APPENDIX

Health and Wellbeing Board Annual Report 2023-24

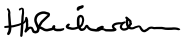
1. CONTENTS PAGE

2. FOREWORD

As chair of the Leicestershire Health and Wellbeing Board I am pleased to present this annual report highlighting the work we have carried out across the year which contributes to delivering our Joint Health and Wellbeing Strategy 2022-2032 and ultimately contributes to improving the health and wellbeing of our residents.

I wish to thank all our partners who have been involved in the work this year and contributed to the successes we have achieved, particularly against a backdrop of having to do more with less. This report provides a flavour of some of the wonderful work that has taken place alongside highlighting some of the ongoing challenges that will form our focus over the next 12 months. Hopefully you will also see the important role HWBs play in the Integrated Care System (ICS). The annual report also demonstrates the commitment of all members of the Health and Wellbeing Board, our partners, subgroups, district colleagues and voluntary organisations, to improve the health and wellbeing of all our residents.

All the Health and Wellbeing Board meetings are public meetings and are recorded via the Leicestershire County Council YouTube Channel, enabling them to be viewed later. Non-Board members and members of the public are welcome to attend, so I would encourage you to come along and see what it is all about. The HWB has recently refreshed its website, providing information about the Board and opportunities for you to get involved and have your say.



Louise Richardson

Chair of the Health and Wellbeing Board

Words from Vice Chair:

As Vice Chair of the Leicestershire Health and Wellbeing Board, I am proud to reflect on a year marked by significant progress and impactful initiatives. Our efforts have been concentrated on expanding community mental health services and promoting healthy lifestyles through our staying healthy campaigns. These initiatives have reached a broad audience, fostering better mental health support and encouraging healthier daily habits across our county.

This year, we have also strengthened the integration of health and social care services, enhancing care delivery for our aging population and those with complex needs. Despite ongoing challenges, particularly in addressing health disparities, our commitment to a more inclusive and accessible health system remains unwavering. As we look forward, our focus will continue to be on prevention, early intervention, and fostering a culture of inclusion and diversity within our community health services.

I am deeply grateful for the dedication and support from our Board members, partners, and the residents of Leicestershire. Together, we will continue to build a healthier, more resilient community for all. Thank you for your ongoing commitment to our shared mission.

Dr Nikhil Mahatma

Vice Chair of the Leicestershire Health & Wellbeing Board

3. ROLE AND MEMBERSHIP OF THE HWB

The Leicestershire Health and Wellbeing Board is a statutory committee of Leicestershire County Council and was established under the Health and Social Care Act 2012. The Board acts as a forum in which key leaders from the local health and care system work together to improve the health and wellbeing of residents.

The Leicestershire HWB is responsible for:

- publishing a joint strategic needs assessment (JSNA) to assess the current and future health and care needs of the local population; and
- producing a Joint Health and Wellbeing Strategy (JHWS) which sets out the priorities for improving the health and wellbeing needs of the population and how the assessed needs will be addressed.

While HWBs do not directly commission health services, they play an important role in informing the allocation of local resources. The JHWS should directly inform the joint commissioning arrangements of the local area and the coordination of NHS and local authority commissioning, including responsibility for signing off the Better Care Fund (BCF) Plans.

3.1 WHO WE ARE

The Leicestershire Health and Wellbeing Board is a partnership chaired by the County Council Cabinet Lead Member for Health, Mrs Richardson, and includes representatives from the Integrated Care Board (ICB), Healthwatch, Leicestershire Partnership NHS Trust (LPT), University Hospitals of Leicester (UHL), the Office of the Police and Crime Commissioner (OPCC), the Police and Local Authority partners; which includes the Cabinet Lead Member for Children and Young People, Cabinet Lead Member for Adults and Communities, and the Directors' of Public Health, Children and Family Services, and Adults and Communities. Recently, a representative from the Voluntary and Community sector (VCS) was invited to become a member of the Board.

The Leicestershire HWB has strong links with system-based partnerships, namely the ICB and the Health and Wellbeing Partnership (HWP) – formally known as the Integrated Care Partnership (ICP). The Leicestershire HWB also has strong links with neighbourhoods. The outcome is better alignment of priorities across system, place and neighbourhood through the Joint Health and Wellbeing Strategy, the Integrated Care Strategy and the Community Health and Wellbeing Plans.

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. Healthwatch is an organisation 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 heard and used to shape future improvements.

During 2023-24 Healthwatch Leicester and Healthwatch Leicestershire published several 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. The reports can be accessed online .

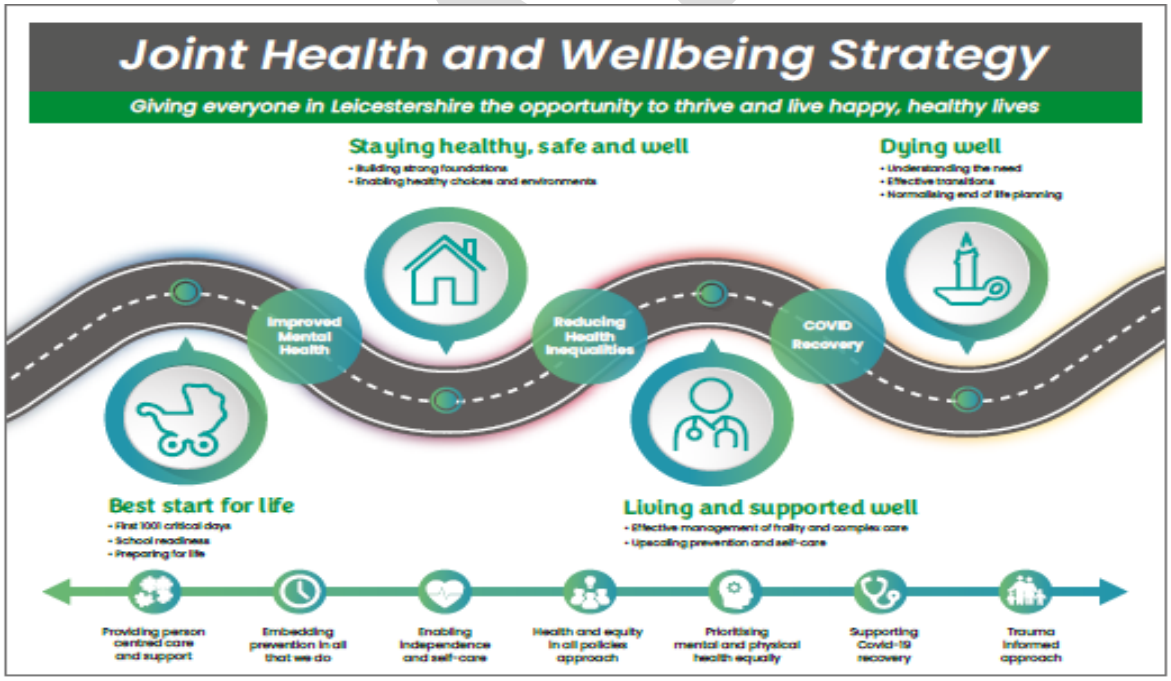
4. Statutory responsibilities of the Board

The HWB has a number of statutory duties as part of its remit to reduce health inequalities and improve health outcomes for its population.

- Joint Health & Wellbeing Strategy
- Joint Strategic Needs Assessment
- Better Care Fund
- Pharmaceutical Needs Assessment

4.1 Joint Health & Wellbeing Strategy

The aim of the Joint Health and Wellbeing Strategy (JHWS) is to improve the health and wellbeing outcomes of the local population. The JHWS for Leicestershire outlines the priority areas, setting out how partners from across the health and care system, as well as the voluntary and community sector will work together to achieve these priorities. The JHWS follows a life course approach – from Best Start in Life to Dying Well, with additional cross-cutting priorities.



The Leicestershire JHWS was approved in February 2022. Each life course strategic priority has a corresponding set of commitments and a delivery plan that sets out the actions and activities which are taking place to help achieve the priorities. This work is overseen by each of the four HWB subgroups with regular updates on progress provided to the HWB.

Over the last 12 months the HWB has worked hard to strengthen its role as a place-based leader for health. Following a development session in July 2023, Board members looked at how the HWB could add value, above and beyond what was already being delivered. This highlighted the

importance of having a space outside of the official meeting structure to allow for more informal discussions. As a result, it was agreed to hold a number of development sessions themed on each of the JHWS life course strategic priorities to unpick some of the more stubborn challenges and work through them together as a partnership. A 12-month forward plan has been produced and development sessions focussing on the priority areas of Mental Health, Dying Well and Best Start in Life have already taken place. The Staying Healthy, Safe and Well and Living and Supported Well themed development sessions have been scheduled to take place over the next 6 months.

Each session is bespoke, led by an external facilitator and shaped by the relevant subgroup. Subject matter experts from across the local authority, health, social care and voluntary sector have been involved to enable contributions from a range of different perspectives. An agreed set of actions and recommendations are taken back for the relevant subgroup to work through. Updates on progress will be fed back to the Board with any unresolved issues escalated for support.

4.2 Joint Strategic Needs Assessment (JSNA)

Needs Assessments, evidence and intelligence processes are integral to local health and social care planning. They ensure that the local authority, ICB and partners base their strategies on robust evidence and real-world data. The aim is to help in the effective allocation of resources, commissioning of services, and development of targeted interventions to improve public health and wellbeing. By involving a range of stakeholders, the JSNA plays a crucial role in shaping effective and responsive health and social care services and the wider determinants of health.

The Health and Wellbeing Board has a statutory responsibility for developing the JSNA on an iterative basis. The 2022-2025 JSNA comprises subject specific chapters which review the current evidence on inequalities, health outcomes and service effectiveness, assess local health and social needs (e.g., prevalence), identify at-risk population groups, analyse local insights into the provision of care, and outline areas for improvement as agreed with stakeholders.

4.3 The Better Care Fund (BCF)

The Better Care Fund (BCF) is a program in England designed to support the integration of health and social care services. It aims to facilitate closer working relationships between the National Health Service (NHS) and local government to improve the quality and efficiency of care for patients, particularly those who require both health and social care support. The BCF represents a significant effort to break down the traditional barriers between health and social care, ensuring a more coordinated and patient-centred approach to care delivery.

4.4 Pharmaceutical Needs Assessment (PNA)

The HWB has a statutory responsibility to produce a pharmaceutical needs assessment within 3 years of its previous publication. The purpose of the PNA is to:

- Identify local pharmaceutical services that are currently available and assess local needs for pharmaceutical services in the future
- Inform the planning and commissioning of pharmacy services

- Inform decision making in response to applications made by pharmacists and dispensing doctors to provide a new pharmacy

The latest PNA was published in 2022 and is available here. The next PNA is timetabled to be completed in 2025.

5. Progress against the Joint Health and Wellbeing Strategy

5.1 Children & Family Partnership – Best Start for Life

Leicestershire Children and Families Partnership is a subgroup of Leicestershire's Health and Wellbeing Board and is responsible for the delivery of the Best Start for Life strategic priority of Leicestershire's Joint Health and Wellbeing Strategy (JHWS). This is achieved through the Children and Families Partnership Plan and comprises of the following priority areas:

- First 1001 critical days
- School readiness
- Preparing for Life

5.1.1 Maternity and Early Years Strategy

We know that the critical development phases from conception to age 2 are when the building blocks for lifelong emotional health and wellbeing are developed and that early social and emotional experiences help build a baby's brain. We also know that children with secure attachment to their parents and carers develop into resilient adults.

The Leicestershire Maternity and Early Years Strategy and action plan for 2023–25 has been launched and aligns to the First 1001 Critical Days and School Readiness priorities. The action plan focuses on:

- Consistent and shared messages across all the providers working in the 0-5 arena to ensure the workforce is informed, has a shared evidence base, a good understanding of services available, and how to access them.
- An ability to prioritise services according to need by developing shared data systems to support the delivery of high-quality services and to target areas or populations with the highest needs.
- Meaningful engagement with Leicestershire communities to ensure voices are heard and responded to in the delivery of this strategy.

As part of this action plan, work has continued to raise awareness of the importance of the First 1001 Critical Days for children's development:

- The Council's Targeted Early Help service (formerly known as the Children and Family Wellbeing Service) has developed an e-learning module which is now mandatory for all new Children and Family Services (CFS) staff and will be shared via the Leicestershire Safeguarding Children Partnership (LSCP) website for all professionals to access.
- Multi-agency webinars have been delivered to CFS, health and midwifery staff and to early years providers, foster carers and Homestart volunteers. Workshops have also been delivered to midwifery students at De Montfort University and students at further education colleges. Information has been shared with families by CFS, health and midwifery, via monthly social media campaigns aimed at parents, sharing key messages and practical ideas for supporting early brain development.
- Resources, including a Five to Thrive leaflet and Baby's First 1001 Days animation have been developed in consultation with local parents to help share practical ideas for promoting children's development.

- Interactive events have been delivered across the county by Children and Family Services, aimed at sharing key messages with families who don't usually engage in services.

5.1.2 School Readiness

Preparing our children for school is an important transition in their lives and allows them to have a positive start to their formal educational journey. We want the pre-school children of Leicestershire to be equipped with the skills they need to enjoy and flourish as they enter foundation years at school.

Work which continues to promote School Readiness includes:

- Improvement in the early identification of children at risk of delay through the sharing of two-year health review data and embedding an integrated pathway of support from Health and the Councils Targeted Early Help and Early Years SEND services.
- Delivering support and training to early years professionals to enable them to support children's communication and language effectively, and to identify children who may need more targeted support.
- Delivering campaigns and developing resources to share key messages with families on the importance of accessing early years provision and hints, tips and practical ideas to support children learning and development in the home environment

Data tells us that:

- 95% of early years providers in Leicestershire are rated by Ofsted as good or better.
- 97% of two-three and four-year olds in Leicestershire access a good or outstanding setting.
- 73.1% of Leicestershire children are reaching their age-appropriate milestones and achieving a good level of development at the 2-year health review.

Work led by the Maternity and Early Years Partnership over the coming 12 months will focus on meeting the challenge of the governments Expansion of Childcare agenda. As Leicestershire have lost childcare places due to Covid, the national recruitment and retention crisis and the cost-of-living crisis, actions will include developing a retention and recruitment strategy, promoting childminding as a career in childcare and continuing to work with the sector to look at capacity and opportunities to offer increased places.

5.1.3. Early Help

The Early Help Partnership is a sub-group of the Children and Families Partnership and over this period has focused on understanding the broader early help system and thinking about the responsibilities all partners have within this system. In December 2023, the partnership developed an Early Years Strategy for the county drawing on the national Early Help System Guide and the updated Working Together to Safeguard Children document, both of which detail the importance of strong partnerships in early intervention and prevention. This strategy and linked action plan are closely aligned to the Maternity and Early Years strategy and action plan and there are shared and linked actions across both action plans around Family Hubs and workforce development.

The Early Help Strategy aligns to the First 1001 Critical Days, School Readiness and Preparing for Life priorities and identified 3 major strands of work for 2023-25:

- Family Hubs - Development of this strategy, implementation of Family Hubs, publication of Start for Life offer, workforce development plan and early help competency framework, promotion of the early help assessment process with all partners. Also included, the Reducing Parental Conflict programme and Supporting Families programme providing intensive support to more complex families.
- Voice, equity, and influence - Developing a mechanism to ensure the voice of families is heard at strategic partnership level, adoption of the Lundy model for engagement, ensuring we hear the voices of those we do not usually reach.
- Data and Information - Ensuring an up to date and comprehensive data sharing agreement is in place, work together to identify useful data sets across the partnership to help inform planning, explore potential for developing further vulnerability data sets to support identification of need.
- Family Hubs are a national programme and Leicestershire was one of twelve local authorities to be successful in applying for Department for Education funding to support the transformation of partnerships and service delivery to create 'one-stop shops' for all families 0-19 (or to 25 for young people with SEND), providing access to information, advice, resources, and support. Community engagement workers contacted organisations and families to promote the hubs, bring together networks and ensure that family voices were heard in all plans. Work undertaken over the past twelve months included: Re-branding and launching 20 Children and Family Wellbeing Centres as Family Hubs and working closely with county libraries (including providing training to Library staff) to create 16 additional 'Hubs in Libraries'.
- Development and launch of a Family Hubs website, as a digital resource that brings together various services, enabling families, young people, professionals, and volunteers to access information and advice online anytime on key topics such as parenting, behaviour, health and wellbeing.
- Launch of the Family Hubs newsletter, to provide regular updates on what has been happening locally. Launching the Reducing Parental Conflict (RPC) toolkit and the Relationships Matter in Leicestershire partnership document. The RPC agenda has been supported by a Department for Work and Pensions (DWP) grant and over 570 professionals and volunteers have been trained in using the Leicestershire RPC practitioner toolkit to promote awareness and understanding of the impact that parental conflict has on children and to help them in their work with families Over the past 12 months, there has been a significant emphasis on engaging with diverse communities in an effort to understand their needs, particularly those associated with accessing maternity care. This engagement has focused on:
- Engaging with rural communities by taking information out to families who may be less able to access Family Hub buildings and may also experience digital poverty.
- A Maternity Champions project in Charnwood to help understand local barriers to maternity services for Black, Asian, and other Minority Ethnic communities and the training of 'Maternity Champions' to promote the importance of maternity and early years services and help services to better understand barriers to accessing services.
- Working with Gypsy and Traveller communities through Leicestershire Gypsy and Traveller Equalities organisation to help develop a greater understanding of barriers to accessing maternity, early years and other universal health services, and to identify solutions and improved ways of working.

Work led by the Early Help Partnership over the coming 12 months will include:

- continuing to expand the range of services delivered from Family Hubs and building on the Family Hubs website to provide a one-stop shop of resources and information for all communities across Leicestershire.
- working with Rutland and Leicester City to explore the development of an early help competency framework to support the key skills, knowledge and approaches needed by services across the early help system.
- progressing the work to develop shared data sets and data sharing agreements.
- implementing a Partnership early help assessment, to help maintain consistent approaches with families and keep their needs at the forefront.
- exploring how Family Hubs can support multi-agency learning and development to assist the constantly evolving early help workforce.

5.1.4 Children Physical Emotional Mental Health

We want to ensure our children are supported to thrive, stay safe and maintain good health and emotional wellbeing as they make their transition from children, into young adults.

Partners continued to meet regularly to progress actions to improve children physical, emotional and mental health, aligned to First 1001 Critical Days and Preparing for Life priorities. These have included:

- Understanding why breastfeeding rates in Leicestershire are lower than the national average: an exploration of data quality issues and input to the LLR Infant Feeding Health Needs Assessment (HNA). There has also been a successful breastfeeding awareness campaign disseminated across the county via the breastfeeding peer support networks.
- A review of data analysis to understand how Emergency Department attendances for 0-4 years can be reduced. A literature review is being undertaken and best practice is being considered.
- National Child Measurement Programme (NCMP) data has been used to create a dashboard to support a better understanding of where to target support for children who are overweight. The Soil Association has been commissioned to support schools with high levels of childhood obesity and changing food culture.
- 'Call the Midwife' early booking campaign has proved successful, and plans are underway to increase this to GP practices and community locations. There has been a newly established role of a Pregnancy Nutritionist to help address obesity and gestational diabetics in the perinatal period.
- Teen Health service embedded within all mainstream secondary schools and contributing to the prevention element of the wider Leicester, Leicestershire and Rutland (LLR) system, with strong links to Mental Health Support Teams (MHST) in schools.

Developments over the next 12 months will include:

- Implementing recommendations of the LLR Infant Feeding Health Needs Assessment.
- Family hubs working towards UNICEF baby friendly accreditation.
- Continued work to reduce Emergency Department attendances utilising evidence and best practice.
- A whole systems approach to address food insecurity and increase community capacity to cook and eat healthily.

- Work to improve access to mental health support for young people by direct referrals from Teen Health to MHST in schools.

5.2 Staying Healthy Partnership – Staying Healthy, Safe & Well

The Staying Healthy Partnership is a subgroup of Leicestershire's Health and Wellbeing Board and is responsible for delivery of the Staying Healthy, Safe and Well strategic priority which comprises of the following priority areas:

- Building strong foundations
- Enabling healthy choices and environments

5.2.1 Building Strong Foundations:

5.2.1.1 - Leicestershire approach to Health in All Policies

Health in All Policies (HiAP) is recognised internationally as an approach to tackle inequities in health, reducing inequalities and tackling the 'causes of the causes'. HiAP aims to effectively address the wider determinants of health which are the wider factors that shape health outcomes, advocating efforts across the social, economic, environmental and commercial influences that impact on health, requiring collaboration across multiple functions and departments. A HiAP approach systematically considers the health implications of decisions across whole organisations, recognises synergies in working and mitigates harmful health impacts in order to improve population health and health equity. It acknowledges that organisations and systems deal with a range of conflicting priorities and health is not and cannot always be the main focus. However, as many of the determinants of health are due to social, environmental and economic factors outside the direct influence of public health work and policies, action is necessary within all sectors to significantly impact on population health.

HiAP is included within both the Joint Health and Wellbeing Strategy (as part of the Staying Healthy, Safe and Well life course priority) and Public Health Strategy. As such, members of the Health and Wellbeing Board approved the decision to embed HiAP across Leicestershire County Council, providing an opportunity to facilitate the strategic outcomes of the Council. This approach creates permanent change in local government decision-making processes so that over time accounting for health considerations becomes part of business as usual across the whole council to reduce health inequality within our population.

The approach in Leicestershire has been based on best practice evidence and recommendations from numerous organisations including The Health Foundation, Local Government Association, Public Health England (now Office of Health Improvement and Disparities (OHID), World Health Organisation and the Town and Country Planning Association (TCPA).

The guiding aims of the approach are to:

- create a common understanding of health and health inequalities across all departments,
- establish a structured process for analysing the health impact across the whole range of Council functions.
- agree a common commitment across the organisation to health.

LCC took measures to formalise health considerations across all functions internally, increasing organisational awareness around wider influences on health and agreed a systematic approach to influencing decisions and policy plans.

As a result, *health impact considerations are now part of corporate decision-making processes*. This ensures all potential health impacts on residents are appropriately assessed for in new policies, proposals, strategies and programmes going through Cabinet and Scrutiny processes. All departments within the County Council can clearly demonstrate how they have effectively considered health impacts to ensure positive outcomes and mitigate any risk to health.

A package of support and resources was developed to support the above, including a tiered training offer to reframe understanding of wider factors that shape health. The training includes e-learning and face to face sessions, designed to raise organisational awareness of the wider determinants of health and to ensure staff are knowledgeable about what structural and socio-economic factors shape health and how it links to their work. This helps to enable staff to make health considerations within their work and recognise likely health impacts of decisions.

The tiered training approach includes:

Since LCC introduced the Leicestershire HiAP approach there have been a number of key achievements and positive outcomes:

- The HiAP approach, including training around health considerations has been delivered across a range of LCC departments, empowering staff to add a health lens to their work to improve health outcomes and better understand the health priorities across Leicestershire.
- National recognition for this work has been received with a national network HiAP describing it as the most *'comprehensive Health in All Policies package and process seen at a local authority level*'. As a result, a number of Local Authorities have asked for more information about the Leicestershire approach to explore how they can learn from our experience and implement a similar approach in their own organisations.
- The Office of Health Improvement and Disparities (OHID), Town and Country Planning Association and The Department of Education have expressed interest in this work and wish to monitor our progress and outcomes.

Work over the next 12 months aims to offer shared learning with, and support district colleagues to embed the approach within their own district council functions and departments.

LCC Public Health will continue to promote across system partners the importance of viewing their organisations and work through a HiAP lens, putting health equality at the heart of all we do: health in all our work, health in all our decisions and health in and though all our policies.

5.2.1.2 Damp & mould in people's homes

In response to the tragic death of 2-year-old Awaab Ishak in 2020, the government committed to improving the quality of social housing in England with a focus on reforming the sector so that residents of social housing are safe, listened to, live in good quality homes and have access to help when things go wrong.

In the Kings speech on 17 July 2024, the new labour government announced that the new Renter Rights Bill 2024 will ban Section 21 'no-fault' evictions and extend Awaab Law to the private sector.

Case Study: Leicestershire - Housing and Respiratory Illness Project

Hinckley and Bosworth Borough Council are in the process of piloting a project to improve living conditions of residents across Leicestershire. Focussing on reducing instances of damp and mould growth in people's homes and ensuring better outcomes for those who currently live in homes with damp and mould. Aligned to the JHWS priority Staying Healthy, Safe and Well, this project aims to deliver on the commitment *'…everyone to have access to a good home'.*

The project hopes to develop a system in which damp and mould concerns identified by professionals who frequently visit customers in their homes, such as NHS visiting clinicians and social services, can be reported centrally to one place, triaged and referrals made to appropriate services. This includes social housing providers, the relevant local housing authority, or other local government services, ensuring appropriate action is taken to improve living conditions and reduce the health inequalities created by these conditions.

Referrals will be made by professionals via the Joy App (a national tool created for Social Prescribers to link clients to local services), enabling Housing Providers to be made aware of any mould issues as the first point of contact. These can be dealt with quickly, effectively, and hopefully avoid any need for escalation to enforcement action by the council or the Regulator of Social Housing.

Further work to develop the pilot project will continue over the next 12 months with an update on progress provided to the Health and Wellbeing Board in due course.

5.2.2 Enabling Healthy Choices and Environments:

5.2.2.1 Healthy Weight Strategy

In Leicestershire nearly 65% of adults are above a healthy weight and 1 in 5 children start school above a healthy weight. This proportion rises to 2 in 5 at year 6 of primary school. Maintaining a healthy weight can improve our health-related quality of life and reduce the risk of health conditions such as heart disease, stroke, type 2 diabetes, liver disease, and some cancers.

However, obesity is a complex and multifaceted problem that requires coordinated, effective action to change the food, physical activity, and social environments from 'obesogenic' to ones that promote a healthy weight. Fresh and nutritious food needs to be affordable, and people need the skills and resources to be able to cook healthy meals. We need to work together with partners in a 'whole systems approach' to create an environment that facilitates healthy choices and supports

individuals to eat a healthy diet and be physically active. This is the approach we are taking in Leicestershire as set out in the Leicestershire Healthy Weight Strategy.

The strategy focuses on three themes. These are:

- Promoting a healthy weight environment
- Support for people to achieve and maintain a healthy weight
- Prioritising healthy weight through systems leadership

Over the last 12 months working groups have been focused on action in each of these areas. Below are some of the successes.

Theme 1: Promoting a Healthy Weight Environment

- *Improving the awareness and availability of healthy and sustainable food and drink in all sectors*

The group undertook an analysis of food schemes in place across the county and assessed whether they were meeting the needs of residents. These included food banks, community kitchens, social supermarkets and community larders. The analysis showed that often people in need were accessing less healthy emergency provision rather than healthier non-emergency affordable food. An alternative model of support was recommended as part of this analysis.

A scoping exercise was also conducted to see what planning policies could be implemented within existing legislation to manage the number and location of takeaway premises and identify 'food swamps' where action could be prioritised. This action needed to be taken at the appropriate time in the Local Plan development cycle. At the time of completing the scoping work North West Leicestershire District Council was developing this part of their Local Plan and so put itself forward to work with the Town and Country Planning Association and Public Health team as a pilot area. As a result of the partnership work the draft Local Plan was released for public consultation and included a newly draft policy that seeks to manage the location of take aways (Policy TC2) and included an assessment created by Leicestershire County Council and North West Leicestershire District Council to assess takeaway applications as they are submitted.

The strategy group was interested in supporting healthier options in out-of-home food environments but was unaware of what had worked in other areas and what the challenges were. A scoping piece of work was undertaken to identify and describe schemes nationally that encourage healthier options in out-of-home food environments. Evidence showed that changing food options available and restructuring food environments has the potential to 'nudge' people towards healthier choices (so-called Choice Architecture), thus creating positive behaviour change.

- *Supporting Settings to Prevent Obesity and Increase Healthy Weight in Adults, Children, and Families*

The workplace provides a prime opportunity for health improvement work. Local authorities are large employers and so supporting them to improve healthy food options for staff at work and opportunities for being more active through travel to work could have a large impact locally and inform strategies for other workplace settings. Action was taken to describe healthy food options and active travel opportunities within the county and district councils. This included an appraisal of food quality in canteens, vending machines, catering, and provision of equipment/facilities (e.g., fridges, microwaves) to allow staff to bring in their own food. The mapping was used to identify and

share areas of good practice and areas of improvement. Learning was also extended to surveys undertaken in over 50 workplaces as part of the Healthy Workplaces programme. This identified low levels of fruit and veg and fluid intake and recommendations for how employers can take supportive action.

Discussions with local sixth form colleges were undertaken to understand existing provision of healthy food on site and support for healthy eating, and relevant local and national policies/guidance that could inform future action were identified. Work is now underway with the Teen Health Service in Leicestershire to determine what support can be offered to further education providers. The teen health website supports parents, carers and young people who want to know more about the help and care available for young people during their adolescent years.

Theme 2: Support for People to Achieve and Maintain a Healthy Weight

- *Coordinate a healthy weight pathway which includes prevention, self-management and weight management support*

A review of access to weight management services for children in Leicestershire was undertaken and potential gaps in service identified. It was concluded that more emphasis should be placed on children with learning disabilities, as well as those children who are malnourished and underweight (given this is a healthy weight strategy and not an obesity strategy). This resulted in mechanisms for malnourished and underweight children to be identified through the National Child Measurement Programme (NCMP) and input from school nurses to support the families.

A Physical Activity and Wellbeing Residents Survey was undertaken in 2022. This included questions specifically related to healthy weight. Responses were analysed to identify insights relating to physical activity and healthy weight and a summary infographic was produced. The insight and associated recommendations will be used to shape resources, websites and social media to improve population behaviour change impact.

Weight management services are commissioned and provided by local government:

- Tier 1 – advice/signposting
- Tier 2 – lifestyle services

And the NHS:

- Tier 3 – new pilot
- Tier 4 – bariatric surgery

As part of the strategy, work was undertaken to improve referrals across the pathway through the GP referral system Prism and through improved information available on a local website.

Partners across the system also worked to develop a business case for a new tier 3 weight management service. Tier 3 services are multidisciplinary and support people who have more complex needs in terms of mental and physical health conditions. The business case was supported, and a new pilot tier 3 weight management service provided by the University Hospitals of Leicester NHS Trust is in place. Referral of patients and uptake of the service has been so successful that it has had to close for referrals as it has reached maximum capacity. Outcomes are now being monitored.

Theme 3: Prioritise healthy weight through systems leadership

- *Support leadership across the system*

Healthy Conversation Skills training supports front line professionals in talking about healthy lifestyles with their patients/clients. The goal is for this training to be embedded in mandatory training across the system to improve the level of confidence and competence people must engage in conversations around a range of health behaviours. As part of this work, a webinar was delivered to Primary Care Network staff during protected learning time, combining e-learning and Making Every Contact Count. Next, action will be taken to develop and implement bespoke healthy weight resources as part of Making Every Contact Count plus (MECC+) and Healthy Conversation Skills training, accessible via the MECC+ website.

Action was taken to identify and work with partners to understand the key activities/services delivered as part of the weight management system, to highlight gaps in services and seek opportunities for greater collaboration/improved efficiency. As a result, a scheme to provide pregnant women and new mums with healthy food boxes has been piloted and referral criteria for different weight management services have been clarified.

Conclusions and next steps

Building on the successes to date, the strategy group is now implementing follow-on actions for the coming year, focusing on the promotion of healthier food availability in a range of settings including schools, colleges and workplaces, increasing the confidence of frontline workers to promote healthy eating, continuing to work with planning authorities to promote health planning policy and improving processes for referral of patients to weight management services.

5.2.3 Community Health and Wellbeing Plans

Place based work is being driven through the Leicestershire JHWS which sets out the strategic vision and priorities for health and wellbeing across Leicestershire over the next 10 years. To support this work, Community Health and Wellbeing Plans (CHWPs) have been developed on a neighbourhood footprint to reflect the variance in health needs and outcomes across different areas of Leicestershire and are collaboratively owned by all partners.

Each plan seeks to understand and improve the health and wellbeing needs of local populations by identifying and addressing key priorities and issues that reflect the local need. The plans are owned by the local Partnership Board within each district to monitor and provide oversight, receiving quarterly progress update reports.

The CHWBPs sit within the remit of the Staying Healthy Partnership who act as sponsor to track progress. Regular updates are fed through to the Leicestershire HWB and the other subgroups. This provides the HWB with greater oversight of the work happening at district level, avoiding any duplication and highlighting opportunities for joint working.

Over the last 12 months, CHWPs have been developed and approved in five of the seven districts within Leicestershire:

- Blaby

- Charnwood
- Hinckley & Bosworth
- Melton
- North West Leicestershire

Plans for Harborough and Oadby & Wigston districts are currently being developed and are expected to be finalised by the end of Autumn 2024.

Whilst the priorities for each plan reflect the needs of the local population, some of the cross-cutting themes that have emerged include:

- Mental Health – for both children and adults
- Cancer screening – early diagnostic rates/prevention
- Dementia
- Preventative and Self-Care – including falls prevention
- Carers
- Health Inequalities, especially in relation to those living with learning disabilities/SEND
- Care planning for end of life

The CHWBPs have provided an opportunity to really strengthen local partnerships. The voluntary sector in particular has provided valuable insights into the health needs of our local communities, enabling a collective support offer based on local need as opposed to a 'one size fits all' approach.

Earlier in the year, the Charnwood Health and Wellbeing Partnership held a 'celebration event' to acknowledge the contributions and efforts of those who put their time and passion into improving the lives of those who work and live in the Charnwood community. It demonstrated how the partners of Charnwood have embarked on a journey to strengthen their community's foundations, tackling key priorities outlined in the Charnwood Health and Wellbeing Plan: Mental Health, Loneliness, Dementia and Dying Well. A full write up of the event by the Chair of the Charnwood Community Health and Wellbeing partnership can be found online here.

Other examples of the impacts already being made as a result of the CHWBPs are listed below. Full details can be found in Appendix A (section 9.1).

Locality	Case Study Examples
Charnwood Borough Council	Active Practice ESCAPE-pain Mental Health Networks
Hinckley & Bosworth Borough Council	Menopause Support Promoting Positive Mental Health
North West Leicestershire District Council	ESCAPE-pain Healthy Weight Management
Oadby & Wigston Borough Council	Grant Scheme
Melton Borough Council	Falls Prevention Exercise Referral

While the CHWPs have been developed for a 3–5-year term, annual refreshes will be carried out to ensure that the identified priority areas remain appropriate and relevant.

5.2.4 People Zones

People Zones is an initiative created by the Office of the Police and Crime Commissioner (OPCC) for Leicester, Leicestershire, and Rutland (LLR). Aligned to the JHWS, it supports the delivery of the Staying Healthy, Safe and Well commitment priorities: *'…..work with Community Safety Partnerships to maintain low levels of crime and support community cohesion…' and '….develop the ABCD, strength-based approach to build social capital and strong, connected and resilient communities….'*

The overall vision for People Zones is to grow safer communities by:

- building on strengths,
- creating connections,
- empowering everyone to play a role.

There are currently three areas designated as a People Zone: Bell Foundry, New Parks, and Thringstone & Whitwick.

The People Zones project relies heavily on multi-agency support to make it work. It follows the Asset Based Community Development (ABCD) principles, adopting a public health approach by collaborating with people who live or work in these communities to better focus on the strengths and assets within the locality. Cohesion, trust, skill-development, health and wellbeing are just some of the protective factors that contribute to stronger, safer, more resilient communities.

The People Zones Grant Fund is a scheme that invites people and organisations who live, work or provide a service within the area to apply for a grant for up to £10,000 to support new projects or develop existing initiatives that will make a positive difference. The total amount of funding awarded in 2023-24 for community projects across all three People Zones was £117, 474.60. Further details about the projects and how they are making an impact to the communities can be found here. Other key highlights of People Zones, specifically in relation to Bell Foundry include:

Multi-agency approach	
Loughborough University's 'Active Healthy Living' project	Conducting research to improve the health and wellbeing of the local community in Loughborough by increasing engagement in and access to physical activity.
Leicestershire Probation Trusts Community Payback Team	Having previously funded another project at Fearon Hall through the OPCCs Community Payback Budget, a new project is being developed to reduce the height of some of the bin stores in the Bell Foundry Estate in collaboration with the local community and Charnwood Borough Council. Currently seen as a 'no go area' it is perceived that once people start to feel safer in these areas, they will become more used. And ultimately have a positive impact on feelings of isolation, physical activity and overall mental health and wellbeing.

The Bell Foundry People Zones is now fairly established and work to further develop the other two areas will be the focus over the coming year.

5.3 INTEGRATION EXECUTIVE – LIVING & SUPPORTED WELL

The Integration Executive is a subgroup of Leicestershire's Health and Wellbeing Board and is made up of partner representatives including Health, Social Care, Public Health, Housing and Healthwatch. The subgroup is responsible for delivery of the Living and Supported Well strategic priority which comprises of the following priority areas:

- Upscaling prevention and self-care
- Effective management of frailty and complex care

Living and supported well focuses on supporting people to live as independently as possible whilst maximising their quality of life. Helping to manage long-term conditions and frailty and preventing further decline into ill health.

Each priority area has a corresponding workplan to focus delivery against the actions. This compliments and is aligned to the delivery of the Better Care Fund national framework and also the NHS 5-year plan.

There are a number of schemes and services which support delivery of the *'upscaling prevention and self-care'* priority area, ranging from advice and guidance (First Contact Plus) to housing support (Housing Enablement Team), to support with living with long term health conditions (care coordination). So far more than 20,000 beneficiaries have benefitted from these services. Table 1 shows the breakdown in more detail.

Table 1- Delivery highlights 2023-24: Upscaling Prevention and Self-care

HWBB priority	Activity	Detail	Beneficiaries	Outcomes
Up-scaling prevention and self-care	Care Co-ordination	A Health and Social Care proactive care approach using risk stratification within the community enabling patients to receive the 'right care, at the right time, at the right place'. 19.5 FTE	7307	Empower patients to self-manage their long-term condition(s)
	Falls – care homes	Reducing the amount of fallers in the care homes with the highest incidences	2736 falls - a reduction of 15% from 3409	Reducing the number of falls within care homes
	Falls – response car	Responding to falls in the community to support at home avoiding admission to hospital	834	Reducing admissions due to falls
	Disabled Facilities Grants	Disabled Facilities Grants help towards the costs of making changes to peoples' home so they can continue to live there.	1135 (approx. based on Q3 return)	People living with disability and long-term conditions have access to the right housing, care and support.
	Primary care enhanced support	Supporting people in discharge to assess beds to enable access to primary care services away from their usual place of residence	540 (approx. based on Q3 return)	Improve access to health and care services including primary care and appropriate funding support
	INT development	Integrated Neighbourhood Teams bring together multi-disciplinary professionals from different organisations across health and care services	Locality based	Co-ordinating opportunities for integration in localities and building asset-based approaches and social prescribing to work with and for people and communities
	First contact plus	First Contact Plus is an online tool which helps adults in Leicestershire find information about a range of services all in one place.	5716	Improving access to health and care services
	Assistive Technology	Offering a wide range of equipment to maintain independence at home	820	Patients self-manage their long-term condition(s) through digital approaches, assistive technology, accessible diagnostics and support

	Housing Enablement Team	Integrated housing offer within clinical care settings, focused on delivering health and wellbeing outcomes for patients to maximise opportunities to contribute towards safe and timely discharges from hospitals	1583	People living with disability and long-term conditions have access to the right housing, care and support

Similarly, there have been approximately 15,000 beneficiaries who have been supported through the services in place to deliver against the *'effective management of frailty and complex care'* priority area. These range from supporting carers (Carers' Support Service) to reablement (HART); from voluntary services (RVS Hospital Service) to Domiciliary care. This can be seen in more detail in table 2 below:

Table 2 - Delivery highlights from 2023-24: Effective Management of Frailty and Complex Care

HWBB priority	Activity	Detail	Beneficiaries	Outcomes
Effective management of frailty and complex care	Carers support services	Support services to carers within adult social care including support payments for carers looking after those discharged from hospital	1053	Supporting people and carers to live as independently as possible and implementing the LLR Carers' strategy
	Integrated HART reablement and therapy teams	Reablement in a persons own home to maximise independence and reduce care needs including the integrated locality teams for therapy and HART	4793 HART / 13,012 Therapy	Provide joined up services that support people and carers to live independently for as long as possible aiming for a 2 day start for all requests
	Home first teams	Support for those in hospital to return home or to a' discharge to assess bed' and step-up support for those in the community needing support	3540	Delivering an effective health and care integration programme that will deliver the Home First step-up and step-down approach for Leicestershire.
	Domiciliary care	Support from independent providers for care packages in the home	2626 people 632,215 hours	Reducing the number of permanent admissions to residential and nursing homes.
	Royal Voluntary Service discharge support	Supports people leaving hospital on pathway 0. Ensuring safe and timely discharge, ongoing support in the community and reducing risk of readmissions	1067	Effective health and care integration programme that will deliver the Home First step up and step-down approach for Leicestershire.
	External workforce development	Team to work with communities to encourage people to work within care settings	N/A	Supporting the creation of an integrated health and social care workforce
	Integrated Personalised Care Framework	Framework for delivering training on a range of joint health and social care tasks across the workforce	N/A	Supporting the creation of an integrated health and social care workforce
	Residential respite	Providing a stay in a care home for a short time to give a carer a break from caring	146	We will provide joined up services that support people and carers to live independently for as long as possible, including those with dementia
	Community response service	Interim support service that provides quick targeted interventions to those in the community that need it to remain at home and avoid admissions	1091	Offer a two-hour crisis response for people that may otherwise need to attend hospital, reducing admissions and increasing community care capacity
	Urgent Care Centres	Provision of walk-in clinics focused on the delivery of urgent ambulatory care in a dedicated medical facility outside of a traditional emergency department	N/A	Reducing the number of emergency bed days people with Long Term Conditions experience

5.3.1 Intermediate Care Programme

One of the key achievements for 2023-24 has been the success of the Intermediate Care Programme.

Intermediate care provides a bridge between hospitals and people's homes at key points in people's lives. It involves time-limited short-term interventions to help people rehabilitate, re-able and recover. This is so they do not then require hospital admission or long-term care, or so they leave hospital with the right wraparound support in place in their own home (usual place of residence) or a community bedded setting. These can be received in a hospital, a care home setting or a person's own home.

In 2023-24, as a health and care system, an additional £1.8 million in the delivery of Intermediate Care was invested. The aims were developed with partners and members of the public. People were consulted on their experiences of care in hospital and how they worked with family, friends and carers on the plans for their recovery after their stay in hospital. The findings from these pieces of work, detailed below, helped to develop the aims for improving intermediate care:

- Increasing the number of people discharged to their own home to 80% and decrease the discharges to care homes or other beds to 20%.
- 95% of those discharged that are eligible go through an intermediate care model of care and support
- Right sizing Community Health Services input to support the intermediate care model at a locality/community level
- Eliminating the use of bedded care that is not supported by Intermediate Care
- Streaming 50% of Intermediate Care Discharge to Assess* (P2 D2A) referrals supported by Community Hospital beds. (90% by April 2025) ***supporting people to leave hospital when it is safe and appropriate to do so.** *Once they've left the hospital, the goal is to continue their care and assessments, so that any support can be put in place for longer term care needs.*
- Commission sufficient capacity for patients with high dependant needs (initially requiring 1 to 1 support)
- Discharge planning to start from admission
- Improving multi-disciplinary team working
- Improving triage decision making

Whilst the programme for improved intermediate care continues into 2024-2025, outcomes have already been seen across the services being delivered:

- Increase in reablement service capacity up to 30% (target to increase by 50% when fully mobilised)
- Discharges from acute hospitals into a follow-on bed now represents 5% of all discharges
- Fully integrated HART and therapy locality teams in the County, resulting in workforce time saved
- 11% increase in packages of care for people going home for UHL compared to previous year
- 0.5 day reduction in length of stay delay for patients awaiting a plan to go home
- 4 day reduction in wait for plans for people returning home per patient
- Circa 15 additional plans for people returning home each week for UHL
- Opened a specific community hospital ward for people requiring nursing care whilst awaiting their assessments for ongoing care
- Commissioned a set of high-dependency discharge to assess beds for those with high-level 1:1 care needs.

As part of this programme of work, the HART reablement teams and Therapy teams in each local area have been integrating to provide a better service for residents. Some of the reasons behind needing to change this approach in the delivery of the community services are highlighted below:

- Duplication of tasks and visits
- Confusion for the customer in roles and reasons for visitors
- Time taken to resolve issues created further complications and delay to both services
- Lack of relationships between services
- Low staff morale
- Confusion over roles and responsibilities in hospital settings
- No reablement presence within community hospitals
- Longer waits to discharge home from hospital

During 2023-24, as part of the integrated HART and therapy offer, the following was actioned:

- Conducted a pilot in Charnwood to integrate the teams
- Trained teams on each other's services, including on first visits, assessments, equipment ordering
- Established daily multi-disciplinary teams (MDT) in each locality
- Included Leicestershire Partnership Trust admin support to co-ordinate tasks
- Streamlined processes to avoid duplication
- Introduced Reablement Team Leaders onto wards in hospital to work with therapists
- Each locality team is linked to a Social Prescribers / Local Area Coordinators / Care Co-ordinators in their area with inclusion in MDTs and cases forwarded on

The outcomes achieved have made a positive impact, benefitting residents, staff and organisations to deliver a joined-up service. This is evidenced below:

- One day per week saved per team ensuring more people can access the services
- Reduction of 8 days in waiting time for non-urgent equipment and 4 days for urgent equipment
- Better and clearer communication by building relationships and increasing staff moral
- Better understanding of roles with increased cross-working at times of high-demand
- 80% of HART reablement referrals in hospital receive a plan to go home within 24 hours – previously only 4% were received in this timescale
- Reducing the amount of time a person waits in hospital once they are assessed as being well enough to leave. On average it takes 1 day to discharge patients down from 3 days previously.
- Contributed to HART increased capacity – increased by 30% in 23/24

As part of the measurement of success, previous case studies are used to review the journey of some of the people worked with in the community; taking into consideration the service they have received, their thoughts on the way it has helped to improve their independence and what level of on-going needs are, if any. This helps to identify areas that have worked well and highlight where improvements need to be made.

<u>Case Study:</u> Integrated Care Model

An example of a person's journey (whose initials are JP) who received care and support from the new integrated model

JP is a patient in Glenfield hospital – ward 28

- Referral form received from ward staff to adult social care staff - 11 May 16:42
- Ward visit completed by social care staff and therapy staff - 12 May – no therapy concerns at time of visit.
- Estimated discharge date – 12 May
- Package of care arranged for JP to receive 2 care calls every day. This begins 12 May with evening call then reablement team to start 14 May evening call
- Care starts on 12 May at 17:30
- Hart reablement welcome visit carried out on 14 May 18:00 where JP and the care staff identified that JP would benefit from a kitchen trolley.
- Therapy/ HART team meeting - 15 May – Therapy team order kitchen trolley, reablement team to assess on delivery and feedback any concerns from JP
- Therapy advises 22 May - kitchen trolley arrives, reablement care worker will assess the use of this with JP and report back
- Reablement care worker follow up visit 23 May – Kitchen trolley assessed with no concerns. Reablement team work with JP and encourage her to do tasks for herself at home to regain confidence and independence
- Therapy / HART team meeting 24 May – Feedback given on trolley and therapy happy to discharge from their caseload
- Reablement follow up – 26 May – JP managing well so evening calls are alternated as JP's needs are reducing
- Reablement follow up 29 May – JP managing all tasks herself. Happy with the service received and regaining her independence. Package of care is closed as no further need.

Previously, JP would have waited between 3 and 7 days to be discharged from hospital, instead this took 24 hours. JP waited 9 days between assessment and equipment delivery. This has reduced from 15 days. JP had continuity of care from a familiar case worker instead of additional workforce visits which can cause confusion and inconsistency.

Looking forward for 2024-25, work on the integrated model will be expanded, providing additional training for staff on other tasks and areas that can be integrated across the teams.

Further future work will also be centred on:

- Creating an options appraisal for people who are discharged from hospital settings into temporary beds for recovery, reablement and rehabilitation.
- Piloting a housing initiative supporting those with respiratory illness in poor housing
- Increasing capacity in combined HART reablement and Crisis Response Service by a further 20% to meet current unmet demand
- Further work on use of population health management data across integrated services
- Developing the role of Integrated Neighbourhood Teams

5.4 Integration Executive – Dying Well

The Integration Executive is responsible for delivery of the Dying Well strategic priority which comprises of the following priority areas:

- Understanding the need
- Effective transitions
- Normalising end of life planning

'Dying Well' focuses on supporting Leicestershire residents to understand, normalise and plan for this stage of life to ensure everyone has choice about their care and treatment, and support for loved ones and carers. This needs to be a dignified, personalised approach for the individual, their friends and family. Services linked to end-of-life planning are commissioned and provided by health partners across Leicester, Leicestershire and Rutland (LLR) so we work with our partners to support the development of strategies and delivery of services.

5.4.1 Developing the LLR Palliative and End of Life Care Strategy

Much of the work undertaken in 2023-24 has been around the joint development of the LLR Palliative and End of Life Care Strategy (PEoLC), which will be published later this year, and aims to deliver the national ambitions for end-of-life care. These are:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is co-ordinated
- All staff are prepared to care
- Each community is prepared to help

The Strategy reflects the views and insights of people with lived experience, carers, families, staff, volunteers, voluntary organisations and patient groups and used two key sources to obtain this:

- Themed End of Life insights provided by the LLR Insights, Behaviour and Research Hub
- Co-production feedback from people with lived experience, staff, voluntary sector and patient groups

Views and information from the above along with recommendations from the Leicestershire End of Life Joint Strategic Needs Assessment (JSNA) published in 2022, were included in a self-assessment to help determine strengths and gaps in current service access and provision across our system. This was then mapped to the national ambitions listed below and helped define the priorities the strategy will deliver against:

Views and Insights recommendations	Leicestershire JSNA recommendations
Ambition 1: Each person is seen as an individual	
➢ Ensure open, honest and timely communication / conversations with individuals, their families and those important to them ➢ Improve understanding of what different services offer, what can be expected and when – especially what to do in an emergency ➢ More culturally appropriate and accessible information ➢ Families not knowing what to do following a death ➢ Better understanding and use of advance care planning and ReSPECT forms ➢ Better access to bereavement support	➢ Analyse place of death data to better understand patient choice versus other factors ➢ Improve advance care planning ➢ Improve awareness of locally available services ➢ Build on work by Dying Matters to provide a central source of information and signposting advice to end of life and bereavement services. ➢ Routine follow-up of recently bereaved
Ambition 2: Each person gets fair access to care	
➢ More culturally sensitive service provision ➢ Conduct a mapping of existing End of Life care and support services	➢ Produce a health equity audit to explore inequalities

➢ Better access to planned care, emergency care and treatment	
Ambition 3: Maximising comfort and wellbeing	
➢ Better access to support at home, especially overnight ➢ Lack of access to out-hours GP services	➢ Develop a more robust community out-of-hours service ➢ Ensure training is available to generalist staff
Ambition 4: Care is coordinated	
➢ Not having to repeat information and good quality communication with, and between, professionals ➢ More effective care integration and coordination across GP surgeries, hospitals and other settings; between professional working in health and social care and with more obvious use of technology	➢ Improve the co-ordination of services ➢ Promote continuity of care
Ambition 5: All staff are prepared to care	
➢ People should be treated with compassion, empathy and respect ➢ Develop an End-of-Life education and training calendar for staff development	
Ambition 6: Each community is prepared to help	
➢ Promote community conversations about death and dying ➢ Improve the involvement of voluntary sector organisations ➢ Better information, advice and support for carers	➢ Improve the acceptability of discussing death and end of life preferences ➢ Utilise MECC to initiate conversations ➢ Engagement to capture views, preferences and experience of those approaching end of life ➢ Improve advice and support to informal carers

As part of the strategy delivery within Leicestershire, the Health and Wellbeing Board held a development session to help define next steps and to ensure that work is joined up. As part of the recommendations from the development session, the End-of-Life JSNA and JHWS priorities have been aligned to the PEoLC Strategy. This will help to determine how priorities will be met and to ensure work is not duplicated across LLR.

Delivery against the workstreams began in March 2024 and will continue to be the main focus throughout 2024-25.

A framework for a training programme within the Training and Workforce Development workstream is currently under development and will utilise funding from the Better Care Fund for delivery of this. This will help staff to understand the services on offer and to inform discussions with patients, families and carers around end-of-life planning. This will also support people to be at home if that is their choice and will deliver on the commitment to educating the workforce as part of the 'Normalising End of Life Planning' priority.

5.5 Mental Health Place-based Group – Improved Mental Health

The Leicestershire Health and Wellbeing Board (HWB) Mental Health subgroup was established in February 2023. As well as a HWB sub-group, the group also acts as the place-based group for the LLR Mental Health Collaborative.

The group has become well established, with representation from a range of partners including local authorities, health, voluntary and community sector, and districts/neighbourhoods.

The priority areas of the Mental Health subgroup are largely driven by the JHWS commitments, along with the Joint Strategic Needs Assessments (JSNA) for both Children and Young People (CYP) and adults.

The JSNAs have highlighted a number of priority areas for the mental health subgroup to address. These include:

- Children and young people
- Step up to great mental health
- Supporting people with Serious Mental Illness
- Suicide prevention
- Self-harm
- Addressing root causes of poor mental health and wellbeing
- Dementia
- Neighbourhood working

5.5.1 Open space engagement event

An 'open space' engagement event was held on 18 September 2023 to provide opportunities for meaningful engagement between people with lived experience, carers and other partners, including the Lead Member for Health, VCSE colleagues from the Falcon Centre and LLR Mind, as well as Leicestershire Partnership NHS Trust (LPT) and the Local Authority. The event focused on identifying what was important to people in relation to agencies collaborating in mental health. Discussions involved an exploration of Transitions (from child to adult services), Access Waiting Lists, Needs Led Provision, and Involving People with Lived Experience.

The event was well received by all those who attended, and the learning was shared with the Mental Health Placed Based group. It was agreed to hold a number of these events across the County to focus on issues that are important to local neighbourhoods/districts. The events will also enable neighbourhoods to identify people who can support in taking forward important areas of work related to mental health.

5.5.2 HWB development session

A HWB Development session themed on mental health was held in December 2023 with relevant key partners across health, the public and voluntary community sector. The aim of the session was to understand the challenges being faced across system partners and identify future areas of focus to be incorporated into the work of the Mental Health group over the next 12 months. These included:

- Identifying and understanding opportunities for proactive early intervention.
- Making sure we routinely focus on the person's perspective ('customer journey').
- Consistent information in place across the whole system communicated in a way that people/residents understand.

5.5.3 Neighbourhood Mental Health Resilience Grants

Leicestershire County Council Public Health Team received and managed the allocation of NHS funding to enable and support organisations in Leicestershire to deliver neighbourhood-based projects, services and activities to help target and provide local mental health prevention and resilience activities for people aged 18 plus. 14 organisations were awarded funding totalling £725,000. More details about some of the projects awarded can be found here.

5.5.4 Mental Health Friendly Places

The Mental Health Friendly Places programme encourages local businesses or organisations in communities such as a beauty salon, barber shop, sports club, tattoo parlour or community centre, to sign up to and gain free training and resources around mental health and wellbeing. The training helps staff and/or volunteers to have confident conversations with customers or visitors about their mental wellbeing and point them in the right direction to get the support they may need. The programme can also support if you are thinking of arranging any local wellbeing activities.

You can spot a Mental Health Friendly Place by the sticker in their window!

Case Study: Mental Health Friendly Place

Fox Hair Design, a hair salon based in Barwell, is now a Mental Health Friendly Place! We spoke to Carl, the owner of Fox Hair Design, to see how the scheme has made a difference to them.

How have you found the Mental Health Friendly Places programme as a whole?

We've found the programme really useful, informative and empowering. At times it challenged us emotionally, but we are proud as a team to be taking part.

How has the programme impacted you, your team and your guests?

I think the programme has really given all of us the confidence to be able to face difficult mental health related conversations with our guests. It has given us the knowledge to be able to spot early signs that a guest may be struggling.

Why did you want to sign up to a programme like this one?

Of our team of 10, 6 of us have been impacted by suicide; be it a family member or a friend. It was greatly important to all of us to be able to raise awareness. Hairdressers and guests share a special bond, we are often the confidant, people open up in the chair in a way that they may not feel able to do with a family member or friend. This puts us in a very privileged position; so, it was imperative to me that my team have the toolkit to be able to navigate sometimes difficult conversations.

Have you been able to help someone with the training you have received?

Yes, we have been able to support two guests specifically who have faced recent challenges. We were able to do this with care, compassion and confidence.

Would you recommend the programme to other organisations who may be in a similar position?

We would 100% recommend this programme. If you are a hair or beauty professional the programme is invaluable. Guests put their trust in us, they confide in us, sometimes they need help. The programme has given my team and I the confidence to have those difficult conversations. We can't solve everyone's struggles, but we may be able to make them a little easier by listening and signposting guests to help and support services.

Priorities for next 12 months

Work to deliver many of the priority areas for the Mental Health group, as detailed above, will continue throughout the coming months. Other key priorities, highlighted via the Adult Mental Health JSNA and requiring targeted focus, will be incorporated into the Mental Health group delivery plan for action:

To continue to build on a life course approach to mental health and wellbeing with particular focus on:

- Children and Young People (CYP) – Supporting and enhancing the CYP offer around mental health and wellbeing including prevention
- Transition to adults for people with mental health needs including those who don't have an education and health care plan (EHCP)
- Serious Mental Illness – Improving health check uptake and follow up support for people with SMI.
- Serious Mental Illness – Improve breast cancer screening uptake in people with SMI
- People with mental health issues experiencing severe and multiple disadvantage (SMD) linked to trauma, homelessness and substance misuse
- Addressing wider social determinants which impact negatively on mental health such as employment and housing.
- Consideration of learning from the gambling related harms needs assessment findings
- Suicide Prevention – through supporting the work of the LLR Suicide Audit and Prevention Group (SAPG) and strategy re-fresh
- Dementia – raising awareness of the role of prevention; and improving dementia diagnosis rates

5.6 CROSS-CUTTING PRIORITY – REDUCING HEALTH INEQUALITIES

5.6.1 Health Determinants Research Collaboration (HRDC)

The publication in 2016 of 'Improving the Health of the Public by 2040' emphasised the need to better understand how to influence important drivers of health, such as housing, and employment to reduce health inequalities. The National Institute of Health and Care Research (NIHR) has subsequently placed increasing importance on funding research on these wider determinants of health. It has also recognised the pivotal role that local government has in influencing these health determinants.

In 2022 the NIHR established the HDRC programme. The aim of this programme is to support local authorities to develop collaborative partnerships with research active organisations and develop its own capacity and capability to undertake research on wider determinants of health. In 2023 the NIHR launched its second round of funding for the HDRC programme, and the County Council was successful in securing £5.25m over 6 years to establish its own HDRC, subject to suitable progress in the interim initial year of funding. The successful funding award is thus a significant achievement, and the Council joins a small group of 30 HDRCs across England, Wales and Scotland.

The HDRC investment will support the County Council to work with partner organisations and residents to generate more of its own data through research, using this and existing evidence to improve the services that it provides and inform the council's strategic priorities.

Partnership working is a core component of the HDRC programme (the 'C' stands for Collaboration). We will work closely with our academic partners at the Universities of Leicester, Loughborough, De Montfort and Nottingham, with the public, NHS and voluntary sector. The HDRC will complement the current business intelligence function and will utilise existing technical infrastructure. It will also fund academic time for mentorship and collaboration, support research skills development and training, fund community engagement and coproduction activity and ensure knowledge exchange and impact, embedding research into practice.

2024 is a development year, paving the way for the full HDRC programme to commence in January 2025. The key deliverables for the development year are:

- Establish a 'research environment' plan for the HDRC: the plan will set out the building blocks for creating an active research environment in collaboration with stakeholders.
- Produce a research workforce development strategy: the strategy will set out how to build a research capable authority, supporting staff research skills development and recruitment of the HDRC team.
- Establish the Public Advisory Group: we will recruit a Public Advisory Group (PAG) so that they can help us develop our public and community involvement, engagement and participation (PCIEP) strategy and understand who our underserved communities are and their health needs.
- Develop a research governance plan: this plan will set out accountability structures and reporting pathways, how the HDRC will be supported through the senior leadership of the council and through the political processes.

Next Steps

Securing funding to undertake research on wider determinants of health in Leicestershire, through the NIHR-funded HDRC programme, has been a significant achievement of the last 12 months and pivotal in helping us achieve our vision of health equity in Leicestershire for a more prosperous and healthy population.

In February 2024, The Health and Wellbeing Board received a briefing report on the Health Determinants Research Collaboration and was supportive of the establishment and growth of place-based collaborative research.

Over the coming months we will continue to deliver on the priorities set out above and as the research team grows and research priorities are identified, we will embed a programme of collaborative research with our academic partners, NHS, voluntary sector and the public.

5.6.2 Health Protection - MMR uptake in Traveller Communities

Health protection practice aims to prevent, assess and mitigate risks and threats to human health arising from communicable diseases and exposure to environmental hazards such as chemicals and radiation. It protects the health of individuals, groups and populations through expert advice and collaboration. The effective delivery of local health protection services requires close partnership working between the local authority, UK Health Security Agency (UKHSA), and the NHS, amongst others.

The COVID-19 pandemic has highlighted the importance of resilient public health systems in identifying, assessing, and managing public health risks. Preventing a resurgence in vaccine-preventable diseases is a priority to reduce the risk of future epidemics, particularly as we have seen a decline in uptake of childhood immunisations.

Vaccination is an important part of protecting the health of ourselves as well as our children. It is also one of the most cost-effective public health interventions. When children and young people receive all the vaccinations included in the National routine childhood immunisation programme, this has a direct positive impact on their health and wellbeing, as well as their communities. Vaccination helps to prevent disease and promote child health from infancy, creating opportunities for children to thrive and get the best start in life.

Part of health protection involves work to reduce inequalities in vaccination uptake. Ensuring that coverage is not only high overall, but also within underserved communities is essential for disease control and elimination strategies.

The 2023 Health Inequalities JSNA chapter highlighted Gypsy or Irish Travellers as a group with particularly high risk of facing health inequalities in Leicestershire and have some of the poorest health outcomes across a range of indicators. Literature has shown that Gypsy and Traveller communities have a higher rate of mortality, co morbidities, long term health conditions and lower rates of childhood immunisation uptake compared to the rest of the population. Inconsistencies in recording health datasets for the Gypsy and Traveller communities means that they have become “invisible” as population groups, meaning data collected to design and evaluate healthcare services may fail to recognise individual needs leading to exclusion and a circle of institutional and policy neglect.

To get a better understanding of vaccine uptake in the Gypsy and Traveller and Roma groups, a scoping exercise and a subsequent engagement activity was undertaken to understand the underlying barriers and any inequalities that prevent engagement in vaccination programmes in the Leicestershire area. Whilst there is little data about the uptake of vaccination among Gypsy and Traveller communities, there have been several historical outbreaks of measles within these communities.

An engagement event was undertaken in Market Harborough. Representatives from the Gypsy Traveller community attended, who were from a range of age groups, including grandparents, mothers, younger women and an expectant mother. Some attended with their children.

The key goal was to identify barriers to vaccination and understand the attitudes and behaviours in relation to uptake of the Measles, Mumps and Rubella (MMR) vaccination. MMR was chosen in response to declining (national) vaccination rates, and as a response to a national resurgence in cases of measles, particularly in the West Midlands.

Barriers

A number of themes emerged that required further exploration, such as:

- understanding the terminology the group identified with. Whilst the group were happy to use the terms Gypsy, Traveller, Irish Traveller, interchangeably, they were keen to be recognised as a specific group with specific needs. The importance of being recognised as a separate group varied depending on the situation: e.g., for educational settings, it was helpful for the school to understand specific needs. However, for healthcare, they indicated that being recognised as a separate group may risk discrimination and hinder their access to healthcare.
- The main cause of hesitation around the MMR vaccine specifically was a fear of autism that the group linked to the MMR vaccine. This mistrust persisted even when they were able to identify autism in children who had not received the MMR vaccine. These are deep rooted, generational associations that are embedded, despite scientific reports discrediting this theory. This inaccurate link stems back to historic media coverage and has been further reinforced by anecdotal reports of autism traits becoming visible after children within the community had received an MMR vaccine.

The group reported no aversion to healthcare or health professionals and were not needle phobic or concerned about typical symptoms from vaccinations such as a sore arm. Contrary to literature findings, the group had no issues accessing primary care and reported their GP practice were aware of the needs of Travellers. All participants were registered with a GP and had no difficulty booking appointments or seeking medical advice.

The idea of using fear of illness was proposed by the group; using the threat of complications arising from measles, mumps and rubella to encourage families to act. Overall, awareness of the severity of illnesses arising from measles, but also from mumps and rubella was low.

The group supported the notion of highlighting the symptoms resulting from vaccine-preventable diseases to improve vaccine uptake. Communicating messages was deemed to be most effective through social media, particularly TikTok.

The next steps for this project will be to implement the suggestions and evaluate the outcome. The ambition is to enable the community to make a decision on vaccination when they have access to all of the information needed in order to make a fully informed choice. Early insights indicate that participants were more open to speaking to their families about vaccinations and felt equipped to have conversations around MMR but also other vaccinations.

A key finding is that these groups are open to discuss their concerns and hesitancies and are keen to have meaningful conversations to help them make a decision that impacts their health.

The aim is to see an increased uptake of MMR vaccination across all age ranges within this community by March 2025.

5.6.3 Health Protection - Cancer Screening – gap analysis

Health protection also encompasses screening. Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or informed decisions. National data has shown that uptake of screening in individuals with a learning disability is significantly lower than individuals without a learning disability, resulting in this group facing a number of health inequalities:

- Bowel cancer is the fourth most common type of cancer in the UK. Bowel screening enables prevention of bowel cancer and can detect cancer at an earlier stage when prognosis for treatment is better. Since April 2019 a free Faecal Immunochemical Test (FIT) home testing kit has been used for population-based bowel cancer screening and is available to everyone aged 56 to 74.

- Breast cancer is the most common type of cancer diagnosed in the UK. Breast screening uses a mammogram to detect cancers at an early stage, when they are too small to be seen or felt. Breast screening can identify breast cancer before any signs or symptoms develop. Females between 50 years and 71 years of age are invited for screening every 3 years, although the programme is being extended to women aged 47 to 49, as well as to those aged 71 to 73. A significantly smaller proportion of patients with a learning disability had a breast cancer screening test in the years 2016-17 to 2020-21 compared to patients without a learning disability.

- In females, cervical cancer is the fourteenth most common type of cancer in the UK with around 3200 new diagnoses every year. The cervical screening programme is intended to detect abnormalities within the cervix that could, if undetected and untreated, develop into cervical cancer. A first invitation for screening is sent to a woman when she is 24.5 years old. Subsequent invites are sent every three years for those aged 25 to 49, and every five years from 50 to 64 years. The literature identified a number of reasons leading to delayed cancer diagnoses in individuals with learning difficulties.

The aim of the gap analysis project was to determine the local Learning Disability (LD) bowel cancer, breast and cervical screening uptake and coverage rates across Leicestershire.

This project looked at three communities: travelling, learning disability and transgender or transitioning. The LD community was focused on in part due to the national trends seen in the NHS England (NHSE) experimental data and a gap analysis approach proposed. This was to ascertain the current state, the future state, the gaps and the actions required to close the identified gaps across the screening service for the local LD community.

Screening service information relevant for the LD community was collated to enable better signposting and to highlight areas of need, now and in the future.

A gap analysis identified a lack of local LD cancer screening data and a lack of fit for purpose equipment (such as a coloscopy chair for HPV cervical screening). To resolve these gaps, data was collected locally to carry out a needs assessment and apply for funding (e.g. for breast screening where it is most needed).

Following on from work undertaken at a practice in Charnwood, collaborative work across Primary Care Networks (PCNs) provided a venue for a specialist LD cervical cancer screening clinic:

- Engagement of LD patients whilst piloting equipment encouraged active participation.
- The outcomes from the engagement activity could then be assessed and developed into a business case to promote wider roll-out.

A number of recommendations emerged from the project:

- Continued and improved collaborative working across organisations
- Source and capture local data
- Ongoing work continues with the Community Infection Prevention and Control and wider PH teams to collate intelligence from LD care providers on the number of eligible people for each cancer screening cohort and local uptake.
- To support the LLR learning from lives and deaths - learning disability mortality review (LeDeR) annual report recommendations and with particular focus on learning from lives of people with a learning disability.

Future work may explore other screening programmes such as Diabetic Eye Screening and abdominal aortic aneurysm screening and support for the local LD population, initially for those in residential care. This would identify whether similar themes and inequalities exist across other programmes and would subsequently inform interventions if needed to mitigate this.

6.0 PROGRESS AGAINST THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

Chosen in the order of commissioning or policy development priority, the Leicestershire JSNA chapters completed so far in this cycle include:

JSNA Chapter	Approved
End of Life Care and Support	December 2022
Mental Health – Children and Young People	May 2023
Health Inequalities	May 2023
Learning Disability Analysis – *partial JSNA*	May 2023
Oral Health	October 2023
Demography	October 2023
Alcohol Misuse	February 2024
Substance Misuse	February 2024
Mental Health - Adults	May 2024

In addition, a range of other more specific needs assessments and related pieces of work have been completed such as the evidence work on learning disability services and for related boards such as on suicide prevention. Needs assessments currently in development to be completed by March 2025 include:

- Gambling Related Harms
- Carers
- Air Quality

A separate exercise will be carried out as part of the Joint Health and Wellbeing Strategy analysis and refresh exercise to identify a future proposal for delivery of the JSNA from 2025 onwards including the next round of the Pharmacy Needs Assessment.

The 2022-2025 JSNA completed chapters are available online.

Case Study: Developing a JSNA chapter - Adult Mental Health JSNA

The outline presented below is an example of the typical process involved in the development of a JSNA chapter.

- The first step of developing the Adult Mental Health chapter of the JSNA was the establishment of a JSNA MH Working Group, which included public health, mental health services leads and business intelligence analysis leads. The groups initial task was to define the objectives and timescales for the project.
- The working group reached out to the Leicestershire Mental Health Place Based Group, a HWB Subgroup, as a means of engaging the relevant stakeholders.
- In the evidence gathering phase of the project, data from a wide range of sources was collected and analysed, including health and social care, public health and socio-economic data. These were enhanced with additional analysis of the local epidemiological trends. The analysis focused on inequalities, trends and patterns in mental health and mental wellbeing, enhanced by insights from qualitative sources, such as surveys.

- The gathered evidence was presented to the Health and Wellbeing Subgroup for a first consultation, followed by a feedback session at the subsequent meeting. As a result of this feedback, the draft was enhanced with more locality-tailored data.
- In the next phase, the JSNA chapter was drafted, compiling the findings, analysis, identified gaps and recommendations into a comprehensive report.
- The draft was then circulated and consulted with the HWB Subgroup members and other stakeholders, followed by all necessary revisions and enhancements.
- The final draft of this JSNA chapter was presented at Leicestershire Health and Wellbeing Board in May 2024, and was approved for publication at that meeting and published online.
- Detailed action plans for key recommendations are in development.

Case Study: Implementation and monitoring of JSNA findings - Substance Misuse and Alcohol JSNA Chapters

The recommendations arising from the Substance Misuse and Alcohol JSNA chapters are largely being taking forward by the Combating Drugs and Alcohol Partnership (CDAP), which is a partnership group comprising of public health, Turning Point, ICB, Probation Services, Leicestershire Police, ICB, and health service providers.

There are a number of recommendations within the report that are being progressed with the majority centred around building on the relationships and pathways already in place.

For instance, a partnership approach is being taken to target certain cohorts for Substance Use interventions. The Substance Use Harm Reduction Network is collectively engaging with families who require support, veterans and relapse prevention via strengthening the recovery network. This is being monitored via the Network and updates given to the CDAP.

Other areas that have been progressed to date include:

- Continuing with a partnership approach to review drug related deaths and to develop and maintain the LLR Drug and Alcohol Related Deaths Review Panel (DARDRP) already in place.
- Strengthening pathways between the smoking cessation service and the substance misuse treatment service
- Liaising with partners to understand the specialist opioid addiction issue and how partners can work collectively to make improvements for residents, which includes national and regional links

7.0 Progress against the Better Care Fund

Within Leicestershire, the Better Care Fund (BCF) supports delivery of the Living and Supported Well priority of the Joint Health and Wellbeing Strategy. The Better Care Fund also has statutory responsibilities to deliver against priorities within its own legislative framework and priorities for delivery in other strategies such as the NHS 10-year plan, Urgent and Emergency Care recovery plans, Winter Plans and Adults and Communities 10-year vision.

7.1 Purpose and Goals

The primary goal of the BCF is to deliver better outcomes for patients and service users by promoting integrated care. This includes reducing hospital admissions, ensuring timely and safe discharge from hospitals, and improving overall patient and service user experiences.

7.2 Funding

The BCF pools funds from the NHS and local authorities to support joint initiatives and services that align with its integration objectives. This pooled budget includes contributions from NHS Integrated Care Boards (ICBs) and local authority social care budgets.

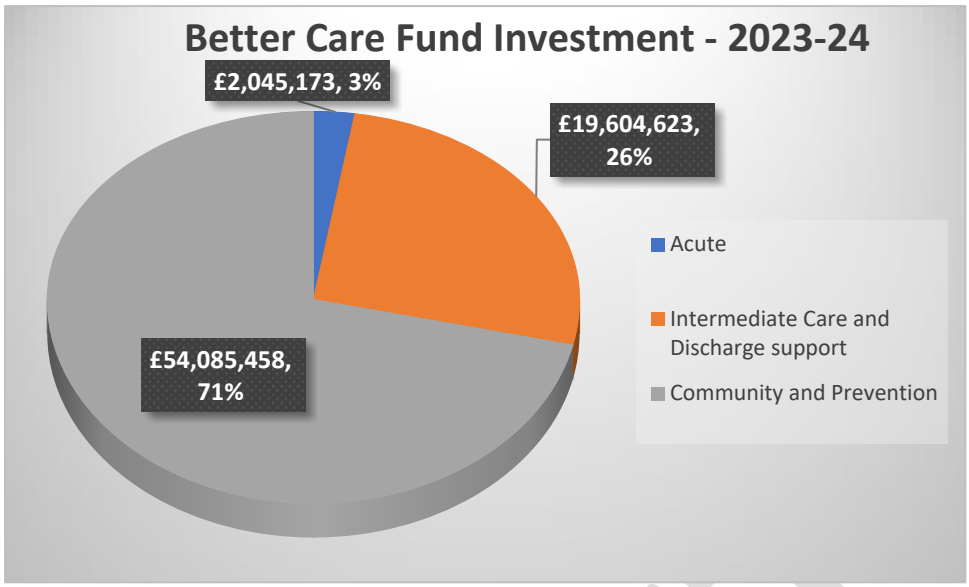
The table below, shows the investment contributions for 2023-24:

ICB minimum NHS contribution	£48,748,385
Improved BCF grant	£17,690,614
Disabled Facilities Grant	£4,447,228
LA Discharge funding	£2,480,197
ICB Discharge Funding	£2,368,831
Total	**£75,735,254**

Key Areas of Investment – what the money should fund:

- Integrated Care Services - Funding initiatives that bridge the gap between health and social care services.
- Community-Based Services - Supporting services that help people remain independent and receive care in their own homes or local communities.
- Prevention and Early Intervention - Investing in programs that prevent health issues from becoming severe and requiring hospital care.
- Support for Carers - Providing resources and support for informal carers.
- Hospital Discharge Planning - Enhancing services that facilitate smooth transitions from hospital to home or other care settings.
- Reablement Services - Funding services that help individuals regain skills and confidence after an illness or hospital stay.
- Support to deliver duties within the care act.

The below diagram shows the areas of investment, the amount of investment and the percentage of overall investment attributed to that area.



7.3 Plans and Reporting

Local areas are required to develop and submit BCF plans that outline how they will use the funds to achieve integrated care objectives. These plans must meet certain national conditions and performance metrics, and areas are required to report on their progress regularly.

These can be found through the Leicestershire Health and Wellbeing Board website as part of the meeting papers for boards.

The statutory duties and responsibilities of the BCF encompass various regulatory and operational requirements aimed at ensuring effective integration and utilisation of pooled health and social care funds. Here are the key duties and responsibilities:

7.3.1 Health and Wellbeing Boards (HWBs)

- HWBs are responsible for overseeing the implementation of the BCF at the local level.
- They must develop joint BCF plans, which outline how the pooled funds will be used to achieve integrated care and improved patient outcomes.

7.3.2 Joint Planning and Commissioning

- Local authorities and NHS Integrated Care Boards (ICBs) must work together to develop and submit BCF plans that meet national conditions and performance metrics.
- The plans should demonstrate how the funds will support integrated care services, reduce hospital admissions, and improve discharge processes.

7.3.3 Pooled Budgets

- The BCF requires the pooling of budgets from both local authorities and NHS bodies to fund joint initiatives.
- This pooling is done under section 75 of the NHS Act 2006, which allows for the establishment of pooled budgets and joint commissioning arrangements.

7.3.4 Meeting National Conditions

Local BCF plans must comply with several national conditions, including:

- Plans must be jointly agreed by local authorities and ICBs.
- Must enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time
- Maintain the NHS contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF) and investment in NHS commissioned out of hospital services.

7.3.5 Performance Metrics and Reporting

- BCF plans must include specific performance metrics to measure progress and outcomes
- Regular reporting on these metrics is required to demonstrate the impact of BCF-funded initiatives and to ensure accountability.

For 2023-24 the below metrics were included:

- admissions to residential and care homes
- unplanned admissions for ambulatory sensitive chronic conditions
- the proportion of older people who were still at home 91 days after discharge from hospital into reablement or rehabilitation services
- emergency hospital admissions due to falls in people over 65

The table below shows the local targets and year end data against the metrics:

Metric	Target	Actual
Indirectly standardised rate (ISR) of admissions per 100,000 population	163.5	209.8
Percentage of people, who are discharged from acute hospital to their normal place of residence	92.6%	92.2%
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	1628.1	1810
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	515	510.8
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	90%	88.4%

7.3.6 Supporting Carers and Reducing Delayed Discharges

- Specific initiatives and funding must be directed towards supporting unpaid carers and reducing delayed discharges, ensuring that patients can move smoothly from hospital to home or other care settings.

7.3.7 Encouraging Innovation and Best Practices

- The BCF encourages local areas to adopt innovative approaches to integrating care and to share best practices across regions to improve overall system efficiency and patient outcomes.

These statutory duties and responsibilities are designed to ensure that the BCF effectively promotes integrated care, improves patient outcomes, and makes efficient use of pooled health and social care resources.

Further details on some of the key achievements as a result of the BCF can be demonstrated within the Living and Supported Well section 5.3.

8.0 LOOKING FORWARD

As well as the many achievements delivered over the past 12 months, it is important to acknowledge the challenges faced throughout 2023-24; cost of living crisis, access to services, budget constraints and even adverse weather conditions. While many of the challenges remain ongoing, navigating our way through them has required a great deal of patience, collaboration and goodwill to ensure that we can continue to support our communities, our partners and the workforce.

Looking ahead to the next 12 months, the HWB will continue to focus on strengthening relationships to improve the collaboration between place and system, and place and neighbourhood; thinking creatively to pool resources to improve efficiency and add value, particularly against a backdrop of increased demand on health and social care services.

The delivery of the HWB statutory duties will remain ongoing. Each of the HWB subgroups will continue to deliver the JHWS priorities for their life course and have outlined within this report the areas they will be focussing on over the coming 12 months. The JHWS 3-year refresh is due to commence early spring 2025 and will require support and input from partners and stakeholders including community engagement.

In addition, the remaining HWB development sessions themed on the S*taying Healthy, Safe and Well* and *Living and Supported Well* JHWS life course are also expected to be delivered by March 2025.

Work to complete the Gambling Harms, Carers, and Air Quality needs assessments as well as the Pharmaceutical Needs Assessment by the end of March 2025 will continue, including development of a new JSNA proposal for 2025 onwards.

There will be a renewed focus on developing the HWB's community engagement capability over the coming year, seeking opportunities to work with partners and the voluntary sector and collaborate on joint pieces of work to bring the community voice to the Board. Plans are already in place to explore how the voices of young people can be heard to gather their insights into what health and wellbeing means to them and the barriers they face in accessing health and social care services. Links with other community groups and networks, such as the adult social care engagement panel, have been made to draw on lived experience and ensure the HWB agenda is reflective of our communities.

Following feedback from our local communities, Healthwatch will be focusing on the following three areas over the coming 12 months:

- **GP Access** - Our data for 2023/24 indicates that GP access is the number one concern for individuals across Leicester and Leicestershire.
- **Dentistry** – People continue to report struggles in accessing NHS dental care. Our feedback highlights availability and affordability as key issues.
- **Young people's mental health** – Long waiting times for referrals and diagnosis are key issues shared with us alongside accessing support services.

The HWB will need to rely on the support and commitment of our partners and communities as we move into the next 12 months to continue our focus on improving the health outcomes and reducing health inequalities in Leicestershire.

9.0 APPENDICES

9.1 APPENDIX A

Community Health & Wellbeing Plans: Case studies by locality

1. Charnwood Borough Council

Active Practice

Active Charnwood with Charnwood Health and Wellbeing Partnership have worked collaboratively with Active Together and Bridge Street Surgery, Loughborough. To develop the first accredited active (GP) practice in Charnwood. placing patients at the heart of the work. There have been demonstrable efforts put in to signposting patients to physical activity opportunities in the borough and have successfully collaborated on instigating a fortnightly patient participation walk from the practice. This walk is led by Active Together and Active Charnwood staff but crucial, is attended by GPs from the practice who offer their time to allow patients to have extended face to face time with them. Communication is sent to targeted patient groups which allows the GPs to address a different topic each walk that is pertinent to the specific health condition and encourages socialisation and support between patients.

ESCAPE-pain

In addition, Active Charnwood are working with the Bridge Street Surgery to pilot the ESCAPE-pain programme directly to their patients. ESCAPE-pain is an education and exercise programme for people with chronic joint pain or osteoarthritis.

Mental Health Networks

In Charnwood, mental health networks have been established in Syston, Shepshed, Sileby, and Birstall, bringing together key stakeholders regularly to enhance mental health for local residents in towns and villages. These specific areas have been singled out as priority locations due to the high rates of urgent care referrals and the prevalence of mental health issues in primary care settings. By collaborating, the networks aim to maximise every interaction by improving conversations, increasing support, improving access, reducing health inequalities, and delivering more cohesive services through building relationships and fostering trust.

2. Hinckley & Bosworth Borough Council

Menopause Support

The Hinkley and Bosworth team have developed a programme that aimed to improve mental and physical health for women who are in the early stages of Menopause. The programme consisted of cardiovascular, stretching, muscle strengthening and relaxation techniques.

The sessions were run in partnership with Places Leisure at Hinckley Leisure Centre and ran for 8 weeks in a closed gym session between 5 and 6 pm. It also provided an opportunity for participants to relax with a coffee and to make new friendships. Sessions enabled the women to work very closely with a qualified gym instructor, who offered a tailor-made gym programme for the group, providing expert advice and help around the type of activities that would benefit them. Numbers were purposely kept low.

The programme was held at the Leisure Centre to give participants the opportunity to continue their journey beyond the 8 weeks. Each session consisted of 45 minutes in a gym session followed by a coffee/tea in the Leisure Centre to enable the group to get to know each other.

Feedback received confirmed that the participants continue to meet on a regular basis at the Leisure Centre to work out and enjoy a coffee to continue their mental and physical wellbeing. One of the participants recorded *"I became very inactive whilst I became menopausal, but after this programme I really enjoyed being more active. I felt in a safe environment whilst doing my exercises with a lovely group of ladies - which we have remained friends and kept that connection."*

Promoting Positive Mental Health

Changing Minds' was set up in 2013 to bring together all the service providers that work to support people with their mental health in the community. Since then, it has developed exponentially to include Local Area Co-ordinators, Social Prescribers, Children and Family Wellbeing, local voluntary and community sector organisations, Public Health, art and leisure services and other organisations involved in wider determinants of mental health such as Housing and Employment services.

The positive impact has been that services are more connected and know what each other are offering. This enables officers, staff and volunteers to signpost people they are working with to appropriate and timely support. New members are joining regularly and the database includes over 131 local organisations and services in Hinckley and Bosworth and the County.

3. North West Leicestershire District Council

ESCAPE-pain

A new programme for North West Leicestershire, Escape-pain is a six week programme of physical activity and education to support small cohorts of residents suffering with knee and hip pain due to osteoarthritis. The programme is delivered by NWLDC Health and Wellbeing Team, funded by Leicestershire Public Health and supported by Active Together.

Four programmes were delivered across North West Leicestershire (NWL) with forty-five participants. The programme was a huge success throughout NWL with great outcomes in both clinical data and through verbal feedback.

The table below demonstrate the percentage improvement in: active daily living (ADL), pain and quality of life.
All participants are surveyed at the start of the programme to understand their ability to meet daily activities, quality of life and how much pain they experience. This gives a score in each area; participants are surveyed again at end of programme and the percentage improvement is calculated.

Cohort	ADL % Improvement	Pain % Improvement	QOL % Improvement
Ashby Leisure Centre	47%	53.3%	27.6%
Whitwick and Coalville Leisure Centre	27.86%	32.56%	39.39%

Measham Leisure Centre	22.18	33.10%	37.14%
Whitwick and Coalville Leisure Centre	27.85%	32.56%	39.39%

Active Together have successfully negotiated for the GP Federation to fund NWLDC to deliver a further six programmes.

Healthy Weight Programme

A subgroup for overweight and obesity or 'Healthy Weight' has been created and an action plan developed. Part of the development was a workshop with wider stakeholder to identify need. This subgroup is chaired by the co-chair of the Leicestershire Healthy Weight Strategy Implementation Group and therefore many actions align and complement the Leicestershire Action Plan.

The action plan focuses on three themes:

1) Promoting a Healthy Weight Environment
2) Support for People to achieve and maintain a healthy weight
3) Prioritise Healthy Weight through systems leadership

Notable achievements include:

- A draft Takeaway Policy was developed and consulted on
- A food poverty action plan was created and delivered that considered quality of food, education of cooking and nutrition and white goods/utensils.
- A comprehensive Holiday Activities and Food (HAF) offer and low-cost holiday day schemes with a healthy snack was developed for families that do not qualify for (HAF) but cannot afford private provision.
- A Local Cycling and Walking Infrastructure plan was developed to support commuter and recreational walking and cycling opportunities.

4. Oadby & Wigston Borough Council

Oadby and Wigston's Community Health and Wellbeing plan is currently in draft with our priorities identified and partners writing up the plan. However, even though the plan hasn't been signed off yet lots of work has been going on in Oadby and Wigston which aligns with the plan.

Grant Scheme

At the end of 2023 Oadby and Wigston Borough Council launched a grant scheme to support community projects in the borough.

£30,000 of funding was made available for non-for-profit groups to bid for a share of the money to invest into projects that benefited the wider community. The fund was designed to boost funds for group that were undertaking a project that supports one of five priority areas: mental health, the older generation, diversity, cost of living and young people.

Through the grant scheme, 12 community groups received funding, covering the whole of the borough and a wide range of activities and services.
One of the successful groups was Wigston Tennis club, they are a local tennis club that put a range of matches and teaching sessions on for local people to play and learn how to play tennis. In their grant application they were seeking funding to resurface two of their tennis courts that were over 20 years old and were becoming unsafe to play on. Through the grant scheme the borough council were able to support Wigston Tennis club with the resurfacing of their tennis courts and improve the club's facilities.

5. Melton Borough Council

Falls Prevention

Sharon is a 66-year-old mother and wife from Melton Mowbray.

12 years ago, she suffered a serious illness due to cancer which was very debilitating meaning she lost a lot of strength particularly in her legs and was given only a 15% chance of survival.

Like many people Sharon tried incredibly hard to get on with life but after a couple of falls - the last one being very serious and resulting in a head injury needing hospital treatment - Sharon realised, she needed to take action and improve her physical health to try and minimise any more falls. As a result, she took part in the 24 week falls prevention course 'steady steps' which is aimed at improving balance and stability.

Outcomes:

Sharon took part in her first 'Steady Steps' class and really enjoyed being in a group that shared the same fears and experiences. She quickly made friends, introducing one of her neighbours to the course as well.

The class motivated Sharon to also become more active at home: *"….after being shown the exercises in class it was easy to transfer that to my home, I've always been someone who tries to help myself and this gave me the skills and confidence to have a go at home".*

Over the 24-week process Sharon noticed a dramatic increase in not only her physical health - in the form of increased stability and balance - but also her confidence. Once fearful of falls and injury Sharon has now independently joined a local gym which she attends on a regular basis and thoroughly enjoys.

Exercise Referral

Gemma is a wife and mother to 3 boys

Gemma has a pretty hectic life, so exercise has never been a priority for her. She has always lived a sedentary lifestyle, resulting in being overweight. This has caused her to be body conscious and led to her suffering from anxiety and depression.

Last summer, Gemma came back from her holiday and was not happy with how she looked. She went to see her doctor who referred her the Melton Physical Activity Service because she didn't want to rely on medication as a treatment.

Outcomes:

After completing the 12 weeks exercise referral programme late last year, she joined Goodlife Health & Fitness Club as a member. She continues to train in the gym 3 times a week, following a training plan that the gym instructor has put in place for her. She also walks 4-5 times a week. Gemma has gone on to make massive strides in terms of physical & mental health and has lost 5 and half stone.

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