LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 27 JUNE 2024

Time: 9:30 am

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

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

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

For Monitoring Officer

NOTE:

This meeting will be webcast live at the following link:-

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

An archive copy of the webcast will normally be available on the Council's website within 48 hours of the meeting taking place at the following link:-

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

MEMBERS OF THE BOARD

Councillors:

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

Councillor Elaine Pantling, Assistant City Mayor, Education

Councillor Geoff Whittle, Assistant City Mayor, Environment and Transport

2 Vacancies

City Council Officers:

Laurence Jones, Strategic Director of Social Care and Education

Rob Howard, Director of Public Health

Dr Katherine Packham, Public Health Consultant

1 Vacancy

NHS Representatives:

Caroline Trevithick, Chief Executive, Leicester, Leicestershire and Rutland Integrated Care Board

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

Dr Avi Prasad, Clinical Place Leader, Leicester, Leicestershire and Rutland Integrated Care Board

Helen Mather - Associate Director of Elective Care, Cancer and Diagnostics, Integrated Care Board

Ruw Abeyratne, Director of Health Equality and Inclusion, University Hospitals of Leicester NHS Trust

Jean Knight, Deputy Chief Executive, Leicestershire Partnership NHS Trust

1 Vacancy

Healthwatch / Other Representatives:

Benjamin Bee, Area Manager Community Risk, Leicestershire Fire and Rescue Service

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

Kevin Allen-Khimani, Chief Executive, Voluntary Action Leicester

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

Kevin Routledge, Strategic Sports Alliance Group

Sue Tilley, Head of Leicester, Leicestershire Enterprise Partnership

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

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

Information for members of the public

Attending meetings and access to information

You have the right to attend formal meetings such as Full Council, committee meetings, City Mayor & Executive Public Briefing and Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

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If you intend to film or make an audio recording of a meeting you are asked to notify the relevant Governance Services Officer in advance of the meeting to ensure that participants can be notified in advance and consideration given to practicalities such as allocating appropriate space in the public gallery etc.

The aim of the Regulations and of the Council's policy is to encourage public interest and engagement so in recording or reporting on proceedings members of the public are asked:

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

Further information
If you have any queries about any of the above or the business to be discussed, please contact **Georgia Humby, georgia.humby@leicester.gov.uk or Kirsty Wootton, kirsty.wootton@leicester.gov.uk of Governance Services.**

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 Governance 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. MEMBERSHIP OF THE BOARD

Members are asked to note the membership of the Board for 2024/25, approved by Annual Council on 16 May 2024:

City Councillors (5 places)

- Councillor Sarah Russell, Deputy City Mayor, Social Care, Health, and Community Safety (Chair)
- Councillor Elaine Pantling, Assistant City Mayor, Education
- Councillor Geoff Whittle, Assistant City Mayor, Environment and Transport
- 2 Vacancies

Council Officers (4 places)

- Laurence Jones, Strategic Director of Social Care and Education
- Rob Howard, Director of Public Health
- Dr Katherine Packham, Public Health Consultant
- 1 Vacancy

NHS Representatives (7 places)

- Caroline Trevithick, Chief Executive, Leicester, Leicestershire and Rutland Integrated Care Board
- Rachna Vyas, Chief Operating Officer, Leicester, Leicestershire and Rutland Integrated Care Board
- Dr Avi Prasad, Clinical Place Leader, Leicester, Leicestershire and Rutland Integrated Care Board
- Helen Mather - Associate Director of Elective Care, Cancer and Diagnostics, Leicester, Leicestershire and Rutland Integrated Care Board
- Ruw Abeyratne, Director of Health Equality and Inclusion, University Hospitals of Leicester NHS Trust

- Jean Knight, Deputy Chief Executive, Leicestershire Partnership NHS Trust
- 1 Vacancy

Healthwatch / Other Representatives (8 places)

- Harsha Kotecha, Chair, Healthwatch Advisory Board, Leicester and Leicestershire
- Rupert Matthews, Police and Crime Commissioner, Leicester, Leicestershire and Rutland
- Barney Thorne, Mental Health Partnership Manager, Leicestershire Police
- Benjamin Bee, Area Manager Community Risk, Leicestershire Fire and Rescue Service
- Kevin Allen-Khimani, Chief Executive, Voluntary Action Leicester
- Kevin Routledge, Strategic Sports Alliance Group
- Sue Tilley, Head of the Leicester and Leicestershire Enterprise Partnership
- Bertha Ochieng, Professor of Integrated Health and Social Care at De Montfort University

4. TERMS OF REFERENCE **Appendix A (Pages 1 - 6)**

Members are asked to note the Board's Terms of Reference approved by Full Council on 16 May 2024.

5. MINUTES OF THE PREVIOUS MEETING **Appendix B (Pages 7 - 16)**

The minutes of the previous meeting of the Health & Wellbeing Board held on 18 April 2024 are attached and the Board is asked to confirm them as a correct record.

6. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair is to invite questions from members of the public.

7. HEALTH NEEDS ASSESSMENT **Appendix C (Pages 17 - 38)**

Laura French, Consultant in Public Health, will present recent findings and data from the review of local sexual health needs.

8. SEXUAL HEALTH SERVICES CONSULTATION **Appendix D (Pages 39 - 62)**

Laura French, Consultant in Public Health, will provide an overview of the process of recommissioning of sexual health services in Leicester and a recent consultation exercise.

9. TUBERCULOSIS IN LEICESTER **Appendix E (Pages 63 - 76)**

Mary Hall, Consultant in Public Health, will present a summary of the picture of Tuberculosis in Leicester and actions being taken.

10. HEALTH & WELLBEING BOARD ANNUAL REPORT **Appendix F (Pages 77 - 110)**

Amy Endacott, Programme Manager Public Health, will provide a summary of the work of the Health and Wellbeing Board from January 2022 to July 2023.

11. BLACK MENTAL HEALTH AND ME REPORT **Appendix G (Pages 111 - 156)**

Mark Wheatley, Programme Manager - Mental Health, will provide an overview of Leicester City Council Division of Public Health's work with the African Heritage Alliance to support an initiative to explore key areas related to black mental health in Leicester.

12. ADDRESSING RACIAL DISPARITIES IN MATERNAL OUTCOMES FOR THE POPULATION OF LEICESTER, LEICESTERSHIRE AND RUTLAND - DRAFT **Appendix H (Pages 157 - 176)**

Dr Ruw Abeyratne, Director of Health Equality and Inclusion, University Hospitals of Leicester, will present a report intentionally focusing on key themes that should underpin work to address maternal inequalities, particularly for Black women and birthing people.

13. DATES OF FUTURE MEETINGS

Members of the Board will be asked to note the meetings that have been arranged for the following dates in 2024/2025 which were submitted to the Annual Council in May 2024.

Thursday 27 June 2024 – 9.30am
Thursday 26 September 2024 – 9.30am
Thursday 12 December 2024 – 9.30am
Thursday 6 March 2025 – 9.30am

Meetings of the Board are scheduled to be held in Meeting Rooms G.01 at City Hall unless stated otherwise on the agenda for the meeting.

14. ANY OTHER URGENT BUSINESS

Leicester City Health and Wellbeing Board

Terms of Reference

Introduction

In line with the Health and Social Care Act 2012, the Health & Wellbeing Board is established as a Committee of Leicester City Council.

The Health & Wellbeing Board operated in shadow form since August 2011. In April 2013, the Board became a formally constituted Committee of the Council with statutory functions and met for the first time on 11 April 2013.

1 Aim

To achieve better health, wellbeing and social care outcomes for Leicester City's population and a better quality of care for patients and other people using health and social services.

2 Objectives

2.1 To provide strong local leadership for the improvement of the health and wellbeing of Leicester's population and work to reduce health inequalities.

2.2 To lead on improving the strategic coordination of commissioning across NHS, adult social care, children's services and public health services.

2.3 To maximise opportunities for joint working and integration of services using existing opportunities and processes and prevent duplication or omission.

2.4 To provide a key forum for public accountability of NHS, Public Health, Adult Social Care and Children's Services and other commissioned services that the Health & Wellbeing Board agrees are directly related to health and wellbeing.

3 Responsibilities

3.1 Working jointly, to identify current and future health and wellbeing needs across Leicester City through revising the Joint Strategic Needs Assessment (JSNA) as and when required. Preparing the JSNA is a statutory duty of Leicester City Council and Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB).

3.2 Develop and agree the priorities for improving the health and wellbeing of the people of Leicester and tackling health inequalities.

3.3 Prepare and publish a Joint Local Health and Wellbeing Strategy (JLHWS) that is evidence based through the work of the Joint Strategic Needs Assessment (JSNA) and supported by all stakeholders. This will set out strategic objectives, ambitions for achievement and how we will be jointly held to account for delivery. Preparing the JLHWS is a statutory duty of Leicester City Council and LLR Integrated Care Board.

3.4 Save in relation to agreeing the JSNA, JLHWS and any other function delegated to it from time to time, the Board will discharge its responsibilities by means of recommendation to the relevant partner organisations, who will act in accordance with their respective powers and duties.

3.5 Ensure that all commissioners of services relevant to health and wellbeing take appropriate account of the findings of the Joint Strategic Needs Assessment and demonstrate strategic alignment between the JLHWS and each organisation's commissioning plans.

3.6 Ensure that all commissioners of services relevant to health and wellbeing demonstrate how the JLHWS has been implemented in their commissioning decisions.

3.7 To monitor, evaluate and annually report on the LLR Integrated Care Board's contribution to the delivery of the JLHWS at the request of NHS England as part of its annual performance assessment.

3.8 Review performance against key outcome indicators and be collectively accountable for outcomes and targets specific to performance frameworks within the NHS, Local Authority and Public Health.

3.9 Ensure that the work of the Board is aligned with policy developments both locally and nationally.

3.10 Provide an annual report from the Health and Wellbeing Board to the Leicester City Council Executive and to the Board of LLR Integrated Care Board to ensure that the Board is publicly accountable for delivery.

3.11 Oversee progress against the Health and Wellbeing Strategy and other supporting plans and ensure action is taken to improve outcomes.

3.12 The Board will not exercise scrutiny duties around health and adult social care directly. This will remain the role of the relevant Scrutiny Commissions of Leicester City Council. Decisions taken and work progressed by the Health & Wellbeing Board will be subject to scrutiny by relevant Scrutiny Commissions of Leicester City Council.

3.13 The Board will need to be satisfied that all commissioning plans demonstrate compliance with the Equality Act 2010, improving health and social care

services for groups within the population with protected characteristics and reducing health inequalities.

3.14 The Board will agree Better Care Fund submissions and have strategic oversight of the delivery of agreed programmes.

4 Membership

Members:

Up to five Elected Members of Leicester City Council (5)

- The Executive Lead Member for Health (1)
- Four Elected Members nominated by the City Mayor (4)

Up to seven representatives of the NHS (7)

- The Chief Executive and three other representatives from the LLR Integrated Care Board (4)
  The Independent Chair of the Integrated Care System (1)
- The Chief Executive of University Hospitals NHS Trust (1)
- The Chief Executive of Leicestershire Partnership NHS Trust (1)

Up to four Officers of Leicester City Council (4)

- The Strategic Director of Social Care and Education (Leicester City Council) (1)
- The Director of Public Health (Leicester City Council) (1)
- A Public Health Consultant leading on improving cross organisational initiatives and communication and developing links with the between system, place and neighbourhood within the Integrated Care System. (1)
- One Officer nominated by the Chief Operating Officer (1)

Up to eight further representatives including Healthwatch Leicester/Other Representatives (8)

- One representative of the Local Healthwatch organisation for Leicester City (1)
- Leicester City Local Policing Directorate, Leicestershire Police (1)
- The Leicester, Leicestershire and Rutland Police and Crime Commissioner (1)
- Chief Fire and Rescue Officer, Leicestershire Fire & Rescue Service (1)
- Two other people that the local authority thinks appropriate, after consultation with the Health and Wellbeing Board (2)
- A representative of the city's sports community (1)
- A representative of the private sector/business/employers (1)

5 Quorum & Chair

5.1 For a meeting to take place there must be at least six members of the Board present and at least one representative from each of the membership sections:

- Leicester City Council (Elected Member)
- LLR Integrated Care Board or NHS England & NHS Improvement - Midlands
- One senior officer Board Member from Leicester City Council
- Local Healthwatch/Other Representatives

5.2 Where a meeting is inquorate those members in attendance may meet informally but any decisions shall require appropriate ratification at the next quorate meeting of the Board.

5.3 Where any member of the Board proposes to send a substitute to a meeting, that substitute's name shall be properly nominated by the relevant 'parent' person/body and submitted to the Chair in advance of the meeting. The substitute shall abide by the Code of Conduct.

5.4 The City Council has nominated the Executive Lead for Health to Chair the Board. Where the Executive Lead for Health is unable to chair the meeting, then one of the other Elected Members shall chair (noting that at least one Elected Member must be present in order for the meeting to be declared quorate).

6 Voting

6.1 The City Council at its meeting on 29 May 2014 resolved to disapply Section 13(1A) of the Local Government and Housing Act 1989 such that the four local authority officers on the Board will not exercise voting rights.

6.2 Any representatives of bodies asked to attend meetings of the Board as 'Standing Invitees' by the Board shall not have a vote.

6.3 All other members will have an equal vote.

6.4 Decision-making will be achieved through consensus reached amongst those members present. Where a vote is required decisions will be reached through a majority vote of voting members; where votes are equal the chair will have a second and casting vote.

7 Code of conduct and member responsibilities

All voting members are required to comply with Leicester City Council's Code of Conduct, including each submitting a Register of Interest.

In addition, all members of the Board will commit to the following roles, responsibilities and expectations:

7.1 Commit to attending the majority of meetings.

7.2 Uphold and support Board decisions and be prepared to follow though actions and decisions obtaining the necessary financial approval from their organisation for the Board proposals and declaring any conflict of interest.

7.3 Be prepared to represent the Board at stakeholder events and support the agreed consensus view of the Board when speaking on behalf of the Board to other parties. Champion the work of the Board in their wider networks and in community engagement activities.

7.4 To participate in Board discussion to reflect views of their partner organisations, being sufficiently briefed to be able to make recommendations about future policy developments and service delivery.

7.5 To ensure that are communication mechanisms in place within the partner organisations to enable information about the priorities and recommendation of the Board to be effectively disseminated.

8 Agenda and Meetings

8.1 Administration support will be provided by Leicester City Council.

8.2 There will be standing items on each agenda to include:

- Declarations of Interest
- Minutes of the Previous Meeting
- Matters Arising
- Updates from each of the working subgroups of the Health & Wellbeing Board.

8.3 Meetings will be held a minimum of four times a year and the Board will meet in public and comply with the Access to Information procedures as outlined in Part 4b of the Council's Constitution.

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 18 APRIL 2024 at 9:30 am

Present:

Councillor Sarah Russell (Chair)	Deputy City Mayor - Social Care, Health, and Community Safety, Leicester City Council (LCC)
Councillor Elly Cutkelvin	Deputy City Mayor (Housing & Neighbourhoods), LCC
Rob Howard	Director of Public Health (DPH), Leicester City Council
Dr Kath Packham	Consultant in Public Health (PH), Leicester City Council
Helen Mather	City Place Lead - Leicester, Leicestershire, and Rutland Integrated Care Board (LLR ICB)
Ruw Abeyratne	Director of Health Equality & Inclusion, University Hospitals of Leicester NHS Trust (UHL)
Harsha Kotecha	Chair of Healthwatch Leicester and Leicestershire
Kevin Routledge	Strategic Sports Alliance Group
Benjamin Bee	Area Manager Community Risk, Leicestershire Fire & Rescue Service
Barney Thorne	Mental Health Manager, Local Policing Directorate, Leicestershire Police
Andres Patino	Deputy Director of Mental Health Services, Leicestershire Partnership Trust

In Attendance

Diana Humphries	Programme Manager - HWB (Public Health, LCC)
Amy Endacott	Programme Manager – Long Term Conditions (PH – LCC)
Michelle Larke	Head of Commissioning, Adult Social Care, LCC
Jacob Mann	Senior Governance Support Officer, LCC
Helen Reeve	Senior Intelligence Manager, Public Health, LCC
Robert Parkinson	Project Manager, SEND Early Help and Education, LCC
Grace Brough	Consultant in Public Health, LCC
Omalara Adegoke	Post Graduate Student – De Montfort University
Alison Williams	Public Health Admin, Leicester City Council (minute taker)

61. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:

- Councillor Vi Dempster - Deputy City Mayor (Education, Libraries &

Community Centres), LCC
- Rani Mahal - Deputy Police and Crime Commissioner for Leicester, Leicestershire, and Rutland
- Jean Knight – Deputy Chief Executive, LPT
- Hardip Chohan, Head of Operations & Services, Voluntary Action LeicesterShire
- Richard Mitchell – Chief Executive, UHL
- Caroline Trevithick – LLR ICB Chief Nursing Officer & LLR ICB Deputy Chief Executive
- Kevin Allen-Khimani – Chief Executive, Voluntary Action LeicesterShire
- Dr Avi Prasad - Place Board Clinical Lead, LLR ICB
- Rachna Vyas - Chief Operating Officer, LLR ICB

62. 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.

63. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 7 March 2024 be confirmed as a correct record.

64. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions from members of the public had been received.

65. JOINT HEALTH, CARE AND WELLBEING DELIVERY PLAN PROGRESS UPDATE - AUGUST - FEBRUARY 2024

Diana Humphries (Programme Manager – Health & Wellbeing Board, Public Health, LCC) presented slides to update members on the delivery plan and strategy progress. A copy of the slides was included in the agenda pack. "Do", "Sponsor" and "Watch" have been allocated to each of the 19 priorities in the Health & Wellbeing Strategy. Each theme area was presented in turn as below, but with a focus on the "Do" priorities:-

Theme A: Healthy Places
The main priority has been to "**improve access to primary and community health and care services"** in two main ways:-

a) Develop integrated neighbourhood teams:-
- The 10 City Primary Care Networks (PCNs) identified 5 Priorities that have been delivered throughout 2023/24 (Bowel Cancer Screening, Weight Management, Hypertension, Integrated Chronic Kidney Disease and Women's

Health). This has been achieved through work including:-
    - The “Joy” app
    - Care Navigators
    - Social Prescribing
    - Direct Enhanced Service
- The next steps are:-
    - Sharing of best practice.
    - Enable PCNs to co-design plans
    - Support PCNs to progress in their Maturity Matrix

b) Deliver the Enhanced Access Service in Primary Care
- This has been delivered across Leicester City from October 2022 and has seen a rise in the number of more accessible appointments.
- The next step is to publish the PCN Direct Enhanced Access guidance/specification for delivery from April 2024.

Theme B: Healthy Start

The main priority has been to **mitigate against the impacts of poverty on children and young people**. This has been tackled in two main ways:-

a) Peer Support Programme
- This is underway, but there remains a risk of not recruiting enough peer supporters with the appropriate lived experience.The next step is around linking with existing voluntary sector programmes who already have volunteers with lived experience.

b) Family Hubs
- 5 Family Hubs early adopter sites are in place.
- Cllr Russell noted that there is Government Funding to develop these Hubs in the City – but it is only for two years and has 182 criteria attached (put in place by the Department for Education). Leicestershire County received less funding but without specific criteria attached to it. Cllr Russell would be happy for an update on Family Hubs to be brought to a future HWB Board meeting.

Theme C: Healthy Lives

The main priority has been to **increase early detection of heart & lung diseases and cancer in adults.** This has been tackled in two main ways:-

a) Hypertension Optimisation
- The ICB reviewed the data to January 2024 and identified the 20 GP practices with the lowest rates. These practices are likely to have low optimisation of blood pressure (which was explained by Dr Packham in the meeting).
- The next steps are around targeting (using data), sharing best practice and promoting consistency.

b) The Faecal Immunochemical Test (FIT) Test Pilot
- This pilot has generated positive feedback and good results (although there is a risk that cumulative data can be misleading).
- The next step is to review the pilot and extend if it has evaluated well.
- Cllr Russell noted that this pilot is specific to lower gastrointestinal issues – but is included in this section of the Strategy as it connects to early detection of bowel cancer.

Theme D: Healthy Minds

The two main priorities have been to:- **i) improve access for children & young people to Mental Health & emotional wellbeing services, and ii) improve access to primary & neighbourhood level Mental Health services for adults**. This has been tackled in four main ways:-

a) Mental Health Support Teams (MHSTs)
- There will be 11 Leicester/Leicestershire/Rutland MHSTs (6 in the city) by the end of this academic term. Access to these is noted as a risk.
- 7,700 young people will have been reached through workshops, and data from that will be used to inform future work.
- Cllr Cutkelvin asked if it was clear whether the MHSTs were targeting young people with low, medium or high mental health needs. The Presenting Officer responded that the MHST offer includes low-level offers (eg school assemblies) up to higher-level offers by way of one-to-one sessions. The Chair noted that a list, of who leads on each part of the mental health offer to young people, would be useful for the Board.
- Members were keen to know how many children are resident in the City – and what percentage of these are covered by the MHSTs; the presenting officer will find out the answers.
- Members were also keen to understand whether the MHSTs cover all schools or just Local Authority ones. The Chair responded that it is all schools – but the service is still being built and so coverage is currently in "pockets".
- The Member representing UHL asked that any system conversation about mental health also include consideration of the home environment and support for parents.

b) City Early Intervention Psychological Support (CEIPS)
- 250 children have been supported on this intervention at the time of the meeting. The contract for this has been extended to March 2025.
- As this relates to an offer in the "middle-level" range of mental health support (and prior to CAMHS) this should be part of the discussion within the aforementioned future Board item.

c) Awareness Raising Roadshow
- This roaming roadshow has spoken with 327 people across 13 events. It has also reached hundreds of employees at Walkers, Tesco and other City businesses.
- The next step will be to roll out "stands" in community spaces as part of the roadshow's extension. Members felt parental support should be included in the extension plans.

d) The '3 Conversation' Project
- Reablement workers are based in Saffron and Eyres Monsell – with more sites coming on board.
- The next step is to establish the programme (which is running until March 2025).

Theme E: Healthy Ageing

The main priority has been to **"enable Leicester's residents to age comfortably and confidently through a person-centred programme to support self-care, build on strengths and reduce frailty**". This has been

tackled by the Discharge to Assess Project:-

- 401 people benefited from this service in its first 3 months (Nov 1st 23 to Jan 31st 24) - with 58% becoming fully independent with no ongoing care needs.
- The next step is to support the high dependency cohort and reduce the risk of double-handed care by 1.6.24.

Comments and questions from the Board:-

The majority of the questions had been raised throughout the presentation – but the following were also noted:-

- The 19 priorities in the Strategy had been agreed by the Board – but the Member representing the Strategic Sports Alliance asked whether these have Key Performance Indicators attached to them. He acknowledged impact will be difficult to measure – particularly the mental health related priorities – but without KPIs it is difficult to assess efficiencies and cost effectiveness. Dr Packham responded that, over the next four months, the priorities will be reviewed to check they are still current and whether more/fewer are required (eg should childhood immunisations or oral health be added) – and some targets will be developed as part of that process. The Chair noted that a development session would be useful to undertake this review.

RESOLVED:

- That the Board thanked the Presenting Officer for the presentation and asked them to take Members comments into account.
- That the Presenting Officer note The Chairs wish for an update on Family Hubs to be brought to a future meeting.
- That the Presenting Officer noted The Chair's wish, for future reporting to the Board, that evaluation on the impact of the FIT pilot to be related specifically to its links to the early detection of bowel cancer.
- That the Presenting Officer will link Cllr Cutkelvin up with the Project Manager in charge of the MHST Service.
- That the Presenting Officer will organise a future Board agenda item around "Mental Health for children and young people". All the comments made during this meeting will be incorporated into the planning for this item (ie inviting the Project Manager, having a focus on the middle-level offer, considering the support for parents and including a list of who leads on each part of the mental health offer to young people).
- That the Presenting Officer will find out how many children are in the City and what percentage of those are covered by the current MHSTs.
- That the Presenting Officer will share, with Rob Melling at LPT, the comments about adding parental support to the extension plans for the mental health roadshows.

That the Presenting Officer will set up a Board Development Session to review the 19 HWB priorities and ensure they are the correct ones to focus on for the next 12-24 months. This will include discussions of any current issues or additional funding pots. Key Performance Indicators will be developed as part of this review.

66. LEARNING DISABILITY PROGRAMME BOARD UPDATE - LEARNING DISABILITY STRATEGY

Michelle Larke (Head of Commissioning, Adult Social Care, LCC) presented on the background/context of the Learning Disability Programme Board, and also an update on the Strategy (the Learning Disability Big Plan).
The following points were noted:

- The Chair noted that she attends the Learning Disability Programme Board and finds it to be an inclusive and proactive meeting – and thanked the Presenting Officer for this.
- The Learning Disability Programme Board was established in 2001 and is attended by NHS, LPT, ICB, Police, Voluntary Sector and families with learning disabilities. Its key role is to be a Place-Based Board to give those with learning disabilities a voice.
- There is a self-advocacy sub-group of the Board called "We Think".
- The Board meets quarterly online – and there will be a development session in May 2024.
- The Strategy (shown in full in the agenda pack) launched in February 2020 and formally ended in December 2023 – although it has now been extended for two further years.
- The Strategy focusses on four main topics/areas:-
  1) Health Inequalities – including:-
     - The Learning Disabilities and Autism Collaborative
     - The Learning From Lives and Deaths Review (LeDeR)
     - Access to health checks, oral health, vaccinations and screening.
  2) The Short Breaks offer - including targeted engagement to find out what families really want.
  3) Support for employment; the Department for Work & Pensions is funding work that will give meaningful opportunities.
  4) Integration; getting the voice of those with learning disabilities integrated into the governance of City services.

Comments and questions from the Board:-

- The Chair noted that the uptake of annual health checks has increased significantly due to the actions of the LD Board – and is a higher uptake rate than most other areas in the Country. She also noted that a significant number of deaths were in people who had not had their annual check.
- The Member representing Leicestershire Police asked how many people had received blood tests at the annual health check. The Presenting Officer and the Member representing the ICB noted that needle phobia is common amongst people with learning disabilities (as found during the Covid-19 pandemic). Funding was secured for a Vena Puncture pilot, and this is now being rolled out with a pathway attached. Primary Care are now looking at phlebotomy as a priority area in general – particularly LPT (with regards to children under 12) and PCNs (with regards to those aged 12 to 16). There is also a "difficult to bleed" service (which can include need phobia or people unable to sit still) – and Helen Mather will speak to staff in this service about linkages to the LD Strategy.

- The Member representing Leicestershire Police felt that it would be a good idea for an “MOT” offer to be developed for those with learning disabilities (so this would include oral health within the annual health check). The Chair agreed that the fewer appointments the less anxiety – and wondered if there was a dental practice that may be keen to work with the Primary Care Networks in order to deliver a dental check at the same time as the health check. The Member representing the ICB responded that this multidisciplinary team approach is already something that is offered to patients with Cystic Fibrosis – so a similar offer could be considered for those with learning disabilities.
- Barney Thorne noted that he will be happy to represent Leicestershire Police on the LD Board.
- The Member representing UHL noted that oral hygiene, for those with learning disabilities, is an inequality that needs to be considered.
- Employment opportunities are being increased – but the Chair felt there may need to be a “starter pack” developed to encourage more organisations to become involved. The Members representing UHL will consider this in relation to hospital opportunities.
- The Member representing Leicestershire Police noted that the “Oliver Macgowan Training” would be more useful to large organisations if there could be group registrations and group sessions.

RESOLVED:

- That the Board thanked the Officer for the presentation and asked them to take Members comments into account.
- That the Presenting Officer and the Member Representing the ICB will check how many people had received blood tests at the annual health check – and also speak to staff in the “Difficult To Bleed” service about comments raised during this meeting.
- The Presenting Officer and the Member representing the ICB will consider the feasibility of developing an “MOT” offer for those with learning disabilities (so this would be a multidisciplinary team approach and include a dental health check within the annual health check).
- That the Presenting Officer will add Barney Thorne to the invitation list for future Learning Disability Programme Board meetings.
- That the Member representing UHL will take away a self-imposed action to consider the inequalities around both oral hygiene and employment opportunities for those with learning disabilities.
- That the Presenting Officer will link the Member representing Leicestershire Police up with the lead (within the ICB) on the “Oliver Macgowan Training”. In addition. any Members interested in getting their staff on this training will contact Michelle Larke.

67. HEALTHY CONVERSATION SKILLS (MECC)

Amy Endacott (Programme Manager, Public Health, LCC) presented on this training as a means of upskilling health/care/voluntary sector workforces in encouraging people they are in contact with to make positive changes to their health and wellbeing. It was noted that:

- The value of an upskilled workforce (both paid and voluntary) is vital to the prevention agenda.
- This training is low cost and evidence based (by NICE) – and is included in the following key local documents:-
    i. The LLR 5 Year Forward Plan
    ii. The UHL Annual Prevention Report
    iii. The Health & Wellbeing Strategy and Action Plan
- The "MECC Plus" national programme was developed locally into the current "Healthy Conversation Skills" package – and is focussed on enabling the workforce to spot opportunities to empower their service-users to be aware of their health/wellbeing and develop their own solutions. This is achieved by focussing on open questions, listening, regular reflection and support/signposting.
- There are three levels of training:-
    i. a 45 minute e-learning package (1500 people have completed this across LLR).
    ii. a three hour face-to-face "HCS Lite"; 800 people have completed this across LLR – with around half of these being city-specific workforce. The completers for the City are mainly from Leicester City Council (Public Health, Housing, Adult Learning, Adult Social Care) and the voluntary care sector (Food Hubs, Open Hands, Leicester City in The Community etc).
    iii. a full six-hour course. This is the Train The Trainer aspect to the programme – and 45 LLR staff have completed this. For the City there are 11 in this network from within Public Health (Live Well Service and Community Champions) and Adult Social Care.
- Another intended impacts is to build workforce confidence/knowledge – and this will then translate into an increase in referral to support services.
- The programme in LLR commenced in 2019 (with some short break between then and now due to Covid-19 and capacity). Initial funding has all been utilised – but some Public Health funds are enabling the programme to continue. The current funding only allows for targeted work (and currently this is with food banks/hub and the voluntary sector).
- The web pages have received nearly two million views.
- Slides within the pack show the dashboard data from the survey results (pre and post course attendance).
- Three case studies were presented:-
    i. Open Hands
    ii. Covid-19 Vaccine Confidence work – which utilised ICB funding to identify reasons for hesitancy and work alongside vaccination clinics.
    iii. "Proof of Concept" work – which is ongoing.
- The Board was requested to input into the upcoming evaluation of the programme, help identify any funding pots to enable it to be sustained - and generally endorse the concept.

Comments and questions from the Board:-

- The member representing Healthwatch was keen for both Healthwatch and Voluntary Action Leicester to be involved.
- The Member representing the Fire Service felt this training would be useful for the Community Educators – ideally linked to a set of

priority messages (which could be chosen by The Board at the upcoming development session).
- The Chair will be happy to have this item back for a future HWB once the evaluation is complete.
- Dr Packham noted that a system-wide/population-level impact will not be achievable unless there is funding identified and allocated.

RESOLVED:
- That the Board thanked the Officer for the report and asked that comments from the meeting are taken into account.
- That the Presenting Officer will get in touch with the Member representing Healthwatch to ensure links.
- That the Presenting Officer will link up with the Member representing the Fire Service (regarding training for the Fire Service's Community Educators).
- That Helen Mather and Cllr Russell will flag up the issue of funding for MECC at a future ICB meeting.

That Diana Humphries will include MECC in the agenda for the upcoming Development Session on reviewing the HWB priorities.

68. BCF Q3 UPDATE

This paper (circulated via email rather than within the agenda pack) was for noting only – and so not formally presented.

RESOLVED:
-That the Board accept and note the update for Quarter 3.

69. DATES OF FUTURE MEETINGS

It was noted that the dates in the agenda pack for June 2024 to May 2025 were no longer correct; a revised set will be confirmed at a Full Council meeting and subsequently circulated via email to members.

RESOLVED:-
Governance Services will email a revised set of dates for future meetings to members as soon as they have been finalised.

70. ANY OTHER URGENT BUSINESS

- Thanks were noted to Alison Williams (from Public Health) for minuting these meetings for the last five sessions.
- The Governance Services Officer allocated to the Health and Wellbeing Board will be changing to Georgia Humby. Thanks were noted to Jacob Mann for his work in this role over recent months.
- There being no other business the meeting closed at 11.30am.

LEICESTER CITY HEALTH AND WELLBEING BOARD
27 JUNE 2024

Subject:	Sexual Health Needs Assessment for Leicester City
Presented to the Health and Wellbeing Board by:	Laura French, Consultant in Public Health
Author:	Laura French

EXECUTIVE SUMMARY:

As part of the Public Health Grant, Local Authority Public Health teams are required to procure a comprehensive sexual health service which provides contraceptive services and STI testing and treatment, as well as outreach services for vulnerable groups, RSE in educational settings and training for the local network. It is important that these services are designed to be responsive to the specific needs of the population they serve. In order to inform the service specification for the re-procurement of these services in Leicester, a refresh of the City's sexual health needs assessment was performed. The results are presented in summary here, along with some of the recommendations also made in the report. A full copy of the report can be found online here: https://www.leicester.gov.uk/media/tpcfvn00/sexual-health-jspna-2023.pdf

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: Note the findings of this needs assessment (and the fact that an update to some of the data will shortly be available), as well as the recommendations therein. Although none of the recommendations are specifically for the HWB to enact, the board is asked to lend support to system partners where possible and advocate for action as suggested in the recommendations.

Health Needs Assessment: Sexual Health in Leicester

Laura French, Consultant in Public Health

Leicester City Council

Contents

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Background

Under the terms of the Public Health Grant, the local authority public health team is required to commission an open access, integrated sexual health service (ISHS) which provides:

- STI testing and treatment
- Complex and non-complex contraception
- Psychosexual Counselling
- SRE in education institutions
- Outreach function with key communities
- HIV Pre-exposure prophylaxis (PrEP)

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Table 1: Commissioning Responsibilities

Commissioning Responsibilities		
Local authorities	**Clinical Commissioning Groups**	**NHS England**
Comprehensive, open access sexual health services including Contraceptive services STI testing and treatment HIV testing National Chlamydia Screening Programme Psychosexual counselling Sexual Health specialist services (including young people's services, teenage pregnancy services, outreach, prevention and promotion, services in educational establishments and pharmacies)	Abortion services Sterilisation Vasectomy Non-sexual health elements of psychosexual services Gynaecology, including contraception for non-contraceptive purposes	Contraception as provided as additional service of GP contract HIV treatment and care (including post- exposure prophylaxis) Promotion of opportunistic testing and treatment for STIs and patient requested testing by GPs Sexual health elements of prison health services Sexual Assault Referral Centres Cervical screening Specialist fetal medicine services

What is a health needs assessment?

- A systematic approach to reviewing the specific health needs of a population and whether or not they are met
- Can be condition specific (e.g. diabetes, CVD), population specific (e.g. care-leavers, older people) or service-based (e.g. sexual health service)
- Can be epidemiological, corporate or comparative (though generally a mixture of all three methods)

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Why a health needs assessment?

- Last one was 2016
- Lots of changes to service and functions since then
- A pandemic!
- Re-commissioning the new service, to start April 2024

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Methods

- Built on previous HNA, looking at info and recommendations and working out what has changed
- Epi element came from SH and population data sources including OHID, Splash, UKHSA, ONS, Fingertips. Also local data provided by the ISHS, UHL and other partners
- Also consulted providers and local experts for info on services, perceived gaps, local need
- Simultaneously running a public consultation exercise for the reprocurement which added valuable context to info in HNA

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Findings- STIs

- Leicester is ranked 58th highest of 154 upper tier local authorities (UTLAs) for new STI diagnoses (excluding chlamydia among 15-24 years) in 2023 with a rate of 461 per 100,000 residents aged between 15 and 64, significantly better than the rate of 520 per 100,000 in England.
- 61% of all new STI diagnoses in Leicester are in young people (15-24) which is higher than the national average in this group
- Chlamydia is still the most commonly diagnosed STI, however, the abrupt national increase in rates of gonorrhoea is a concern. Rates in Leicester hardly fell in contrast to other STIs over 2020/21

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Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower CI	95% Upper CI
England	→	-	296,888	520		518	522
Neighbours average	→	-	-	-		-	-
Brent	→	6	4,462	1,308		1,270	1,347
Manchester	→	13	6,412	1,127		1,099	1,155
Ealing	→	15	3,669	992		960	1,024
Nottingham	→	1	2,382	725		696	755
Hounslow	→	11	2,050	706		675	737
Enfield	→	12	2,194	670		643	699
Barking and Dagenham	→	7	1,339	609		576	642
Luton	→	2	1,190	524		495	555
Wolverhampton	→	8	1,397	522		495	550
Derby	→	9	1,373	521		494	549
Coventry	→	3	1,850	520		497	545
Hillingdon	→	14	1,544	497		472	522
Sandwell	→	5	1,630	474		451	497
Birmingham	→	4	5,420	468		456	481
Leicester	→	-	1,721	461		439	483
Slough	→	10	692	435		403	468

New STI Diagnoses (excl chlamydia) per 100,000 population for Leicester and statistical neighbours for comparison.

Findings- HIV

- Leicester is considered a high prevalence area for HIV, with a rate of 2.8 per 1000 (age 15-59), which is the highest in the CIPFA neighbours group and significantly above the England average of 1.7
- Leicester City is the 5th highest prevalence area outside London
- Testing coverage indicators are generally good, reflecting the work being done in the communities and by the hospital
- However, there are comparatively higher numbers of late diagnoses in Leicester than the England average
- Leicester City also has lower than average repeat testing rates in gay, bisexual and men who have sex with men (GBMSM)

Findings- Contraception

- Long-acting reversible contraception (LARC) methods are recommended by the NHS and NICE
- Rates of uptake of LARC in Leicester are lower than the national average and there is considerable variation between communities
- There has been a year-on-year decrease of prescribing and spending on contraception in general practice (this pre-dates the pandemic)
- Post-natal contraception provision needs improving

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Findings- termination of pregnancy(TOP)

- Provision has changed since the last HNA
  - There is now a BPAS centre in the city
  - The service at UHL is now open to self-referral as well as clinician-referral and provides a range of post-termination contraceptive options
- The rate of TOP in Leicester is 20.4 per 1,000 female population aged 15-44 years, significantly higher than the England rate of 19.2 and an increase on previous years
- The increasing TOP rate is an area of focus nationally and locally for the health system.

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Findings- Teenage pregnancy

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- The under 18 conception rate in the city has reduced significantly over the last twenty years, falling a massive 80% between 1999 and 2020.
- The rate in 2020 was 11.4 per 1,000 15-17 year olds, which is similar to the national average.
- Although the overall Leicester rate is similar to the national average, there is significant variation across the city, with the more deprived wards in the south and west of the city having significantly higher teenage conception rates than the national average.

Vulnerable communities and outreach

Leicester has some demographic challenges for planning a sexual health service including:

- A younger than average population (i.e. the group that use services the most)
- Areas of severe deprivation (correlated with poor sexual health outcomes)
- Diversity; people from different backgrounds, cultures and ethnicities have different needs in order to make services acceptable and accessible

Vulnerable communities and outreach continued

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There are also specific groups whose needs much be taken into account including:

- Young people (especially including those with special educational needs)
- Gay, bisexual and men who have sex with men (GBMSM)
- Commercial sex workers
- Newly arrived to the city including refugees and asylum seekers
- University Students

Recommendations

There is a table of recommendations in the final document with around 30 or so detailed recommendations for the various commissioners, and around 12 pulled out in the exec summary. Overall themes:

- Access- people want and need a range of access methods including online, telephone and face to face appointments plus a mixture of pre-booked and sit and wait. Also a single point of access for LARC appointments

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Recommendations

- Service-user led services: the aim is for an open access ISHS and community sexual health services that work for everyone. This includes specific outreach for communities in need and working with communities to co-design services in a way that works for them
- Better integration across the system: The commissioning landscape is fragmented however the formation of the ICS and the move of some commissioning responsibilities represents an opportunity to have better integration across the system

Challenges

- Financial
- Staffing- there is a shortage of skilled, trained clinicians working in CSRH as older cohorts retire but smaller numbers of training numbers are released, plus GUM has fewer trainees too
- Changes to ways of working (also an opportunity): covid forced unprecedented change which has continued (remote and telemedicine)
- Rising rates of gonorrhoea and syphilis ?emerging infections
- Rising rates of abortions in over 25s

Challenging targets in HIV action plan

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Questions

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LEICESTER CITY HEALTH AND WELLBEING BOARD
27 JUNE 2024

Subject:	Public Engagement and Consultation on Re-procurement of the Sexual Health Services: Findings and Actions
Presented to the Health and Wellbeing Board by:	Laura French, Consultant in Public Health
Author:	Laura French

EXECUTIVE SUMMARY:

As part of the Public Health Grant, Local Authority Public Health teams are required to procure a comprehensive sexual health service which provides contraceptive services and STI testing and treatment, as well as outreach services for vulnerable groups, RSE in educational settings and training for the local network. It is important that these services are designed to be responsive to the specific needs of the population they serve. In order to inform the service specification for the re-procurement of these services in Leicester, a comprehensive programme of public and stakeholder engagement was undertaken and the results analysed. The findings and recommendations are summarised here, but a report in the 'You said, We Did' format is available online here: https://consultations.leicester.gov.uk/communications/sexual-health/

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: Note the findings of the consultation programme and understand how they have gone on to inform the specification of the new service. The public health team behind the consultation and re-procurement would also like to use this opportunity to publicly thank all of those who gave their time to share their thoughts and expertise with us on this subject. It really was invaluable and is hugely appreciated.

Integrated Sexual Health Service for Leicester: Designing a service to meet need

Dr Laura French, Consultant in Public Health

A presentation to the Leicester City Health and Wellbeing Board

June 2024

Leicester City Council

Contents

- Summary of the re-procurement process and outcome
- Public consultation and stakeholder engagement:
  - What we asked
  - Who we asked
  - What we found out
  - How we used it

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What do we commission?

- Since the transfer of public health services from the NHS into local authority in 2013, one of the things that LA public health has had responsibility for is commissioning sexual health services
- Unfortunately, the commissioning landscape is complex, since some responsibility has remained with the NHS via the Integrated Care Boards but is changing…

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Local authorities

- comprehensive sexual health services including most contraceptive services and all prescribing costs, but excluding GP additionally-provided contraception
- STI testing and treatment, chlamydia screening and HIV testing
- specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies

Since 2021, commissioning responsibility for PrEP is now ours

~~Clinical commissioning groups~~

- most abortion services
- sterilisation
- vasectomy
- non-sexual-health elements of psychosexual health services
- gynaecology including any use of contraception for non-contraceptive purposes

44 CCGs were replaced by ICBs in July 2022

NHS England

- contraception provided as an additional service under the GP contract
- HIV treatment and care (including drug costs for PEPSE)
- promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs
- sexual health elements of prison health services
- sexual assault referral centres
- cervical screening
- specialist fetal medicine services

HIV commissioning is transferring to the ICB

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Timeline

- Previous contract due to end on 31st March 2024
- At the time we re-commenced the process at the end of 2022, the new NHS procurement rules (provider selection regime) were not in force so we undertook a competitive tender process
- Between January and March 2023 we undertook a comprehensive programme of engagement with the public and other stakeholders to inform the specification and other aspects of the service

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Timeline

- Mid-April 2023 we advertised the contract
- Award was made in autumn 2023 after an excellent bid by our existing providers, Midlands Partnership Foundation Trust (MPFT)
- October 2023 to March 2024 was spend working on mobilization and the new contract started 1/1/24.
- This time, we were procuring alone as Leicester City instead of as LLR

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SO WHY IS CONSULTATION SO IMPORTANT?

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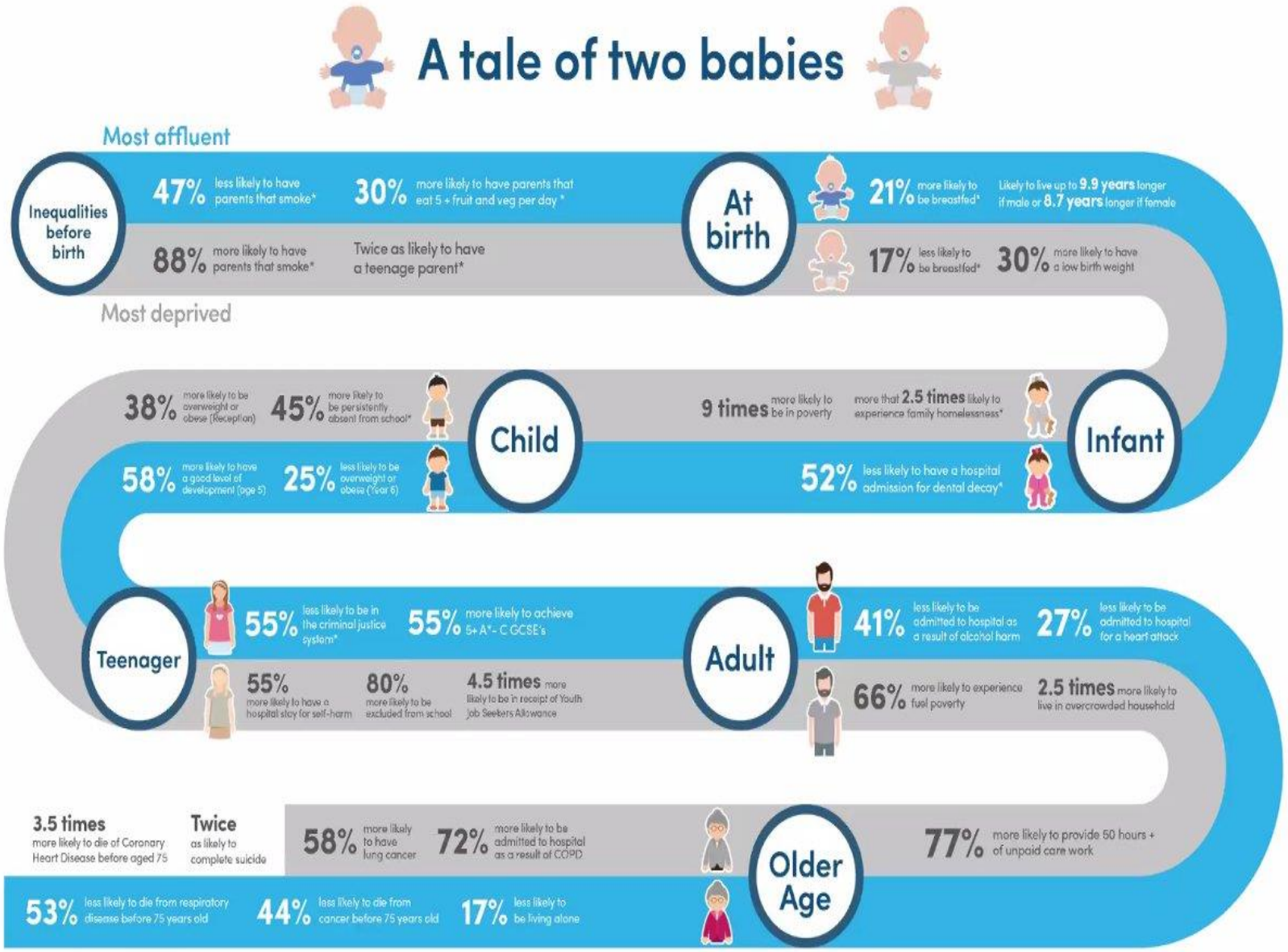
A tale of two babies
Most affluent
Inequalities before birth
47% less likely to have parents that smoke*
30% more likely to have parents that eat 5 + fruit and veg per day *
88% more likely to have parents that smoke*
Twice as likely to have a teenage parent*
At birth
21% more likely to be breastfed*
Likely to live up to 9.9 years longer if male or 8.7 years longer if female
17% less likely to be breastfed*
30% more likely to have a low birth weight
Most deprived
Child
38% more likely to be overweight or obese (Reception)
45% more likely to be persistently absent from school*
58% more likely to have a good level of development (age 5)
25% less likely to be overweight or obese (Year 6)
Infant
9 times more likely to be in poverty
more that 2.5 times likely to experience family homelessness*
52% less likely to have a hospital admission for dental decay*
Teenager
55% less likely to be in the criminal justice system*
55% more likely to achieve 5+ A*- C GCSE's
55% more likely to have a hospital stay for self-harm
80% more likely to be excluded from school
4.5 times more likely to be in receipt of Youth Job Seekers Allowance
Adult
41% less likely to be admitted to hospital as a result of alcohol harm
27% less likely to be admitted to hospital for a heart attack
66% more likely to experience fuel poverty
2.5 times more likely to live in overcrowded household
Older Age
3.5 times more likely to die of Coronary Heart Disease before aged 75
Twice as likely to complete suicide
58% more likely to have lung cancer
72% more likely to be admitted to hospital as a result of COPD
77% more likely to provide 50 hours + of unpaid care work
53% less likely to die from respiratory disease before 75 years old
44% less likely to die from cancer before 75 years old
17% less likely to be living alone

Health Inequalities in Sexual Health

- Health inequalities are systematic differences in health between different groups. They are unfair and avoidable.
- As with all adverse health outcomes, poor sexual health is not evenly distributed within the population, with those living with deprivation more likely to experience poor sexual health.
- In addition, there are many groups that are more vulnerable to poor sexual health who need special consideration when thinking about sexual health services.

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One size does not fit all…

- Although there is a national specification framework published for sexual health services, we know that we need to work with our communities to design a service that works best for them.
- Though we did not wish to make any substantive changes to the model in Leicester which was generally well thought of by patients and staff, there were still important things that we needed people's input into

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Such as…

- Where to put any ‘spoke’ or peripheral clinics and how often
- What sort of a balance to have between online and face to face appointments
- What sort of balance to have between pre-booked appointments and ‘sit-and-wait’ style clinics
- Where people like to be able to access different services (oral contraception, coils and implants, STI testing etc)
- How we could make services more accessible to all
- How people would like to see us work more closely with communities

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Who we asked

- Two facets to the consultation
  - On online public consultation open for 8 weeks
  - Face-to-face sessions were delivered with groups at the following places:

-Wesley Hall Community Centre - Women4Change - Afro Innovation Group - AAG (Autism Advocacy Group) - Autism Partnership Board - Young Persons session (Participation Engagement Group) - Shama Women's Centre - Belgrave Neighbourhood session - Bangladesh Action Resource Centre - University of Leicester (Student Engagement Event)

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What we asked

- Topics covered by the consultation included:
- Online appointment bookings
- Face to face services
- Vending machines
- Sexually transmitted infection test kits
- Phone consultations / advice
- Clinics
- Contraception
- Coils and implants
- Additional services and community wellbeing champions

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What we found out

- The results from the online questionnaire and the face-to-face focus groups were written up, combined and analysed thematically to allow us to group them
- We received almost 300 responses to the questionnaire from people from a range of ages, genders and ethnicities. The majority of responses came from people in the age range 18-55, and of those who answered the question, the majority identified as female (64%)

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What we found out

- There were five key themes identified in the responses:
  - Education and training
  - Beliefs and perceptions around sexual health
  - Barriers to accessing services
  - The important of age-appropriate services
  - Information sharing and signposting

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You said, we did:

1. **We asked: if we should increase the number of online booking appointments available for the sexual health service?**

- **You said:** 64% of responses answered ‘definitely’ and a further 17% answered ‘possibly’ for increasing the number of online booking appointments.
- **We did:** Worked with providers to ensure that online appointment booking was made available again as this had had to be reduced or suspended during covid. As a result, online appointment bookings are now fully operational again and are very popular.
- **For the new contract We will**: Work with our provider for the new contract model to ensure that online booking for appointments is always available where possible, rather than having to phone-up. Where patients do need or want to phone up for an appointment, we are working with the provider on making this a more straightforward and faster process.

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2. **We asked: how you would prefer to access face to face services?**

- **You said:** 53% of responses were in favour of having a mixture of both drop-in (turn up and wait) and bookable appointments, whilst 32% of responses stated that they would prefer bookable fixed appointments only.
- ***We did:*** Walk-in appointments (i.e. sit and wait rather than pre-booked) have also been reinstated by popular demand and these are up and running again. These appointments tend to be particularly popular with younger people. It was also clear from the responses however that some people prefer to be able to book in advance, so this option remains available- and is now available again online too (see above)
- **For the new contract, we will**: Ask the provider to ensure a proportion of appointments at the hub and spoke clinics remain pre-bookable, and that there is a straightforward way for people to see what options are available to them when accessing the website or phoning up to make an appointment.

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4) We asked: if working more closely with communities and community organisations would positively or negatively impact the individual or group responding?

You said: 66% of respondents said that this would have a positive impact for working more closely with communities and community organisations.

We did:

- Links were made and established with community organisations we ran engagement and focus group sessions with brought to our attention some groups who did not know of the service at all or how to access it. As a result, these organisations have since been offered scheduled visits to look around the integrated sexual health service (ISHS) to help people feel more comfortable in accessing the service.
- Improved communication links between the service provider, community organisations and the PH community wellbeing champions team to address ongoing needs for those identified communities and assist the service in their ongoing diverse communities work.
- Ongoing dialogue and communication will be maintained with the focus groups and organisations to develop specific action plans for areas of the service. For example, identifying community link workers to bridge the gap between service provider and communities.

For the new contract, we will:

- Continue to work with our provider and with our Community Wellbeing Champions network to enable open and honest conversations around sexual health which are appropriate to and meet the needs of all our residents.
- Support the provider to engage and work with community link workers to help communities engage with the service
- Support people for whom language is a barrier to access the service more easily
- Work with our young people to co-design services that work for them
- Enable to provider to work with our Community Wellbeing Champions Network to deliver information and education sessions on sexual health and related topics in their communities in a way that feels accessible and understandable.

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You said, we did…

- That is just a selection of the findings. There is a report available on the LCC website via:

https://consultations.leicester.gov.uk/communications/sexual-health/

Leicester City Council

Where are we now?

- New contract began on 1st April 2024
- Mobilisation is going well but some things are taking time to set up, such as a single point of access phone number for LARC
- Working on several bits of important cross system work including the Women's Health Strategy and the HIV action plan
- Consultation identified a gap in young person representation (16-24) to feed into ongoing service development so there are plans to establish a better way of doing this

Leicester City Council

Thank you!

- If you would like more information, please contact me (laura.French@Leicester.gov.uk) or my colleague Dan Hallam (Daniel.Hallam@Leicester.gov.uk).

Leicester City Council

Leicester City Health and Wellbeing Board

Update on Tuberculosis (TB)
June 2024

Leicester City Council

TB: a disease of poverty

- An infection caused by the mycobacterium tuberculosis bacterium.
- Mainly infects the lungs but can infect any part of the body.
- Only infectious if in the lungs and in sufficient quantity.
- Spread by breathing in infected droplets (coughing/sneezing).
- Can be latent for many years: between 5 and 10% of people with latent TB will eventually develop active TB disease.
- If infectious and untreated can infect @10 – 15 people/year.
- Causes range of symptoms depending on site of infection including persistent cough, high temperature, loss of appetite, enlarged lymph nodes.

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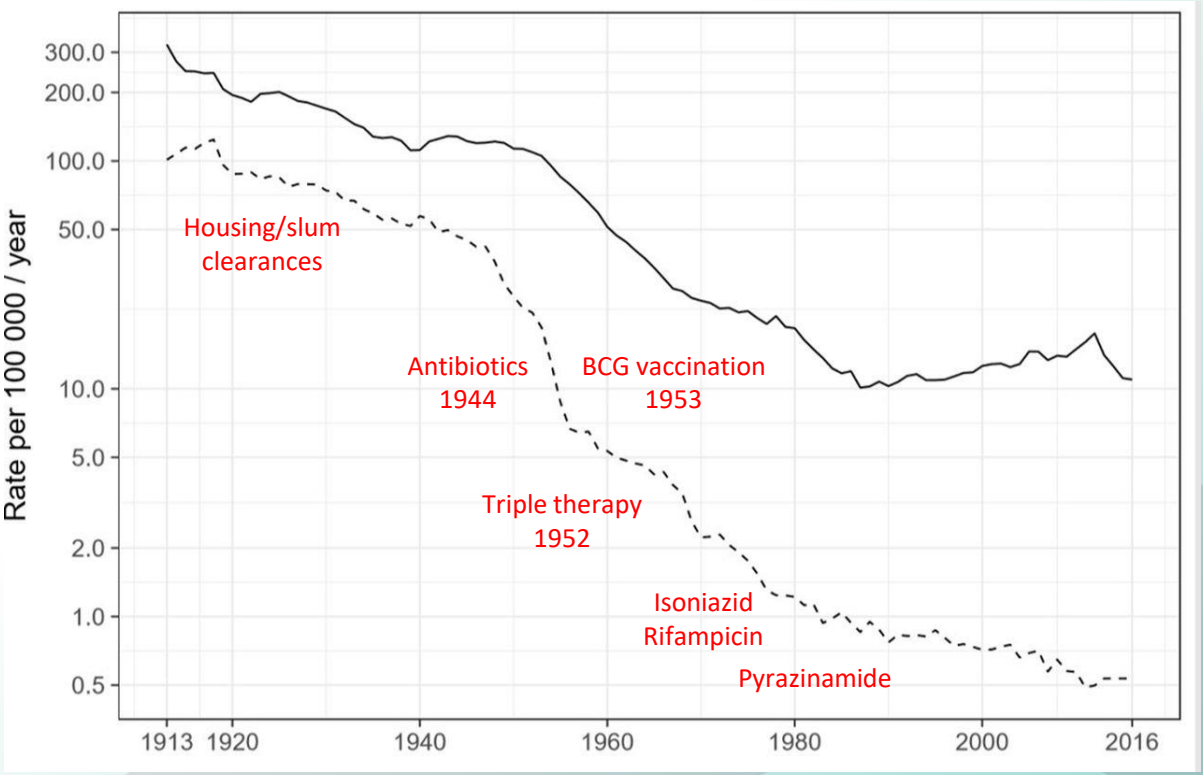
A history of TB in England and Wales



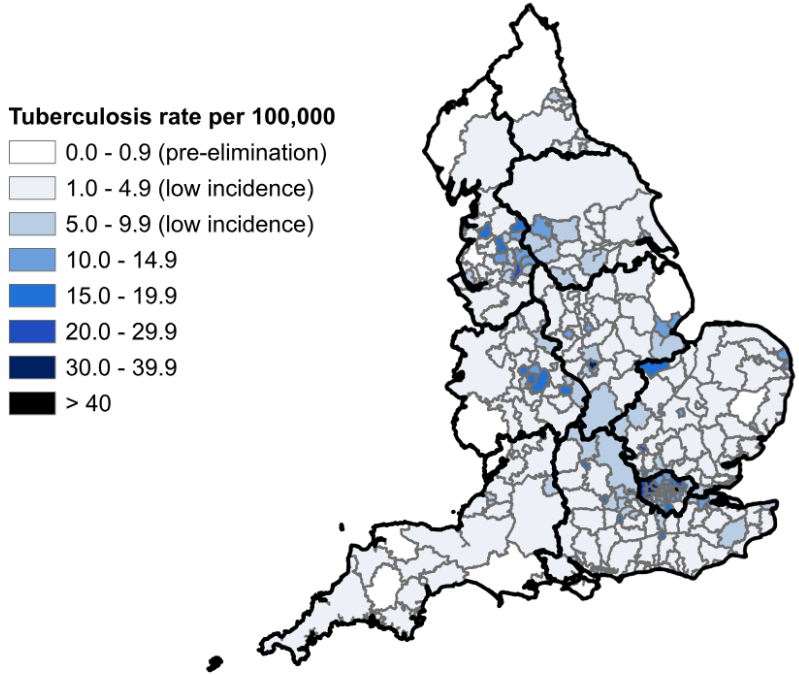
TB incidence (solid line) and mortality (dashed line) rates per 100 000 populations per year in England and Wales, 1913–2016.

Philippe Glaziou et al. Thorax 2018;73:702-703

THORAX

Leicester City Council

TB rates in England 2020 - 2022



Three-year average TB notifications by LA, England. 2020 - 2022

Source: TB incidence and epidemiology, England, 2022 - GOV.UK (www.gov.uk)

TB notification rates vary widely across the country with Leicester having the 2nd highest rate at 39.0/100,000 population.

Rates increase with deprivation: 13.5/100,000 in the 10% most deprived areas compared to 2.6/100,000 in the least deprived.

Almost 80% of active TB in 2022 was in people born outside of the UK.

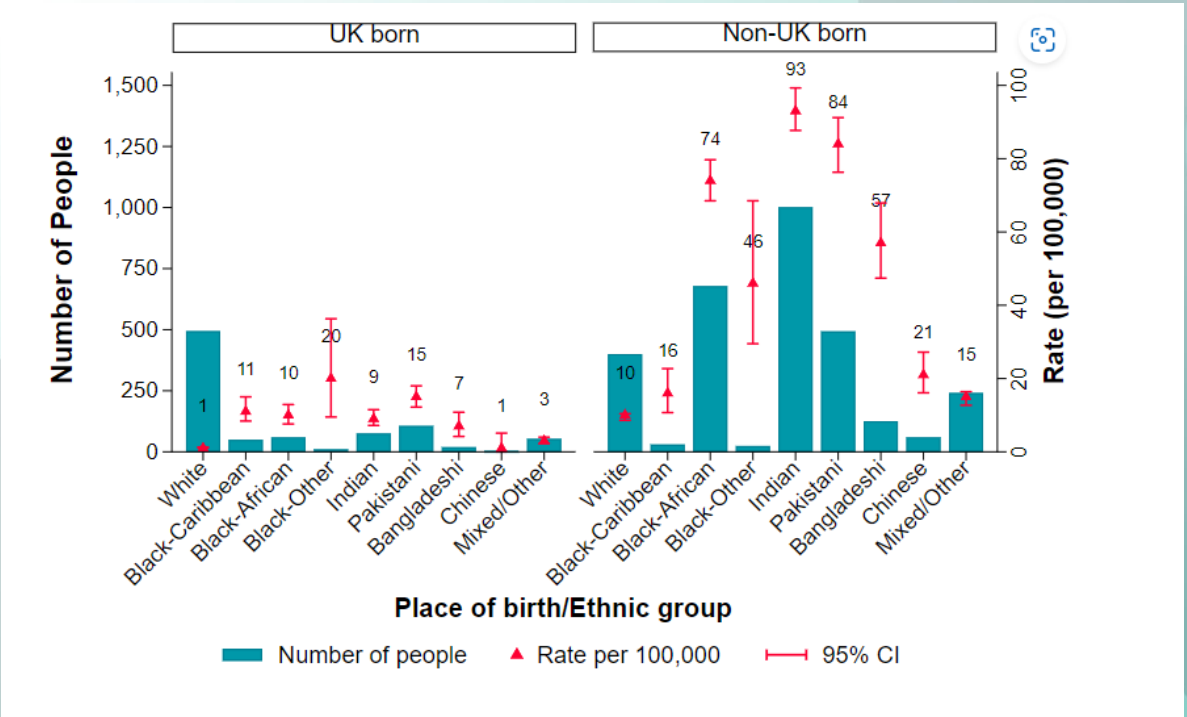
21.6% of those born in the UK have at least one social risk factor compared to 15.3% of the non-UK born.

54.7% of cases had pulmonary TB.

Leicester City Council

TB notifications by place of birth, England 2022

- The highest number of cases in the UK born population is from a white background but this is the lowest rate.
- The most common countries of birth for non-UK born residents are India, Pakistan, Romania, Bangladesh & Eritrea.
- The highest number of cases and rate in the non-UK born population is of Indian ethnicity.
- Numbers in the S Asian ethnic group reached a peak in 2011, declined until 2018 and since then have risen by 10.1%.



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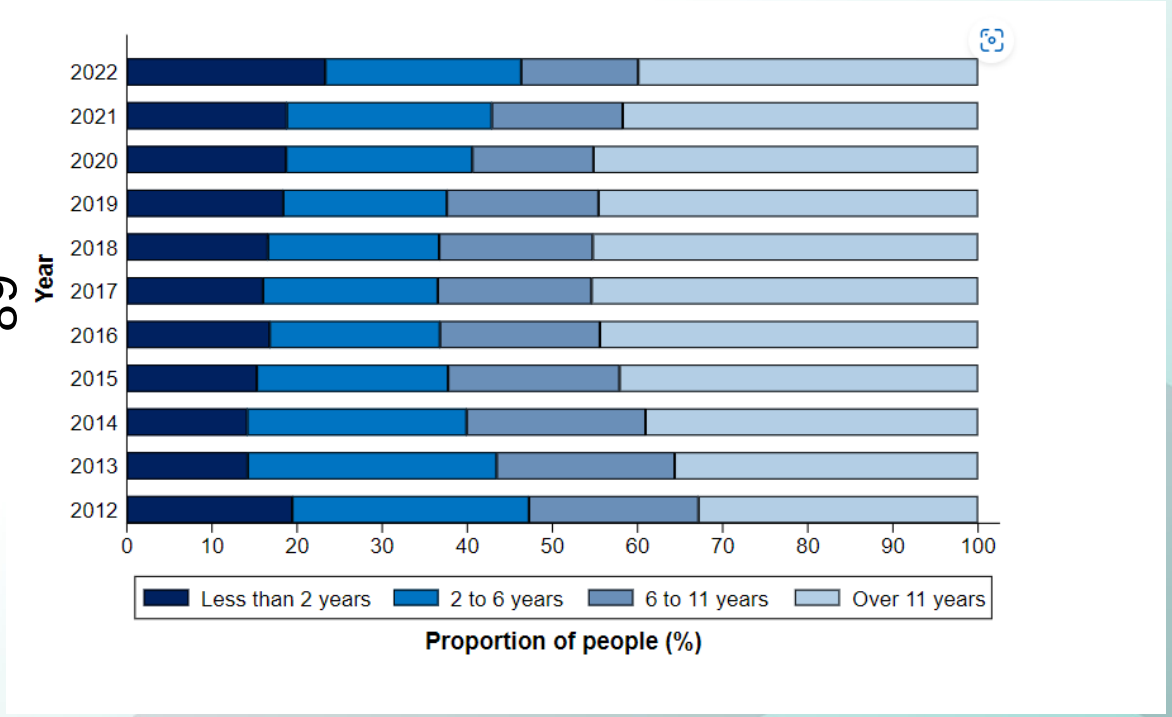
Time between entry to the UK and TB notification, England 2011 to 2022



46.3% of people born outside the UK with a known year of entry were notified less than 6 years before entry; 23.6% were notified within 2 years of entry – the highest proportion since 2012.

Source: [TB incidence and epidemiology, England, 2022 - GOV.UK (www.gov.uk)]

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Latent TB (LTBI) screening programme

- In local authority areas where incidence is high.
- Available for all new entrants who
  - Have entered the UK within the past 5 years
  - Have lived in sub Saharan Africa or a country with a TB rate ≥ 150/100,000 for at least 6 months.
  - Are between 16 and 35 years of age.
- An audit of our LTBI programme showed:
  - A decline in screening after 2019
  - Large variation across the city
  - An opportunity to identify many more case of latent TB.

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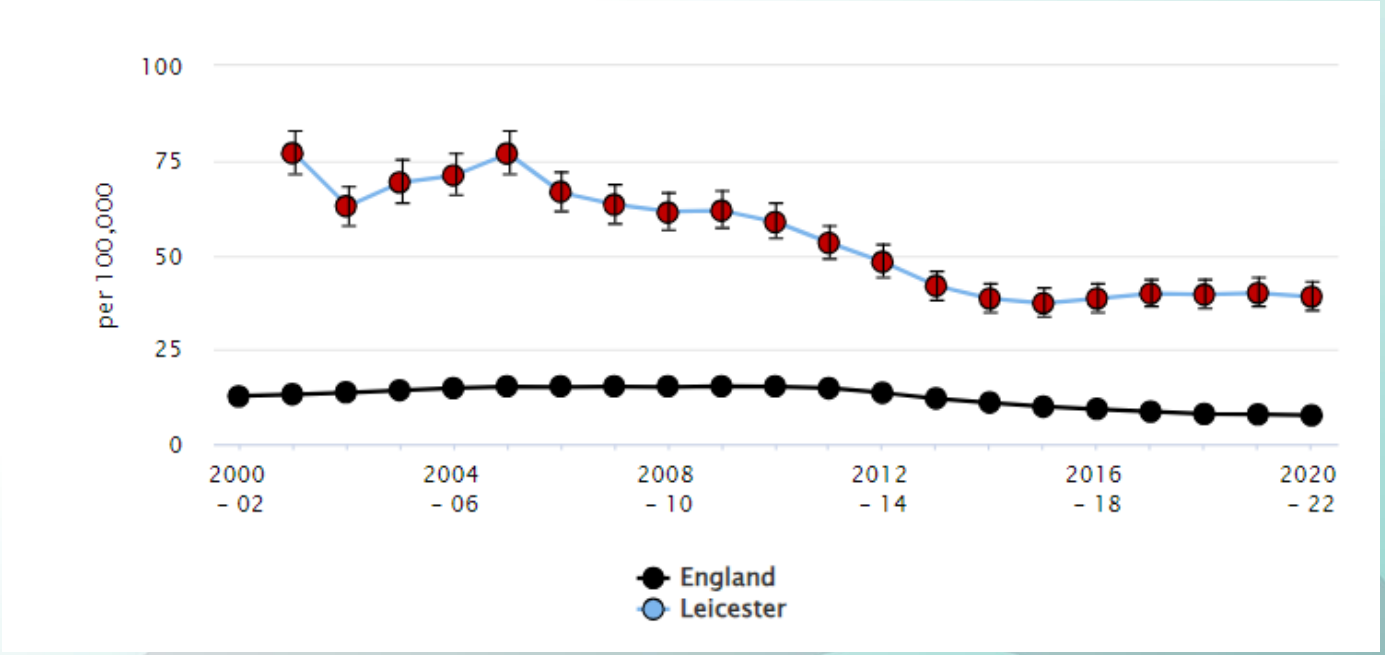
TB rates in Leicester



Three year average rates, 2000 to 2022

Source: [TB Strategy Monitoring Indicators - Data - OHID (phe.org.uk)]

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Why the reversing trend?

- Changing patterns of migration.
- Delayed diagnosis.
- Access to the latent screening programme.
- Access to treatment and the treatment itself.
- Stigma.
- Associated social risk factors.

Leicester City Council

Risks for Leicester

- A continued rise in cases including latent cases.
- Capacity and resources:
  - TB services
  - Primary care
  - Latent screening programme
  - Community engagement
- Treatment preferences and beliefs.
- Stigma and social risk factors.
- Changing patterns of migration.

Leicester City Council

What are we doing?

- Get it right first time (GIRFT) review.
- LLR TB strategy development.
- TB needs assessment.
- Audit of latent TB screening programme.
- Prompt response to outbreaks.
- BCG vaccinations in eligible newborns.

Leicester City Council

The LLR TB strategy

- To increase detection and control of both active and latent TB.
- To maintain and build on successful completion rates of active and latent TB.
- To ensure a skilled workforce that works within its capacity and resources.
- To horizon scan: interventions and projections
- Actively harnessing insights from people with lived experience.

Leicester City Council

What support is needed?

- A sense of urgency: our treatment services have very high completion rates yet cases are still growing. Unless we do much more, TB will become more and more common in our city.
- A system wide approach:
  - To lobby for additional support using Newham as an example.
  - To raise awareness and reduce stigma.
  - To embed a 'TB aware' approach in our local employers & workforce.
  - Collective action across LLR.
- An increase in our latent TB screening programme.
- Recognition of the needs of the most vulnerable and apply resources in accordance with need.

Leicester City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD
27 JUNE 2024

Subject:	Health and Wellbeing Board Annual Report – January 2022 – July 2023
Presented to the Health and Wellbeing Board by:	Amy Endacott – Public Health Programme Manager, Leicester City Council
Author:	Dr Katherine Packham/Amy Endacott

EXECUTIVE SUMMARY:

The Health and Wellbeing Board is a statutory board of the council, established under the Health and Social Care Act 2012, and is a forum in which key leaders from the local health and care system work as a multi-stakeholder partnership to set strategic direction for improving the health and wellbeing of the local population. The Board is also a forum for public accountability.

The Health and Wellbeing Board terms of reference outline that it is a requirement to provide an annual report from the Health and Wellbeing Board to the Leicester City Council Executive and to the Board of the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) to ensure that the Board is publicly accountable for delivery.

There has been an absence of an annual report during the COVID-19 pandemic and as such this annual report covers a period of 18 months, slightly longer than the usual 12 months, to bridge the gap between the previous report and the upcoming 2023/24 report which will be produced during the second half of 2024.

This annual report covers:

- An overview of how the Health and Wellbeing Board works
- The statutory responsibilities it must enact and how they have been met during the reporting period. Those are:
    - Producing and refreshing a Joint Strategic Needs Assessment to identify current and future health and wellbeing needs across Leicester, enabling commissioning and policy decisions to be evidence-based.
    - Preparing and publishing a Joint Health and Wellbeing Strategy which clearly outlines the health and wellbeing needs of Leicester's population and plans to address them., communicating and engaging with local people on how they can be supported to exercise choice and control over their personal health and wellbeing to enable them to achieve the best possible quality of life.
    - Producing a pharmaceutical needs assessment to assess needs for pharmaceutical services in Leicester.

    - Approving the Better Care Fund plan; a programme which supports partners across the local system to deliver the integration of health and social care in a way that supports person-centred care, sustainability, and better outcomes for people and carers. It allows the NHS and Local Authority to pool funding to spend in ways which join up care more effectively.
- A summary of the work of partnership boards who work with the Health and Wellbeing Board.
- An overview of key communications and engagement activity with stakeholders and local people, and how this is used to shape and influence their work.
- The key challenges and achievements during the reporting period
- Looking ahead to 2023/24.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Receive the report and note the content.

- Note that an annual report for the 23/24 period will be produced later this year, and offer comment on the structure and content of that report.

Health and Wellbeing Board Annual Report
January 2022 – July 2023

Chair's foreword

I am pleased to introduce this annual report of the Health and Wellbeing Board.
Whilst still tackling the legacy that COVID-19 has left on the health and wellbeing of our residents and workforce, this period has also seen significant structural changes to the planning and delivery of our health and care systems with the abolishment of Clinical Commissioning Groups and the introduction of Integrated Care Systems. What has not changed, however, is our ethos for strong partnership working and commitment to empower our residents to achieve the best possible health and wellbeing outcomes that they are able to. With change comes opportunity, and this report highlights the achievements which have been made, including:

- Publication of the new Joint Local Health and Wellbeing Strategy, development of the associated delivery action plan, and good progress against the initial six priorities.
- Decisive action to understand and address the impacts of the cost-of-living crisis across Leicester.
- Collaborative working between Education and NHS partners to encourage and support people with learning difficulties in meaningful employment.
- Engagement with our local communities across a range of areas to listen to what matters to them, and using this insight in the shaping and development of services
- Innovation across the health and social care systems to deliver services in ways which best meet the needs of those who use them during the winter period, when increasing pressures were being experienced across the system.

Having taken over the role of Chair of the Board in May 2023, I know that we will continue to face challenges in the year ahead, not least the increasingly tightening budgets experienced by the Local Authority and NHS services, but I look forward to continuing to build upon the outcomes that this Board has already achieved and the strength in partnership which has been repeatedly demonstrated through the activity which is described in this report. I would like to thank: the Board members for their continued dedication; all of the staff who continue to provide high-quality health and care services care to our residents despite pressures experienced across the system; and give special thanks to the countless volunteers across Leicester who work tirelessly to support the health and wellbeing needs of our local population.

Cllr Sarah Russell
Deputy City Mayor – Social Care, Health and Community Safety

Terminology and acronyms used in this report

Any words in **bold** throughout this report may require explanation or further detail. There is a 'glossary and links to further information' section at the end of this document to explain this terminology and to provide full details of websites or links to further information which have been referred to in this report.

1. Introduction

We, the Health and Wellbeing Board, represent and address health and wellbeing needs in Leicester by bringing together key partners from across the health and social care system to meet, in public, to discuss the issues which face Leicester's residents, and to identify and agree ways to address them collaboratively. Meeting agendas, minutes and webcasts of individual meetings are publicly available on the Leicester City Council website, but the purpose of this annual report is to provide an overview of our activity during the period being reported on, along with plans for the future.

Ordinarily a report would be produced annually and would cover a single year period, but in recognition that no report was produced during the COVID pandemic, the time period covered by this report has been expanded to 18 months.

2. Who we are and what we do

2.1 What is the Health and Wellbeing Board?

The Health and Wellbeing Board is a statutory committee of Leicester City Council, established under the **Health and Social Care Act 2012**. Our primary purpose is to make sure that all residents of Leicester are able to achieve the best possible health and wellbeing that they are able to. We recognise that this will be different for every individual.

2.2 Who represents the Health and Wellbeing Board?

We are a partnership forum which is made up of leaders from local health and social care systems who understand the health and wellbeing of the local population, and work together to improve it. Board membership aims to be representative of the organisations who support health, care and wellbeing needs across our city and the communities we serve. Membership for 2022-23 comprised of:

Elected members of Leicester City Council (5) - Voting
• Executive Lead Member for Health • Four further Elected Members
NHS representatives (7) - Voting
• Chief Executive plus 2 other representatives from the LLR ICB • Director of Strategic Transformation – NHS England and NHS Improvement, Midlands • Independent Chair of the Integrated Care System • Chief Executive of University Hospitals NHS Trust • Chief Executive of Leicestershire Partnership NHS Trust
Officers of Leicester City Council (4) - Non-voting
• Strategic Director of Social Care and Education • Director of Public Health

• Public Health Consultant • 1 vacant post
Further representatives of the wider community (8) – 7 Voting, 1 non-voting
• Local Healthwatch • Leicester City Local Policing directorate, Leicestershire Police • LLR Police and Crime Commissioner • Chief Fire and Rescue Officer, Leicestershire Fire and Rescue Service • A representative of the Sports Community • (Chairman of Leicester Riders) • A representative of the private sector/business (LLEP) • A representative of the voluntary services (Voluntary Action Leicester) • A representative of Leicester's Universities (DeMontfort/Leicester University)

2.3 Vision, aims and objectives of the Board

Our primary aim is to achieve better health, social care and wellbeing outcomes for Leicester City's population, and a better quality of care for patients and other people using health and social services. Our objectives are to:

- Provide strong local leadership for the improvement of the health and wellbeing of Leicester's population and work to reduce health inequalities.
- Lead on improving the strategic coordination of commissioning across NHS, adult social care, children's services and public health services.
- Maximise opportunities for joint working and integration of services using existing opportunities and processes, and prevent duplication or omission.
- Provide a key forum for public accountability of NHS, Public Health, Adult Social Care, Children's Services, and other commissioned services directly related to health and wellbeing.

2.4 Statutory responsibilities of the Board

We have some statutory duties which we must carry out. They are to:

Produce Joint Strategic Needs Assessments (JSNAs) which assess the health and wellbeing needs of Leicester's populations, and refresh them as needed.

The **Joint Strategic Needs Assessment (JSNA)** is a comprehensive document that evaluates the health profile of a population, identifying health inequalities and unmet needs. The JSNA also projects future health trends, providing recommendations for enhancing population health. JSNA's are an important tool in helping to develop local strategies and to inform decisions about the types of services which need to be commissioned to support local health and wellbeing. During the time period this report covers, the following JSNA's and **Joint Specific Needs Assessments (JSpNA's**) have been completed:

- Pharmaceutical Needs Assessment (PNA) 2022
- Oral Health JSpNA 2022
- Oral Health JSNA 2023
- Drug and alcohol JSpNA 2023
- Alcohol JSpNA 2023

- Drug JSpNA 2023
- Mental health JSNA 2023
- End of life care JSNA 2023
- Children and Young People's (CYP) JSNA Chapter 1: Overview 2022
- Children and Young People's (CYP) JSNA Chapter 2: Early years (0-4 yrs) 2023
- Sexual health JSpNA 2023
- Healthy Weight JSpNA 2022
- Dementia JSNA 2023
- Living in Leicester 2023

Case Study

The Oral Health JSNA chapter has been used as a case study, to demonstrate how we use the JSNAs to help to improve health and wellbeing locally.

Context: Poor oral health impacts quality of life and is caused by factors like inadequate oral hygiene, sugary diets, tobacco, alcohol, and lack of dental care. In children, good oral health is crucial to prevent issues like dentinal caries, pain, infections and issues with speech development; all of which impact a child's ability to grow, learn and play.
Process and findings**:** In 2013, the Oral Health JSNA showed Leicester's children had worse oral health than the national average. Specifically, 53% of 5-year-olds had dentinal decay. Recommendations included a partnership-driven oral health strategy for children, introducing educational campaigns such as the supervised tooth brushing programme in early years settings, increasing the provision and uptake of fluoride varnish application, and overall building a community interest in oral health.
Outcomes**:** A number of Public Health initiatives were born from the JSNA including the development of the Oral Health Promotion Strategy (2014-2017) and the start of the supervised toothbrushing and Healthy Teeth, Happy Smiles programmes in Leicester, both of which are educational campaigns. Fluoride varnish application benefits were promoted through social media, reaching around 7,000 individuals in some posts. Community partnerships and resources improved child oral health through education, dental supplies (e.g. toothbrushes) and advice around best practice.
Impact**:** Leicester's decay rate decreased from 53% (2012) to 38% (2022), a 15.4% decrease, demonstrating the effectiveness of these measures.
Alignment with the priorities of the Health and Wellbeing Board: The JSNA aligns with the Health and Wellbeing Board's Healthy Start priorities: mitigating the impact of poverty in children, ensuring the best start for all children by focusing on the critical 1001 days, empowering health self-care in families with young children, and ensuring that all children can play and learn.
The JSNA identified areas needing attention and targeted work due to deprivation, and proposed tailored interventions that would mean services and provision would be increased in areas of higher need. The relationship between deprivation and oral health continues to be closely monitored. The JSNA also highlighted the concern with prolonged bottle feeding, often with sugary drinks, which often causes incisor caries (tooth decay). In 2022, incisor caries were found to be significantly higher in Leicester than the national average. To minimise this risk, health visitors encourage parents and carers to stop using feeding bottles at the appropriate developmental stage and bottle swap promotional schemes are targeted within areas of the city with higher incisor caries, including the centre and north west of the city. In addition, the educational campaigns that were

introduced following the Oral Health JSNA empower families by raising awareness and understanding of oral health importance to that both children and their parents and carers can proactively maintain oral hygiene. Finally, addressing health inequalities and prioritising areas of higher need has ensured a focus on equal opportunities for all children, allowing children to learn and play.

Produce a **Joint Local Health and Wellbeing Strategy (JLHWS)** to show what the local priorities are for addressing the health and wellbeing needs of Leicester's population, and a plan for how those needs will be met.

A refreshed **Joint Health, Care and Wellbeing Strategy 2022-2027** for Leicester was published in 2022, giving recognition to the impact of the COVID pandemic on health and wellbeing across our city and widening health inequalities. The strategy outlines the current and future heath, care and wellbeing needs of Leicester's residents and sets out 19 key priorities which were agreed, through extensive consultation with residents, professionals, voluntary organisations and other stakeholders across Leicester as being important to address in order to enable Leicester residents to live healthy and fulfilling lives. Alongside the strategy is a detailed delivery action plan which includes the specific actions and activities which are taking place to help us achieve our priorities. The plan brings together partners from across the health and care systems, as well as the voluntary and community sector, to work collaboratively to address these priorities. The strategy and its associated delivery plan cover five areas, addressing the range of health, care and wellbeing needs experienced across the life-course. They are: Healthy Start, Healthy Places, Healthy Lives, Healthy Minds, and Healthy Ageing. It is intended that the 19 priorities will be addressed in phases in recognition that the same level of resource and focus cannot be given to all 19 priorities at the same time. They have been categorised into **'do,' 'sponsor,' and 'watch'**, with initial focus being given to six 'do' priorities which were identified as being the most pressing to address.

A summary of progress since the delivery action plan was implemented from January 2023 can be found on pages 6 – 17.

Healthy Start

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

We have…

- Worked collaboratively with partners to fund and train advisors in the community to provide energy awareness advice.
  Leicester Energy Action (LEA) City and Guilds training webinars have provided front line worker with the knowledge and skills to support people experiencing fuel poverty. During the early set up phase (early 2023-July 2023) 12 delegates were trained in the City and Guilds Level 3 award in Energy Awareness. 52 delegates attended key webinars. National Energy Action (NEA) estimates based on historic work suggest each delegate goes on to support in the region of 22 people per year.

  <u>Case study of a newly qualified trainer</u>
  Atifa works with a group that supports people in Leicester communities with an array of issues. She attended the City and Guilds Level 3 Award in Energy Awareness training with Leicester Energy Action.
  Since getting her qualification, she’s started to run drop-in and appointment-based sessions in places like Wesley Hall, Belgrave Neighbourhood Housing Association, Angels and Monsters, Belgrave Library, Highfields Library, and Freedom Refugee Youth Club - all focusing on energy advice.
  This is a great example of how we’re working to embed advice and support in communities
  ‘’I really enjoyed the course, honestly – it was great. I thought three days was going to feel long, but it didn’t! I really did enjoy it. I was quite proud when the examiner emailed me. I was in the office. I ran downstairs to tell everyone I’d passed the exam! I was screaming because everyone knew I was waiting for the results. One of my first cases came into a library to see me. They felt their energy bills were too high. I went through their bills with them, and we looked at other providers, and we had a conversation about behaviour change, about what habits they could change around the house. Everyone’s worried about their bills, the prices of cost of living are just affecting everyone.’’

- Brought together partners to form a ‘task and finish’ group to address the specific issues relating to maternity services accessibility and experience of women from the Black and Asian ethnic minority community, and used the learning to shape further discussions and events to address this issue.

- Published an anti-poverty strategy and framework, designed through a co-production approach, engaging with more than 500 people.

- Awarded anti-poverty grants to a number of organisations to develop and run projects which mitigate against the impact so of poverty for residents across Leicester.
  An overview of some of the health-related anti-poverty grants which were awarded can be found in Table 1 below.

Table 1 – Health-related anti-poverty grants awarded during reporting period, and evaluation of impact

Organisation and project	Voluntary Action Leicester (VAL) and Leicester City Council (LCC) evaluations of impact
Fosse Mutual Aid Association Electric blankets £1,560	VAL: Single blankets: 118 Double blankets: 106 Total: 224 224 households supported 58 families with 1-4 children – all were provided with blankets. 20 people prioritised as received DLA, PIP, or pension credit Reduced energy bills where heating was used – some families had no heating due to the financial costs. LCC: 224 electric blankets distributed. Priority from our initial grants allowed supporting disabled/elderly/medical conditions and those on certain benefits. Further alternative funding allowed support to all service users.
Antoin Akpom Achievements Foundation Community Takeaways £4,755	VAL: Provided hot meals to 78 families and individuals once a week for 45 weeks. Project allowed identification of additional needs and gaps for future project development. Service users with high needs with signposting – cancer patient, kidney transplant patient, child in need of funds for school uniform, mobile phones sourced for struggling families. LCC: 78 families receiving continuing support; providing culturally appropriate family resources.
Baby Basics Warm care £9,072	VAL: Volunteers provided 50 packages of equipment and packages of clothing to mother and child. 10 double buggies, foot muffs, head support and 20 cots and pushchairs. 80 families were supported This would equate to 145 individuals supported. Feedback from health professionals indicates reduced pressure on their services. Collections and deliveries achieved through referral leads. LCC: 50 warm care packages of gloves/scarf/hat/socks and toiletries, 10 Double buggies, Cots.

B-Inspired Cooking on a Budget £8,427	VAL: Cooking sessions delivered - 4-hour sessions for 4 weeks. 16 sessions delivered. 23 people attended sessions. With family members, total of 54 beneficiaries. Feedback from community indicates stronger community engagement, reduced isolation, greater increased confidence. LCC: 24 participants attending 4 weekly 2.5hr sessions for a total of 240hrs of cooking class reach - £35 hr session cost + slow cooker and food. Some participants are now supporting B-Inspired as volunteers.
New Parks Adventure Playground £5 Family Meals £7,119	VAL: Thursday Sessions teaching children to cook meals Delivery of 2-hour sessions weekly Ingredients and recipe – taken home for family to then eat. Each child had mainly 5 family members in that household. 15 children a week from March 2022 ongoing Engaged 720 children Ongoing project – added to their wider current project model Able to identify a crisis with family through this support. LCC: Delivered 4-monthly over 12 months, 12-18 children per session. At least 150 families supported in these cooking courses at a cost of £47 per family.

Healthy Places

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

We have…

- Worked to develop Integrated Neighbourhood Teams to work in a more coordinated way with partners at local level, through the evolution of Primary Care Networks. This has included, from April 2023 onwards, identifying and beginning to progress five key priority areas which city Primary Care Networks need to focus on (bowel cancer screening, women's health, obesity, integrated chronic kidney disease (CKD), and hypertension).
  Data to highlight the impact and outcomes of progress against these priorities during the first year will be included in the next Annual Report of the Health and Wellbeing Board (23/24).

- Boosted the use of social prescribing and the Additional Roles and Reimbursements Scheme (ARRS) to support primary care functions and ensure the right care is provided by the most appropriate provider.
  The table below highlights how many ARRS roles were operational between April – July 2023.

April 2023	May 2023	June 2023	July 2023
203	201.1	204	212.8

  ARRS roles included (but were not limited to) Advanced Practitioners, Care Coordinators, Clinical Pharmacists, Mental Health Practitioners, Digital and Transformation Leads, and Social Prescribing Link Workers. The ARRS has facilitated Primary Care and Primary Care Networks by supporting demand through:
  Increased Access, enabling PCNs/practices to be innovative and improve access, and through appropriate access to non-GP direct patient care staff.
  Increased multi-disciplinary team (MDT) working, supporting the option for patients to see a clinician most equipped to manage their care, enabling GPs to focus on complex and long-term continuity of care.
  Enhanced Staffing, a scheme to bolster staffing levels and enhance the capacity of primary care teams as outlined in the NHS Long Term Plan to increase the workforce in General Practice.
  Quality Improvement and Shared Decision Making – an LLR-wide survey is planned to gather information and views from patients on their care through an ARRS role.

- Collaborated with a range of partners to train volunteers to support patients in medical practices with their use of the digital technologies which support management of their health needs.
  A project delivered through Reaching People to train staff and volunteers, and to support patients at group and individual levels, to use the NHS app and online GP service was launched in July 2023. Data to highlight the outcomes and impact from

this project will be reported in the 23/24 Annual Report of the Health and Wellbeing Board.

- Delivered an Enhanced Access service in primary care to enable more people to receive appointments and care at a time and place which is accessible for them. Extended Access clinics have provided an opportunity for patients to access evening and weekend appointments to better meet patient needs and to provide winter appointments focussed on coughs and colds. There have been increases in the following dedicated clinics:
  - NHS Health Checks
  - Cervical screening
  - 'Flu clinics
  - Learning disability health checks
  - Preventive/long-term management
  - Structured medication reviews
  - Cancer screening

  Total Enhanced Access hours delivered Feb – July 2023 – 11, 392
  Average per month – 1899
  Average per week - 475

Healthy Lives

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

We have…

- Carried out pilot projects to help to identify people with undiagnosed hypertension, and to develop long-term conditions champions to work alongside GP practices. These projects are now being evaluated to understand the impact they have had.
  Two city PCNs were part of a wider LLR-wide 6-week initiative using 'hypertension detection stations' to invite patients from the relevant GP practices for a blood pressure check on a Saturday or weekday evening, either at their GP practice or local community pharmacy. Four out of five patients who were invited attended the appointment, indicating that setting up the clinics out of working hours was effective.

- Developed a video text message to raise awareness of prostate cancer identification in Black and Asian ethnic minority men. This approach is also being used to target patients who have not attended cervical screening to increase attendance.

- Completed years 1 and 2 (of 3) of a trial – called the Galleri trial – aimed at detecting cancer markers in fit and healthy people aged over 50 through a simple blood test.
  Evaluation of this trial will be completed once the trial concludes. There has been a 93% retention rate of participants from year 1, which is above the national rate.

- Brought together partners to understand and improve the one-year survival rate for colorectal cancer in Leicester, leading to significant changes to the faecal immunochemical test (FIT) pathway – including a reduction in the age eligibility to 56 and therefore enabling a greater number of people to participate in testing, a targeted project to increase one-year survival rates in the LE4 area of Leicester, and a reduction in the screening age and recruitment of a PCN to pilot direct provision of FIT testing kits from the GP practices, therefore reducing postal delays. FIT testing has been embedded within the colorectal pathway with an improvement from 47% in January 2023 to 69.6% in July 2023.

Healthy Minds (Children and Young People)

Priority: "We will improve access for children and young people to mental health and emotional wellbeing services."

We have…

- Extended contracts for high-performing Emotional Health and Wellbeing Services to enable continued service delivery.
  One of these services, Relate, provided support to 643 CYP through their Early Intervention Service and 2529 CYP through the Community Chill Out Zones between February and July 2023.

- Launched an online self-referral system to the Triage and Navigation system aimed at improving service access for children and young people, and removing barriers by minimising the need to see a GP for referral.
  The website was launched at the end of May 2023. During the first month after the website went live (June 2023) there were 1700 website views and 801 referral sessions. In July 2023 there were 1000 website views and 484 referral sessions. With regard to the higher volume of website views compared to referrals to the service, it is hope that this is indicative that the young person, parent or carer found the supporting information they required on the website.

- Rolled out Mental Health Support Teams in schools, with further teams due to be rolled out in areas of Leicester with the greatest deprivation and highest need.
  Mental Health Support Teams commenced in November 2020 with the first Leicester team being set up in Leicester East, as part of Wave 3. Since then, the Service has experienced annual growth through the implementation of Waves 5, 7 and 9, and will grow further across Leicester, with Wave 11, commencing in September 2024 with a further two teams. Between February and July 2023 the MHST service were in 34 schools, which covered 22,179 children and young people between 5-19 years. During this period, the service received 207 referrals from schools.

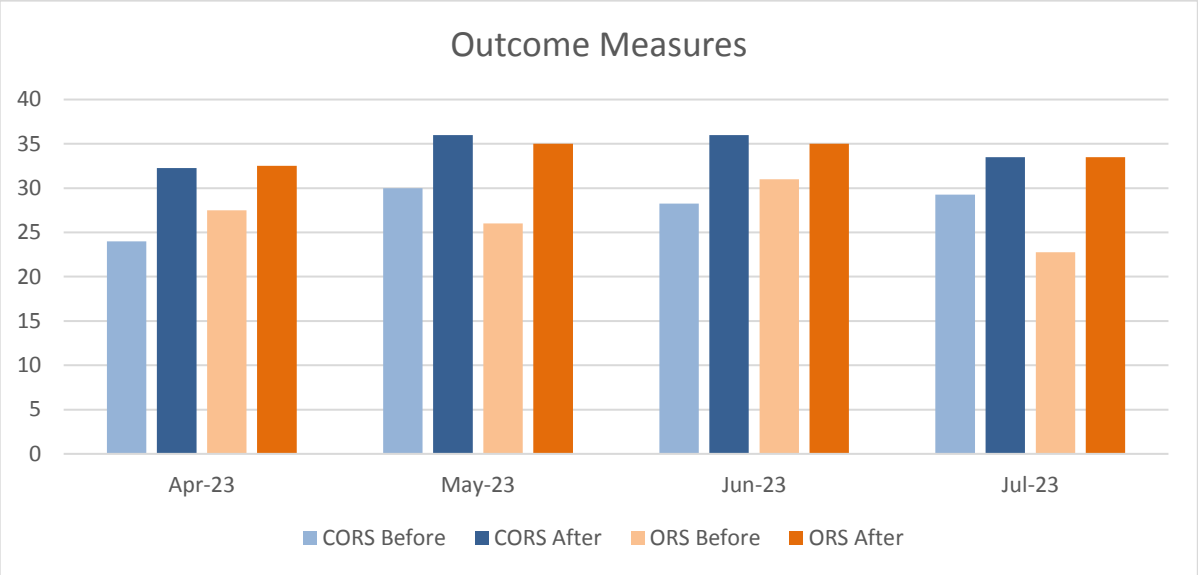
  Outcome measures were undertaken for all children and young people. The data obtained through the scoring evidenced a clear improvement in the emotional and mental health of the CYP accessing the service from prior to the programme of care to discharge from the service.

  ORS – Outcome Rating Scale; The ORS is a simple, four item rating scale designed to assess areas of life functioning known to change as a result of therapeutic intervention. The scale used is 0-10, with a higher score indicating a higher level of functioning as perceived by the young person.

CORS – Child Outcome Rating Scale; The CORS was developed for the younger child, 6-12years. It is the same format as the ORS but is more child friendly and engaging for the younger person.
For both the ORS and CORs, the maximum score is 40 with an increase in score representing improvement. An increase of 5 or more points on the total score represents statistically significant improvement.

Please see chart 1 below for further information.

Chart 1 – Outcome measures for CYP accessing MHSTs – Feb – July 2023



Healthy Minds (Adults)

Priority: “We will improve access to primary and neighbourhood level mental health services for adults”

We have…

- Awarded grants for ‘Getting Help in Neighbourhoods’ to 13 organisations and awarded five additional Neighbourhood Mental Health Cafés, bringing the total across the city to 11.
  There were 17,883 contacts between February and July 2023. The services have supported people experiencing a range of, often very complex, mental health, social, and other challenges.

  Case study**:** “We have been working with a lady aged 44 who has been taking part in the ladies class weekly and has also been doing the circuits class. She often has a difficult time with her daughter, who is being assessed for autism and displays very challenging behaviour and also doesn't sleep very well. Often, she comes to the class feeling stressed, tired and upset. 'Taking part in the wellbeing class really lifts my mood. It makes me feel good and allows me to talk to other mums that are going through similar situations whilst keeping healthy at the same time' The classes have really helped me to feel good and feel fitter at the same time. I always leave the class with a smile on my face.”

- Launch recommissioned mental health and wellbeing services
  224 people have received Community Recovery Support (ongoing support across 8-12 sessions). Service impact at individual level is measured at six-week reviews against nine individual outcomes rated from 1-5. Average outcome scored demonstrated an improvement of 0.5 for quarter 4 of 2022/23.
  338 people have received Advice and Navigation (one-off support).

- Recruited three Mental Health Leads to work in the City to facilitate new ways of working, organise local mental health networks, and facilitate improvement projects which align with local strategies and needs.

- Widely promoted the newly rebranded NHS Talking Therapies (previously known as Improving Access to Psychological Therapies).

- Worked on the development of a refreshed Dementia Strategy, the resulting actions of which were informed from a wide-scoping engagement activity undertaken by LLR commissioners with professionals, Age UK LeicesterShire and Rutland Dementia coproduction group, and during a Younger Onset Dementia event. Healthwatch Leicester and Leicestershire undertook a mixed-methods engagement exercise scoping 350 people. Consultation on the proposed strategy received 319 responses, with 91 being from the City.

- Collaborated with the voluntary and community enterprise sector (VCSE) to deliver a dementia forum, focussing on establishing connections between grass roots organisations and the council, helping to strengthen the relationships between services to better support people experiencing dementia. Examples include a smaller organisation delivering services funded by the dementia grant to people primarily in the African Caribbean community being able to link with the largest provider of dementia support services in the area to add an additional information offer to their service.

Healthy Ageing

Priority: "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."

We have…

- Supported the development of a framework for local delivery of anticipatory care (now called 'proactive care') through a designated project group.
  This framework is no longer up and running. Following recommendations that came out of the Fuller report, the focus of this work has shifted to work that is more preventative in nature.

- Worked on the development of the MyChoice directory to include voluntary sector preventative service, and community assets to reduce loneliness and isolation.
  Whilst there are no specific performance metrics that could be directly correlated with the MyChoice directory, MyChoice forms part of the information advice and guidance approach to managing demand on Adult Social Care. At the end of this financial year an increase in overall demand for support has been seen (2022/23 number of new requests for support 11,147 v 12,451 forecast 2023/24). Whilst promotion of the directory continues, and more organisations are being added all the time, there is no baseline in relation to the reduction of loneliness and isolation to enable robust comparisons. The future of MyChoice is being considered separately as there is now system investment into an alternative: The JOY platform.

- Supported the commissioning of a range of services and opportunities to provide alternatives to residential care.
  Numbers of admissions to residential nursing care have reduced with 286 permanent admissions 2022/23, v 275 forecast 2023/24
  Following a successful tender exercise at the end of 2022 the new Day Opportunities framework commenced 1st April 2023, with 10 providers across the following 6 service areas:

1. Older People
2. Learning Disabilities & Autism
3. Physical and Sensory disabilities, include acquired brain injury and other neurological conditions
4. People living with Dementia
5. Specialist Support for people with complex and multiple needs
6. Specialist support for people who are Deafblind

It is a 5 Year open Framework with the option to extend up to 2 further years. The framework can be reopened to attract more/new providers. The framework was co-produced and developed with key stakeholders including:

- People who use Day Opportunities, their families and carers
- Day Opportunity Providers

- Social Work Teams
- Integrated Care Board (NHS)
- Other ASC colleagues

Lot 5 - Specialist Support for people with complex and multiple needs was jointly commissioned with health – this is to ensure consistency of rates and provision across the health and social care market. Support is minimum of a 1:1 basis and an hourly rate is paid per person, per hour of support. It was agreed that health can make their own call offs from the providers on this lot for people who have Continuing Health Care funding. Due to the limited number of successful providers for Lots 2 & 5 a second Tender opportunity was advertised in Jan '23 and any additional provision to join the framework from 1st October 2023

During Feb – July 2023 a decision was made to extend the provision of short-term residential beds (initially to September 2023) – those beds were commissioned to provide a therapy led offer for LLR and whilst based in city care homes provided ten beds during this period to support system pressures (and ensured demand modelling of 25 beds for therapy led services was met). The remaining beds (15) procured under Lot 1 – D2A P2 Rehabilitate, Reable, Recover (RRR) therapy led P2 beds were mobilised successfully during that time period, reflecting a change in contract from the Sovereign unit ICB commissioned beds to ones which we commissioned on behalf of the system. That contract went live on 1 July for two years with an up to 24 -month option to extend.

- Undertaken commissioning reviews for: Homecare, to agree and implement a model of delivery for 2024; and carer support services.
  Homecare and carer support service commissioning reviews were both active between February and July 2023 and refreshed models were in the process of being developed with procurement exercises planned.

The remaining 13 priorities (the 'sponsor' and 'watch' priorities) are discussed further in the 'Looking forward' section of this report.

Core20PLUS5

Core20PLUS5[1] is the NHS framework for reducing healthcare inequalities by targeting services and support to those most at risk of experiencing healthcare inequalities. The Core20 refers to the 20% most deprived areas within a locality. '5' relates to five clinical areas which are linked to greater **health inequalities**. These are: Maternity; Severe mental illness (SMI); Chronic respiratory disease; Early cancer diagnosis; Hypertension case-finding and optimal management, and lipid optimal management. PLUS refers to groups identified locally as experiencing the poorest access, experience and outcomes with health and care services, regardless of their deprivation status or clinical needs.

In Leicester, the 'PLUS' groups which have been identified for initial focus are people experiencing homelessness, people with a learning disability, and people with severe mental illness. This is because these are the groups which are identified as having the lowest life expectancy, and poorer than average access to, and experience of, health and care service, and there is a clear need to address these issues. Across the health, care and wellbeing delivery plan, additional consideration is being given to how the unique needs of the identified plus groups can be considered and met to ensure that any activity is delivered adopting a proportionate universalism approach. The PLUS groups and the progress for these groups will be reviewed periodically.

Produce a Pharmaceutical Needs Assessment (PNA) for Leicester

The **Pharmaceutical Needs Assessment** (PNA) is used to understand the current and future pharmaceutical needs of people in Leicester, and whether they are being met by the community pharmacies. This information is used to help to make decisions about the planning and commissioning of pharmaceutical services and new pharmacy applications made to NHS England and NHS Improvement. It is a statutory requirement to complete a PNA every three years to assess the demography of the area and needs of different localities, sufficient choice of pharmaceutical services; surrounding areas, and future need.

Pharmaceutical services provided include:
Essential services**:** required in all pharmacies and include dispensing, disposal of unwanted medicines, discharge medicines, signposting, healthy lifestyle promotion and healthy living pharmacies.

Advanced services: optional nationally commissioned services including new medicines services, appliance use reviews, community pharmacist consultation service, stoma appliance customisation, hypertension case-finding, hepatitis C testing, seasonal influenza vaccination
Locally commissioned services: optional local services including emergency hormonal contraception, C-Card condom provision, needle exchange, supervised methadone consumption, palliative care and child influenza vaccination service. This is a valuable service for local residents to access services as an alternative to making a GP appointment.

[1] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

National Enhanced Services: such as Covid-19 vaccination service.

Leicester's most recent PNA was completed in 2022. This concluded that overall provision of essential and advanced pharmacy services is adequate for the population of Leicester, but that there are some differences in local provision across the city which may mean that some residents have to travel a little further to access a particular service outside of normal working hours. Recommendations were made for NHS England and NHS Improvement (and where relevant Leicester City Council and Leicester, Leicestershire and Rutland Integrated Care Board) focussing on three areas:

Equity of service

- 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

- 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).

Implications of community pharmacies policy

- 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.

Agree the Better Care Fund (BCF) submissions.

The **Better Care Fund (BCF)** is a programme which supports partners across the local system to deliver the integration of health and social care in a way that supports person-centred care, sustainability, and better outcomes for people and carers. It allows the NHS and Local Authority to pool funding to spend in ways which join up care more effectively. The BCF supports a range of services and schemes that contribute to the overarching vision of the Health and Wellbeing Board and the strategic priorities set out in the Joint Health, Care and Wellbeing Strategy and Delivery Plan. There is a well-established **place-based** infrastructure which supports the preparation and execution of the BCF plan. The Health and Wellbeing Board has a responsibility to approve the BCF submission to NHS England; the Joint Integrated commissioning Board has delegated authority from Leicester City Health and Wellbeing Board to develop BCF strategy and to sign off BCF plans, pending HWB sign-off; the Integrated Systems of Care board meets monthly to oversee operational delivery of BCF services and recommends any commissioning required to meet its objectives.

The BCF pooled budget for the period from April 2022 – March 2023 was £48,405,390, including the Improved BCF element (to support Local Authorities) and the Disabled Facilities Grant, which are received from central government via the BCF.
In addition to supporting core social care, community health, therapy and adaptations activity, the BCF funded the following key place-based services in 2022/23:

- Prevention support including services from local Voluntary and Community Organisations
- Care Navigation and coordination to support early help
- 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
- Housing support
- Support for mothers and young children with additional vulnerabilities

The Leicester BCF was refreshed in April 2023 in accordance with national guidelines.

2.5 Meetings of the Health and Wellbeing Board

During the period this report covers, the Health and Wellbeing Board held four formal Board meetings. Full agendas, minutes and webcasts of these meetings can be found on the **Leicester City Council Health and Wellbeing Board webpages**. Additional **development sessions** provided an opportunity for Board members, along with wider partners, to collaborate strategically and in greater depth ahead of discussions being brought to a formal Board meeting. Two development sessions were held during 2022 to progress the

development and implementation of the Joint Health, Care and Wellbeing Strategy. The first, in March, reviewed the feedback from engagement on the strategy and the proposed approach to progressing priorities. The second, in November, reviewed the detail of the health and wellbeing delivery action plan and considered appropriate governance arrangements in advance of it being brought to a formal Board meeting for final approval.

3. How we work

3.1 Working as a 'place' with our partners – changes to the system structure

2022 was a period of significant change to the structure of the systems which are in place to plan and deliver health and care services. **Clinical Commissioning Groups (CCGs**) which previously held this responsibility were replaced by **Integrated Care Systems (ICSs)** on July 1st 2022, bringing together partners with relevant knowledge and expertise from across the health and care system.

The ICS covers the whole of Leicester, Leicestershire and Rutland, also known as **'system-level',** which is important because many health and care services serve all three of those areas (for example, the hospitals). However, the uniquely different needs of each area within that system must also be considered if we are to be able to plan and deliver the right services to meet those needs. Residents in Leicester have vastly different health and care needs to those in Leicestershire and Rutland, and it is critical that those needs are addressed within the context of the wider ICS. Leicester, Leicestershire and Rutland are individually referred to as '**places**' – each have their own Health and Wellbeing Board, which is the place board for supporting health and wellbeing for that locality. The Health and Wellbeing boards bring together partners from across the health and care system within the individual 'places' to ensure that decisions relating to health and care services meet the needs identified at place level, whilst also feeding into the wider ICS.

3.1.1 Other 'place' level Health and Wellbeing Board partnership boards

Mental Health Partnership Board

The Mental Health Partnership Board brings together various partners including health, social care, the voluntary sector, employment services, housing and the police. The board is also attended by people with lived experience of mental illness and by carers.
From January 2022 to June 2023, there have been nine occurrences of the Mental Health Partnership Board. The Board has driven forward actions on the **Leicester City Joint Integrated Commissioning Strategy for Adult Mental Health 2021-25.** The strategy has three key priorities: Prevention, Accommodation and Education, Employment & Volunteering.
As part of the development of mental health collaboratives at system and place level, the Mental Health Partnership Board has taken on the role of the place-based board for mental health in Leicester City. To facilitate this change in a collaborative way, the October 2022 meeting included a workshop where partners were invited to comment on how the Mental Health Partnership Board could be adapted to take on the function of the place-based board. Since this workshop, recommendations have been implemented to establish the Mental Health Partnership Board in its new role. This includes improvement of accountability, representation and making the best use of data at the Board, as well as increasing the frequency.

The Mental Health Partnership Board has worked to influence key developments, ensuring that they are delivered in line with local priorities and need. This includes the expansion of **Neighbourhood** Mental Health Cafés, the rollout of Getting Help in Neighbourhoods grant funding and support for carers.
The Board has also responded to concerns raised by people with lived experience of mental ill health, for example, by encouraging engagement of Board members with Leicester City Council's Fuel Poverty Project.

Learning Disabilities Partnership Board (LDPB)

The **LDPB** meets four times a year and its purpose is to influence developments in the city that can make a difference to people with learning disabilities and their family carers. We organise our work around key priorities that people with learning disabilities and their families have told us are important. These priorities are captured in our coproduced joint health and social care strategy for Leicester City which we refer to as our Learning Disability Big Plan. This plan has just been extended for a further two years until 2026; during this next couple of years, the focus will be on three main themes which are: addressing health inequalities, support for our carers and work, college and money with an emphasis on supporting employment opportunities for people with a learning disability. The LDPB and its membership, which is made up of people with learning disabilities, carers, representatives of health, social care and other statutory partners like the police and the Department for Work and Pension, as well as our voluntary and community sector, work together to deliver on the actions in the Big Plan. A summary of what has been achieved over the last three years of the Big Plan is available on Leicester City Council's website.

The board also provides an effective way of making sure the voices of people with learning disabilities and families are heard in all our strategic forums, particularly as move towards integration through our formal collaboratives. One of the first Collaboratives to be launched in Leicester, Leicestershire and Rutland (LLR) was the learning disability and autism collaborative (LDA); underpinning the work we do together as a partnership is our coproduced vision which is that we want:

- everyone to be able to have good, happy lives.
- everyone to be as healthy as they can be
- to make sure everyone has the chance to the things that make them happy and join in with things.
- to make sure everyone has the chance to do the things that make them happy close to where they live
- to make sure everyone has the chance to do the things that make them happy with people they want to spend time with.

In terms of how we make sure our shared vision becomes a reality for people with learning disabilities, work has been done to align our Big Plan objectives with those of the Collaborative. Whilst the Collaborative structure supports the delivery of our key priorities at system level, leadership and delivery at place continues to be provided by the LDPB, building on the strength of coproduction, participation and engagement that exists within the board. The LDPB through its existing governance will, in turn, continue to report to the Health and Wellbeing Board, ensuring we have a joined-up place-based approach to address inequalities for those with learning disabilities in Leicester City.

Joint Integrated Commissioning Board (JICB)

The Joint Integrated Commissioning Board (JICB) is an operational group reporting to the Health and Wellbeing Board. Membership of the JICB includes senior managers from Adult Social Care, Children and Young People's Services, Public Health and Housing within the local authority as well as senior manages and governing body members from Leicester, Leicestershire & Rutland Integrated Care Board (ICB).

The Health and Wellbeing Board has worked collaboratively with JICB during 2023 on the development and delivery of priorities within the Health Care & Wellbeing Delivery Plan for Leicester, following a refresh of the Health and Wellbeing Strategy during 2022.
The JICB has provided an opportunity for senior leaders to gain a shared understanding of the pressures and responsibilities on each of the partners which throughout 2023, have ranged from the Adult Social Care Reforms programme, Care Quality Commission Assurance through to the recommendations for Integrated Care Systems arising from the NHS England's commissioned Fuller Stocktake Report as well as local **Anti-Poverty** and **Fuel Poverty** strategies.

The JICB has overseen the joint commissioning arrangements for both homecare and discharge to assess workstreams across adult social care and the ICB and has also retained its governance role as part of the BCF. In partnership with the Integrated Systems of Care (ISOC) group, it continues to agree funding allocations, monitor progress and approve statutory returns to central government.

3.2 Public accountability

The agenda for each Board meeting is published on the Leicester City Council website five clear days before the meeting. All meetings are webcast (live) and can be viewed via the link on the website which will be published alongside the agenda.
Minutes from each meeting are published on the website after the meeting (usually within 14 days of the meeting), along with a link to the recording of the webcast, meaning it can be viewed at any point after the meeting as well as live on the day.
Health and Wellbeing Board meetings are **meetings held in public**. There is a public gallery area at all meetings and members of the public are welcome to view the meeting from the public gallery area. Members of the public are also able to submit questions in advance of the meetings to raise general matters of health concerns at a Health and Wellbeing Board meeting, and these will be addressed during the meeting.

3.3 Communications and engagement

Community engagement

Engagement with the community is one of the core functions of the Health and Wellbeing Board, and there has been a range of communication and engagement activity over the period covered by this report, including:

<u>Pharmaceutical Needs Assessment</u>
The process of completing the PNA includes asking for the views of people who use pharmaceutical services in Leicester. A public questionnaire was published to gain views on service provision, including the quality, location, opening hours and accessibility of services. 11

people responded, with 84% of respondents agreeing that their pharmacy provides a good service.

Joint Local Health and Wellbeing Strategy

A range of engagement took place to consider the proposed draft priorities and do, sponsor, watch approach. This included an online consultation which took place over a period of eight weeks, supported by an easy read version, a social media campaign, radio promotion, and promotion of the consultation and feedback through a wide range of stakeholder groups meetings. 213 responses were received, with 66% of responses coming from members of the public or representatives of community organisations, and 84% of responses being from Leicester City residents. 62% of respondents agreed that the right priorities had been identified with a further 30% partially agreeing, and only 5% disagreeing.

Community Wellbeing Champions

The Community Wellbeing Champions (CWC) project was set up in light of the Covid-19 pandemic to increase Public Health's engagement with communities, especially those worse affected by health inequalities, and the organisations that support them. The purpose of the project is to help Public Health be more effective in (a) reaching people with health messages and services, and (b) gaining quality insight into the needs of different communities and the barriers they face in having those needs met.

To do this, the project has set up a network of Community Wellbeing Champions to help with reaching underheard and underserved groups and areas across the city. The 'Champions' are organisations and individuals that promote and support people's physical and mental health and wellbeing at a community level. This includes VCSE, faith, and other organisations such as sports clubs and businesses, trusted community figures, volunteers, and professionals.
The project supports communication, information-sharing, networking, and collaboration across partners for greater collective impact on strategic priorities and health inequalities Leicester. By working with and through the Champions, Public Health can engage with communities in a more coordinated, timely, and effective way on important health and wellbeing issues, and connect with residents that we might not otherwise reach. The CWC project also seeks to increase Public Health's presence and profile in communities through more direct engagement with residents at local health and wellbeing events, to help build confidence and trust in Public Health guidance and services.

The impact of the CWC project so far has been to help build closer working relationships between Public Health and VCSE and other community organisations, and to increase engagement with underheard and underserved communities, both directly and with the help of the Champions. The insight and learning from communities about their health, wellbeing, support, and communication needs has in turn helped to shape Public Health practice. Finally, the creation of the Leicester CWC Network has helped to strengthen the local authority's crisis response infrastructure, as seen with how engagement with and support for community organisations was mobilised in response to the cost-of-living crisis.

Case study
In autumn 2022, while the city was still recovering from the impact of the Covid-19 pandemic, the rapid increase in the cost of living presented another crisis for residents and the council set up an Incident Management Team (IMT) to coordinate its response. Recognising that the increased cost of utilities and other necessities would not just affect

residents but the community organisations upon which they relied as well, Public Health was tasked with mobilising engagement with VCSE and other organisations through the Leicester Community Wellbeing Champions Network. The CWC Team immediately set up a range of engagement channels to provide flexible ways for community organisations to inform the council about the impact of the increased cost of living on them, their workforce (staff and volunteers), and the people that access their services, so that the council could identify and respond to risks and issues as they emerged. Through this, qualitative insight was gained into, and support was provided for, a range of cost-of-living concerns for local organisations and their communities.

Healthwatch

Healthwatch are an organisation who are independent from the health and social care system, whose role is to represent the voice of local people to ensure that their experiences of health and social care services are both heard and used to shape future improvements. Health and Wellbeing Boards have a statutory requirement to include Healthwatch in the membership, providing a unique opportunity for Healthwatch to ensure that the views of local people are built into the statutory functions carried out by the Health and Wellbeing Board.
During 2022-23 Healthwatch Leicester and Healthwatch Leicestershire published 20 reports, some of which are LLR-wide, relating to improvements that local people highlighted as being needed to improve their local health and care systems. They engaged with people from across a range of different communities including the deaf community, Somali women, Bangladeshi and Pakistani communities, people living with Dementia, Polish communities, asylum seekers and refugees.

Case studies

Vaccine hesitancy

"With the COVID-19 pandemic disproportionately impacting Bangladeshi and Pakistani communities and vaccination uptake remaining consistently low, we reached out to communities in Leicester to hear their experiences.

We were able to explore unexpected insights that arose during our conversations, including how these communities communicated with each other to share health messages during the pandemic. People told us that there is a lack of literature in the media, local GPs, dentists and hospitals in other languages for example; Urdu, Bengali and Gujarati.

The findings have been shared with service providers to help improve future communications."

Emergency Department (ED) at Leicester Royal Infirmary (LRI)

"Waiting times are a growing concern for people. Based on what people told us about their experiences of using the Emergency Department (ED) we conducted an Enter & View visit in September 2022.

The patient feedback we received gave high praise for the medical staff and treatment once seen. However, patients are sharing increasing struggles of, generally, navigating emergency care systems and, specifically, their difficulties with LRI ED processes and environment.

University Hospitals of Leicester NHS Trust has welcomed the patient and public feedback on the ED and is looking at where further improvements can be made based on the recommendations in our report."

During the period covered by this report the contract term for Healthwatch with their previous provider came to an end. From April 2023, following competitive procurement undertaken by Social Care and Education, the contract was awarded to Voluntary Action LeicesterShire and contract management responsibility transferred to the Public Health Team. Healthwatch will continue to fulfil their role in independently representing the views of the local population. Healthwatch publish outcomes from all of their engagement work, as well as their future planned activity on the Healthwatch Leicester and Healthwatch Leicestershire website.

4. Achievements, challenges, and opportunities in 2022-23

Achievements

Good progress has been made across all six of the priorities which are covered by the Health and Wellbeing Delivery Action Plan, as summarised in section 2.4 of this report. Further work will now take place to identify proxy measures to enable the impact of the activity to be demonstrated. In addition to this progress the Health and Wellbeing Board has been influential in the development of other initiatives to improve health and wellbeing for people more at risk of health inequalities. For example:

Project Search

The Head Teacher of Ellesmere College presented to the Board in October 2021 on an initiative called Project Search, which aims to bring people with learning difficulties into paid employment. As a result, University Hospitals Leicester (UHL) took up the opportunity to be involved in the project and a successful event was held at UHL, enabling students to work at UHL on a supported internship. Employment provides many benefits for people with learning difficulties, including economic benefit, social support, and increased wellbeing, and the Board were delighted to have been able to facilitate progression of this project.

Voluntary, Community or Social Enterprise (VCSE) associate network

A presentation at the March 2023 Health and Wellbeing board meeting from Jamila's Legacy, a local charitable organisation aiming to normalise mental health conversations by supporting and education communities, highlighted the huge emotional investment that people working in voluntary services supporting mental health give to their roles, often with limited support to manage their own resilience. First steps have been taken to consider the needs of this specific group of voluntary service workers with a view to developing an associate network bringing together resources and services available to support volunteers own mental health and resilience.

Housing and complex tenants

A presentation was brought to the Board by Leicester City Council's Director of Housing in January 2023 setting out the increasing challenge of helping complex applicants and tenants, in particular those experiencing homelessness or vulnerable new tenants, and the importance of health in managing this, whilst also outlining a greater need for Housing and Health to work closely to ensure that health service pathways are accessible and timely for tenants with

complexities. Board members were asked to note the increasing challenges faced by Housing in supporting these tenants, and a request to:

- Support the opportunity for Health services to collaborate with Housing on bids to both the Supported Housing fund (£300m) and also the Single Homeless Accommodation Programme (£300m) with a drive to achieve more suitable accommodation for people with complex needs, and wrap around and health pathways to meet differing complex needs.
- Support the need to jointly review the current health pathways for Homeless/Rough Sleepers to core/key service provision utilising the new Public Health needs assessment to identify which are key services/areas.

As a result, a task and finish group was set up comprising partners from across the health and care system and voluntary sector to address the specific issues highlighted to the Board. One of the actions arising from this group was to produce a JSNA chapter around homelessness to look at current and future needs of this population; this is currently in progress.

Additionally, Housing have accessed funding from the Department of Health through the Recovery Housing Support Grant to provide specialist floating support and develop supported accommodation for council tenants with dual diagnosis and complex needs. This was a collaborative bid with Public Health and Housing to address the housing-related support needs of individuals with problematic substance use, and to increase the number of people accessing recovery services in the city.

Furthermore, the Council, in conjunction with Action Homeless East Midlands Housing, were successful in securing £725k in capital funding and £1.045m from the Single Homelessness Accommodation Programme (SHAP) in revenue funding to deliver 18 housing units to support complex people going through the homelessness pathway. Unfortunately, Government ultimately decided not to finalise the arrangements or fund for the Supported Housing Fund, and this was withdrawn.

Challenges

It would be remiss not to reference some of the challenges which have been experienced during the reporting period, and the collective effort of the organisations represented on the Board to tackle them.

Post-COVID recovery is ongoing and whilst the significant pressure which was placed across the whole health and social care system in the thick of the pandemic has eased, many services are still experiencing the strain of working through backlogs, or managing new health and social care needs which have arisen directly as a result of COVID. A special winter-themed Health and Wellbeing Board was held in March 2023 to outline the innovative services which health and social care services continued to deliver during the winter of 2022, when pressure on health and social care systems was high, highlighting our ability to achieve more across the system when working in true partnership. The full minutes from that meeting can be found on the Health and Wellbeing Board web pages and include details of:

- Delivery of the NHS winter plan, focussing on 20 key actions the city which were anticipated to make a difference to individuals, communities and staff groups working across the health system.

- Development of an Integrated Crisis Response Service across health and care to ensure people who do not need an acute service are able to be safely cared for at home instead, removing pressures on emergency care, including a falls response service.
- Development and use of virtual wards, enabling patients who wish to, and are able to, be looked after within their own home with to do so with digital or technological support from wraparound services and empowering them to use those technologies.
- LLR unscheduled care hub to support and provide the most appropriate care for patients contacting the ambulance service by bringing together a range of health and care providers to carry out a multi-disciplinary assessment to assess what is right for the patient *with* the patient and their carer/family, and provide that to the patient in their home where appropriate.
- Supporting discharge by facilitating wider needs to enable patients to return home into a safe environment when this is otherwise preventing them from being discharged from hospital.
- Provision of night-time care at home through adult social care services to support hospital discharges, enabling patients to recover at home with the right support in place.
- Supporting out of hours working in the independent sector to support the discharge process.
- A carers grant scheme to support carers with expenses incurred by taking care of a family member who has been discharged from care and needs to be supported by family.

Leicester, like the rest of the country, has felt the impact of the increased costs of living, and particularly the increases in the cost of fuel, which risked plunging a significant proportion of the population into poverty. The Local Authority, along with partners from across the health and social care system and the VCSE, were quick to take action. An Incident Management Team was mobilised along with a range of additional cells with specialist remit to address specific areas in a coordinated, efficient manner. A ”no wrong door” approach was adopted to ensure that no matter where our residents presented for help they were able to get the support they needed from whichever service they approached.

In addition, in response to the rapidly increasing levels of fuel poverty in the city as a result of steeply rising fuel prices, the ICB were able to provide funding which enabled a programme to be developed with National Energy Advice, recruiting energy advisors to work across communities in the city providing education, training and advice to individuals, communities and staff across various sectors. This programme will be independently evaluated to establish numbers reached and impact.

Across the health and social care system, organisations have increasingly been faced with reduced budgets and the necessity to make tough decisions about how to spend money in ways that bring the most benefit to the residents of Leicester. This will continue to challenge us into 2024 and beyond, and will require us to act innovatively, continuing the strong ethos of working in partnership to achieve more together.

5. Looking forward

At the annual council meeting in May 2023, and following the local elections, the City Mayor announced some changes to the portfolio areas held by his Executive Team. A new Chair for the Health and Wellbeing board – Cllr Sarah Russell - was announced, bringing with her some changes to the Elected members representing the Health and Wellbeing Board.

There will be six Health and Wellbeing Board meetings held in public during 2023/24, an increase from four in previous years. Some of these meetings will have a focussed theme to ensure opportunities for fuller consideration of issues impacting specific areas or groups on a periodic basis. As part of the Board's commitment to continuous improvement of the health, care and wellbeing of Leicester's residents, there will be occasions when a particular area needs to be explored in greater depth before being brought to a formal Board meeting. In these instances, the Board may hold a development session.

There is no intention to further refresh the Joint Health, Care and Wellbeing Strategy before 2027 unless there is a need identified. The Health and Wellbeing Board looks forward to continued partnership working across the system, building further on the outcomes already achieved, and driven by the Joint Health, Care and Wellbeing Strategy and associated delivery action plan. The first phase of this work has focussed on the initial six 'do' priorities, and future phases of the work will consider how progress towards the 'sponsor' and 'watch' priorities can be built into the current reporting structure. Further work will go into considering how to measure success in delivering the action plan.

There are plans to refresh and update chapters of the Joint Strategic Needs Assessment, and all updated or new chapters will be published on the Leicester City Council website.
The change in system structure to an Integrated Care System has given rise to consideration of how the Health and Wellbeing Board operates as a place-based board, collaboratively with the partners and stakeholders who feed into, and out of, the Board. This has presented an opportunity to review the current form and function of the Health and Wellbeing Board and its subgroups, with a view to further strengthening partnerships and what the Board is able to achieve. This work will be ongoing into 2023-24.

The Board will continue to adopt a proportionate universalism approach to ensure that fair focus is able to be given to the issues which have the greatest impact on people's ability to remain in good health and wellbeing for as long as possible. To support this, a number of further JSNA chapters providing are either in development or planned outlining key health and wellbeing issues affecting city residents.

Glossary and links to further information

Anti-Poverty - Anti-poverty strategy (leicester.gov.uk)

Better Care Fund (BCF) – Supports local systems to deliver the integration of health and social care through collaborating with the Department of Health, Ministry of Housing Communities and Local Government, NHS England and Improvement, and the local government association. NHS England » Better Care Fund

Clinical Commissioning Groups (CCG's) – CCG's were clinically-led statutory NHS bodies who held responsibility for planning and commissioning of healthcare services in their local area. They were replaced by Integrated Care Systems in July 2022.

Core20PLUS5 – NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

Development sessions (of the Health and Wellbeing Board) – Development sessions are opportunities for members of the Health and Wellbeing Board and, where appropriate, wider partners to come together to consider an issue in detail before bringing to a formal board meeting. They are not held in public.

Do, sponsor, watch – An approach to addressing the priorities set out in the Joint Local Health and Wellbeing Strategy which recognises that the same level of resource and effort cannot be focussed on all 19 priorities simultaneously. This approach gives more intensive focus on a small number of 'Do' priorities (those agreed by the Health and Wellbeing Board as the most important to progress in initial years), whilst ensuring some level of focus on *all* priorities identified, with opportunity for any risk to progress of 'sponsor' and 'watch' priorities to be escalated through reporting to place-based groups.

Equity – this means "fairness" – in health and wellbeing it means that in order to achieve good outcomes for everyone recognising that not everyone is starting from the same place, and that adjustments need to be made to ensure that everyone can achieve their full potential for good health and wellbeing. We sometimes use the term **health equity**, which means the absence of unfair, avoidable, or remediable differences in health among population groups defined socially, economically, demographically, or geographically.

Fuel Poverty – a household is considered to be experiencing fuel poverty when they spend 10% or more of their income on energy. More information can be found at What is fuel poverty? - National Energy Action (NEA)

Health and Social Care Act 2012 – The Health and Social Care Act 2012 introduced a number of reforms to the NHS including the establishment of Health and Wellbeing Boards to bring together partners from across health and social care services to plan how to meet the health and care needs of their local populations.

Health and Wellbeing Board meetings – Health and Wellbeing Board (leicester.gov.uk)

Health inequalities – health inequalities are the unfair, avoidable and systematic differences in health and wellbeing between different populations or groups.

Healthwatch Leicester and Healthwatch Leicestershire - An independent watchdog which aims to make local health and social care services better for people by ensuring that their views and experiences are considered by those entrusted to design and run services. It is independent of the CQC/ NHS and is ran by and for local people. They have a statutory place on local Health and Wellbeing Boards and have the authority to enter and view health and social care services using their trained volunteers. HealthwatchLL - Healthwatch LL

Integrated Care Systems (ICS's) – Integrated Care Systems were established in 2022. They are Partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners. They collectively plan health and care services to meet the needs of their population. In the LLR region this is currently a system partnership between the three statutory organisations with their respective legislative roles. More information about how ICS's are structured and operate can be found at NHS England » What are integrated care systems?

Joint Local Health and Wellbeing Strategy (JLHWS)– Leicester's Care, Health and Wellbeing Strategy 2022-2027

Joint Strategic Needs Assessment/Joint Specific Needs Assessment (JSNA/JSpNA) – Analyse the health needs of populations. The purpose of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages. It should be viewed as a continuous process of strategic assessment and planning with the aim to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Joint Strategic Needs Assessment (leicester.gov.uk)

Learning Disability Partnership Board (LDPB) - Learning Disability Partnership Board (leicester.gov.uk)

Leicester City Joint Integrated Commissioning Strategy for Adult Mental Health 2021-25 - Mental Health BOOKLET8a (leicester.gov.uk)

Meetings held in public – these are meetings which members of the public are able to attend and observe. Members are the public are not permitted to join in any discussions at Health and Wellbeing Board meetings but are allowed to submit questions in advance of the meeting in line with statutory guidance, which will be asked and discussed during the meeting.

Person-centred care – this means making sure care is focussed on the needs of the individual.

Place-based/Place/System (and neighbourhood) – System, Place and Neighbourhood refer to geographical areas. **System** covers populations off around 500,000 – 3 millions. In this report System means Leicester, Leicestershire and Rutland. **Place** covers populations of around 250,000-500,000. In this report, Place means Leicester city). **Neighbourhoods** cover smaller populations of around 30,000 to 50,000 people. In this report **Place-based** means thinking about the local need for Leicester. **Place-based** partnerships bring together a broad range of partners including local government, NHS providers, voluntary/community sector organisations, social care providers and others in order to integrate the planning and delivery

of services through a multi-agency approach and address the social, economic and wider health needs of their population.

Pharmaceutical Needs Assessment (PNA) – A legal requirement for Health and Wellbeing Boards to produce every three years. It is a statement of needs from pharmacy services in the local area and is designed to ensure provision of local pharmaceutical services is effective for the needs of the local population. It can be used to direct commissioning decisions by CCGs and help NHS England in regulating new and existing pharmaceutical practice. Pharmaceutical Needs Assessment (PNA) (leicester.gov.uk)

LEICESTER CITY HEALTH AND WELLBEING BOARD
27 JUNE 2024

Subject:	Black Mental Health and Me
Presented to the Health and Wellbeing Board by:	Mark Wheatley, Public Health, Leicester City Council A representative from African Heritage Alliance
Author:	Momodou Sallah De Montfort University Brian Simmonds African Heritage Alliance

EXECUTIVE SUMMARY:

"I struggle to access mental health services because of my African heritage; the Black community does not have organisations catering to their mental health service; I feel uncomfortable accessing mental health services from the general avenue".

These words, from a participant in the 2023 Black Mental Health and Me consultation, give pause for thought. Almost 20 years on from the NHS initiative, Delivering Race Equality in Mental Health (DRE), there is much to be done to engage with local communities, to deliver appropriate and responsive mental health services.

Leicester City Council Division of Public Health worked with African Heritage Alliance to support an initiative to explore key areas related to black mental health in Leicester. Funding for the project was approved by Public Health Divisional Management Team and Lead Member.

Past initiatives, such as DRE, suggested that people from minority ethnic backgrounds are more likely to be compulsorily detained, to be treated in hospital, to be subject to measures like seclusion and to encounter health services through the criminal justice system.

The Black Mental Health and Me report shows that these issues continue to deter some people from Black/Black British ethnic backgrounds from seeking support early in their illness. It highlights the following themes:

- Positive and negative experiences of engagement with mental health services
- Challenges with mental health services
- Effectiveness of handling issues of diversity and inclusion.

This report is timely, the NHS Patient and Carer Race Equality Framework was launched in November 2023, and its adoption by providers will be mandatory by the end of 2024-25.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

Encourage commissioners, providers and organisations linked to mental health care, to consider and promote the implementation of the recommendations of Black Mental Health and Me. These are summarised on page 11 and described, along with the findings, in section 4. They include:

- To develop and deliver a pilot programme to promote mental wellbeing for people from African Heritage backgrounds.
- To prevent mental health problems though tailored provision for people from African Heritage backgrounds.
- To build capacity for those delivering mental health care to people from African Heritage backgrounds.
- To raise awareness of black mental health in Leicester.
- To develop and employ a black mental health engagement lead.

African Heritage Alliance

BMHM

BLACK MENTAL HEALTH AND ME

Black Mental Health Report for Leicester City Council

REPORT
OCTOBER 2023

Author : Momodou Sallah

Leicester City Council

SUBJECT: REPORT ON THE BLACK MENTAL HEALTH AND ME RESEARCH PROJECT

OCTOBER 2023

African Heritage Alliance (AHA) Committee Members,

I am writing to provide you with a comprehensive report on the Black Mental Health and Me research project, as conducted by First Contact 2.0. The project aimed to explore key areas related to black mental health engagement process which, including communication, finances, and timelines. Below, I will highlight the key findings and outcomes of the project, both positive and negative.

Key Areas Explored

a) Black Mental Health Awareness on engagement: The project successfully raised awareness about black mental health issues within the community and encouraged conversations surrounding mental well-being.

b) Community Engagement: Extensive community engagement initiatives were undertaken, including focus groups, questionnaire, and outreach events. These activities facilitated meaningful participation and gathered valuable insights.

c) Research Methodology: Rigorous research methodologies, including quantitative and qualitative approaches, were employed to gather comprehensive data and ensure the validity and reliability of the findings.

d) Partnerships: Collaborative partnerships were established with local mental black organizations, healthcare providers, and community leaders, enabling a multi-stakeholder approach to addressing black mental health concerns.

Positive Outcomes

a) Increased Awareness: The project successfully increased awareness about the unique mental health challenges faced by the black community, thereby reducing stigma and promoting mental well-being.

b) Empowerment: Through various workshops and educational programs, individuals were empowered with knowledge and tools to recognize and address mental health concerns effectively.

c) Community Support Networks: The project facilitated the development of support networks and resources within the community, ensuring individuals had access to culturally sensitive mental health services.

d) Policy Recommendations: Based on the research findings, the project provided evidence-based policy recommendations to address systemic issues and disparities in black mental health care.

Challenges and Areas for Improvement

a) Limited Funding: The project faced financial constraints, which limited the scale and scope of some activities. Additional funding opportunities should be explored to expand the project's impact.

b) Recruitment and Retention: Engaging participants for long-term Programproved challenging due to various factors, such as time constraints and distrust of research initiatives. Strategies for improving participant recruitment and retention should be considered in future projects.

c) Time Management: The project experienced delays in certain phases, mainly due to unforeseen circumstances and logistical challenges. Implementing robust project management techniques and contingency plans could mitigate such issues in future endeavours.

Communication

a) Stakeholder Engagement: Regular communication with stakeholders, including community members, organizational partners, and researchers, played a vital role in ensuring project success.

b) Dissemination of Findings: The project actively shared research findings through various mediums, such as community forums, academic publications, and online platforms, to maximize the impact and reach of the project.

Finances

a) Budget Allocation: A detailed budget wasn't developed at the project's outset, allocating funds to research activities, community engagement initiatives, staffing, and overhead costs.

b) Financial Accountability: Financial records were maintained meticulously, adhering to organizational policies and guidelines.

Timelines

a) Project Phases: The project was divided into distinct phases 1 & 2, each with predefined timelines and deliverables.

b) Milestone Achievements: Milestones were achieved within the projected timelines, ensuring the project progressed smoothly. However, certain unforeseen circumstances caused delays in specific stages to extended.

In conclusion, the Black Mental Health and Me research project has made significant strides in addressing black mental health concerns within the community. The project successfully raised awareness, fostered community engagement, and provided evidence-based recommendations for policy improvements. While facing challenges related to funding, recruitment, and time management, the project has learned valuable lessons that can guide future initiatives.

We express our gratitude to AHA for their support throughout the project, and we remain committed to furthering our efforts to improve black mental health outcomes. We welcome any feedback, recommendations, or questions you may have concerned the report or the project.

Thank you for your attention and continued collaboration.

BRIAN SIMMONDS

First Contact 2.0

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Acknowledgment

We would like to express our sincere appreciation to the management of AHA (African Heritage Alliance), particularly Amanda Toussaint and Chizor Onwuegbute, the AHA Health Stream lead, for their invaluable contributions to this project commissioned by the Leicester City Council. A special note of gratitude goes to Brian Simmonds from the Black Mental Health & Me team for his exceptional conceptualization and leadership throughout the project. We would also like to extend our thanks to Jenaitre Farquharson, Anthony Francis, and Selena Kabengele for their dedicated efforts in participant recruitment, as well as their support during the focus groups and outreach program. Furthermore, we are immensely grateful for the vital research support provided by Dr. Sainabou Taal and Dr. John Asu, whose contributions played a crucial role in the success of the research project. We extend our deepest gratitude to all the remarkable community hub organisations: Tara Munroe of Opal22, Pawlet Brooke of Serendipity,Gerry Burke of Highfield Rangers FC, Marcia Brown of African Caribbean Centre and all participants who generously dedicated their time to engage in the focus groups; your insights and active participation were invaluable to the research project. Lastly, we would like to express our thanks to the Leicester Black community for their cooperation in completing the questionnaires and participation with the outreach Programwhich allowed us to gain further insights into this significant endeavour Leicester Black Mental Health & Me.

01 Executive Summary

1.1: The Problem

NHS England (2023) estimates that one in four adults experience mental illness and the Mental Health Foundation report that more than 4 million people have mental health problems which positions the issue of mental illness as central to a substantial number of people in England. The issue of how race/ethnicity plays into this is seen in the poor treatment Black mental health patients are said to have received when accessing services in England in general, and Leicester in this particular research project. For example, Black people are four times more likely to be detained under the Mental Health Act than their White counterparts and African Caribbean people are 3 to 5 times more likely than any other group to be diagnosed and admitted for more severe Mental health illness. Previous research has attributed these to racism, discrimination, and socio-economic factors (Mental Health Act Commission 2006; Keating 2007), in addition to a lack of understanding of their distinctive needs.

The Leicester City PCT (2008) has estimated that 60,000 people at any one time are affected by mental health issues and it also states that people from deprived areas are 1.7 times more likely to be registered with mental health. Other studies in Leicester have also identified a range of factors including having less equitable access to Community Mental Health Teams, over-representation of Black people in psychiatric inpatient facilities and underrepresentation in therapeutic approaches, as discriminatory undertones that impinge negatively on Black mental health patients' lives (Raghavan and Griffin 2014; Leicester City Council 2015).However, the report to the Scrutiny Commission on 'Mental Health Services for Black/Black British Young Men in Leicester' in 2015 and research by Raghavan and Griffin (2014) both decried the dearth of empirical data in relation to Black people and mental health in Leicester. This research project starts from the position that the "lived experiences" of Black people and their experiences of engagement with mental health services is often removed from mainstream narratives; it therefore seeks to redress this gap.
The research shows therefore that a bespoke approach to black metal health is essential in order to cater to the specific needs of those from the African heritage community. To this effect the African Heritage Alliance are making the following recommendations to enhance the service provision here in Leicester.

1.2: This research

This research project seeks to explore the lived experiences of Black people in Leicester around mental health; it departs from a phenomenological positionality solely, which is a method used in qualitative research, to study and understand human experiences as they are lived and perceived by individuals, without imposing theoretical frameworks or preconceived notions onto them. Instead, it was preoccupied with how Black people have experienced mental health services in Leicester and their perception in relation to positive experiences, negative experiences, challenges, perception of effective inclusivity and diversity, as well as recommendations.

The constructivist approach on the other hand is a theoretical framework. It suggests that individuals actively construct their understanding of the world and reality through their experiences, interactions, and interpretations, constructivism emphasises the role of the learner as an active participant in the learning process. Using a constructivist approach and an opportunity sampling, five focus groups made up of 31 Black people between the ages of 18- 63 were conducted based on the following categories: Women Focus Group, Men's Focus Group, Young People's Focus Group, Professional Focus Group, and Lived Experience Focus Group, which were manually analysed and presented under the following themes: positive and negative experiences of engagement with mental health services; challenges with mental health services; and effectiveness of handling issues of diversity and inclusion. This is then followed by recommendations.

1.3: Findings

The findings in this research gives the reader novel and critical insights into the lived experiences of Black people and their engagement in Leicester; it significantly contributes to new ways of understanding the Black mental health experience in Leicester in particular, and England in general. Across all the five focus groups composed of 31 individuals between the ages of 18- 63, about 30 percent of respondents recounted some element of positive experience with their GPs as first point of contact, especially in relation to being signposted to other relevant services or to access CBT (Cognitive behavioural therapy). However, the vast majority of respondents (about 70%) recounted having episodes of negative experiences ranging from inappropriate and culturally incompetent encounters with their GPs, to a perception of being constantly offered medication over therapy, having to engage with an already over-stretched mental health service that they are not able to access at the point of urgent need and often only available at "crisis point" or when things reach "richter scale". There were also narratives articulated by respondents that there appears to be disproportionate use of force in relation to Black people and mental health, and being sectioned or involving the Police.

Concerning challenges, it was constantly raised across all the focus groups that there were no services within the public and private sectors that adequately catered for the specific needs of Black people in Leicester. The late Pam Campbell and her sterling work with Akwaaba Ayeh (a Black led organisation that ran for 30 years and closed due to loss of funding) were consistently mentioned as an example of a great practice that responded to the genuine needs of Black people. The issue of racism, both at the individual and institutional levels, were painfully raised with a respondent giving two clear examples that led to fatalities. The lack of representation of Black people as professionals within the service, lack of cultural situatedness and understanding of Black people's constructed realities and a service that "don't understand us" was repeatedly raised. In relation to diversity and inclusivity, it was also raised that this needs significant improvement, not only in terms of staff representation but also in terms of food, entertainment, Christmas pantomimes, music choices, and the availability of cultural products in mental health facilities.

1.4: Implications and way forward

The strength of this research lies in its significant ability to contribute to a much greater understanding of the Black "lived experience" in relation to mental health services in England in general and Leicester in particular. It points to significant gaps in the provision of mental health services in relation to perceived racial discrimination both at the individual and institutional levels, lack of representation of Black staff within the services where they are over-represented, use of medication over therapy, disproportionate use of force and other associated defects in the engagement of Black people in the mental health services. The recommendations for the public, voluntary and private sectors will go a long way in redressing the imbalance towards a more culturally relevant and effective service for Black people in Leicester.

1.5: Recommendations

a) Prevention through tailored provision

The case and the research are clear, as it is with all health matters, prevention is better than cure. There is a need to ensure that those in the black community are supported to remain mentally healthy through a series of activities and offerings that are culturally appropriate and speak to the specific challenges faced. This could be achieved via utilising the Five Ways to Wellbeing (New Economic Foundation); Connect with other people, be physically active, learn new skills, give to others, and pay attention to the present moment (mindfulness).

A programme of workshops, events, outings, and learning experiences would be devised that speaks to the various audiences of women, men, LGBTQ+ community, young people and intergenerational groups. There would be provision touching each of the five factors and these would have a social, cultural, and therapeutic aspect to each.

b) Building the capability for those delivery mental health provision

From those participating in the research conducted as well as the findings nationally the perception of those in the black community after accessing mental health services is that the provision fell short of meeting their needs due to the lack of cultural competence of the professionals delivering the service(s). An education and training programme for mental health professionals therefore is seen to be essential.

The programme for professionals working in the mental health space would provide the awareness and skills for them to be able to better support those presenting mental illness from the black community by highlighting the cultural aspects as well as how poor mental health may present itself within the black community, and by gender in the black community.

The minimum of a dedicated, annual training day for all those in mental health in Leicester should be mandated and a quarterly newsletter and/or updates provided.

c) Raising awareness of black mental health within Leicester

The awareness of black mental health in Leicester has multiple strands, firstly, within the black community itself, secondly within the mental health services in Leicester, and thirdly, within the institutions that govern health outcomes in Leicester and Leicestershire to ensure that they are serving the community effectively.

It is suggested therefore, that mental health service providers should liaise with groups supporting those in the African heritage community to understand the offer from a mental health perspective and how to best access such provision.

Institutions governing health in the city would need to ensure that there is a strategy, action plan and objectives in place that are seeking improvements in the mental health engagement and outcomes for the black community. The first being that there is indeed a specific need for those in the black community and it needs specific action(s). In addition, there must be a focus on improvement, rather than over analysis of the issues, as the research here in Leicester and nationally aligns and the drive must be on, effective, culturally appropriate provision. This report, therefore, should be a reference point for all those working in mental health in the city and the recommendations embedded into practice.

d) Black Mental Health Engagement Lead

What gets measured, gets done! Black mental health needs specific focus, and to support this it is recommended that a new role of a Black Mental Health Engagement Lead is established in the city. This role would ensure that the mental health services in Leicester are indeed effective for those in the black community. Some of the ways this role would achieve this would be through, measuring and monitoring of services, working closely with African heritage organisations to raise awareness and to devise (new) provision for the black community. They would be a visible presence in the community on all matters relating to black mental health and establish and maintain relationships with mental health service providers to build effective relationships and to deliver black mental health training. The post holder would also act as the lead for the 5 factors to wellbeing programme.

e) 5 Year Programme

A cohesive and co-ordinated programme of work is needed to achieve a positive impact in black mental health in Leicester. It is suggested that a 5-year programme is implemented, with the understanding that pulling the correct mental health levers will take time before positive impact takes effect.

To provide assurance that the programme is operating effectively, partners will set, and learn from, shared annual objectives and action plans. Each year the programme would demonstrate progress and updates, building towards a longer term commitment.

Momodou Sallah Lead Researcher

Literature review 02

2.1: Black People and mental health services in Leicester

It is cardinal to clarify from the onset that by Black people, we refer to those of African Heritage, in England and from the diaspora. In 2023, NHS England reported that one in four adults experience mental illness*1* , while Mental Health Foundation have stated that more than 15 million people - 30% of the UK population - live with one or more long-term conditions. More than 4 million of these people will also have mental health problems*2* . Furthermore, the COVID 19 pandemic exacerbated mental illness in the UK – increasing the risk of poor mental health in British Black and South Asian people in the UK during lockdown (Jaspal and Lopes 2020)*3* .

Studies have shown that, in England, African Caribbean people are 3 to 5 times more likely than their White counterparts to be diagnosed and admitted to a hospital for more severe mental illnesses such as schizophrenia and psychosis. This is at odds with incidence rates reported for Caribbean countries which are comparable to the rates for White people in England. For example, the Mental Health Foundation stated that Black men are likelier to have experienced a psychotic disorder in 2022 than White men. Black people are also four times more likely to be detained under the Mental Health Act than their White counterparts, which aligns with the findings in the Count Me In national census 2010*4* and most studies on this topic. Mental Health Foundation have attributed racism, discrimination, and social and economic inequalities as factors that can increase the risk of mental illness in Black people*5* . Over the past 20 years, the literature on Black people and mental health have argued that Black people receive lower quality medical care than White people (van Ryn et al. 2014)*6* and coercive treatment within mental health services due to providers fearing Black people and lack of understanding of their distinctive needs.

[1] https://www.england.nhs.uk/mental-health/
[2]https://www.mentalhealth.org.uk/explore-mental-health/statistics/people-physical-health-conditions-statistics
[3] https://www.tandfonline.com/doi/epdf/10.1080/13674676.2020.1871328?needAccess=true&role=button
[4] National Mental health Development Unit. Count Me in 2010. https://www.mentalhealthlaw.co.uk/media/CQC_Count_me_in_2010.pdf
[5] https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/black-asian-and-minority-ethnic-bame-communities[
[6] The impact of racism on clinician cognition, behaviour, and clinical decision making. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3993983/

As a result, Black people with mental health issues are not provided with adequate treatment which explains why a significant number of studies describe the Black experience with mental health services in England as negative and why there is an over-representation of African and Caribbean men in psychiatric inpatient in the UK because they are less likely to receive treatment that meets their needs (Keating and Robertson 2004)[7] .

Social inequalities and racism are highlighted in the literature as key contributors to Black people's negative experience with mental health services in the UK. The Department of Health's 'Delivering Race Equality Plan Review 2010' stated that "evidence to date does not suggest the absence of discrimination within services." However, fear, distrust, lack of information, and cultural misconceptions among Black people also explain the fraught relationship between Black communities and mental health services according to Keating and Robertson (2004).

'A Race Equality Foundation briefing paper' by Keating (2007)[8] affirms that African and Caribbean men are over-represented in mental health services. This paper states that Black people come to the attention of services through the police and the criminal justice system, and they are more likely to receive the harsher end of services, such as seclusion, control, and constraint." This assertion is supported by the Mental Health Act Commission (2006) Count Me In The national mental health and ethnicity census 2005, which found that the rate of referral for African and Caribbean people from the criminal justice system was higher than average, there was greater involvement of police in referrals, and there were higher rates of control and restraint.

Memon et al. (2016) state that the negative experience of Black people in society impacts their mental and emotional well-being, influencing how they perceive mental health services. They argue that Black people distrust mental health services, and those who work within them fear them, which means there is a lack of engagement on both sides.

[7] Frank Keating and David Robertson (2004) Fear, black people and mental illness: A vicious circle? https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2524.2004.00506.x

[8] Frank Keating (2007), African and Caribbean men and mental health .https://www.researchgate.net/profile/Frank-Keating/publication/265620509_African_and_Caribbean_men_and_mental_health/links/571762e608aeb56278c458ed/African-and-Caribbean-men-and-mental-health.pdf

In their study on perceived barriers to accessing mental health services among Black and minority ethnic (BME) communities, Memon et al. 2016 highlight several issues they argue prevent Black people from seeking help for their mental health. For example, long waiting times for initial assessment, language barriers, poor communication between service users and providers, inadequate recognition or response to mental health needs, imbalance of power and authority between service users and providers, cultural naivety, insensitivity, and discrimination towards the needs of BME service users and lack of awareness of different services among service users and providers. While these issues also appear in other studies as deterrence for Black people in mental health, the limitations of this study include; the analysis is not ethnicity-specific, half of the participants did not answer questions about their ethnicity, and participants have similar backgrounds therefore, their views may not represent the entire strata of the BME population.

2.2: Black People and mental health services in Leicester

The Leicester City PCT mental health needs assessment in 2008 estimated that 60,000 people in Leicester were suffering from mental ill health at any one time. The assessment identified clear health inequalities across Leicester. For example, the people living in the most deprived areas are 1.7 times more likely to be registered with mental health services than people living in the most affluent areas. Leicester City Council attributes poor mental health to the broader health inequalities in Leicester. However, it can be argued that the experience of Black people and mental health in Leicester is not unique. There is an over-representation of people from African and Caribbean communities in psychiatric inpatient facilities and under-representation in the use of counselling/psychological therapies ..." (Leicester City PCT and Leicester City Council Joint Strategic Needs Assessment 2008-09: p98)[9] . Raghavan and Griffin (2014) assert that Black people in Leicester experience, on average, higher incidences of mental illness – yet there's a lack of research evidence about access to mental health services in Leicester and Leicestershire by people from BME communities (p5).

[9] https://www.leicester.gov.uk/media/178808/adults-jsna.pdf

The Council also found that during the period 2012-14, people from Black/Black British ethnic backgrounds in Leicester had better access to psychological therapy in comparison with other peer areas such as NHS Nottingham City and NHS Central Manchester (p10). This is mainly due to initiatives such as the Triage Car, a mental health need-accessible car that helped reduce the number of people detained under the Mental Health Act.

However, access to treatments including specialist therapies was a particular problem. Raghavan and Griffin's (2014) study on 'Mental health services for Black and Minority Ethnic groups in Leicester, Leicestershire, and Rutland: A documentary Analysis'*10* found that people from Black/Black British ethnic backgrounds in Leicester, Leicestershire, and Rutland had less equitable access to Community Mental Health Teams, and that the rate of access for this ethnic group was lower than the England average and some peer areas in 2011/12 and 2012/13 (p7).

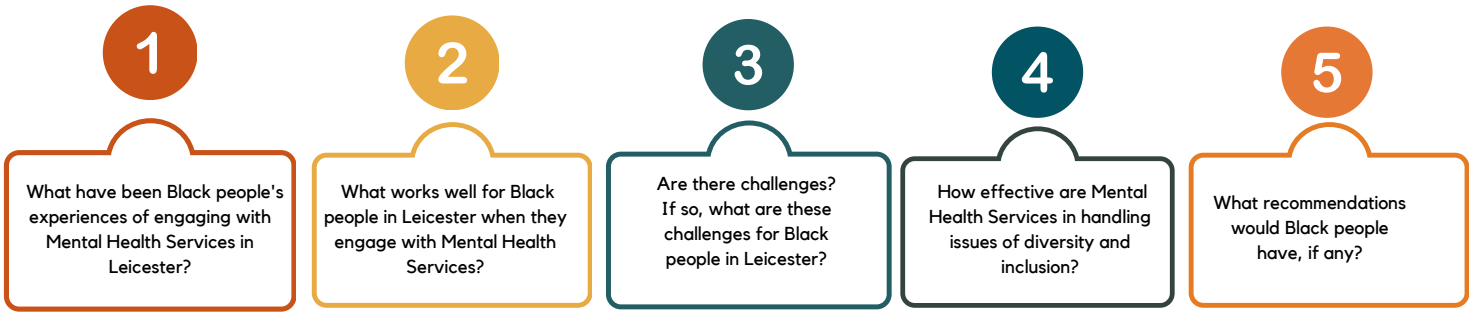
In 2015, the 'Scrutiny Commission on Mental Health Services for Black/ Black British Young Men in Leicester' expressed that "better information is necessary for service planning, especially for a group where research findings show inequity of access and outcome" (p10). They expected that better information collection should be a means to achieve real change in how services are organised and delivered for Black/Black British men. However, more recent evidence shows that little change has been achieved since this Commission.

[10] https://dora.dmu.ac.uk/bitstream/handle/2086/10396/MENTAL%20HEALTH%20AND%20ETHNICITY%20LEICESTER%20MSRC%201%20WORKING%20PAPER%208.pdf?sequence=1f

Methods and Methodology 03

The current research discusses mental health in Leicester, using five focus groups: men, women, young people, professionals, and those with lived experiences of mental health. The study aims to explore the perception of Black people in relation to their engagement with mental health services in Leicester. Their experiences and challenges faced, due to ethnicity, and the recommendations to improve Black people's experiences of accessing mental health services in Leicester are also proposed in this study. The research sought to investigate the following questions:

3.1: Research questions



3.2: Methods

Methodology, methods & technique Based on a constructivist and phenomenological approach, the research project employed a qualitative research method to explore the 'lived experiences' of Black people in Leicester; this utilised a focus group technique. Five focus groups were conducted to elicit their constructed realities in relation to their engagement with mental health services.

3.3: Sampling and Recruitment

Purposeful sampling technique commonly used in qualitative research, involves selecting participants based on specific criteria or characteristics that are relevant to the research question or objectives. This approach allows researchers to strategically choose participants who can provide valuable insights into the phenomenon being studied.

This approach was used to recruit Black people to take part in the research project based on the earlier mentioned categories. Two support staff were employed to invite potential respondents from the Black community in Leicester to express an interest in participating. Those who expressed an interest were followed up and sent consent forms to 12 sign before participating in the focus groups. Focus groups were conducted between December 2022 to January 2023 virtually on Zoom.

3.4: Demographics

The data for the current research was obtained from 5 focus group interviews with 31 participants. The data show that the professional experience focus group (PFG) recorded the highest number of participants (8), including 4 males and 4 females. The young people's group (YFG) followed with 7 participants, including 5 males and 2 females. The lived experience focus group (LFG) recorded 5 participants, 2 males and 3 females. Finally, the women's focus group (WFG) recorded 6, and the men's focus group (MFG) registered 5 participants. Figure 1 shows the number of participants for each group and the distribution of gender for individual groups.

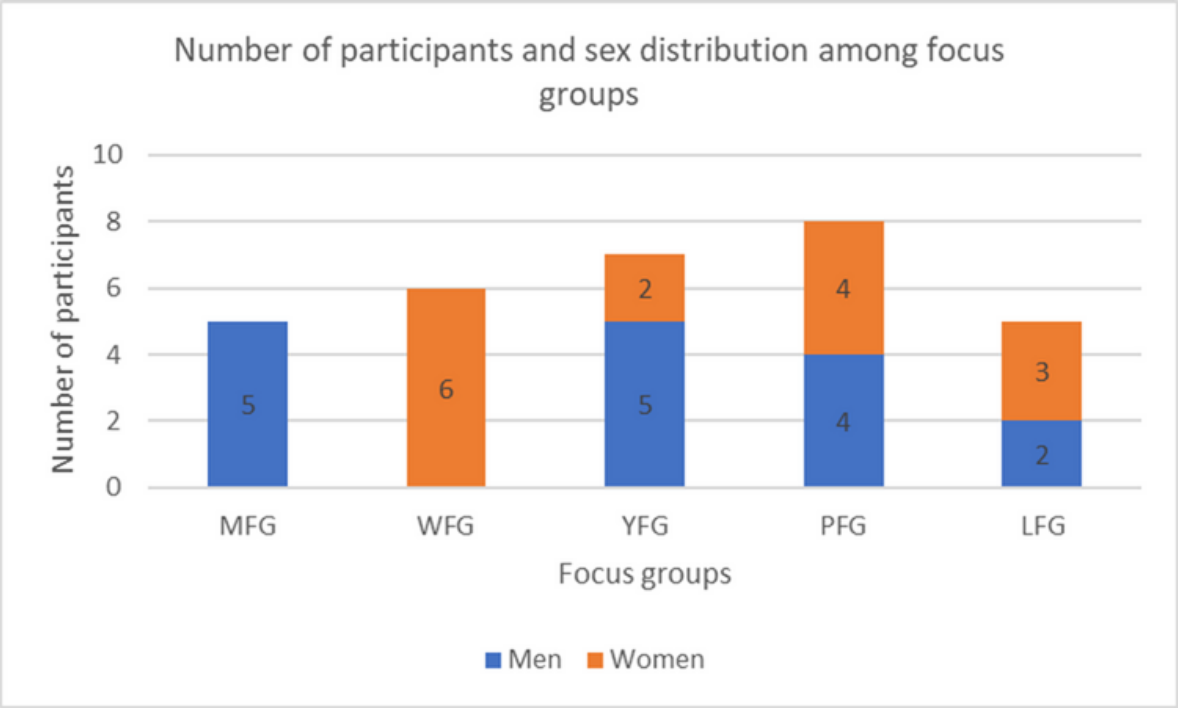


Figure 1: Respondents distribution across focus groups

Age is a key factor to consider when evaluating the opinion of research respondents; the age distribution of the respondent for the current research ranges between 18 and 63 years. Most of the YFG and the LFG range between 18 and 30 years, while the MFG, WFG, and PFG recorded an age range between 31 and 63 years. Based on the age distribution, we assume that respondents with a higher age could be more experienced in the context. Therefore our findings are based on people's significant experiences of mental health services.

Concerning the occupation of participants, students recorded the highest number of participants, followed by educators and mental health professionals, including various professions related to mental health services. The distribution of respondents' location shows that 91% of the participants are from Leicester. In comparison, the remaining 9% have worked in Leicester at one point (See Figure 2).

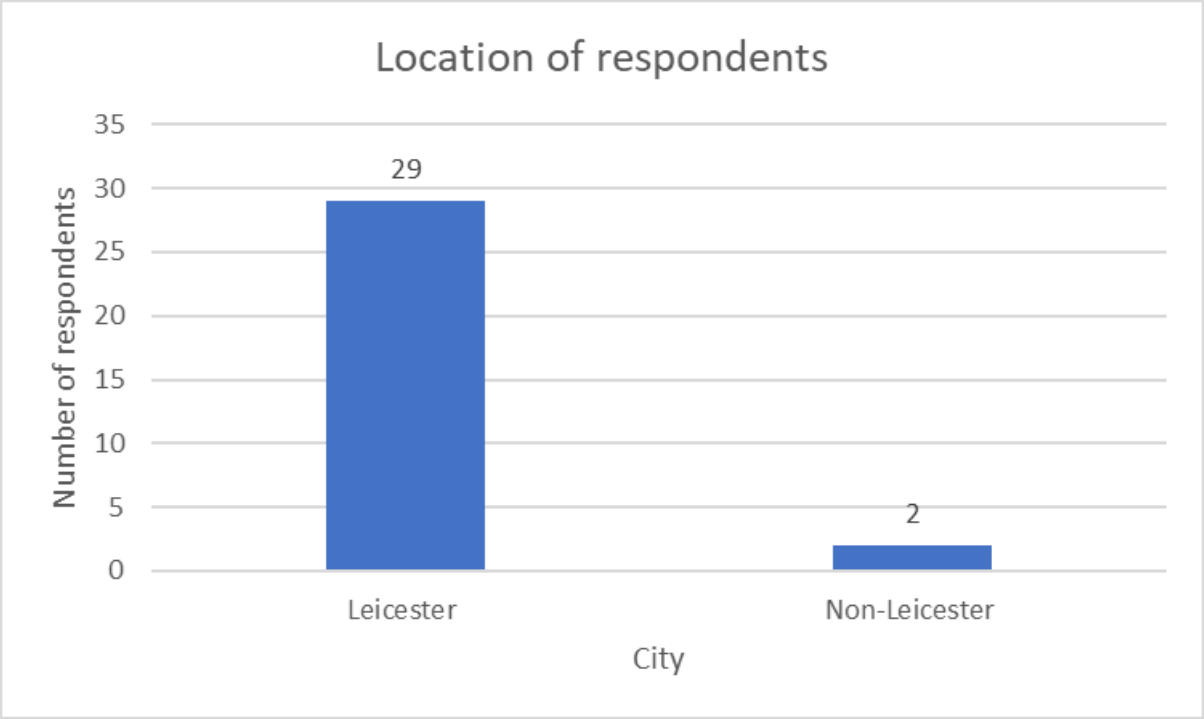


Figure 2: Respondents location

04 Findings and Recommendations

The current study considers data sets from five focus group interviews to explore the perception of Black people when accessing mental health services in Leicester. The focus group included men, women, young people, professionals, and lived experience groups. The popularity and salience of a finding were assessed using simple descriptive statistics of the percentage of respondents who mentioned a particular key term or opinion during the focus group interview. The following are six major themes of the findings.

- MEN
- WOMEN
- YOUNG PEOPLE
- PROFESSIONALS
- LIVED EXPERINCE

Focus Group Flyer

4.1: What have been your or other Black people's experiences engaging with Mental Health services in Leicester?

The study identified varying opinions based on Black people's experiences of engaging with mental health services in Leicester. These include positive, negative, and the GP experience, as illustrated in the coming section.

Respondents from the five focus groups reported on their positive and negative experiences of mental health services, these included instances where an individual had died.

4.1.1: Positive experiences with the Mental Health Services in Leicester

Across most focus groups, there were reported positive experiences of GP referrals where GPs treated or signposted respondents as their first point of contact. For instance, a women's focus group (WFG) respondent expressed satisfaction with the GP experience: "The support I got from my GP; it was a good service I received." *Another respondent (WFG) also reflects on a positive experience with the GP: "In recent years, my experience of going to the GP has been a better one where the doctor takes the time to talk to me and then referred me for support. Then I have had therapy and medication as well. That was more helpful."*

In addition, many respondents reported getting help from Mental Health Support Groups as positive. For example, a respondent said getting adequate support from The Sudden Infant Death Syndrome Support group is an excellent way to support victims' families: *"They use to come and see me, and counsel me… I felt that I was being looked after."* Other positive experiences of the respondents include being signposted to receive CBT in some instances and patients tend to get better due to emotional support. For instance, a respondent from the WFG reflected that: *"Met a therapist, her energy and vibe meant that I connected and gravitated towards her, Black lady, …she understands my background, and where I am from as a Black woman, I didn't have to explain where I am from … and did not have to explain how a Black mother …being able to speak freely with that person that knows, they know what we go through, they know the struggle we go through.."*

This particular respondent spoke of her struggle with self-harming (pulling out her eyelashes and hair from different parts of her body) for over a decade and being able to have effective engagement with mental health services via CBT. Overall, the findings show that about 30% of respondents reported some positive engagement with Mental Health Services in one shape or the other.

Some of the respondents from the Professional Focus Group (PFG) implied in this assertion of positive experiences the work of Turning Point, suggesting that: "Turning Point works well with young people and schools and they have been effective", and more significant is the mention of Akwaaba Ayeh (a Black led group that ran for 30 years but lost funding about 10 years ago). The respondent expressed a positive view of the work of Akwaaba Ayeh. Furthermore, as a non-statutory organisation, Akwaaba Ayeh was highly praised as an organisation that spoke to and effectively addressed the mental health needs of Black people in Leicester. The community-organised events were also seen as vital spaces to engage with mental health issues from a community-based approach; "Real Talk" as part of Black History – lecture, arts etc., connecting generations and bringing generations and communities together – providing solutions and positivity. In this view, a respondent from the WFG opined that: "that chance to speak…the situation that we all go through, our physical and mental wellbeing … a chance to share with others and hear other people as well."

4.1.2: Negative experiences with the Mental Health Services in Leicester

The significance of this study has been its ability to tap into some Black people's lived reality in Leicester concerning an interaction with mental health services. In this vein, about 70% of respondents across all focus groups reported negative experiences for themselves, family members, friends, or colleagues. These range from ineffective GP referral to overstretched services, discrimination, being given medication over therapy, and some heavy-handedness to Black people.

Following a thematic analysis of all the focus groups, the following points were identified as key negative experiences: The issue of GPs not dealing with or addressing the needs of Black people, given that they are often the first point of contact for many patients, was highlighted repeatedly in almost all the focus groups. There was a reported perception of almost being stereotyped and not being engaged by GPs in culturally competent ways. For instance, some respondents in the WFG said, *"Did not really listen to me, just put her on anti-depressants … It's been just a tick box exercise, you are rushed in and cut off mid-sentence; we will see you next time, and it's all over."*

Some other reflections of negative experiences by respondents include the story of a 30-year-old who hung himself; the respondent from the WFG suggested that: "*He has been to his GP 4 times in 5 weeks with regards to how he was feeling, … reaching out for help (GP) changed his medication 2 times, at no time did he refer him, he was not at that stage when he had to be sectioned but he was in a very bad place, he left 3 young kids fatherless …… that is an example of reaching out for help and not getting it."* The above quote is a microcosm of representations made by respondents about their perception of not being given the right level of support or timeliness in responding to their needs as pertinent to Black people and their engagement with GPs around mental health services in Leicester. In addition, many respondents highlighted not being supported properly and given the support they needed with the grounded situatedness of their digital capability or literal capacity. For instance, a respondent from the WFG said that: *"I have also had some experience where the GP said I would text you some websites and you can self-refer; when you are feeling quite low and a little overwhelmed, you don't have the motivation to fill all these online. And I find this quite unhelpful…"* It could further discourage the patient from seeking further mental health services.

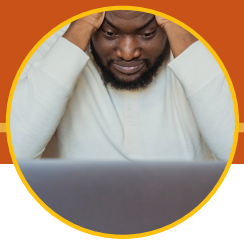
> "Did not really listen to me just put her on anti-depressants … It's been just a tick box exercise, you are rushed in and cut off mid-sentence; we will see you next time, and it's all over."

Most respondents from the MFG reflect a significant level of negative experience whilst accessing mental health services in Leicester. For instance, a respondent said: *"I struggle to access mental health services because of my African heritage; the Black community does not have organisations catering to their mental health service; I feel uncomfortable accessing mental health services from the general avenue".*

These expressions of the participants reflect some element of complexity that may have resulted from some indicators or cultural background. Similarly, another respondent believes that *"The Black experience of mental health is much different from their European counterpart; this is because the Black community has a cultural stigma on handling mental health issues".*

The participants also expressed negative experiences in perceptions of persons with mental health issues. The respondent believes they have a stigma attached to persons with mental health challenges. For instance, the respondent's view in the MFG includes, *"Because of a lack of mental health awareness, most people in the Black community would use inappropriate terminologies to classify people with mental health issues. As a result, Black people feel a stigma when accessing mental health services in Black communities".* Most of the identified factors have demotivated Black people from accessing mental health services, with an emphasis on young Black people. In addition, race is also a key factor emphasised by the respondents. In this regard, some respondents in the MFG further suggested that *"Most Black people feel less accepted when consulting with medical personnel of different skin colours, which results in issues of mistrust when accessing mental health services as a Black person".*

“Most black people feel less accepted when consulting with medical personnel of different skin colours, which results in issues of mistrust when accessing mental health services as a black person”.



4.1.3: Medication over therapy

A reported perception, especially in the women, professional, and lived experience focus group, was that they were often more likely to be medicated than given therapy. For instance, a respondent from the WFG revealed that *"Black people mostly receive medication over therapy....her friend, who is a clinical psychologist, also said …one of my children suffers from anxiety, and we don't want her to go down the medication route". This is a strong perception that respondents have repeatedly highlighted. Again, the respondent said, "…our blueprint for any group of people is quite medicalised …. makes them dozy…lethargic …." .*

4.1.4: Over-stretched services

All the focus groups highlighted that mental health services are overstretched in Leicester for most residents and, more specifically, for Black people. For example, in the Lived Experience Focus Group (LFG), a respondent with over six years of close contact with mental 18 health services (6 years of her brother being sectioned, and herself having also been sectioned for a short period) puts this aptly: *"I don't see anything positive with mental health services for Black people or anyone, it does not matter if they are Black neither, the whole mental health service needs shape up, and it's really bad… my little brother was there for 6 years, and I had to deal with 6 years of incompetence ….".*

The respondents also expressed dissatisfaction with the delay in accessing mental health services in many ways, as illustrated in the following quotes, which often must reach a crescendo of the threat of suicide before action is taken. A respondent from the WFG reveals that "only when young people attempt suicide (are then it) speeds them up through the system." Similarly, the PFG respondents believe that the *"Waiting list is up to 18 months …by the time, they would now be adults … and staff off."* This point is highly significant because the respondent in the PFG reveals that the "Professionals within the health services are stretched.. "…You have to be Richter scale before you can get help …. Community needs to intervene before…we need prevention before cure …". Another respondent from the PFG also reveals that *"only when young people attempt suicide (are then it) speeds them up through the system…" ."They will not get support until it reaches crisis point."* From the respondents' reported perspectives, it is a serious indictment on the NHS that people had to be at the stage of being suicidal before they could access urgent services. These significant delays in supporting vulnerable Black people with mental health issues have consequences as vulnerable people are not picked up on time, and it might even be too late by the time they are picked up.

It has been a negative experience for another respondent in the LFG, who experienced racial elements because of inefficiency in the mental health service: "… (who has) been turned away from visits because there was not enough staff, and no pictures were allowed on birthdays," these in her view had a racial dimension.

4.1.5: Disproportionate use of force

It was also reported in some focus groups that there is often a greater tendency and frequency to employ the use of force (Police intervention, prison or use of section) and disproportionately when it involves Black patients due to individual discriminatory tendencies and collective institutional discrimination. Some respondents (LFG) reported: *"Why are they always about our community, when it is to do with mental health, instead of accessing, they're taken straight to prison, and then they're also treated like if they're criminals, and not given the support they need or the right care, they are there a long time before anyone can access and deal with them…at least 3 people have told me of similar incidents"* .

These result in other issues, for example, the respondent suggests, *"How we emotionally react to situations, they treat you aggressively."* Another respondent in the same group also revealed that: *"…for the last 20 years, I worked in Forensic mental health, so my experience of Black people …I didn't meet Black patients until they committed an offence, or they were deemed to be that dangerous that they couldn't be managed within hospital settings."*

Expanding on this, the respondent suggests that *"Black patients were in crisis and hit rock bottom…when you read the case files of patients …they should have been picked up earlier." (PFG).* There was also a suggestion from respondents from the LFG that Black people with Mental Health issues within the prison services are not also being taken care of or their needs being addressed: *"Mental health with Black people in prisons. It's not being addressed; they are not getting assessed, they are not getting the support when they get out of prison, around mental wellbeing …it is very difficult for them."*

"Mental health with Black people in prisons. It's not being addressed; they are not getting assessed, they are not getting the support when they get out of prison, around mental wellbeing …it is very difficult for them."

4.2: Are there challenges, and if so, what are these?

The respondents across the focus groups have also identified the challenges Black people face when accessing mental health services. The challenges range from issues of no specific services for Black people, lack of awareness, cases of racism, representation, and understanding of the perception of Black people with mental health challenges.

4.2.1: No specific services for Black people

Respondents repeatedly reported in all the focus groups a perception that there are no specific services that cater to the needs of Black people in Leicester, which does not allow them to receive adequate services. A consistent point of reference as an example of great practice highlighted in most focus groups is that of Akwaaba Ayeh . For instance, a member of the WFG revealed that "There is nothing specifically for us as a people in Leicester …. My brother used to speak highly of Akwaaba Ayeh,… now it is all medication". The respondents repeatedly mentioned Pam Campbell as a great champion of Black mental health services, especially with her pioneering work with Akwaaba Ayeh and her outreach work. In the direct words of the respondent (WFG), *"Pam Campbell used to run the mental health day at the ACC(African Caribbean centre), and this was usually well attended .. since it has been gone, I have not seen anything in the community as well as hospitals".* It implies that the Black community would appreciate such services if still available. Akwaaba Ayeh was seen as delivering culturally appropriate services premised on cultural affinity and underpinned by cultural competence as opposed to the absence of this in the mainstream service. Other respondents from the WFG also supported this by sharing some more experience with such services:

"There was a connection, and the mirror image helped …Seeing yourself, seeing a Black person in front of you, understanding your dialect, not going into stereotypes that all professionals have. Someone able to sit with you into these meetings where they're using words that you think, who on earth needed 40 letters to articulate themselves… used to bamboozle people."

The respondent from the WFG further suggested the diversification from the public health service to private health services where more attention is given to clients. The participant revealed that "Black women have the persona that we have to be strong, sometimes it is heavier than we want to admit behind the scenes".

The findings revealed that the challenges are similar across the focus groups. For instance, in the case of specific services for Black people, a respondent from the MFG also revealed that "We had mental health services specific to the community for about ten years, but they disappeared. But people still talk about the benefit of community mental health services, such as personal engagement in mental health services within the Black community". However, the YFG think most Black people find it uncomfortable to talk about their mental health issues for fear of stigmatisation and ridicule. The participants frequently used stigma, self-esteem, and ridicule when discussing the challenges. The direct comments from the respondent from the young people focus group (YFG) include: "Most black people find talking about their mental health uncomfortable for fear of ridicule", "Most black people cannot access mental health because they are worried about what people say—self-esteem, complex, and withdrawal because of stigma and judgement", "Many black people do not want to say how they feel because they fear being seen negatively (stigma)", and "Many black people do not want to say how they feel because they fear being seen negatively (stigma)". It demonstrates a lack of awareness and the urgency for a public engagement campaign on how to access mental health services.

The solution could be through mental health education and awareness; many other respondents think similarly. For example, a respondent from the YFG said, "Lack of clarity and awareness of mental health services: Most Black people are unaware of how to access the available mental health services", "Black people have limited knowledge of mental health care services", "Lack of awareness of seeking mental health services even when not in serious challenges", and "Black people have a mistrust of the mental health system. This is because most of the health professionals are other than black".

The respondents from the MFG have also highlighted the perceived challenges faced when accessing mental health service. Most of the respondents in the MFG suggest that the lack of knowledge on the benefit of mental health services and communication style among the youth are significant challenges for most Black people. However, the direct comments of the respondents, "One of the major challenges in Leicester is the lack of awareness; you need much evidence to convince Black people about mental health", "In Leicester, we don't know the benefit of mental health services because we don't have it for the Black community", and "Some people, not necessarily Black, could say, I am not going to access mental service; what will other people know about me that I don't know by myself?".

It implies that participants across the groups have questions about the lack of awareness and the benefit of mental health. As such, policymakers could consider increasing awareness of the perceived need to access mental health services in various ways. Other comments by the respondents from the MFG that show the lack of awareness of the need for mental health services include comments by respondents such as *"How many people can come forward to identify with mental health issues? Or to say their challenges", "Most Black people are not aware of their mental issues", and "Most young black people do not know the benefit of accessing mental health, which means they do not know what they are missing".*

Another major challenge identified by respondents in the MFG is how young people communicate with each other. The respondents revealed that confrontation is more aggressive than normal: *"Communicating between most young people is mostly confrontational and could result in gang violence and police ……. I am in my late 50s; I have decent communication with people, but young people in their 20s show hostility in their voices. This is evidence of a lack of communication …. There is a different communication mentality between the young and the evidence in age"*. However, these challenges could be addressed through continuous engagement with young people in various innovative ways .

> "Most young black people do not know the benefit of accessing mental health, which means they do not know what they are missing".

4.2.2: The Case for Racism

Racism, either at the point of access or premised on individual bias, was raised consistently in all the focus groups; in its widest sense, it is reportedly manifested in an incoherent interpretation of cultural situatedness built from the axis of Eurocentrism. In the direct words of the participants from the WFG, "...we are individualistic rather than collective, western-based; we don't recognise and embrace the collective mindset". Other respondents from the same group (WFG) stated that: *"I think racism is connected to mental health ... As Black people, we have to compensate more, stretch more with the things that we need, because the systems are not made for us, because they are trying to service us using the White system ... so we don't get the support that we need because they don't understand us ...the jargon, we have to explain certain things..".*

However, the views of the YFG are more sentimental. For instance, *"Black people feel that skin colour influences accessing mental health services''.* Another respondent from the YFG also said, "I feel that medical professionals of other races may not know what I may be going through with my health because of cultural differences". Without proper awareness, people with such beliefs may not want to access mental health services if not attended to by professionals of the same race. There is also an issue of the lack of mental health education and awareness. From the individual biases, it was also strongly postulated that institutional discrimination affected the delivery of Mental Health Services to Black people, and some participants have expressed similar opinions.

A respondent from the PFG revealed that *"Organisations are institutionally racist; our experiences of them will show us that ...".* Another respondent from the LFG presented an example of how this institutional racism and stereotypical approach to Black people in the Mental Health Service in Leicester has led to at least two deaths that she is aware of.

The respondent said: *"She went to hospital frequently and was also unwell and complaining about pains, so she was taken to the hospital, and they said there was nothing wrong with her, and her son said he would pick her up after work. They didn't contact her son, they got an ambulance taxi to take her home, they didn't even see her into the house so when he came home, the door was ajar, and he found her dead on the floor ...they thought she was a black crazy lady. She wasn't given the support that she needed, and that was about colour, they tend to ignore a lot, and that ended causing her death...".* The respondent went further to share another similar experience faced by another family member. She said: *"It is not the first time, I have had another family member whereby he actually had an asthma attack at work, they took him to the hospital, he contacted me and said that he wasn't well. No one would listen to him; he actually sent me a text and said: 'I am dying, and no one would listen to me', they told him that if he came back in, they were gonna section him; he went home and died on his settee".*

4.2.3: Representation

The issue of representation was consistently and strongly raised in all the focus groups and elicited powerful emotions throughout; it was reportedly perceived as a strong barrier to effective engagement with mental health services in Leicester. For example, a WFG respondent said: *"But of all those services, I never saw anybody that looks like me"*. And 24 another from the PFG also said, *"Having people who look like them".* Similarly, a practitioner (PFG) in the Mental Health field claimed, *"Only in the last 3 years, they would have seen doctors that looked like them".*

However, a widely respected media practitioner who has had both professional and personal engagement with Mental Health Services said, *"They are not (inclusive in Leicester), they don't represent, the representation is not there …intrinsic behaviour that different cultures hold …the training is very generic, the literature does not exist, how different cultures and communities understand mental health …".*

4.2.4: Don't understand us

Throughout all the focus groups, the phrase "don't understand us" was used in different variations, denoting the lack of understanding of Black people's situatedness and positionality, manifested in incomprehension of their constructed reality and ways of knowing and being. Lack of culturally appropriate food and entertainment, *"cultural products are not in the shops' ', and "you could get the meals, but the process could be long"* in the wards, were also cited as physiological needs and psychological location. It should be clearly acknowledged that Black experiences are not homogeneous. In addition to intersectionality, which engages different variables, the consistency of *"they don't understand us"* throughout the focus groups is significant and alarming. The following would give an insight into the reader into how these emotions are articulated: *"Our community should tell them, not them assuming …"*.

Another respondent from the WFG said: *"I find a few of the non Black professionals don't seem to understand our grief or how it affects us …how we engage with our family members is very different, they don't understand how these things affect us culturally".* In addition, a respondent from the PFG revealed that *"I don't think the thought has been given to accommodate any needs …BAME, for example, refugees from Syria, no thought given to unlocking their trauma ..".*

The respondents from the professional focus group have also proposed the need for mental health services to understand the cultural implications of Black people relative to mental health. For example, a respondent said, *"...cultural connection to make people feel centred or relaxed or at home, that is what I feel has been my mission ...". Again, "I think the language needs to be simplified, for example CBT''.*

Lastly, from the PFG, a respondent said, *"Don't understand your culture, language, your expressions, it is gonna be harder to understand how you're feeling because people are gonna be looking at you strangely or not understanding what you are saying ...".*

From the opinion of the YFG, most respondents suggested an increase of Black professionals in the mental health service. It is because Black people are freer to express their mental health issues to Black professionals who understand the cultural implications for Black people with mental health issues.

For example, a YFG respondent revealed, *"Black people should have access to Black mental health professionals; I am more at peace consulting with Black doctors and nurses". Another respondent said, "I experience exceptional treatment when consulting with medical personnel of the same colour, ... this makes me more comfortable when attended to by Black doctors and nurses". And finally, one of the respondents insisted that "I feel a sense of care and relationship when consulting with Black doctors and nurses; they are passionate about their service".*

The findings show that mental health workers could consider more awareness of the need for inclusion and diversity across all races.

4.3: How effective are mental health services in handling issues of diversity and inclusion?

4.3.1: More diversity

Concerning handling issues of diversity and inclusion, most respondents in all the focus groups raised it as an issue ranging from lack of cultural competence, addressing Black people's physiological and psychological needs, to representation with Mental Health Services. For example, "They need to be more diverse, as I see the faces …because when you are in a low mood or in a really bad place, you don't have the energy to explain. Oh, culturally ….they should be a lot more knowledgeable. Having someone like you helps; it is rear to see a Black mental health nurse (Asians and Blacks). ..people have to explain themselves repeatedly; they don't get it…(WFG)"

Another respondent from the WFG view that "Ed. Psychologists need to refer young people to CAMHS (Children and Adolescent Mental Health Service); we need representation at a certain level to understand the cultural context" (Across Leicester, only one Black GP, in her 22 years of teaching, she only met one Black Ed, Psychologist). The respondents across groups believed in accessing mental health services from mental health professionals of the same race and culture. For instance, a respondent from the WFG said, "If I am talking to someone from my culture, then the job is half done … .they may not understand that specific experience…but may relate to the cultural aspect…". This is how critical the issues of inclusion and diversity in accessing mental health services among Black people could be, in support, a respondent from the PFG reflected on an experience saying, "… a young man was asked to close his eyes (they were trying to do some CBT with him) but he said that he is not going back, he thought that it is witchcraft (applies to people from Syria, Afghanistan and Sudan).

Most of the opinions of the MFG suggest ineffective management and handling of issues of diversity and inclusion. They emphasised the lack of coordination between mental health agencies and Black mental health organisations. For instance, a respondent said, *"There is no effective management or handling of diversity and inclusion in Leicester's mental health service. The lack of community service for Black people needing mental service suggests the lack of inclusion and diversity"*

The respondents from the YFG have also highlighted key issues relating to diversity. For example, *"Most people have been put into the system without understanding the culture"*, *"More Black people are needed to join the mental health profession: this would help balance diversity and inclusion"*, and *"Consulting with people of the same race should be encouraged. It makes patients feel free to express their feeling".*

4.4: Conclusion

The journey to conduct this research project was initiated by the African Heritage Alliance in a quest to better understand the mental health concerns of Black people in Leicester in particular and those in England in general. The literature review illustrated the disadvantaged situatedness of a significant number of Black people in relation to accessing mental health services; of equal significance is the recognition of the lack of empiric evidence in relation to their lived realities, especially in Leicester. This study has sought, in this light, to understand the experiences of Black people in their engagement with mental health services in Leicester; the challenges they face, how diversity and inclusion is handled, and recommendations they might have. Following a critical reflection on the earlier presented findings, the following recommendations are hereby presented to the African Heritage Alliance and its partners:

1.Negative experiences with the mental health services in Leicester

As a host of issues were raised under these this theme, the following can be considered:

- **Cultural competence within mainstream services -** The lack of perceived cultural competence in some of the front facing (as well as those embedded deeper) components of the mental health services need urgent review and recalibration. In addition to mainstream personnel to understand the positionality and situatedness of Black people when treating them; there is also an urgent need to engage with culturally appropriate services in relation to food, entertainment, and other relevant cultural products.

- **Medication over therapy -** There is a reported perception that a significant number of Black people who engage with mental health services in Leicester are more likely to be given medication than therapy. This perception needs to be engaged with and addressed both in terms of public health campaigns and the training of personnel. This also requires monitoring and sharing such data, with the active participation of the affected communities.

- **Overstretch services** - Whilst the mental health services seems to be overstretched and bursting at the seams; this reportedly has a disproportionate effect on Black people in Leicester. The recommendation is that whilst Black service users are sometimes having to wait for 18 months, it is important to engage Black organisations to develop authentic solutions to fill this gap in the short term as well as work with mainstream services to address it in the medium and longer term.

- **Disproportionate use of force -** The reported perception that Black people are more likely to be engaged by the Police, sectioned, or sent to prison when they display mental illness is a worrying one, the recommendation is to conduct a systematic review of existing practice, with the active involvement of Black communities in Leicester. It would also be good practice to engage a monitoring group composed of affected communities to be involved in monitoring the problem and mutually developing solutions

2. Challenges with the mental health services

- **No specific services for Black people -** As a significant finding, raised in almost all the focus groups, it is strongly recommended that the work of Akwaaba Ayeh be resurrected and expanded across mainstream services. Community run spaces, where a sense of belonging exists, premised on cultural affinity, is urgently needed. This will also require Leicester City Council to release funding to support this important work. Where cases of good practice exist, it is strongly recommended that they are shared widely with Black communities, through community engagement campaigns, involving Black organisations.

- **The Case for Racism -** There has been significant concern reported, both at the individual and institutional levels, as a result of bias and unbiased racism, in some cases leading to reported fatalities, that need urgent attention. We urgently recommend that further research be done in this area, reporting and monitoring mechanisms be enhanced, with the active involvement of Black and community organisations to mutually find solutions with mainstream organisations.

- **Representation -** The lack of representation in mental health services is quite worrying, as reported throughout most of the focus groups. Staff monitoring data should be reexamined and active recruitment and retention policies and strategies engaged. Community services and training for members of diverse communities should also be embarked on. Promotion should also be given proper attention. There should be long term partnerships with organisations like the defunct Akwaaba Ayeh.

- **Don't understand us -** As indicative of the title of this report, it was constantly and loudly echoed that “they don’t understand us”. This ranges from lack of culturally competent services, lack of representation, not understanding Black service users constructed reality, or even not knowing the location of culturally appropriate services. We strongly recommend that training around cultural competence be enhanced in professionally qualifying courses, and CPD courses be developed specifically for key personnel in the mental health services. That Black community organisations be involved in the delivery of services to Black communities; and that a reporting mechanism be transparent and readily available for the Black community.

3.How Effective are mental health services in handling issues of diversity and inclusion

- **More diversity -** The echo of more diversity in the mental health services has rang throughout the research and we recommend that coordination between mental health agencies and Black mental health organisations is facilitated to achieve better outcomes around diversity; we also recommend that there is regular consultation with Black organisations and communities in make the face and delivery of mental health services more diverse.

4.5: Recommendations

a) Prevention through tailored provision
The case and the research are clear, as it is with all health matters, prevention is better than cure. There is a need to ensure that those in the black community are supported to remain mentally healthy through a series of activities and offerings that are culturally appropriate and speak to the specific challenges faced. This could be achieved via utilising the Five Ways to Wellbeing refer to New Economic Foundation; Connect with other people, be physically active, learn new skills, give to others, and pay attention to the present moment (mindfulness).

A programme of workshops, events, outings, and learning experiences would be devised that speaks to the various audiences of women, men, LGBTQ+ community, young people and intergenerational groups. There would be provision touching each of the five factors and these would have a social, cultural, and therapeutic aspect to each.

b) Building the capability for those delivery mental health provision
From those participating in the research conducted as well as the findings nationally the perception of those in the black community after accessing mental health services is that the provision fell short of meeting their needs due to the lack of cultural competence of the professionals delivering the service(s). An education and training programme for mental health professionals therefore is seen to be essential.

The programme for professionals working in the mental health space would provide the awareness and skills for them to be able to better support those presenting mental illness from the black community by highlighting the cultural aspects as well as how poor mental health may present itself within the black community, and by gender in the black community.

The minimum of a dedicated, annual training day for all those in mental health in Leicester should be mandated and a quarterly newsletter and/or updates provided.

c) Raising awareness of black mental health within Leicester
The awareness of black mental health in Leicester has multiple strands, firstly, within the black community itself, secondly within the mental health services in Leicester, and thirdly, within the institutions that govern health outcomes in Leicester and Leicestershire to ensure that they are serving the community effectively.

It is suggested therefore, that mental health service providers should liaise with groups supporting those in the African heritage community to understand the offer from a mental health perspective and how to best access such provision.

Institutions governing health in the city would need to ensure that there is a strategy, action plan and objectives in place that are seeking improvements in the mental health engagement and outcomes for the black community. The first being that there is indeed a specific need for those in the black community and it needs specific action(s). In addition, there must be a focus on improvement, rather than over analysis of the issues, as the research here in Leicester and nationally aligns and the drive must be on, effective, culturally appropriate provision. This report, therefore, should be a reference point for all those working in mental health in the city and the recommendations embedded into practice.

d) Black Mental Health Engagement Lead

What gets measured, gets done! Black mental health needs specific focus, and to support this it is recommended that a new role of a Black Mental Health Engagement Lead is established in the city. This role would ensure that the mental health services in Leicester are indeed effective for those in the black community. Some of the ways this role would achieve this would be through, measuring and monitoring of services, working closely with African heritage organisations to raise awareness and to devise (new) provision for the black community. They would be a visible presence in the community on all matters relating to black mental health and establish and maintain relationships with mental health service providers to build effective relationships and to deliver black mental health training. The post holder would also act as the lead for the 5 factors to wellbeing programme.

e) 5 Year Programme

A cohesive and co-ordinated programme of work is needed to achieve a positive impact in black mental health in Leicester. It is suggested that a 5-year programme is implemented, with the understanding that pulling the correct mental health levers will take time before positive impact takes effect.

To provide assurance that the programme is operating effectively, partners will set, and learn from, shared annual objectives and action plans. Each year the programme would demonstrate progress and updates, building towards a longer term commitment.

Momodou Sallah Lead Researcher

Appendixes

Appendix 1: Participant Information Sheet

Title of project: AHA Black Mental Health Research in Leicester

Please take some time to read this information and ask questions if anything is unclear.
Contact details can be found at the end of this document.

252 participants completed questionnaire

What is the purpose of this study?

This study aims to explore the experiences of Black people of African and African Caribbean heritage in Leicester in relation to mental health, especially around their perceptions and lived experiences.

Who is organising this research?

The research for this study is being undertaken by Prof. Momodou Sallah, an independent researcher, carrying out this research on behalf of First Contact.

Why have I been chosen?

Using an opportunity sampling approach, you have been chosen because you are a member of the Black community in Leicester who can provide valuable insight into the issues being researched.
We aim to conduct 5 focus groups with an average of 7-9 participants from Leicester's Black community.

Do I have to take part?

Participation in this study is voluntary, and you may ask the researcher questions before agreeing to participate. However, we believe your contribution will provide invaluable insight into the researched issues.
You will be asked to sign a consent form if you agree to participate. However, at any time, you are free to withdraw from the study, and if you choose to withdraw, we will not ask you to give any reasons.

What will happen to me if I take part?

If you agree to take part in this study, we will invite you to participate in a focus group which will be audio recorded. Professor Momodou Sallah will conduct the interview, which will last about an hour.
We may ask you to participate in a follow-up interview, though participation in this is optional.

What are the possible benefits of participating?

The study aims to find out the experiences and perceptions of Black people in relation to mental health in Leicester, and your participation in this research will greatly help with a better understanding of the challenges they face and recommendations we can make. Your participation is a great opportunity to contribute to this process as well as have the opportunity to reflect on these pertinent issues.

What are the possible risks of taking part?

While we hope that your experience will be pleasant, the nature of the issues that might arise may make you uncomfortable. At any time during the interview, you can choose to withdraw.

How will my interview be used?

The interview will be transcribed and analysed to inform the findings. The final report will be handed to AHA (African Heritage Alliance) Contact to inform policy and practice.

On the consent form, we will ask you to confirm that you are happy to assign your (or where relevant, your child or vulnerable adult in your legal charge) copyright for the interview to us, which means that you consent to the researcher using and quoting from your interview.

What will happen to the results of the project?

All the information we collect about you during the research will be kept strictly confidential. You (or, where relevant, your child or vulnerable adult in your legal charge) will not be identified in any reports or publications, and your name and other personal information will be anonymised.

What happens to the interviews collected during the study?

Interviews will be [transcribed/filmed/audio recorded and stored digitally], managed by the researchers for the project's duration. Only the researchers and First Contact Advisory Group will have access to the interviews and personal information.

What happens at the end of the project?

If you agree to participate in this project, the research will be written up as a report. You may request a summary of the research findings by contacting First Contact. Upon successful submission of the report, it will be deposited in print and online with First Contact.

What about the use of the data in future research?

If you agree to participate in this project, the research may be used by other researchers and regulatory authorities for future research.

Who is funding the research?

The Leicester City Council funds this research.

What should I do if I have any concerns or complaints?

If you have any concerns about the project, please speak to the researcher, who should acknowledge your concerns within ten (10) working days and indicate how your concern will be addressed. If you remain unhappy or wish to make a formal complaint, please get in touch with us via email enquiries@africanheritagealliance.org or via call 07789 13948/07553 140468

Appendixes

Appendix 2 report produced by Brian Simmonds

Appendix 2: Outreach Program(Conducted and presented by Brian Simmonds)

The Impact of Community-Based Organizations on Engagement with Mental Health Services and Empowerment: Insights from the Black Mental Health & Me Outreach Programme

Abstract:

The Programexamines the effectiveness of community-based organisations in promoting engagement with mental health services and empowering individuals within the Black community. The study utilised a mixed-methods approach, incorporating both qualitative and quantitative research methods. The findings highlight the significance of community-based organisations in facilitating access to mental health resources and combating the stigma associated with seeking help. Additionally, online questionnaires were employed to gather data from participants. The community hub partners involved in the research were the African Caribbean Centre, Opal22 & Serendipity, and the Highfield Rangers Football Club. Each partner contributed unique perspectives and initiatives towards supporting mental health within the Black community.

Introduction

The Black Mental Health & Me 4 week Outreach Programaimed to explore the impact of community-based organisations on engagement with mental health services and individual empowerment. This research paper presents the findings from the programme, focusing on two aspects derived from the research findings.

Methodology

The study utilised a mixed-methods approach, combining qualitative and quantitative data collection methods. Online questionnaires were employed to gather quantitative data, while qualitative data was obtained through five weekly drop-in sessions and the additional 9 workshops conducted within the programme. These sessions served as a platform for signposting individuals to mental health services and discussing their experiences.

Community Hub Partners

3.1 African Caribbean Community Centre

The African Caribbean Community Centre played a crucial role in the programme, providing resources hosting a weekly drop in sessions, supporting, and guidance to individuals seeking mental health services. Their involvement helped bridge the gap between the community and mental health institutions**.**

3.2 Opal22 & Serendipity Art organisations

Opal22 & Serendipity focused on exploring how loss and healing are navigated within the Black community. Their unique perspective contributed to understanding the specific challenges faced by individuals and developing tailored strategies for support.

3.3 Highfield Rangers Football Club

The Highfield Rangers Football Club focused on empowering Black men to seek help for their mental health, addressing the stigma associated with mental health issues. Through their initiatives, the club aimed to create a safe and supportive environment for individuals to access the necessary resources.

Appendixes

Findings

The Programme findings highlighted the following key insights:

4.1 Engagement with Mental Health Services

The utilisation of community-based organisations significantly enhanced engagement with mental health services among individuals from the Black community. The presence of familiar and culturally sensitive spaces facilitated a sense of trust, making individuals more inclined to seek help and support.

4.2 Empowerment and Stigma Reduction

The involvement of community-based organisations empowered individuals to take control of their mental health journeys. By creating platforms for open discussions and challenging the stigma surrounding mental health, these organisations helped individuals feel supported and encouraged to seek the assistance they needed.

Conclusion

Mental health service providers should liaise with African heritage organisations to ensure offers of mental health support are understood and the access to this care is clear. The knowledge that such groups have of their community will enhance engagement. Specific and tailored approaches to engagement could include, radio talk shows, mailing lists, social media and bespoke events. The messaging can then be shared and cascaded by the community, for the community, making the participation more likely to occur.

Outreach Launch Flyer

BMHM Launch Event
Anthony Francis, Brian Simmonds, Chizor Onwuegbute, Jenaitre Farquharson, Momodou Sallah

LEICESTER CITY HEALTH AND WELLBEING BOARD
27 JUNE 2024

Subject:	Addressing racial disparities in maternal outcomes for the population of Leicester, Leicestershire and Rutland (LLR) - DRAFT
Presented to the Health and Wellbeing Board by:	Dr Ruw Abeyratne – Director of Health Equality and Inclusion, University Hospitals of Leicester
Author:	Dr Ruw Abeyratne, on behalf of LLR Maternal Racial Disparities Working Group – full acknowledgement in final publication of report, date TBC

EXECUTIVE SUMMARY:

This report and framework was established to answer the specific question, “what is happening in Leicester to address the disparities experienced by black women and people during pregnancy and childbirth?” In drawing together a number of experts across disciplines, it is clear that there is already a significant drive to address this problem, with multiple individual workstreams to address various facets. However, it is also fair to say that more needs to be done, especially if the work that is happening is to move from a reactive state to a proactive and sustainable change.

This report intentionally focuses on key themes that should underpin work to address maternal inequalities, particularly for Black women and birthing people. For the impact to be felt most deeply, these themes should be aligned to key areas of clinical focus that any organisation highlights as a source of maternal inequality.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to note the recommendations of the report with specific reference to six key themes that should be adopted to underpin and improvement work that is focused on addressing ethnic disparities in maternal outcomes.

Addressing racial disparities in maternal outcomes for the population of Leicester, Leicestershire and Rutland (LLR)

Introduction

The MBRRACE-UK - Saving Lives, Improving Mothers' Care report (Knight M B. K., 2020) reviewed maternal deaths from 2016-2018, and provided firm evidence that women from Black ethnic groups are four times more likely to die in pregnancy when compared to White women.

A follow up report in 2022, 'Saving Lives, Improving Mother's Care' (Knight M B. K.-U., 2022) produced supplementary analysis which shows that this stark inequality persists despite widespread awareness. The report, the ninth MBRRACE-UK annual report of the Confidential Enquiry into Maternal Deaths and Morbidity, includes surveillance data on women who died during or up to one year after pregnancy between 2018 and 2020 in the UK. This shows that Black women remained 3.7 times more likely to die than White women, and Asian women 1.8 times more likely. Figure 1 demonstrates that women from the most deprived neighbourhoods were 2.5 times more likely to die compared to those from the least deprived, and this difference is increasing.

MBRRACE-UK

Mortality rates amongst different population groups 2018-20

	Total maternities 2018-20	Total deaths	Rate per 100,000 maternities	95% CI	Relative risk (RR)	95% CI
Age						
<20	58,627	9	15.35	7.02 to 29.14	1.82	0.74 to 4.05
20 – 24	284,079	24	8.45	5.41 to 12.57	1 (Ref)	-
25 – 29	571,632	50	8.75	6.49 to 11.53	1.04	0.62 to 1.76
30 – 34	692,078	69	9.97	7.76 to 12.62	1.18	0.73 to 1.96
35 – 39	400,386	53	13.24	9.92 to 17.31	1.57	0.95 to 2.65
≥ 40	94,860	24	25.30	16.21 to 37.64	2.99	1.63 to 5.51
IMD Quintiles (England only)						
I (Least deprived/ highest 20%)	252,869	18	7.12	4.22 to 11.25	1 (Ref)	-
II	287,258	20	6.96	4.25 to 10.75	0.98	0.49 to 1.96
III	319,035	24	7.52	4.82 to 11.19	1.06	0.55 to 2.07
IV	376,393	37	9.83	6.92 to 13.55	1.38	0.77 to 2.58
V (Most deprived/ lowest 20%)	445,465	80	17.96	14.24 to 22.35	2.52	1.50 to 4.47
Ethnic group (England only)						
White (inc. not known)	1,386,873	128	9.23	7.70 to 10.97	1 (Ref)	-
Asian	186,086	30	16.12	10.88 to 23.01	1.75	1.13 to 2.62
Black	76,487	26	33.99	22.21 to 49.80	3.68	2.32 to 5.65
Chinese/ others	73,025	6	8.22	3.02 to 17.88	0.89	0.32 to 1.99
Mixed	32,782	4	12.20	3.32 to 31.24	1.32	0.35 to 3.47

Figure 1

A FiveTimesMore report in May 2022 (Peter M, 2022) also concluded that though both positive and negative experiences were reported, negative experiences far outweighed those in which black women were happy with the care that they had received. These negative experiences were found to fit within a framework overarched by three interrelated constructs centred around the healthcare professional (HCP):

– *Attitudes* (e.g., using offensive and racially discriminatory language; being dismissive of concerns),

– *Knowledge* (e.g., poor understanding about the anatomy and physiology of Black women; poor understanding of the clinical presentation of conditions in babies of Black women)

– *Assumptions* (e.g., racially based assumptions about the pain tolerance, education level, and relationship status of Black women).

Leicester City stands out as England's only plural city with 49.5% of its population being from non-White groups, in stark contrast to Leicestershire and Rutland, where non-White residents comprise 8.6% and 2.9% Black and Asian ethnicity respectively. Language diversity is also a notable factor; 27.5% of all Leicester City residents communicate primarily in a language other than English, a percentage

significantly higher than that of Leicestershire (3.8%) and Rutland (1.8%). With a dynamic population, which had grown by over 10% at the last census (ONS, n.d.), the number of women in their reproductive years (aged 15-44 years) is predicted to increase by 8% to reach 222,000 across the region by 2039.

Recognising the intersection between ethnicity and deprivation is vital. The prevalence of stillbirths among women of Black or Black British ethnicity living in more deprived areas and aged over 40 years is higher. Babies born to mothers facing these conditions disproportionately experience adverse outcomes. Leicester city is known to have some of the most deprived neighbourhoods in England. Between 2014-2021, the number of children living in relative poverty in Leicester city had increased by 11.7%, equivalent to 14,000 children (Cities, 2024).

In the realm of pregnancy, the amplified prevalence of obesity and diabetes within non-White communities in the United Kingdom has substantial implications for expectant mothers and their infants. The Leicester Health and Wellbeing Survey 2018 showed that 27% of women of childbearing age (16-44) in Leicester are overweight, with 19% classified as obese (Rigby & Wheeler, 2018). While the combined overweight and obesity rate of 45% is notably lower than the national average for England (52%), these figures must be understood within the framework of Leicester's diverse demographic landscape.

The babies of women with a pre-pregnancy BMI of over 35 have an increased risk of perinatal mortality compared with the general maternity population in the UK. Maternal complications associated with obesity include miscarriage, hypertensive disorders such as pre-eclampsia, gestational diabetes mellitus, infection, thromboembolism, caesarean section, instrumental and traumatic deliveries, wound infection, and endometritis (infection in the endometrium).

Adding to the complexity, diabetes rates underscore health disparities during pregnancy with variance visible between the two maternity sites of University Hospitals of Leicester NHS Trust. Data from Leicester Royal Infirmary illustrates disproportionately high rates among the Asian population (48%) and somewhat elevated rates in the White/other ethnicity (44%) population, with a comparatively lower rate in the Black community (8%). At Leicester General Hospital, diabetes rates are 73% for the Asian community, 22% for the White/other ethnicity, and 5% for the Black population.

What is the problem we are trying to solve?

Between 2016 and 2018, 34 Black women died among every 100,000 giving birth. The figure for Asian women was 15 and 8 white women died among every 100,000 giving birth (UK, 2021). Women from Black and minoritised groups have a higher maternal mortality rate than white women (Knight M B. K., 2020) . The overall wellbeing of the Black and minoritised populations are at higher risk of suffering health inequalities primarily because of systemic and institutional racism, direct and indirect discrimination, stigma, fear, and trust (PHE, 2020).

Racism is the biggest driver of health inequalities whilst also exposing other intersecting determinants of health such as low socio-economic states (Bhopal R, 2020). Structural racism further exacerbates the inequities faced by non-White women in maternity care. Socioeconomic factors, such as limited access to healthcare facilities, affordable transportation, and housing instability can create barriers to receiving appropriate prenatal and postnatal care. Additionally, racial bias and discrimination can influence decision-making processes during pregnancy and childbirth, leading to suboptimal treatment plans and increased risks for complications. This can also contribute to disparities in access to prenatal care, postpartum support, and mental health services.

Clinical bias, cultural differences and institutional racism within healthcare services derive from stereotypical behaviours. There is lack of knowledge among healthcare professionals on the diverse cultures non-White individuals are accustomed to. The lack of understanding of non-White individuals' experiences effects the quality of health services they have access to and their experience of those services. These historical based reasons and daily lived experiences of non-White communities contribute to suspicion, mistrust, and fear of not receiving equitable healthcare.

What do we want to achieve?

The aim of this report is to provide an overview of current actions being taken to address racial injustice in maternal outcomes for the people of LLR while making recommendations on how to advance this work.

The goal of this is to move towards equitable maternal healthcare provision across LLR, for all people who need it. This will be demonstrated in incremental improvements in data relating to access, experience and outcomes for people of non-White ethnicity in contrast to the current trends above.

The current interventions below are themed in alignment with the recommendations of the 2022 FiveTimesMore report (Peter M, 2022) under the heading of Knowledge, Attitudes and Assumptions. Further recommendations also follow the same themes.

What actions are being taken to address racial injustice in maternity for people in Leicester, Leicestershire, and Rutland (LLR)?

1. LLR Maternity Equity and Equality Action Plan - Knowledge, Attitudes and Assumptions

The LLR Maternity Equity and Equality Action plan (LLR Equity and Equality Action Plan 2022-2027, n.d.) was approved and published in public in 2022. In September 2021 NHS England/Improvement published The Equity and Equality Guidance for local maternity and neonatal systems (LMNS) setting out two aims relating to equity and equality for maternity and neonatal care:

• To achieve equity for **parents and babies** from Black, Asian and Mixed ethnic groups, and those living in the most deprived areas.
• To achieve equity of experience for staff from minority ethnic groups; the NHS People Plan states "…where an NHS workforce is representative of the community that it serves, patient care and patient experience is more personalised and improves" (Belonging in the NHS, n.d.).

LMNSs were asked to create the conditions to help achieve equity by considering the factors that will support high quality clinical care working with system partners and the Voluntary, Community and Social Enterprise (VCSE) sector to address the social determinants of health.

The LLR maternity equity action plan 2022 to 2027 is aligned to the five strategic priorities relating to health inequalities outlined by NHS England.

- Priority 1: Restore NHS services inclusively.
- Priority 2: Mitigate against digital exclusion.
- Priority 3: Ensure datasets are complete and timely.
- Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor health outcomes.
- Priority 5: Strengthen leadership and accountability.

Community engagement was key to informing the LLR Maternity Equity and Equality Action Plan in addition to an in-depth equality analysis undertaken by the LLR Integrated Care Board. Some of the key themes relating to race-related disparities are summarised below:

- Gestational diabetes and diabetes is higher in certain ethnic groups (Asian, African and Chinese) across Leicester and Leicestershire.
- Maternal obesity is higher in White British, Asian British: Indian and other White Background.
- Premature births are higher within the Black or Black British: Caribbean ethnic group.
- Infant mortality for LLR overall for babies living in the most deprived areas is significantly higher than for those living in the least deprived areas.
- Infant mortality rates for LLR in Asian/Asian British, Black/Black British and babies from other ethnic groups is higher than for White babies.
- User experience: poor *for people of Black and Asian ethnicities* in the following areas, compared with the national position: time spent on antenatal discussions, involvement in antenatal care, responsive postnatal hospital care. Women reported feeling that they aren't heard or listened to, that services were difficult to access, and information was not explained.

The full LLR Maternity Equity and Equality Action Plan can be found here.

2. Addressing language as a barrier to care – Knowledge and Assumptions.

Data from the 2021 Census showed that just under 30% of the population of Leicester do not speak English as a main language (Open Leicster, n.d.). Language barriers in healthcare settings lead to miscommunication between patients and healthcare professionals, resulting in low levels of health literacy, diminished experience of care, poorer quality of care, higher frequency of healthcare interactions and poorer outcomes (Al Shamshi H, 2020). Recognising this, interventions are proactively underway in LLR to address language as a barrier to high-quality maternal care.

Written information is available in translated formats, however this does not equate to a healthcare conversation in an individual's main language and communities frequently report that reading proficiency is limited even in main spoken languages. Adapting to the cultural norms of different communities is also vital, for example enabling the provision of audio-visual sources of information in multiple languages, an area currently being explored by University Hospitals of Leicester NHS Trust (UHL).

Interpretation and translation is available to all individuals accessing maternity services at UHL for both planned and unplanned attendances. As part of a standard procurement exercise to renew the supplier of interpretation and translation services a survey of staff was carried out to explore user experiences and gaps in the current service provision. Although largely positive, there were notable instances of interpreters in particular languages being unavailable, difficulty accessing the technology needed and reliance on ad-hoc solutions such as online translation tools which are not validated for healthcare settings.

In response to the variable experiences of staff and service-users, a pilot study was successfully conducted with CardMedic, an app based interpreting tool to determine if availability of this additional resource would improve the patient and staff experience. This pilot demonstrated that 47% of midwives were able to use the app to relay short and simple instructions, 29% used the app when they didn't have time to access other translation services, and 24% used the app when they couldn't obtain an interpreter (University Hospitals of Leicester NHS Trust and CardMedic, n.d.) facilitating higher

quality care. UHL and LLR Integrated Care System are awaiting the outcome of a bid for funding to implement CardMedic.

The Janam App, developed by Prof Angie Doshani and midwife Jethi Karavadara, aims to address language barriers experienced by people of South Asian heritage during pregnancy and the perinatal period. It is an intuitive, comprehensive, singular information resource to support women in making informed decisions about their perinatal care. The contents are co-designed with patients, community representatives and healthcare professionals (primary and secondary care) based on the most recent evidence, guidelines, and expertise. The app interface supports multiple South Asian languages commonly spoken by the target South Asian patient population (English/Hindi/Punjabi/Urdu/Bengali, and Gujarati). Users can easily switch between languages to access content in their preferred language.

The JanamApp is unique in that it mainly presents content in the format of visual aids, graphics, and multimedia elements. Visuals can enhance understanding and transcend language and cultural barriers. Illustrations, diagrams, videos, or animations have been used to demonstrate medical procedures, symptoms, or treatment instructions.

The content includes:

1. Emergencies- (information on when and how to contact emergency services)
2. Your pregnancy journey (This section provides information on changes in pregnancy, what happens at the various midwife and hospital appointments and what you need to do or ask)
3. Problems in pregnancy (This section highlights the common problems that may occur in mum and baby during pregnancy e.g.: hypertension/diabetes/small baby/preterm labour/mental health problems)
4. Labour (This section discusses the various stages of labour, birth choices interventions that may occur, and pain relief options)
5. Postnatal care (What to expect after vaginal/instrumental and cesarean birth. Signs of complications/ sepsis, when and how to seek help)
6. The baby (NIPE)
7. Frequently asked questions.

The app has been recognised by the NHS Race Health Observatory and is an important step towards addressing racial inequity in maternal disparities in LLR.

<u>3. Addressing late booking for ante-natal care – Knowledge, Attitudes and Assumptions.</u>

'Booking' for antenatal care, when a person informs their healthcare provider of a current pregnancy, is a crucial step in pregnancy and impacts outcomes for mothers and babies; poor access to antenatal care is associated with poor maternal outcomes, including mortality (Knight M B. K.-U., 2022).

Presently, early booking is considered to be prior to 10 weeks gestation (NICE, 2021). Approximately 78% of people who give birth in UHL book prior to 10 weeks. However, on average 57% of Black (-African and Caribbean) people booked after 10 weeks' gestation and 34% of those of Asian (-Indian, -Pakistani and -Bangladeshi) ethnicity booked after 10 weeks' gestation between 2021-2023. From a review of those with suboptimal outcomes in pregnancy for the black population one third booked late.

Methods of booking are direct contact with healthcare professionals via GP services or via Maternity Assessment Units if seen for a pregnancy related problem. Booking can also be performed remotely

by an online enquiry form but relies on digital system access and pertinent information such as a home address and GP are required. This form applies Google technology to translate the form to the language of the user.

Suggested barriers to early booking using the current system include lack of access to and/or awareness of GP or maternity services (for example if new to the country or of more deprived background), lack of a home address, lack of access to technology or digital literacy skills, language or literacy barrier.

A clinical project exploring the reasons why Black people book later for antenatal care is being undertaken at UHL with the support of the Institute for Healthcare Improvement (IHI). The aim of this work is to understand the root causes driving late bookings for care to enable co-design of appropriate solutions to improve early antenatal booking rates for those in the Black population. Partnering with the IHI in this work has enabled a quality improvement, evidence-based approach to this work and has highlighted racial equity work that is imperative to enable sustainable change.

4. Pre-conception education: The STORK Programme; delivering better health for babies.

Parents, carers and families in Leicester are benefitting from a programme designed to narrow neo-natal healthcare inequalities in the area.

Together with local partners and communities, UHL has developed and implemented an education and training programme for new and expectant parents which seeks to raise awareness around infant mortality; embedding neonatal public health messaging within hospital-based care. The STORK programme which stands for, Supportive Training Offering Knowledge and Reassurance aims to narrow the healthcare inequalities experienced by local people living in areas of high deprivation or from non-White groups who are at higher risk of their babies dying.

Nearly half of babies born into UHL neonatal services are of non-White heritage and Leicester city is within the lowest 10% of the most socio-economically deprived local authorities in England. UHL also has amongst the highest infant mortality rates in England.

All parents and families with babies in neonatal services, both in hospital and the community, are offered the opportunity to take part in the programme. Groups at risk of experiencing healthcare inequalities, including those from non-White communities, teenage pregnancies, people who recreationally misuse substances, people experiencing homelessness and those with mental illnesses, are also targeted by the Trust's midwifery team.

The STORK Programme embeds a public health initiative into the fabric of the Trust. Two facilitators run the programme which is delivered in person and via an online app, covering topics including recognising signs of illness in babies, safe sleeping, and how to reduce the risk of sudden infant death. Other topics include healthy lifestyles, smoking cessation, coping with a crying baby, perinatal mental health support and breastfeeding support. There are also practical sessions on basic life support and responding to a choking baby.

The programme seeks to establish behavioural changes amongst new and expectant mothers and their families which will support healthier lifestyles and help to reduce infant mortality. It meets key recommendations around provision of support for parents of preterm and sick babies and for bystander basic life support.

The power of this initiative extends beyond infancy and will help families to adopt healthier lifestyle approaches which will benefit them both now and in the future.

5. Creating a Culture of Speaking Up – Attitudes and Assumptions

The NHS People Plan (Employers, n.d.) states, "We all need to feel safe and confident when expressing our views. If something concerns us, we should feel able to speak up. If we find a better way of doing something, we should feel free to share it. We must use our voices to shape our roles, workplace, the NHS, and our communities, to improve the health and care of the nation… When our people speak, we must listen and then take action."

Maternity services at UHL, embarked on the Empowering Voices programme in 2022. An independent Coach and Mentor was assigned to complete individual and group fact finding sessions enabling staff to speak freely about their experiences working for UHL and the NHS. Staff were unsure of the process initially but soon embraced having the time to talk about their experiences and any inequalities they had personally experienced or witnessed.

As a result, key themes and actions identified, which the trust is addressing through the Maternity and Neonatal Improvement programme group (MNIP) who provide assurance and support. All staff are actively encouraged to speak up to the trust's Freedom to Speak Up guardians if they have any concerns or the maternity Safety champions for clinical issues. The trust is actively supporting safe spaces where colleagues of the Global Majority can report any issues of racism.

The maternity department have recently employed 21 international midwives and nurses who do not have a dedicated support network once they have completed professional registration and their supernumerary status. Consultant Midwives are actively undertaking a scoping exercise to determine how best to support newly recruited international colleagues.

6. Hearing the voices of non-White women and birthing people in LLR

LLR Maternity and Neonatal Voices Partnership was launched in June 2018, to address the significant gap in helping new mothers to speak up and ensure that their experience voices are heard. Since inception the LLR MNVP has become an established local network whilst also linking other regional MNVPs in national partnership. Leicester Mammas was invited to deliver the MNVP programme following a formal tender process from April 2023.

The MNVP is designed to be a co-production forum, working with communities impacted by inequalities, to address the barriers and disparities experienced by new parents and their babies. The work focuses on five key principles:

i. Work creatively, respectfully and collaboratively to co-produce solutions together.
ii. Work together as equals, promoting and valuing participation. Listen to, and seek out, the voices of women, families and carers using maternity and neonatal services, even when that voice is a whisper. Enabling people from diverse communities to have a voice.
iii. Use experience, data and insight as evidence.
iv. Understand and work with the interdependency that exists between the experience of staff and positive outcomes for women, parents, families and carers.
v. Pursue continuous quality improvement with a particular focus on closing inequality gaps.

Leicester Mammas was founded in 2008 to ensure that the experiences of parents from under-served communities play an instrumental role in improving services. The initial focus of the organisation was to support breastfeeding parents, however an intentional move to embrace all feeding methods has enabled Leicester Mammas to become a more inclusive support service with a focus on those in the most deprived communities. Over the past five years Mammas' scope has widened to encompass the

'First 1001 Days' (The best start for life: a vision for the 1,001 critical days, n.d.). Membership of Mammas is diverse and broadly represents that wider LLR region, with work to do to improve representation by some ethnic groups.

A core aim of the MNVP led by Leicester Mammas is to hear the voices of women who are least likely to feel, or recognise, that their experiences matter. A concerted effort has been made to establish trusted links with local community organisations and the VCSE sector. This has been achieved through attending planned events as well as hosting listening events. Leicester Mamma's also work closely with clinical teams on specific improvement projects that aim to address racial disparities in maternal care. The full MNVP annual report for 2023/24 can be found here.

In addition to the work of the MNVP, UHL's Patient and Community Engagement team are also key to building trusted relationship and giving platform to those communities who are under-represented and subject to inequity. Similarly to Leicester Mammas, this small team has provided dedicated support to projects focusing on addressing racial disparities in maternal care that are detailed elsewhere in this report.

What more do we need to do to address racial injustice in maternity for people in LLR?

Outlined below are six key areas of intervention that the group membership believe are important to drive forward action on racial injustice in maternal health for the people of LLR. These are grouped under the themes referenced in the FiveTimesMore report:

Knowledge:

1. Use data to define the problem explicitly and specifically for the population.
2. Embed quality improvement (QI) methodology as a strategic enabler of addressing health inequalities and work with academic partners to deliver inclusive research.

Attitudes:

1. Confront and address systemic and institutional racism through learning.
2. Focus on maternal mental health to deliver integrated services to meet service users' multifactorial needs.

Assumptions:

1. Discover and understand the upstream causes of race-related disparities specific to the population through cross-sector, inter-disciplinary collaboration.
2. Amplify the voices of non-white women and birthing people, focusing intentionally on black communities.

Knowledge:

1. **Use data to define the problem explicitly and specifically for our population.**

MBRRACE reports provide healthcare providers with an oversight of the experiences and outcomes of the populations that they serve. Clinicians at UHL are developing a maternal health inequalities dashboard through which local data analysis can drive decision making through data intelligence.

The Ockenden report into Maternity services in the Shrewsbury and Telford NHS Trust (2022) highlighted that:-

"Pregnancy is a well-known catalyst that can exacerbate maternal vulnerability and inequalities that already exist in some women's lives."

The Perinatal Inequality Dashboard is an innovative tool that combines demographic data on Race, Ethnicity, postcode, preferred language, with adverse pregnancy outcome data such as Stillbirths, early neonatal death, severe perineal trauma (3rd and 4th degree tear rates), major haemorrhage and referral rates to the perinatal mental health team. The interactive dashboard enables the population to be subdivided into smaller groups, and the outcomes of the examined group to be assessed against the baseline for the population. The dashboard has been created collaboratively by the obstetric, neonatal and perinatal mental health to illustrate differences in healthcare outcomes based on ethnicity and deprivation scores. As the data is displayed over time, as interventions are being introduced, we hope that we can observe the impact of that intervention on various outcome parameters being measured.

An example of this is how the maternity dashboard highlights that Leicester is an outlier for its rates of severe perineal trauma after child birth (3rd/4th degree tears). The Perinatal Inequality Dashboard highlights that third- and fourth-degree tears rates, are significantly more common in Asians than in other Race/Ethnic groups. When the groups are further categorised into English speaking and non-English speaking, the rates in the non-English speaking groups are almost five times higher than the English-speaking groups. Through raising awareness and lowering the bar for interventions in this cohort (such as being ready to conduct an episiotomy, reducing lithotomy positioning in labour, and encouraging this group of women to use warm compresses and perineal massage antenatally) may improve outcomes. All these characteristics have been found to minimise the chance of tears, but we recommend focusing resources on the subset of women who are most likely to benefit before expanding to the entire maternity community.

Additionally, the group have worked with social scientists and conducted focus group interviews, to have a deeper review of the root cause of the disparity and start to coproduce guidelines and patient information resources to ensure that the care provided is equitable. A recent audit has shown that over the past 6 months the rates of third and fourth degree tears is now below the national average.

The objective is that by making the dashboards interactive, relevant, informative and current, the impacts of any new measures to eliminate inequity can be followed in real time. Furthermore, by integrating key parameters within the dashboard the necessity for lengthy audits can be avoided.

2. Embed quality improvement (QI) methodology as a strategic enabler of addressing ethnicity driven health inequalities and work with academic partners to deliver inclusive research.

Quality Improvement

University Hospitals of Leicester (UHL) have recently created a maternity and neonatal quality improvement team involving both clinical and non-clinical staff to drive improvement forward based on both national drivers and local recommendations.

The team involves multidisciplinary colleagues from within maternity and neonatal services to be involved and shape improvements in their department. Targeted task and finish groups and working parties have been formed to aid prompt progression and momentum and clinical medical, midwifery and nursing leads are assigned to work streams. A team of Project Support Officers use the IT system 'Monday.com' to collate evidence and monitor action trackers relating to specific work streams.

A monthly forum called QUAIL (QUAlity, Improvement & Learning) in Action is led by the Maternity and Neonatal Quality Improvement team where updates are shared and staff present their own QI projects; influencing and motivating others to get involved in quality improvement. There is also a monthly newsletter which is produced for staff to celebrate achievements to encourage and improve staff engagement in QI work.

Maternity have built strong partnerships with the local Maternity and Neonatal Voices Partnership (MNVP) so service users are involved in quality improvement work streams for example, Induction of Labour. Maternity at UHL also have strong relationships with the Trusts QI and Audit teams for support and advice.

Within the last year there have been multiple examples of improvements made to services within maternity including:

- The Janam App: a virtual information guide which includes videos and animations relating to pregnancy, birth and beyond in multiple languages (English, Urdu, Gujarati, Hindi, Punjabi and Bengali).
- 'My Maternity Journey – a personalised care plan': a paper booklet for women/birthing people to document their preferences regarding their pregnancy and birth.
- Creation of the East Midlands Maternal Medicine Network: monitoring and caring for women/birthing people who have pre-existing medical conditions.
- Pain relief in labour information: posters have been developed with QR codes in different languages to provide information about pain relief and epidural analgesia.

Inclusive Research

The recent NHS Race and Health Observatory's (Esan O, Adeji N, Saberian S, Christianson L, M Philip, Penningotn A, Geary R, Ayorinde A, 2023) report on existing policy interventions highlights a significant gap in addressing ethnic health inequalities in maternity and neonatal care in England. It reveals a concerning scarcity of interventions at organizational levels that target the structural and institutionalized processes perpetuating racism and ethnic inequalities. Notably, specific interventions for underrepresented groups such as Black African, Black Caribbean, Roma, Gypsy, and mixed ethnic groups—as well as migrants, refugees, and asylum seekers—are limited. This shortfall is particularly acute outside London, with no completed research evaluations to substantiate the impact of existing interventions.

This report accentuates the urgent need for investment in research aimed at reducing ethnic health disparities in maternal and neonatal health. It stresses the importance of understanding the intersectional factors affecting patients' access to care, including socioeconomic contexts and community environments. However, evidence of effective interventions in reducing maternal health inequalities remains scant, signalling a pressing need for co-produced research and interventions involving women from ethnic minority groups. This is echoed in findings from multiple reports, such as the House of Commons Committee Black Maternal Health Report (House of Commons Women and Equalities Committee, 2023) and the Fivexmore report (Peter M, 2022), which highlight a distinct lack of research into the maternity experiences of Black women. These gaps indicate that the nuances of how Black women perceive care during maternity are poorly understood, emphasising the need for more inclusive and participatory research methodologies.

In response to these critical insights and following recommendations from the Fivexmore Report (Peter M, 2022), a collaborative research project has been developed. This project, funded by the

University of Leicester's LIAS and conducted in partnership with the University of Leicester and Public Health, aims to examine the historical and current maternity experiences of Black and Mixed Black women in Leicester and Leicestershire. The research focuses on collecting qualitative oral histories from women in the region, thereby enriching our understanding of how past experiences influence current perceptions of the NHS and advice shared within communities.

Moreover, this initiative is part of a broader effort involving multiple maternal health organizations and support groups across the UK to address maternal inequalities. An application for the NIHR Maternity Challenges consortium funding (£50 million) is underway to co-design further research with underserved groups. This consortium aims to deeply understand the experiences of ethnic minority women along the maternal health pathway and develop interventions to improve inequities in access, experience, and outcomes. A cross-cutting theme that focuses on addressing inequalities and inequities in care across the maternal health pathway for ethnic minority women, in partnership with UHL to further our work in this area will be a significant area of focus.

Finally, as part of our commitment to broader research inclusion, training must be co-produced with people from underserved groups in their community settings, targeting inclusive research practices across various health inequalities. An approach to this has been established in LLR an provides a model for co-produced training with underserved groups. The goal for future co-design training is to enhance healthcare professionals' and researchers' understanding and improve the quality of maternal care for all ethnic groups. With this approach and work package in mind, we have drafted the NIHR Maternity Challenge grant consortium application, aiming to secure funding to further develop this research and training initiative.

Attitudes:

1. **Confront and address systemic and institutional racism through learning.**

(i) Decolonise midwifery.

It is suggested that a collaborative partnership with the University of Leicester and practice partners clinical practice educators be established to review current content of mandatory training for all grades of employees involved in maternity care. The aim is to encourage a greater understanding of the needs of women and families, current and future workforce from all races, ethnicities, cultures and backgrounds while re-constructing education from a global perspective to produce a robust and accurate evidence-based curriculum.

This will be achieved by embedding recommendations from the Royal College of Midwives (RCM) Decolonising Midwifery Education Toolkit (RCM, 2023) on recruitment, curriculum, assessments and practice. It can reasonably be expected that this will increase racial concordance, racial literacy and decolonise midwifery education to encourage a greater understanding of the needs of women and families from all races, ethnicities, cultures and backgrounds, in line with the Nursing and Midwifery Council (NMC) Standards of proficiency for midwives (NMC, Standards of proficiency for midwives, 2019) and the Nursing and Midwifery Code (NMC, The Code, 2018).

(ii) Recognise ethnicity related workplace trauma.

Colleagues who are of non-White ethnicity experience race related discrimination and trauma as evidenced by local Workforce Race Equality Standard data. Race and ethnicity are still felt to be a taboo subject for colleagues to discuss and it is felt that cultural awareness and competency training

should be prioritised. Learning from others, clinicians at Leicester Partnership Trust have engaged with Birmingham and Solihull Perinatal services to learn how they have begun to address ethnicity related barriers to improvement within their services.

Ethnicity related workplace trauma may traditionally be ascribed to experiences of racial discrimination or profiling. It may also be the consequence of adaptation to the workplace environment with the intention of creating a sense of belonging and the unintended consequence of vicarious trauma. UHL have begun initial conversations about exploring and understanding the heritage of colleagues' names, the meanings these have and how these contribute to a sense of self and even purpose. Though in the early stages of development, this piece of work aims to recognise the trauma of mispronounced, anglicised or changed names and how these impact on the workplace experience and ultimately patient care.

(iii) Embed inclusive leadership.

In collaboration with Leicester Partnership Trust (LPT) and the LLR Integrated Care System (ICS), UHL have formed the LLR ICB Nursing, Midwifery & Allied Health Professionals Inclusion leadership group, with a specific maternity representative in the group.

This group has been established to promote inclusive recruitment practices free from bias including, but not limited to, embedding diverse interview panels throughout the organisation. There will be a focus on strengths-based recruitment, moving away from traditional recruitment models which are known to adversely impact non-White candidates. In order to promote this, the Developing you, Developing Me Talent Acceleration Programme was launched in October 2023. The programme aims to ensure personal development through mentorship and is aimed specifically at non-White colleagues.

Further work of the group will include reviewing Workforce Race Equality Standards (WRES) data and NHS staff survey reports when published to ensure appropriate and impactful responses to discrimination which are aligned to the Trust's broader action plan.

Two newly recruited Consultant Midwives with a portfolio for inclusion in maternity care have also recently been recruited and commenced work with the specific remit of improving inclusion in midwifery and tacking health inequalities. The Consultant midwives are also visiting lecturers to the University of Leicester and De Montfort University, strengthening links to research and promoting inclusion in maternity and neonatal research and undergraduate education.

(iv) Embed inclusive recruitment and retention.

Over 80% of the midwifery workforce is of White British ethnicity though there has been a notable increase is non-White recruits since 2020. Similarly, 75% of midwifery support staff are white British, though there has been a 9% increase in non-White midwifery support staff between 2019-2023. Given the diversity of the population of Leicester, ensuring that our workforce represents our communities is paramount.

A newly established programme to increase international recruitment of midwives with support from NHS England has seen 14 international midwives recruited to UHL in 2023. An Education and Practice Development midwife for international recruitment has been employed to continue to develop this pipeline of recruitment. This midwife liaises closely with the Recruitment, Retention and Pastoral Care team (see below) when midwives join the professional register following a successful conversion programme to sustain support. Recruits are offered support with accommodation and relocation costs.

Non-white colleagues are proportionately more likely to be un-registered ie not on a professional register and in a 'non-skilled' role. Non-traditional training routes will support increases in inclusive recruitment into midwifery and allied professions. A focus on apprenticeships and development from bands 2 and 3 to band 4 with a new initiative of nurse associate trainees in maternity will support this.

UHL have have employed three Recruitment, Retention and Pastoral Care Midwives and a Safe Staffing Matron. Their role is to support newly qualified and new to the trust midwives to achieve UHL competencies and to provide staff well-being support and advocacy when required. The team carry out stay and exit interviews and share reports with the midwifery senior leadership team.

Sustained outputs from the Empowering Voices programme to address cultural microaggressions and improve cultural competency will support recruitment and retention of non-White colleagues. Unconscious bias training is now mandatory for all registered and non-registered staff.

2. **Focus on maternal health to deliver integrated services to address individual and multifactorial needs.**

The separation of services across multiple sites and trusts increases the challenge of delivering holistic healthcare, the impact of which is exacerbated in vulnerable groups, including those at risk of health inequity. Using perinatal mental health as a case study we propose that deeper integration of services and joining up of care is vital to ensuring that inequalities in maternal outcomes are addressed. This will also have long standing benefits to the healthcare system more broadly.

The Perinatal Mental Health Service is a psychology-led, trauma-informed service. The team is made up of Mental Health professionals that provide personalised and specialist care to people living in Leicester, Leicestershire and Rutland who have complex or severe mental health problems relating to pregnancy, childbirth and the first year following a child's birth (also known as the Perinatal Period). The team has been going through a process of change with expansion of the service and aiming to advertise the service to the general community and professionals such as GPs, Midwives, Health Visitors and community support groups. The service covers a wide variety of needs, including: pre-conception and early pregnancy advice, medication advice and monitoring, safeguarding, breastfeeding support and much more.

However, there are notable gaps and areas of improvement needed including, but not limited to: the workforce does not reflect the diversity of the population and the service user cohort does not reflect the diversity of the population. Integrated provision of services will allow resource and expertise to be brought together to ensure focused work to ensure disparities are addressed.

Assumptions

1. **Discover and understand the upstream causes of race-related disparities specific to the population through cross-sector, inter-disciplinary collaboration.**

In an effort to show progress, it would be easy to move towards a solution focussed approach to maternal disparities and health inequalities more broadly. However, key to sustainability is ensuring that both the 'why?' and 'what?' are addressed. Why do disparities exist? What is the specific disparity affecting the population in question?

Taking a quality improvement approach to service improvement and ensuring that clinical research is inclusive, as described above, will be vital, in particular for addressing the 'what?' and will enable health specific solutions to be hypothesised. Understanding why disparities exist however is entangled

with the root causes of social determinant factors such as education status, employment status and housing status. While healthcare only contributes to 20% of inequalities, it influences the wider determinants of health more broadly and it is widely accepted that the intersection between wider determinants impacts on individuals' health status. Further cross-sector, inter-disciplinary research is desperately needed to understand why specific communities experience disparities compared to others before targeted solutions can be co-designed and co-implemented with communities themselves.

A project bringing together the University of Leicester's Population Health Sciences, Sociology and Medical School, UHL and Leicestershire County Council Public Health division has recently been given a small amount of seed funding to explore and develop an Historical Understanding of Black Maternity and Motherhood Health Experiences in Leicestershire".

Collaborative work of this nature underpins sustainable change but is largely absent from the academic evidence base in maternal disparities. Sensitive exploration of historical experiences contextualise today's disparities and support confronting and difficult conversations about systemic and institutional racism, without which race related disparities cannot be addressed.

2. **Amplify the voices of non-white women and birthing people, focusing intentionally on black communities.**

As stated previously, the NHS people plan points out that when the workforce represents the population, quality and experience of care improves with positive impact on outcomes (Belonging in the NHS, n.d.). Similarly, it is accepted that focused and intentional community engagement positively influences health related behaviours (Cyril, Smith, Possamai-Inesedy, & A, 2015). For community engagement to be impactful it too must be representative of the community in question *citation*.

Through careful quality improvement work, using data insights as described above, engaging with specific communities will enable partner organisations across LLR to work with communities to develop understanding of disparities and solutions to problems identified by communities specifically. Targeted work is already underway in LLR, for example work to address late bookings for antenatal care in Black communities, as described above.

However, trust remains low within non-White communities and emphasis must therefore be placed on establishing relationships and fora that enable mutual accountability for actions to address disparities. UHL will launch the UHL Health Equality Partnership in the summer of 2024 with a view to continuing work that has already happened to build bridges, however it is recognised that this is a small step in what will be a long and difficult journey, owing to the years of dis- and mistrust that has become embedded. In view of this, focusing on specific relationships with leaders of the Black community will be a key action through the work described above to address maternal disparities for these communities.

Conclusion

This report and framework was established to answer the specific question, "what is happening in Leicester to address the disparities experienced by black women and people during pregnancy and childbirth?" In drawing together a number of experts across disciplines, it is clear that there is already a significant drive to address this problem, with multiple individual workstreams to address various

facets. However, it is also fair to say that more needs to be done, especially if the work that is happening is to move from a reactive state to a proactive and sustainable change.

Important practical and process-based improvement will undoubtedly help, for example work to understand why black people book later for antenatal care. However, authentic and meaningful improvement in disparities experienced by non-White women will only happen if the foundational work to understand upstream causes of disparities is given due priority and urgency. Similarly, increasing representation in the workplace will have limited impact without concurrent work to address systemic and institutional racism alongside personal bias through efforts to improve cultural competency across the workforce.

The 2022 Fivetimesmore report provides a useful thematic framework for the recommendations outlined above and summarised below. It is important to recognise and accept that while some change may happen at pace, longer lasting change will take time. The authors strongly believe that persistent focus on these actions will lead to improvements in outcomes for non-White people and their babies, with sustained, embedded change that has the potential to influence health and healthcare more widely.

Knowledge:

1. Use data to define the problem explicitly and specifically for the population.
2. Embed quality improvement (QI) methodology as a strategic enabler of addressing health inequalities and work with academic partners to deliver inclusive research.

Attitudes:

1. Confront and address systemic and institutional racism through learning.
2. Focus on maternal mental health to deliver integrated services to address individual and multifactorial needs.

Assumptions:

1. Discover and understand the upstream causes of race-related disparities specific to the population through cross-sector, inter-disciplinary collaboration.
2. Amplify the voices of non-white women and birthing people, focusing intentionally on black communities.

This report intentionally focuses on key themes that should underpin work to address maternal inequalities, particularly for Black women and birthing people. For the impact to be felt most deeply, these themes should be aligned to key areas of clinical focus that any organisation highlights as a source of maternal inequality.

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