£16,714	Existing
35	City GP Registration Service	City GP Registration Service	Prevention / Early Intervention	Other	Outreach to marginalised groups to	Primary Care		CCG			CCG	Minimum NHS Contribution	£40,000	New
36	Dear Albert	Day Centre support for those with substance misuse issues	Prevention / Early Intervention	Risk Stratification		Community Health		CCG			Local Authority	Minimum NHS Contribution	£5,824	New
37	MDT Team Leader	Leads new integrated neighbourhood team in LA	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			Local Authority	Minimum NHS Contribution	£55,000	New

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 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. Safeguarding 4. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS 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 should 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.
18	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 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Leicester

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	275.7	261.2	274.4	223.9	This plan is based on the target of 7.2% reduction on last year's out turn performance. Balancing the continued challenges from the affects of Covid and extended lockdown in Leicester, against the continued positive effect of integrated	*Expanding the PTCDA service (prehospital emergency care for frail older people).J10 *Piloting an unscheduled care hub triaging calls from the EMAS Stack enabling referrals to be diverted into the community. *Continue 24/7 ICRS support for fallers
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Indicator value	243.2	241.2	239.8	236.1		
	Denominator	354,000	354,000	354,000	354,000		

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
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)	Quarter (%)	92.9%	93.3%	92.6%	92.8%	We plan to continue to make incremental annual improvements in our ability to have people discharged to their usual place of residence. - In this case around 0.5%.	*Developing a 3R intake model with partners to increase the availability of Recovery, Rehabilitation and Reablement within a person's normal place of residence. Initial 2 million investment. *Large scale expansion of Virtual Wards
	Numerator	6,646	7,007	6,693	6,306		
	Denominator	7,154	7,510	7,224	6,792		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Quarter (%)	93.3%	93.7%	93.0%	93.2%		
	Numerator	6,905	7,280	6,953	6,551		
	Denominator	7,404	7,772	7,476	7,029		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
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	433.5	557.2	514.9	569.2	We have seen a rise in the number of placements being made, in part linked to hospital discharge demand and use of pathway 2 beds. On this basis, and given the demographic changes noted, a level of increase is included in the target which	continued focus on P1, community options and reablement
	Numerator	189	250	231	260		
	Denominator	43,602	44,865	44,865	45,680		

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

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	91.6%	92.1%	88.2%	90.3%	This remains a top quartile ambition but reflects the increased complexity of people being supported on discharge from hospital at an ever earlier point in their recovery, which impacts on the risks of their not being at home 91 days later	focus on early discharge planning, health support, redesign of P1 capacity and pathway
	Numerator	185	198	150	167		
	Denominator	202	215	170	185		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 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
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 ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? 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	Cover sheet Cover sheet HWBB 13/10/22 Narrative page 1 and 3 Metric target methodology agreed across LLR Narrative doc page 4		
	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 • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of 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 document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes	Narrative pages 9-10 Narrative page 9 Narrative pages 9-10, 13-15		
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (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 DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	Narrative page 2 Narrative pages 12-13 Narrative page 2		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS 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			
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 NHS minimum BCF contribution?**	Does the total spend from the NHS 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			
NC4: Implementing the BCF policy objectives	**PR6**	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes	Narrative pages 4, 8-10 Yes Narrative page 11		

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 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS 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 plan Narrative plans, expenditure tab and confirmation sheet	Yes	Yes Yes Narrative page 12		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes	Yes Narrative page 4		

LEICESTER CITY HEALTH AND WELLBEING BOARD
Thursday 26th January 2023

Subject:	Delivery and action plan (2023-2025) for Leicester's Health, Care and Wellbeing Strategy.
Presented to the Health and Wellbeing Board by:	Katherine Packham, Consultant in Public Health, Leicester City Council
Author:	Core Working Group on behalf of the Health and Wellbeing Board

EXECUTIVE SUMMARY:

Leicester's Health, Care and Wellbeing Strategy (2022-2027) was approved in 2022. This strategy will be published on a microsite of Leicester City Council's website. This microsite is in its final stages of development. The strategy contains 19 priorities. These were divided into do, sponsor and watch categories, with the six 'do' priorities given highest priority. These six priorities are:

- Healthy Places: We will improve access to primary and community health/care services.
- Healthy Minds: We will improve access for children and young people to mental health and emotional wellbeing services.
- Healthy Minds: We will improve access to primary and neighbourhood level mental health services for adults.
- Healthy Start: We will mitigate against the impacts of poverty on children and young people.
- Healthy Lives: We will increase early detection of heart and lung diseases and cancer in adults.
- Healthy Ageing: We will enable Leicester's residents to age comfortably and confidently through a person-centred programme to support self-care, build on strengths, and reduce frailty.

Existing and future actions being taken by a range of partners to meet the above priorities have been identified and collated. Progress against these actions will be reported to place groups including Integrated Systems of Care, Joint Integrated Commissioning Board and Health and Wellbeing Board.

As part of the NHS England's approach to reducing Health Inequalities, CORE20 PLUS 5, work has been undertaken to identify three PLUS groups for focus in the initial years of the strategy by Health and Wellbeing Board and its member organisations. The PLUS groups identified for initial focus are:

- people with learning disabilities,
- people who are homeless, and
- people with severe mental illness.

These groups have been selected due to the considerable inequalities they face as measured by life expectancy.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: APPROVE the Delivery action plan (2023 – 2025) for the six ‘do’ priorities of the Leicester’s Health, Care and Wellbeing Strategy.

Leicester Health and Wellbeing Board - Delivery Action Plan and Tracker 2023 - 2025 (Oct 2022)

1. Purpose of this Document

This Delivery Action Plan (DAP) document shares the Leicester Health and Wellbeing Board delivery priorities and corresponding actions that will be collectively focussed on initially for 2023-2025 . This plan has been informed by the views of Leicester people, local staff, partnership groups and health and care commissioners through various channels over the last 12-18 months. This plan includes our commitments to engaging and involving the local populations as part of a continual journey that will support planning, delivery and aid Health and Wellbeing Board decision making.

This document aims to give stakeholder visibility around the high priority actions identified during the development of the Leicester Joint Health and Wellbeing Strategy 2022-2027 . It provides a single focused strategic partnership portfolio overview with detail of the actions we will deliver to make improvement. It also includes key measures to enable us to check if we are seeing improvement through our collective efforts and includes information to help us to keep track of progress in one place.

3. Partnership Delivery Governance

It is anticipated that groups such as the Leicester Integrated Systems of Care (ISOC) partnership group will be a primary recipient / user of the detailed information contained within this document. This action plan will be a key partnership tool to enable all partners to see which activities are the highest priorities for Leicester's Health and Wellbeing Board, how these are progressing and support escalation of risks/issues during delivery for timeline mitigation. The tool will also provide ongoing opportunity for stakeholders/partners to reflect, using the guiding principles, on where their contributions can help deliver the aims of the partnership.

It is important to note that some of the actions within this tool have direct links to longer term major NHS strategic priorities for Leicester, Leicestershire, and Rutland (LLR) ICS. It has dependencies on other complex organisational partners and/or national programmes requiring closer working with local and national partners at all levels and our communities to ensure we successfully deliver this plan for the people of Leicester.

2. Our Guiding Principles for Delivery

1. Help reduce health inequalities (key focus on Core20Plus5)	1a. Multi-agency/partnership working	1b. Strengthen collaborative/ integrated working between organisations/services	1c. Proportionate universalism
Building upon LLR HI framework with agreed core services for the areas of highest deprivation/ prevalence in the City. Early interventions on the primary determinants of ill health – not necessarily starting with services by default.	*Co-drive Strategic partnership approach to collectively plan and commission care and services across the City Place*	*Ensure continued collective and coordinated approach and ownership at local level*	*Allocate healthcare resources on a sliding scale, based on geographical need, with those with the greatest need provided with a greater share of resources.*

2. Improve equity of access (and experience) to services	3. Address unwarranted variation within the city and/or against the England average	4. Communicating and Engaging with people on the actions	5. Involvement of the voluntary community sectors and communities
Actions will be grounded in our collective efforts to address the inverse care law. "People & Action for those in greatest need."	*Key to driving change and demonstrating tangible improvements in outcomes.*	*Building upon success of Vaccine Ambassador programme, harnessing community power and supporting citizen participation and education (health literacy). Engaging citizens of care which could be co-designed and re-reviewed where possible and appropriate.*	*Drawing upon expertise and experience of VCSE to support principle 4, utilising co-design and co-production methodology.*

4. Guidance on RAG Status for partnership Delivery Leads:

Overall	**What is overall status of Action / Project to deliver as per plan?**
	Progressing as Planned nothing to escalate
	Progressing as planned but some challenges with risks or issues/Timeline / Finance that can or are being resolved
	Challenges / risks or issues that cant be resolved and require escalation as will not deliver as planned

Risk	**What is the lowest rated risk for your Action / Project?**
	Low Risk to delivery against plan
	Medium Risk to delivery against plan
	High Risk to delivery against plan

Improvement Trajectory	**What is the status against the overall trajectory of improvement?**
	There is evidence that this is heading in the right direction of travel and it is on track to make improvement from baseline
	There is some evidence of improvement but it is not yet clear to see through dashboard reporting mechanisms
	There is a risk to making improvement against the baseline as there is no evident improvement

Healthy Places: We will improve access to primary and community health and care services

AMBITION	WE WILL	BY	I WILL
To make Leicester the healthiest possible environment in which to live and work	**1. Develop integrated neighbourhood teams that work in a coordinated way with partners at a local level improving Primary Care**	Develop an agreed approach with our partners to align local integrated delivery models (INTs) with Primary Care in the community	I will receive the right support at the right time, at the right place from the right professional (s) to meet my health and care needs
		Recruit Additional Roles in Primary Care and develop these to optimise access for people in most need	
		Develop and optimise the use of Social Prescribing and other ARRS workforce in Leicester	
		Put in place the appropriate infrastructure and support for all neighbourhood teams through clinical and estate strategies for each PCN in Leicester and availability of Digital kit and digital services	
		Roll-out carer awareness training to staff working in INT's to ensure carers are identified, registered with GP's and signposted to sources of support	
	2. Enabling people to improve their literacy of local technology solutions	Explore and scope future opportunities to help people to learn and develop digital literacy through support from Leicester Adults Skills and Learning Group and Leicester practices	I will have the opportunity to use Digital technology equipment and services that are being locally offered to enable me to stay healthy and well
		Develop an Outreach approach to local communities to enable Digital Fluency/Literacy and Health literacy in using Health Technology (BPM for Hypertension)	
		Develop resources inc. Short videos in various languages to educate patient's around active sign posting and one stop shop approach	
		Run workshops/seminars to train communities such as the VCSE, community champions, social prescribers and Carers to learn about pathways and associated technology (Focus on Hypertension, Blood Pressure Monitoring and NHS App)	
	3. Deliver enhanced access in Primary Care	Increase health checks for people on our learning disability register	I will have the opportunity to receive the Health and Care that I need when I need it so that I can stay healthy and well
		Increase recording of ethnicity data in Primary Care Systems	
		Tackle unmet needs of specific populations at a Neighbourhood level	
		Identify further cohorts of unregistered residents (inc. family Carers) of Leicester and enable their registration with local GPs (Is there any localities) - Belgrave and Highfields	
		Ensure parity of access to services 6:30pm – 8:30pm and 9-5 Sat through each PCN delivering , we will feedback the findings of this into the development of INTs	
	4. Undertake a review of our current urgent care services for people in Leicester with minor injuries and illnesses	Review and define options of clinical model of Urgent Care at LRI and Merlyn Vaz (In and Out of Hours)	I will have access to the Urgent Care services I need to enable me to stay out of hospital and remain in the community
		Develop and seek agreement of Business Case with options for all LLR UTCs	
		Agreed Operational commissioning of LLR UEC services including offer at Merlyn Vaz and Leicester Royal Infirmary	

Healthy Minds (CYP): We will improve acess for children & young people to Mental Health & emotional wellbeing services

AMBITION	WE WILL	BY	I WILL
To promote positive mental health across the life course	**1. Develop a communication plan and clear map of Emotional Health and Wellbeing Service services for promoting access including the digital offer for schools, CYP and their families (inc. Family Carer)**	Explore options through development of a Business Case and obtain agreement of preferred option to implement and commission	TBC
		Promote EHW support and services available to CYP via school MHST's (whole school approach with low referrals schools)	TBC
	2. Focus city based CYP MH projects to areas of lowest uptake and high deprivation	Commission and Implement the plan Inc. actions for MHST	TBC
		Identify areas of low referral into MH services and increase the community services in the area to reach out	TBC
		Identify information needed to develop the demographic metric, ensure providers are submitting and develop this to demonstrate improvement on inequality	TBC
	3. Promote existing MH services to Primary Care Network and key children's workforce	Identify which GP practices and other workforces have low number of referrals to CYP mental health services in the city from the demographic matrix	TBC
		Target and support number of GP Practices by mental health practitioners offering advice, outreach and drop-in sessions	TBC
		Increase new roles in PCN with support of ARRS by be embedded as part of multi-disciplinary team	TBC

Healthy Minds (Adults): We will improve access to primary & neighbourhood level Mental Health services for adults.

AMBITION	WE WILL	BY	I WILL
To promote positive mental health across the life course	**1. Delivering increased Mental health focused voluntary sector offers**	Review and award grants for Getting Help in Neighbourhood round 2	TBC
		Review and award grants for Crisis café bids for City	TBC
	2. Tailor the workforce to local need in neighbourhoods	Launch recommissioned mental health and wellbeing services (10/22)	TBC
		Agreement on recruitment plan for City PCNs for 22/23 ARRS mental health workers	TBC
		Recruitment against 22/23 ARRS scheme completed	TBC
		Develop proposal for initial city neighbourhood mental health workforce reconfiguration from profiles	TBC
		Agree proposal and implementation plan	TBC
	3. Increase MH leadership and coordination through development of new ways of working	Set up project team and allocate resources for innovation site in south Leicester neighbourhood	TBC
		Evaluation of 13-week innovation site and establishing plan for other city neighbourhoods (????)	TBC
	4. Expand psychological offers in Leicester	Expansion of IAPT offer	TBC
		Develop Proposal Inc. implementation plan for expanding wider psychological offer to neighbourhoods	TBC

Healthy Lives: We will increase early detection of heart & lung diseases and Cancer in adults.

AMBITION	WE WILL	BY	I WILL
To encourage people to make sustainable and healthy lifestyle choices	**1. Implement a proactive care at home framework focussing on Hypertension**	Strengthen the use of the Community Pharmacy Hypertension Case-finding Service	TBC
		Explore the use of BP 'arm-machines" in practices identified as struggling with prevalence	TBC
		Recruit and develop LTC Champions to improve practice processes and reduce variation in Hypertension management/case-finding	TBC
		Enable Shamia Women's Centre, South Asian Health Action community delivery partners to be able to encourage better case finding in key City communities	TBC
		Work with Leicester City Council to support them in increasing the number of NHS Health Checks completed	TBC
		Implement the MECC Standard Operating Procedure for Blood Pressure checking in COVID-19 vaccination centres	TBC
	2. Increase early diagnosis in Cancer pathways through early detection and follow-on pathway developments	Review of prostate cancer identification in BAME groups with recommendations for improvement. Target men with familial history <60 and black men through targeted case findings and supported through the PCN Cancer DES	TBC
		Continuation in participation of the NHS Galleri clinical trial. Utilising opportunities to expand the trial where possible and indicated nationally	TBC
		Implementation of the Targeted Lung Health checks within LLR and primarily within the City. Notts is due to go live shortly with LLR the next priority site. This will be run in collaboration with the smoking cessation work by the LCC	TBC
		Improve colorectal cancer detection at early stage. Implementing the use of FIT as a diagnostic tool and with all 2WW to over 18 years (NICE requirements over 40).	TBC
		Targeted project within LC and in particular LE4 to increase the 1 year survival rate. Reduction of the screening age to 56 will be rolled out across LLR by the national programme.	TBC
		Review and agreed approach to identify patients at high risk of cancer in City – PCN Pilots targeted case finding	TBC
		Development of VCS HI connectors delivery plans with ongoing local monitoring (x3)	TBC
	3. Increase uptake of cervical screening	LD Screening programme being undertaken led by National Screening team	TBC
		Transformation within next 12 months to include self-testing HPV as piloted in London and risk stratified recall.	TBC
		Review of DNAs for Screening with PM to inform	TBC
		Pilot at PCN level using video texting to target patients who have not attended smears and appointments were provided outside of the core hours	TBC

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

AMBITION	WE WILL	BY	I WILL
To enable Leicester residents to age comfortably and confidently	**1. Create fully operational Integrated Neighbourhood Teams, focusing on Multi-Disciplinary Teams using anticipatory approaches with older people who may be at risk**	Making every contact count	TBC
		Develop a framework for local delivery of anticipatory care focusing on the role out of the MDT facilitator at PCN level	TBC
	2. Continue to develop MyChoice so that it is kept up to date with local VCS preventative services and community assets to reduce loneliness and isolation	Enable people who use MyChoice to have an easy way of feeding back their experiences of using it to inform improvements and work programme of steering group	TBC
		Work to improve useability so that people and professionals such as social prescribers have a positive experience and find what they are interested in	TBC
		a) Include personal assistants on MyChoice b) Develop 'social prescribing' add on to MyChoice which will encourage people to contact support agencies directly without a need for 'professional referral' c)As community connector programme develops, ensure services and groups set up to tackle isolation and loneliness feature on MyChoice	TBC
	3.Commission a range of services and opportunities that provide an alternative to residential care that support older people to self -care, build on strengths and reduce frailty wherever possible	Community Opportunities and short breaks	TBC
		Dementia Support Service	TBC
		Short term residential beds & D2A Pathway 2 review	TBC
		Homecare – new contracts to be in place 2024	TBC
		Hospital Bridging Service	TBC
		Respite review	TBC
		Supported living arrangements for older people	TBC
		Carer support services	TBC
	4.Delivery high quality Home-first services that are integrated, responsive and meet the Ageing Well ambition	LLR D2A P1 remodelling work to increase reablement capacity	TBC
		Continue to roll out Phase 2 of the ICRS EoL pilot !! 1.ELR D2A P1 remodelling work to increase reablement capacity 2.Continue to roll out Phase 2 of the ICRS EoL pilot Deliver and fully evaluate the ICRS Night Support Service offer	TBC

Healthy Start: We will mitigate against the impacts of poverty on children and young people.

AMBITION	WE WILL	BY	I WILL
To give Leicester's children the best start in life	**1. Tackling Poverty in Leicester**	Establishing an Anti-poverty partner network	TBC
		Anti-poverty board progress checks	TBC
	Set out actions and intentions for each themes in the framework: •Homes, furniture and utilities •Food and Clothing •Money debt and advice •Childcare & Schools •Jobs, skills & Transport •Health & wellbeing •Community	Review progress of intentions associated with the framework	TBC
		Monitor partner network activity and impact, and in areas most in need.	TBC
	3. Offer the Anti-poverty community grants scheme to more organisations	Grants of offered for local groups and organisations to develop and run projects that mitigate the impacts of poverty for residents across Leicester	TBC
	4. Deliver the Maternity and Neonates Equity and Quality Co produced action plans with a focus on the most deprived areas / most vulnerable/complex groups	Relaunch Peer Support Programme to support women and act as their advocate in perinatal mental health initially	TBC
		Expand the Stork Project for rollout to GP / Obstetrics / Health Visitors in Leicester and also offer Preconception education, support, and signposting through rolling out school education programmes, timing of pregnancy, smoking /drugs in pregnancy and breastfeeding	TBC
		To agree/develop how local Maternity services in Leicester can integrate with Family Hub "One Stop Shop" model developments	TBC
		Task and finish group commenced to look at Improving Maternity Access and Experience for Women from BAME Community	TBC

Healthy Places: We will improve access to primary and community health and care services

Ref	WE WILL	Delivery Stage	How will this demonstrate improvement?	No	Key Activities / Deliverables / Milestones	Will activities improve/increase equity at a local level? (Y/N)	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue RAG	Improvement Trajectory RAG
1	Develop integrated neighbourhood teams to work in a more coordinated way with partners at a local level through enabling the evolution of Primary Care	Delivery	•Reduction in unwarranted variation in access, experience, and outcomes (agree metrics with partners) •Increase referrals to Social Prescribers in areas of most need (Use IIF data to monitor referrals) •Evaluation of the Delivery of PCN Proactive social prescribing plans •Increase in referrals into promoted pathways (e.g. Long Covid, Sickle Cell) •Increase in the numbers of Carer identified and registering with their GP •Increase in the numbers of Carers identified and accessing commissioned services (Which ones?)	1.1	Develop an agreed approach with our partners to develop local integrated delivery models (INTs) with Primary Care in the community (East / West config??)	Y	Y (Existing)	Promotion of Social Prescribing and ARRS pathways to Leicester City PCNs	Primary Care Transformation Board	ICB/PCN (LA, LLR Leadership Academy, LPT CHS)	2023 - 2025	Mayur Patel / Jeremy Bennett	Green	Green	Green	Green
				1.2	Recruit Additional Roles in Primary Care and develop these to optimise access for people in most need											
				1.3	Develop and optimise the use of Social Prescribing and other ARRS workforce in Leicester											
				1.4	Put in place the appropriate infrastructure and support for all neighbourhood teams through clinical and estate strategies for each PCN in Leicester and availability of Digital kit and digital services											
				1.5	Roll out carer awareness training to staff working in INT's to ensure carers are identified, registered with GP's and signposted to sources of support											
2	Empower citizens to use technology where appropriate by enabling people to improve their literacy of local technology	Delivery	•Bring parity to Leicester residents for opportunity to access NHS App services through enabling an increase in registrations •Increase in use of Digital services •Patient feedback on use of Digital Services	2.1	Explore and scope future opportunities to help people to learn and develop digital literacy through support from Leicester Adults Skills and Learning Group and Leicester practices	Y	N		Primary Care Transformation Board	ICS (ICB,LA,VCS, PCNs)		???	Not Started	Not Started	Not Started	Not Started
				2.2	Develop an Outreach approach to local communities to enable Digital Fluency/Literacy and Health literacy in using Health Technology (BPM for Hypertension)											
				2.3	Develop resources Inc. Short videos in various languages to educate patient's around active sign posting and one stop shop approach											
				2.4	Run workshops/seminars to train communities such as the VCSE, community champions, social prescribers and Carers to learn about pathways and associated technology (Focus on Hypertension, Blood Pressure Monitoring and NHS App)											
3	Deliver the enhanced access in Primary Care	Delivery	•Evaluation of Hours of DES Delivery •Increase in Same day appointment (%) from overall •Increase in registered GP population in most deprived areas •No of hours-of-service enhanced access for PCNs	3.1	Increase health checks for people on our learning disability register	Y	Y (Existing)			PCN		Mayur Patel	Green	Green	Green	Green
				3.2	Increase recording of ethnicity data in Primary Care Systems											
				3.3	Tackle unmet needs of specific populations at a Neighbourhood level											
				3.4	Identify further cohorts of unregistered residents (Inc. family Carers) of Leicester and enable their registration with local GPs (Is there any localities) - Belgrave and Highfields											
				3.5	Ensure parity of access to services 6:30pm – 8:30pm and 9-5 Sat through each PCN delivering , we will feedback the findings of this into the development of INTs											
4	4. Undertake a strategic review of urgent care services for patients with minor injuries and illnesses (which will incorporate the Urgent Treatment Centres in Leicester (Merlyn Vaz and at Leicester Royal Infirmary)	Feasibility	Reduced ED Attendance and admissions of Leicester Residents 0-1 LOS impact metric (more so than reduced ED) Increase in positive Leicester resident feedback on experiences of access to UEC services	4.1	Review and define options of clinical model of Urgent Care at LRI and Merlyn Vaz (In and Out of Hours) (Dec 22)	Y	Y (Existing)	Formal Public Consultation Spring 23	LLR Access Strategic Review Group	ICB (DHU, PCNs,UHL)		Sarah Smith / Alex ?	Green	Green	Green	Green
				4.2	Develop and seek agreement of Business Case with options for all LLR UTCs (Apr 23)											
				4.3	Agreed Operational commissioning of LLR UEC services including offer at Merlyn Vaz and Leicester Royal Infirmary (Sept 24)											

Healthy Minds: We will improve access for children & young people to Mental Health & emotional wellbeing services

Ref	WC Wins	Delivery/Align	How will this demonstrate implementation?	No:	Key Activities / Deliverables / Milestones	Will this work help to reduce/close inequity at a local level? Y/N	Revision: Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue Area	Improvement Trajectory Area
1	1. Develop a communication plan and offer for Children and Young People and Wellbeing Service services for promoting access including the digital offer for schools, CYP and their families (inc. Family Cares)	Delivery	Reduce prevalence in CYP Increase access to wider community Target uptake in the BAME Communities	1.1	Explore options through development of a Business Case and obtain agreement on a preferred option to implement and commission	Y	Y	Undertake consultation and coproduction with young people to explore what works for them.	EHW CYP Delivery Group All Age Mental Health Delivery Group		Mar-23	Justin Hammond/John Edwards				
				1.2	Promote EHW support and services available to CYP via whole SHCFS (whole school approach with low referrals schools)											
				1.3	Commission and implement the plan inc. actions for MHST											
2	Focus city based CYP MH projects to areas of lowest uptake and high deprivation	Delivery	Improve access to CYP in the area of low referral and high deprivation	2.1	Identify areas of low referral into MH services and map existing community services in the area to reach out	Y		Some engagement has already taken place and further work will take place to develop a wide range of communication with CYP and their families group to implement the findings. Involvement and engagement of faith and community leaders, faith, community and voluntary organisations resources and their target to promoting positive mental and support available e.g. Outreach project Ensure leaflets and TikTok, other leaflets are available to them	EHW CYP Delivery Group All Age Mental Health Delivery Group		Sep-23	Justin Hammond/John Edwards				
				2.2	Identify information needed to develop the demographic metric, ensure providers are submitting and develop this to demonstrate improvement on inequality											
3	Promote existing MH services to Primary Care Network and key children's workforce	Delivery	Increase local access to services Increased awareness of mental health support and how to access it across Primary care network and children's workforce in the city	3.1	Identify which GP practices and other workforces have low number of referrals to CYP mental health services in the city from the demographic matrix	Y	Y	Some engagement has already taken place and further work will take place to develop a wide range of communication with CYP and their families group to implement the findings Undertake presentation in Primary Care Network group and other workforce around low referrals linked to demographic matrix	EHW CYP Delivery Group All Age Mental Health Delivery Group		Mar-23	Justin Hammond/John Edwards				
				3.2	Target and support number of GP Practices by mental health practitioners offering advice, outreach and drop-in sessions											
				3.3	Increase new roles in PCN with support of ARRS to be embedded as part of multi disciplinary team											

Healthy Minds (Adults): We will improve access to primary & neighbourhood level Mental Health

Ref	WE WILL	Delivery Stage	How will this demonstrate improvement?	No	Key Activities / Deliverables / Milestones	Will activities improve/increase equity at a local level? (Y/N)	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue RAG	Improvement Trajectory RAG
1	Delivering increased Mental health focused voluntary sector offers	Delivery		1.1	Review and award grants for Getting Help in Neighbourhood round 2	Y	Y (SDF, MHIS and LA (relating to 10% of MH and wellbeing service))		Task and finish group reporting through place based group	ICB		Justin Hammond/John Edwards				
				1.2	Review and award grants for Crisis café bids for City											
				1.3	Launch recommissioned mental health and wellbeing services (10/22)											
2	Tailor the workforce to local need in neighbourhoods	Delivery		2.2	Agreement on recruitment plan for City PCNs for 22/23 ARRS mental health workers	Y	Y (SDF and NHIS and ARRS)	Engagement and review of proposal	Task and Finish Group	ICB		Justin Hammond/John Edwards				
				2.3	Recruitment against 22/23 ARRS scheme completed											
				2.4	Develop proposal for initial city neighbourhood mental health workforce reconfiguration from profiles											
				2.5	Agree proposal and implementation plan											
3	Increase MH leadership and coordination through development of new ways of working	Delivery		3.1	Set up project team and allocate resources for innovation site in south Leicester neighbourhood	Y	Y (SDF and NHIS)		Making it happen task and finish group	Collab		Justin Hammond/John Edwards				
				3.2	Evaluation of 13-week innovation site and establishing plan for other city neighbourhoods (????)											
4	Expand psychological offers in Leicester	Delivery		4.1	Expansion of IAPT offer	Y	Y(MHIS)			ICB	Oct-23	Justin Hammond/John Edwards				
				4.2	Develop Proposal Inc. implementation plan for expanding wider psychological offer to neighbourhoods											
5	Continue to implement the joint LLR Dementia Strategy which includes people who are diagnosed with early onset dementia (those between the ages of 30-65yrs)	Delivery		5.1	Continue to review and monitor the dementia grants scheme for grass roots organisations to support healthy ageing, brain health, exercise, and nutrition	Y	Y (ASC)		LLR Dementia Programme Board / MH Collaborative	ASC		Kate Galioppi / Bev White				
				5.2	Work to refresh dementia strategy	Y	Y(ASC)	Yes – timeline not yet available	LLR Dementia Programme Board / MH Collaborative	ASC		Kate Galioppi / Bev White				

Ref	WE WILL	Delivery Stage	How will this demonstrate	No	Key Activities / Deliverables / Milestones	Will activities improve/increase	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue RAG	Improvement Trajectory RAG
1	Tackling Poverty in Leicester	Delivery	Anti-poverty framework – tracking as below Anti-poverty partner network	1.1	Co-design of strategy and framework (at series of engagement events with over 500 people.	Y	Y (LCC)	Engagement for strategy development carried out Establishing an Anti-poverty partner network	Anti-poverty board	Leicester City Council with a developing anti-poverty partner network	Ongoing, anti-poverty microsite launched in May 2022					
				1.2	5 strategy objectives were agreed to cover: •Preventing fall into poverty •Crisis interventions •Short/medium term support •Long term infrastructure change •National lobbying											
				1.3	Anti-poverty board progress checks											
2	Set out actions and intentions for each themes in the framework: •Homes, furniture and utilities •Food and Clothing •Money debt and advice •Childcare & Schools •Jobs, skills & Transport •Health & wellbeing •Community	Delivery	There are a series of metrics associated with each of the existing actions and intentions	2.1	Review progress of intentions associated with the framework	Y	Y (LCC and partner network resource)	There are a series of engagement activities associated with each of the existing actions and intentions.	Anti-poverty Board	Leicester City Council with a developing anti-poverty partner network	Update provided at each Anti-poverty Board					
				2.2	Monitor partner network activity and impact, and in areas most in need.											
3	Offer the Anti-poverty community grants scheme to more organisations	Delivery	Assessing impact for each project Tracking of project progress and impact at Anti-poverty Board Assessing impact for each project Tracking of project progress and impact at Anti-poverty Board	3.1	Grants of offered for local groups and organisations to develop and run projects that mitigate the impacts of poverty for residents across Leicester	Y	Y (LCC & partners)	Offer to apply is open across the voluntary, private and public sector in Leicester.	Anti-poverty board	Leicester City Council	Launch of scheme planned for Nov 2022 Award of grants up to £10k in December 2022 Award of grants £10k+ in early 2023					
				3.2	Application rounds will be made to a panel											
4	Deliver the Maternity and Neonates Equity and Quality Co produced action plans with a focus on the most deprived areas / most vulnerable/complex groups	Delivery	Local women's feedback Workforce diversity trajectory Breastfeeding BFI/UNICEF Guidance compliance rates	4.1	Relaunch Peer Support Programme to support women and act as their advocate in perinatal mental health initially	Y	Y (Some existing transformation but new funds may be needed e.g. Family Hubs)	Local Schools Relaunch of MVP will link in with the developments Linking in with Leicester Mammas and Shama Women's Centre	Health Equity Committee / Anti-Poverty	Local Maternity System (H&WB Boards, ICS partnerships, PH, LHknown, LPT, Education	Start 2022 End 2024					
				4.2	Expand the Stork Project for rollout to GP / Obstetrics / Health Visitors in Leicester and also offer Preconception education, support, and signposting through rolling out school education programmes, timing of pregnancy, smoking /drugs in pregnancy and breastfeeding											
				4.3	To agree/develop how local Maternity services in Leicester can integrate with Family Hub "One Stop Shop" model developments											
				4.4	Task and finish group commenced to look at Improving Maternity Access and Experience for Women from BAME Community											

Healthy Lives: Increase early detection of heart & lung diseases and Cancer in adults

Ref	WE WILL	Delivery Stage	How will this demonstrate improvement?	No	Key Activities / Deliverables / Milestones	Will these activities improve/increase equity at a local level? (Y/N)	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue RAG	Improvement Trajectory RAG
1	Implement a proactive care at home framework focussing on Hypertension	Delivery	• Reduction in the number of strokes and heart attacks for City patients • Improved life expectancy at age 65 • Increase in competencies / knowledge in Primary Care • Increased use of Comm Pharmacy HTN service in the City • Reduce the number of high-risk patients with Hypertension • Increase in the % of City Health Checks completed •Progress Reporting of HI Connectors delivery of KPIs	1.1	Strengthen the use of the Community Pharmacy Hypertension Case-finding Service	Y	Y (Existing) e.g. QOF, DES and Core Connectors Project Funding	(Core Connectors) Workshops and core working group with community Delivery Partners Develop links with Community Wellbeing Champions Network (CWC) Promotion of Social Prescribing and ARRS pathways to Leicester City PCNs	Primary Care Transformation Board / LLR Health Equity Committee	ICB/PCNs/Community Delivery Partners	2023 - 2025	Mayur Patel / Jess Lucas	Green	Green	Green	Green
				1.2	Explore the use of BP 'arm-machines' in practices identified as struggling with prevalence											
				1.3	Recruit and develop LTC Champions to improve practice processes and reduce variation in Hypertension management/case-finding											
				1.4	Enable Shama Women's Centre, South Asian Health Action community delivery partners to be able to encourage better finding in key City communities											
				1.5	Work with Leicester City Council to support them in increasing the number of NHS Health Checks completed											
				1.6	Implement the MECC Standard Operating Procedure for Blood Pressure checking in COVID-19 vaccination centres											
2	Increase early diagnosis in Cancer pathways through early detection and follow-on pathway developments	Delivery	•Reduce prevalence in adults? •Increased uptake in South Asian Communities •Reduction in early death from cancer and respiratory diseases (NW and South HNN's) •Increased early-stage cancer diagnosis across key cancers •Progress Reporting of HI Connectors delivery of KPIs	2.1	Review of prostate cancer identification in BAME groups with recommendations for improvement. Target men with familial history <60 and black men through targeted case findings and supported through the PCN Cancer DES	Y	N	Lord Mayors Office meeting with Prostate and Genomics took place on 7/9/22. Focus campaign in March 2023 Work with local communities/ VCS to understand barriers to uptake Core20PLUS Cultural: Engagement with ethnic minority community organisations in the most deprived areas	Primary Care Transformation Board Cancer Transformation Group	ICS (ICB,LA,VCS, PCNs)	22/23 with review in line with ICB priorities to confirm 23/24	Vivek Varakantam/Pawan Randev/Helen Mather/Matt Archer	Amber	Amber	Amber	Amber
				2.2	Continuation in participation of the NHS Galleri clinical trial. Utilising opportunities to expand the trial where possible and indicated nationally											
				2.3	Implementation of the Targeted Lung Health checks within LLR and primarily within the City. Notts is due to go live shortly with LLR the next priority site. This will be run in collaboration with the smoking cessation work by the LCC											
				2.4	Improve colorectal cancer detection at early stage. Implementing the use of FIT as a diagnostic tool and with all 2WW to over 18 years (NICE requirements over 40).											
				2.5	Targeted project within LC and in particular LE4 to increase the 1 year survival rate. Reduction of the screening age to 56 will be rolled out across LLR by the national programme.											
				2.6	Review and agreed approach to identify patients at high risk of cancer in City – PCN Pilots targeted case finding											
				2.7	Development of VCS HI connectors delivery plans with ongoing local monitoring (x3)											
3	Increase uptake of cervical screening	Delivery	More working age women receiving screening Videos available in alternative languages and delivered by professionals and patients of different ages	3.1	LD Screening programme being undertaken led by National Screening team	Y		Engagement with communities – Macmillan EOI to be developed to engage Cancer Champions in communities.	Cancer Transformation Gtoup	ICS (ICB,LA, PCNs)	22/23 with review in line with ICB priorities to confirm 23/24	Pawan Randev/Helen Mather				
				3.2	Transformation within next 12 months to include self-testing HPV as piloted in London and risk stratified recall.											
				3.3	Review of DNAs for Screening with PH to inform											
				3.4	Pilot at PCN level using video texting to target patients who have not attended smears and appointments were provided outside of the core hours											

Healthy Ageing:

Ref	WE WILL	Delivery Stage	How will this demonstrate improvement?	No	Key Activities / Deliverables / Milestones	Will activities improve/increase equity at a local level? (Y/N)	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Owner	Timescale	Partnership Lead Contacts	Overall RAG Status	Status Change from Last Period	Highest Rated Risk/Issue RAG	Improvement Trajectory RAG
1	Create fully operational Integrated Neighbourhood Teams, focusing on Multi-Disciplinary Teams using anticipatory approaches with older people who may be at risk	Delivery	Power BI dashboard which monitors programme activity and outcomes – {in development} Ageing Well programme metrics	1.1 1.2	Making every contact count To develop a framework for local delivery of anticipatory care, which ensure consistency with the national operating model, but encourages flexibility at a place neigbourhood and pcn level focusing on the role out of the MDT facilitator at PCN level	Y	Y	Comms and engagement plan in place. Further details available from Paul Miles & Ibrahim Elias Co-design workshops planned for Oct/Nov 22	LLR Prevention & Inequalities Board (if still in operation) or LLR MECC Review Group LLR Anticipatory Care Project Group	ASC/ICB	2022 - 2024					
2	Continue to develop MyChoice so that it is kept up to date with local VCS preventative services and community assets to reduce loneliness and isolation	Delivery	Steering group performance measures in relation to most searched for terms, times that people are using mychoice, number of hits etc.	2.1 2.2 2.3	Enable people who use MyChoice to have an easy way of feeding back their experiences of using it to inform improvements and work programme of steering group Work to improve useability so that people and professionals such as social prescribers have a positive experience and find what they are interested in a) Include personal assistants on MyChoice b) Develop 'social prescribing' add on to MyChoice which will encourage people to contact support agencies directly without a need for 'professional referral' c)As community connector programme develops, ensure services and groups set up to tackle isolation and loneliness feature on MyChoice	Y	Yes ASC	None Planned	My Choice Steering Group meets 6 weekly. Reps from across the system attend that group. Escalation through ASC senior leaders	ASC	Started 2021, no planned end date as project is ongoing					
3	Commission a range of services and opportunities that provide an alternative to residential care that support older people to self -care, build on strengths and reduce frailty wherever possible	Delivery	Reduced permanent admissions to residential care	3.1 3.2 3.3 3.4 3.5 3.6 3.7 3.8	Community Opportunities and short breaks Dementia Support Service Short term residential beds & D2A Pathway 2 review Homecare – new contracts to be in place 2024 Hospital Bridging Service Respite review Supported living arrangements for older people Carer support services	Y	Y	Various	LA SCE Leadership & LA commissioning boards, project groups LLR Dementia Programme Board ISOC / JICB	ASC	Various for each commissic					
4	Delivery high quality Home-first services that are integrated, responsive and meet the Ageing Well ambition	Delivery	Increase numbers of older people who return to their usual home following time in hospital Increase numbers of people going through the reablement pathway Increase in the numbers of people who die in their place of choice	4.1 4.2	LLR D2A P1 remodelling work to increase reablement capacity Continue to roll out Phase 2 of the ICRS EoL pilot 1.LLR D2A P1 remodelling work to increase reablement capacity 2.Continue to roll out Phase 2 of the ICRS EoL pilot Deliver and fully evaluate the ICRS Night Support Service offer	Y	Y	None Planned	LLR Homefirst Collaborative End of Life Care Group	ASC	2022 - 2023					

Leicester Health and Wellbeing Board

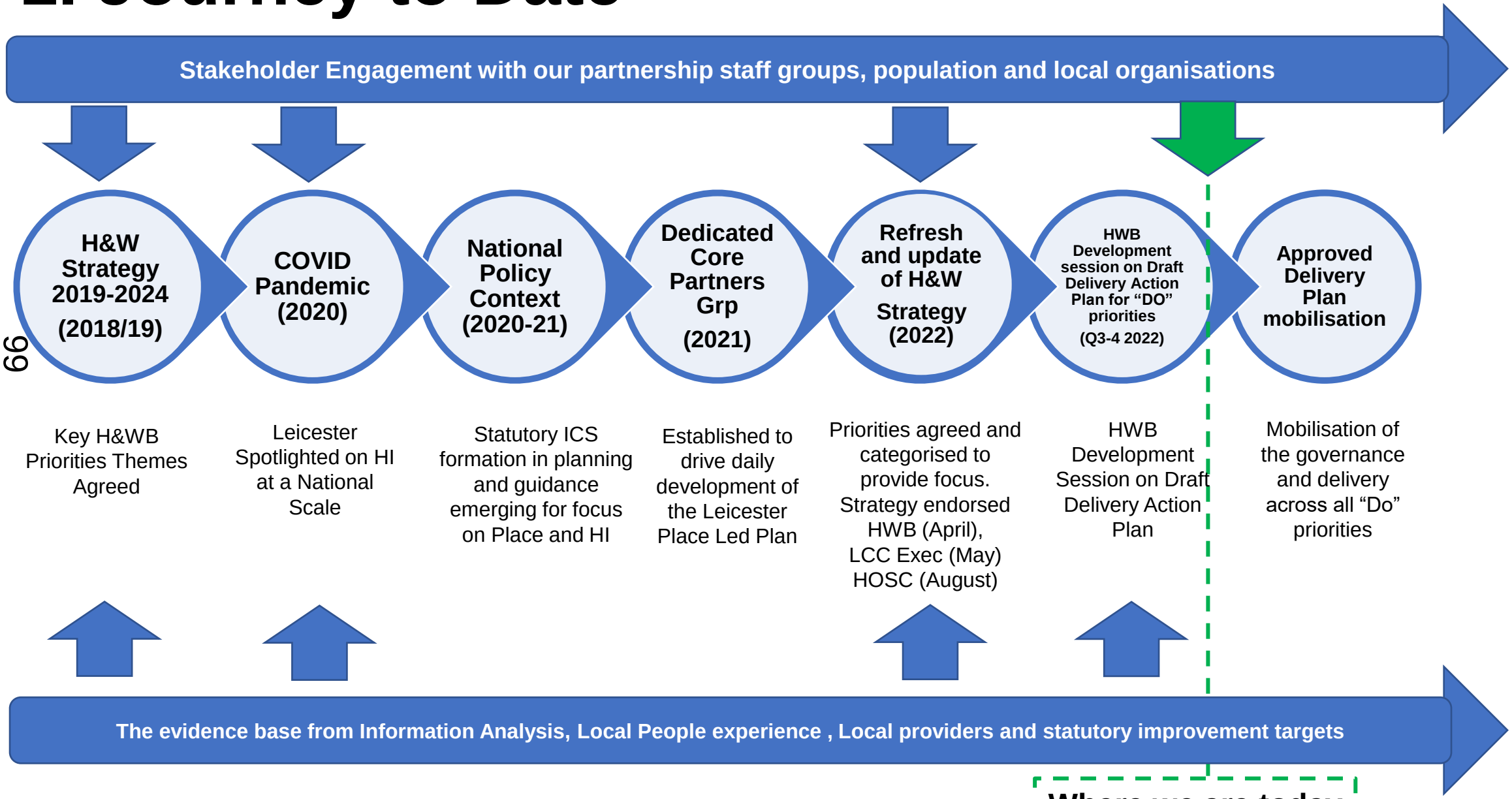
Leicester Health Care and Wellbeing Strategy Delivery Plan (2023-2025)

December 2022

Overview

1. Journey to date
2. 171122 HWB Development Day Feedback/Actions
3. Priorities and Guiding Principles
4. Plus Groups Recommendations
5. Structure of Delivery Plan
6. Summary of Key Actions (Ongoing Development)

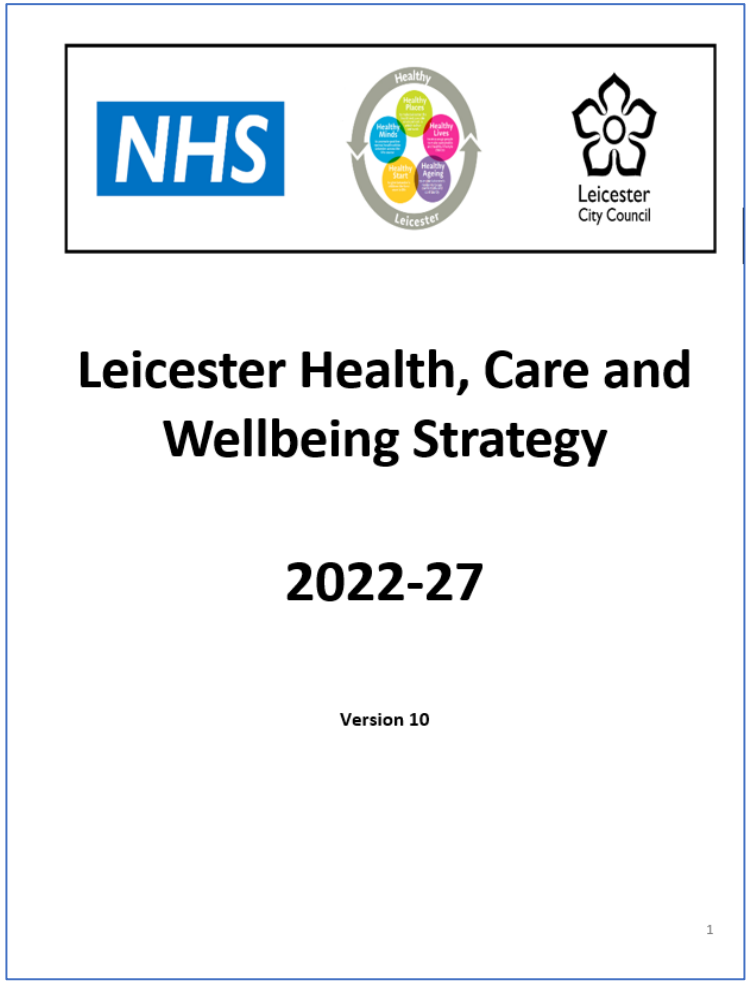
1. Journey to Date



1. Journey to Date: Leicester Place Led Plan

Integrated Care Systems

System	• 1-3 million people
Place	• c. 250,000 – 500,000 people
Neighbourhood	• c. 30,000 – 50,000 people



1. Journey To Date: Core Group Membership

Katherine Packham	Leicester City Council
Kate Galoppi	
Jane Pierce	
Nicola Cawrey	
Alex Barker	
Shivan Thakrar	
Amy Endacott	
Prof. Fahad Rizvi	LLR Integrated Care Board
Dr Avi Prasad	
Amit Sammi	
Yasmin Sidyot	
Mayur Patel	
Sarah Ferrin	
Mark Pierce	
Adhvait Sheth	
Jit Parekh	
Jo Ryder	
Melanie Barnes	
Shelpa Chauhan	
Sarah Morley	Leicestershire Partnership Trust
Harsha Kotecha	Healthwatch Leicester
Gemma Barrow	

1. Journey To Date: Partnership Approach

- **Collaborative working** to develop a Delivery Action Plan in line with HWB ambitions and our Guiding Principles for Leicester
- **Driven by dedicated core working group made up of partners**: PH managerial and registrar leads, LA Adults and CYP leads, LPT leads, Place Clinical leads, ICB cross directorate managerial leads including those involved in LLR wide NHS transformation
- **Engagement with local stakeholders** - Leicester Community Well Being Champions, Patient and Staff groups, plus range of local organisations given opportunity to feed in
- This is **not a plan of individual organisations** delivery
- **Strategically aligned umbrella portfolio** of integrated work – existing/new
- **Golden thread** of addressing Health Inequalities throughout
- **Ongoing** partnership development and refinement

1. Journey To Date: Engagement Insights

*INFORMATION	*ACCESS	*GP SERVICES	*CULTURAL UNDERSTANDING
Confusion over what services are for and where to go, especially out of hours care and urgent care	City residents ask for the local delivery of services which address health inequalities	Simplifying access to GP appointments (particularly phone bookings)	Lack of understanding community and cultural nuances and how to apply to services
Use of jargon, terminology and names – simplify messaging to appeal to audiences and delivered by reputable local sources	Use of technology for virtual and online appointments is limited due to software, equipment and language barriers	Need for more consistency across the city between practices	Understanding of and need for alternative, holistic and non medical approaches
Targeted information and support/advice on long term conditions and self care	Interactions and information between patients, carers and services needs improving	Reliance of support from GPs – education on wider services available from GP practice to avoid unnecessary A&E visits	Access to translations and lack of understanding of rights

****Carers** | ****Comms and Engagement** | ****VCSE** | ****Co-Design/Development**

***Toplines findings from analysis of multiple sources of data** collected around urgent care services, including clinical navigation and NHS 111, acute maternity reconfiguration, Covid-19 report, feedback from family carers, care home and domiciliary care, support at the end-of life, mental health services, planned care, experiences of those with long term conditions and with delivering digitally enabled care across the NHS*

****Leicester Community Wellbeing Champions 2022***

1. Journey To Date: Stakeholders

Local organisations that have had opportunity to feed in views

- System Design Groups
- staff Communication – City Council, CCG, LPT and UHL. Newsletters – Primary Care, Your Leicester
- LLR Citizens Panel.
- Carers Got Talent
- Mental Health Partnership Board
- "Leicester Loudspeaker Advocacy Group / Forum Supporting those with lived experience (MH)"
- Dementia Programme Board
- LLR Autism Partnership Board
- Learning Disability Partnership Board
- We Think (learning disability advocacy group)
- Parent Carer Forum
- Big Mouth Forum (CYP with Disabilities)
- CLASS – City of Leicester
- Early Years Network
- South Asian Health Action (Leicester City)"
- "Ashioma Consults (African Caribbean Community)"
- "Carers Centre"
- "Council of Faiths"
- "Equality Action (Leicestershire)"
- "Duale Consultancy - Hashim Duale MBE"
- "British Deaf Association"
- "LGBT Centre "
- "Project Polska"
- "Shama Women's Centre"
- "Somali Development Services"
- VAL
- Adhar Project
- The Race Equality Centre
- "YMCA"
- Youth Education Project Ltd
- Leicester Centre for Integrated Living
- Parent Carer Forum Support
- Healthwatch Leicester & Leicestershire
- ENRYCH
- RNIB
- Turning Point
- Richmond Fellowship
- ADHD Solution
- Age UK
- Inclusion Healthcare
- Centre Project

2. HWB Development Day 171122

The HWB Said	What we are doing
• Develop outcomes narrative linked to the Delivery Priorities to inform sponsorship	• Outcome Statements developed for priorities and Comms and Engagement included on its own
• Reflect Communications and Engagement as a standalone priority	• ICB Comms/Engagement leads working on Strategic narrative/actions focus for Leicester
• Suggest plus groups focus for Leicester including indication of actions where this group could be supported	• Initial focus on SMI, LD and Homelessness due to life expectancy and high degree of intersectionality and fundamental inequality across all these groups
• Consider reporting going forward	• Mapping of existing reporting
• Continue to develop DAP	• Engage with stakeholders / further refine DAP

2. HWB Development Day 171122 – Follow Up

Communications and Engagement

- Extensive communications and engagement activity in Leicester City has taken place across the ICS over the years.

- This information has been mapped across each priority in the delivery plan (currently for the ICB and Healthwatch)

- Ongoing communication and engagement with communities across the city is an ongoing key priority for LLR ICS (particularly in health) and there is a lot of activity already in progress

- However, not all areas are covered that will need to be to achieve what is in the delivery plan.

2. HWB Development Day 171122 – Follow Up

Communications and Engagement

Actions

1. Research existing communications and engagement projects, campaigns and insights across the ICS
- *ICB/CCGs and Healthwatch has already been completed*

2. Examine gaps against the Leicester City Delivery Plan priorities:
- Where are the gaps in our insight?
- What communications and/or engagement needs to be done?

3. Agree our approach:
- Can we use existing mechanisms?
- What is the purpose/what can be influenced and what is the timeline?
- Who is best placed to conduct the communication/engagement?
- Map stakeholders across the ICS
- Can we utilise the Voluntary, community and social enterprise sector through the VCSE Alliance?
- Agree evaluation and analysis process
- Record and capture new insights

3. All Priorities

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 Encouraging people to make sustainable and healthy lifestyle choices	9. We will take action to reduce levels of unhealthy weight across all ages.
	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 to support self-care, build on strengths and reduce frailty.
	18. We will promote independent living, so that older people can live in their own homes and communities.
	19. We will reduce the number of falls for people aged 65+ in Leicester.

3. “Do” Priorities

Added Following HWB Development Day 171122

Theme	Delivery Priorities		Outcome Statements	
HEALTHY PLACES Making Leicester the healthiest possible environment in which to live & work	We will improve access to primary and community health/ care services	**INVOLVE OUR PEOPLE** We will co-ordinate partnership communications and engagement to include appropriate opportunities for Co-Design/ Co-Production through harnessing local populations and using community assets with support from the local VCSE	Clearly understood local services and multi-disciplinary staff teams working closely to focus on need in their neighbourhood	All people to receive consistent messages about planned transformation and have appropriate opportunities for local communities and/or populations to contribute to delivery of actions that affect them
HEALTHY MINDS Promoting positive mental health within Leicester across the life course	We will improve access for children & young people to Mental Health & emotional wellbeing services.		A whole person CYP approach with closer collaboration with schools, social services, family hubs etc with a focus on prevention	
	We will improve access to primary &neighbourhood leve Mental Health services for adults.		Increased and expanded Mental Health resources at a Neighbourhood level reflective of local need with people getting support that builds on their strengths, wishes and personalities.	
HEALTHY START Giving Leicester’s children the best start in life.	We will mitigate against the impacts of poverty on children and young people.		Provide funding opportunities to ensure services and support are available for those who need it most	
HEALTHY LIVES Encouraging people to make sustainable and healthy lifestyle choices	We will increase early detection of heart & lung diseases and Cancer in adults.		Reduced premature mortality, with an average increase in Life Expectancy at age 65 in the top 20% deprived areas in Leicester	
HEALTHY AGEING Enabling Leicester’s residents to age comfortably & confidently	We will enable Leicester’s residents to age comfortably and confidently through a person-centred programme to support self-care, build on strengths and reduce frailty.		An increase in the number of older people who are able to remain living independently in their own homes, with a reduction in the numbers of people requiring long term residential care	

3. Guiding Principles (all of equal importance and to be applied where possible/appropriate when developing delivery plan)

1. Help reduce health inequalities (key focus on Core20Plus5)	1a. Multi-agency/partnership working	1b. Strengthen collaborative/ integrated working between organisations/services	1c. Proportionate universalism
*Building upon LLR HI framework with **targeted interventions for the most deprived 20%** noting deprivation prevalence in the City. Early intervention on the primary determinants of Ill health – not necessarily starting with services by default.*	*Continue **Strategic** partnership approach to collectively plan and commission care and services across the City Place*	*Ensure continued cohesive and coordinated approach at an **Operational** level*	*Allocate healthcare resources on a sliding scale; based on deprivation and need, with those with the **greatest need provided with a greater share of resources**.*

2. Improve equity of access (and experience) to services	3. Address unwarranted variation within the city and/or against the England average	4. Communicating and Engaging with people on the actions	5. Involvement of the voluntary community sectors and communities
*Actions will be grounded in our collective efforts to address the **inverse care law**. "Peddle fastest for those in greatest need."*	*Key to driving change and demonstrating **tangible improvements in outcomes**.*	*Building upon success of vaccination programme, harnessing community power and supporting **citizen empowerment** and education (health literacy). Exploring elements of plan which could be co-designed and re-reviewed where possible and appropriate.*	*Drawing upon **expertise and experience of VCSE** to support principle 4, utilising co-design and co-production methodology.*

4. Plus Groups - Recommendation

Objectives:

1) Identify populations experiencing inequality in health and care provision and/or outcomes

2) Implement actions to tackle the unmet needs of chosen focus populations through flexing our universal offers we have in place and developing a structured programme of actions to reflect these populations unmet needs (**in the context of Delivery Priorities**)

4. Plus Groups - Recommendation

Existing PLUS Groups for consideration

Learning Disabilities

Homelessness

Severe Mental Illness (SMI)

Asylum Seekers

Ethnic Minorities

Traveller Communities

Intersectionality

Limited English-speaking populations

Revised PLUS Groups for Focus in Initial Years (Subject to Review)

Learning Disabilities

Homelessness

Severe Mental Illness (SMI)

Asylum Seekers

Communications and Engagement needs of this group would need to be captured. We can review the focus of this group in future using insights from local updated health needs assessments and in the meantime there are some basic things like registration with GP would be impactful

Ethnic Minorities

*This group is captured to a degree given the focus on deprivation/ wider determinants and other targeted actions planned with communities of Leicester. In addition the Census has highlighted that this group is now the majority and therefore further supports that these groups **should already be captured** through delivery actions.*

Intersectionality

Importance considered in everything that we do, meaning some individuals will be more likely to have poorer health outcomes due to their unique circumstances.

Limited English Speaking Population

As part of our broad communications and engagement plan we will need to take into account the needs of this group across all priorities

4. Plus Groups - Rational

- The rational is that **Learning Disabilities, Homelessness and Severe Mental Illness (SMI)** groups have the largest gap (and therefore the worst) in Life Expectancy against the LLR and England averages
- These groups are all fundamentally disadvantaged through inequalities in Leicester
- In addition to the Health Inequalities these groups suffer, these groups all also suffer Health Inequities around – Access, Experience and Outcomes
- These groups have the poorest health outcomes of the groups identified and intersectionality is likely to be a key added factor within this
- Work is underway to engage stakeholders and to review the current priority actions to understand where these groups have unmet needs to inform specific focus

4. Plus Groups – Other Groups

Work continues across the partnership with these other identified groups as part of our daily work:

Asylum Seekers

Communications and Engagement needs of this group would need to be captured. We can review the focus of this group in future using insights from local updated health needs assessments and in the meantime there are some basic things like registration with GP would be impactful

Ethnic Minorities

*This group is captured to a degree given the focus on deprivation/ wider determinants and other targeted actions planned with communities of Leicester. In addition the Census has highlighted that this group is now the majority and therefore further supports that these groups **should already be captured** through delivery actions.*

Intersectionality

Importance considered in everything that we do, meaning some individuals will be more likely to have poorer health outcomes due to their unique circumstances.

Limited English Speaking Population

As part of our broad communications and engagement plan we will need to take into account the needs of this group across all priorities

5. Structure of Delivery Plan

Theme: Healthy Places

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

Ref	WE WILL	Delivery Stage	How will this demonstrate improvement ?	No	Key Activities / Deliverables / Milestones	Will activities improve/increase equity at a local level? (Y/N)	Resources Y/N (Source)	Planned Engagement	Delivery Governance	Timescale	Lead Contacts	Overall RAG Status	Status Change from Last Period	Risk /Issue RAG	Improvement Trajectory RAG
Ref	We will statement of key actions identified to progress priority	Where is the action in relation to: Started, Feasibility Delivery, Evaluation Complete	As per guiding principle 1 and 2, how does this action enable improvement in equity	Activity Ref	What are the key partnership activities that enable and underpin implement ation of the action and by when	As per guiding principle 1 and 2, does this action enable improvement in equity – initial assurance for ongoing monitoring	Are there any identified resources that underpin delivery of the action	As per guiding principle 4 and 5, how are we engaging with our communities in order to support implementation and delivery of actions.	Where does overall governance for delivery of this action sit, will be different for different actions	To ensure actions are SMART	To know which ley officers are leading across partners	Overall Status of Action to deliver against plan	Overall Status of Action previous reporting period	Highest rated risk/issue RAG	Is there evidence of improvement against planned trajectory RAG

5. Structure of Delivery Plan (Public Microsite)

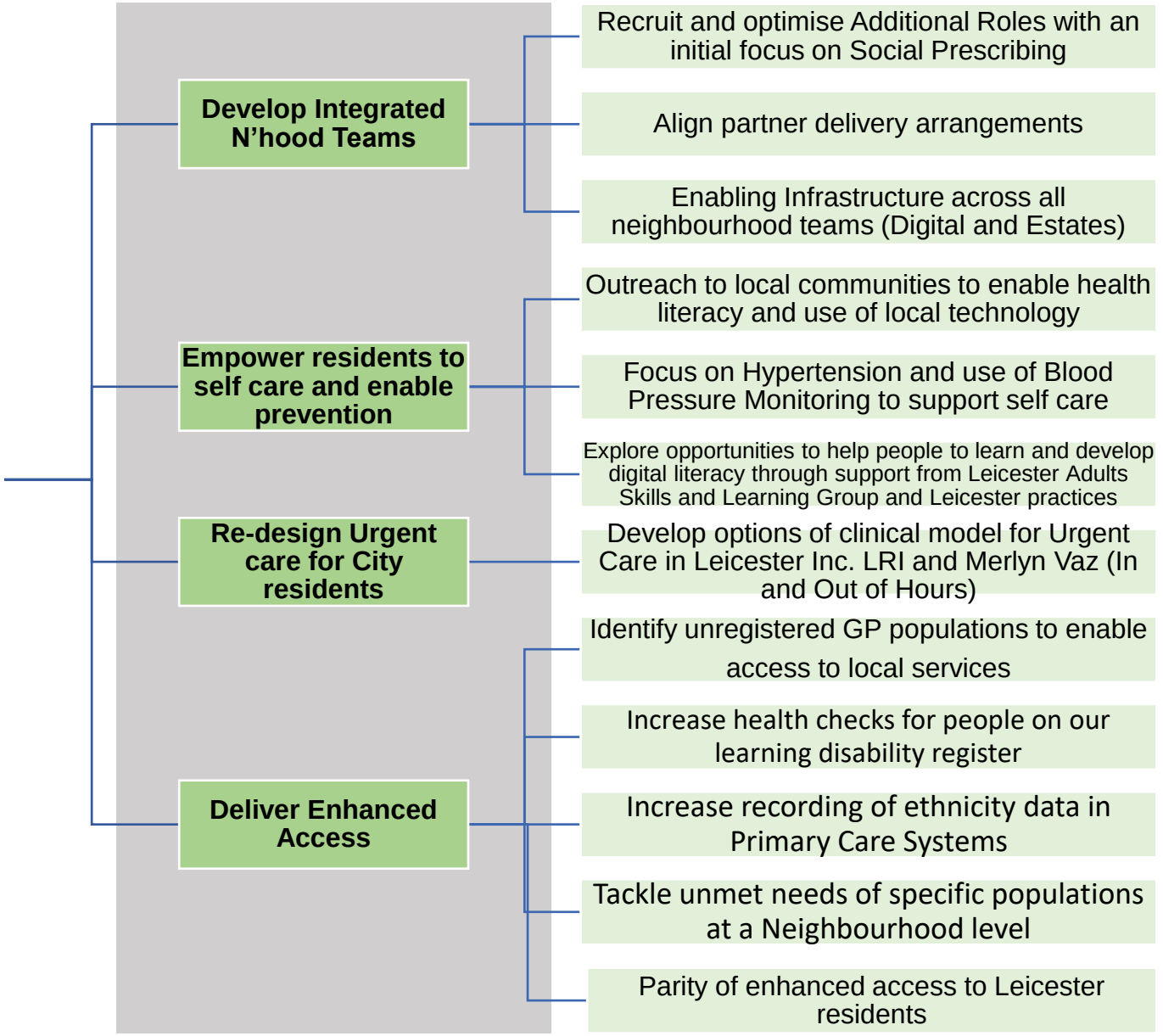
Healthy Places: We will improve access to primary and community health and care services

AMBITION	WE WILL	BY	I WILL
HEALTHY PLACES To make Leicester the healthiest possible environment in which to live and work	**1. Develop integrated neighbourhood teams that work in a coordinated way with partners at a local level improving Primary Care**	Develop an agreed approach with our partners to align local integrated delivery models (INTs) with Primary Care in the community	I will receive the right support at the right time, at the right place from the right professional (s) to meet my health and care needs
		Recruit Additional Roles in Primary Care and develop these to optimise access for people in most need	
		Develop and optimise the use of Social Prescribing and other ARRS workforce in Leicester	
		Put in place the appropriate infrastructure and support for all neighbourhood teams through clinical and estate strategies for each PCN in Leicester and availability of Digital kit and digital services	
		Roll out carer awareness training to staff working in INT's to ensure carers are identified, registered with GP's and signposted to sources of support	
	2. Enabling people to improve their literacy of local technology solutions	Explore and scope future opportunities to help people to learn and develop digital literacy through support from Leicester Adults Skills and Learning Group and Leicester practices	I will have the opportunity to use Digital technology equipment and services that are being locally offered to enable me to stay healthy and well
		Develop an Outreach approach to local communities to enable Digital Fluency/Literacy and Health literacy in using Health Technology (BPM for Hypertension)	
		Develop resources Inc. Short videos in various languages to educate patient's around active sign posting and one stop shop approach	
		Run workshops/seminars to train communities such as the VCSE, community champions, social prescribers and Carers to learn about pathways and associated technology (Focus on Hypertension, Blood Pressure Monitoring and NHS App)	
	3. Deliver enhanced access in Primary Care	Increase health checks for people on our learning disability register	I will have the opportunity to receive the Health and Care that I need when I need it so that I can stay healthy and well
		Increase recording of ethnicity data in Primary Care Systems	
		Tackle unmet needs of specific populations at a Neighbourhood level	
		Identify further cohorts of unregistered residents (Inc. family Carers) of Leicester and enable their registration with local GPs (Is there any localities) - Belgrave and Highfields	
		Ensure parity of access to services 6:30pm – 8:30pm and 9-5 Sat through each PCN delivering , we will feedback the findings of this into the development of INTs	
	4. Undertake a review of our current urgent care services for people in Leicester with minor injuries and illnesses	Review and define options of clinical model of Urgent Care at LRI and Merlyn Vaz (In and Out of Hours)	I will have access to the Urgent Care services I need to enable me to stay out of hospital and remain in the community
		Develop and seek agreement of Business Case with options for all LLR UTCs	
		Agreed Operational commissioning of LLR UEC services including offer at Merlyn Vaz and Leicester Royal Infirmary	

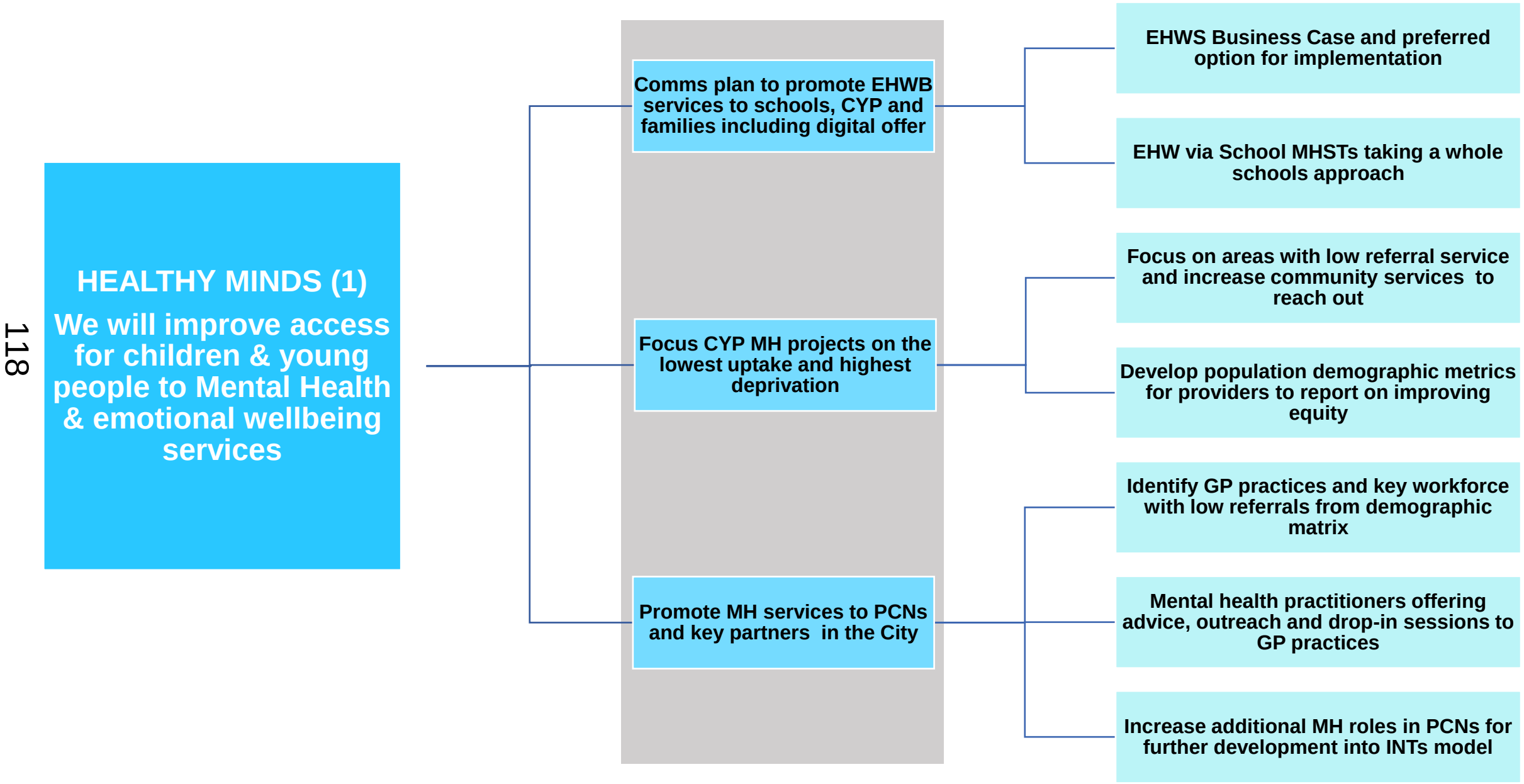
6. Summary of Key Actions

HEALTHY PLACES

We will improve access to primary and community health/ care services



6. Summary of Key Actions



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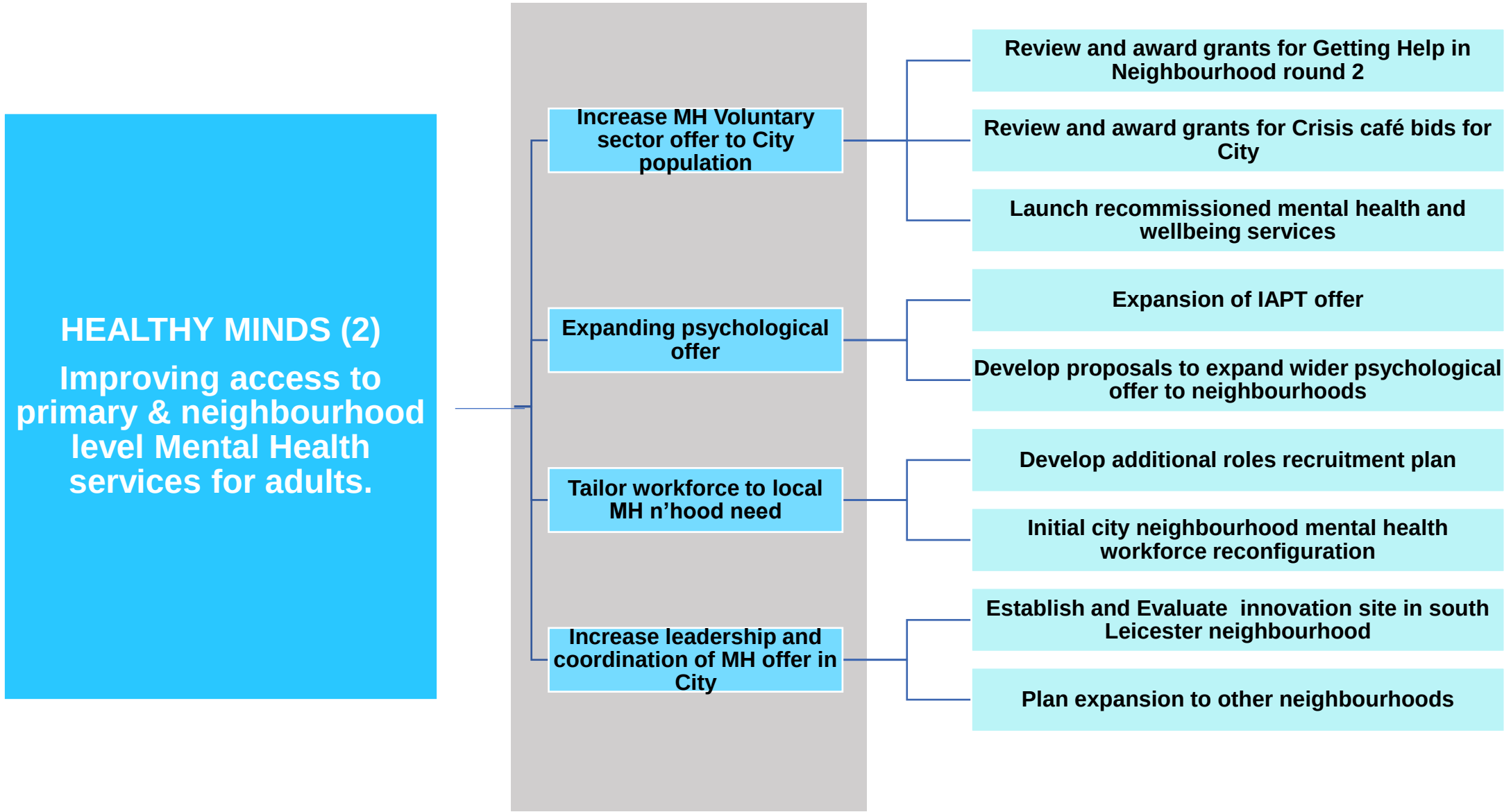

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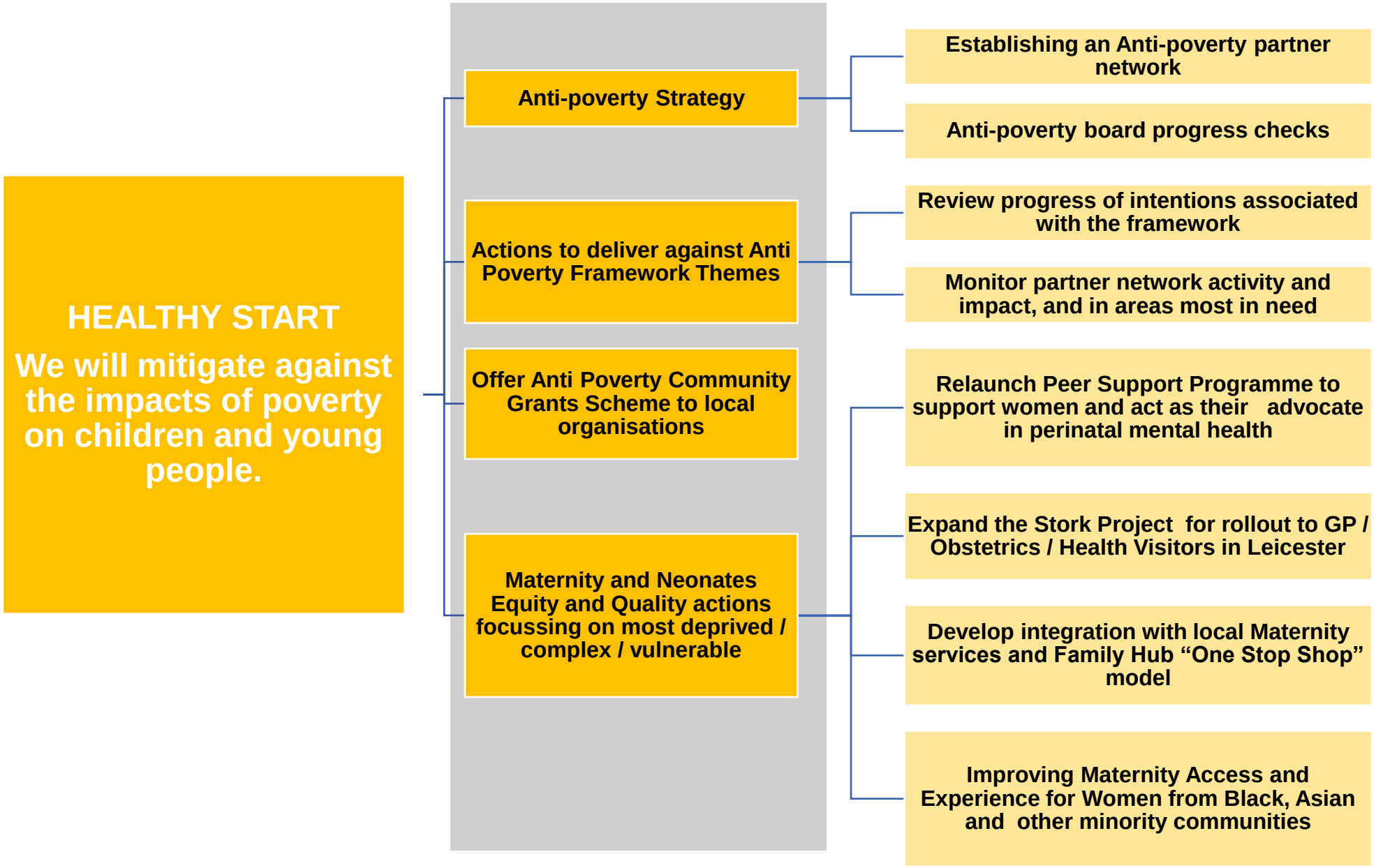
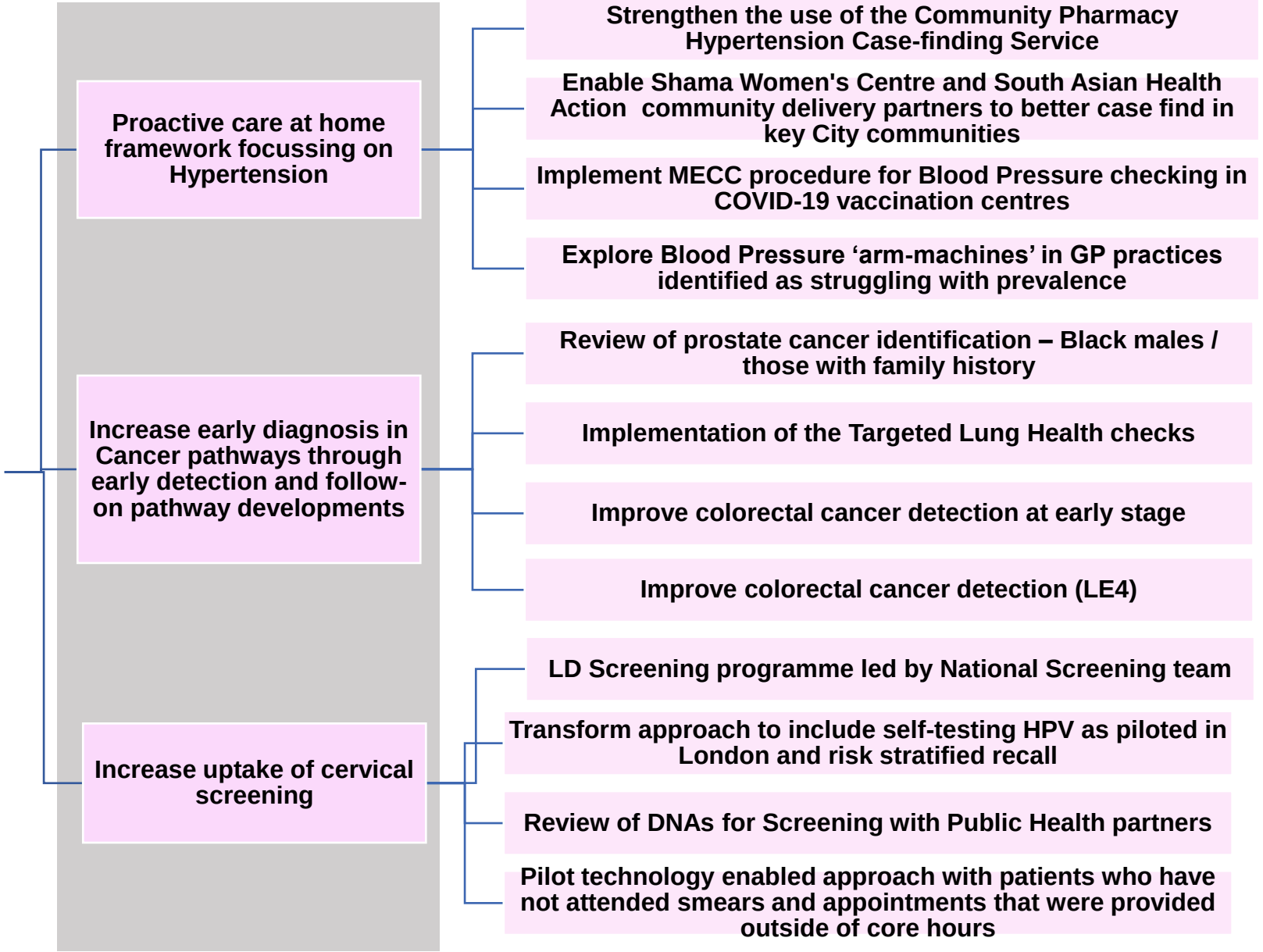


6. Summary of Key Actions

HEALTHY LIVES

We will increase early detection of heart & lung diseases and Cancer in adults



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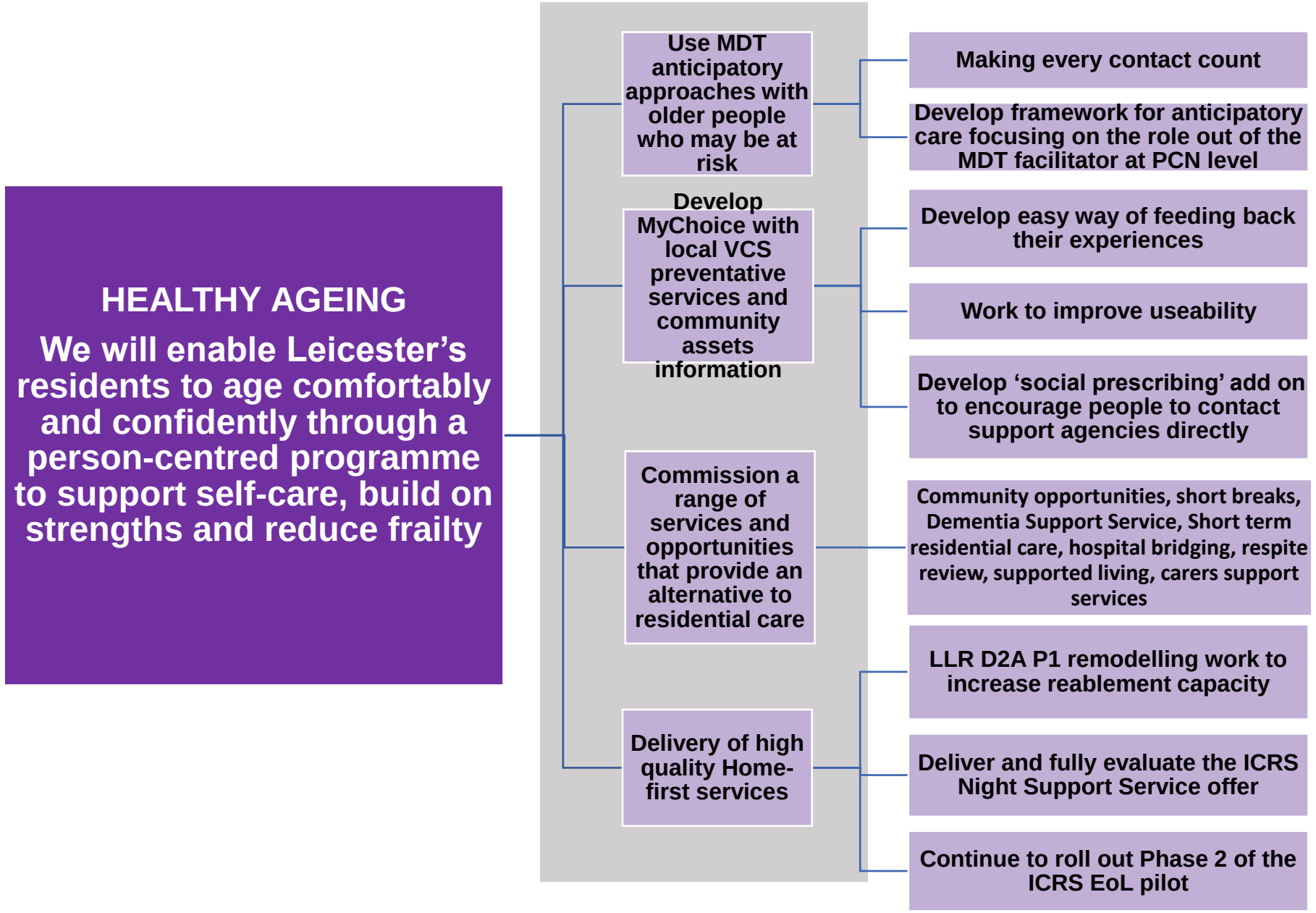


LEICESTER CITY HEALTH AND WELLBEING BOARD
26 January 2023

Subject:	Children and Young People in the Considerations of the Health & Wellbeing Board
Presented to the Health and Wellbeing Board by:	Martin Samuels, Strategic Director for Social Care & Education, Leicester City Council
Author:	Martin Samuels

EXECUTIVE SUMMARY:

Given the pressures on the NHS and on Adult Social Care, it would be easy for discussions at the Health & Wellbeing Board, and the various groups and forums that report to it, to become focused on the needs and issues affecting adults, and of older people in particular. Given that Leicester is one of the most youthful cities in England, with 27% of our population aged 0-19 (the 8th highest of any LA area), this would run the risk of overlooking more than a quarter of the people living here.

Senior leaders for children's services from across the LLR system have therefore come together to form the Children & Young People's Collaborative. The new group has identified a number of key priorities for shared work in this area. The Collaborative and the priorities (set out in the attached report) were endorsed by the LLR Health & Wellbeing Partnership on 15 December 2022.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the establishment of the LLR CYP Collaborative
- Note the agreed priorities
- Consider how the Leicester HWB can ensure that these priorities are reflected in its wider work programme, and that issues affecting children and young people are considered when taking forward other aspects of that work programme

Sub Regional health and wellbeing priorities for children

Report by the LLR Statutory Directors of Children's Services

Director of Children and Family Services, Leicestershire County Council

Strategic Director, Social Care and Education, Leicester City Council

Strategic Director Children and Families, Rutland County Council

Introduction

The following report highlights the key health and wellbeing priorities for children and young people across Leicester, Leicestershire and Rutland as a whole:-

- Prevention
- Mental Health
- Special Educational Needs and Disabilities

The report also sets out proposed governance arrangements for the LLR Children's System.

Recommendations

The Board is asked to:

- Note and comment on the key priorities for children and young people
- Note and support the proposed governance arrangements

Priority Areas

There is clear evidence that the full spectrum of more intensive services for children and young people across LLR are seeing a significant increase in demand, whether in the form of requests for Education, Health, and Care Plans (EHCPs), referrals for Children in Need of social care or mental health support, or urgent and emergency care. This appears to be driven by a combination of factors associated with the social and psychological impact of lockdown, the cost-of-living crisis, and the withdrawal of some services during the pandemic with the resulting deterioration in individuals' condition.

Not only does this represent a significant impact on the LLR population in terms of poor life experience and the potential for ongoing dependence on services, the increase in demand is pushing many of these services to the brink in terms of their capacity, while the associated costs are threatening the financial stability of all partners across the health and care system.

In these circumstances, the three DCSs believe that there is a powerful argument for shared action across the LLR system to address these issues in a coordinated manner. Although they are expressed in different ways in each of the three Places, our view is that the issues themselves are common across the whole of LLR. Based on our analysis of the position, and having regard to the emerging LLR Health & Wellbeing Strategy, it is suggested that there are three priority areas for shared action: prevention, mental health, and SEND.

Prevention

Why is this a priority?

Preventing children and young people from reaching the stage where they need health and social care specialist services is a key priority to reduce demand in the system. The three levels of prevention, from universal to tertiary, are all critically important to improving children and young people health and wellbeing outcomes. Responding to the needs of children and young people earlier will enable them to be resilient and will thereby reduce the need for more costly interventions in health and social care (including SEND) in the future.

The pandemic has exacerbated the need or highlighted further where targeted support is needed. The trauma experienced by young people has increased, resulting in increased anxiety, low mood and low self-esteem.

What are the opportunities?

- A Population Health management approach to children and young people offers coherence across the range of initiatives
- Dental services are lacking, with a need for more NHS dental capacity which could impact on future oral health, which in turn has significant impact on wider health and wellbeing
- Trauma Informed Practice weaved into all services
- More access to existing services, such as CAMHS
- Services to support children with eating disorders
- Special school nursing services
- Integration of services and resources to support children and young people at a preventive stage – exploration of a 'Better Care Fund for Children'
- 'Whole family' approaches across the partnership
- Specific focus on areas where children and young people require a multi-agency input where there is no single agency currently responsible (e.g tier 4 step downs)

Emotional Wellbeing and Mental Health

In the last three years, the likelihood of young people having a mental health problem has increased by 50% (Mental Health of Children and Young Peoples in England, 2020, NHS Digital, 22.10.20). 52% of 17- to 23-year-olds have experienced a deterioration in mental health in the last five years (First Port of Call, The Children's Society, 18 June 2021). 1 in 6 children aged 5-16 are likely to have a mental health problem (Mental Health of Children and Young People in England, 2020, NHS Digital, 22.10.20)

We know that the children we work with are more likely to experience trauma and therefore more likely to experience associated issues, such as Mental Health issues, which can have a detrimental effect on their development, wellbeing and outcomes.

Learning from recent case reviews in 2017 -2018 and from analysis by the Child Death Overview process (CDOP) has highlighted the incidence of self-harm and suicide in teenagers with identification of a number of risk factors.

Self-harm is a common behaviour in children and young people, affecting around one in 12 Peoples, with 10% of 15-16 year olds self-harming at any time (Young Minds, 2018). Published prevalence data of adolescents in England found that 15% had self-harmed at some point (Morey et al, 2017) and that the average age of starting self-harm was 13yrs (Gillies et al,2018)

Toxic stress can damage brain architecture and increase the likelihood that significant mental health problems will emerge either quickly or years later. Because of its enduring effects on brain development and other organ systems, toxic stress can impair school

readiness, academic achievement, and both physical and mental health throughout the lifespan. Circumstances associated with family stress, such as persistent poverty, may elevate the risk of serious mental health problems. Young children who experience recurrent abuse or chronic neglect, domestic violence, or parental mental health or substance abuse problems are particularly vulnerable.

Even when children have been removed from traumatising circumstances and placed in exceptionally nurturing homes, developmental improvements are often accompanied by continuing problems in self-regulation, emotional adaptability, relating to others, and self-understanding. When children overcome these burdens, they have typically been the beneficiaries of exceptional efforts on the part of supportive adults. These findings underscore the importance of prevention and timely intervention in circumstances that put young children at serious psychological risk.

It is essential to treat young children's mental health problems within the context of their families, homes, and communities. The emotional well-being of young children is directly tied to the functioning of their caregivers and the families in which they live. When these relationships are abusive, threatening, chronically neglectful, or otherwise psychologically harmful, they are a potent risk factor for the development of early mental health problems. In contrast, when relationships are reliably responsive and supportive, they can actually buffer young children from the adverse effects of other stressors. Therefore, reducing the stressors affecting children requires addressing the stresses on their families.

What are the opportunities?

- Development of a whole system approach to Children's Mental Health services that is adequately resourced.
- Better transition from CAMHS to adult Mental Health services.
- Development of a 0-25 CAMHS offer for care experienced children and young people to prevent impact of poor transition and limited trauma informed responses and intervention from adult services.
- An understanding of the needs of the cohort who were with CAMHS, but who are not eligible for a transition to adult Mental Health Services, and whether there is a gap in provision here too.

Special Educational Needs and Disabilities.

Why is this a priority?

Children with SEN or a Disability are amongst the most vulnerable children in our communities and often have additional physical or mental health needs. Special Educational Needs requires a multiagency response in order to ensure early targeted support for children. In the post-covid period there can be particular issues around anxiety and mental health. There are also rising numbers of children on the Neuro-developmental Pathway or with a diagnosis of autism. Post covid there appears to be a significant increase both in the number of requests for an EHCP and in the number of early years children requiring EHC Needs Assessment and special school provision.

There is an increased challenge around school refusal, children missing education and requests for elective education or packages of support outside of the mainstream system. Many of these children have health needs that mean they are unable to access education without support.

What are the opportunities?

- Support for children on the Neurodevelopmental Pathway, including pre-diagnosis, diagnosis and post diagnosis.
- Joint commissioning arrangements for children with complex needs
- Sufficient Designated Clinical Officer (DCO) capacity in Health. Capacity is needed to continue to attend key decision-making panels and to provide expert health advice at Tribunals, including where child not meeting threshold for Health input but parents presenting private health reports that require informed challenge or input.
- Joint working through the LLR SEND Joint Commissioning Strategy.
- Pooled resources and budgets to meet the needs of children with SEND

Impact

Some impacts will only become clear some years into the future. To measure shorter-term changes, we will use data, wherever possible, that is already regularly collated. Broad impacts to be expected include:

- Understanding of the gaps in service for children and young people helps to inform the design of future services and how these will be funded.
- Adverse Childhood Experiences have less impact on children and families - through prevention and support to manage/recover – thereby reducing demand for acute services.
- Family Hubs operating 0 to 19 (25 yrs. SEND), seamless and integrated services for families in place and well used. Families and professionals are clear on what is available from the 'start for life' offer, what this is for and how it can be accessed.
- Improved dental care access for children and young people, thereby reducing longer-term health problems
- Children with additional or special educational needs are better supported with responses that are tailored to them. This includes robust joint commissioning arrangements. This will reduce the likelihood of crises and the intensive provision this often then demands
- Children with SEND are having their health checks in a timely fashion, reducing the emergence of more serious health conditions.
- More families and young Peoples find it easier to get the mental health support they need and in a more timely fashion, reducing the need for higher cost specialist services.
- Local services for mental health are clearly defined, well understood, timely and delivered closer to home where possible.

Governance

In order to drive the work for children and young peopl across the system it is proposed that a monthly Children and Young Peoples Collaborative is established. The Children and Young Peoples Collaborative will promote joint and integrated working between partner organisations at a strategic system level.

This system wide collaborative is important as we know there are a plethora of ‘Place’ level groups for children and young Peoples services but very little at strategic system level. We feel that the Children and Young Peoples Collaborative would fill this gap, clearly having a relationship with the existing LLR CYP design group and the three Place children’s partnerships.

The Children and Young Peoples Collaborative will report into the ICP and will receive reports from the CYP Design Group (and others as necessary) on progress against the identified priorities and provide strategic direction where necessary.

In order to meet its objectives, it is vital that the Children and Young Peoples Collaborative has suitably senior representatives with decision making powers and ability to wholly represent their 'home' organisations.

We will also need to consider children and young people's voice and how this influences and is used effectively in plans.

Appendix 1 – Children and Young Peoples Collaborative Terms of Reference

Terms of Reference – Children and Young Peoples Collaborative

The CYP Collaborative will promote joint and integrated working between partner organisations and work at a strategic system level. It will have a relationship with the existing LLR CYP design group and the three Place children's partnerships.

The CYP Collaborative will receive a report from the CYP Design Group (and others as necessary) on progress against the identified priorities and provide strategic direction where necessary.

Purpose

- Provide strategic direction on CYP priorities identified as being of shared interest across the LLR system (the 'Integrated Care System') by the LLR Health & Wellbeing Partnership (the 'Integrated Care Partnership'), recognising the statutory leadership role of Local Authority Directors of Children's Services in respect of all matters affecting CYP
- Review strategic priorities, taking into account reports from independent regulators (e.g. CQC and Ofsted) and other key bodies
- Consider the relationship of work to address the agreed LLR system-wide priorities with work being undertaken in each of the LA-based Place health & wellbeing strategies, and vice versa
- Promote joint and integrated working between the partner organisations, with a particular focus on joint commissioning on an LLR basis between the three LAs and the NHS ICB and between the LAs and the emerging NHS mental health provider collaborative
- Consider CYP health and care investment/disinvestment plans and their impact on strategic priorities, giving guidance and direction
- Resolve issues escalated from relevant sub-groups
- Provide a route for further escalation of issues and risks to the LLR Health & Wellbeing Partnership, or other forums as may be appropriate, if issues cannot be resolved
- Consider and provide oversight for a potential pooled budget, in the form of a 'Better Care Fund for Children'

Scope

The group will be responsible for the strategic direction of ICS system services for children and young people across LLR aged 0-19 years. This will be extended to the 0-25 age group for certain areas of work (e.g. the SEND agenda).

The main focus of the group will be on those issues relating to CYP that have been identified as being of shared priority and importance across the NHS and Local Authorities. The group may seek updates and reports on other services and issues that have an impact on CYP, and may make recommendations to other services from that perspective.

Membership and Chairing

The group will be chaired by one of the LA Directors of Children's Services and membership will comprise:

Role	Organisation
NHS	
Executive Lead for Children & Young People (delegated to Deputy Chief Nursing Officer)	NHS LLR ICB
Executive Director of FYPC & LD	Leicestershire Partnership NHS Trust – Helen Thompson
Chief Nurse (delegated to Deputy Chief Nurse)	UHL
Local Government	
Strategic Director, Social Care & Education	Leicester City Council
Director of Children and Family Services	Leicestershire County Council
Director of Children and Family Services	Rutland County Council
Director of Public Health	Leicestershire County Council and Rutland County Council
Director of Public Health	Leicester City Council
OTHER	
NHSE Regional Lead – may be invited to attend for specific agenda items	

Other relevant colleagues may be asked to join the group as advisory members or attend for specific agenda items. A balance will need to be struck between making the group inclusive and ensuring it remains small enough to be effective. Engagement of young people, to ensure that their voice had audience and impact, is recognised as being essential. Rather than risk tokenism through limited membership of the group, the voice of young people will be actively sought by each of the partners.

The group will not be a decision-making body and has no powers to take binding decisions. Agreements will be sought through consensus, with members taking any necessary formal decisions through the governance arrangements of their own organisations as may be required.

Reporting Responsibilities

The Chair will provide a regular update on progress to the ICP.

Reports will be submitted to each of the Health and Wellbeing Boards on a six-monthly basis. Members are responsible for reporting into their constituent bodies.

The CYP Design Group will have a dotted reporting line to the group, with the responsibility to report on any matters that may affect the strategic priorities agreed by the ICP and being taken forward by the Children and Young Peoples Collaborative. The Children and Young Peoples Collaborative may task the CYP Design Group with specific actions arising from its agreed priorities.

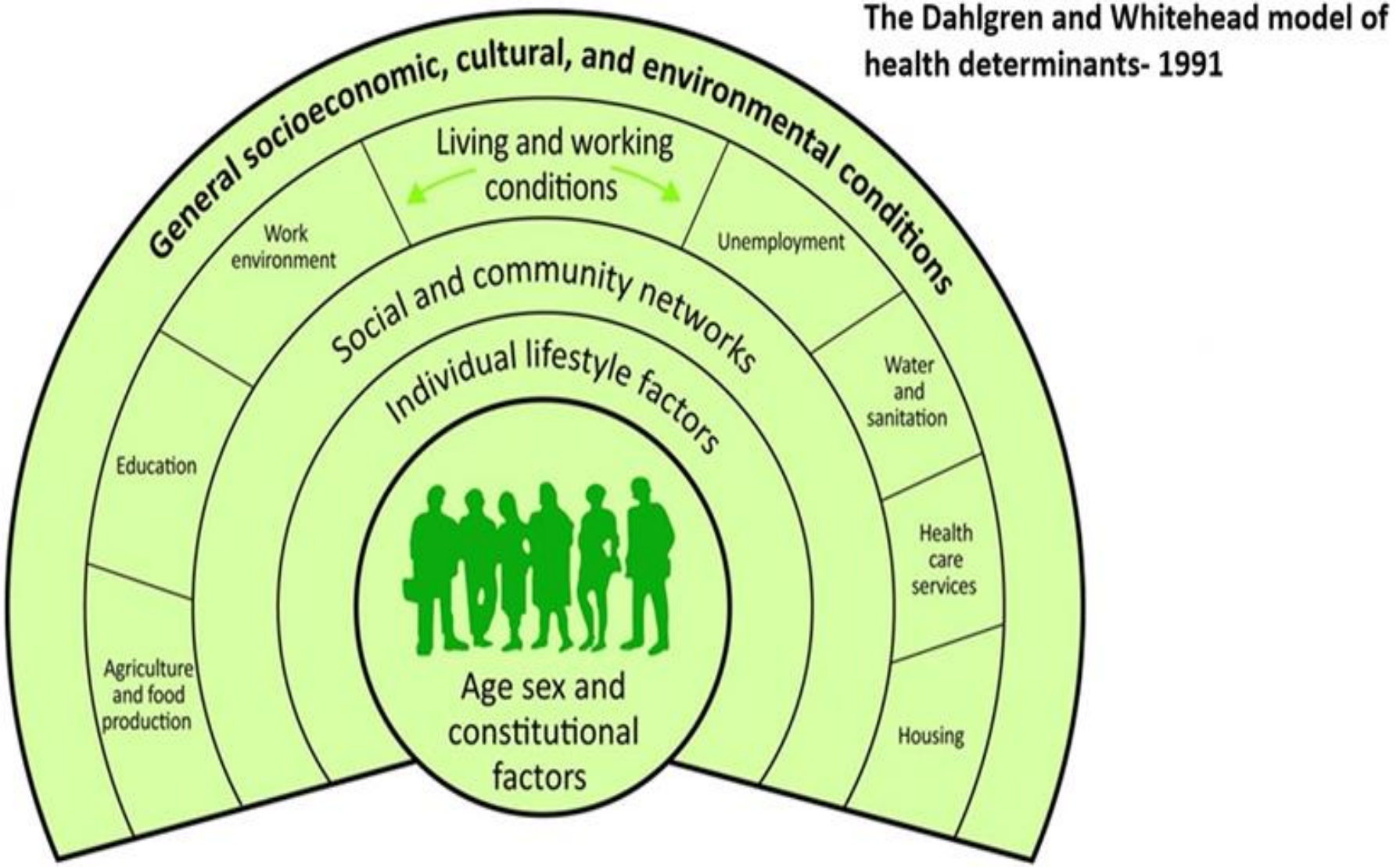
Health & Wellbeing Board Meeting the needs of Complex People

26th January 2023

APPENDIX E

Leicester City Council

The Impact of Housing on Health



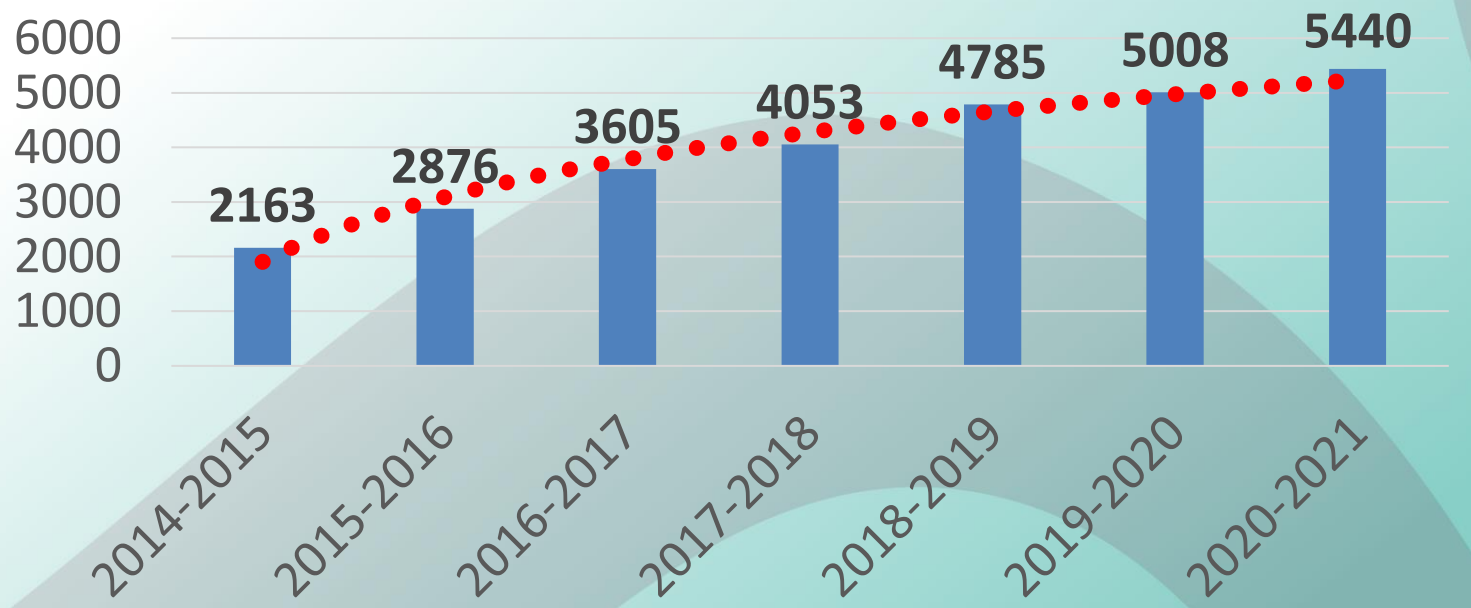
Housing Crisis?

- Increasing Homelessness
- Lack of suitable housing to meet changing and more complex needs
- The Health & Wellbeing of our Citizens is being affected
- Lack of Truly affordable housing

Leicester City Council

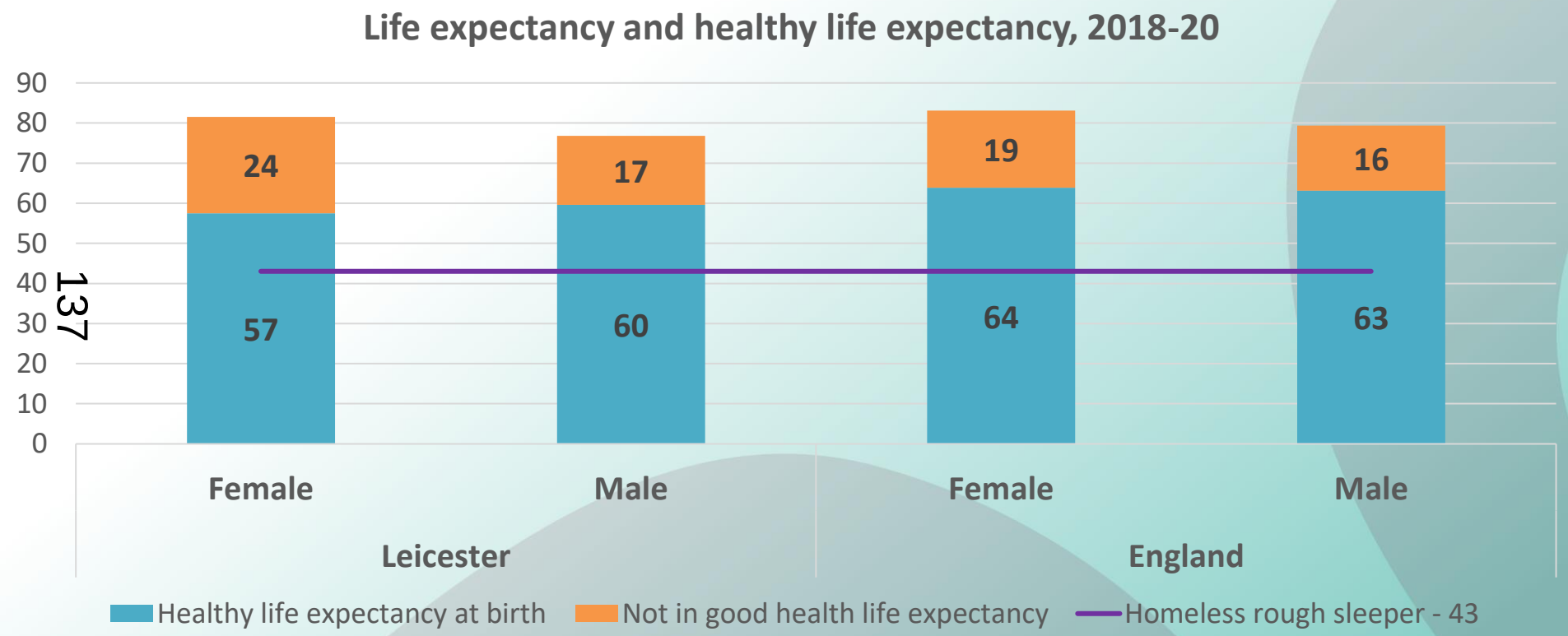
What is homelessness?

People can be homeless if they have nowhere to stay and are living on the streets, they can also be considered homeless even if they have a roof over their head



Leicester City Council

The Impact of Housing & Homelessness on life expectancy: the homeless population have a life expectancy of 43. On average men and women who are homeless at or around the time of their death live 31 years and 38 years fewer than the average.



Leicester City Council

Source: ONS Life Expectancy data 2018-20 , ONS deaths of homeless people 2018

The Impact of Housing & Homelessness on Health

- Homelessness has a detrimental impact on physical and mental health, and is one of the most damaging experiences that anyone can have.

- Homelessness is associated with tri-morbidity, this is a combination of physical ill health with mental illness and drug or alcohol misuse.

- Mental illness is a cause and a consequence of homelessness. 70% of homeless service users in England have mental health problems. Deliberate self-harm, including suicide, is 7 times higher than that of the general population.

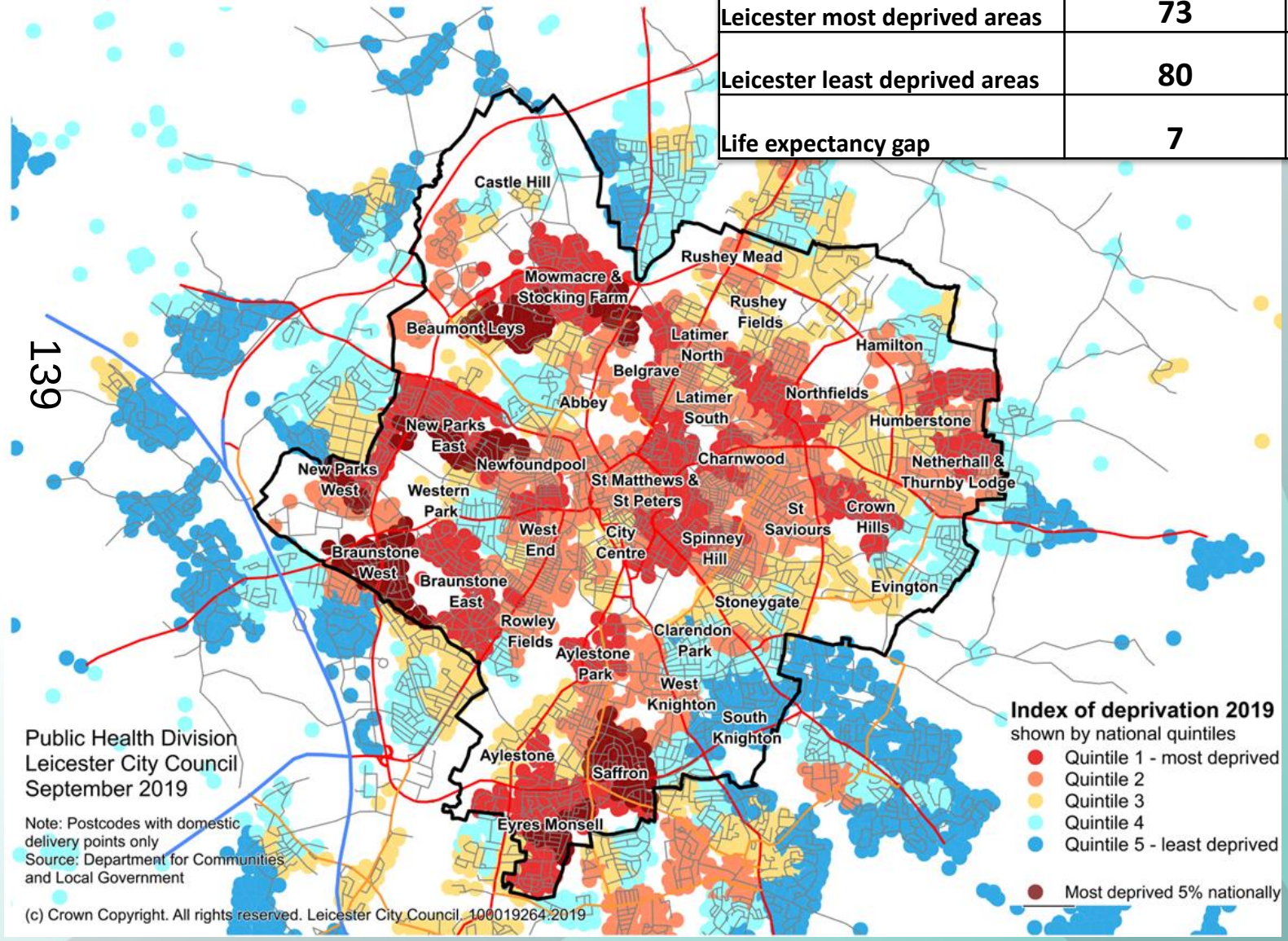
- Homeless people are over-represented attenders in A&E. A homeless drug user admitted to hospital is 7 times more likely to die over the next 5 years than a housed drug user with the same medical problem. Without early intervention homeless children and young people are likely to enter such a cycle.

- Nationally, unscheduled care costs of homeless people are 8 times that of the housed population. Many studies show that Accident and Emergency (A&E) departments are the first point of contact for many rough sleepers and the homeless population.

Leicester City Council

The Impact of deprivation on life expectancy: There are life expectancy differences between those living in the most and least deprived areas in Leicester.

Life expectancy 2018-20	Males	Females
Leicester most deprived areas	73	79
Leicester least deprived areas	80	85
Life expectancy gap	7	6



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Needs

Support need	% clients recorded as having this support need
Mental health problems	56.2%
Drug problems	32.0%
Alcohol problems	22.6%
Physical or sensory disability	14.2%
Learning disabilities	3.6%
People with HIV/AIDS	0.7%

(Based on over 800 clients provided with temporary accommodation between 2015 to 2022)

Leicester City Council

Case Study

- Woman with suspected serious mental health and alcohol issues
- Causing ASB to neighbours
- We have being trying to manage this situation for 2 years
- Mental Health Services won't work with her because she has not been referred by her GP
- She will not go to GP for referral, thinks she is okay, social services have assessed her as having capacity
- We don't want to take legal action as she is vulnerable and we don't want to make her homeless
- Tenancy Management and STAR have been working with her and finally managed to convince her to move, it has taken months to find her a suitable property despite a direct let being approved
- Meanwhiles other tenants in block are suffering and asking to move, preparing management cases for them takes more time and resources
- We have now finally identified a property for her and are working towards a positive outcome and still trying to get her to access mental health support
- Housing officer and support worker are providing mental health and ASC support

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What are Housing Doing

- Continue to prevent over 70% of those facing Homelessness ever becoming Homeless
- Lowest Council rents in the Country
- £200m invested in new Council Housing delivering with over 1100 new homes delivered and a plan being developed for over 1500 more Affordable homes
- Launched a new PRS Strategy and action plan to drive up standards
- Strengthened already robust Homelessness services with £5m invested in these each year , with Floating support in place for tenants and PRS 'No one needs to sleep rough'
- Secured over £10m of additional funding towards helping Complex people (Changing Futures, Rough Sleepers Drug & Alcohol, DV Respite Rooms, protect Pathway, Rough Sleepers Initiative, Homeless Prevention grant)

Leicester City Council

What are Housing Doing

- Developing a new Homelessness Strategy for 23-28 to continue to drive the service – and as part of this undertaking a Health Needs assessment for this group
- Developing new Housing options (Flora Lodge, Stepped accommodation, Trainer Accommodation, Supported Accommodation). Bidding to the £200m SHAPs pot for stepped accommodation.
- Reconfiguring the Dawn Centre as an assessment centre with extra space and developing this with a Multi Service Hub planned for 2023 with Physical, Mental Health, Turning Point, DWP,
- Invested over £9m in DFGs and adaptations to help people remain in their homes
- Due to develop an Adaptations strategy
- Launched an Overcrowding Strategy and action plan
- Announcing a Housing crisis with clear demands of Central government and Local Government
- Due to bid for the £300m Supported Housing funding pot as soon as opened

Leicester City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD
26th January 2022

Subject:	Roles and Responsibilities of Integrated Care Boards
Presented to the Health and Wellbeing Board by:	Sarah Prema, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board
Author:	Sarah Prema, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board

EXECUTIVE SUMMARY:

1. This paper sets out the roles and responsibilities of Integrated Care Boards which replaced Clinical Commissioning Groups from July 2022.

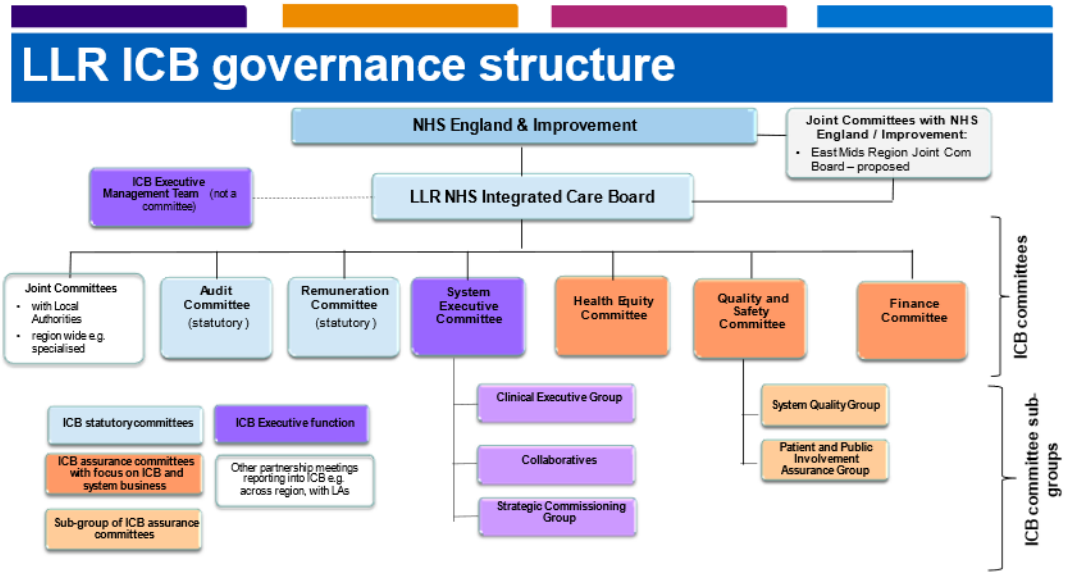
BACKGROUND

2. On the 1st July 2022 Integrated Care Boards were established. They replaced Clinical Commissioning Groups and have responsibility for arranging health care provision in their area. This includes:

   - Securing the provision of health services to meet the needs of the local population
   - Responsible for the co-ordination of the local NHS
   - Set strategic direction and responsibility for strategic planning across the local NHS
   - Bring together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population
   - Developing a plan to meet the health needs of the population within their defined geography
   - Taking on the commissioning functions of the clinical commissioning groups (CCGs)
   - Accountable for NHS spend and performance within their area
   - Developing a revenue and capital plan for their area
   - Being part of a wider partnership working to tackle population health and enhance health and care services

3. Integrated Care Boards are statutory organisations governed by a constitution with a Board made up of both NHS and Local Authority members. The constitution for the Leicester, Leicestershire and Rutland Integrated Care Board can be found at https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2022/10/2.-LLR-ICB-Constitution_20220519_V19_September-2022-APPROVED-Oct-2022.pdf

4. The Integrated Care Board is supported to discharge its duties by several committees and groups as set out in the following governance structure.



ROLES AND RESPONSIBILITIES OF AN INTEGRATED CARE BOARD

5. As well as the roles and responsibilities set out in paragraph 2 the ICB has several legal duties most of which have been transferred from the Clinical Commissioning Group. These are**:**

- To promote the NHS Constitution in securing health care services and awareness with patients, staff and public
- To be effective, efficient and economic
- To secure improvements in quality of services including continuous improvement in quality outcomes and effectiveness of services, safety and experience of services
- To reduce health inequalities across both access and outcomes
- Promote involvement of patients and their carers in decisions relating to prevention and diagnosis of illness and their care and treatment
- Promote patient choice with a view to enabling patients to make choices with respect to aspects of health services provided to them
- To obtain appropriate advice to enable effective discharge of responsibilities
- To promote innovation in the provision of health care services
- To promote research on matters relevant to the health service and the use in the health service of evidence obtained from research
- To promote education and training to support health service delivery
- To promote integration where it would improve the quality of services and or reduce inequalities in outcomes and access.
- Make decisions having regard to all likely effects of that decision in relation to the health and wellbeing of people; the quality of services provided to individuals; efficiency and sustainability in the use of resources
- To support relevant climate change legislation in the discharge of their duties.

6. In addition, Integrated Care Boards have a duty to involve and consult with their population. This requires that ICBs must make arrangements to secure that individuals to whom the services are being or may be provided are involved in:

   - The planning of the commissioning arrangements put in place by the ICB
   - In the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them
   - In decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decision would (if made) have such an impact.

ICB ROLE WITHIN AN INTEGRATED CARE SYSTEM

7. As well as the duties and responsibilities set out above the Integrated Care Board is part of a wider system (known as the Integrated Care System). The Integrated Care System has four key purposes:

   - Improving the population health and healthcare
   - Tackling unequal outcomes and access
   - Enhancing productivity and value for money
   - Helping the NHS to support broader social and economic development

8. The ICB has a responsibility to support the above four areas.

HEALTH AND WELLBEING PARTNERSHIP

9. As part of the legislative changes on the 1st of July 2022 the Leicester, Leicestershire and Rutland Health and Wellbeing Partnership was established as a statutory committee jointly formed by all the upper tier local authorities in LLR and the LLR Integrated Care Board. The partnership is co-chaired by the Chairs of the LLR Health and Wellbeing Boards and the Chair of the LLR ICB. Its membership if formed from health, local authorities and wider partners.

10. The primary purpose of the HWP is to support the development of a plan to address the health and wellbeing of the people in Leicester, Leicestershire and Rutland through enhanced integration.

11. As an ICB we have responsibility to contribute to the development of the Health and Wellbeing Partnership both as healthcare providers and commissioners but also how we can support the broader social and economic development.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

NOTE the content of the paper.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

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

EXECUTIVE SUMMARY:

The Health and Wellbeing Board has a statutory requirement to produce a Pharmaceutical Needs Assessments (PNA) every 3 years. This PNA was published on 1st October 2022.

The purpose of the Pharmaceutical Needs Assessment is to:

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

This PNA has reviewed pharmacy coverage in relation to the population health needs of the people of Leicester City. This has involved looking at the existing services, their locations, the range of services they are providing and the views of the people who are using them.

The PNA concluded there were sufficient pharmacies (85) within Leicester to serve the population of Leicester. However, pharmacies and the range of pharmacy services offered are not distributed evenly over the city, with more pharmacies located within the north central and eastern areas of the city. This means some residents will need to travel a little further to access a pharmacy or specific pharmaceutical service.

A short presentation will provide further information on the assessment, findings and recommendations.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the conclusions and recommendations
- Provide comment on areas identified for improvement.

Pharmaceutical Needs Assessment 2022

Leicester City

Leicester City Council

Introduction and Background

'Pharmaceutical' refers to the need for medicines or other health services including prevention and whether this is met by the arrangements with community pharmacies in Leicester.

Purpose of the Pharmaceutical Needs Assessment (PNA): to identify pharmaceutical services currently available and assess need for future services, inform planning and commissioning and inform decision making in response to new pharmacy applications made to NHS England & NHS Improvement (NHSE&I).

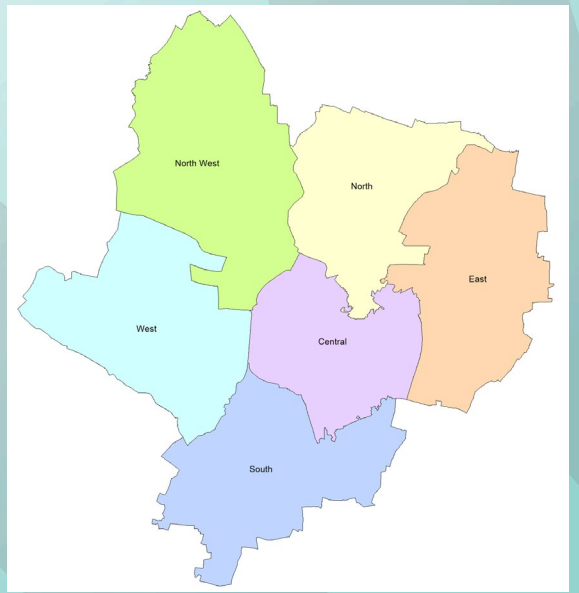
There is a statutory requirement to produce a PNA every 3 years

Involves looking at the existing pharmacies, their locations, the range of services they are providing and the views of the people who are using them.

The assessment covers essential, advanced, locally commissioned and national enhanced services in relation to the health needs of the local population.

Prison and hospital pharmacies are excluded from the scope of the PNA.

Service provision is considered across Leicester by six locality areas: Central, East, North, North West, South, West - consistent with those used in the Health and Wellbeing Survey 2018. Not everyone will choose their nearest pharmacy, however, by providing rates for smaller locality areas this helps to show variation in provision of services for local populations across the city.



Legislative Background

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating Pharmaceutical Needs Assessments (PNAs).

The regulations require that a series of statements be covered within the PNA:

Pharmaceutical services that the Health and Wellbeing Board has identified as

- necessary to meet the current need
- not provided but are needed to meet current or future need
- securing improvements or better access now or in the future

Other NHS services that affect pharmaceutical services

Other information to be included:

- Information on the demography of the area
- how the localities in its area have been determined
- how the different needs of the different localities and the different needs of those who share a protected characteristic have been taken into account
- whether there is sufficient choice with regard to obtaining pharmaceutical services
- the provision of pharmaceutical services in neighbouring Health and Wellbeing Board areas
- a map that identifies the premises at which pharmaceutical services are provided
- a report on the consultation

Surveys

Two surveys were conducted as part of the PNA process:

Pharmacy Contractor Questionnaire

- to gain a better understanding of the services Leicester pharmacies provide/intend to provide, the facilities they have available, the accessibility of their services, recruitment information and their view on the services offered in their area
- 31 (36%) out of 85 pharmacies in Leicester responded
- All respondents have a closed consultation area on the premises
- A range of accessibility facilities are provided across the respondents
- In addition to English, the most commonly reported languages spoken by pharmacy staff were Gujarati (87%), Punjabi (74%) and Urdu (48%).
- 87% of respondents report that the amount and location of pharmacies in a three-mile radius of their own pharmacy are 'excellent' or 'good' and 13% report as 'adequate'.

Public Questionnaire

- to gain views on service provision, including the quality, location, opening hours and accessibility of services
- 111 respondents that reported to be living in the Leicester City local authority completed the survey
- Quality of service, location and availability of medication were the most important pharmacy services to respondents.
- Eighty-four percent of respondents agreed that their pharmacy provides a good service (62% strongly agree and 22% tend to agree).

Leicester
City Council

Health Needs in Leicester

Leicester is characterised by rich diversity.

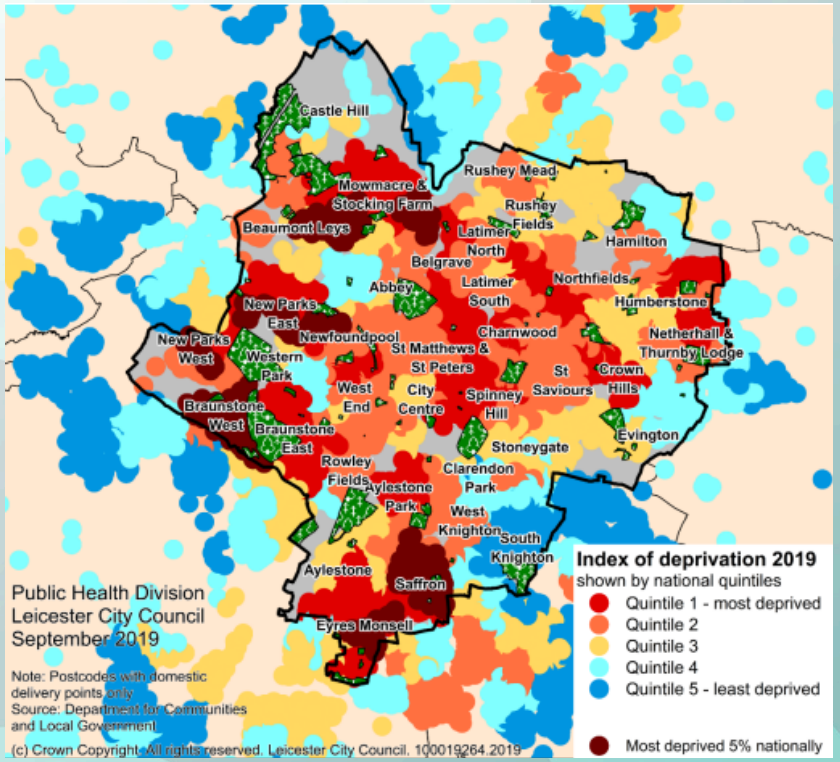
Around half of Leicester's residents are from an ethnic group other than White British.

Leicester has a younger population than England.

Leicester experiences high levels of deprivation, with around 35% of its residents living in the 20% most deprived areas in the country.

Health needs within Leicester are not evenly distributed – the worst outcomes are often concentrated in the most deprived areas.

Life expectancy for men and women in Leicester is significantly lower than the England average.



Sources: Census 2011, ONS 2020 mid year population estimates, Index of Multiple Deprivation 2019

Health needs by locality area

North West: 39% residents within 20% most deprived areas, 67% of residents are White

- Higher prevalence of hypertension, COPD and Cancer, poor mental health

West: 48% residents within 20% most deprived areas, 76% of residents are White, lower % of over 65s (11%)

- Lower life expectancy for men and women, high levels of hypertension and stroke, COPD, Cancer
- Higher levels of smoking

South: highest % of White residents (79%), highest % of residents within the 20% least deprived areas (12%)

- Higher levels of dementia, heart disease, cancer, COPD, Asthma

North: All residents within 0-60% most deprived areas (25%), highest % of BAME residents (80%)

- Highest female life expectancy, high levels of heart disease, and hypertension and diabetes, more carers, lower prevalence of smoking

East: highest % of 0-19 year olds, 29%) 15% over 65s, lowest % of residents in 20% most deprived areas (25%), 54% BAME residents

- Higher levels of long term conditions including heart disease and diabetes

Central: highest % of 20-29 year olds (33%), lowest % of over 65s (9%), 53% BAME residents, 26% of residents in 20% most deprived areas

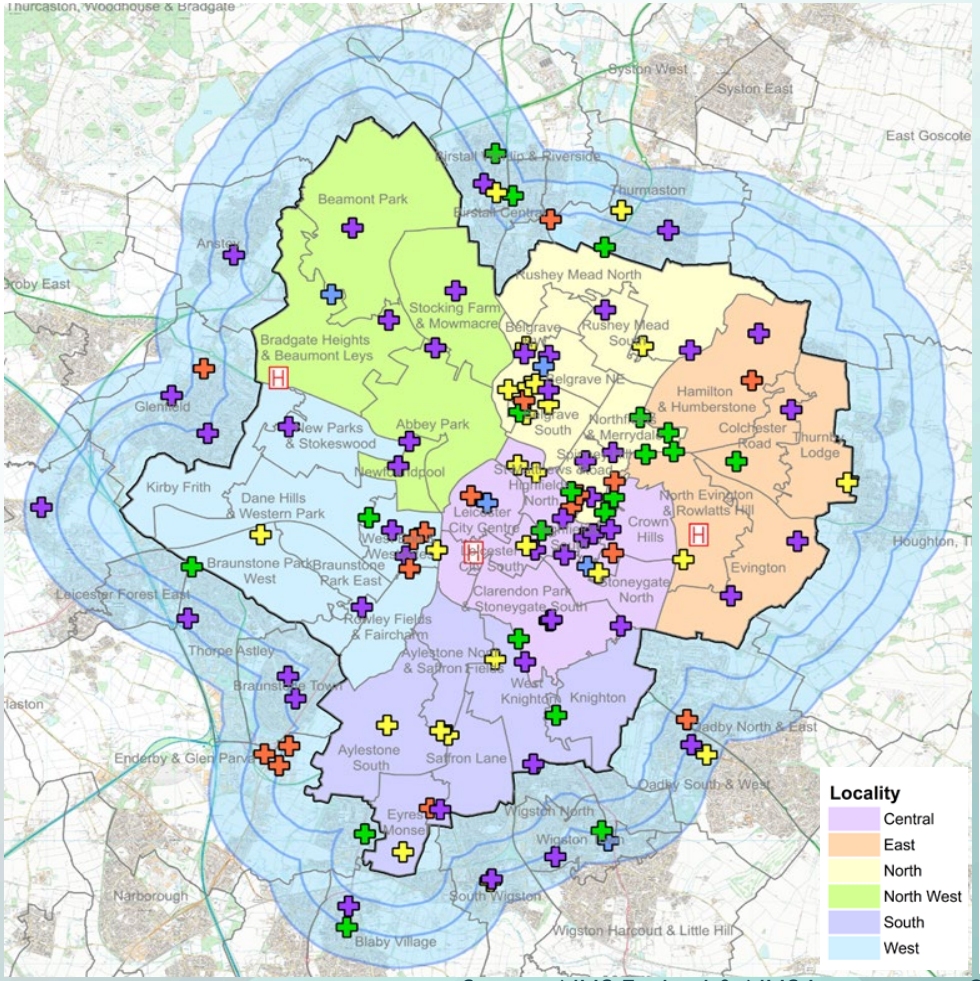
- Lower prevalence of long term conditions, poor mental health, low levels of physical activity

Pharmacy provision in Leicester (as of March 2022)

85 pharmacies in Leicester - equivalent to 2.4 pharmacies per 10,000 population (2.1 in England)

33 Pharmacies within 1.5km of Leicester border

All Leicester residents can walk to their nearest pharmacy within 20 minutes and can reach a pharmacy within 15 minutes by public transport or driving (99% of residents within 10 minutes when driving)



More pharmacies are concentrated in the North central and East central areas with fewer in the outer areas of the city

All pharmacies are open for 40 hours per week with 8 open for 100 hours

Leicester Pharmacy opening hours:

- 7 days (4)
- 7 days late (11)
- Weekdays and Sat (15)
- Weekdays and Sat am (33)
- Weekdays Only (22)

Pharmacy opening hours within 1.5km of Leicester boundary:

- 7 days (2)
- 7 days late (6)
- Weekdays and Sat (7)
- Weekdays and Sat am (13)
- Weekdays Only (5)

Sources: NHS England & NHS Improvement, ONS 2020 mid-year population estimates

Community Pharmacy Services

Four types of services are covered in the Leicester PNA: Essential, Advanced, Locally Commissioned and National Enhanced Services.

- *Essential Services* are offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework (CPCF), the 'pharmacy contract'.
- Community pharmacies can choose to provide *Advanced Services*, of which there are currently eight within the NHS CPCF, following appropriate training and as long as they meet the requirements set out in the Secretary of State Directions.
- *Locally Commissioned Services* are commissioned to meet the needs of the local population. These services can be contracted via a range of routes and commissioners including Local Authorities, Integrated Care Boards (ICB) and local NHSE&I teams. Pharmacies can choose whether to provide these services.
- The *National Enhanced Service* is a nationally specified Enhanced Service commissioned by NHSE&I. Allows agreement of standard conditions nationally, while still allowing flexibility for local decisions to commission the service to meet local population needs, as part of a nationally coordinated programme.

Sources: Pharmaceutical Services Negotiating Committee, National Pharmacy Services - PSNC Website

Essential Services

Essential services: required in all pharmacies and include

- Dispensing and repeat dispensing of medicines
- Repeat prescription
- Dispensing appliances
- Promotion of healthy lifestyles
- Disposal of unwanted medicines
- Promotion of healthy lifestyles (Public Health)
- Signposting advice, treatment or support that the pharmacy cannot provide
- Support for self-care
- Clinical governance
- Discharge medicines service (when a person is discharged from hospital)
- Healthy Living Pharmacies (from 2021)

There is adequate provision for the population of Leicester - essential services are provided by all pharmacies.

However, some residents may have further to travel where pharmacies are more sparsely distributed and opening hours are shorter (particularly in the north west of Leicester).

Advanced Services: pharmacy services provided as at March 2022

New Medicines Services provided by 93% of pharmacies (79)

Community Pharmacist Consultations provided by 89% of pharmacies (76)

Seasonal influenza vaccinations provided by 81% of pharmacies (69)

	Total Number of Pharmacies	New Medicine Service (NMS) Activity	Appliance Use Reviews (AUR) Activity	Stoma Customisation (SAC) Activity	Community Pharmacist Consultation Service (CPCS) Activity	Hepatitis C Antibody Testing Service Activity	Seasonal Influenza Vaccination Activity	Hypertension Case-Finding Service
Central	23	21	0	2	20	0	18	16
East	9	9	0	1	9	0	8	8
North	24	22	0	0	19	0	18	14
North West	7	7	0	0	7	0	6	7
South	11	9	0	1	10	0	9	8
West	11	11	0	2	11	0	10	9
Leicester City	85	79	0	6	76	0	69	62

Distance from Leicester boundary	Total Number of Pharmacies	New Medicine Service (NMS) Activity	Appliance Use Reviews (AUR) Activity	Stoma Customisation (SAC) Activity	Community Pharmacist Consultation Service (CPCS) Activity	Hepatitis C Antibody Testing Service Activity	Seasonal Influenza Vaccination Activity	Hypertension Case-Finding Service
0km to 0.5km	10	8	0	0	8	0	6	7
0.5km to 1km	15	15	0	2	12	0	13	13
1km to 1.5km	8	8	0	1	7	0	7	6
Total within 1.5km of Leicester	33	31	0	3	27	0	26	26

No pharmacies provided Appliance Use Reviews or Hepatis C Antibody Testing

More services available via greater number of pharmacies in central and north areas of Leicester

Leicester City Council

Sources: NHS England and NHS Improvement 2022, NHS Business Services Authority – Advanced service flu report, June 2022, Office for Health Improvement & Disparities, 2022

Locally Commissioned Services: Activity

Supervised Consumption – offered by 43 (51%) pharmacies in 2021/22, over 73,700 dispenses. Highest uptake in centre of city (over 29, 200 dispenses).

Needle Exchange – offered by 14 (16%) pharmacies in 2021/22, over 16,900 transactions. Highest uptake in centre of city (over 7,200 transactions). 0 transactions in east of city.

EHC – 12 pharmacies offering end of March 2020, 10 pharmacies offering March 2021 and 9 pharmacies offering in March 2022 - could be the result of the Covid-19 pandemic. Majority of uptake is through city centre pharmacies.

C Card – 18 (21%) pharmacies are signed up to deliver in 2021/22. Higher number in centre (6) and west (5) of the city.

Palliative Care – 5 (6%) pharmacies in 2020/21 commissioned for urgent supply of palliative care and specialised medicines. Two in centre of city, one in each of north, north west and west locality areas.

Child Influenza Vaccinations – 9 (11%) pharmacies eligible to provide in 2021/22.
At least one in each locality area.

Sources: EHC: Pharm Outcomes, C Card: Midlands Partnership NHS Foundation Trust, Supervised consumption and needle exchange: Turning Point, Palliative care: PSNC, Child Influenza Vaccinations: Leicestershire Partnership Trust.

National Enhanced Services

National Enhanced Services: nationally specified services with agreement of standard conditions nationally while allowing the flexibility for local decisions to commission the service to meet local population needs, including

- Covid Vaccination Service (From Autumn 2022 - previously a Local Enhanced Service)

In 2021/22 13 pharmacies provided Covid Vaccination Service.

Covid-19 Vaccination Service
Provision by locality area (2021/22)

Locality area	Number of pharmacies providing Covid Vaccination Service
Central	2
East	2
North	4
North West	2
South	1
West	2
Leicester City	13
Distance from boundary	**Number of pharmacies providing Covid Vaccination Service**
0km-0.5km	0
0.5km-1.0km	2
1.0km-1.5km	1
Total within 1.5km of boundary	3

Source: NHS England and NHS Improvement

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Projected Future Needs

- Applying the ONS population projections for 2021-2043 to the Census 2021 data suggests that by 2043 the population of Leicester is predicted to grow by around 29,850 to give a total population of around 398,459.
- Projections indicate that Leicester will have an increase of 15,167 people aged 65 and over, which represents an increase in the proportion of the population aged 65 and over from 12% in 2021 to 15% in 2043.
- With the current provision of 85 pharmacies in Leicester, this would offer a rate of 2.1 pharmacies per 10,000 population in 2043.
- The current rate in Leicester is 2.4, and nationally 2.1 per 10,000 population based on the numbers of pharmacies alone; it does not take into account variation in opening hours and services provided.

Leicester City Council

Sources: ONS Population Projections - 2018, Census 2021

Consultation

There is a statutory requirement to consult the following bodies about the contents of the PNA for a minimum of 60 days:

- the local pharmaceutical committee,
- the local medical committee,
- pharmacy and dispensing appliance contractors included in the pharmaceutical list for the area of the Health and Wellbeing Board,
- dispensing doctors included in the dispensing doctor list for the area of the Health and Wellbeing board, if any,
- any pharmacy contractor that holds a local pharmaceutical services contract with premises that are in the Health and Wellbeing Board's area,
- Healthwatch, and any other patient, consumer, or community group in the area which the Health and Wellbeing Board believes has an interest in the provision of pharmaceutical services,
- any NHS trust or NHS foundation trust in the Health and Wellbeing Board's area,
- NHS England and NHS Improvement, and
- any neighbouring Health and Wellbeing Board

Consultation 6th July to the 4th September 2022:

- 48 respondents
- Majority agreed/strongly agreed that the purpose of the PNA has been clearly explained (67% of respondents) and that **the PNA adequately reflects the current community pharmacy provision in Leicester** (52% of respondents)
- Forty percent of respondents agreed/strongly agreed that **the needs of Leicester residents have been adequately reflected in the PNA**, with 29% of respondents having no opinion either way.
- Five respondents (10%) **identified gaps or issues in pharmaceutical provision in Leicester that had not been reflected in the draft PNA**.
- The gaps/issues in pharmaceutical provision noted by the respondents were wasted knowledge with training not being put to good use, the need for full access to summary care records and Type 1 Diabetes Mellitus services.

Conclusions

- All Pharmacies provide essential services, most provide advanced services and pharmacies can choose which, if any, locally commissioned services they wish to offer.
- Overall provision of essential and advanced pharmacy services is adequate for the population of Leicester.
- All Leicester residents can walk to their nearest pharmacy within 20 minutes and can reach a pharmacy within 15 minutes by public transport or driving (99% of residents within 10 minutes when driving)
- More pharmacies are located within the North and Central areas of the City
- There are differences in the local provision of services across the city and it may be that residents in some areas have to travel a little further to access a particular service or outside of normal working hours
- With the current provision of 85 pharmacies in Leicester, this would offer a rate of 2.1 pharmacies per 10,000 population based on the calculated population projections for 2043
- Use of pharmacy services has changed during the Covid-19 pandemic (2020-2021) – difficult to predict whether changes will continue into the future or revert to pre-pandemic patterns

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Recommendations

Equity of Service

- Keep under review locations and opening times
- Review cross-city and county-border service provision to ensure uniformity of access and quality of service
- Work with pharmacies and Local Pharmaceutical Committee to examine how to address equity issues
- Work with ICB and Primary Care Networks to tackle health inequalities and address digital literacy
- Consider additional pressure on pharmacies due to workforce shortage – work to mitigate impact
- Encourage pharmacies to offer discretionary services in relation to local need

Promotion of Health and Healthcare Management

- Ensure that the promotion of healthy lifestyles (Public Health) requirement of essential services contract is fulfilled
- Collate information on all of the services provided by Leicester pharmacies
- Assess levels of uptake of advanced and locally commissioned services and follow up low or high performers to share best practice
- Work with pharmacies to consider replacing recently decommissioned popular services

Implications of Community Pharmacies Policy

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

Leicester
City Council

Leicester Pharmaceutical Needs Assessment 2022

September 2022

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1 Executive Summary

1.1 Introduction and background

'Pharmaceutical' refers to the need for medicines or other health services including prevention and whether this is met by the arrangements with community pharmacies in Leicester.

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

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

The PNA is a statutory document that is used by NHS England and NHS Improvement to agree changes to the commissioning of local pharmaceutical services. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at https://www.legislation.gov.uk/uksi/2013/349/contents[1]

The report identifies whether there are any unmet pharmaceutical needs or gaps in service provision and produces recommendations to strengthen service provision.

This PNA has reviewed pharmacy coverage in relation to the population health needs of the people of Leicester City. This has involved looking at the existing services, their locations, the range of services they are providing and the views of the people who are using them. The PNA refers to the services that were provided on the 31st March 2022 where available. Where this is not available, data is provided to 31st March 2021.

The PNA analysis focusses on the services that are currently provided in pharmacies and not those that have been decommissioned since the last PNA.

**Note: The PNA includes services commissioned by Leicester City Clinical Commissioning Group (CCG) during the period to 31st March 2022. It is acknowledged that Leicester, Leicestershire and Rutland (LLR) CCGs was replaced by LLR Integrated Care Board on 1st July 2022. Any reference to LLR CCGs throughout is referring to LLR Integrated Care Board post 1st July 2022.*

1 National Health Service. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. (2013). at http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf

Within the scope of this document, the PNA concludes that community based pharmacies are meeting the current needs of residents in Leicester City for essential and advanced services where they are offered.

1.2 Community Pharmacy Contractual Framework

The PNA must relate to all pharmaceutical services provided and assess the following:

- the demography of its area and needs of different localities
- whether there is sufficient choice of pharmaceutical services within its area
- the pharmaceutical services provided by surrounding areas that may affect need within the area
- future pharmaceutical needs of the population

The assessment covers:

Essential services: required in all pharmacies and includes

- Dispensing and repeat dispensing
- Promotion of healthy lifestyles
- Disposal of unwanted medicines
- Signposting advice, treatment or support that the pharmacy cannot provide
- Support for self-care
- Clinical governance
- Discharge medicines service (when a person is discharged from hospital)
- Healthy Living Pharmacies (from 2021)

Advanced services: optional nationally commissioned services. As at March 2022, these include

- New Medicines Service (NMS)
- Appliance Use Review (AUR)
- Community Pharmacist Consultation Service (CPCS)
- Stoma Appliance Customisation (SAC)
- Seasonal influenza vaccination
- Hypertension case-finding service
- Hepatitis C testing service
- Smoking cessation service

** Medicine Use Reviews Service was decommissioned 31st March 2021 and the C-19 Lateral Flow Device Distribution Service and Pandemic Delivery Service were decommissioned 31st March 2022. For more information visit: Advanced Services : PSNC Main site.*

Locally commissioned services: optional locally commissioned services including

- Emergency hormonal contraception (EHC)
- C-Card (Condom provision and Sexual Health advice)
- Needle exchange
- Supervised methadone consumption
- Palliative care
- Child influenza vaccination service

National Enhanced Services: nationally specified services with agreement of standard conditions nationally while allowing the flexibility for local decisions to commission the service to meet local population needs, including

- Covid Vaccination Service

Pharmacies may also choose to provide additional services on a voluntary basis that are of direct benefit to the patient. These include services such as prescription collection and delivery, monitored dosage system, minor ailments and many others.

This PNA has reviewed community pharmacy need and provision for the population of Leicester city as of 31st March 2022 where available (otherwise 31st March 2021). Prison or hospital pharmacies are excluded from the scope of the PNA. The PNA also considers future pharmaceutical provision. It presents an analysis of actual or potential gaps in service and recommendations for improvement.

1.3 Health Needs in Leicester

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

1.4 Location and access to pharmacies

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

There are more pharmacies concentrated in the centre and north of the city, and fewer in the east and north west of the city. Travel time analysis indicates that generally nearest pharmacies can

be reached within 15 minutes of walking. There are a few areas of the city where walk times may be more than 15 minutes but these should be accessible by car or public transport within 15 minutes. Leicester residents can also make use of several pharmacies just into Leicestershire; 9 pharmacies within 0.5km and 15 between 0.5 and 1km of the city boundary.

1.5 Pharmaceutical service provision

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

Service provision is considered across Leicester by six locality areas. These have been defined by, and are consistent with, those used in the Health and Wellbeing Survey 2018. It is acknowledged that not everyone will choose their nearest pharmacy, however, by providing rates for smaller locality areas this helps to show variation in provision of services for local populations across the city.

1.6 Projected future needs

Applying the ONS population projections for 2021-2043 to the Census 2021 data suggests that by 2043 the population of Leicester is predicted to grow by around 29,850 to give a total population of around 398,459. Projections indicate that Leicester will have an increase of 15,167 people aged 65 and over, which represents an increase in the proportion of the population aged 65 and over from 12% in 2021 to 15% in 2043.

With the current provision of 85 pharmacies in Leicester, this would offer a rate of 2.1 pharmacies per 10,000 population in 2043. The current rate in Leicester is 2.4, and nationally 2.1 per 10,000 population based on the numbers of pharmacies alone; it does not take into account variation in opening hours and services provided.

1.7 Consultation

There is a statutory requirement for each Health and Wellbeing Board to consult a number of bodies about the contents of the pharmaceutical needs assessment for a minimum of 60 days. The consultation period took place between 6th July and 4th September 2022, 48 responses were received.

1.8 Analysis of gaps in service

Pharmacies and local populations:

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

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

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

Access and travel times:

Analysis of access and travel times suggests most residents will be able to access their nearest pharmacy within 15 minutes by walking, car or public transport. Travel times by car and public transport will be subject to traffic variations during the day. Residents may have to travel further to reach a pharmacy outside of normal opening hours.

Opening hours:

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

Essential Services:

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

Advanced Services:

The majority of pharmacies provide the advanced services Community Pharmacist Consultation Service, Flu Vaccination Service and New Medicines Services. Few pharmacies offer Stoma Appliance Customisation. Despite no activity reported for the Appliance Use Review (AUR) and Hepatitis C Testing Services in the data received from NHS England and NHS Improvement, five pharmacies reported providing AUR and three pharmacies reported providing Hepatitis C Testing services in the pharmacy survey.

Locally Commissioned Services:

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

Where data is available, the PNA presents maps showing the location of pharmacies

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

1.9 Conclusions and recommendations

This PNA has reviewed the provision of pharmaceutical services as of March 2022 (where available, otherwise at March 2021) and concludes that overall provision is adequate for the population of Leicester. There are differences in local provision of services across the city and it may be that residents in some areas have to travel a little further to access a particular service or out of normal working hours.

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

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

Whilst many other services and GP facilities were often closed, community pharmacies remained open during the Covid-19 pandemic. Throughout this period the accessibility and provision of some pharmaceutical services changed. However, it is difficult to predict whether such changes will continue into the future or whether they will revert to pre-pandemic levels within the lifespan of this PNA. Given the potential benefits to patients, it is recommended that pharmacies are encouraged to maintain improved service provision.

Equity of service:

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

- Keep under review locations and opening times to assess whether access is equitable for all residents
- Work with pharmacies and Local Pharmaceutical Committee to examine how equity issues can be addressed further
- Review cross-city and county-border service provision to ensure uniformity of access and quality of service

- Work closely with Integrated Care Board and Primary Care Networks to tackle health inequalities and address digital literacy

- Consider the effects of the additional pressure on pharmacies due to the national pharmaceutical workforce shortage and work with pharmacies to mitigate the impact of these on service provision

- Encourage pharmacies to offer discretionary services in relation to local need.

Promotion of health and healthcare management:

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

- Encourage the implementation of Healthy Living Pharmacy to promote healthier lifestyles through pharmacies so that individuals can gain advice and support in reducing unhealthy behaviours and adopting healthier ones.

- Ensure that the requirement for promotion of healthy lifestyles campaigns through pharmacies (Public Health) is fulfilled

- Collate information on all of the services provided by the pharmacies in Leicester as this will help to develop a better understanding of the wide range of services offered across the city. In turn this will enable the promotion of the services offered to local communities and inform plans to reduce health inequalities across the city.

- Consider and encourage the opportunity to include and develop the role of pharmacies in commissioning strategies and through the Integrated Care System - particularly in relation to providing services which deflect work out of primary care general practice.

- Assess levels of uptake of advanced and locally commissioned services and follow-up low or high performers in order to share best practice.

- Keep under review the appropriateness of monitoring and quality visits to pharmacies, in addition to pharmacy self- assessment, in order to provide assurance of effectiveness and to promote service improvement.

- Work with pharmacies to consider replacing recently decommissioned popular services (e.g. Medicine Use Reviews).

Community Pharmacies Policy:

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

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

2. Background and Introduction

The Pharmaceutical Needs Assessment (PNA) is a statutory document that reviews the pharmaceutical services provided within an area in relation to the needs of the local population. The PNA is updated every 3 years, however due to Covid-19, an extension has been granted until October 2022. This report presents the fourth PNA for Leicester City and will be published in October 2022 to replace the previous PNA published in 2018.

2.1 Purpose of the PNA

The PNA is the key local tool for understanding the provision of local pharmaceutical services in an area, identifying any gaps in services and assessing future need. It is primarily used by NHS-England and NHS-Improvement, when making decisions on applications to open new pharmacies. If a pharmacist, dispenser of appliances or a GP wants to provide NHS pharmaceutical services, they are required under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) regulations to apply to NHS England and NHS Improvement to be included on a pharmaceutical list. They must prove they are able to meet a pharmaceutical need as set out in the relevant PNA. This is known as the NHS "market entry" system.

'Pharmaceutical' refers to the need for medicines or other health services including prevention and whether this is met by the arrangements with community pharmacies in Leicester.

Additionally, Local Authorities and Leicester, Leicestershire and Rutland Integrated Care Board may consider the PNA when commissioning or reviewing a service to meet local health needs and priorities. NHS England and NHS Improvement is the principal body responsible for managing the main contract with community pharmacies.

2.2 Legislative background

The Health and Social Care Act 2012 established Health and Wellbeing Boards (HWBBs). From 1 April 2013, Health and Wellbeing Boards (HWBBs) became responsible for publishing and updating PNAs.

The regulations[2] require that a series of statements be contained in the PNA. In summary, the regulations require a series of statements of:

- the pharmaceutical services that the Health and Wellbeing Board has identified as services that are necessary to meet the need for pharmaceutical services

- the pharmaceutical services that have been identified as services that are not provided but which the Health and Wellbeing Board is satisfied need to be provided in order to meet a current or future need for a range of pharmaceutical services or a specific pharmaceutical service

[2] Pharmaceutical Needs Assessments – information pack for local authority health and wellbeing boards, October 2021. Department of Health & Social Care. Available at: https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

- the pharmaceutical services that the Health and Wellbeing Board has identified as not being necessary to meet the need for pharmaceutical services but have secured improvements or better access

- the pharmaceutical services that have been identified as services that would secure improvements or better access to a range of pharmaceutical services or a specific pharmaceutical services, either now or in the future

- other NHS services that affect the need for pharmaceutical services or a specific pharmaceutical service

Other information to be included or taken into account:

- how the Health and Wellbeing Board has determined the localities in its area
- how it has taken into account the different needs of the different localities and the different needs of those who share a protected characteristic
- a report on the consultation
- a map that identifies the premises at which pharmaceutical services are provided
- information on the demography of the area
- whether there is sufficient choice with regard to obtaining pharmaceutical services
- any different needs of the different localities
- the provision of pharmaceutical services in neighbouring Health and Wellbeing Board areas

Regulation 8 requires each HWBB *must* also consult the following bodies for its area about the contents of the assessment.

- the local pharmaceutical committee,

- the local medical committee,

- pharmacy and dispensing appliance contractors included in the pharmaceutical list for the area of the Health and Wellbeing Board,

- dispensing doctors included in the dispensing doctor list for the area of the Health and Wellbeing board, if any,

- any pharmacy contractor that holds a local pharmaceutical services contract with premises that are in the Health and Wellbeing Board's area,

- Healthwatch, and any other patient, consumer, or community group in the area which the Health and Wellbeing Board believes has an interest in the provision of pharmaceutical services,

- any NHS trust or NHS foundation trust in the Health and Wellbeing Board's area,
- NHS England and NHS Improvement, and
- any neighbouring Health and Wellbeing Board

These bodies must be consulted at least once and for a period of 60 days.

2.3 Process followed in the development of the PNA

The PNA has been developed for the Health and Wellbeing Board in accordance with the NHS regulations[1]

As many of the relationships required for the PNA are Leicester, Leicestershire and Rutland (LLR) wide, a PNA Reference group was established to oversee and develop the PNA with representation from NHS England and NHS Improvement, the Leicestershire Pharmaceutical Committee and the Local Professional Network for Pharmacists.

The PNA process consisted of the following three key stages:

- Review of the current provision of pharmaceutical services in Leicester
- Assessment of the need for pharmaceutical services in the local population
- A consultation period to gather feedback from the public and other stakeholders

To gather additional intelligence for the PNA, two surveys have been run; one survey to ask service users for their views on the current pharmaceutical provision and the second to ask pharmaceutical professionals to provide data including the services offered, the opening times and the facilities within the pharmacy.

The PNA was subject to a 60-day statutory consultation period running from 6th July to 4th September 2022.

**Note: The PNA includes services commissioned by Leicester City Clinical Commissioning Group (CCG) during the period to 31st March 2022. It is acknowledged that Leicester, Leicestershire and Rutland (LLR) CCGs will be replaced by LLR Integrated Care Board on 1st July 2022. Any reference to LLR CCGs throughout is referring to LLR Integrated Care Board post 1st July 2022.*

3. PHARMACY POLICY

Pharmacies deliver personalised patient care through health professionals with expertise in the use of medicines and promotion of their safe and effective use[3]. Pharmacists and their teams can improve patient care and reduce health inequalities through:

- personalised pharmaceutical services
  - expanding access and choice
  - more help with medicines
  - reducing inappropriate hospital admissions
  - supporting patients as they move between hospital and the community
  - supporting healthy living and better care
  - improving communications and relationships
  - facilitating personalised care for people with long-term conditions
  - a trusted, convenient first port of call for episodic healthcare advice and treatment

Clinical pharmacists can work directly in general practice as part of the multi-disciplinary team in patient facing roles, clinically assessing and treating patients using their expert knowledge of medicines for specific disease areas. They can be prescribers and work alongside the general practice team, taking responsibility for patients with long term conditions and undertaking clinical medication reviews especially for older people and those in care homes. They can provide specialist expertise in medicines use while helping to address both the public health and social care needs of a patient at the practice(s).

Pharmacists in general practice will provide leadership to ensure all people get the best use out of their medicines. They will help support the further integration of general practice with the wider healthcare teams (including community and hospital pharmacy) to help improve patient care and safety.

3.1 The Community Pharmacy Contractual Framework

The Community Pharmacy Contractual Framework for 2019/20 to 2023/24 was published in 2019[4] setting out how community pharmacy will support the delivery of the NHS Long Term Plan. The NHS Long Term Plan describes the development of local Primary Care Networks (PCN) with general practices coming together to form networks typically covering 30,000-50,000 patients. PCNs will build on existing primary care services and develop more integrated health and social care services in response to the needs of the patients they serve.

The key elements of the Community Pharmacy development plan include the introduction of pharmaceutical services in response to urgent care, prevention and medicines optimsation and safety.

[3] Pharmacy White Paper, *Pharmacy in England – Building on strengths and delivering the Future,* April 2008
[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/819601/cpcf-2019-to-2024.pdf

- **Urgent Care:**
    - Introduction of the Community Pharmacist Consultation Service with referrals from Urgent Treatment Centres
    - palliative care service pilots
- **Prevention:**
    - Introduction of a Hepatitis C testing service in pharmacies for any patients using needle and syringe programmes
    - Introduction of a pilot for case finding undiagnosed cardiovascular disease
    - Introduction of a pilot for stop smoking referrals from secondary care
    - Introduction of pilots for point of care testing in community pharmacy to support efforts to tackle antimicrobial resistance
    - All pharmacies required to be accredited Level 1 Healthy Living Pharmacies by April 2020
- **Medicines Optimisation and Safety**
    - Phasing out of Medicines Use Reviews
    - Introduction of a medicines reconciliation service as part of a transfer of care around medicine service

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3.2 Integration and innovation: working together to improve health and social care for all

In 2021, the government published Integration and innovation: working together to improve health and social care for all[5], a paper setting out how NHS and local authorities have a duty to collaborate with each other to deliver improved outcomes in health and wellbeing for local people.

Key measures in the white paper include:

- The NHS and local government to establish integrated care systems to plan health and care services
- Focusing on preventative healthcare; moving services out of hospitals and into the community,
- The NHS will only need to tender services when it has the potential to lead to better outcomes for patients
- The Healthcare Safety Investigations Branch to become a statutory body so it can continue to reduce risk and improve safety
- Introduction of new requirements about calorie labelling on food and drink packaging and the advertising of junk food before the 9pm watershed
- A package of measures to deliver on specific needs in the social care sector

5 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-web-version.pdf

3.3 Integrated Care Systems (ICSs)

Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people who live and work in their area[6]. Forty-two ICSs will be established across England on a statutory basis on 1 July 2022. They will bring together systems to support integration and develop a plan to address the systems' health, public health and social care needs through joint place-based working between NHS, local government, community health services and other partners in the voluntary and community sector. ICSs were recommended to have stronger responsibilities for commissioning primary medical, dental, ophthalmology and pharmaceutical services.

The **purpose** of ICSs is to bring partner organisations together to:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- enhance **productivity and value for money**
- help the NHS support broader **social and economic development**.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

LLR ICS Purpose, Principles and Priorities

From 1st July 2022, Leicester, Leicestershire and Rutland will be designated as an Integrated Care System (ICS). In the ICS, NHS and other partners such as local authorities and the voluntary and community sector take on greater responsibility for working together and collectively managing resources. They aim to improve the health of residents by preventing illness, tackling inequalities and variation in care.

They do this by joining up care for those with multiple conditions and breaking down current barriers people experience in accessing health and social care holistically. They will also improve the support available for people with lifelong illnesses and help them to lead healthy lives.

[6] https://www.kingsfund.org.uk/audio-video/integrated-care-systems-health-and-care-act

The draft LLR ICS[7] describes the purpose, principles and priorities and outlines the approach for integration and transformation of services

Covid-19 has further highlighted inequalities for people across LLR. These are significant challenges and can only be addressed by the NHS, local government and ICS working together to tackle the wider determinants of health that often lead to poor health outcomes.

[7] https://cabinet.leicester.gov.uk/documents/s122703/Leicester%20Health%20and%20Wellbeing%20Board%20ICS%20Discussion%20Final%20290721.pdf

4. Pharmaceutical Services and Pharmacy Contracts

All national NHS pharmaceutical service providers must comply with the contractual framework that was first introduced in April 2005. The national framework is set out below and can be found in greater detail on the Pharmaceutical Services Negotiating Committee (PSNC) website: http://psnc.org.uk/contract-it/the-pharmacy-contract/

The contractual framework is made up of three different service types:

- *Essential* services – which must be provided by all contractors - that is, all community pharmacy services nationwide
- *Advanced* services – nationally defined services that can be provided by contractors subject to accreditation requirements
- *Locally commissioned* services – services commissioned locally by Clinical Commissioning Groups, Local Authorities and NHS England and NHS Improvement (Enhanced Services) in response to the needs of the local population.

Quality assurance:

NHS England and NHS Improvement (NHSE&I) regional teams monitor the provision of Essential and Advanced Services and the pharmacy contractors' compliance with the terms of the Community Pharmacy Contractual Framework. Each year, every pharmacy must complete a short questionnaire which will determine whether a pharmacy needs visiting.

The General Pharmaceutical Council carry out inspections in all registered pharmacy premises to ensure that they comply with all legal requirements and regulatory standards. The inspector will examine how the pharmacy operates with the aim of securing and promoting the safe and effective practice of pharmacy services[8].

All pharmacies are required to conduct an annual community pharmacy patient questionnaire (Patient Satisfaction Questionnaire) which allows patients to provide feedback to community pharmacies on the services they provide[9].

4.1 Types of service

4.1.1 Essential services

The essential services which **must** be provided by all contractors are briefly described in table 1 below.

[8] https://www.pharmacyregulation.org/standards
[9] http://psnc.org.uk/wp-content/uploads/2013/07/cppq2020annex20a.pdf

Table 1: Essential pharmacy services

Essential Service	Description
Dispensing Medicines and Appliances	The supply of medicines and appliances ordered on NHS prescriptions, together with information and advice, to enable their safe and effective use by patients and carers. Records are kept of all medicines dispensed, significant advice provided, referrals and interventions made.
Repeat Dispensing	At least two thirds of all prescriptions generated in primary care are for patients needing repeat supplies of regular medicines. Under the repeat dispensing service, pharmacy teams will: • Dispense repeat prescriptions issued by a GP • Ensure that each repeat supply is required • Seek to ascertain that there is no reason why the patient should be referred back to their GP. The majority of repeat dispensing is now carried out via the Electronic Prescription Services (EPS) and is termed electronic Repeat Dispensing (eRD).
Disposal of unwanted medicines	Pharmacies accept unwanted medicines from individuals for safe disposal.
Discharge Medicines Service (DMS)	The DMS became a new essential service in February 2021. The service aims to reduce the risk of avoidable medication related harm when a person is discharged from hospital. Patients are digitally referred to their pharmacy after discharge from hospital, at which point the pharmacist reviews the referral information and any prescription changes since before the patient was admitted to hospital. The pharmacist then discusses these changes with the patient and/or their carer, checks their understanding of what medicines they should now be taking/using and provides any other relevant advice to support medicine use.
Promotion of healthy lifestyles (Public Health)	Each financial year pharmacies are required to participate in up to six health campaigns at the request of NHS England and NHS Improvement. This involves opportunistic one to one advice on healthy lifestyle topics such as stopping smoking, flu vaccination and increasing physical activity.
Signposting	Where pharmacies cannot provide help, they will refer patients to other healthcare professionals, care providers or other sources of help such as local or national patient support groups.
Support for self-care	Pharmacy staff can provide advice and support to patients to enable them to derive maximum benefit from caring for themselves or their families. The main focus is on self-limiting illness, but also support for people with long term conditions.

Essential Service	Description
Clinical governance	Pharmacies must have a system of clinical governance to support the provision of excellent care. Requirements include: • Provision of a practice leaflet for patients • Use of standard operating procedures • Patient safety incidence reporting to the National Reporting and Learning Service (NRLS) • Conducting clinical audits and patient satisfaction surveys, having complaints and whistle-blowing policies • Acting upon drug alerts and product recalls to minimize patient harm • Cleanliness and infection control measures
Healthy Living Pharmacies (HLP)	Pharmacies are commissioned to reduce health inequalities within the local community by delivering high quality health and well- being services, promoting health and providing proactive health advice to customers. There are three levels of service delivery within the HLP framework; promotion, prevention and protection. Healthy Living Pharmacies (HLP) have a health and wellbeing ethos, where everyone in the team works together to proactively engage their customers in health promotion activities through advice on smoking cessation and obesity/healthy weight. They need a health promotion zone in the pharmacy and at least one full-time equivalent health champion, who has qualified for a Royal Society for Public Health (RSPH) level 2 award in understanding health improvement. Pharmacy contractors must ensure that they are compliant with the HLP requirements from 1st January 2021, however the Distance Selling Pharmacy (DSP) website requirements do not have to be complied with until 1st April 2021.

Further information is available via: http://psnc.org.uk/

4.1.2 Advanced Services

There are eight nationally commissioned advanced services within the NHS Community Pharmacy Contractual F ramework as shown in table 2 below. Community pharmacies can choose to provide any of these listed services following appropriate training and or accreditation by NHS England and NHS Improvement.

Table 2: Advanced pharmacy services

Service	Description
New Medicine Service (NMS)	This service is designed to support patients' understanding of a newly prescribed medicine for a long term condition with the aim of improving medicine adherence. The pharmacist will provide advice and information on the new medicine and how to use it when it is first dispensed. The second stage is a follow up call/meeting in around 2 weeks to discuss how the patient has been getting on with the new medicine. A final consultation around 21-28 days from starting the new medicine discusses any further issues or concerns that may require referral to the GP.

Service	Description
Appliance Use Review (AUR)	This service can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. AURs should improve the patient's knowledge and use of any 'specified appliance' by • establishing the way the patient uses the appliance and the patient's experience of such use • identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient. • advising the patient on the safe and appropriate storage of the appliance and advising the patient on the safe and proper disposal of the appliances that are used or unwanted.
Community Pharmacist Consultation Service (CPCS)	Since 1st November 2020, general practices and NHS 111 have been able to refer patients for a minor illness consultation via CPCS, once a local referral pathway has been agreed. This service replaces the NHS Urgent Medicine Supply service pilot. This service aims to relieve pressure on the wider NHS by connecting patients with community pharmacy which should be their first port of call as they can deliver a swift, convenient and effective service to meet their needs.
Stoma Appliance Customisation (SAC)	The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure the proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. If the pharmacist is unable to provide the prescribed service, they should either refer the patient to another pharmacy or provide the patient with the contact details of at least two pharmacies or providers that are able to supply the service.
Seasonal Influenza (Flu) Vaccination Service	Community pharmacy has been providing flu vaccinations under a nationally commissioned service since September 2015 to support GP services in increasing vaccination rates. Each year from September through to March the NHS runs a seasonal flu vaccination campaign aiming to vaccinate all patients who are at risk of developing more serious complications from the virus. The accessibility of pharmacies has proved popular with patients seeking vaccinations.
Hepatitis C Testing Service	The Hepatitis C Testing Service commenced on 1st September 2020, focusing on the provision of point of care testing (POCT) for Hepatitis C (Hep C) antibodies for people who inject drugs who haven't yet moved to the point of accepting treatment for their substance use. Where people test positive for Hep C antibodies, they are referred for a confirmatory test and treatment. This service, in the first instance ran until 31st March 2022, but in March 2022, NHSE&I, the Department of Health and Social Care and PSNC agreed that the service should continue to be commissioned until 31st March 2023.
Hypertension Case-Finding Service	Also known as the NHS Blood Pressure Check Service, from 1st October 2021 pharmacies provide blood pressure testing to those aged over 40 to identify those with high blood pressure. Where clinically indicated, pharmacies offer 24 hour ambulatory blood pressure monitoring (ABPM), the results of which are shared with the patient's GP to inform a potential diagnosis of hypertension.

Service	Description
Smoking Cessation Service	Commissioned as an advanced service from 10th March 2022, this service enables NHS trusts to refer patients to a community pharmacy of their choice to continue their smoking cessation treatment, including providing medication and support as required, with the aim of creating additional capacity in the smoking cessation pathway.

Medicine Use Reviews service was decommissioned 31st March 2021 and the C-19 Lateral Flow Device Distribution Service and Pandemic Delivery Service were decommissioned 31st March 2022. For more information visit: Advanced Services : PSNC Main site.

4.1.3 Locally commissioned services

In addition to the services listed above, pharmacies can also offer services commissioned by local health commissioning organisations, Clinical Commissioning Groups and Local Authorities to meet the health needs of their local populations. Pharmacies can choose whether to provide these services.

Table 3 lists the current locally commissioned services across Leicester.

Table 3: Locally commissioned pharmacy services as at 31st March 2022

Service	Description
Emergency Hormonal Contraception (EHC)	Some pharmacies are commissioned to provide a free service to women up to 25 years of age following unprotected sexual intercourse to prevent unintended pregnancies. Pharmacies offering this service are required to undertake specific training and maintain a prescribed number of consultations per year.
C-Card Service	Some pharmacies provide a free and confidential sexual health service available to young people. The scheme was originally offered to people aged under 25 years but since removing the age limit, increasing numbers of over 25s are using the scheme. It is a plastic registration card that enables quick and easy access to free condoms. The service also offers information and advice about sexual health and relationships.
Child influenza vaccination service	The children's influenza service is normally administered in schools, however, where children are unable to have this done at school, they can receive the Fluenz/nasal flu vaccine at a local pharmacy providing this service. The purpose of the service is to ensure that patients and their parents have convenient access to the Fluenz/nasal flu vaccine.
Needle exchange	Pharmacies are commissioned to provide intravenous drug users with sterile injecting equipment in order to reduce the transmission of blood borne infections such as hepatitis and HIV.
Supervised consumption	Pharmacies are commissioned to provide registered drug addicts regular monitored doses of an opiate substitute to support them becoming progressively drug free.

Palliative Care	Pharmacies are commissioned to provide patients in the last phase of their lives (and their representatives) with access to palliative care medicines. Pharmacies accredited for this service are trained in the use of palliative care medicines and can provide advice to carers and other healthcare professionals.

4.2 National Enhanced Service (NES)

Table 4: National Enhanced Services

Service	Description
Covid Vaccination Service	In December 2020, the NHS commenced its Covid-19 vaccination programme. Since the start of the Covid-19 pandemic, over 1,500 community pharmacy sites have been vaccinating patients and health and care workers under a Local Enhanced Service against coronavirus alongside vaccination centres, hospitals and Primary Care Network (PCN) sites. From December 2021, provisions were made within the NHS (pharmaceutical and Local Pharmaceutical Services) Regulations 2013 for a new type of Enhanced Service, the NES. Under this type of service, NHS England & NHS Improvement commissions an Enhanced service that is nationally specified. A NES allows the agreement of standard conditions nationally, while still allowing the flexibility for local decisions to commission the service to meet local population needs, as part of a nationally coordinated programme. From autumn 2022, the Covid-19 Vaccination Service will be commissioned as a National Enhanced Service (NES).

4.3 The wider role of community pharmacies: non-contracted services

In addition to the above essential, advanced and locally commissioned services, all of which are commissioned by the NHS or the local authority, pharmacies also provide other significant services directly to their customers on their own account. These services are not commissioned by the CCG or Local Authority and instead are a direct arrangement between the pharmacy and patients. These can be viewed as adding to the convenience, compliance and safety of medicine collection and use.

A questionnaire has been issued to all Leicester pharmacies to collect information on other services offered locally. 31/85 pharmacies completed the questionnaire.

These additional services provided by pharmacies include;

Collection and delivery service (prescriptions)

Monitored dosage system (dosette box)

Extended-spectrum beta-lactamase (ESBL) stock-holding (stockholding of antibiotics used to

treat more antibiotic-resistant bacteria)
Contraception
Emergency contraception
Champix
Childhood vaccinations
Travel vaccinations
Other vaccinations
Patient Group Direction Service
Period delay
Salbutamol inhalers
Supply of medicines and/or other appliances to care homes
Travel medication
Weight loss
Services for specific conditions (Chlamydia, Cholesterol, Diabetes, Gonorrhoea, Erectile dysfunction, H. pylori, Hair loss, Hay fever (fexofenadine), HbA1C, Hepatitis, HIV, HPV, Other)

4.4 Community Pharmacy IT

The Electronic Prescription Service (EPS) enables new and repeat prescriptions to be sent electronically from the GP Practice to the patient's nominated pharmacy.

Pharmacies are now able to access an electronic summary care record (SCR) for patients. The NHS Summary Care Record (SCR) is an electronic summary of key clinical information (including medicines, allergies and adverse reactions) about a patient, sourced from the GP record with the patient's consent. SCR was rolled out to pharmacies from March 2016 and helps support safer patient care and treatment.

There are also a number of apps that patients can use for ordering NHS repeat prescriptions and booking appointments.

A web-based system called PharmOutcomes[10] collates information on pharmacy services. Local and national analysis and reporting of PharmOutcomes helps to improve the evidence base for more effective community pharmacy services.

4.5 Pharmacy Contracts

4.5.1 Types of Pharmacy contracts

There are four types of pharmacy contractors:

Standard contract

[10] http://psnc.org.uk/services-commissioning/pharmoutcomes/

Healthcare professionals working in pharmacies that are held on a pharmaceutical list.

Appliance contractor

An appliance contractor provides services to people who need appliances such as stoma and incontinence care aids, trusses, hosiery, surgical stockings and dressings. Appliance contractors do not supply drugs. There are no appliance contractors in Leicester.

Dispensing Practices

GP Practices are allowed to dispense medicines and appliances to patients who live in an NHS England and NHS Improvement determined controlled locality (Rural Area) and live more than a mile from a community pharmacy. Patients may choose to receive this service and request to be considered as a dispensing patient by the GP practice. There are no dispensing practices in Leicester.

Distance selling pharmacies

Distance selling pharmacies (eg internet pharmacies) are able to provide the full range of essential, advanced and enhanced services to the population without face-to-face contact. Distance selling pharmacies receive prescriptions electronically or via post, dispense them at the pharmacy and then deliver or arrange to courier to the patient. They must provide essential services to anyone, anywhere in England where requested to do so. They may choose to provide advanced and enhanced services as long as no essential service element of the service is provided to persons present at the premises.

4.5.2 Local Pharmaceutical Service Scheme

This scheme provides pharmacy contractors on the list at 1st September 2016 and are located more than 1 mile from the nearest pharmacy with a guaranteed minimum income where their dispensing volume falls below a defined threshold. The purpose of the scheme is to secure provision in an area where it would not otherwise be viable. Local Pharmaceutical Service contracts are kept under review with regard to pharmacy provision for the local population.

4.5.3 Pharmacy Access Scheme

The revised Pharmacy Access Scheme started from January 2022 and supports patient access to isolated, eligible pharmacies. This scheme does not replace the Local Pharmaceutical Service scheme. There are additional eligibility criteria for this scheme which includes pharmacies in very deprived areas (top 20% of the Index of Multiple Deprivation) that are more than 0.8 of a mile from the next nearest pharmacy.

5. Health Needs in Leicester

5.1 Age profile

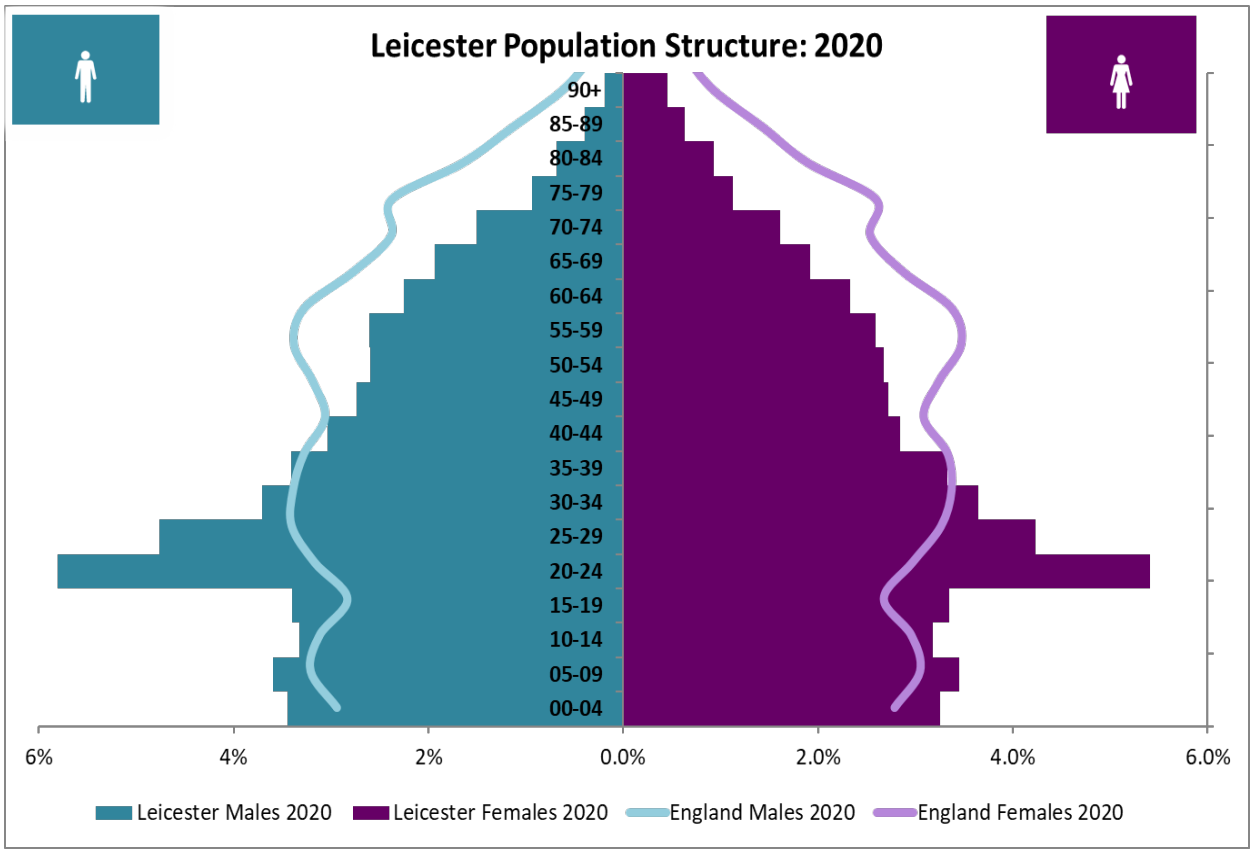
Leicester is the largest city in the East Midlands, with a population of around 354,000[11]. As shown by figure 1, Leicester's population is relatively young compared

[11] ONS Mid-year population estimates, 2020

with England; 20% of Leicester's population are aged 20-29 years old (compared with 13% in England), and 12% of the population are aged over 65 (compared with 19% in England). The larger proportion of younger people in Leicester reflects the student population attending Leicester's two universities and migration into the city from outside of the UK.

Note: The latest census 2021 population estimate for Leicester is 368,600, larger than the 2020 mid-year estimate (354,036) with a 4.1% difference. The census 2021 population structure (age and sex breakdown) for Leicester is shown in figure 24 in section 8 'Projected future needs' of this report. The latest census 2021 data has not been used throughout this PNA as the data is not yet available at a lower geography level.

Figure 1: 2020 Leicester population pyramid



Data: Mid-2020 population estimates, ONS

5.2 Diversity

Leicester is home to a diverse range of faiths and communities. The following diversity data for Leicester is based at the time of the 2011 census. Leicester residents come from over 50 countries, and around a third of Leicester residents were born outside of the UK[12]. Almost half of Leicester's residents classify themselves as belonging to an

[12] Office for National Statistics, Census 2011

ethnic group that is not White. Leicester has one of the country's largest Asian communities (37% of the population), with 28% of all residents defining themselves as of Indian heritage. At 3.8%, Leicester's African community is a notably larger proportion of the population than that for England (1.8%).

Leicester's Black, Minority Ethnic (BME) population is generally younger than the white population and there are fewer elderly people in black and minority ethnic groups.

5.3 Deprivation

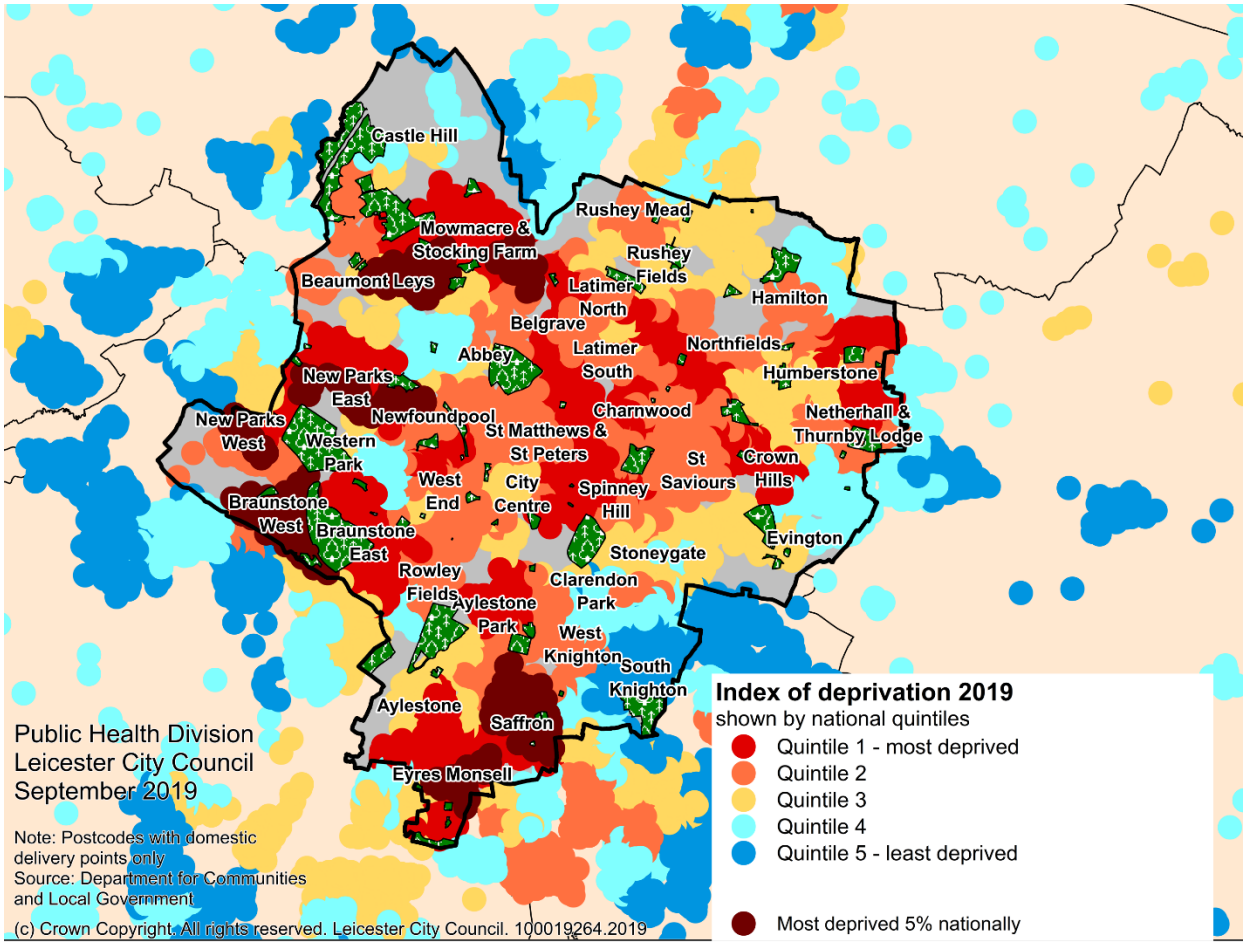
The English indices of deprivation 2019[13] use separate measures, across 7 domains of deprivation, to calculate the Index of Multiple Deprivation 2019 (IMD 2019). This is an overall measure of multiple deprivation experienced by people living in an area. The seven domains of which the measures cover are; income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services, crime, and living environment deprivation.[14] The data is often presented in 'deciles' or 'quintiles' of deprivation. Areas of Leicester which fall into quintile 1 are the most deprived fifth (20%) of areas in England through to those which fall into quintile 5 which are the least deprived fifth (20%) of areas in England. Similarly, areas in decile 1 are the most deprived 10% of neighborhoods nationally through to those in decile 10 which are the least deprived 10% of neighborhoods nationally.

Leicester has a high level of deprivation compared to the country as a whole and is ranked 32nd most deprived out of 317 lower-tier local authority areas. Thirty-Five percent of Leicester's population live in the 20% most deprived areas in England, and a further 38% live in the 20-40% most deprived areas. Only 2% of the Leicester population live in the 20% least deprived areas. Figure 2 shows deprivation in Leicester by Lower Super Output Area (LSOA).

[13] English indices of deprivation 2019, Ministry of Housing, Communities & Local Government, Gov.UK, **Error! Hyperlink reference not valid.**

[14] The English indices of deprivation 2019 (Technical report), Ministry of Housing, Communities & Local Government, Gov.UK, English Indices of Deprivation 2019: technical report (publishing.service.gov.uk)

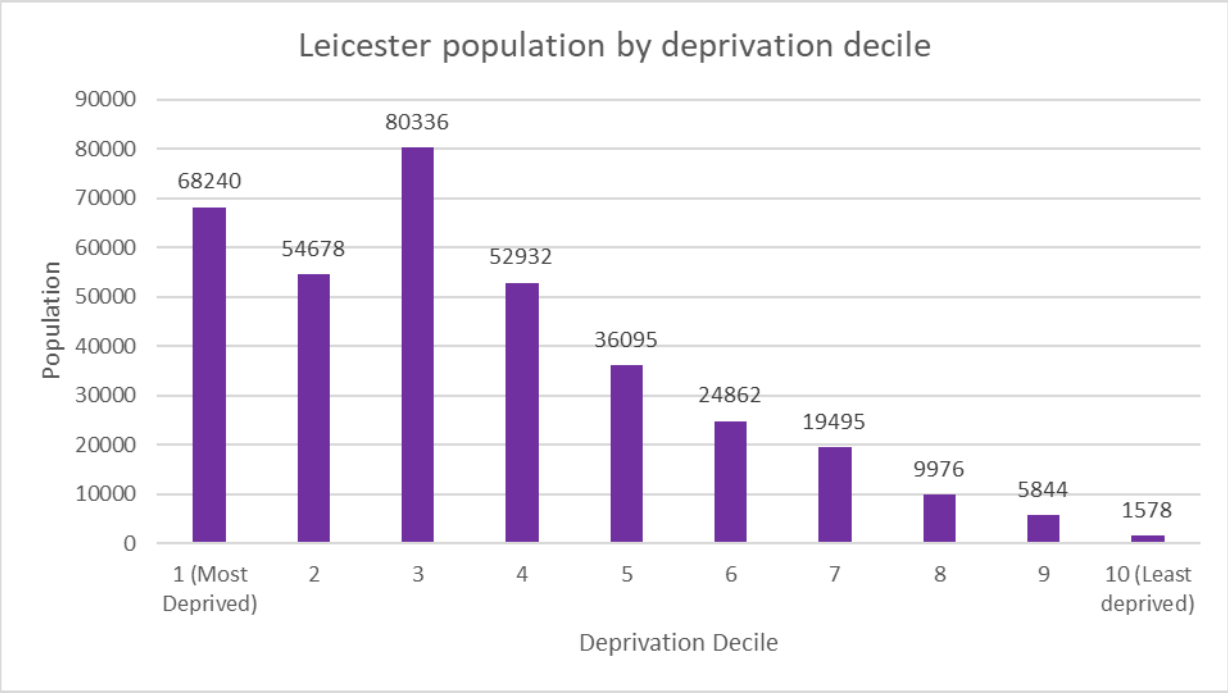
Figure 2: Deprivation in Leicester by lower super output area



Data: Index of multiple deprivation 2019

As shown in figure 3, 19% of Leicester's population (68,240 people) live in the most deprived 10% of areas in England (decile 1). 83% of Leicester's population live in the 50% most deprived areas in England (deciles 1-5). Only 1578 people in Leicester (0.4% of Leicester's population) live in the least deprived 10% of areas in England (decile 10).

Figure 3: Population by deprivation decile in Leicester City



Data: Indices of Deprivation 2019, Mid-2020 population estimates, ONS

5.4 Leicester locality area demographics

For the purposes of this PNA, Leicester City has been divided into smaller areas, these have been defined by, and are consistent with, those used in the Leicester Health and Wellbeing Survey. The Middle Super Output Areas (MSOAs) within the City have been grouped into six locality areas (Central, East, North, North West, South and West Leicester). The demographics of each of the six locality areas in Leicester City have been summarised below and in table 5.

Central:

- MSOAs: St Matthews & Highfields North, Crown Hills, Highfields South, Stoneygate North, Clarendon Park & Stoneygate South, Leicester City South and Leicester City Centre
- Leicester City locality area with the highest proportion of 20-29 year olds (33.1%), significantly higher proportion of 20-29 year olds than Leicester (20.2%) - reflects the student population attending Leicester's two universities in the centre of the City
- Smallest proportion of 65+ year olds (8.5%) of the six locality areas
- Second highest proportion of BAME residents (68.9%) of the city's locality areas

East:

- MSOAs: Hamilton & Humberstone, Colchester Road, North Evington & Rowlatts Hill, Evington and Thurnby Lodge
- Highest proportion of under 19s (29.4%) of Leicester City locality areas and a significantly higher proportion than Leicester as a whole (27.0%)

- Significantly higher proportion of the population aged 65+ (15.1%) compared to Leicester (12.3%)
- Lowest proportion of residents living in the 20% most deprived areas in England (25.3%) compared to the other locality areas in Leicester

North:

- MSOAs: Rushey Mead North, Rushey Mead South, Belgrave North West, Belgrave North East, Belgrave South, Northfields & Merrydale and Spinney Hill Road
- Highest proportion of residents classified as BAME (80.5%) and Asian (71.3%) when compared to other locality areas in Leicester and significantly higher proportions than for Leicester overall (49.5% and 37.1% respectively)
- Whole population lives in the 0-60% most deprived areas in England

North West:

- MSOAs: Beaumont Park, Stocking Farm & Mowmacre, Bradgate Heights & Beaumont Leys, Abbey Park and Newfoundpool
- Significantly higher proportion of the population classify themselves as part of a white ethnic group (67.1%) than in Leicester's population overall (50.5%)
- Significantly higher proportion of the population living in the 20% most deprived areas in England (38.9%) when compared to Leicester City as a whole (34.7%)

South:

- MSOAs: Aylestone North & Saffron Fields, Knighton, Aylestone South, Saffron Lane, Eyres Monsell, West Knighton
- Significantly higher proportion of the population aged 65+ (15.5%) than Leicester City overall (12.3%) and the highest proportion of all of the Leicester locality areas
- Significantly higher proportion of the population classify themselves as white (78.6%) compared to Leicester (50.5%), this is the highest proportion of all of the Leicester locality areas
- Highest proportion of residents living in the 20% least deprived areas in England (12.3%) compared to the other locality areas in Leicester, this value is significantly higher than Leicester (2.1%)

West:

- MSOAs: New Parks & Stokeswood, Dane Hills & Western Park, West End & Westcotes, Braunstone Park West, Braunstone Park East, Rowley Fields & Faircharm, Kirby Frith
- Significantly higher proportion of 20-29 and 30-49 year olds and a significantly lower proportion of 65+ year olds than Leicester
- Significantly higher proportion of residents classified as white (76.4%) than Leicester (50.5%)
- Significantly higher proportion of population living in the 20% (48.4%) and 20-40% (40.0%) most deprived areas in England compared to Leicester as a whole (34.7% and 37.6% respectively) and the locality area in Leicester with the highest proportion of its population living in these quintiles of deprivation

Table 5: Demographic summary of the six locality areas of Leicester City

		Central	East	North	North West	South	West	Leicester City
	Number of MSOAs	7	5	7	5	6	7	37
	ONS Mid-2020 population estimate	83,285	52,218	64,233	47,946	45,476	60,878	354036
Age profile	% Under 19	24.5%	29.4%	27.2%	28.5%	27.1%	26.8%	27.0%
	% 20-29	33.1%	13.0%	14.3%	16.7%	15.3%	21.4%	20.2%
	% 30-49	22.6%	25.7%	26.5%	28.0%	25.2%	26.0%	25.4%
	% 50-64	11.3%	16.8%	17.5%	15.3%	17.0%	14.7%	15.1%
	% 65+	8.5%	15.1%	14.6%	11.5%	15.5%	11.1%	12.3%
Ethnicity	BAME/Not White	68.9%	53.7%	80.5%	32.9%	21.4%	23.6%	49.5%
	White	31.1%	46.3%	19.5%	67.1%	78.6%	76.4%	50.5%
	Of BAME % Asian	52.8%	41.8%	71.3%	18.2%	12.2%	11.7%	37.1%
IMD 2019 quintile	% in most deprived 20%	26.3%	25.3%	27.9%	38.9%	47.8%	48.4%	34.7%
	% in 20-40% most deprived areas	38.6%	31.2%	53.5%	35.4%	20.1%	40.0%	37.6%
	% in 40-60% most deprived	24.2%	26.1%	18.6%	16.1%	10.2%	4.7%	17.2%
	% in 60-80% most deprived	8.7%	17.4%	0.0%	9.6%	9.6%	6.9%	8.3%
	% in least deprived 20%	2.2%	0.0%	0.0%	0.0%	12.3%	0.0%	2.1%

Significantly lower than Leicester City
Significantly higher than Leicester City

Data: Indices of Deprivation 2019, Mid-2020 population estimates, ONS, Census 2011

5.5 Local Health Needs:

Deprivation contributes to poor health outcomes for many residents and overall health in Leicester is generally poorer than nationally. Key health issues for Leicester residents are summarised in table 6 and below:

Table 6: Health and lifestyle profile summary for Leicester City

Topic	Indicator	Time Period	Leicester	England
Overarching indicators	Life expectancy at birth (Male, 1 year range)	2020	75.0	78.7
	Life expectancy at birth (Female, 1 year range)	2020	80.4	82.6
	Healthy life expectancy at birth (Male)	2018-20	59.6	63.1
	Healthy life expectancy at birth (Female)	2018-20	57.5	63.9
Wider determinants of health	Children in relative low income families (under 16s)	2019/20	31.4%	19.1%
	Violent crime - hospital admissions for violence (including sexual violence) (per 100,000 population)	2018/19-2020/21	39.0	41.9
	Homelessness - households owed a duty under the Homelessness Reduction Act (per 1,000 population)	2020/21	19.4	11.3
Health improvement	Under 18s conception rate (per 1,000)	2020	11.4	13.0
	Obesity in early pregnancy	2018/19	23.8%	22.1%
	Smoking in early pregnancy	2018/19	18.2%	12.8%
	Smoking status at the time of delivery	2020/21	10.2%	9.6%
	Reception: Prevalence of overweight (including obesity)	2019/20	19.4%	23.0%
	Year 6: Prevalence of overweight (including obesity)	2019/20	38.4%	35.2%
	Emergency Hospital Admissions for Intentional Self-Harm (per 100,000)	2020/21	140.5	181.2
	Percentage of adults (aged 18+) classified as overweight or obese	2020/21	60.2%	63.5%
	Percentage of physically active adults	2020/21	55.4%	65.9%
	Percentage of physically inactive adults	2020/21	33.2%	23.4%
	Smoking Prevalence in adults (18+) - current smokers (APS)	2020	12.2%	12.1%
	Estimated diabetes diagnosis rate	2018	83.0%	78.0%
	Admission episodes for alcohol-related conditions (Narrow): New method (Persons)	2020/21	527.0	456.0
	Self-reported wellbeing - people with a high anxiety score	2020/21	27.3%	24.2%
Health protection	Population vaccination coverage - Flu (at risk individuals)	2020/21	46.2%	53.0% *
	Population vaccination coverage - Flu (aged 65+)	2020/21	76.1%	80.9% *
Healthcare and premature mortality	Infant mortality rate (per 1,000)	2018-20	5.8	3.9
	Under 75 mortality rate from causes considered preventable (2019 definition) (1 year range) (per 100,000)	2020	195.6	140.5
	Under 75 mortality rate from all cardiovascular diseases (1 year range) (per 100,000)	2020	117.9	73.8
	Under 75 mortality rate from cancer (1 year range) (per 100,000)	2020	143.9	125.1
	Under 75 mortality rate from respiratory disease (1 year range) (per 100,000)	2020	43.1	29.4
	Premature mortality in adults with severe mental illness (SMI) (per 100,000)	2018-20	164.4	103.6
	Suicide rate (per 100,000)	2018-20	9.8	10.4
	Hip fractures in people aged 65 and over (per 100,000)	2020/21	679	529
	Excess winter deaths index	Aug 2019 - Jul 2020	17.9%	17.4%

Recent trend key:

—	Could not be calculated
↓	Decreasing & getting better
↑	Increasing & getting worse
→	No significant change
↓	Decreasing & getting worse
↑	Increasing & getting better

Significance rating key (compared to benchmark):

Data: Public Health Outcomes Framework, Fingertips, Office for Health Improvement & Disparities, 2022

Life expectancy

As shown in figure 4, life expectancy[15] at birth in Leicester is significantly lower (worse) than the England average for both males[16] and females[17] and has been since the recording of this indicator began in 2001. In 2020 life expectancy for males in Leicester (75.0 years) is around 3.5 years lower than England (78.7 years), and for females in Leicester (80.4 years) it is around 2 years lower than England (82.6 years). Cardiovascular diseases are the largest contributor to the adverse life expectancy gap between Leicester and England, accounting for 37% of the life expectancy gap in males and 34% in females.[18]

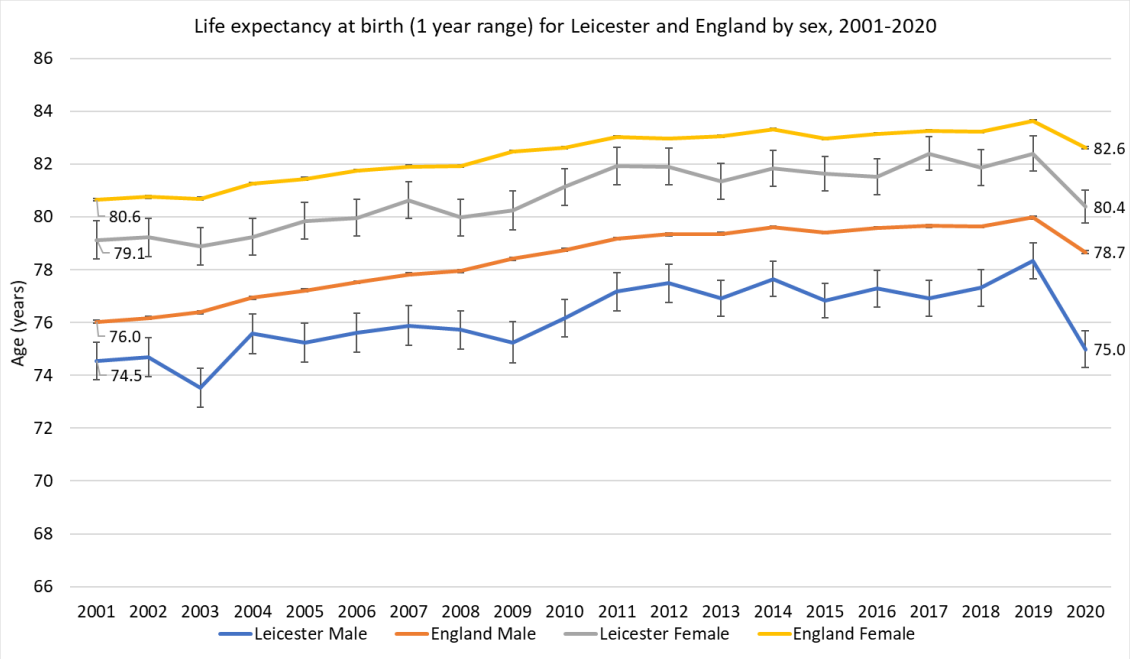
[15] Average life expectancy at birth is widely used as a proxy indicator for the overall health of the population; it estimates how long a newborn child would be expected to live if the current age-specific mortality rates remain constant. However, it does not forecast how long babies born today will actually be expected to survive, as age-specific mortality rates are unlikely to remain constant for an extended length of time.

[16] Public health profiles - OHID (phe.org.uk)

[17] Public health profiles - OHID (phe.org.uk)

[18] Public Health England, Segment Tool, Breakdown of the life expectancy gap between Leicester as a whole and England as a whole by cause of death, 2015-17, https://analytics.phe.gov.uk/apps/segment-tool/

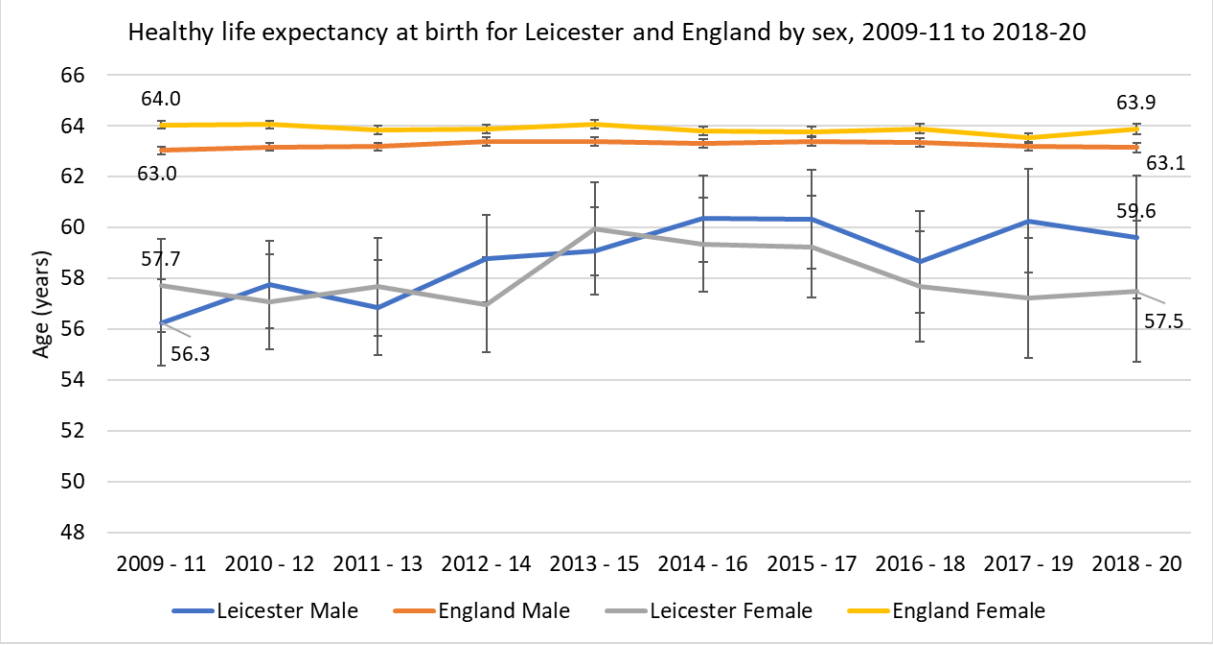
Figure 4: Life expectancy at birth (1 year range) for Leicester and England over the period 2001 to 2020



Data: Fingertips, Office for Health Improvement & Disparities, 2022

As shown by figure 5, Leicester has performed significantly worse than England for healthy life expectancy at birth for both males and females since the recording of the indicators began in 2009-11. In 2018-20, healthy life expectancy at birth for Leicester males was 59.6 years compared to 63.1 years for England. Healthy life expectancy at birth for females in Leicester and England in 2018-20 was 57.5 years and 63.9 years respectively.

Figure 5: Healthy life expectancy at birth for Leicester and England over the period 2009-11 to 2018-20



Data: Fingertips, Office for Health Improvement & Disparities, 2022

Disease prevalence

People in Leicester suffer from a number of long term conditions, as shown in table 7 below. Based on GP registers in Leicester City, the largest recorded prevalence is for cardiovascular diseases including hypertension, Coronary Heart Diseases (CHD), stroke and heart failure. Leicester also has a significantly higher than average percentage of people diagnosed with diabetes (9.6%), mainly in Leicester's South Asian population. The prevalence of people experiencing Mental Health conditions in Leicester (1.1%) is significantly higher than the England average (1.0%). Overall, Leicester has a lower prevalence of cancer and Chronic Kidney Disease (CKD) which may also be related to the diverse ethnicity found in Leicester's residents.

Since the last PNA Leicester has seen an increase in the prevalence of diabetes (0.6% increase), hypertension (increase of 0.4%), all cancers (0.3% increase), heart failure (increase of 0.1%), asthma (0.1% increase) and mental health (0.1% increase). For these diseases the prevalence for England increased by 0.5% for diabetes, 0.1% for hypertension, 0.8% for all cancers, 0.1% for heart failure, 0.5% for asthma and 0.1% for mental health.

Table 7: Percentage of patients registered at GP practices in Leicester diagnosed with long term conditions

		Long term condition	Leicester Register	Leicester Prevalence	England Prevalence
Cardio-vascular	CVD	Hypertension	51,333	12.2%	13.9%
		CHD	10,010	2.4%	3.0%
		Stroke or TIA	5,114	1.2%	1.8%
		Heart Failure	3,531	0.8%	0.9%
High dependancy		Diabetes (17+)	32,031	9.6%	7.1%
		All cancers	6,908	1.6%	3.2%
		CKD (18+)	7,685	2.3%	4.0%
Respiratory	Respiratory diseases	Asthma	19,885	5.1%	6.4%
		COPD	5,800	1.4%	1.9%
Mental Health	Mental health	Mental Health	4,429	1.1%	1.0%
		Dementia	2,332	0.6%	0.7%

Significantly below England average
Significantly above England average

Data: Quality Outcomes Framework, 2020/21

Lifestyles

Poor lifestyles have an adverse effect on health outcomes and Leicester shows poorer lifestyles than nationally[19] in terms of

- **Smoking prevalence**: the highest levels are seen in the west of Leicester (25%) where the smoking prevalence is significantly higher than Leicester overall (20%)[20]
- **Alcohol consumption:** significantly lower percentage never drink over recommended maximum alcohol limit in west (39%) and south (29%) than

[19] Public Health England Health Profiles: https://fingertips.phe.org.uk/profile/health-profiles
[20] Leicester Health & Wellbeing Survey, 2018. PowerPoint Presentation (leicester.gov.uk)

Leicester City overall (51%)[23]

- **Physical activity levels are low;** low percentage of adults achieving at least 150 minutes of physical activity per week (55.4%)[21]
- **Levels of diabetes;** significantly higher diabetes (17+) prevalence in GP practices in the north (14.0%) and east (10.6%) of the city than Leicester City overall (9.6%)[22]
- **Levels of obesity;** adults are similar to nationally (Leicester: 60.2%, England: 63.5%), year 6 children are significantly worse (Leicester: 38.4%, England: 35.2%)[23]
- **Teenage conceptions:** under 18 conception rates for Leicester (11.4 per 1,000 population) not significantly different to England (13.0 per 1,000 population)[24]

Leicester Locality Area Health and Lifestyle Breakdown

The health and lifestyle of each of the six locality areas in Leicester City has been summarised below and in table 8.

Central:

- Significantly higher female life expectancy than Leicester City as a whole (Central: 82.8 years, Leicester: 81.7 years)
- Significantly lower prevalence of dementia, hypertension, CHD, stroke, asthma, COPD, diabetes (17+) and cancer than Leicester City
- Significantly lower prevalence of physical activity (53.0%) and poor mental health and wellbeing (14.0%) than Leicester City (58.0% and 17.0% respectively)

East:

- Significantly higher prevalence of dementia, hypertension, CHD, stroke, asthma, COPD, diabetes (17+) and cancer than Leicester City
- Prevalence of physical activity (51.0%) is significantly lower than in Leicester City as a whole (58.0%)

North:

- Highest female life expectancy (83.5 years) across the six locality areas of Leicester and significantly higher value than for Leicester City overall (81.7 years)
- Significantly higher carer prevalence (17.0%) than Leicester City (13.0%)
- Significantly lower prevalence of cancer, COPD and asthma and a significantly higher prevalence of hypertension, CHD and diabetes (17+) than Leicester overall
- Significantly lower prevalence of smoking (14.0%) and physical activity (49.0%)

[21] Office for Health Improvement & Disparities, Fingertips, 2019/20. Public health profiles - OHID (phe.org.uk)
[22] Diabetes: QOF prevalence (17+), 2020/21, Fingertips, Office for Health Improvement & Disparities. Public health profiles - OHID (phe.org.uk)
[23] Office for Health Improvement & Disparities, Fingertips, 2019/20. Public health profiles - OHID (phe.org.uk)
[24] Office for Health Improvement & Disparities, Fingertips, 2019. Public health profiles - OHID (phe.org.uk)

compared to Leicester (20.0% and 58.0% respectively)

North West:

- Significantly higher prevalence of hypertension, COPD and cancer and a significantly lower prevalence of diabetes (17+) compared to Leicester
- Significantly lower alcohol prevalence (5.0%) than Leicester (9.0%) but a significantly higher prevalence of poor mental health and wellbeing (North West: 23.0%, Leicester: 17.0%)

South:

- Significantly higher prevalence of dementia, mental health, hypertension, CHD, stroke, asthma, COPD and cancer and a significantly lower prevalence of diabetes (17+) than Leicester
- Significantly higher prevalence of physical activity (69.0%) than Leicester (58.0%)

West:

- Life expectancy at birth for both males (74.8 years) and females (79.2 years) is significantly lower than in Leicester (76.9 and 81.7 years respectively)
- Prevalence of hypertension, stroke, asthma, COPD and cancer is significantly higher than Leicester and the prevalence of diabetes (17+) is significantly lower than Leicester
- Significantly higher prevalence of smoking (25.0%) and physical activity (72.0%) than Leicester (20.0% and 58.0% respectively)

Table 8: *Health and lifestyle summary of the six locality areas of Leicester City*

		Central	East	North	North West	South	West	Leicester City
Life expectancy at birth (years)	Males	76.9	77.2	77.8	77.6	77.5	74.8	76.9
	Females	82.8	81.7	83.5	81.8	81.5	79.2	81.7
Long term conditions	Dementia prevalence	0.4%	0.9%	0.6%	0.6%	0.8%	0.7%	0.6%
	Mental Health prevalence	1.0%	1.1%	1.0%	1.0%	1.3%	1.1%	1.0%
	Hypertension prevalence	8.4%	13.7%	14.1%	12.7%	13.7%	12.6%	12.1%
	CHD prevalence	1.7%	2.8%	2.8%	2.5%	2.7%	2.4%	2.4%
	Stroke prevalence	0.7%	1.6%	1.2%	1.3%	1.5%	1.3%	1.2%
	Asthma prevalence	4.4%	6.0%	4.6%	5.4%	5.8%	5.7%	5.1%
	COPD prevalence	0.5%	1.7%	0.8%	1.9%	2.3%	2.2%	1.4%
	Diabetes (17+) prevalence	5.8%	8.0%	10.6%	7.0%	6.1%	5.9%	7.4%
	Cancer prevalence	0.9%	2.1%	1.4%	1.9%	2.2%	2.0%	1.6%
Lifestyle	Smoking prevalence	18.0%	16.0%	14.0%	23.0%	24.0%	25.0%	20.0%
	Alcohol prevalence	13.0%	8.0%	7.0%	5.0%	10.0%	12.0%	9.0%
	Physical activity prevalence	53.0%	51.0%	49.0%	57.0%	69.0%	72.0%	58.0%
	Poor mental health and wellbeing prevalence	14.0%	16.0%	17.0%	23.0%	16.0%	17.0%	17.0%
	Carer prevalence	11.0%	14.0%	17.0%	10.0%	15.0%	12.0%	13.0%

Significantly lower than Leicester City
Significantly higher than Leicester City

Data: SystmOne June 2020, Leicester Health and Wellbeing Survey 2018, ONS deaths 2016-2020, ONS mid-year population estimates 2016-2020

More information on health in Leicester and health priorities can be found in:

- ***Leicester Joint Strategic Needs Assessment:***

  This is a series of briefings on adults and children and young people covering the health and wellbeing of people in Leicester, including data and links to

related information. Joint Strategic Needs Assessment (leicester.gov.uk)

- ***Health profiles:*** Public health profiles - OHID (phe.org.uk)
- ***Local health information*:** http://www.localhealth.org.uk
- ***Health and Wellbeing Strategy:***

  This sets out 5 strategic priorities which will be used to inform yearly operational and commissioning plans:

  - Healthy places – to make Leicester the healthiest possible environment in which to live and work
  - Healthy lives – to encourage people to make sustainable and healthy lifestyle choices
  - Healthy ageing – to enable Leicester's residents to age comfortably and confidently
  - Healthy start – to give Leicester's children the best start in life
  - Healthy minds – to promote positive mental health within Leicester across the life course

  The Joint Health and Wellbeing Strategy 2019-2024 (leicester.gov.uk)

- ***Leicester City Clinical Commissioning Group Strategic Priorities:***

  The Leicester City Clinical Commissioning group holds the following strategic aims:

  - Increase the health outcomes of the Leicester, Leicestershire and Rutland population.
  - Reduce health inequalities across the Leicester, Leicester and Rutland population.
  - Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.
  - Deliver a sustainable system financial plan – ensuring funding is distributed to where services are delivered.
  - Deliver NHS Constitutional requirements.
  - Develop and deliver services with providers that are evidenced based and offer value for money.
  - Deliver integrated health and social care.

  Strategies and reports - Leicester City Clinical Commissioning Group Leicester City Clinical Commissioning Group (leicestercityccg.nhs.uk)

  From 1st July 2022, Clinical Commissioning Groups will be replace by Integrated Care Systems.

- ***Leicester, Leicestershire and Rutland Integrated Care System (ICS):***

  From 1st July 2022 new ICS partnerships were formed, building on the lessons of the earlier systems and achievements of earlier work through sustainability and transformation partnerships. Leicester, Leicestershire and Rutland ICS represents a new partnership between the organisations that meet health and care needs across the area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. More information on ICSs is available here: NHS England » What are

integrated care systems?

More specific information to the LLR ICS is available here: Leicester, Leicestershire and Rutland gets go-ahead to become Integrated Care System - Leicester City Clinical Commissioning Group Leicester City Clinical Commissioning Group (leicestercityccg.nhs.uk)

6. LOCATION AND ACCESS TO COMMUNITY PHARMACIES IN LEICESTER

Leicester has 85 community pharmacies (as of 31 March 2022) and 57 GP Surgeries (and nine branch surgeries). Leicester has an overall rate of 2.4 community pharmacies per 10,000 population, higher than the England rate of 2.1[25]. The number of pharmacies has decreased by one since 2017, Leicester has witnessed only a slight increase in population of around 500 from 353,540[26] to 354,036[27]. All Leicester pharmacies are open for at least 40 hours and 8 are open for 100 hours. Of Leicester's 85 pharmacies, 9 are distance selling pharmacies, one is a Local Pharmaceutical Service pharmacy and one pharmacy is eligible for the Pharmacy Access Scheme. There are no dispensing GP Practices in Leicester and no appliance contractors.

Pharmaceutical Needs Assessments do not cover prison pharmacy services, as found in HM Prison Leicester, Welford Road, nor hospital pharmacy services, as found in University Hospitals of Leicester NHS Trust.

6.1 Pharmacies do not serve a defined population

It is important to keep in mind, as this PNA considers the location of, and access to, community pharmacies, that pharmacies do not have a designated service area and customers, patients or the public are free to choose which pharmacy to use. This report considers provision of pharmaceutical services across Leicester city and within 1.5km of the City boundary. These pharmacies are an essential part of the picture of provision for people living in the wider urban area of Leicester who will routinely travel to pharmacies which, depending on where they live, are outside or within the city boundary, as is convenient to them.

This report considers variation in pharmacy provision across the six locality areas (Central, East, North, North West, South and West Leicester) based on the community pharmacies located within these localities and provides rates based on the populations.

This PNA considers access and use of pharmacies on the basis that people will generally use a pharmacy near to their home, but it should be clear that there is no requirement on them to do so and similarly no power for NHS England and NHS Improvement, or any other commissioner, to direct the geographical location of existing pharmacies within Leicester (or anywhere else).

25 https://www.nhsbsa.nhs.uk/statistical-collections/general-pharmaceutical-services-england/general-pharmaceutical-services-england-201516-202021

26 Office for National Statistics, mid-year population estimates 2017

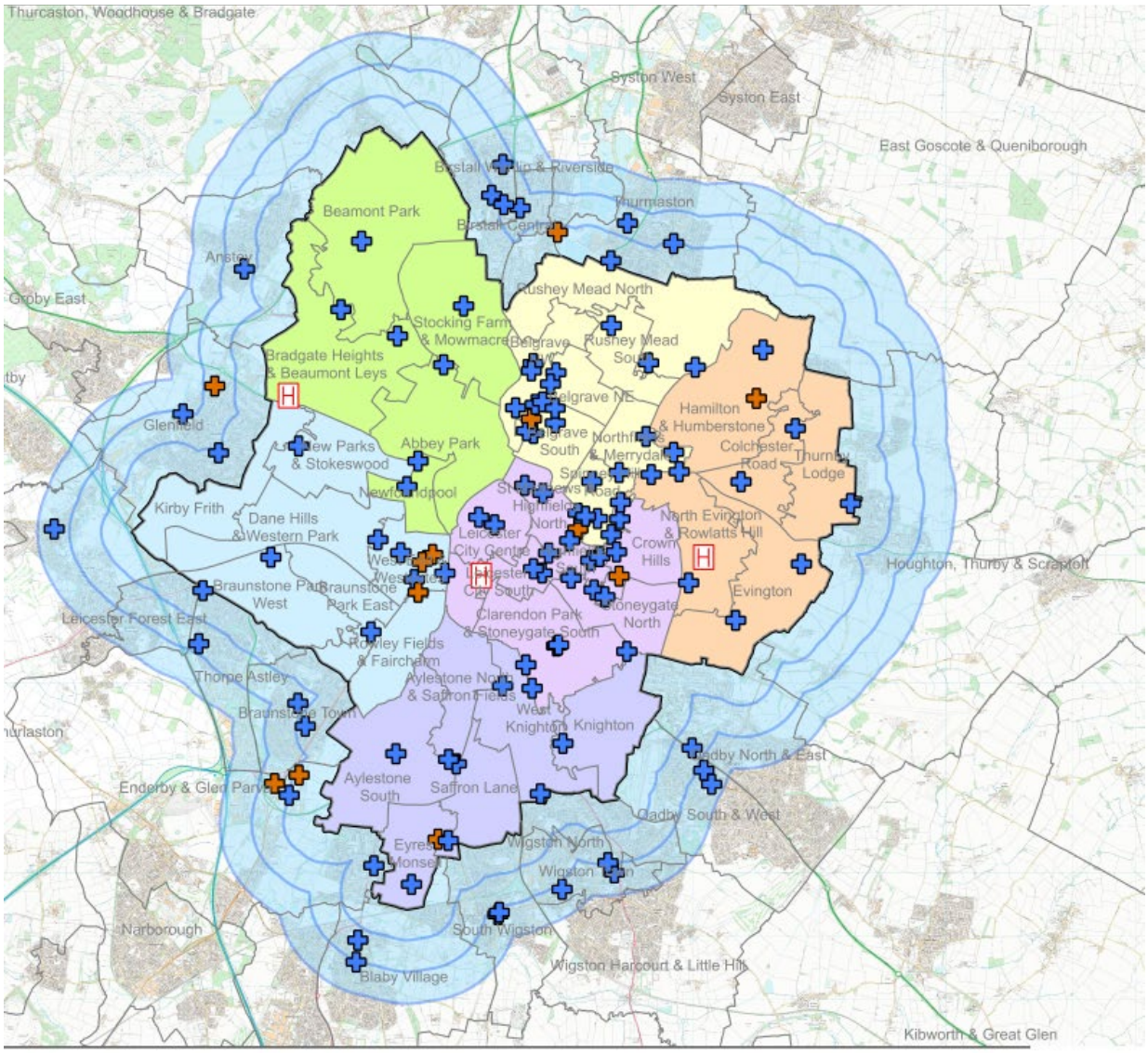
27 Office for National Statistics, mid-year population estimates 2020

6.2 Location and access to pharmacies

6.2.1 Distribution of community pharmacies

Figure 6, below, shows that, in addition to the pharmacies located within the city boundary, there are 9 pharmacies within 0.5 km, a further 15 between 0.5 and 1km and 9 between 1km and 1.5km of the Leicester boundary. These pharmacies are an essential part of the picture of provision for people living in Leicester, particularly on the outskirts of the city who may travel to pharmacies outside of the city boundary. Leicestershire County Council has pointed out that proximity to Leicester City pharmacies reduces the impact of, for example, a lack of 100 hour pharmacies in some areas of the County. The impact of pharmacy service provision in Leicestershire resulting from Leicester's pharmacy service provision levels, should be kept under review, as well as issues of quality and uniformity of access to advanced and community based services.

Figure 6: Pharmacies in and around Leicester City



Pharmacies in Leicester and surrounding area by standard and extended (100 hours) opening hours

Pharmacy opening hours

- Standard hours (106)
- 100 hours (12)

Locality

- Central
- East
- North
- North West
- South
- West

- University Hospitals of Leicester
- 0.5km buffer

Public Health Division
Leicester City Council
Created: April 2022

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Data: NHS England and NHS Improvement Pharmacy data, CDS GP Practice data

Table 9 below shows the location and types of pharmacies by locality area in Leicester.

The highest rates of pharmacies are found in the north and centre of the city. There is at least one 100 hour pharmacy located in each of the locality areas with the exception of the north west of the city. There are internet/distance selling pharmacies in the central, north and south locality areas of the city. The highest number of GP surgeries are found in the centre and north of Leicester.

Table 9: Pharmacy types, GP Practices and pharmacies per 10,000 population in Leicester by locality area, 2020/21

Locality Area	Total No. of Pharmacies	100hr Pharmacies	Internet/Distance Selling Pharmacies	No. GP Surgeries (including branch surgeries)	Pharmacies per 10,000 population
Central	23	2	3	19	2.8
East	9	1	0	8	1.7
North	24	1	4	14	3.7
North West	7	0	0	7	1.5
South	11	1	2	7	2.4
West	11	3	0	11	1.8
Leicester City	85	8	9	66	2.4

Data: NHS England and NHS Improvement, ONS 2020 mid-year population estimates

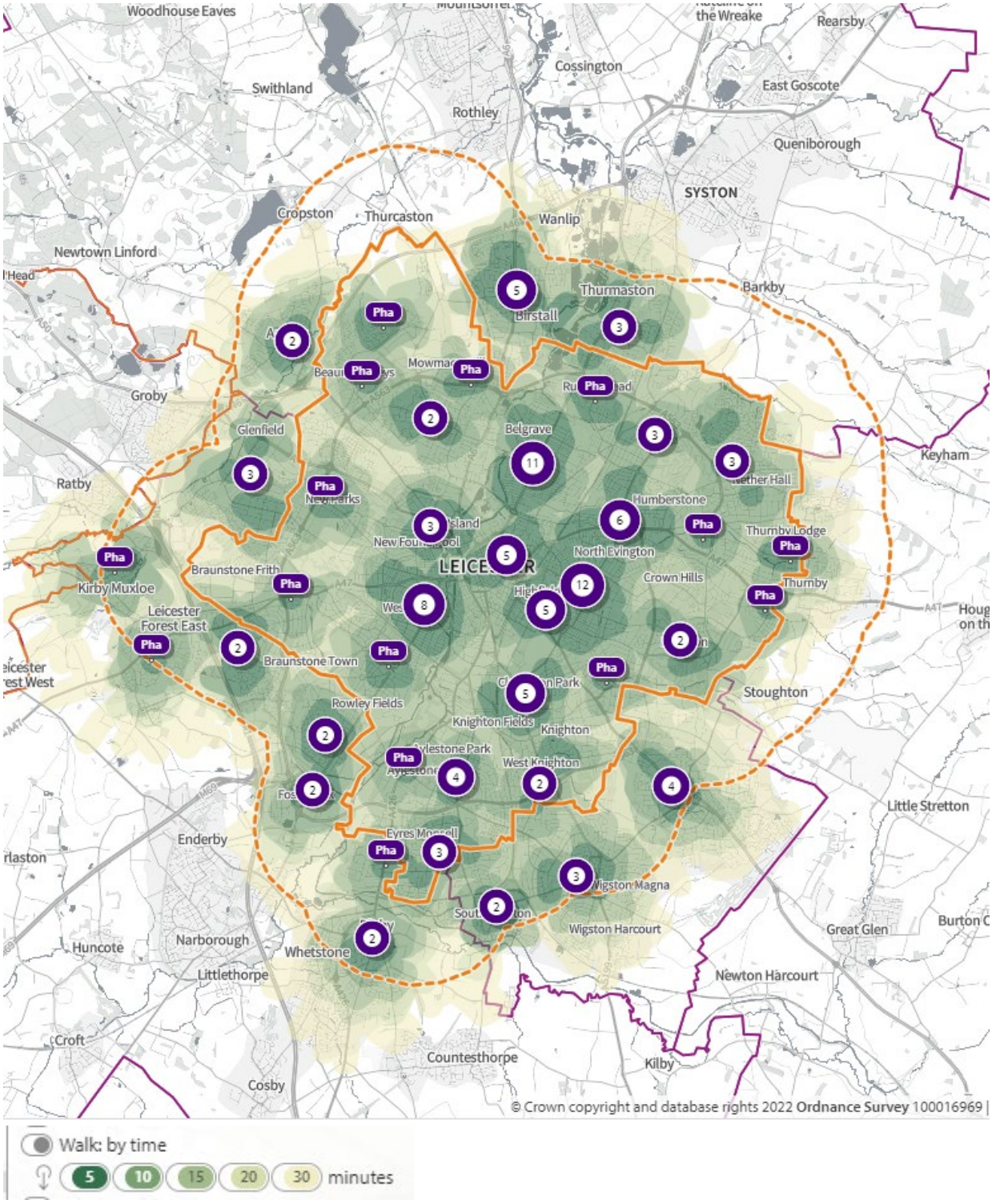
6.2.2 Walk-times to Pharmacies

The map below (figure 7) shows pharmacies accessible within 5 minute walking times.

All Leicester residents can walk to their nearest pharmacy within 20 minutes

- 96% of residents can walk to their nearest pharmacy within 15 minutes
- 86% of residents can walk to their nearest pharmacy within 10 minutes
- 58% of residents can walk to their nearest pharmacy within 5 minutes

Figure 7: Walk times to pharmacies in Leicester



Source: Strategic Health Asset Planning and Evaluation tool: https://shapeatlas.net/

There are a few areas of Leicester indicated as being above a 15 minute walk-time from a pharmacy. These are in the west of the city to the north of New Parks and in Braunstone Frith.

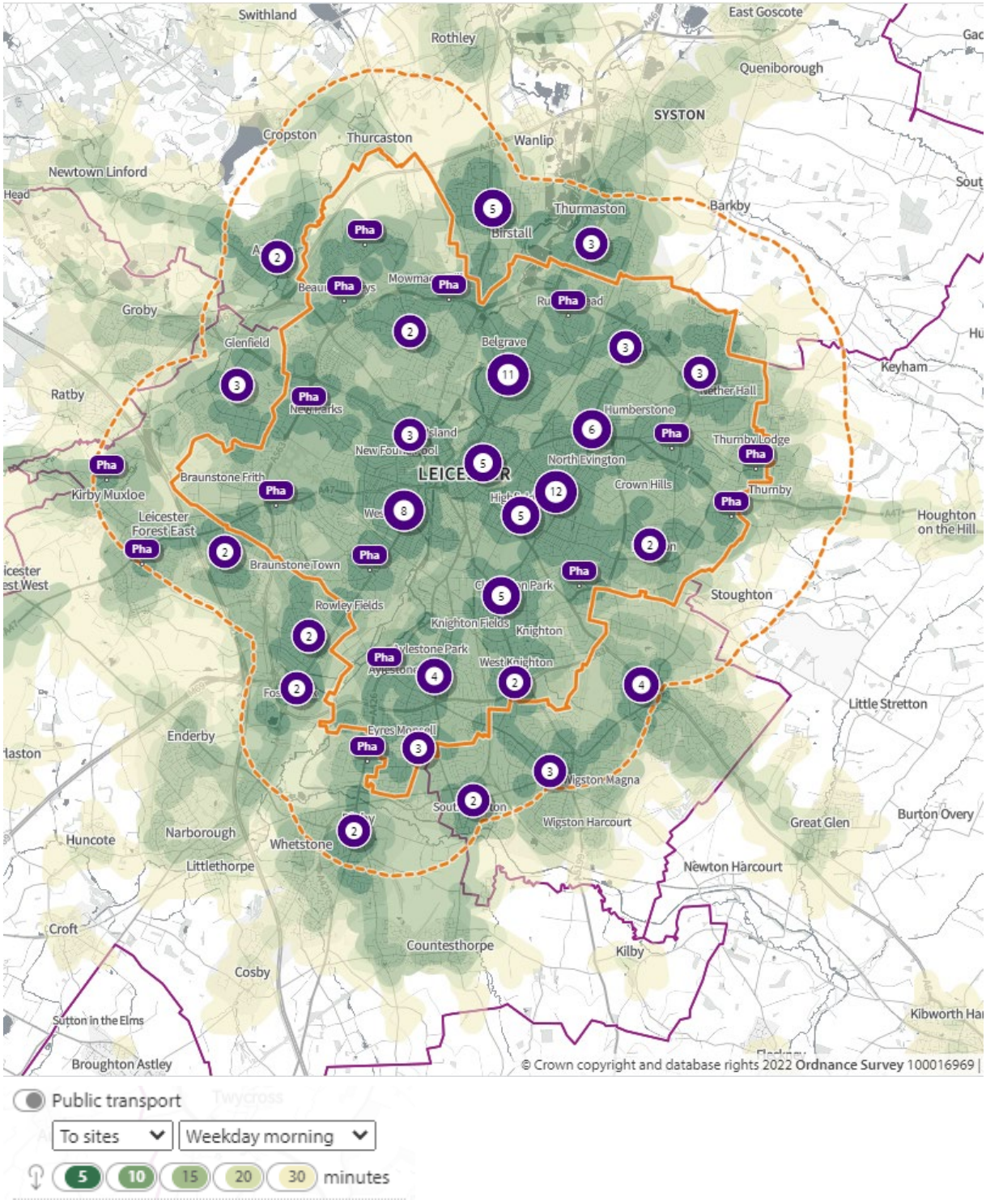
6.2.3 Public transport travel times to pharmacies

The following map (figure 8) shows travel times by public transport to pharmacies, based on travel times on a weekday morning

Based on this map, the proportion of Leicester residents able to reach their nearest pharmacy by public transport:

- all residents can reach a pharmacy within 15 minutes
- 99% of residents can reach a pharmacy within 10 minutes
- 74% can reach a pharmacy within 5 minutes

Figure 8: Public transport travel times to pharmacies



Source: Strategic Health Asset Planning and Evaluation tool: https://shapeatlas.net/

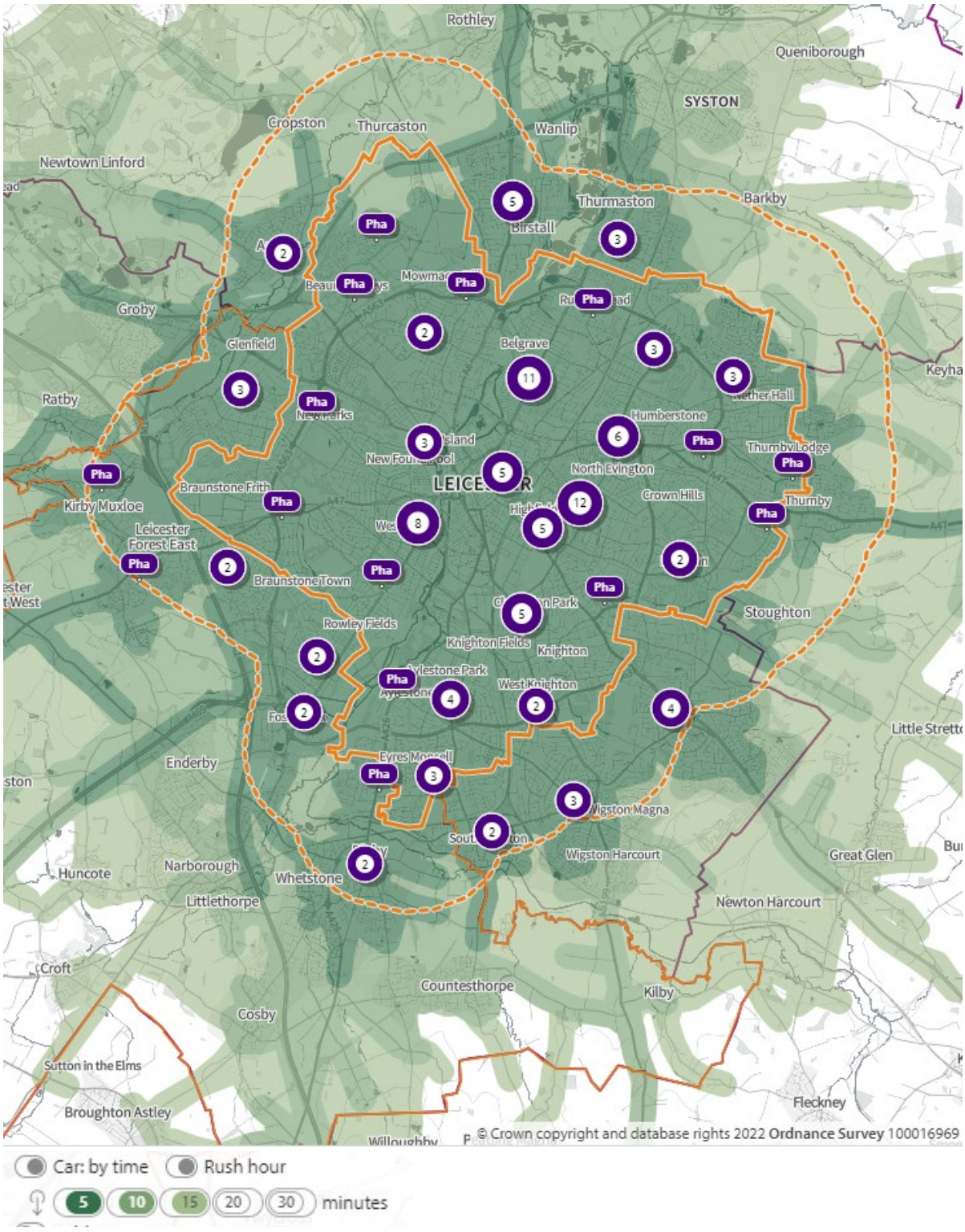
6.2.4 Drive times to Pharmacies

Figure 9 shows that all of Leicester's population can drive to their nearest pharmacy within 15 minutes and 99% can reach their nearest pharmacy within 10 minutes.

However, it should be noted that the percentage of the Leicester population which does

not own a car is significantly higher than the average for England (37% v 26%: Census 2011) and there is considerable variation across the city.

Figure 9: Drive times to pharmacies in Leicester



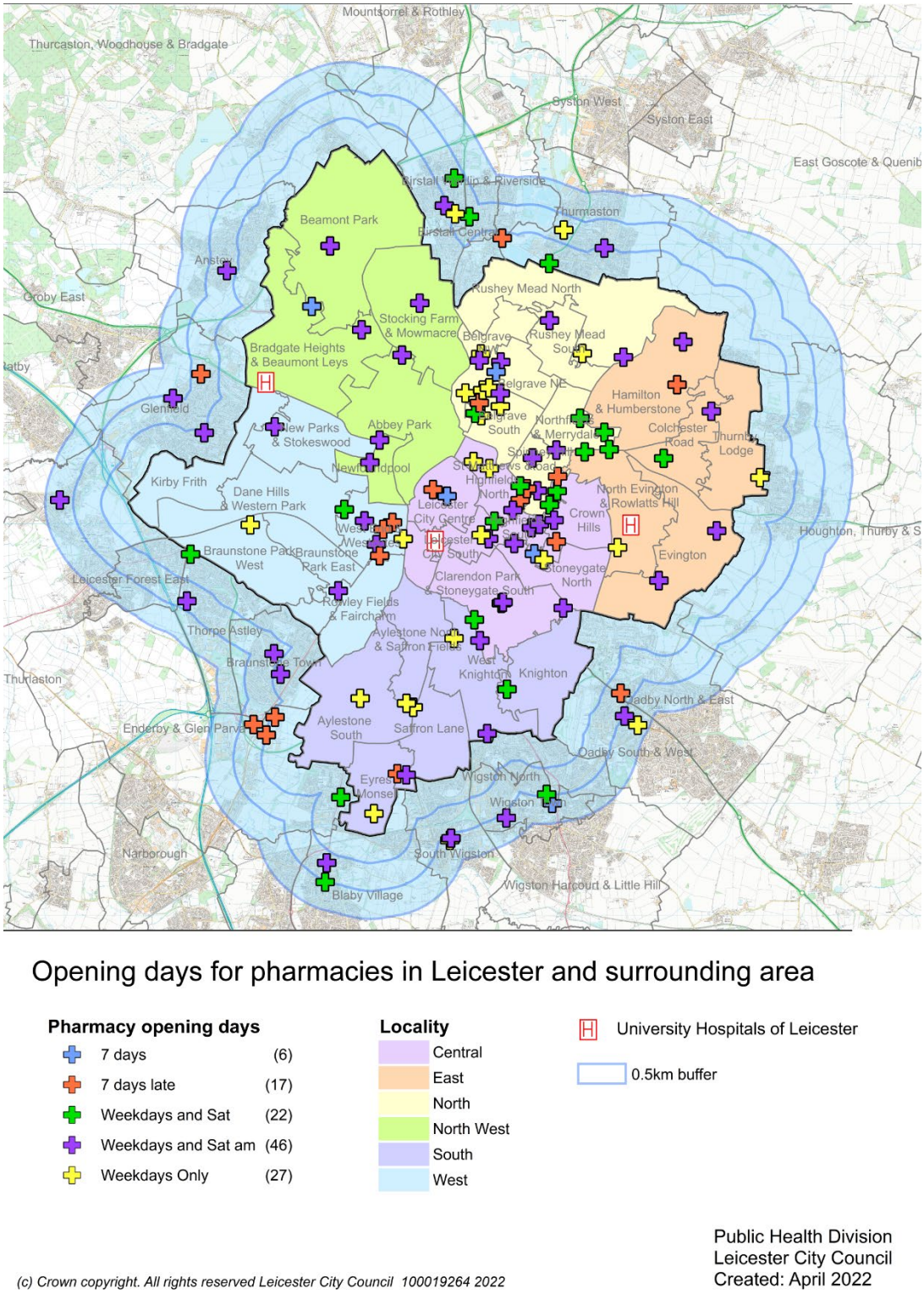
Source: Strategic Health Asset Planning and Evaluation tool: https://shapeatlas.net/

6.3 Pharmacy opening times

The map below (figure 10) shows pharmacies in Leicester and surrounding areas, categorised by the number of days pharmacies are open and by standard or extended hours.

Note: Pharmacies are categorized as open 'late' where they open after 18:30 on weekdays

Figure 10: Pharmacies in Leicester and surrounding area by opening hours



As shown in table 10 below:

- Across Leicester's locality areas, pharmacy opening times range from 335 hours to over 1200 hours per week. Areas of North West Leicester have the smallest number of open hours per week.
- The central area of Leicester and areas of North Leicester have the highest number of total weekly open hours (over 1200 open hours per week each).
- Across the city 17.6% (15) of pharmacies are open 7 days a week (including standard and late opening hours).
- 56.5% (48) of pharmacies are open weekdays and at least some time on Saturday (weekdays and sat and weekdays and sat am).
- All locality areas have at least two pharmacies open Saturday am, with only North West Leicester having no pharmacies open Saturday pm.
- Services are more restricted on Sundays.
- 25.8% (22) of pharmacies are open only on weekdays.

Table 10: Pharmacy opening days by locality area, 2020/21

Locality Area	7 days	7 days late	Weekdays and Sat	Weekdays and Sat am	Weekdays Only	Leicester City Total	Of Leicester total - distance selling pharmacies	Weekly total hours open	Population	Hours open per 10,000 population
Central	2	3	5	9	4	23	3	1234.4	83285	148.2
East	0	1	2	4	2	9	0	481.3	52218	92.2
North	1	3	5	8	7	24	4	1231.5	64233	191.7
North West	1	0	0	6	0	7	0	335.8	47946	70.0
South	0	1	2	2	6	11	2	549.0	45476	120.7
West	0	3	1	4	3	11	0	696.4	60878	114.4
Leicester City Total	4	11	15	33	22	85	9	4528.4	354036	127.9

Distance from Leicester boundary	7 days	7 days late	Weekdays and Sat	Weekdays and Sat am	Weekdays Only	Total within each distance of Leicester boundary
0.0 - 0.5km	0	2	3	4	1	10
0.5 - 1.0km	0	4	4	5	2	15
1.0 - 1.5km	2	0	0	4	2	8
Total within 1.5km of Leicester	2	6	7	13	5	33

Data: NHS England and NHS Improvement, ONS 2020 mid-year population estimates

The opening hours of individual pharmacies by locality areas are given in Appendix 1.

6.4 Accessibility of services

Within the pharmacy questionnaire, pharmacies were asked which facilities they have to help people access services. The results showed that just over half (52%) of pharmacies have wheelchair ramp access, with 55% having large print labels/leaflets, 45% having dementia-friendly space and 45% having automatic door assistance. Other accessibility facilities were also provided across the 31 pharmacies which responded, such as a hearing loop (29%), disabled toilet facility (13%) and bell at the front door (13%).

6.5 Conclusions

This section has described the types and locations of community pharmacies in Leicester. It should be noted that this PNA does not include pharmacy services not open to the general public, that is prison and hospital pharmacy services.

There is currently sufficient provision of pharmacies in Leicester City. Leicester has 85 community pharmacies (as of 31st March 2022) - a rate of 2.4 community pharmacies per 10,000 population which is higher than the average for England, 2.1 pharmacies per 10,000 population.[28],[29]

Community pharmacies do not serve defined populations or geographical areas. This PNA considers access and use of pharmacies on the basis that people will generally use a pharmacy near to their home, GP surgery or workplace.

Generally, almost everyone in Leicester is able to access a pharmacy by walking, public transport or private car within what can be considered a reasonable time. A distance within 1km, or 20 minute walk, 15 minute public transport journey or 5 minute drive are considered to be reasonable access times and distances to a community pharmacy.

It is evident that there is clustering of pharmacy locations not necessarily related to underlying health need but rather to historical and commercial decisions made over a number of years, or decades. More pharmacies are concentrated in the north central and east central areas of the city with fewer in the west and outer areas of the city.

All pharmacies in the city are open for at least 40 hours and 8 are open for 100 hours. A number of pharmacies open for longer than their contracted hours.

There are nine pharmacies within 0.5 km, a further 15 between 0.5 and 1km and nine between 1km and 1.5km of the Leicester boundary. These pharmacies are an essential part of the picture of provision for people living in Leicester, particularly toward the outskirts of the city.

Further details of the services provided by community pharmacies and their delivery are considered in the next chapter.

[28] NHS Business Service Authority. General Pharmaceutical Services in England: 2015-16 to 2020-21. (2021) General Pharmaceutical Services in England 2015/16 - 2020/21 | NHSBSA

[29] ONS mid-year 2020 population estimates

7. Current Pharmacy Service Provision

This section provides information regarding the delivery of essential, advanced and locally commissioned services by pharmacies in Leicester. All pharmacies provide essential services, most provide advanced services and pharmacies can choose which, if any, locally commissioned services they wish to offer.

7.1 Essential Services

Essential services are described in section 4.1.1 and constitute the following:

- Dispensing and repeat dispensing of medicines
- Dispensing appliances
- Repeat prescription
- Clinical governance
- Promotion of healthy lifestyles (Public Health)
- Discharge medicines service
- Disposal of unwanted medicines
- Signposting
- Support for self-care
- Healthy Living Pharmacies (2021)

7.1.1. Dispensing and repeat dispensing

During 2020 the total prescribing costs for Leicester City CCG were over £51,500,000 (see table 11 below). The top three causes for prescriptions were the endocrine system, central nervous system disorders, and cardiovascular diseases. These accounted for more than half of the total cost of prescriptions. Prescribed items are associated with the GP practice of the patient rather than the patient's residence, so it is not possible to show the data by area of residence.

Table 4: Prescription items and associated costs, Leicester City CCG, 2020

Description	Number of Items	Total Cost (£)
Endocrine System	875,095	£10,895,757.65
Central Nervous System	1,178,056	£8,570,168.62
Cardiovascular System	1,991,352	£6,943,342.29
Respiratory System	429,825	£5,262,686.10
Nutrition and Blood	390,049	£4,676,206.04
Gastro-Intestinal System	580,496	£2,721,513.59
Appliances	281,958	£2,645,008.94
Stoma Appliances	37,596	£1,897,800.39
Skin	179,661	£1,473,964.42
Obstetrics,Gynae+Urinary Tract Disorders	140,941	£1,042,268.79
Eye	121,900	£1,034,114.92
Infections	167,647	£893,607.46
Musculoskeletal and Joint Diseases	163,077	£729,417.05
Malignant Disease & Immunosuppression	20,239	£638,006.04
Immunological Products and Vaccines	64,946	£596,815.44
Dressings	17,118	£518,029.25
Ear, Nose and Oropharynx	58,890	£347,217.73
Incontinence Appliances	12,330	£288,499.42
Anaesthesia	10,033	£279,919.26
Other drugs and preparations	5,017	£156,649.15
Grand Total	**6,726,226**	**£51,610,992.55**

Data: OpenPrescribing.net

7.2 Advanced Services

Community pharmacies can choose to provide a range of advanced services as long as they meet the requirements set out in the Secretary of State Directions.

There are 8 advanced services: [30]

- Appliance Use Review (AUR)
- Community Pharmacist Consultation Service
- Flu Vaccination Service
- Hepatitis C Testing Service
- Hypertension Case-Finding Service
- New Medicine Service (NMS)
- Stoma Appliance Customisation (SAC)
- Smoking Cessation Service (Commissioned as an advanced service from 10th March 2022)

Note: The Medicines Use Review and Prescription Intervention Service (MUR) was decommissioned on 31st March 2021. The Covid-19 Lateral Flow Device Distribution Service ran from March 2021 to March 2022. Both are excluded from this PNA.

Where available, data on the provision of these advanced services in Leicester has been provided in the sections below.

Table 12 shows the provision of advanced services in Leicester pharmacies.

Table *12*: Advanced Service Provision in Leicester Pharmacies – Number of pharmacies providing each advanced service, as at March 2022

	Total Number of Pharmacies	New Medicine Service (NMS) Activity	Appliance Use Reviews (AUR) Activity	Stoma Customisation (SAC) Activity	Community Pharmacist Consultation Service (CPCS) Activity	Hepatitis C Antibody Testing Service Activity	Seasonal Influenza Vaccination Activity	Hypertension Case-Finding Service
Central	23	21	0	2	20	0	18	16
East	9	9	0	1	9	0	8	8
North	24	22	0	0	19	0	18	14
North West	7	7	0	0	7	0	6	7
South	11	9	0	1	10	0	9	8
West	11	11	0	2	11	0	10	9
Leicester City	85	79	0	6	76	0	69	62
Distance from Leicester boundary	**Total Number of Pharmacies**	**New Medicine Service (NMS) Activity**	**Appliance Use Reviews (AUR) Activity**	**Stoma Customisation (SAC) Activity**	**Community Pharmacist Consultation Service (CPCS) Activity**	**Hepatitis C Antibody Testing Service Activity**	**Seasonal Influenza Vaccination Activity**	**Hypertension Case-Finding Service**
0km to 0.5km	10	8	0	0	8	0	6	7
0.5km to 1km	15	15	0	2	12	0	13	13
1km to 1.5km	8	8	0	1	7	0	7	6
Total within 1.5km of Leicester	33	31	0	3	27	0	26	26

Source: NHS England and NHS Improvement 2022, NHS Business Services Authority – Advanced service flu report, June 2022, Office for Health Improvement & Disparities, 2022

[30] Advanced Services : PSNC Main site

7.2.1 New Medicines Service

The New Medicines Service (NMS) is available for people with the conditions below who have been newly prescribed a listed medicine:

- asthma and COPD
- diabetes (Type 2)
- antiplatelet / anticoagulant therapy
- hypertension
- high cholesterol
- osteoporosis
- gout
- glaucoma
- epilepsy
- Parkinson's disease
- urinary incontinence or retention
- heart failure, coronary heart disease, atrial fibrillation or heart attack
- stroke or transient ischaemic attack (TIA)

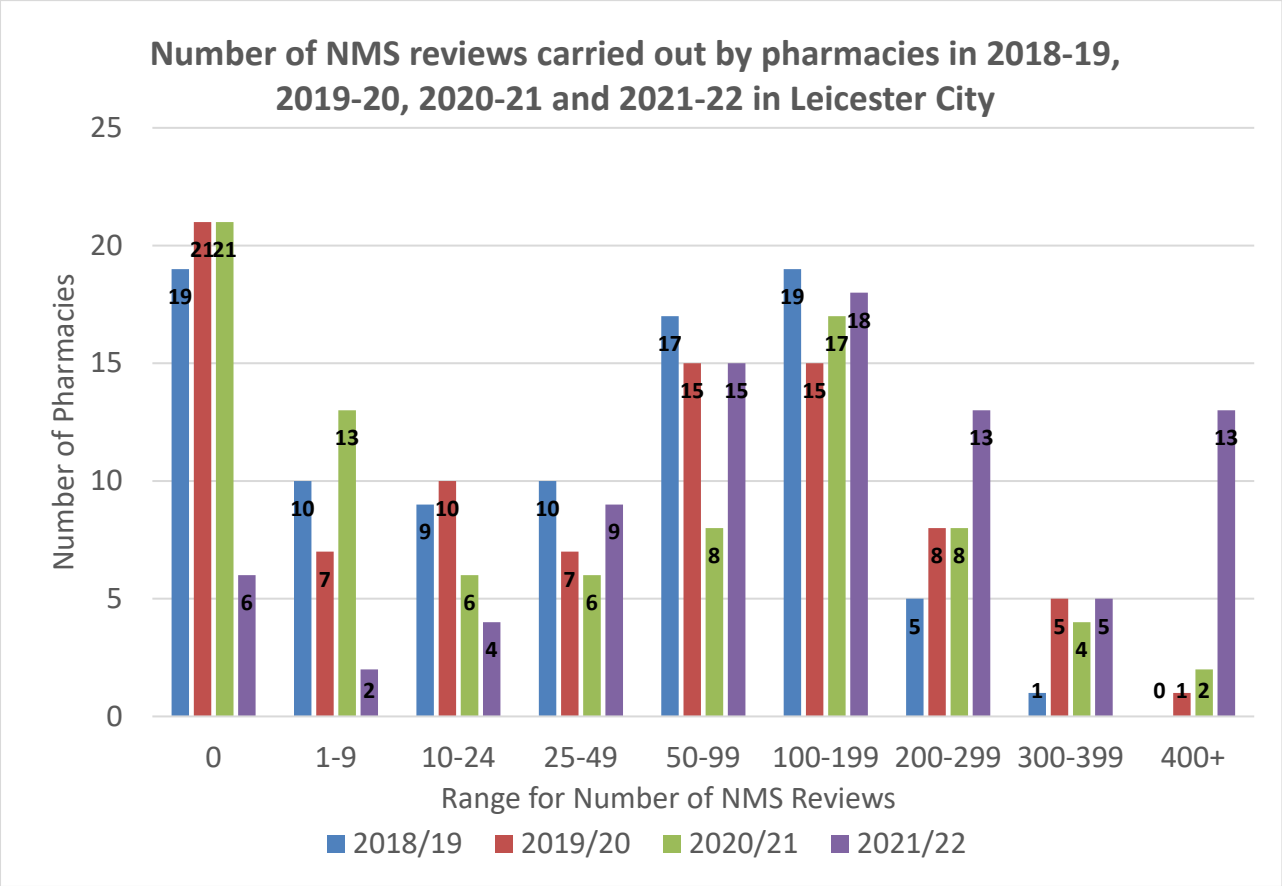
Pharmacists can intervene and provide support and advice to patients managing a long-term condition, making sure patients understand how the medication should be taken, thus improving their self-management of the condition.

Around 16,405 NMS reviews were carried out by 79 pharmacies during 2021/22. This represents 46 NMS per 1,000 population, with the lowest rate in the east of the city and the highest rate in the north of the city (see figure 12).

The number of NMS reviews carried out by any accredited pharmacy in Leicester ranged from 1 to 782 in 2021/22, with most pharmacies carrying out over 100 reviews.

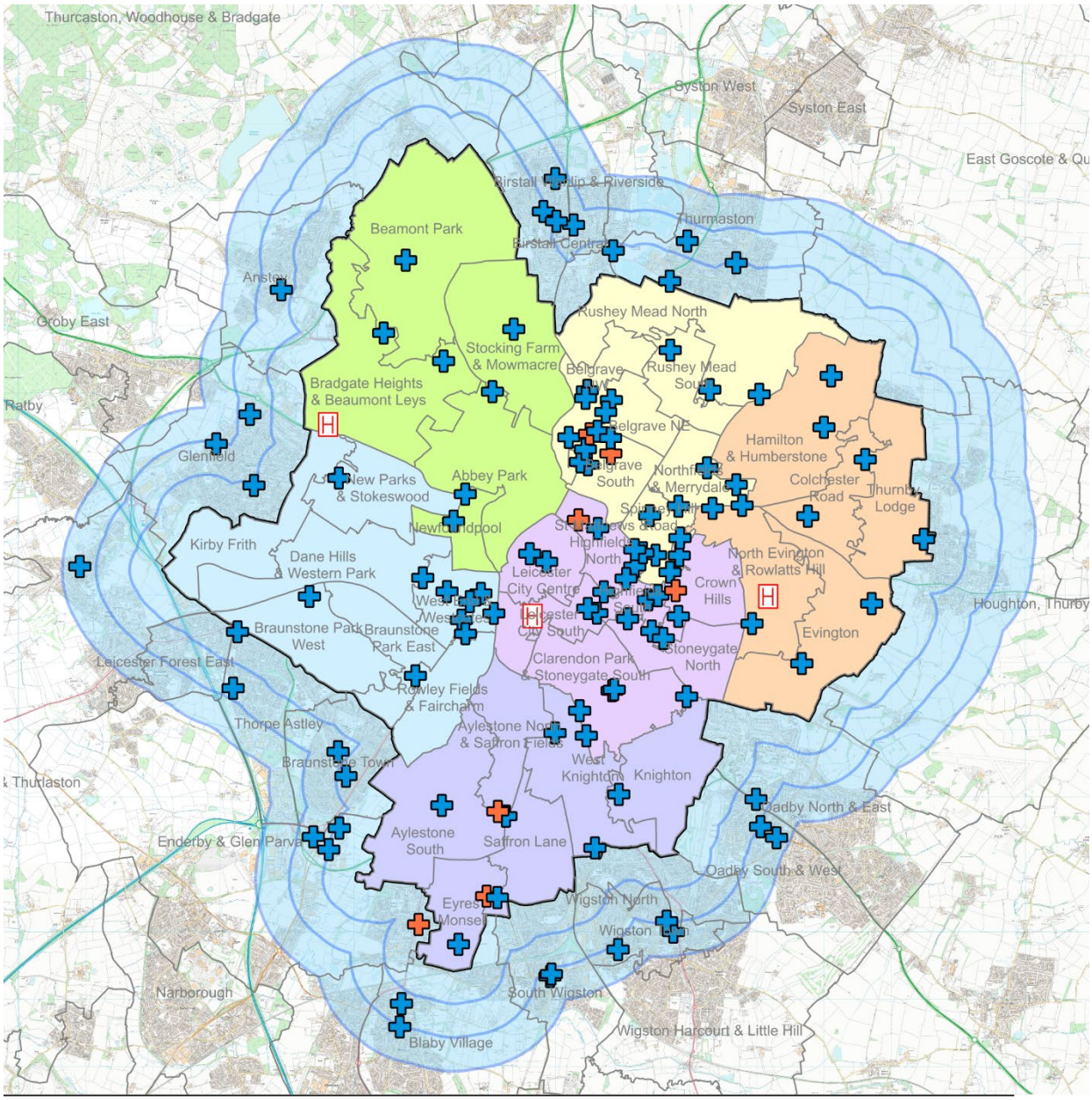
Larger numbers of NMS reviews were carried about by more pharmacies in 2021-22 than in previous years, potentially as a result of the Covid-19 pandemic (see figure 11 below).

Figure 11: Number of NMS carried out by pharmacies in 2018/19, 2019/20, 2020/21 *and 2021/22*



Data: NHS England and NHS Improvement

Figure 12: Pharmacies providing New Medicines Services



Pharmacies providing New Medicines Services in Leicester and surrounding area

New Medicines Service 2022

- New Medicines Service provided (110)
- New Medicines Service not provided (8)

Locality

- Central
- East
- North
- North West
- South
- West

- University Hospitals of Leicester
- 0.5km buffer

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Leicester City Council
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Data: NHS England and NHS Improvement

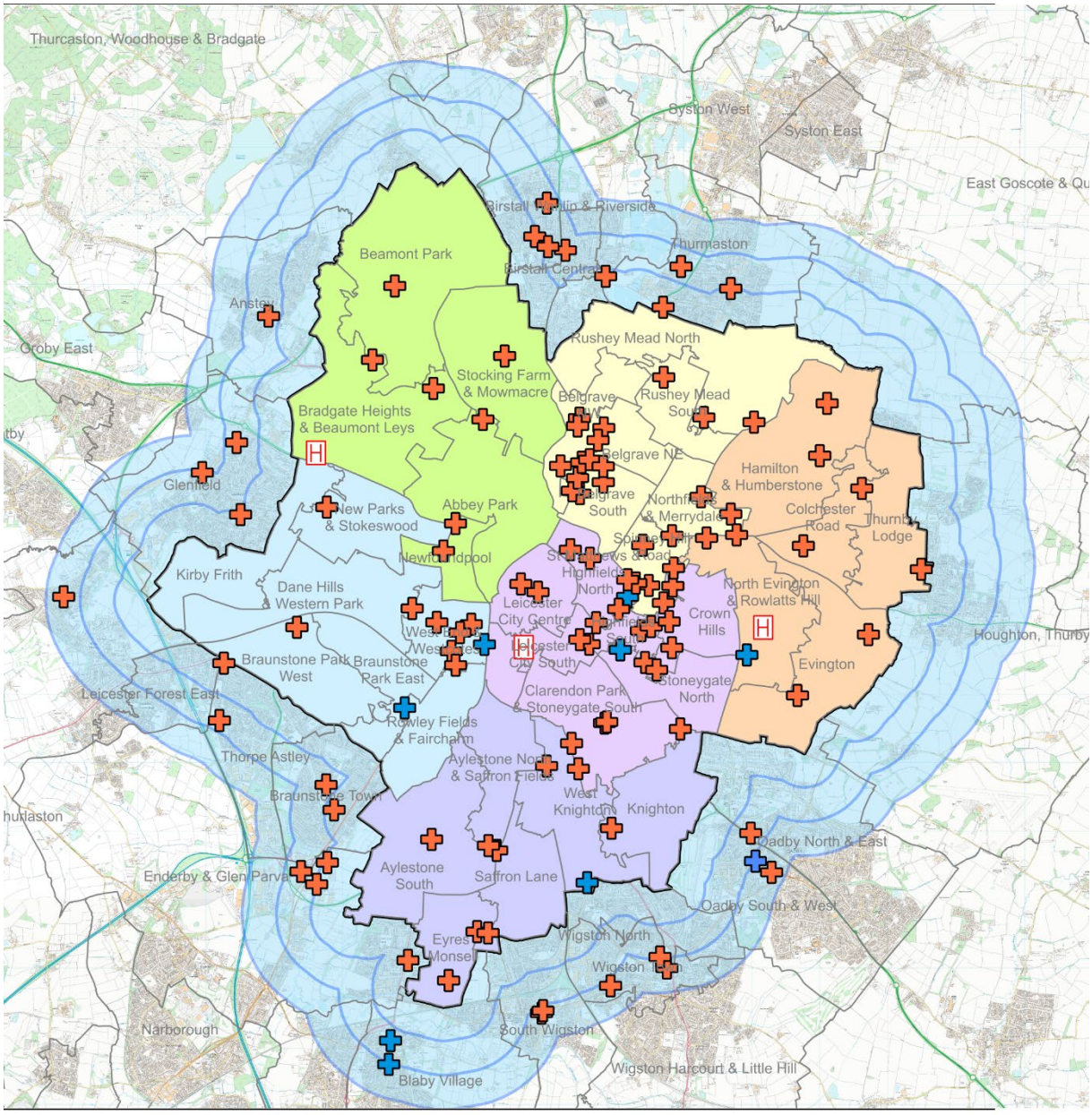
7.2.2 Stoma Appliance Customisation

This service ensures comfortable fitting of the stoma appliance (based on the patient's measurements or a template) and proper use of the appliance to improve patient comfort, the duration of usage and level of waste.

As shown in figure 13, Stoma Appliance Customisation (SAC) was provided at 6 out of 85 (7.0%) pharmacies in Leicester in 2021/22, an increase on the 4.4%, 4.5% and 3.5% of pharmacies providing SAC in 2018/19, 2019/20 and 2020/21 respectively. The percentage of pharmacies providing SAC in Leicester in 2021/22 is lower than the national average of 10.9% of community pharmacies and appliance contractors providing SAC services in 2020/21[31]. The SAC service usually involves delivery to the patient's home and is also available from other providers.

[31] General Pharmaceutical Services Report, England 2015/16 to 2020/21: General Pharmaceutical Services in England 2015/16 - 2020/21 | NHSBSA

Figure 13: Pharmacies providing Stoma Appliance Customisation



Pharmacies providing Stoma Appliance Customisation Service in Leicester and surrounding area

Stoma Appliance Customisation Service 2022

- Stoma Appliance Customisation provided (9)
- Stoma Appliance Customisation not provided (109)

Locality

- Central
- East
- North
- North West
- South
- West

- University Hospitals of Leicester
- 0.5km buffer

Public Health Division
Leicester City Council
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Source: NHS England and NHS Improvement

7.2.3 Appliance Use Reviews

Appliance Use Reviews (AURs) can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. AURs should improve the patient's knowledge and use of any 'specified appliance'.

The service allows 1 AUR per 1,000 prescriptions. There was no AUR activity reported for pharmacies in Leicester in 2021/22, with no recorded activity for this service in Leicester since 2018/19. Nationally, 0.6% of community pharmacies and appliance contractors provided AUR services in 2020/21[32].

7.2.4 Community Pharmacist Consultation Service

The Community Pharmacist Consultation Service (CPCS) launched on 29th October 2019 as an advanced service. This service replaced the NHS Urgent Medicine Supply Advanced Service (NUMSAS) pilots and connects patients who have a minor illness or need an urgent supply of a medicine with a community pharmacy. Since 1st November 2020 general practices, NHS 111, Integrated Urgent Care Clinical Assessment Services and in some cases the 999 service have been able to refer patients for a minor illness consultation via CPCS.[33] The aim is that the CPCS will relieve pressure on the wider NHS by connecting patients with community pharmacy.

As shown in table 13, in 2021/22 over 6,700 community pharmacist consultations were provided through 76 pharmacies in Leicester, a rate of 2.1 pharmacies providing consultations per 10,000 population – the same rate as for 2020/21. 89% of pharmacies in Leicester were providing the community pharmacist consultation service in 2021/22. Leicester witnessed an increase in the number of consultations provided from 2020/21 to 2021/22 with 2,047 and 6,780 consultations provided across the city respectively.

North Leicester had the highest rate of pharmacies providing the community pharmacist consultation service per 10,000 population in 2021/22 with a rate of 3.0 per 10,000 population, whilst North West Leicester had the lowest rate (1.5 per 10,000 population) (see figure 14).

[32] General Pharmaceutical Services in England, 2015/16 to 2020/21 General Pharmaceutical Services in England 2015/16 - 2020/21 | NHSBSA

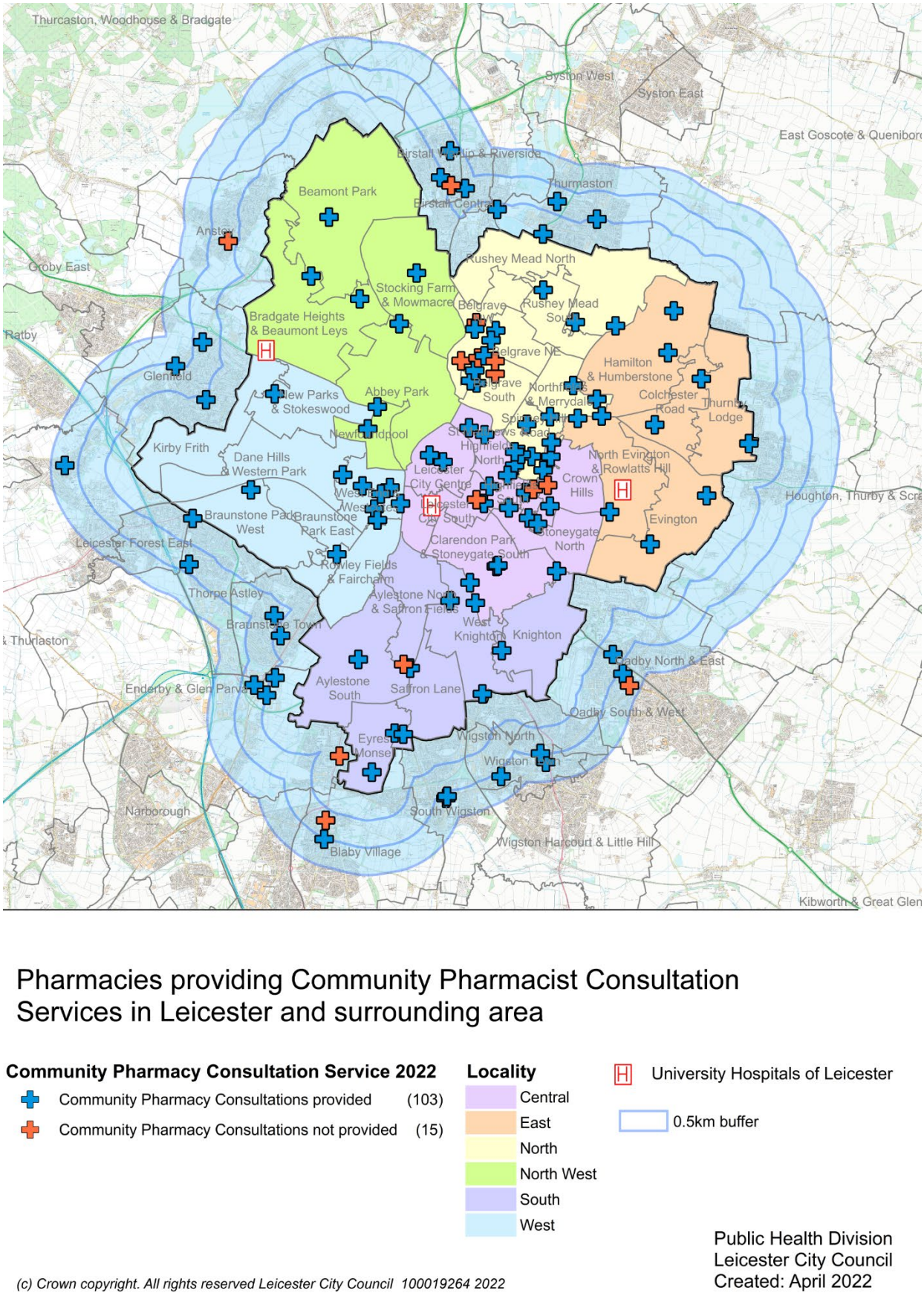
[33] Pharmaceutical Services Negotiating Committee, Community Pharmacist Consultation Service (CPCS) Community Pharmacist Consultation Service (CPCS) : PSNC Main site

Table 13: Provision of CPCS in Leicester pharmacies, 2021/22

Locality Area	Number of pharmacies providing CPCS	Number of consultations provided	Population (2020 MYE)	Pharmacies providing CPCS per 10,000 population
Central	20	1250	83285	2.4
East	9	684	52218	1.7
North	19	1816	64233	3.0
North West	7	732	47946	1.5
South	10	535	45476	2.2
West	11	1763	60878	1.8
Leicester City	76	6780	354036	2.1
Distance from boundary	**Number of pharmacies providing CPCS**	**Number of consultations provided**		
0km-0.5km	8	1167		
0.5km-1.0km	12	2773		
1.0km-1.5km	7	339		
Total within 1.5km of boundary	27	4279		

Data: NHS England and NHS Improvement

Figure 14: Pharmacies providing Community Pharmacist Consultation Services



Pharmacies providing Community Pharmacist Consultation Services in Leicester and surrounding area

Community Pharmacy Consultation Service 2022

- Community Pharmacy Consultations provided (103)
- Community Pharmacy Consultations not provided (15)

Locality

- Central
- East
- North
- North West
- South
- West

- University Hospitals of Leicester
- 0.5km buffer

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Leicester City Council
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Data: NHS England and NHS Improvement

7.2.5 Flu vaccination Service

The flu vaccination service runs each year alongside the GP service, aiming to vaccinate all patients who are at risk of developing more serious complications from the virus. These include people aged 65 years and over, pregnant women and those with certain health conditions.

In 2021/22, over 28,120 flu vaccinations were provided through 69 pharmacies in Leicester, a rate of 2.6 pharmacies providing flu vaccinations per 10,000 population 18+ (see table 14). This has increased compared to the 2016/17 data included in the previous version of this document where Leicester City had a rate of 1.7 pharmacies providing flu vaccination services per 10,000 population 18+. 81% of pharmacies in Leicester were providing flu vaccinations in 2021/22 compared to 84.4% of community pharmacies nationally.

Central (2.7 per 10,000 population 18+), South (2.6) and North (3.7) Leicester have the highest rates of pharmacies providing flu vaccinations per 10,000 population 18+, with North West (1.7) Leicester having the lowest rate (see table 14 and figure 15).

Table 14: Provision of flu vaccinations in Leicester pharmacies, September 2021 – March 2022

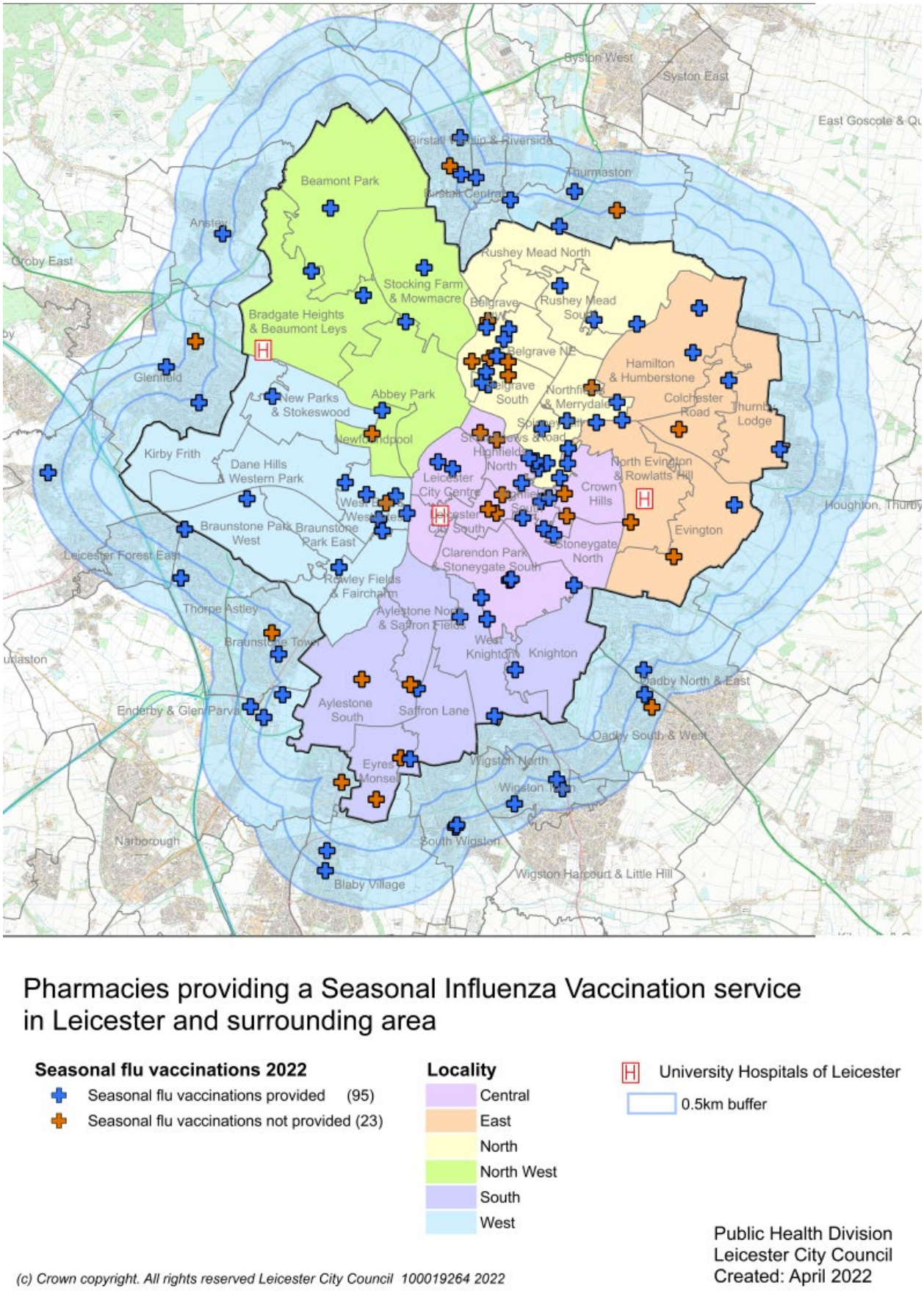
Locality Area	Number of pharmacies providing flu vaccinations	Total number of vaccines administered 2021/22	Population (18+) (2020 MYE)	Pharmacies providing flu vaccinations per 10,000 population 18+
Central	18	7445	67010	2.7
East	8	2244	38174	2.1
North	18	9207	48602	3.7
North West	6	3820	35491	1.7
South	9	1668	34452	2.6
West	10	3744	46238	2.2
Leicester City	69	28128	269967	2.6

Distance from Leicester boundary	Number of pharmacies providing flu vaccinations	Total number of vaccines administered 2021/22
0km-0.5km	6	2294
0.5km-1.0km	13	9224
1.0km-1.5km	7	5543
Total within 1.5km of Leicester	26	17061

**Note: Submissions are accepted from contractors up to six months after the dispensing month and accredited to the dispensing month. Therefore, historical data on this report may well change.*

Data: NHS Business Services Authority – Advanced service flu report, June 2022, ONS mid-2020 population estimates

Figure 15: Pharmacies accredited for flu vaccinations in Leicester, 2021/22



Data: NHS Business Services Authority – Advanced service flu report, June 2022, ONS mid-2020 population estimates

7.2.6 Hepatitis C Testing Service

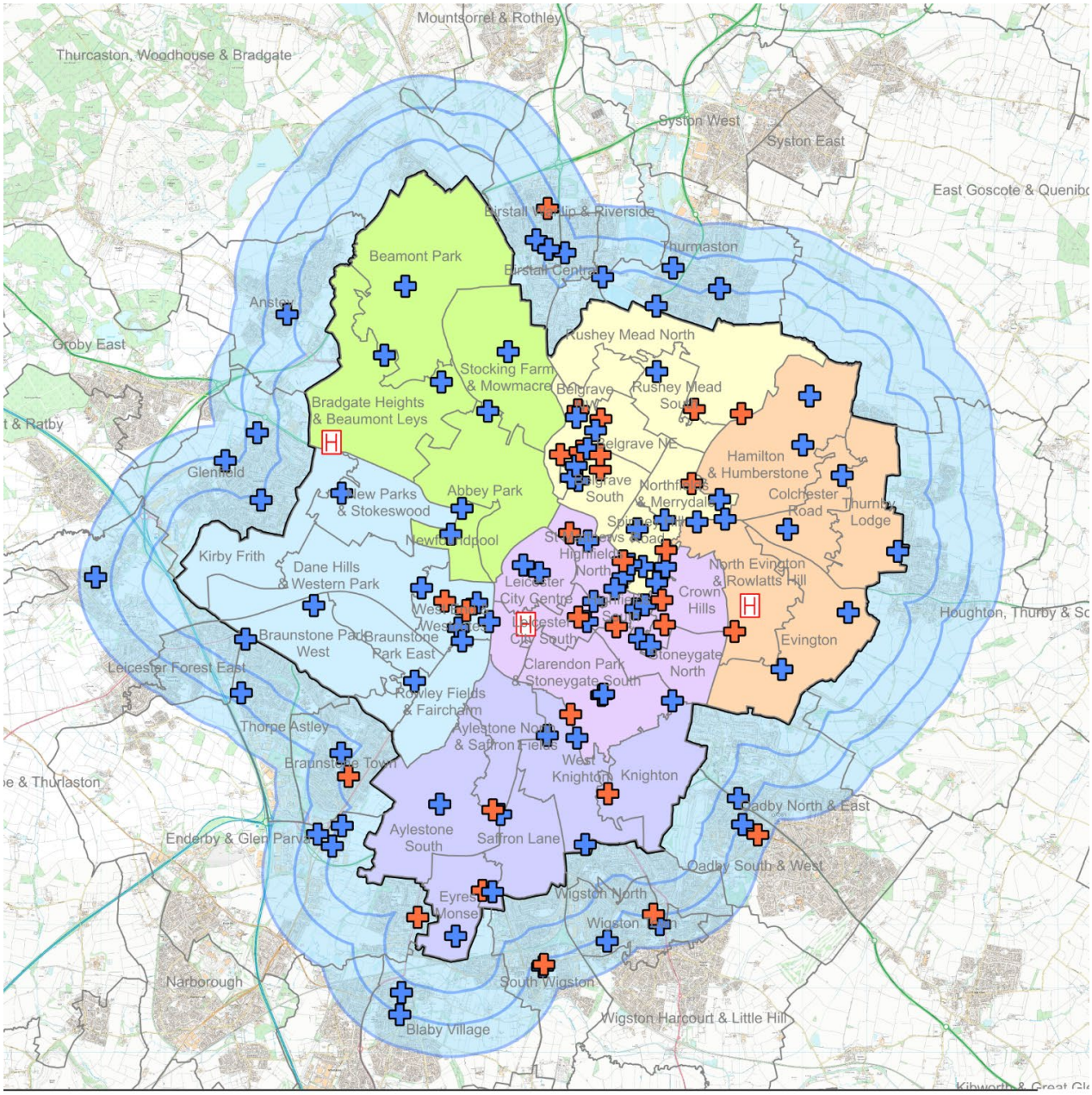
In September 2020 the Community Pharmacy Hepatitis C Antibody Testing Service was added to the Community Pharmacy Contractual Framework. This service focuses on the provision of point of care testing (POCT) for Hepatitis C (Hep C) antibodies in those who inject drugs but are yet to accept treatment for their substance use. When someone tests positive for Hep C antibodies, they are referred for a confirmatory test and treatment, where appropriate. There was no activity reported for this service in pharmacies in Leicester.

7.2.7 Hypertension Case-Finding Service

The Hypertension Case-Finding Service, also known as the NHS Blood Pressure Check Service, was commissioned as an advanced service from 1st October 2021. The service aims to identify people with high blood pressure aged 40 years or older (who have not previously had a diagnosis of hypertension) and refer them to general practice to confirm the diagnosis and for appropriate management of the condition. At the request of a general practice the service undertakes ad hoc clinic and ambulatory blood pressure measurements.

As shown in figure 16, 62 out of 85 (73%) pharmacies in Leicester were signed up for the Hypertension Case-Finding Service as of July 2022. There were more pharmacies providing this service in the centre and north of the city, with 16 and 14 pharmacies providing this service in these areas respectively. The other four locality areas in Leicester each had 7-9 pharmacies providing this service. There were 26 pharmacies within 1.5km of the Leicester city boundary signed up to provide the service.

Figure 16: Pharmacies accredited for Hypertension Case-Finding Service in Leicester, 2021/22



Pharmacies providing Hypertension case-finding Services (BP checks) in Leicester and surrounding area

Hypertension case-finding service 2022

- Hypertension case-finding service (BP) provided (88)
- Hypertension case-finding service (BP) not provided (30)

Locality

- Central
- East
- North
- North West
- South
- West

- University Hospitals of Leicester
- 0.5km buffer

Public Health Division
Leicester City Council
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Data: Office for Health Improvement & disparities, 2022

7.2.8 Smoking Cessation Services

The Smoking Cessation service is one in which pharmacies provide one-to-one support and advice to people who want to give up smoking. The service aims to:

- Improve access to and choice of stop smoking services, including access to pharmacological and non-pharmacological stop smoking aids.
- Reduce smoking related illnesses and deaths by helping people to give up smoking.
- Improve the health of the population by reducing exposure to passive smoke.
- Help service users access additional treatment by offering referral to specialist services where appropriate.

The smoking cessation service became an advanced service from March 2022.

7.3 Locally Commissioned Services

These are services commissioned locally from community pharmacies to meet the needs of the population. Locally commissioned community pharmacy services can be contracted via a range of routes and commissioners including local authorities, Clinical Commissioning Groups (CCGs) and local NHS England *and NHS Improvement* teams. Further details of locally commissioned services are available on: Services and Commissioning : PSNC Main site.

The following locally commissioned services are available across Leicester:

- Emergency Hormonal Contraception (EHC)
- C-Card (Condom provision and Sexual Health advice)
- Needle Exchange Service
- Supervised Consumption Service
- Palliative Care Service
- Child Influenza Vaccination Service

Pharmacies may also choose to provide additional services directly. Details of these services have been sought via a questionnaire issued to all pharmacies in Leicester.

Where available, data on the provision of locally commissioned services in Leicester has been provided below.

7.3.1 Emergency Hormonal Contraception (EHC)

There are two types of emergency contraception:
(1) The insertion of an intrauterine device up to 5 days after unprotected sexual intercourse. This can only be provided by a trained clinician and is available at GPs and the Integrated Sexual Health Service.
(2) The provision of the oral emergency hormonal contraception pill. You need to take the emergency contraceptive pill within 3 days (Levonelle) or 5 days (ellaOne) of

unprotected sex for it to be effective. Both are available from most GPs, the city's Integrated Sexual Health Service (including online), over the counter at most pharmacies (which must be paid for) and as a free scheme for Levonelle for under 25s at community pharmacies commissioned by Leicester City Council.

The aim of the service commissioned from community pharmacists is to reduce unintended pregnancy and improve sexual health through the provision of emergency hormonal contraception (Levonelle) to women under 24 along with advice and information relating to contraception, pregnancy testing sites and local sexual health services.

EHC was provided by 12, 10 and 9 pharmacies in Leicester in 2019/20, 2020/21 and 2021/22 respectively. The number of consultations, levonelle supply and levonelle 2nd dose provided in Leicester City has decreased year on year since 2019/20, this could be the result of the Covid-19 pandemic.

As shown in table 15 below, EHC has not been provided in the south of Leicester in 2019/20, 2020/21 or 2021/22. As shown in figure 17, the area in Leicester with the highest number of pharmacies where EHC was provided in 2021/22 was the city centre, with four pharmacies providing EHC here. The majority (91%, 1905 of 2095) of consultations were provided through city centre pharmacies. It is probable that young women prefer to access this service in the city centre where there is potentially a greater level of anonymity available.

Two community pharmacies accounted for over three quarters of all EHC consultations in 2021/22:

• Boots Chemist in Highcross (1,401 consultations, 67%)

• Boots Chemist Gallowtree Gate (270 consultations, 13%)

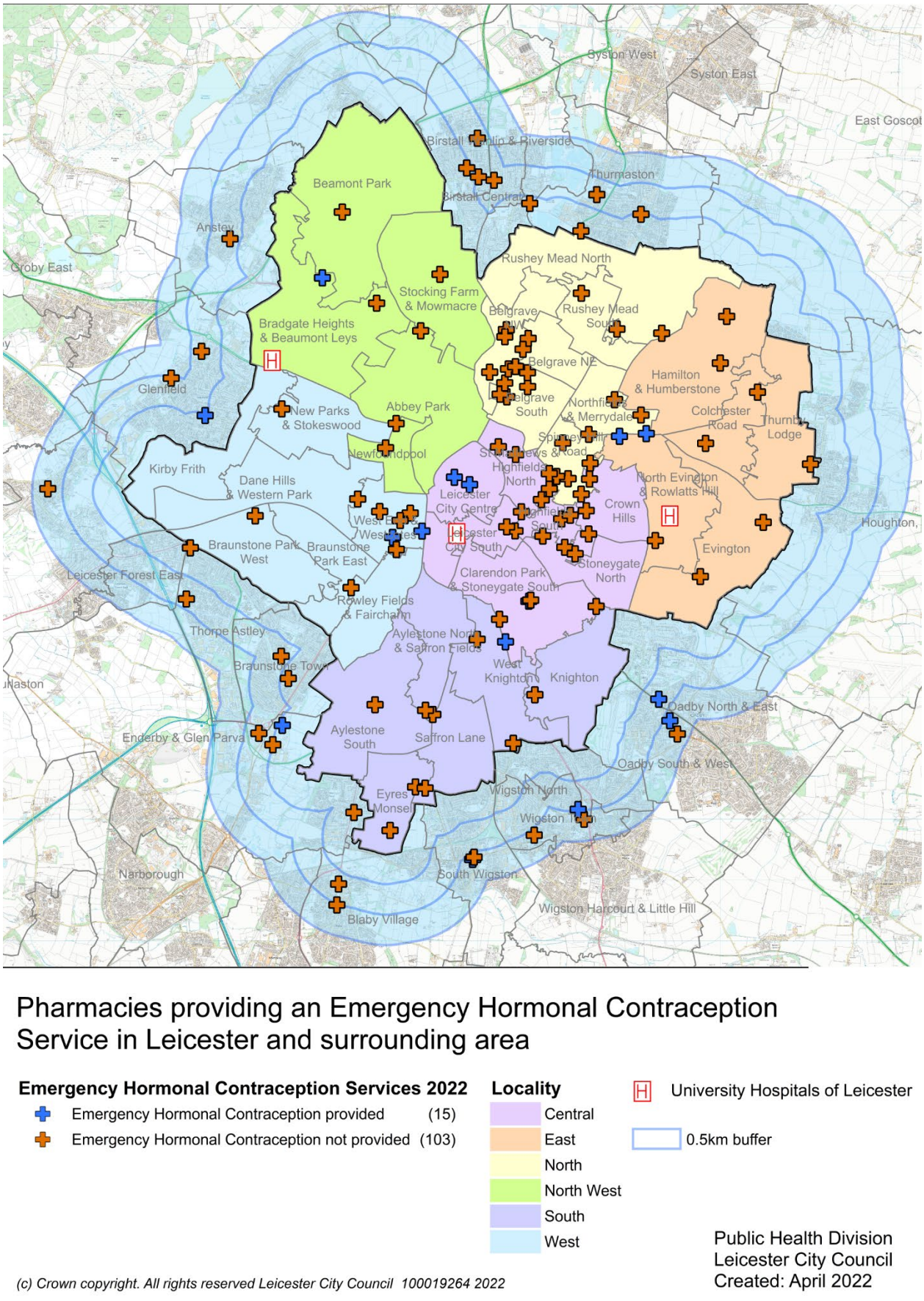
Table 15: Provision of Emergency Hormonal Contraception in Leicester pharmacies, 2021/22

	2019-20			2020-21			2021-22		
	Total Consultations	Total Levonelle Supply	Total Levonelle 2nd dose	Total Consultations	Total Levonelle Supply	Total Levonelle 2nd dose	Total Consultations	Total Levonelle Supply	Total Levonelle 2nd dose
Central	2125	1991	639	1953	1841	596	1905	1792	587
East	41	40	6	55	55	10	20	20	2
North	8	6	0	38	35	2	28	25	3
North West	11	11	0	62	60	22	49	49	15
South	0	0	0	0	0	0	0	0	0
West	677	640	146	152	148	43	93	91	17
Leicester City	2862	2688	791	2260	2139	673	2095	1977	624
Distance from Leicester boundary				Total Consultations	Total Levonelle Supply	Total Levonelle 2nd dose	Total Consultations	Total Levonelle Supply	Total Levonelle 2nd dose
0-0.5km				16	10	1	19	5	4
0.5-1km				42	8	3	57	6	0
1-1.5km				9	4	1	17	1	0
Total within 1.5km of Leicester				67	22	5	93	12	4

Data: Pharm Outcomes and Pinnacle Health

** Note: The data for Leicestershire County pharmacies within 1.5km of the Leicester City boundary is only available for April 2020 onwards.*

Figure 17: Pharmacies accredited for Emergency Hormonal Contraception in and around Leicester 2021/22



Data: Pharm Outcomes

7.3.2 C-Card Service

Some pharmacies provide a free and confidential sexual health service available to young people. The scheme was originally offered to people aged under 25 years but since removing the age limit, increasing numbers of over 25s are using the scheme. It is a plastic registration card that enables quick and easy access to free condoms. The service also offers information and advice about sexual health and relationships.

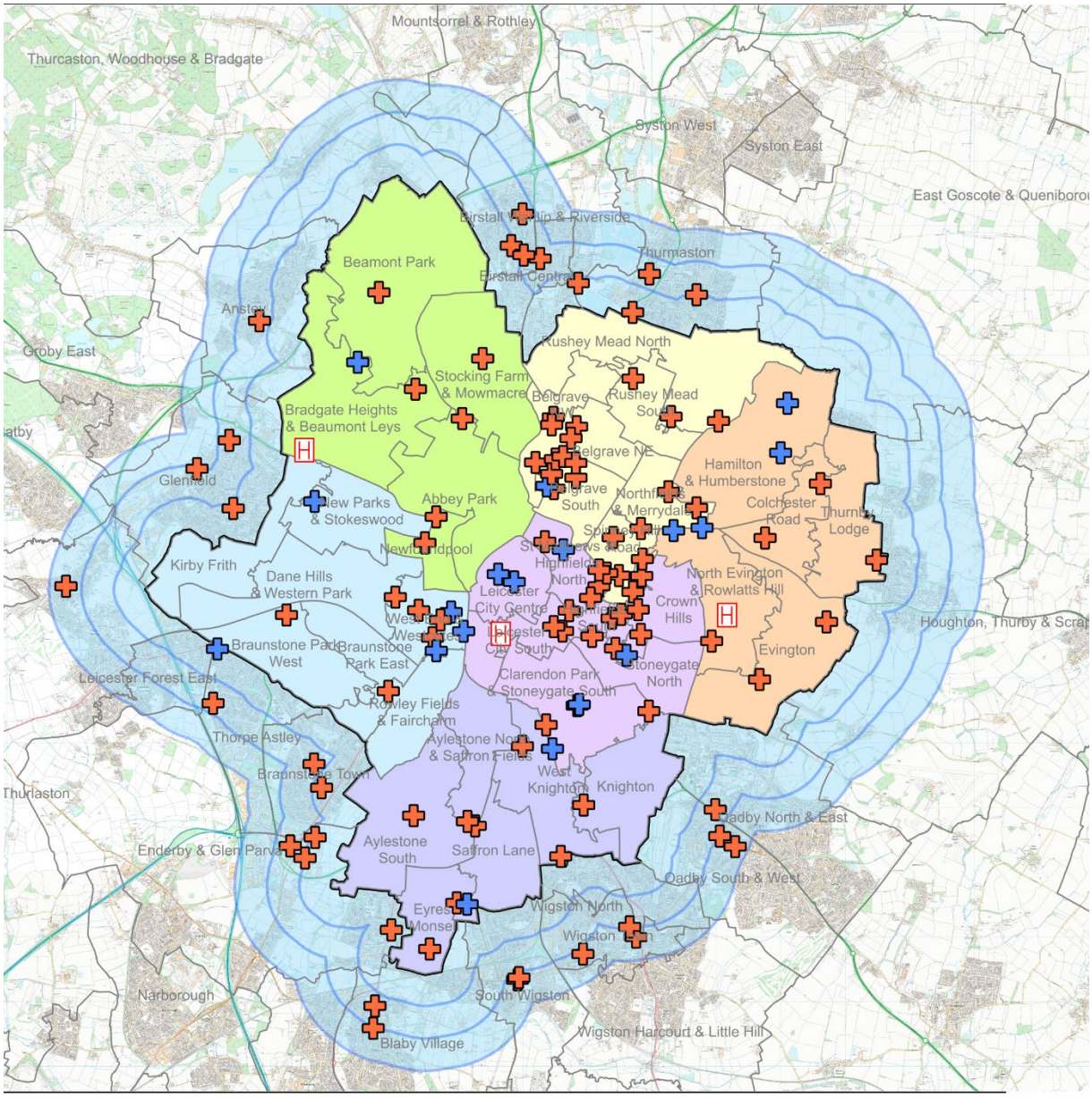
The C-card scheme is available across the city in local access points in schools, colleges, pharmacies and a range of other local services. As shown below in table 16 and figure 18, in Leicester 18 pharmacies are signed up to deliver the C Card scheme. Each locality area in Leicester had at least one pharmacy providing this service in 2021/22. The centre (6) and west (5) of the city had a higher number of pharmacies providing this service than other locality areas. Training and condom packs are supplied to participating community pharmacies by the Integrated Sexual Health Service.

Table 16: Pharmacy C-Card Service provision by locality area in Leicester, 2021/22

Locality Area	Number of Pharmacies
Central	6
East	3
North	2
North West	1
South	1
West	5
Leicester Total	18

Data: Midlands Partnership NHS Foundation Trust

Figure 18: Pharmacy C-Card service provision by locality area in Leicester, 2021/22



Pharmacies providing C-Card Service in Leicester City

C-Card Service 2022

- C-Card Service provided (18)
- C-Card Service not provided (101)

Locality

- Central
- East
- North
- North West
- South
- West

- University Hospitals of Leicester
- 0.5km buffer

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Leicester City Council
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Data: Midlands Partnership NHS Foundation Trust

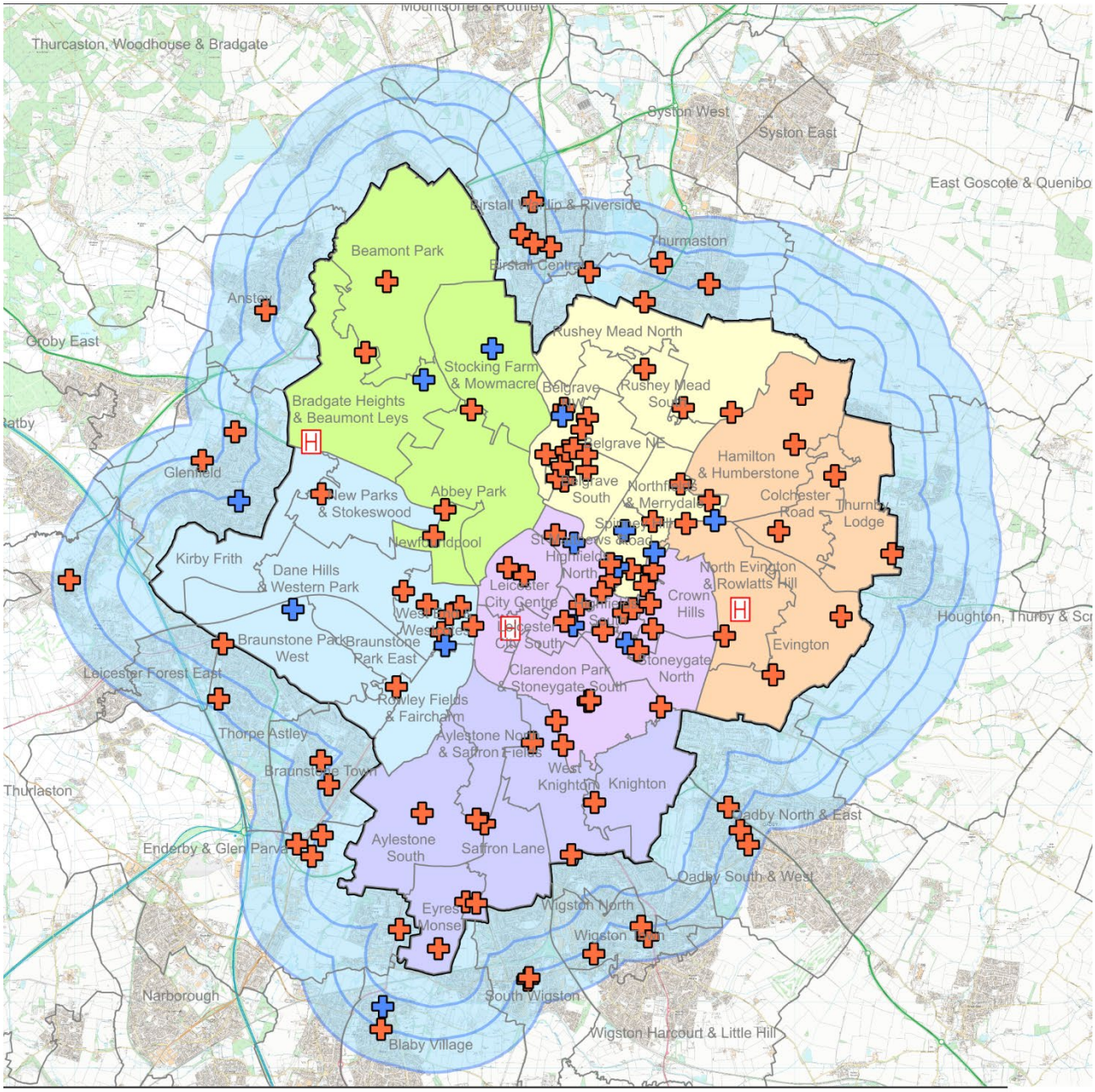
7.3.3 Substance Misuse: Needle Exchange

There are two services commissioned for the management of substance misuse; needle exchange and supervised consumption.

Pharmacy needle exchanges aim to reduce the rate of sharing and other high-risk injecting behaviours by providing sterile injecting equipment and other support, as well as ensuring the safe disposal of used injecting equipment. Pharmacy needle exchange facilities are available to all adult injectors who are using drugs illicitly.

As of 2021/22 needle exchange services are offered at 14 pharmacies across the city and 2 within 1.5km of the boundary, as seen in the map below (figure 19).

Figure 19: Pharmacies accredited for Needle exchange services in Leicester in 2021/22



Pharmacies providing a Needle Exchange Service in Leicester and surrounding area

Needle Exchange Service 2022

- Needle Exchange service provided (16)
- Needle Exchange service not provided (102)

Locality

- Central
- East
- North
- North West
- South
- West

- University Hospitals of Leicester
- 0.5km buffer

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Leicester City Council
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Data: Turning Point

Needle exchange services are offered at hubs and pharmacies in Leicester, pharmacy needle exchange services account for 87% of transactions in the city. Table 17 below shows the uptake of needle exchange services in pharmacies during April 2021-March 2022.

As shown in table 17, there were over 16,900 transactions for needle exchange services in pharmacies in Leicester in 2021/22. The highest uptake of the service is in the centre of the city, with over 7,200 transactions during the 12 month period. The lowest uptake is in the east of the city where there were 0 transactions for the same period.

Table 17: Pharmacy needle exchange service transactions by locality area in Leicester (April 2021 –March 2022)

Locality Area	Number of Pharmacies	Number of transactions
Central	3	7241
East	0	0
North	5	1378
North West	2	1294
South	1	989
West	3	6022
Leicester Total	14	16924
Distance from Leicester boundary	Number of Pharmacies	Number of transactions
0km to 0.5km	1	868
0.5km to 1km	1	95
1km to 1.5km	0	0
Total within 1.5km of Leicester	2	963

Data: Turning Point

7.3.4 Substance Misuse: Supervised Methadone Consumption

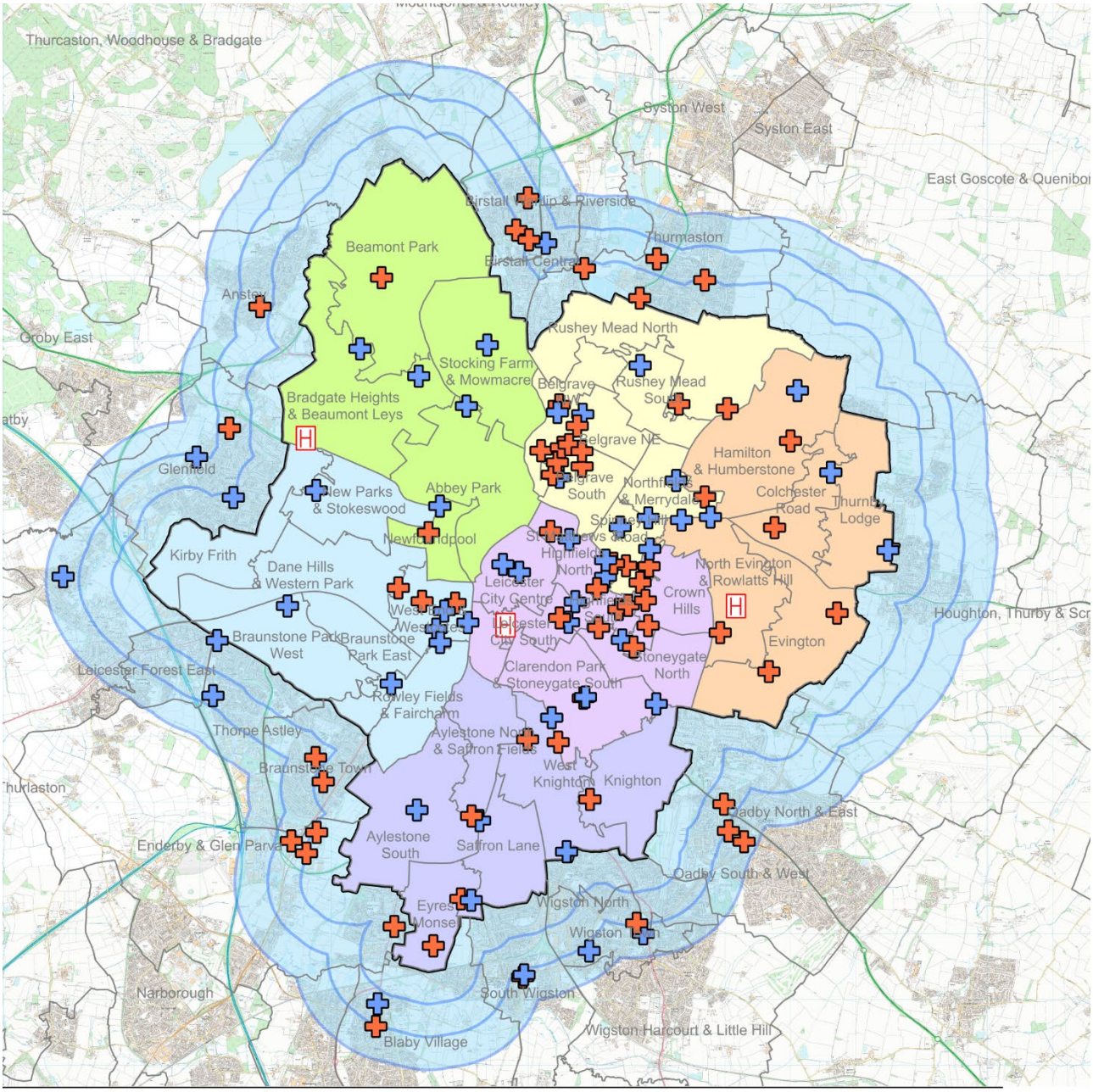
Supervised consumption services are for drug users and aim to ensure compliance with the agreed treatment plan by;

- Dispensing prescribed medication in specified instalments
- Ensuring each supervised dose is correctly administered to the patient for whom it was intended (doses may be dispensed for the patient to take away to cover days when the pharmacy is closed)
- Liaising with the prescriber, named key worker and others directly involved in the care of the patient (where the patient has given written permission)
- Monitoring the patient's response to prescribed treatment; for example if there are signs of overdose, especially at times when doses are changed, during titration of doses, if the patient appears intoxicated or when the patient has missed doses. The pharmacist may if necessary withhold treatment if this is in the interest of patient safety, liaising with the prescriber or named key worker as appropriate
- Improving retention in drug treatment

- To reduce the risk to local communities of:
    - Overuse or underuse of medicines
    - Diversion of prescribed medicines onto the illicit drugs market
    - Accidental exposure to the dispensed medicines

As of 2021/22 supervised consumption services are offered at 43 pharmacies across the city and 11 within 1.5km of the boundary, as shown in the map below (figure 20)

Figure 20: Pharmacies accredited for Supervised consumption services in Leicester in 2021/22



Pharmacies providing a Supervised Consumption Service in Leicester and surrounding area

Supervised Consumption Service 2022

- Supervised Consumption provided (54)
- Supervised Consumption not provided (64)

Locality

- Central
- East
- North
- North West
- South
- West

- University Hospitals of Leicester
- 0.5km buffer

Public Health Division
Leicester City Council
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Data: Turning Point

Table 18 below shows the uptake of supervised consumption services during April 2021-March 2022 in Leicester. There were over 73,700 dispenses of the service across pharmacies in the city. The highest uptake of the service is in the centre of the city, with over 29,200 dispenses here during the 12 month period. The lowest uptake is in the south of the city where there were just over 3,700 dispenses within the same time period. All locality areas of the city are represented by at least four pharmacies offering the supervised consumption service.

Table 18: Supervised consumption service dispenses by locality area (April 2021 –March 2022)

Locality Area	Number of Pharmacies	Number of transactions
Central	11	29209
East	5	4735
North	9	8500
North West	4	12043
South	6	3716
West	8	15520
Leicester Total	43	73723
Distance from Leicester boundary	Number of Pharmacies	Number of transactions
0km to 0.5km	2	3417
0.5km to 1km	4	2171
1km to 1.5km	5	2055
Total within 1.5km of Leicester	11	7643

Data: Turning Point

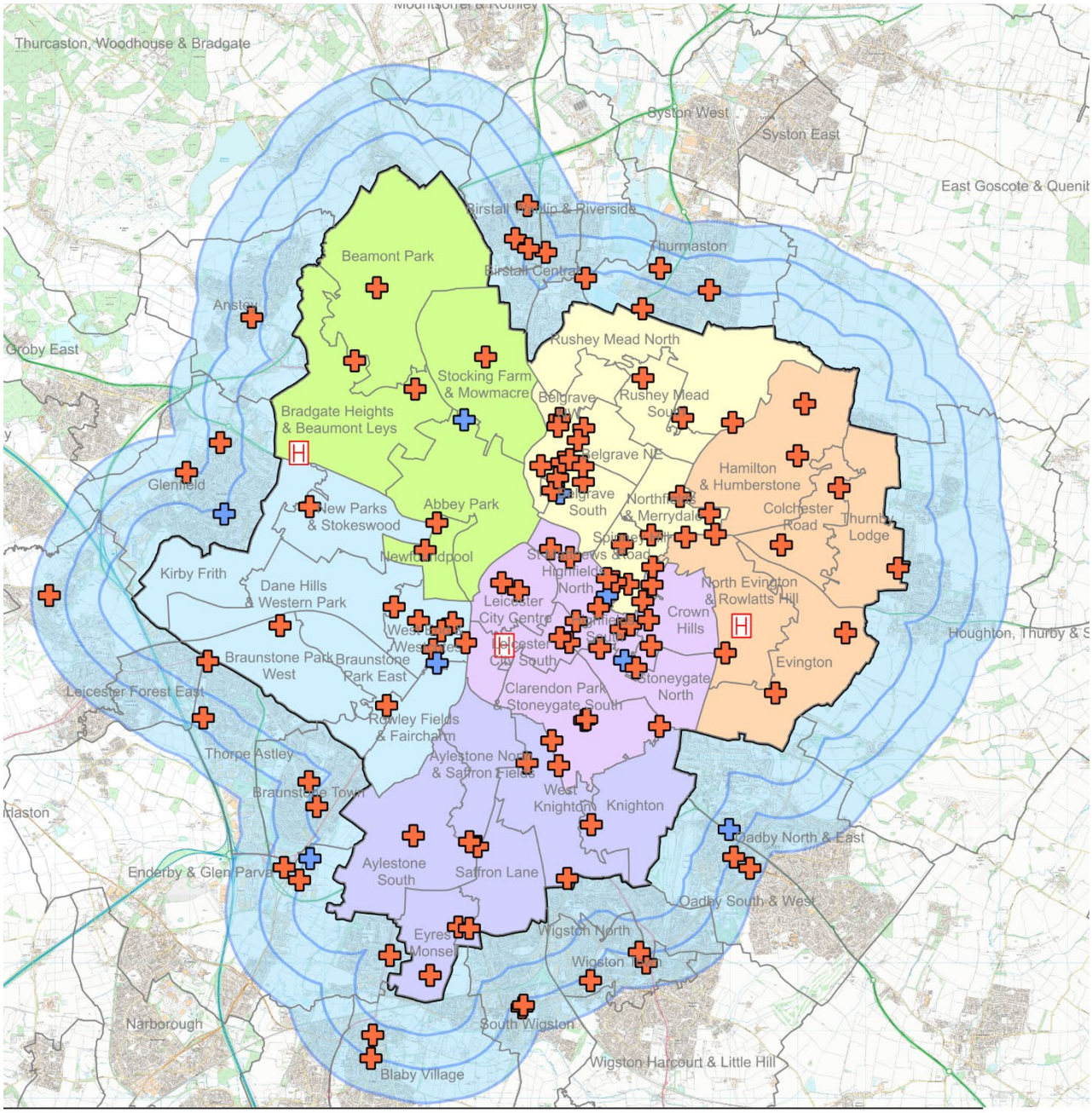
7.3.5 Palliative Care

The demand for palliative care drugs can be urgent and/or unpredictable. Although all pharmacies can be expected to meet the needs of their population with regard to routine supply of palliative care drugs, in some cases treatment needs to be accessed quickly and from a wider range of drugs than may be routinely stocked. A number of the drugs used in palliative care are rarely used in other circumstances and are therefore often not widely available in community pharmacies. The palliative care service ensures there is appropriate access to a range of palliative care drugs in accessible locations particularly in the out of hours period, and when treatment is needed urgently.

Selected pharmacies hold a stock of an agreed range of drugs used in palliative care. The pharmacist will provide information and advice to the user, carer and clinician. They may also refer to specialist centres, support groups or other health and social care professionals where appropriate.

There were five community pharmacies commissioned for the urgent supply of palliative care and specialised medicines in 2020/21 in Leicester City, of which two were in the central locality area and one in each of the north, north west and west locality areas (figure 21). There were three community pharmacies providing palliative care services within 1.0km of the Leicester boundary.

Figure 21: Pharmacies providing Palliative Care Services



Pharmacies providing a Palliative Care Service in Leicester and surrounding area

Palliative Care Service 2021

- Palliative Care provided (8)
- Palliative Care not provided (110)

Locality

- Central
- East
- North
- North West
- South
- West

University Hospitals of Leicester

0.5km buffer

Public Health Division
Leicester City Council
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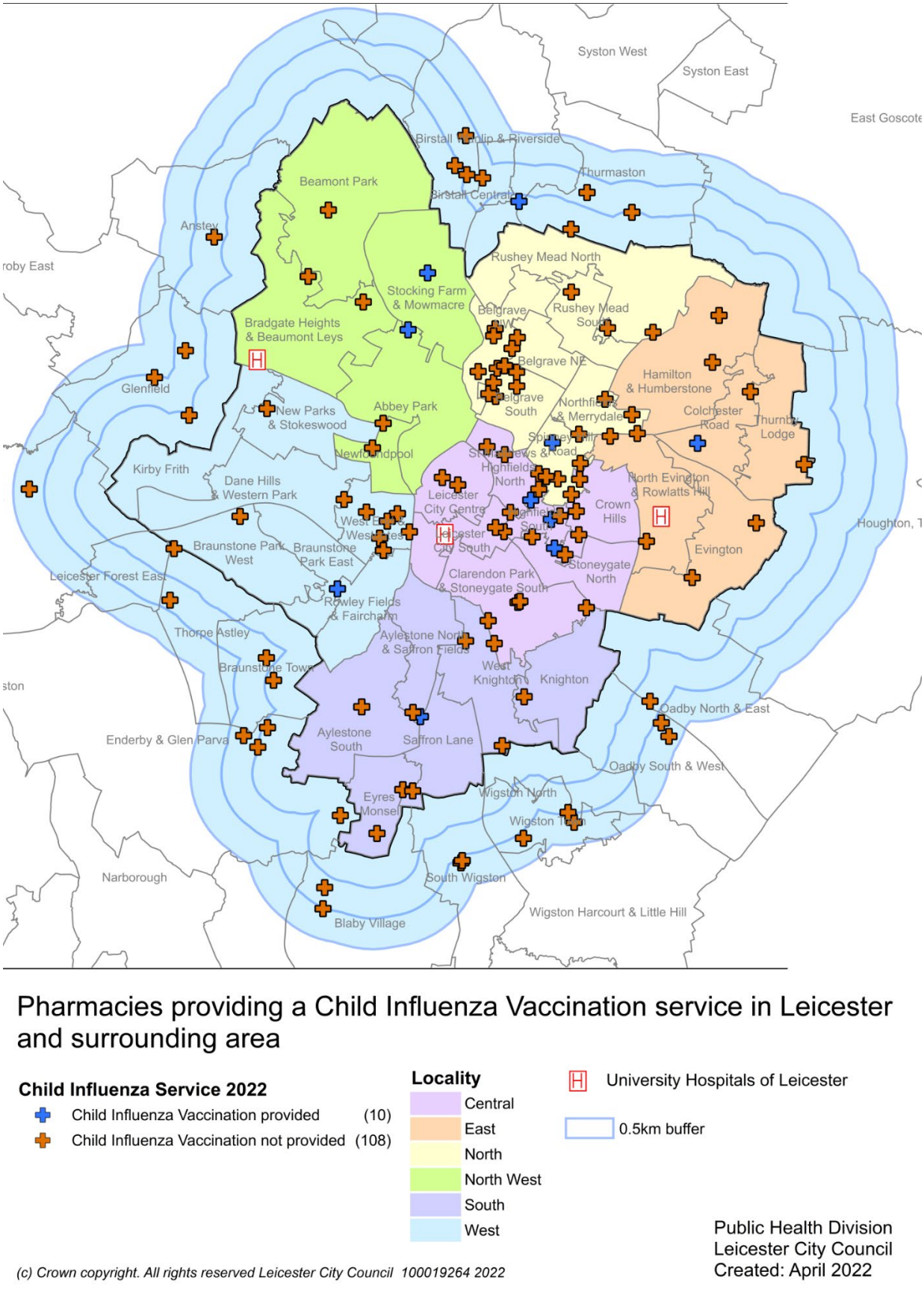
Data: PSNC

7.3.6 Child Influenza Vaccinations

The children's influenza service is normally administered in schools however where children are unable to have this done at school, they can receive the Fluenz/nasal flu vaccine at a local pharmacy providing this service. In 2021/22, nine pharmacies in Leicester City are eligible to provide child influenz vaccinations (figure 22). There is at least one pharmacy in each of the localities which can provide the service (2 in north west, 3 in central areas and one pharmacy within each of the other locality areas).

Figure 22: Pharmacies accredited for Child Influenza Vaccinations



Source: Leicestershire Partnership Trust

7.4 Local Enhanced Service and National Enhanced Service (NES)

7.4.1 Covid Vaccination Service

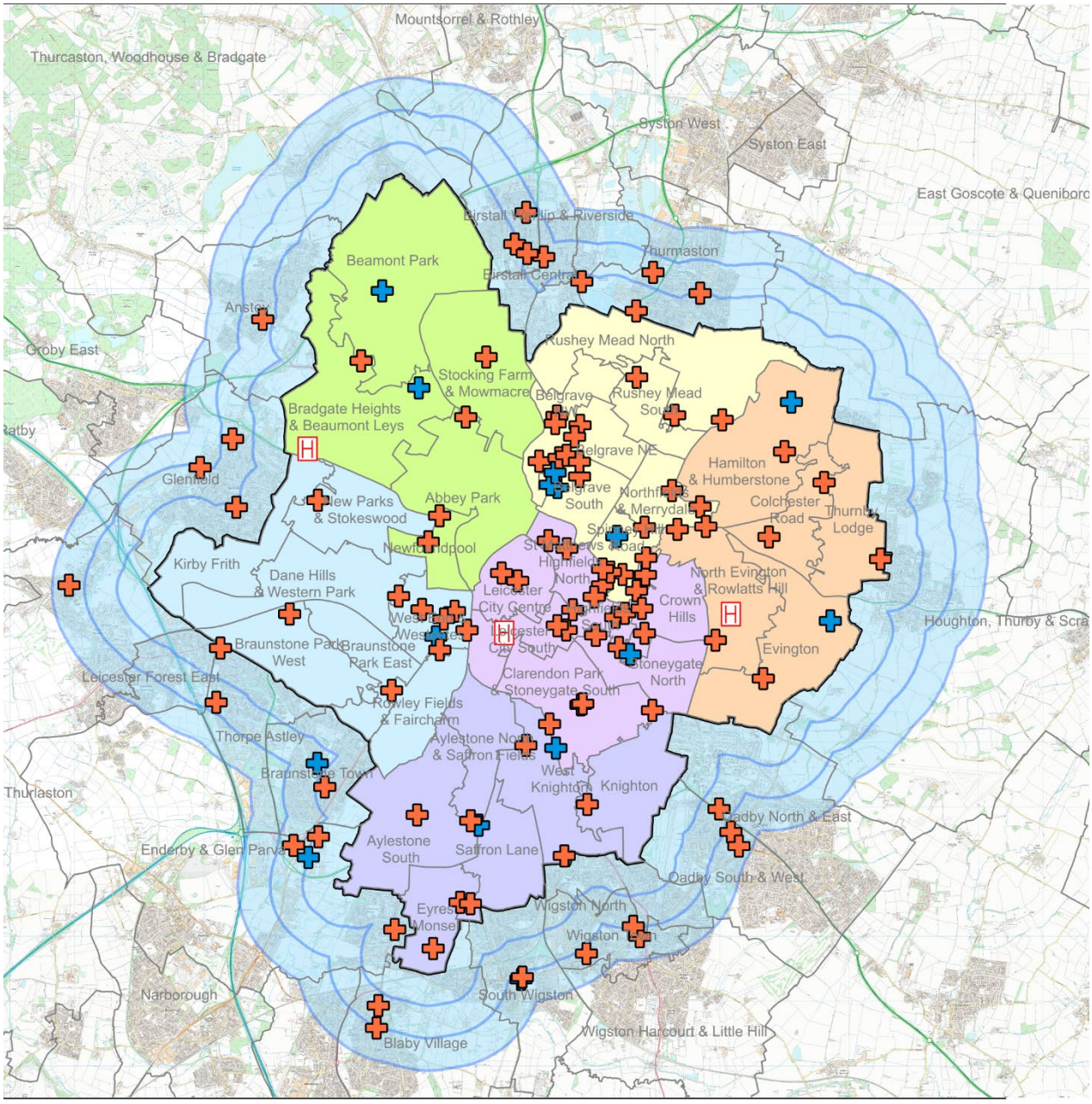
In December 2020, the NHS commenced its Covid-19 vaccination programme. Since the start of the Covid-19 pandemic, over 1,500 community pharmacy sites have been vaccinating patients and health and care workers under a Local Enhanced Service against coronavirus alongside vaccination centres, hospitals and Primary Care Network (PCN) sites. Table 19 and figure 23 show that 13 pharmacies provided this service across Leicester in 2021/22. Each locality area within Leicester had at least one pharmacy providing this service. The locality area with the largest number of pharmacies providing this service, with four pharmacies providing this service, was the North of Leicester. In 2021/22, 3 pharmacies provided this service within 1.5km of the Leicester city boundary.

Table 19: Covid-19 Vaccination Service Provision by locality area (2021/22)

Locality area	Number of pharmacies providing Covid Vaccination Service
Central	2
East	2
North	4
North West	2
South	1
West	2
Leicester City	13
Distance from boundary	**Number of pharmacies providing Covid Vaccination Service**
0km-0.5km	0
0.5km-1.0km	2
1.0km-1.5km	1
Total within 1.5km of boundary	3

Source: NHS England and NHS Improvement

Figure 23: Pharmacies accredited for Covid-19 Vaccination Service



Pharmacies providing a Covid-19 Vaccination Service in Leicester and surrounding area

Pharmacies providing a COVID-19 vaccination service 2022

- COVID-19 Vaccination service provided (16)
- COVID-19 Vaccination service not provided (102)

Locality

- Central
- East
- North
- North West
- South
- West

University Hospitals of Leicester

0.5km buffer

Public Health Division
Leicester City Council
Created: April 2022

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Source: NHS England and NHS Improvement

From December 2021, provisions were made within the NHS (pharmaceutical and Local Pharmaceutical Services) Regulations 2013 for a new type of Enhanced Service, the NES. Under this type of service, NHS England & NHS Improvement commissions an Enhanced service that is nationally specified. A NES allows the agreement of standard conditions nationally, while still allowing the flexibility for local decisions to commission the service to meet local population needs, as part of a nationally coordinated programme. From autumn 2022, the Covid-19 Vaccination Service will be commissioned as a National Enhanced Service (NES).

7.5 Impact of Covid-19

Whilst many other services and GP facilities were often closed, community pharmacies remained open throughout the Covid-19 pandemic. Throughout this period accessibility and provision of some pharmaceutical services changed. In 2021/22, larger numbers of New Medicines Reviews were carried out by more pharmacies than in previous years, Stoma Appliance Customisation was provided by 6 pharmacies compared to 3 in 2020/21 and 4 in 2018/19 and 2019/20 and there were 6780 community pharmacy consultations provided in Leicester compared to 2047 in 2020/21. Further, in the previous version of this document Leicester City had a rate of 1.7 pharmacies providing flu vaccination services per 10,000 population 18+ compared to a rate of 2.6 pharmacies per 10,000 population 18+ in 2021/22. The number of EHC consultations, levonelle and levonelle 2nd dose provided in Leicester decreased year on year between 2019/20 and 2021/22. However, it is difficult to predict whether such changes will continue into the future or whether they will revert to pre-pandemic levels within the lifespan of this PNA.

7.6 Conclusion

This section has described the elements of the Community Pharmacy Contractual Framework and provided information on the essential, advanced and locally commissioned services required or offered for delivery by community pharmacies.

Essential services are required as part of the NHS Community Pharmacy Contractual Framework and must be provided by community pharmacies working to this contract. The advanced services are defined in the NHS community pharmacy contractual framework, but pharmacies can choose to provide any of these services following appropriate training and or accreditation. Both types of services are overseen by NHS England and NHS Improvement.

The advanced services Community Pharmacist Consultation Service, Flu Vaccination service and New Medicines Services are provided by the majority of pharmacies. Few pharmacies offer Stoma Appliance Customisation in Leicester, with no activity reported for Appliance Use Reviews or Hepatitis C Testing Service.

Locally commissioned services have a more variable uptake by pharmacies and

therefore the availability of these services varies across Leicester. For example, EHC is provided in four pharmacies in the central locality area of Leicester compared to no pharmacies in the south of the city.

A number of factors influence the extent to which services are taken up for delivery by pharmacies. These include the need and availability of additional training required for staff, the assessment of the likely extent of take up of services by customers, practicalities such as the availability of facilities, referrals from GPs where these are necessary, and whether the payment provided by the commissioner is sufficient to cover costs.

Take up can also be inhibited by consumer behaviour. For example, 91% of the take up of emergency hormonal contraception (including consultations, levonelle and levonelle 2nd dose) is in busy, more central pharmacies reflecting a likely preference by young women for a degree of anonymity less likely to be available in neighbourhood pharmacy locations closer to home.

The locally commissioned services provided are not necessarily the same in Leicester as in adjacent areas of the Leicestershire County. Some services are available from county pharmacies and not from Leicester pharmacies, and vice versa.

Pharmacies also provide from their own resources other significant free services directly to their patients. These are not commissioned by NHS England and NHS Improvement, Leicester City CCG or the Local Authority and instead are a direct arrangement between the pharmacy and patients. These services include the collection of prescriptions, and in most pharmacies the delivery of medicines, and the mainly free availability of monitored dosage systems. Such services are viewed as adding to the convenience, compliance and safety of medicine collection and use. Some pharmacies also provide blood pressure measurement, educational sessions on self-care and making use of health services.

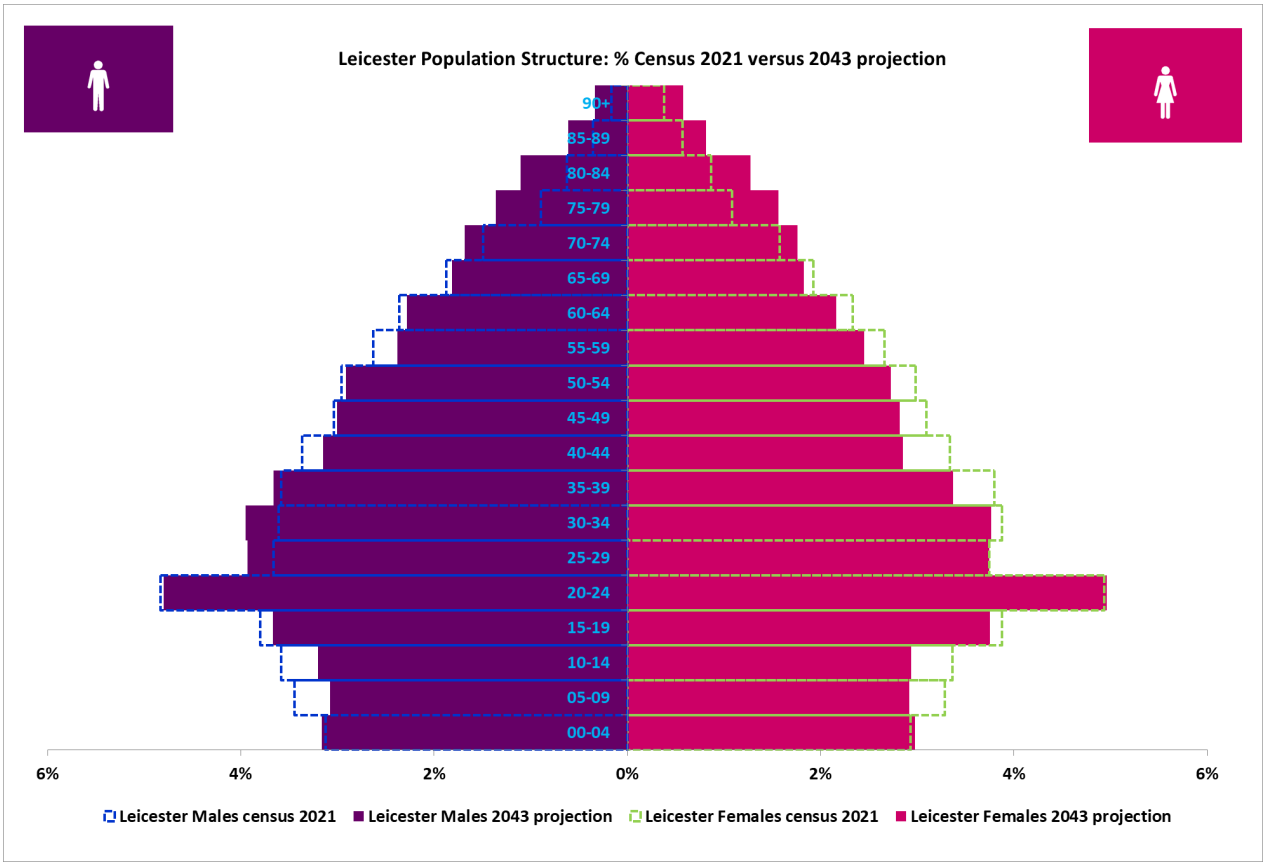
8. Projected future needs

8.1 Population growth

Applying the ONS 2018 population projections for 2021-2043 to the Census 2021 data suggests that by 2043 the population of Leicester is predicted to grow by around 29,850 to give a total population of around 398,459. Projections indicate that Leicester will have an increase of 15,167 people aged 65 and over, which represents an increase in the proportion of the population aged 65 and over from 12% in 2021 to 15% in 2043.

With the current provision of 85 pharmacies in Leicester, this would offer a rate of 2.1 pharmacies per 10,000 population in 2043. The current rate in Leicester is 2.4, and nationally 2.1 per 10,000 population based on the numbers of pharmacies alone; it does not take into account variation in opening hours and services provided.

Figure 24: Leicester population structure census 2021 with projections for 2043



Source: ONS Population Projections – 2018, Census 2021

8.2 Growth in number of people with long term conditions

With these projected increases of over 15,000 in the older population, there will be increases in the numbers with long term health conditions. Table 20 below shows the increases in numbers aged 65 and over, based on the current prevalence of

these conditions[34].

Whilst the current number of pharmacies will provide a rate of 2.2 per 10,000 based on population projections, the increase in the population size and number likely to have long term conditions will put additional pressure on pharmacies.

Table 20: Estimates of numbers of over 65 year olds in Leicester with longstanding health conditions, 2020-2040

Long term health condition	% of over 65s (2020)	2020	2025	2030	2035	2040
Moderate or severe hearing impairment	67%	29,625	32,434	36,194	39,859	42,683
Cardiovascular disease	31%	13,841	15,405	17,038	18,437	19,463
BMI of 30 or more	30%	13,384	14,794	16,254	17,380	18,087
Limiting long term illness whose day-to-day activities are limited a lot	29%	12,889	14,267	15,793	17,245	18,369
Limiting long term illness whose day-to-day activities are limited a little	27%	11,715	12,972	14,352	15,392	16,115
Falls	26%	11,638	12,778	14,130	15,417	16,368
Unable to manage at least one activity on their own	18%	7,973	8,711	9,638	10,721	11,610
Bladder problem at least once a week	16%	7,136	7,907	8,722	9,490	10,057
Diabetes	12%	5,490	6,067	6,692	7,169	7,474
Depression	9%	3,772	4,166	4,588	4,919	5,138
Moderate or severe visual impairment	9%	3,770	4,184	4,681	5,118	5,480
Dementia	7%	3,060	3,313	3,708	4,185	4,673
Severe depression	3%	1,187	1,320	1,458	1,582	1,682
Hospital admission as a result of falls	3%	1,365	1,470	1,683	1,891	2,081
Bladder problem less than once a week	3%	1,404	1,544	1,713	1,867	1,984
Longstanding health condition caused by bronchitis and emphysema	2%	743	825	909	978	1,023
Total population 65 and over		44,000	48,500	53,600	57,500	60,100

Data: Projecting Older People Population Information System (POPPI, 2020)

8.3 Growth in housing

The housing plan for Leicester is still underway and the consultation document planned for release in autumn 2022.

The local housing need study undertaken for Leicester identified a local housing need of 2,464 dwellings per year to accommodate growth in population to 2036 (39,424 homes over the plan period 2020-2036). Unmet need is estimated at around 18,700 over the plan period.

The previous trajectory for housing supply published alongside the draft plan consultation is given below although this will be subject to change. It is anticipated that the commitments (full planning permissions) will come forward in the first five years.

Table 21: Previous Housing Supply for Leicester City

Year	19/20	20/21	21/22	22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	35/36	Total
Total Supply	1733	1733	1759	1839	1871	1535	1675	1636	1636	1695	877	769	775	752	641	244	192	21362

Source: Leicester City Council, Planning, Development and Transportation

[34] Projecting Older People Population Information system (POPPI, 2020). http://www.poppi.org.uk/

9. Consultation

9.1 Statutory 60 day consultation:

There is a statutory requirement for each Health and Wellbeing Board to consult a defined number of bodies about the contents of the pharmaceutical needs assessment for a minimum of 60 days. The consultation took place between the 6th July and the 4th September 2022. There were 48 respondents to the survey and the majority agreed/strongly agreed that the purpose of the PNA has been clearly explained (67% of respondents) and that the PNA adequately reflects the current community pharmacy provision in Leicester (52% of respondents). Forty percent of respondents agreed/strongly agreed that the needs of Leicester residents have been adequately reflected in the PNA, with 29% of respondents having no opinion either way. Five respondents (10%) identified gaps or issues in pharmaceutical provision in Leicester that had not been reflected in the draft PNA. The gaps/issues in pharmaceutical provision noted by the respondents were wasted knowledge with training not being put to good use, the need for full access to summary care records and Type 1 Diabetes Mellitus services. A summary of the consultation results is provided as Appendix 2.

The response from the Leicestershire & Rutland Integrated Care Board (LLR ICB) was supportive of the conclusions and recommendations reached in the PNA. The response noted that accessibility, from both a geographical and opening hours throughout the week perspective, is encouraging, equally noting that no gaps in the provision of essential pharmaceutical services across Leicester were identified in the PNA. Further, the benefits of community pharmacy being embedded within local communities in Leicester, such as accessibility to support without an appointment system, unique insights into our residents' health and teams which can converse in a multitude of languages, were acknowledged.

Services including the Community Pharmacist Consultation Service (CPCS), Discharge Medicine Service (DMS) and Hypertension Case Finding Service are highlighted within the response as crucial areas to maintain and promote. The value of the child influenza vaccination catch-up programme, the palliative care service and digital solutions such as the ordering of repeat prescriptions via the NHS app was recognised. The response supports the need for full access (including read-write access) to summary care records in order to further develop the clinical services within community pharmacy.

The LLR ICB response suggests that the expertise and experience of community pharmacies should be harnessed to aid in reducing health inequalities and that the impact of new housing and population growth should be continually assessed to ensure pharmacy provision remains able to meet the current, and future, needs of Leicester's residents.

9.2 Pharmacy questionnaire for local professionals:

In addition to the statutory consultation, a questionnaire was circulated to all community pharmacies in Leicester, to gain a better understanding of how they serve the local population.

As of 5th September 2022, 31 (36%) out of 85 pharmacies in Leicester City have responded to the pharmacy contractor questionnaire. A summary of responses is given below. A more detailed summary of responses can be found in Appendix 3.

- Most pharmacies (83%) receive between 1,001 and 25,000 over the counter enquiries per year.
- Pharmacies see an average of 27 consultations (range from 1 to 150 consultations) in the consultation room in an average week.
- All respondents have a closed consultation area on the premises and 14 pharmacies (45%) were willing to undertake consultations in the patient's home/other suitable site.
- Just over half (52%) of pharmacies have wheelchair ramp access, with 55% having large print labels/leaflets, 45% having dementia-friendly space and 45% having automatic door assistance. Other accessibility facilities were also provided across the 31 pharmacies, such as a hearing loop (29%), disabled toilet facility (13%) and bell at the front door (13%).
- In addition to English, the most commonly reported languages spoken by pharmacy staff were Gujarati (87%), Punjabi (74%) and Urdu (48%). Between 7 – 10% of respondents reported Arabic (7%), Bengali (or Sylheti or Chatgaya) (10%), British Sign Language (7%), Somali (7%) and Polish (7%) as languages spoken by pharmacy staff.
- 87% of respondents to this question use locum pharmacists and 35% of respondents use relief pharmacists.
- 49% of respondents agreed/strongly agreed that they had experienced recruitment difficulties for the role of community pharmacist, with 24% of respondents not having experienced recruitment difficulties for pre-registration pharmacist roles and mixed experiences in the extent of difficulties in recruiting other roles.
- The majority of respondents provide or intend to provide within 12 months, the community pharmacist consultation service (100%), new medicine service (100%), flu vaccination service (93%), hypertension case-finding service (86%), pandemic delivery service (75%) and the stop smoking service (56%).
- Most respondents would be willing to provide NHS England and NHS Improvement, CCG and local authority commissioned services, especially with training and/or facilities provided.
- 7 out of 20 non-commissioned services listed are provided by over half of respondents. The 7 services are the collection of prescriptions from GP practices, delivery of dispensed medicines – selected patient groups, delivery of dispensed medicines – selected areas, delivery of dispensed medicines – free of charge on request, monitored dosage systems – free of charge on request,

contraception, emergency contraception.

- The majority of respondents indicated that they would provide the other non-commissioned services if training and/or facilities were provided. This is with the exception of the monitored dosage systems with charge for which 58% of respondents reported that they were not currently willing to provide this service.
- The majority of respondents do not provide non-NHS funded services but most are willing to with training and/or facilities provided.
- For the next year, just over half (52%) of respondents plan to expand their business and 45% plan to continue operating to the same level. More specifically, 26% plan to expand online pharmacy services in the next year, with 45% reporting 'don't know/not applicable' to this question.
- 87% of respondents report that the amount and location of pharmacies in a three-mile radius of their own pharmacy are 'excellent' or 'good' and 13% report as 'adequate'.
- Views on the range of services provided by pharmacies in a three-mile radius of their own pharmacy are slightly lower with 80% reporting 'excellent' or 'good', 13% reporting 'adequate' and 7% reporting 'poor'.

9.3 Pharmacy questionnaire for public:

A questionnaire was also circulated to the general public to review pharmacy provision in their area.

As of 23rd August 2022, 111 respondents reported to be living in the Leicester City local authority had completed the survey. A summary of the responses is given below.

- Most respondents (65%) were very satisfied with the advice they receive about taking their medicines from the pharmacy/chemist, with a further 21% of respondents fairly satisfied.
- Quality of service, location and availability of medication were the most important pharmacy services to respondents whilst prescription collection from their GP practice, physical accessibility and private areas to speak to a pharmacist were also noted as important.
- Eighty-four percent of respondents agreed that their pharmacy provides a good service (62% strongly agree and 22% tend to agree).
- Almost three quarters of respondents agreed that if they wanted to, they could speak to a pharmacist at their pharmacy without being overheard (51% strongly agreed and 21% tend to agree).
- Of those with access needs relating to a physical disability (15% of respondents), 36% reported that these were always met, 50% reported that they were sometimes met, with 14% reporting that their pharmacy never met these physical access needs.
- Of respondents who help an adult family member or friend to use pharmacy services, 42% reported that their pharmacy always meets their needs as a carer and 44% indicated that their pharmacy sometimes meets their needs as a carer.
- Eighty-five percent of respondents were most likely to get their prescription medicine from a pharmacy/chemist's shop, with 99% of these respondents reporting that their usual one is based in Leicester.

- Most respondents usually travel to the pharmacy by walking (56%) or car (driver) (32%) and for the majority of respondents travelling to their usual pharmacy takes less than 15 minutes (86%).
- Responses highlight varied frequency of use of a pharmacy for a health reason from a few times a month (27%), once a month (41%), every two to three months (22%) to once or twice a year (10%).
- The majority of respondents (84%) most commonly use pharmacy services between 9am-6pm on weekdays, with 71% of respondents agreeing (42% strongly agree and 29% tend to agree) that the opening hours for pharmacy services meet their needs.
- When thinking about their usual pharmacy services, 93% of respondents found it easy to find an open pharmacy during the day, 33% found it easy to find an open pharmacy in the evening (after 6pm) and 56% of respondents find it easy to find an open pharmacy at the weekends.
- The majority of respondents were very likely to visit the pharmacy in person to access pharmacy services within the next three years but were not very likely or not at all likely to receive prescriptions by post (69%) or via online home delivery services (55%).

10. Analysis of gaps in service

As of 31 March 2022, Leicester has 85 pharmacies located across the City, including 9 distance selling pharmacies and one local pharmaceutical service.

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

Pharmacies and local populations:

There are more pharmacies in the north (24) and central (23) locality areas of the city, with several closely located in Belgrave (around Belgrave Road) and another cluster around Spinney Hills towards Stoneygate. In the west of the city the pharmacies are more widely spread, although there are a number along the Narborough Road area In the West End.

Using locality area populations, the rate of pharmacies per 10,000 population ranges from 1.5 in the north west of the city to 3.7 in the north of the city. Locality area populations have been used to give a crude indication of the local population, however, it is recognised that some residents may be closer to a pharmacy in a different locality area. But, as explained in the main body of the text above, locality areas provide some way of talking about geographical differences in a situation where pharmacies do not serve defined populations and where locations of pharmacies are, in a large part, historically based. Additionally, the population rates do not consider the number of hours the pharmacies are open, the size of the pharmacy or the number of whole time equivalent staff. Opening hours per week per 10,000 locality area population range from 70.0 in the north west to 192.3 in the north of the city.

Access and travel times:

Access and travel times to pharmacies in Leicester appear to be reasonable based on travel time analysis. Leicester residents should be able to access their nearest pharmacy within a few minutes by car, although this may take longer at peak travel times. All residents will also be able to walk to their nearest pharmacy within 20 minutes, with 96% of residents able to walk to their nearest pharmacy within 15 minutes. It is difficult to show travel times by public transport as these will vary during the time of day and day of the week. However, based on a weekday morning, it shouldn't take more than 15 minutes to reach the nearest pharmacy. Travel analysis has only looked at travel times to a resident's nearest pharmacy and has not considered services offered or opening times. Residents may have to travel further for some services or to reach a pharmacy outside normal opening hours.

Opening hours:

All Leicester pharmacies are open for at least 40 hours per week. Over half (47) are open up to 50 hours per week and Leicester has 8 pharmacies classified as 100 hour pharmacies. With longer opening hours, pharmacies are able to offer more flexible access later in the evenings and on weekends. The 100 hour pharmacies are located in the west (3 pharmacies), central (2), east (1), north (1) and south (1) locality areas of the city. There is lower provision for extended opening hours in the

north west of Leicester, however, there are two 100 hour county pharmacies within 1km of the City border towards the north west of the city.

Essential services:

Essential services are provided by all pharmacies. All Leicester residents have access to a pharmacy within 20 minutes of their home, although some walk-times may be longer. There are fewer pharmacies in the north west of Leicester compared with the north and central areas and opening times are generally shorter, however this does not imply inadequate provision.

Data regarding pharmacies providing a collection and delivery service shows that the vast majority do so, which to some extent may compensate, at least for patients with regular medicines, for there being smaller numbers of pharmacists in certain parts of the city.

Advanced services:

There are eight advanced services which pharmacies may be accredited to offer. These include New Medicines Services, Appliance Use Reviews (AURs), Community Pharmacist Consultation Service, Flu Vaccination Service, Hepatitis C Testing Service, Hypertension Case-Finding Service, Stoma Appliance Customisation (SAC) and more recently the Smoking Cessation Service.

The advanced services Community Pharmacist Consultation Service, Flu Vaccination service and New Medicines Services are provided by the majority of pharmacies. Few pharmacies offer Stoma Appliance Customisation. Despite no activity reported for the Appliance Use Review (AUR) and Hepatitis C Testing Services in the data received from NHS England and NHS Improvement, five pharmacies reported providing AUR and three pharmacies reported providing Hepatitis C Testing services in the pharmacy survey.

Locally Commissioned Services:

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

The number of pharmacies offering the services below is reported at March 2022 where available.

Emergency Hormonal Contraception:

There has been a reduction in the number of pharmacies providing EHC. At the end of March 2020, 12 pharmacies were offering this service, in March 2021, 10 pharmacies offered EHC and in March 2022, 9 pharmacies offered this service. The majority of uptake is through the city centre pharmacies. Whilst this is an area with a

high number of young people, it is also likely that many young people choose to use this service at a more anonymous pharmacy in town rather than one that is close to their home.

C-Card

The C-card scheme is available across the city in local access points in schools, colleges, pharmacies and a range of other local services. In Leicester, 18 pharmacies are signed up to deliver the scheme across the city. Training and condom packs are supplied to participating community pharmacies by the Integrated Sexual Health Service.

Needle exchange:

Needle exchange services were provided by 14 pharmacies in Leicester in 2021/22. In the twelve months from April 2021 to March 2022 over 16,900 transactions were reported. This service is part of a wider scheme in helping individuals to manage and recover from substance misuse. The highest uptake of this service was in the centre of the city, with over 7,200 transactions here during the twelve month period.

Supervised consumption:

Supervised methadone consumption was provided by 43 pharmacies across Leicester in 2021/22. As with needle exchange, this is part of a wider scheme in substance misuse harm reduction and recovery.

Palliative care:

Five pharmacies provided palliative care services in 2020/21. This service enables access to palliative care medicines and advice for patients during the last phase of their life.

Palliative care should be targeted towards areas with high risk population, hospital discharges and those with respiratory problems. A review of the uptake of this service would provide information into how well this service is being used and with an ageing population, the potential for greater demand in the future.

11. Conclusions and Recommendations

This assessment looks at current provision of pharmacy services and concludes that overall provision of essential and advanced pharmacy services is adequate for the population of Leicester. The quality of services is monitored via quality visits to pharmacies and these provide assurance of pharmaceutical services for individual premises.

This PNA has reviewed the location and access to pharmacies for the residents of Leicester as at the end of March 2022. There are differences in local provision of services across the city and it may be that residents in some areas have to travel a little further to access a particular service or out of normal working hours.

It has given information showing which pharmacies provide advanced and locally commissioned services in addition to their essential services as at the end of March 2022, where available, otherwise as at the end of March 2021. This includes services commissioned by NHS England *and NHS Improvement*, the CCG or Leicester City Council. Pharmacies may also choose to provide additional services directly of benefit to patients on a 'voluntary' basis.

Community based services offer a range of locally commissioned services to the local population that can be tailored to meet specific local healthcare needs. The uptake of some of these services has been included to give an idea of numbers, however, data is not available for uptake of services provided directly by pharmacies (ie not commissioned by the NHS, Local Authority or Leicester City Clinical Commissioning Group), so the PNA cannot assess whether the services adequately meet the needs of the population.

Pharmacies can provide a valuable service to patients, particularly underserved populations who can take advantage of a drop-in service at a time more convenient to themselves without the need for an appointment. It may also be more appealing to use a less formal environment within a pharmacy compared with the GP surgery.

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

11.1 Regulatory statements

It is a legislative requirement that PNAs are developed in accordance with the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.1 Regulation 4 Schedule 1 of the 2013 regulations set out the minimum information to be contained in a PNA. Detailed below are the seven statements included in schedule 1.

Statement 1: current provision of necessary services

A statement of the pharmaceutical services that the health and wellbeing board (HWBB) has identified as services that are provided:

- *in the area of the HWBB and which are necessary to meet the need for pharmaceutical services in its area; and*
- *outside the area of the HWBB but which nevertheless contribute towards meeting the need for pharmaceutical services in its area (if the HWBB has identified such services)*

There is currently sufficient provision of pharmacies in Leicester City delivering essential pharmaceutical services. Currently there are 85 pharmacies in Leicester serving a population of 354,036 residents, of which nine are distance selling pharmacies and eight are 100-hour pharmacies. This equates to a rate of 2.4 pharmacies per 10,000 residents (or one pharmacy per 4059 residents) which is greater than the England rate of 2.1 (or one pharmacy per 5056 residents)

This PNA has also considered 33 pharmacies which lie within 1.5 km of the Leicester City boundary as an approximation of pharmacies that are located within an acceptable range of access by foot, public transport or by car. Of these 28 are community pharmacies, 4 are 100 hour pharmacies and 1 is a distance selling pharmacy. Pharmacies located across the city boundary to the North West and West are able to serve residents in these areas where there are fewer pharmacies.

Statement 2: gaps in provision of necessary services

A statement of the pharmaceutical services that the HWBB has identified (if it has) as services that are not provided in the area of the HWBB but which the HWBB is satisfied:

- *need to be provided (whether or not they are located in the area of the HWBB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area;*
- *will in specified future circumstances, need to be provided (whether or not they are located in the area of the HWBB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area*

No gaps in the provision of essential pharmaceutical services across Leicester were identified in this PNA.

The PNA has considered population growth based on population projections and

provision of pharmacy services. It is not currently possible to assess any future need for pharmaceutical services in terms of additional housing planned by local areas. Leicester's Housing Plan is hoped to be published for consultation in Autumn 2022.

Statement 3: current provision of other relevant services

A statement of the pharmaceutical services that the HWBB has identified (if it has) as services that are provided:

- *in the area of the HWBB and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;*
- *outside the area of the HWBB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;*
- *in or outside the area of the HWBB and, whilst not being services of the types described above, they nevertheless affect the assessment by the HWBB of the need for pharmaceutical services in its area*

An array of enhanced services are provided across Leicester and the PNA has considered services provided by pharmacies within 1.5km of the city boundary. Data on additional services provided by community pharmacies was sought via a pharmacy contractor questionnaire. There were 31 responses (out of 85, 36%) to this questionnaire. Knowledge of local services contracted directly by the pharmacies in Leicester is limited. It is recommended that the system collates information on all of the services provided by the pharmacies in Leicester as this will help to develop a better understanding of the wide range of services offered across the city. In turn this will enable the promotion of the services offered to local communities and inform plans to reduce health inequalities across the city.

Statement 4: improvements and better access, gaps in provision

A statement of the pharmaceutical services that the HWBB has identified (if it has) as services that are not provided in the area of the HWBB but which the HWBB is satisfied:

- *would, if they were provided (whether or not they were located in the area of the HWBB), secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type in its area*
- *would, if in specified future circumstances they were provided (whether or not they were located in the area of the HWBB), secure future improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area*

The majority of pharmacies provide enhanced services to Leicester residents. The advanced services Community Pharmacist Consultation Service, Flu Vaccination service and New Medicines Services are provided by the majority of pharmacies. Few pharmacies offer Stoma Appliance Customisation and a few pharmacies reported Appliance Use Review and Hepatitis C Testing services in the pharmacy survey. A pharmacy survey was conducted to collect information on additional services contracted directly by pharmacies. There were 36 responses (from 85 pharmacies) so

a full review of gaps in provision of additional local services has not been possible.

Future commissioning of these services would likely lead to further health improvements for residents.

Statement 5: other NHS services

A statement of any NHS services provided or arranged by a local authority, the NHSCB, a CCG, an NHS trust or an NHS foundation trust to which the HWBB has had regard in its assessment, which affect:

- *the need for pharmaceutical services, or pharmaceutical services of a specified type, in its area; or*
- *whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area*

As part of the PNA process, local authority commissioners, Leicester City Clinical Commissioning Group and local NHS England & Improvement were consulted to produce an up to date list of additional pharmaceutical services provided across Leicester city.

Provision of Covid-19 vaccinations in community pharmacies has provided additional locations for patients to access this service. Pharmacy provision of Covid-19 booster vaccinations in Care Homes is under consideration.

Statement 6: how the assessment was carried out

An explanation of how the assessment has been carried out, and in particular:

- *how it has determined what are the localities in its area;*
- *how it has taken into account (where applicable)*
  - *the different needs of different localities in its area, and*
  - *the different needs of people in its area who share a protected characteristic; and*
- *a report on the consultation that it has undertaken.*

The scope of this PNA was to assess the pharmaceutical needs and service provision within Leicester city. The localities were selected as the Health and Wellbeing areas as used in the Health and Wellbeing Survey. These are groups of 3-4 middle super output areas and help to show variation across the city. An assessment of population health needs and pharmacy provision within these locality areas has been included in the PNA. Additionally, each pharmacy in Leicester was asked to complete a survey which included questions on facilities and aids that would assist individuals with a physical or mental disability in accessing the pharmacy premises and pharmacy services. A summary and results of 3 consultations (public consultation, pharmacy consultation and statutory 60-day consultation are included in the PNA.

Statement 7: map of provision

A map that identifies the premises at which pharmaceutical services are provided in the area of the HWBB

A map is provided in chapter 6 (figure 6) which details the location of each pharmacy at a locality level and whether the pharmacy is a community pharmacy, distancing selling or 100-hour pharmacy.

11.2 Recommendations:

Equity of service:

Leicester has a higher rate of pharmacies per 100,000 of population than is found in England overall. However, Leicester's pharmacies are not evenly distributed throughout the city. The reasons for this are historic and commercial. The result is that some areas of the city have clusters of pharmacies while in other areas coverage is more thinly spread, and, working on the basis that people generally prefer to go to a nearby pharmacy, patients have a greater or lesser degree of choice, depending on where they live in the city. Equity in a service context can be viewed through the lens of access - can people physically get to the service? Take up - are there cultural, language or attitudinal barriers that may deter use? Outcome - do customers get the service they need and feel satisfied with that service?

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

- Keep under review locations and opening times to assess whether access is equitable for all residents.
- Review cross-city and county-border service provision to ensure uniformity of access and quality of service
- Work with pharmacies and Local Pharmaceutical Committee to examine how equity issues can be addressed further. A review of service quality and uptake, including consideration of cultural and equalities needs could provide insight into the effectiveness of these local services.
- Work closely with Integrated Care Board and Primary Care Networks to tackle health inequalities and address digital literacy
- Consider the additional pressure on pharmacies due to the national pharmaceutical workforce shortage and work with pharmacies to mitigate the impact on service provision
- Encourage pharmacies to offer discretionary services in relation to local need.

Promotion of health and healthcare management:

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

- Ensure that the promotion of healthy lifestyles (Public Health) requirement of the essential services contract is fulfilled (see section 4.1.1). While NHS England and NHS Improvement retains responsibility for this area of the pharmacy contract, local campaigns should in future be jointly defined by NHS England and NHS Improvement, Local Authority Public Health and Leicester, Leicestershire and Rutland Integrated Care Board to promote healthier lifestyles through pharmacies so that individuals can gain advice and support in reducing unhealthy behaviours and adopting healthier ones.

- Consider and encourage the opportunity to include and develop the role of pharmacies in commissioning strategies and through the Integrated Care System - particularly in relation to providing services which deflect work out of primary care general practice.

- Collate information on all of the services (including those directly commissioned by pharmacies) provided in Leicester as this will help to develop a better understanding of the wide range of services offered across the city. In turn this will enable the promotion of the services offered to local communities and inform plans to reduce health inequalities across the city.

- Assess levels of uptake of advanced and locally commissioned services and follow-up low or high performers in order to share best practice.

- Keep under review the appropriateness of monitoring and quality visits to pharmacies, in addition to pharmacy self- assessment, in order to provide assurance of effectiveness and to promote service improvement.

- Work with pharmacies to consider replacing recently decommissioned popular services (e.g. Medicine Use Reviews).

Implications of Community Pharmacies Policy

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

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

GLOSSARY OF TERMS

AUR	Appliance Use Review
BME	Black and Minority Ethnic
CBS	Community Based Services
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
EHC	Emergency Hormonal Contraception
EPACT	Electronic Prescribing Analysis and Costing
EPS	Electronic Prescription Service
GP	General Practitioner
GPhC	General Pharmaceutical Council
H. Pylori	Helicobacter Pylori
HLP	Healthy Living Pharmacy
HWB	Health and Wellbeing
HWBB	Health and Wellbeing Board
ICB	Integrated Care Board
ICS	Integrated Care System
IMD	Index of Multiple Deprivation
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LCC	Leicester City Council
LCCCG	Leicester City Clinical Commissioning Group
LLR	Leicester, Leicestershire and Rutland
LPC	Local Pharmaceutical Committee
LPS	Local Pharmaceutical Services
MDS	Monitored Dosage System
MSOA	Middle Super Output Area
MUR	Medicines Use Review
NHS	National Health Service
NHSE	National Health Service England

NMS	New Medicines Service
NRT	Nicotine Replacement Therapy
ONS	Office for National Statistics
PhAS	Pharmacy Access Scheme
PNA	Pharmaceutical Needs Assessment
PSNC	Pharmaceutical Services Negotiating Committee
POPPI	Projecting Older People Population Information System
RSPH	Royal Society for Public Health
SAC	Stoma Appliance Customisation
SCR	Summary Care Record
STP	Sustainability and Transformation Plans

LEICESTER CITY HEALTH AND WELLBEING BOARD
26 January 2023

Subject:	**Leicester, Leicestershire and Rutland Health and Wellbeing Partnership Initial Draft for Engagement Integrated Care Strategy**
Presented to the Health and Wellbeing Board by:	Sarah Prema, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board
Author:	Jo Grizzell, Senior Planning Manager, Leicester, Leicestershire and Rutland Integrated Care Board

EXECUTIVE SUMMARY:

The purpose of this report is to share for engagement purposes the initial draft of the Leicester, Leicestershire and Rutland Health and Wellbeing Partnership Integrated Care Strategy.

The final version of the strategy will be developed following feedback for approval no later than Autumn 2023.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- **REVIEW** and **PROVIDE** feedback on the draft Integrated Care Strategy

LEICESTER CITY HEALTH AND WELLBEING BOARD

26 January 2023

Introduction

1. As part of the legislative changes Integrated Care Partnerships are statutorily required to develop an Integrated Care Strategy. To support this, the DHSC published guidance in August 2022 setting out the broad requirements of an Integrated Care Strategy. This set out that an initial strategy must be published by December 2022, however, this is not a mandated requirement.

2. The initial draft of the strategy was presented to the LLR Health and Wellbeing Partnership at its meeting in December 2022. It was agreed that further engagement with the Local Authority Health and Wellbeing Boards would be undertaken in the first quarter of 2023 to gain feedback with a view to getting a final strategy approved and published by the latest Autumn of 2023.

Strategy Development

3. To support the development of the strategy, a working group was established that met on a weekly basis. The groups' membership consisted of public health colleagues from the three local authorities and LLR Integrated Care Board directorate representation.

4. Initial priorities set out in the draft strategy were developed by a joint meeting of the three Leicester, Leicestershire and Rutland Health and Wellbeing Boards and the Leicester, Leicestershire and Rutland Integrated Care Board in June 2022.

5. These were further supplemented by a development session of the LLR Health and Wellbeing Partnership in October 2022, the purpose of which was to gain feedback on the proposed content of the strategy. The combined priorities from both these sessions form the basis of the draft strategy.

6. It was agreed that the strategy should be relatively short and succinct, setting the strategic direction of the LLR Health and Wellbeing Partnership. Which would then inform the Integrated Care Board's 5-year joint forward plan which needs to be developed by the Integrated Care Board by the end of March 2023. NHSE published guidance for the latter on 23 December 2022 (https://www.england.nhs.uk/wp-content/uploads/2022/12/B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf).

7. As outlined in section 2 above, the draft strategy was presented to the LLR Health and Wellbeing Partnership at is meeting in December 2022 where next steps were agreed which includes engagement with each Health and Wellbeing Board plus Healthwatch, wider public and organisational engagement.

8. The draft strategy for engagement is attached (Appendix 1) which incorporates feedback prior to the LLR Health and Wellbeing Partnership meeting in December 2022. As we go through the engagement phase feedback will be

gathered with a view of producing a final strategy for approval by at the latest the Autumn of 2023. It is anticipated that an update on progress of engagement and emerging feedback will be provided to the next meeting of the LLR Health and Wellbeing Partnership in April 2023.

9. The initial draft has not yet been designed; work is commencing on developing a designed version including the graphics. However, amendments will be made to the document once the engagement phase has been completed to minimise versions.

Next steps

10. The Leicester City Health and Wellbeing Board members can provide feedback directly to the LLR Integrated Care Board's Strategy Directorate at llricb-llr.strategyandplanningteam@nhs.net

11. The aim is for the Health and Wellbeing Partnership to approve a final version by the latest Autumn of 2023.

Recommendations:

The Health and Wellbeing Board is requested to:

- **REVIEW** and **PROVIDE** feedback on the draft Integrated Care Strategy

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Improving Health and Wellbeing in Leicester, Leicestershire and Rutland

Our Initial draft strategy for engagement 2022-2027

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Foreword

We are pleased to present this inaugural Leicester, Leicestershire and Rutland (LLR) Integrated Care Strategy.

We have a rich history of working together and this strategy is another key milestone in our integration journey, building on our foundations to now go further and faster to transform health and care for the residents and communities of LLR.

We face many challenges across LLR: finances are stretched in our Local Authorities and NHS; there are workforce shortages across health and social care; and people experience problems in accessing services in a timely manner. Developing this Strategy has provided the opportunity to co-develop system-wide ***areas of focus*** aimed at preventing ill health, improving people's health and wellbeing, reducing health inequalities and making it easier for people to access the services they need. Our aim is not to duplicate the efforts of our individual partner organisations as they address financial, workforce, access and other challenges in the shorter-term but, rather, to focus on where collective effort, at a system level, can harness the greatest impact in the longer-term.

This Strategy also underpins and supports our three Places - Leicester, Leicestershire and Rutland - each of which have their own distinctive characteristics, challenges and priorities, many of which are best addressed locally.

There is more work to do to engage with wider stakeholders and local people to ensure that this Strategy reflects their views. That is why this Strategy is currently considered a *draft* and it is our intention to undertake wider engagement, in the early part of 2023, the outcomes of which will be reflected in an updated Strategy.

<Signature> **<Signature>**	**<Signature>**	**<Signature>**	**<Signature>**
David Sissling Councillor Samantha Harvey	Councillor Vi Dempster	Councillor Louse Richardson	Councillor Samantha Harvey
Co-Chairs, Leicester, Leicestershire and Rutland Health and Wellbeing Partnership	Chair, Leicester City Health and Wellbeing Board	Chair, Leicestershire County Health and Wellbeing Board	Chair, Rutland County Council Health and Wellbeing Board

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Who we are

Our local councils, local NHS organisations and patient representatives have come together as the Leicester, Leicestershire and Rutland (LLR) Health and Wellbeing Partnership. Our role is to agree the key issues that need to be addressed to improve people's health and care across LLR. We do this by listening to what local people, groups and organisations have to say about health and care services, as well as by looking at the data and evidence of health and care needs. We also have a role in overseeing progress on addressing these key issues.

Who has this document been written for?

This is a public document setting out the Health and Wellbeing Partnership's strategy for the next five years and is, therefore, designed to be read by anyone with an interest in local health and care.

This is the first Integrated Care Strategy 'product' to be developed and it is an initial draft for engagement. We will develop other Integrated Care Strategy 'products', as advised by our engagement teams, to meet specific stakeholders needs.

Purpose of this Strategy

This Strategy is a blueprint for delivering a healthier future for people in LLR. It is designed to guide our care and health organisations, staff, and the voluntary sector to **key areas of focus** where, collectively, we can make a difference to improve people's health and wellbeing over the coming years.

Working together, over the next five years, we will focus on:
Focus 1: Reducing Health Inequalities
Focus 2: Preventing illness and helping people to stay well
Focus 3: Championing integration
Focus 4: Fulfilling our role as 'Anchor' organisations

In the shorter term (2022-2024) we will also focus on two additional issues:
Focus 5: Co-ordinated action on the Cost-of-Living crisis
Focus 6: Making it easier for people to access the services they need

Supporting our Places to deliver their Priorities

Our three Places - Leicester, Leicestershire and Rutland - each have their own distinct characteristics, challenges and opportunities. Each Place, therefore, has its own Joint Health and Wellbeing Strategy (JHWS) aimed at delivering four LLR priorities (Figure 1), as these priorities are best addressed at a Place or community level.

This Integrated Care Strategy underpins and supports Place work by focussing attention and effort on those areas where collective and longer-term action, at a system level, can harness the greatest impact.

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Figure 1: Our LLR Transformational Priorities

[NOTE: INFOGRAPHIC TO BE RE-DESIGNED AND STANDARDISED FOR EASE OF VIEWING]

Each JHWS details the strategic vision and priorities for each respective place. Due to the varying demographics and needs of each place, it is not unexpected that there are some differences across each of these strategies in terms of priorities and timescales. Table 1 summarises some of the key priorities across the LLR JHWS's as aligned with the ICS life course transformational priorities (Figure 1).

Many of the broad themes in the three strategies are similar. This is to be expected considering the evidence base behind improving health and wellbeing outcomes and improving health equity.

In order to achieve the identified priorities, different approaches will need to be taken in the three places. For instance, actions to achieve every child having the Best Start for Life are likely to vary between places. There are many areas of deprivation and high need in Leicester, so a broader approach may need to be taken for a priority such as school readiness (ready to play and learn). In Leicestershire, there may be particular areas where a more focused approach is required. In Rutland there may be certain groups that need more support such as the children of serving military personnel. Therefore, although the priorities may appear similar on the outset the lens and services in which they are implemented is likely to vary across each place.

Table 1 Summary of LLR JHWS alignment to ICS Transformational Priorities

	Strategic priority		
ICS priority	**Leicester**	**Leicestershire**	**Rutland**
	5 years (2022-2027)	**10 years (2022-2032)**	**5 years (2022-2027)**
Best Start in Life	Healthy Start	Best Start for Life	The best start for life
Staying Healthy and Well	Healthy Lives	Staying Healthy, Safe and Well	Staying healthy & independent: prevention
	Healthy Places		Preparing for population growth & change
Living and Supported Well	Healthy Ageing	Living and Supported Well	Healthy ageing & living well with long term conditions
			Equitable access to health & wellbeing services

Dying Well	Healthy Ageing	Dying Well	Ensuring people are well supported in the last phase of their lives
Cross Cutting Themes	Healthy Minds	Improved Mental Health	Supporting good mental health
	Working together to enable everyone in Leicester to have opportunities for good health and wellbeing	Reducing health inequalities	Reducing health inequalities
	Covid impact considered within theme areas.	Covid Recovery	Covid -19 Recovery

[NOTE: TABLE TO BE DESIGNED]

Further information and reading:

Leicester City Council:
Joint Health and Wellbeing Strategy
JSNA

Leicestershire County Council:
Joint Health and Wellbeing Strategy
JSNA

Rutland County Council:
Joint Health and Wellbeing Strategy
JSNA

Our Vision and Principles

We worked closely with partners and stakeholders to develop a vision and principles that act as a 'golden thread' for how we operate: for how we focus on a better future for local people; for how we transform and improve health and care; and for how we interact with each other.

Our Vision

Working together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives

Our Principles

Principles Everything we do is centred on the people and communities of LLR and we will work together with respect, trust, openness and common purpose to		
Ensure that everyone has equitable access to health and care services and high quality outcomes	Make decisions that enable great care for our residents	Deliver services that are convenient for our residents to access
Develop integrated services through co-production and in partnership with our residents	Make LLR health and care a great place to work and volunteer	Use our combined resources to deliver the very best value for money and to support the local economy and environment

[NOTE: INFOGRAPHIC TO BE RE-DESIGNED AND STANDARDISED FOR EASE OF VIEWING]

How we will work together

This strategy requires collaboration across all our Partners and, to support this, we set out, at Table 2 below, how we will work together.

Table 2: How Health and Wellbeing Partners will work together

Person-centred focus	1. We will meet our citizens' needs by working together within our joint resources, as one health and care system. We will develop a model of care and wellbeing that places the individual at its heart, using the combined strengths of public health, health, social care and allied organisations.
	2. Citizens are integral to the design, co production and delivery of services.
	3. We involve people, communities, clinicians and professionals in decision making processes.
	4. We will take collective action to release funds for prevention, earlier intervention and for the reduction in health inequalities.
	5. We strive for our leadership to be representative of the population, and we focus on the causes of inequality and not just the symptoms, ensuring equalities is embedded in all that we do.
Subsidiarity	6. Decisions taken closer to the communities they affect are likely to lead to better outcomes. Expectation is for decisions to be taken as close to communities as possible, except where there are clear and agreed benefits to working at greater scale.
	7. Collaboration between partners in a place across health, care services, public health, and the voluntary sector can overcome competing objectives and separate funding flows to help address health and social inequalities, improve outcomes, transform people's experience, and improve value for the tax payer.
Collaboration	8. Collaboration between providers across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.
	9. Through formal and informal collaboration as a system we will be better placed to ensure the system, places, and individual organisations are able to make best use of resources.
	10. We prioritise investments based on value, ensuring equitable and efficient resource allocation, and we take shared ownership in achieving this.
	11. We are coming together under a distributed leadership model and we are committed to working together as an equal partnership.
Mutual Accountability & Equality	12. We have a common understanding of the challenges to be addressed collectively and the impact organisations can have across other parts of the system. We engage in honest, respectful, and open dialogue, seeking to understand all perspectives and recognising individual organisations' agendas and priorities. We accept that diverse perspectives may create dissonance, which we will seek to address, moving to conclusions and action in service of our citizens. We strive to bring the best of each organisation to the Partnership.
	13. We adhere to a collective model of accountability, where we hold each other mutually accountable for our respective contributions to shared objectives and engage fully in partners' scrutiny and accountability functions, where required.
	14. We develop a shared approach to risk management, taking collective responsibility for driving necessary change while mitigating the risks of that change for individual organisations.
Transparency	15. We will pool information openly, transparently, early, and as accurately and completely as possible to ensure one version of the truth to be used by partners across the system.
	16. We work in an open way and establish clear and transparent accountability for decisions, always acting in service of the best outcomes for the people of LLR.
Sustainability	17. We will strive to will strive to reduce the impact of our actions on our environment, and work towards building a healthy living and working environment for all our population and staff.

[NOTE: TABLE TO BE DESIGNED]

Overview

Place holder for infographics (page 1 of 2)

NOTE:

- Infographics describing local health and wellbeing need, finances, quality, performance and workforce are being developed.
- Public Health colleagues have developed a synopsis overview of health and wellbeing need in LLR, across key themes, and this overview will be published as a compendium to this Strategy and also as a stand-alone resource for Partners.
- A 2-page summary of the overview is being developed and infographically designed to include in this Strategy, once available.

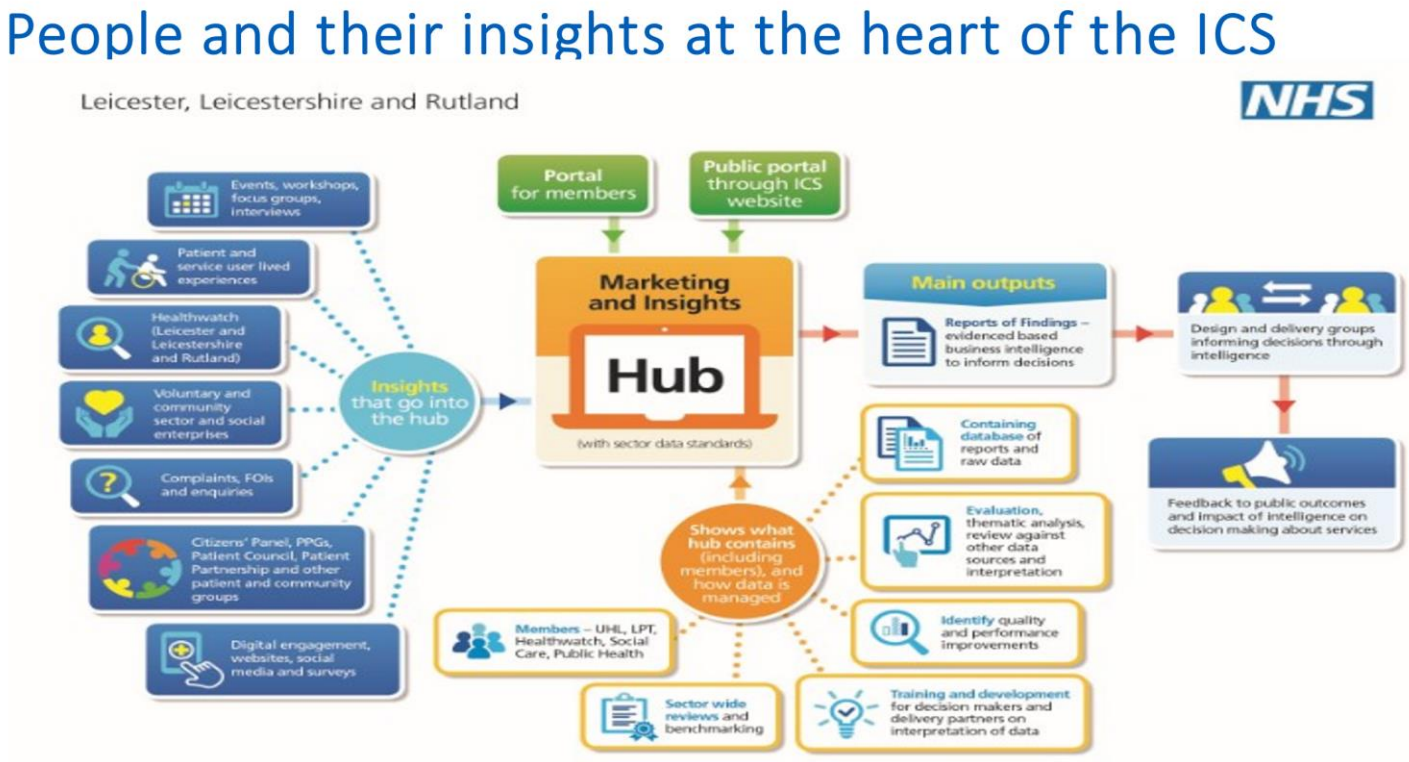
Place holder for infographics (page 2 of 2)

How we have used insights and engagement to develop this strategy

This Strategy builds on firm foundations of participation, involvement and engagement with people and communities, over many years. It has also been built on an inclusive learning culture, to deeply understand the needs of our population and design services appropriate to those needs.

We continuously and actively work with local people, patients, interest groups, voluntary organisations and a wide range of others to understand people's health and care needs, as well as hear about their experiences of services. We then use these insights and knowledge to improve care and services and, ultimately, have a positive impact on people's health and wellbeing.

Figure 2: How engagement and insights inform the design and delivery of local health and care services



NOTE: INFOGRAPHIC TO BE RE-DESIGNED AND STANDARDISED FOR EASE OF VIEWING

Public and patient participation has been refined over time. The last two years has seen significant work to engage with people, including those with protected characteristics. Through a range of engagement work, we have heard from over 45,000 people who have shared with us their insights about a range of physical and mental health and care services. We have used this intelligence to shape this Strategy.

Figure 3, below, identifies some of the ways we have obtained insights and views. We plan to continue to engage with our Partners to validate our understanding of what matters most to people, before this initial draft is approved at our Partnership meeting in December 2022. Then, in early 2023, we will continue to engage with wider stakeholders and the public to ask if there is anything else we need to think about to improve services. This will lead to an updated version being re-approved later in 2023.

Figure 3: How insights and engagement have influenced this Strategy

NOTE: INFOGRAPHIC TO BE DESIGNED AND STANDARDISED FOR EASE OF VIEWING

We will continue to undertake our comprehensive programme of engagement to shape this Strategy, ensuring that all partners, key stakeholders and the wider public have an opportunity to influence its development and on-going refresh. This current version of the Strategy is, intentionally, an initial draft as we want to continue engaging over the coming months to ensure that we've got it right.

Further information and reading:

Leicester City Council:

LLR Integrated Care Board
ICB People and Communities Strategy 2022/24

Rutland County Council:
Communications and Engagement Strategy 2022-27

Leicestershire County Council:
Engagement standards

Key areas of focus

Having taken account of health and wellbeing evidence, as well as the views of partners, we concluded that this Strategy should focus on areas where, firstly, working collectively across LLR will have the greatest impact on improving people's health and wellbeing and reducing health inequalities and, secondly, we can support our Places to deliver their priorities.

Working together, over the next five years, we will focus on:

Focus 1: Reducing Health Inequalities

Focus 2: Preventing illness and helping people to stay well

Focus 3: Championing integration

Focus 4: Fulfilling our role as '*Anchor*' organisations

In the shorter term (2022-2024) we will also focus on two additional issues:

Focus 5: Co-ordinated action on the Cost-of-Living crisis

Focus 6: Making it easier for people to access the services they need

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Focus 1: Reducing Health Inequalities

What do we mean by health inequalities?

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

Why focussing on this is important to us

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

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

Actions we will take

Priorities to address health inequalities will be determined and delivered at LLR level, in our three Places (Leicester City Council, Leicestershire County Council and Rutland County Council) through each of their JHWS; and in our communities.

At LLR level, we will:

Action 1: Apply our Health Inequalities Framework (NOTE: Hyperlink to be added) principles across our three Places
Action 2: Make investment decisions across LLR that reflect the needs of different communities
Action 3: Establish a defined resource to review health inequalities across LLR
Action 4: Ensure people making decisions have expertise of health inequity and how to reduce it
Action 5: Understand the impact of Covid-19 on health inequalities, to allow effective and equitable recovery.
Action 6: Improve data quality and use to enable a better understanding of and reduce health inequity
Action 7: Health equity audits will inform all commissioning or service design decisions
Action 8: Staff will be trained to understand and champion approaches to reducing health inequalities.

Example of JHWS actions include:

Infant mortality in Leicester: Tackling higher than the national average infant mortality by reducing the risk factors through targeting new mothers and families with support and information.
Implementing 'proportionate universalism' in Leicestershire: Interventions will be targeted with the aim of bringing those experiencing poorer outcomes the opportunity to 'level up' to those achieving the best outcomes.
Focus on areas and specific groups in Rutland: To ensure all people have the help and support they need, the focus is on those living in the most deprived areas and households of Rutland, as well as some specific groups (for example the military, carers and learning disability population and those experiencing

significant rural isolation).

What does success look like?

If we are successful in driving effective action, we expect to see the following:

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

A local case study

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

Our Approach

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

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

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

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

▶ Design of intervention in partnership with community

In Reach Pop Up Clinic

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

Community Engagement

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

▶ Rate after interventions

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

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

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

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

Feedback from staff and patients

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

▶ How we have applied this learning elsewhere

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

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

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

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

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

[NOTE: CASE STUDY TO BE RE-DESIGNED AND STANDARDISED FOR EASE OF VIEWING]

Further information and reading:

LLR Health and Wellbeing Partnership:
Tackling health inequalities
Link needed to HIF

Leicester City Council:
Joint Health and Wellbeing Strategy
JSNA

Rutland County Council:
Joint Health and Wellbeing Strategy
JSNA

Statistics on social determinants of health:
Index of Multiple Deprivation (IMD).

Leicestershire County Council:
Joint Health and Wellbeing Strategy
JSNA

Focus 2: Preventing illness and helping people to stay well

What do we mean by Prevention?

It's helpful to think of prevention in three categories. Firstly, we can take action to prevent health and wellbeing problems from occurring at all, for example, through clean air legislation or immunisation programmes. This is called **Primary** prevention.

Secondary prevention is about detecting the early stages of harm and intervening before symptoms develop, for example, cancer screening programmes and targeted weight management services.

Finally, we can soften the impact of an ongoing illness or injury that has lasting effects - **Tertiary** prevention – for example, stroke and cardiac rehabilitation programmes.

Why focussing on this is important to us

Everyone knows that prevention is better than cure. We want people to live the best life that they can, for as long as they can, free from illness, disease and other health problems. We want local people to be proactive about their health and wellbeing. This can increase independence and delay the need for health and care services. Where illness or disease is at risk of occurring, we want to identify this early and intervene to minimise the impact.

Priorities for local prevention include smoking, obesity and diabetes, alcohol related harm, cancer, cardiovascular disease, respiratory disease and preventing and reducing harm (for example, from substance misuse, child criminal exploitation and domestic and sexual violence). There are also health inequalities in prevention, for example, barriers in how services are provided mean that ethnic minority women are less likely to attend cervical cancer screening.

Actions we will take

Many preventative actions are determined and delivered nationally (for example, government policy to protect citizens, some screening programmes), regionally (for example, through the East Midlands Cancer Alliance) and locally (for example, through our council's public health teams). Our Place JHWS also focus on prevention, for example, promoting the health benefits of sustainable transport and improving air quality in Leicester, improving the offer of a health check in Rutland, and reducing the number of falls that people over 65 experience across Leicestershire

At LLR level, we will:

Action 1: Ensure that prevention is at the forefront of local policy planning and commissioning across health and care

Action 2: Champion and relentlessly drive for health equity in prevention

Action 3: Embed prevention as a fundamental part of all professionals' roles across LLR**,** delivering Making Every Contact Count Plus interventions

Action 4: Support people to increase their sense of control and resilience in their lives (Including, for example, improved co-production, preventing harm through violence work, and health literacy)

Action 5: Promote action that will help people with long-term health conditions to be able to self-manage.

Action 6: Provide leadership to System-wide responses to preventing and reducing harm

What does success look like?

If we are successful in driving effective action, we expect to see the following:

- Prevention is a priority in policy and funding decisions
- A reduction in the health equity gap in prevention
- Health and care staff discuss prevention and self-care with people they come into contact with
- Improvements in people's reported experience of their resilience and ability to self-manage

A local case study

Tackling health inequalities in cancer screening

Left to right: Richard Gray – Care Coordinator, Dr Leslie Borrill – Carillon Clinical Director, INT Chair for Charnwood Integrated Neighbourhood Team & Health Inequalities Clinical Lead, Kristy Mackinson – Head of PCN Development and Health Inequalities Management Lead

Community groups and public health staff are working together to improve access to cancer screening for all.

A new project – a partnership between Leicestershire County Council's public health teams and community groups in Charnwood – is exploring the reasons behind poor uptake of cancer screening in some parts of the community.

The team have identified communities where attendance at cancer screening clinics is lower – Bangladeshi, Polish, the homeless community, travellers, sex workers and carers. They then ran a series of focus groups to understand the barriers people faced, and the things that would make it easier for them to attend.

The results are now being used to make changes to services and help improve uptake across all communities. For example, some GPs have offered extra clinics, extended their hours, arranged outreach support and provided information in other languages.

Project Lead, Dr Bharathy Kumaravel, said: "It is our role as guardians of our community to tackle health inequalities and this partnership approach is helping us do this really well."

It is hoped that the project can be widened to include other areas within LLR over the coming months.

Dr Leslie Borrill, GP lead for Charnwood Integrated Neighbourhood Team, said: "We're not doing our job properly if we don't do all we can for every single person in our community, a 'one size fits all' approach doesn't work."

Dr Anu Rao, LLR Place Clinical Director for Primary Care, agreed: "It has helped us understand what's stopping people from engaging with our services and allowed us to develop appropriate solutions that are already having a positive impact."

The team is now working with University Hospitals Leicester to adopt a similar approach to engaging with patients who fail to attend respiratory appointments and to fully understand the barriers they face. Further plans to explore other key priority areas in the community are also being considered.

Councillor Louise Richardson, lead member for Public Health at Leicestershire County Council, said: "One of the focus areas in our latest Public Health Strategy is building on the strength of people in our communities. We can only do that by working together - listening and learning. The individuals that came forward to the focus groups have played a crucial role in uncovering what more we can do to encourage people to attend screenings in a way that suits their needs and lifestyle." ●

For further information on cancer screening, please check:
www.nhs.uk/conditions/nhs-screening

Bharathy Kumaravel, Project Lead

"It is our role as guardians of our community to tackle health inequalities and this partnership approach is helping us do this really well."

The barriers

A selection of responses to the study:

"If the information and tests come through the post we will do it, if it doesn't come we will not." Bangladeshi men's group

"At the best of times we don't understand the importance of attending screening and usually there are many barriers to why we don't attend. I feel if people could better understand in their own language what the screening involves, the importance of it and also hear from others about why they attend and the difference it can make, more people will go." Mrs Begum, member of the Bangladeshi community

"I haven't got much family around. I couldn't do it at school time and I had to take my boys with me. It wasn't a good experience taking my children with me." Polish women's group

"If you're homeless, even if you got something wrong with you, they won't hold you, they'll just boot you back out and leave you on the street." Homeless group. ●

[NOTE: CASE STUDY TO BE RE-DESIGNED AND STANDARDISED FOR EASE OF VIEWING]

Further information and reading:

NOTE: To be included

Focus 3: Championing Integration

What do we mean by Integration?

Local people have told us that, at times, the care and support they receive can feel un-coordinated and disjointed. Integration is about how our partner organisations work better together to meet the needs of our residents, ensuring that they receive the right support from the right service at the right time in a seamless and coordinated manner.

Why focussing on this is important to us

People are living longer and often with one (or more) long-term health conditions. This means that people increasingly need long-term care and support from lots of different services and a variety of professionals. Integrated care is critical to doing this successfully. Our partner organisations also face budget pressures and, while integrating care may not necessarily save money, it will help us to make better use of our limited budgets to improve people's care experience, improve outcomes and drive down health inequalities.

Actions we will take

Many of the actions needed to achieve integrated care will happen in our three Places (Leicester City Council, Leicestershire County Council and Rutland County Council) and, indeed, more locally at community and team level.

At LLR level, we will:

Action 1: Break down barriers and embed whole-pathway approaches to service design based, first and foremost, on what's best for local people

Action 2: Create an environment where integrated working is the default and second nature to our staff and colleagues

Action 3: Develop shared goals and outcomes, where we commit to work in partnership with each other and hold each other to account to deliver the best care for our LLR residents.

Action 4: Promote and support the development of Collaboratives (see Further Information and Reading, below), where these can improve integration of care

Action 5: Champion the co-production of pathways of care with staff and the people who use the services.

Action 6: Maximise the opportunities that pooled budgets permits, where these can improve integration of care and value for money.

What does success look like?

If we are successful in driving effective action, we expect to see the following:

- Improvements in peoples reported experience of the services that they receive
- Improvements in outcomes and a reduction in health inequalities
- Demonstrable improvements in system value for money through shared ownership, accountability and streamlined services
- Partner organisations coalesce, support and celebrate delivery against our shared outcomes.

A local case study

An integrated approach to promoting health and wellbeing in Rutland

Rise is an Integrated Neighbourhood Team in Rutland jointly funded by the Primary Care Network, Rutland County Council, and the Better Care Fund. The aim of Rise is to promote health and wellbeing for the local population through taking a holistic approach, encouraging people to have an active role in their own care and wellbeing, and building on local community assets. The team has been in existence since 2018 and roles include Integrated Care Coordinator, Community Mental Health Care Manager, Domiciliary Care Lead, Social Prescriber Link Worker, and Clinical Care Home Coordinator. It is led by the Head of Service in the Local Authority who meets weekly with each team member and arranges monthly team meetings. Staff with a clinical role also receive professional supervision with a suitable health colleague and the team engages in wider networks such as neighbourhood forums. The team leader also meets regularly with the PCN manager to discuss new opportunities and shared challenges. The MDT has used the Office for National Statistics well-being survey (ONS4) to understand what difference its support has made to people - 94% reported improvement in their life satisfaction, feeling of life being worthwhile, happiness, and/or levels of anxiety.

The integrated approach of Rise has been supported through the development of a new digital platform. This allows GPs to refer someone through their electronic patient record system and for the MDT to then provide updates back to the GP. The platform also enables team members to introduce someone to community resources and supports interactive discussions with these organisations. It then identifies if someone has been offered support and highlights if there are any delays. The system is open to the public so that they can explore themselves what options are available and directly contact a resource so that they do not need to access via a GP. It also provides useful data for commissioners and voluntary organisations on referral trends, if there has been any change in their use of GP services, support that people would like to access but not is not available, and on the impacts that people report in relation to their wellbeing.

Development of more integrated care in Rutland has been facilitated through the geographic boundaries of the Local Authority and the PCN being similar. In relation to the ICS, Rutland is both a neighbourhood and a place. Monthly neighbourhood forums are held to bring together health and social care professionals, and the voluntary and community sector to discuss the challenges facing the local population and how best to respond to health and social inequalities. This was helpful in COVID when RISE were able to co-ordinate vaccinations with the clinically vulnerable and advise when wider changes such as temporary disruptions in utilities. Other enablers include - positive long-term relationships and high degree of trust between the lead individuals in health and social care; sharing of capacity and skills between Rise and the other teams in the locality to respond to demand; and, training and development opportunities being offered across teams to enable them to become familiar with each other and their roles.

[NOTE: CASE STUDY TO BE DESIGNED AND STANDARDISED FOR EASE OF VIEWING]

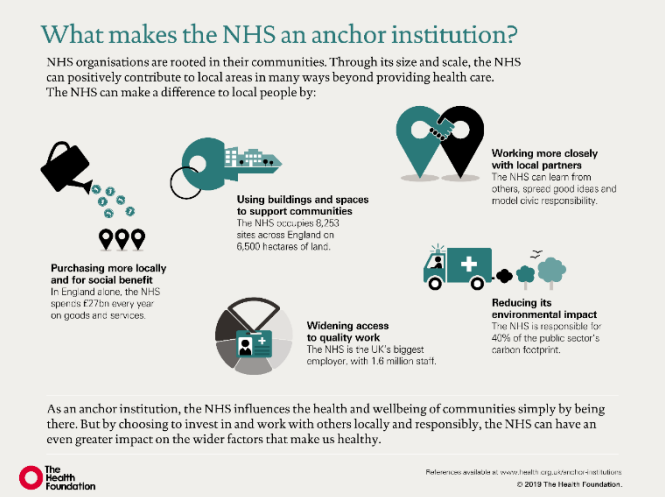
Further information and reading: Collaboratives

LLR Health and Wellbeing Partnership:
Integration in action

Focus 4: Fulfilling our role as *Anchor* organisations

What do we mean by an 'Anchor' organisation?

Anchor organisations are large organisations that have a significant stake in the local area. They have sizeable assets that can be used to support the local community's health and wellbeing and tackle health inequalities, for example, through purchasing power, training, employment, professional development, buildings and land use. '*Anchors'* get their name because they are unlikely to relocate, given their connection to the local population. Our Partners - the local NHS (hospitals, community facilities, GP practices, etc.), our local authorities and our Universities - are Anchor organisations.



NOTE. Need different image

Why focussing on this is important to us

The NHS and councils are the biggest local employers. We own and operate many local buildings and facilities. We spend hundreds of millions of pounds each year on goods and services. We want to fully harness our assets, and those of our wider Partners, including our colleges, universities and industry, to influence wider economic development and environmental balance, in order to improve people's health and wellbeing and reduce health inequalities.

Actions we will take

We will:

Action 1: Widen access to quality careers and work (Please see Enabler 2 on page X)
Action 2: Maximise the use of our buildings and space to support local communities
Action 3: Purchase more locally and for social benefit
Action 4: Work more closely together to learn, spread good ideas and model civic responsibility
Action 5: Each Partner will deliver their organisation's Green Plan commitments
Action 6: Consider how we can balance meeting people's needs, with environmental and economic sustainability.

What does success look like?

If we are successful in driving effective action, we expect to see the following:

- Improved recruitment and retention to lower paid roles within our health and care workforce
- Achieving our carbon neutral trajectories as set out in each Partner organisation's Green Plan
- Our buildings are user friendly and are used to strengthen our communities
- Increased support to local business opportunities, recirculating wealth and community benefits locally
- Demonstrating that we work well together and share good practice

DRAFT

A local case study

Hidden Talents Pilot – Refugee Apprentice Programme

Growing Points is a local charity that provides support and mentorship to those that have made Leicester their home and have been given Refugee status. The charity works alongside other sectors and statutory organisations, such as Sanctuary Leicester, to enable people to access the right support, have access to jobs and provide peer and mentor support.

We have started a pilot that guarantees 10 apprenticeships per year, with an ambition to grow each year, for those that are being supported by Growing Points. The programme not only ring-fences apprentice opportunities but also ensure that there is wrap around support for applicants to remove as many barriers to accessing a career in health and care as possible. Some of these barriers are the way we advertise and select for roles and, by changing our approach, we hope to make a career in the sector more accessible.

[NOTE: CASE STUDY TO BE DESIGNED AND STANDARDISED FOR EASE OF VIEWING]

Further information and reading:

The Health Foundation:
The NHS as an anchor institution

The King's Fund:
Anchor Institutions and how they can affect people's health

LLR Integrated Care Board:
Link needed to People Plan
Link needed to Estates Strategy
Link needed to Green Plan

DRAFT

Focus 5: Co-ordinated action on the Cost-of-Living crisis

What do we mean by the Cost-of-Living crisis?

A combination of factors, some international and others national and local, have come together to squeeze people's ability to afford basic necessities. International factors include implications of Covid 19, energy availability and cost and climate change. National and local factors have also impacted, including long-standing pockets of deprivation and inequity in LLR.

Why focussing on this is important to us

Food, energy and heating have seen the biggest price increases and this has a disproportionate impact on lower income groups who spend around 90% of their income (Bank of England, July 2022) on essential goods and services, such as these. Health inequalities are already stark across LLR (see Focus 1) and the cost-of-living crisis is likely disproportionately impacting on those people and communities who already have the worst health and wellbeing outcomes.

Actions we will take

Individually, our partners are taking action to support more vulnerable people and communities, as well as our staff. For local people, this includes providing access and signposting to services. For staff, this includes action on transport, energy and food costs.

We will:

Action 1: Establish a task and finish group to co-ordinate action across our partner organisations, sharing learning, co-ordinating communication messaging and focussing on key groups

Action 2: Ensure a unified focus on key groups, including those who are 'just about managing'

Action 3: Better co-ordinate work with voluntary and faith-based organisations, as well as link workers, local area coordinators and social prescribers, to support key groups

Action 4: Actively reach out to regional and national partners, sharing, gathering and implementing best practice and schemes

Action 5: Look after our staff, helping them directly, as well as informing and signposting them to support

Action 6: Consider medium and longer term interventions that will support cost-of-living resilience amongst key groups

DRAFT

A local case study

NOTE: Place Holder for case study

DRAFT

Further information and reading:

Bank of England:
Financial Stability Report

Leicestershire County Council:
Find help with cost of living

Leicester City Council:
Benefits and other support

Rutland County Council:
Cost of living support

Focus 6: Making it easier for people to access the services they need

What do we mean by access?

Local people have told us that it can be a difficult and confusing knowing which service to access, from which location and at what time. Disjointed access leads to poor experience of health and care services. It can also lead to some services (for example, A&E) becoming overwhelmed, because people may not have the best information to hand when deciding what service to access. Our insights have also shown us that people want access to relevant and reliable self-care information so they can play a greater role in their own health and care.

Why focussing on this important to us?

We want people to have the information, ability and confidence to access the right support from the right place at the right time. We also want people to be informed and proactive about their health and wellbeing, with a focus on self-care, as this can increase independence and delay the need for health and care services.

Actions we will take:

We will:

Action 1: Work with communities and local people to ensure that targeted and tailored information is made available to help navigating the health and care system, promoting access to the right support from the right place at the right time, an example being the "Get In The Know" campaign

Action 2: Work with communities and local people to improve health and care literacy and promote self-care

Action 3: Improve digital literacy to empower and equip local people to utilise and navigate digital tools (for example, the NHS App and 111 online) to help with access challenges.

What does success look like?

If we are successful in driving effective action, we expect to see the following:

- Improvements in peoples reported experience of accessing timely services from the right place
- Better flow and capacity throughout our system as local people are engaged and informed regarding what service to access and from where.
- Improvements in local people's reported experience of their resilience and ability to self-manage
- Increase in confidence and use of health and care digital solutions

Further information and reading:

NHS LLR Integrated Care Board
Get in the know about local health services

NHS Services
Services near you

NHS 111 Online
Get help for your symptoms

NHS App
NHS App and Account

A local case study

CASE STUDY
Identification of Unregistered Patients Programme

The NHS Constitution states that *"You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by parliament…"*. This applies 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 3 months. Types of patients include those who are asylum seekers, refugees, homeless patients or overseas visitors.

Our Approach

Identify unregistered patient population working geographically and focussing on four main hotspot areas - places of worship, local community supermarkets, community centres and walk in Covid-19 Vaccine clinics

Design of Intervention in Partnership with Community

Since the launch of GP Registration programme in January 2021 and November 2022:

- We have engaged with 10,100 patients across LLR.
- We have held 35 events across LLR engaging with approximately 2,300 patients.
- We have attended 26 Vaccination clinics across LLR engaging with approximately 7,800 patients.
- We have created and translated easy read leaflets into 9 different languages
- We have targeted radio advertising across cultural and community specific radio stations to discuss the GP registration programme.
- We have received over 800 enquiries by phone and email in relation to GP registration.
- We have provided personalised support to Afghan refugees, helping 76 Afghan families to register with a GP.
- We have worked with our Local Authorities to help and support Ukrainian refugees to register with a GP.

Rate after Interventions

The GP Registration programme was introduced in Leicester City for the period of January 2021 until End of December 2021.

- Comparing to year 2020, total number of patients registered in Leicester City was 29,222 and since the introduction of GP registration programme in Leicester City in year 2021, total number of patients registered was 51,545. This is a rise of 22,323 patients reflecting over 76% increase.

- Due to the success of the programme in Leicester City, it is now introduced across LLR since January 2022 following similar approach taken in city to promote GP registration programme. The number of patients registered to date end of October as follows: -
  - Leicester City: 29,703 registered patients
  - Northeast Leicestershire and Rutland CCG: 17,146 registered patients
  - Northwest Leicestershire: 22,292registered patients

[NOTE: CASE STUDY TO BE DESIGNED AND STANDARDISED FOR EASE OF VIEWING]

Enabling this Strategy to be delivered

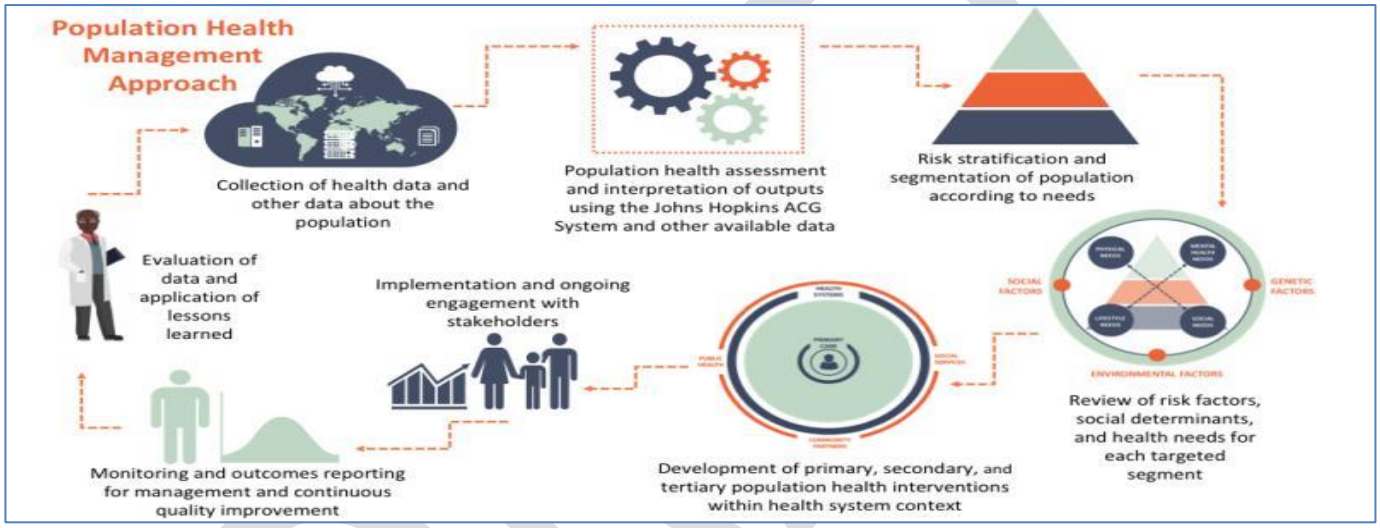
Below are the key enablers to help us to achieve our key areas of focus.

Enabler 1: We will use a Population Health Management (PHM) approach:

PHM is a term that describes compiling data and insights to understand people's health, care and wellbeing needs and current usage of services, and how they are likely to change in the future. These data and insights can then be used, in co-production with the people who will use the services, to plan and develop services, community development and other sources of help and support.

Employing a PHM approach allows us to support people with long term conditions, provide better case management and target resources where they are most needed. PHM aims to promote independence, improve physical and mental health outcomes, reduce health inequalities and help us live our extra years in better health.

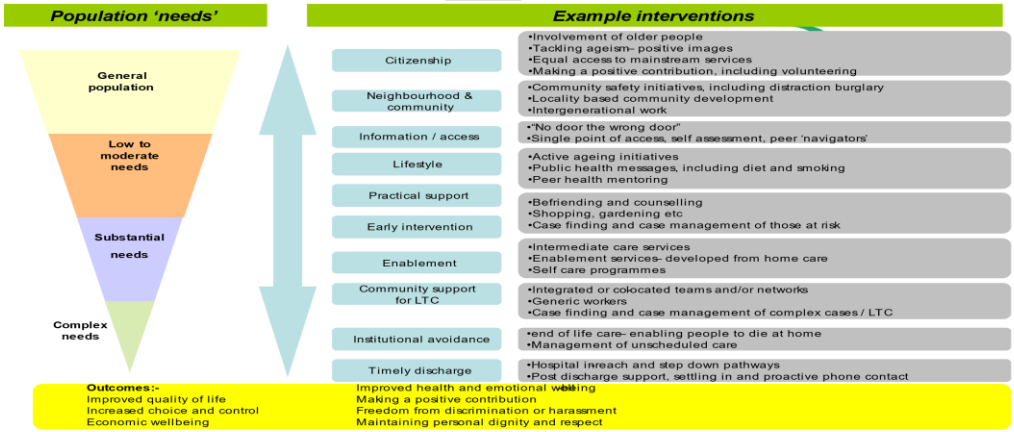
Figure 4: How Population Health Management works



[NOTE: INFOGRAPHIC TO BE RE-DESIGNED AND STANDARDISED FOR EASE OF VIEWING]

Figure 5, below, demonstrates how a PHM approach can be used to segment a population, understand that population needs and develop interventions to support people at each stage.

Figure 5: Using a PHM approach to deliver bespoke interventions



[NOTE: INFOGRAPHIC TO BE RE-DESIGNED AND STANDARDISED FOR EASE OF VIEWING]

A local case study

Population Health Management approach to better support end-of-life patients

Willows Health in Leicester is part of the Aegis Primary Care Network (PCN). The team have adopted a proactive approach towards PHM, which includes identifying patients potentially nearing the end of their lives to ensure they are given appropriate care and support. The team of GPs and experts had previously struggled to proactively identify this population in a comprehensive manner, but using a new algorithm called the Mortality Risk Score[1] generated from outputs of the Johns Hopkins Adjusted Clinical Group (ACG®) System, they were able to identify a number of patients who had not previously been included on the palliative care register.

This innovative work by the team at Willows Health has enhanced and supported their care planning work with palliative care patients and enabled them to provide patient-centred reviews and end-of-life care plans for those with higher levels of risk. The tool supports the group's clinical programme enabling proactive assessments, enhancing the quality and experience of care through optimisation of long-term conditions, undertaking medication reviews, signposting to additional support systems and exploration of patients' care preferences and best interests in this context. They are now able to offer the right support to a greater number of patients who are nearing the end of their life.

[NOTE: CASE STUDY TO BE DESIGNED AND STANDARDISED FOR EASE OF VIEWING]

Further information and reading:

The King's Fund:
What is a population health approach?

NHS England
Population Health and the Population Health Management Programme

Enabler 2: We want LLR to be a great place for health and care staff to live, work and grow

Workforce is one of the greatest challenges facing our local health and care system and is mirrored nationally.

We are committed to addressing workforce shortages through retaining our existing workforce, supporting staff, building new roles, and attracting new talent. It is our ambition to make LLR a great place to work and we will create an environment that ensures our 'people' thrive. Population health needs will underpin

[1] The MRS was developed by Dr Peter Austin et al in Ontario, Canada. The outcome of their research was a points-based scoring system that predicts risk of mortality in the adult population in the next 12-month period. The MRS combines values for a person's age, sex, and the Aggregated Diagnostic Groups (ADG) information from the ACG System. More information can be found at www.ncbi.nlm.nih.gov/pubmed/21921849

workforce modelling and integration. The recent experience of Covid 19 has taught us that we deliver the best care to local people when we work together. We will prioritise the following:

1. Embrace community and Place working with an integrated sustainable workforce;
2. Make LLR a great place to work – ensuring staff are well engaged, supporting wellbeing, promoting diversity and career development;
3. Address workforce shortages, attracting new talent and making the most of new roles; and
4. Ensure workforce models reflect population need and maximise the capacity and capability to deliver the right care, at the right time, by the right person to local people.

This will be achieved through:

- **Rewarding** and **Recognising** staff achievements;
- **Engaging** our staff;
- **Supporting** Resilience;
- **Embedding** mufti-professional leadership;
- **Enabling** our people and teams to innovate;
- **Listening** and **Responding** to the needs of our People;
- **Developing** and building apprenticeship pathways, and talent management; and
- **Supporting the economic and social recovery** of local communities through targeted employment offers, in-reaching into communities to spot hidden talent, and creating an employment pathway for refugees.

Further information and reading:

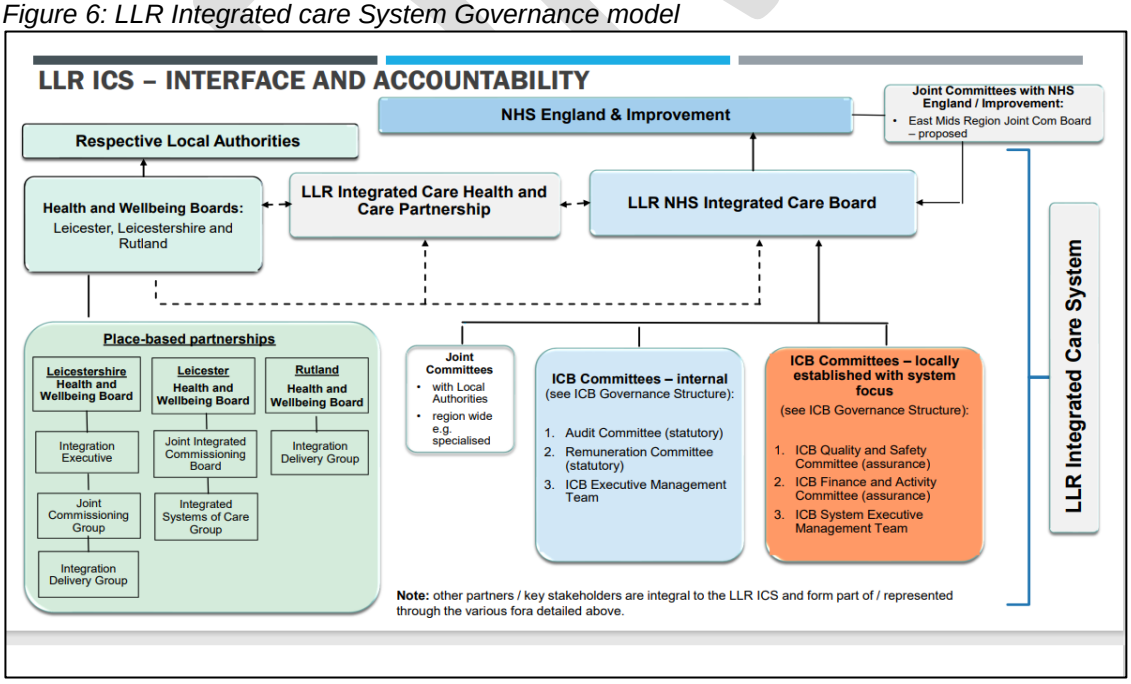
LLR Integrated Care Board:
Link needed to LLR People Plan

Leicestershire County Council:
People Strategy 2020-2024

Enabler 3: Good Governance

We have put in place governance arrangements that facilitate, support and hold to account our Partnership for the delivery of this Strategy, as illustrated in Figure 6, below.

Figure 6: LLR Integrated care System Governance model



Further information and reading:

LLR Health and Wellbeing Partnership:
Link needed to LLR ICS Functions and Decisions map

Enabler 4: Digital, data and information sharing

We have a robust digital strategy that will build on the digital innovation achieved during the Covid 19 pandemic and which will implement a shared care record across LLR

Our vision for improving data and information sharing:

Data sharing: Our data sharing across health and care will be vastly improved by the LLR Shared Care record. Initially commencing within primary, secondary, acute and emergency care settings, this will, in 2023, be joined by care homes, hospices and community pharmacies. This care record programme will deliver a unified view of a person-centred health and social care record across LLR with the aim to provide health and social care professionals with information to support direct care.

Intelligence and Population Health: An LLR wide intelligence function will be established to drive improved reactive and proactive use of data, population health management and business intelligence.

Automating data processes: We are scoping robotic automation processes (RPA). RPA processes could support greater efficiency, connect systems at process level and free up more time to be spent on direct care.

Digital Communication and transfer of data: We have a vision of a connected digital ecosystem of strategic solutions focused on the needs of the ICS and local people, to allow secure, seamless system interoperability and data sharing. This will be achieved through a rationalisation of our key systems to reduce and ultimately eradicate unnecessary system sprawl. The current landscape of duplicated and partially connected systems is a huge obstacle to allowing people the transparency of accessing their own health data and providing true person-centred care.

Further information and reading:

LLR Integrated Care Board:	Rutland County Council	Leicestershire City Council:
Link needed to LLR Digital Strategy	Digital Rutland Strategy 2019-2022	Smart Leicester

Enabler 5: Research and innovation

We know that research can change as well as save lives. It is only through research that we can develop better treatments and care as well as improve diagnosis and prevention. Every year thousands of people from all ages and backgrounds volunteer for research studies taking place across LLR. In 2019–2020 and 2020-2021 alone over 52,000 people from our hospitals and partnership trusts were new recruits into our research trials.

COVID-19 has shown clearly the importance of research in tackling major health issues. LLR received national and international acclaim to their response to COVID-19. More than 29,000 people took part in COVID-19 research at UHL alone, more than recruited from the whole of Scotland and over 95% of

COVID-19 patients in the first wave were recruited to a least one study with over 50% entering interventional trials.

We are developing an LLR Research Strategy, in collaboration with local communities, our culture and sports clubs, our universities, our NHS hospitals and partnership trusts, our primary care, our councils, our third sector partners, our industry partners and regional partners.

Further information and reading:
LLR Health and Wellbeing Partnership:
Link needed to LLR ICS Embedding Research into Practice discussion document

DRAFT

Our Partners

Leicester City Health and Wellbeing Board
https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-health/health-and-wellbeing-board

Leicestershire County Council Health and Wellbeing Board
https://www.healthandcareleicestershire.co.uk/health-and-wellbeing-board

Rutland County Council Health and Wellbeing Board
https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/health-and-wellbeing-board

Leicester, Leicestershire and Rutland Integrated Care Board
https://leicesterleicestershireandrutland.icb.nhs.uk

Leicester City Council
https://www.leicester.gov.uk

Leicestershire County Council
https://www.leicestershire.gov.uk

Rutland County Council
https://www.rutland.gov.uk

University Hospitals of Leicester NHS Trust
https://www.leicestershospitals.nhs.uk

Leicestershire Partnership NHS Trust
https://www.leicspart.nhs.uk/

Healthwatch Leicester and Leicestershire
https://healthwatchll.com/

Healthwatch Rutland
https://www.healthwatchrutland.co.uk

Leicester, Leicestershire and Rutland Health and Wellbeing Partnership

https://leicesterleicestershireandrutlandhwp.uk