Chapter 4: Cross cutting themes

In this chapter, we describe how we will address important themes that reach across all the service delivery areas identified in Chapter 3.

4.1 Improving health equity

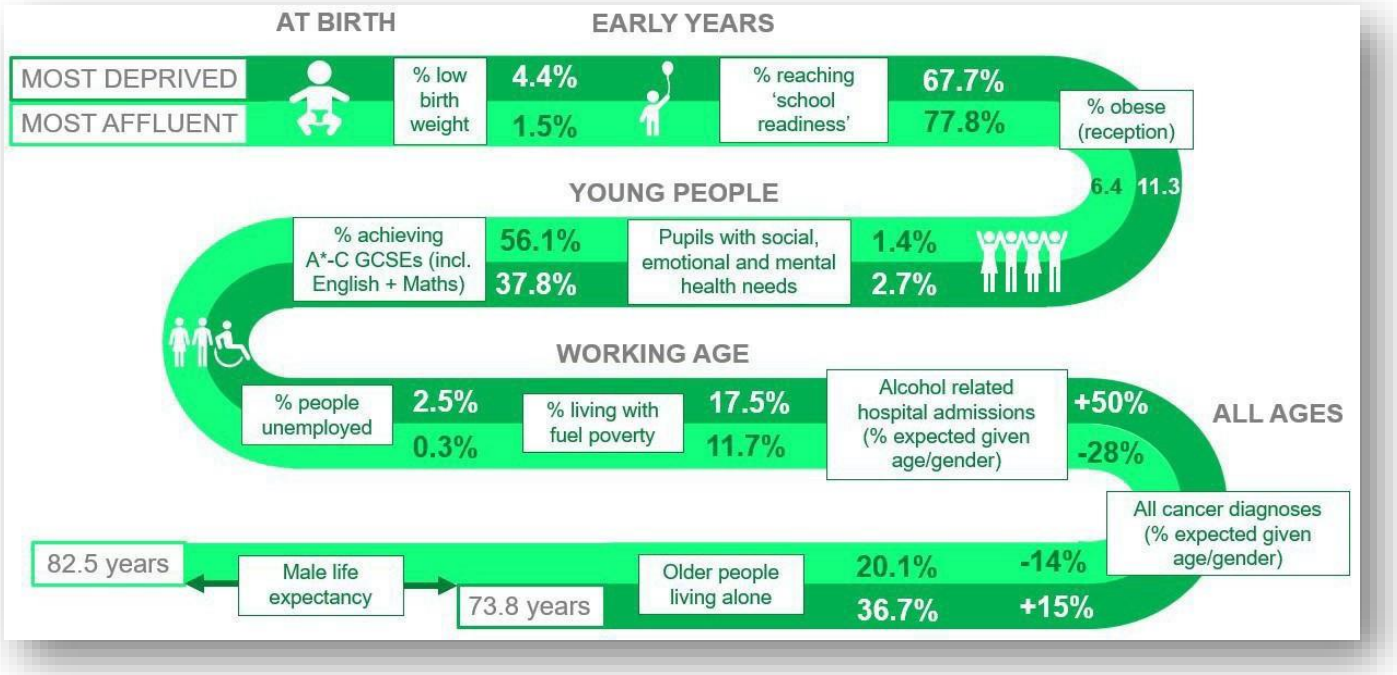
What do we mean by health equity?

Health equity is about removing the avoidable and unfair differences in health between different groups of people. Health equity concerns not only people's health but the differences in care they receive and the opportunities they have to lead healthy lives.

Why focussing on this is important to us

There are stark gaps in health equity across LLR. A boy born today in our most deprived area could be expected to die up to nearly nine years earlier than a boy born in the least deprived area. Furthermore, people from less affluent areas will be spending a greater proportion of their (often shorter) lives in poor health compared to people from more affluent parts of our area (see figure 10).

Figure 10*: Difference in health indicators between the most and least deprived local areas of LLR*



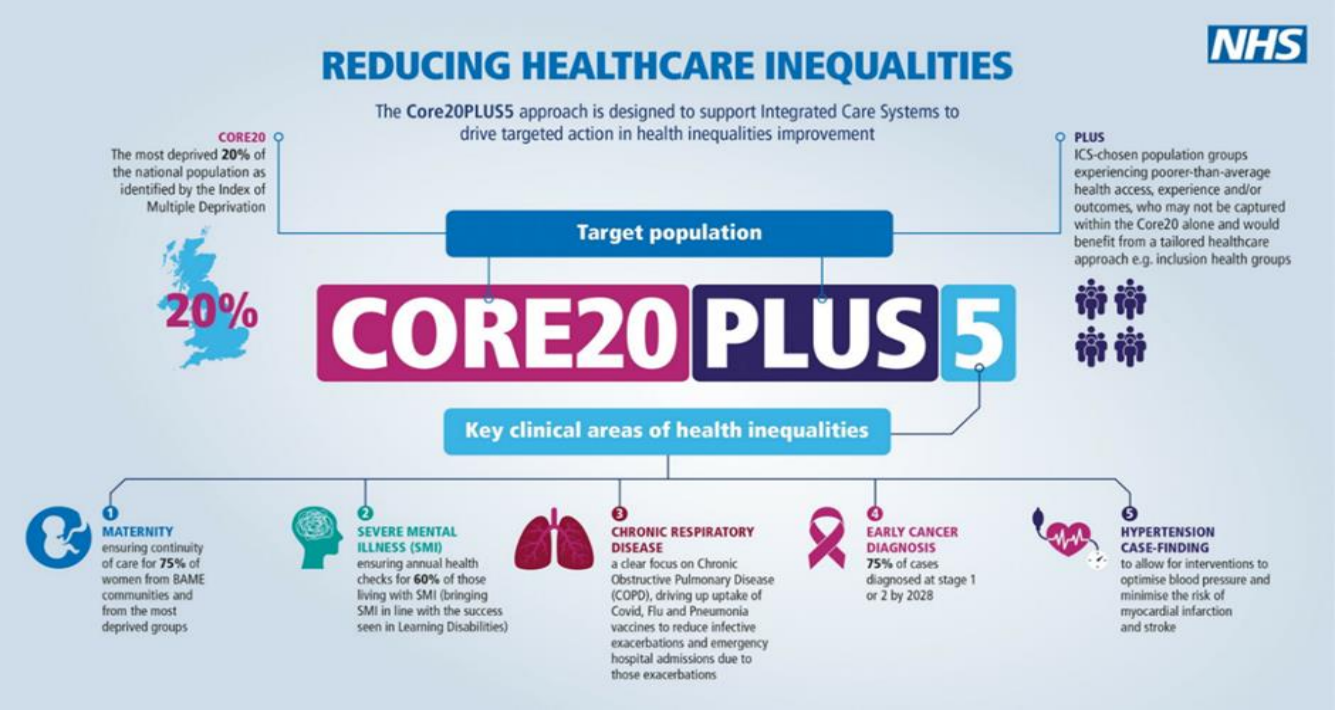
We want local people to be healthier, with everyone having a fair chance to live a long life in good health. Therefore, this Plan aims to 'level up' services and funding.

Our approach – Core20PLUS5

Core20Plus5 is the national approach to improving health equity and focuses on:

1 The people in LLR who live in the 20% most deprived parts of England (whom we know have disproportionately poor access and outcomes);
2 LLR seldom heard and underserved groups with additional barriers to good outcomes, such as those with learning disabilities, ethnic minority groups, carers and older people; and
3 Five key clinical areas (within 2, above) which are known to have the greatest adverse impact on life expectancy and healthy life expectancy (see Figure 11). More information about this approach, as well as on the CORE20Plus5 approach for children and young people can be found in Better Care for All, our Health Inequalities Framework.

Figure 11: The Core20Plus5 approach to improving health equity



System-wide interventions to improve health equity

Action to improve health equity happens at a number of levels. Firstly, we have included interventions, that the local NHS will implement, within the relevant sections of this Plan, most specifically, Chapter 3 (Delivery Plan).

We also work with our councils to support the delivery of health equity improvements highlighted within their Joint Health and Wellbeing Strategies (see 2.1) and Community Health and Wellbeing Plans.

Finally, key system-wide interventions are led by all LLR partners, with the ICB as a core Partner, and these are set out in Table 14, below, with more information available in the LLR Health and Wellbeing Partnership Integrated Care Strategy.

Table 14: Our key system-wide interventions to improve health equity

Intervention [From the LLR Integrated Care Strategy]	Timeline
1. Apply our Health Inequalities Framework principles across our three Places	23/24 onwards
2. Make investment decisions across LLR that reflect the needs of different communities	23/24 onwards
3. Establish a defined resource to review health inequalities across LLR	23/24 to 25/26
4. Ensure people making decisions have expertise of health inequity and how to reduce it	23/24 onwards
5. Improve data quality and use to enable a better understanding of and reduce health inequity	23/24 onwards
6. Health equity audits will inform all commissioning or service design decisions	23/24 onwards
7. Staff will be trained to understand and champion approaches to reducing health inequalities	23/24 onwards

Case Study

Improving health equity – Covid19 vaccine hesitancy in St Matthews

What was the issue?

Covid19 vaccine uptake data by ethnic group demonstrated that Leicester's Somali population had 49% uptake in over 50s, at March 2021, compared with 78% in the population overall. Over half of the Somali population live in two neighbouring areas of the city; St Matthews and St Peters.

Intervention

In-reach pop up clinic at a local faith centre

Community engagement:

- Zoom webinars hosted by a local GP and community leader
- YouTube video cascaded via the local community Whatsapp group
- Written materials sent to local shops, mosques, schools and community organisations
- Information sharing on the COVID helpline by population advocates
- Social media activity

Impact

Within a week of the interventions (by end March 2021), uptake in the over 50s Somali population had increased from 49% to 60%.

By August 2021, dose 1 uptake in the over 50s Somali population had reached 78%.

Applying the learning

The interventions have been used to target other communities and work settings where vaccine hesitancy existed.

4.2 Population Health Management

What do we mean by Population Health Management (PHM)?

At its most basic, PHM uses data – be that health, social care, education, demographic or housing data – to understand the needs of a population. Its main purpose is to help identify groups (cohorts) of people and match them to the correct intervention to improve health outcomes.

PHM includes two key tools – segmentation and stratification:

- Segmentation essentially means dividing people into groups. This could be by common illness, groups of illness, age or other factors
- Stratification is simply another term for sorting, but there is more analysis applied here, as the sorting is into risk factors

Principles of our Population Health model

The "Manage Need, Not Just Demand" model

- Prevention at every stage: Prevent – Reduce - Delay
- Parity of esteem for mental and physical health
- Health as co-production between clinicians, communities, families and individuals
- Relentless transformation for greater health equity - of access to care, experience of care, and outcomes of care. Driving up health equity will require integrated and collaborative work with partners to address the wider determinants of health alongside NHS care
- Focus on value-based commissioning of services with Partners – including a proportionately universal approach to resource allocation
- Evidence-based treatment, at scale where possible – research to fill in the gaps in the evidence
- A "learning culture" to improve the model – rigorous evaluation based on the quintuple aim of PHM
- A life-course approach to optimal health – it's never too late to improve experience of care or outcomes of care

Our approach

Make every contact by the NHS count **(MECC)**

We will use all types of contact that people have with the NHS to promote health and help people prevent illness or manage it effectively (see 3.1).

Self-management and self-care programmes delivered at scale for those with chronic conditions

Living well and staying well when you have a condition that cannot be cured requires practical skills and a knowledge of when to look for support from others. These skills will be taught and refreshed through structured programmes based on the latest theories of learning and behaviour change (see 3.2).

Population needs profiling

We will utilise, for example, JSNAs, risk stratification, segmentation, impact profiling and feedback from people with lived experience.

Integrated Care for a targeted cohort

With multi-morbidity/frailty or evident disadvantages in the wider determinants of health (see 3.3).

Time-bound (though intensive) case-management
For a small cohort of people with emergent instability of symptoms.

A shared record that is well-coded and well-tended
This is essential both for continuity of intent/care AND as the basis for better health equity and evaluation of schemes (see 4.6).

A tiered matrix of out-of-hospital urgent and emergency care
Bring comprehensive assessment and senior decision makers to bear on presenting illness in a timely and appropriate manner. Linked back to risk stratification profiles and self-management programmes (see 3.3).

A well-structured programme of informal carer support
This will include identification, registration, health checks, vaccination, respite, benefits optimisation, training and skills.

Delivering prevention, health promotion and treatment on a household footprint
Rather than to individuals, where possible.

Work in concert with other system Partners to help address issues relating to the wider determinants of health
Beyond the scope of this Plan – though a core part of our approach.

Case Study

Population Health management – better end-of-life support

What was the issue?

The team at Willows Health in Leicester had previously struggled to proactively identify people who were potentially nearing the end of their lives, in order to ensure they are given appropriate care and support

Intervention

The team adopted a PHM approach and, using a new algorithm called the Mortality Risk Score, they were able to identify a number of patients who had not previously been included on the palliative care register.

Impact

This approach has supported care planning work with palliative care patients and enabled the team to provide patient-centred reviews and end-of-life care plans for those with higher levels of risk.

Applying the learning

The team are now able to offer the right support to a greater number of patients who are nearing the end of their life.

4.3 Quality Improvement

Core Responsibilities and Functions

Our approach to quality and performance improvement is underpinned by our Quality and Performance Improvement Strategy, as well as NHS England's Quality Functions and Responsibilities of Integrated Care Systems, which summarises how quality functions are expected to be delivered:

1. Establishing quality governance arrangements, including a System Quality Group
2. Putting in place quality systems and assurance
3. Implementing arrangements to ensure patient safety
4. Improving people's experience of care
5. Ensuring clinical effectiveness
6. Safeguarding arrangements
7. Enacting new duties (abuse and violence, mental health and quality improvement programmes): and
8. Sustainability.

Our Priorities for quality improvement

Patient Safety

Whilst our individual healthcare providers are accountable for their learning responses to patient safety incidents, we work collaboratively, across LLR, to facilitate and provide supportive oversight, including in the implementation of the new Patient Safety Incident Response Framework (PSIRF). The PSIRF sets out the NHS's revised approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Infection Prevention and Control

We work collaboratively with our healthcare providers, bringing oversight, leadership, support, and guidance to ensure effective management in the prevention and control of infections.

Serious Violence Duty

We work as a member of the LLR Strategic Partnership Board (SPB) with local authority, police, justice system, fire and rescue and other Partners to share information and collaborate on interventions to prevent and reduce serious violence and crimes. In order to discharge our duties under the Police, Crime, Sentencing and Courts Act 2022, the SPB will develop and implement a Strategy to prevent and reduce serious violence across LLR. At a more local level, we are members of Community Safety Partnerships (CSPs), which provide a multi-agency approach to tackling local issues with the aim of making communities safer.

Safeguarding

It is the responsibility of each of our Partner organisations to ensure that people in vulnerable circumstances are safe and receive the highest possible standard of care. We are committed to promoting the safety and wellbeing of children, young people and adults who may be at risk of abuse or neglect and ensuring the health and well-being of Looked After Children.

Working closely with our Local Authorities, healthcare providers, safeguarding partnership and network of professionals we deliver against agreed Safeguarding Adults and Children's Boards Business plans. This work includes but is not limited to:

- Child Protection-Information Sharing
- Serious Violence Duty
- Female Genital Mutilation
- Prevent
- Modern Slavery and Human Trafficking
- Domestic Abuse
- Child Exploitation
- Mental Capacity
- Child Death Overview Panel

Special Educational Needs and Disability (SEND)

The ICB is working in partnership with Leicester City, Leicestershire and Rutland Councils, University Hospitals Leicester and Leicestershire Partnership NHS Trust, to collaborate in improving services and support for children and young people with SEND, as directed by the SEND Code of Practice 2015 (Children and Families Act 2014).

As an ICB we will:

- Commission services in partnership with our local authorities for children and young people aged 0-25 years old with SEND
- Work with local authorities and NHS health organisations to contribute to the Local Offer and provide information about health care services
- Work closely with: Leicester City and Rutland Parent Carer Forums and Leicestershire SEND Hub; supporting groups that represent young people with SEND; Health Watch; the voluntary sector; and community groups
- Make health care provision available where exceptional clinical health needs related to education are specified in Part C and G of individual Education, Health and Care Plan (EHC plan), as part of our commissioning role
- Work with local authorities in making decisions at all key stages for EHC plans.

Our NHS health organisations will:

- Support identification and support for children and young people requiring SEND provision and promote Individual Health Care Plans (IHCPs)
- Respond to requests for advice for EHC plans within the required timeframe
- Work with local authorities to contribute to the local offer of SEND services available
- Work closely with: Parent Carer Forums supporting groups that represent young people with SEND; Health Watch; the voluntary sector; and community groups.

The ICB SEND Designated Clinical Officer (DCO) is a dedicated role that supports Leicester, Leicestershire & Rutland and LLR ICB in implementing and embedding-statutory responsibilities for children and young people with SEND. The DCO supports health colleagues across the ICB and our health providers to ensure children and young people 0-25 with SEND have the right health support to achieve the best outcomes they possibly can. The DCO also works with the local authorities in making decisions at all key stages for EHC plan and agrees the health services within an EHC plan.

Medicine Optimisation and Safety

We will enable transformation and support the pharmacy workforce to:

- Reduce health inequalities through improving access and optimisation of medicines
- Tackling antimicrobial resistance
- Tackling overprescribing and reducing the prescribing of drugs of dependence
- Reduce the environmental impact of medicines and dispensing
- Transform community pharmacy to support acute and elective care pathways
- Develop an integrated system workforce approach driven by the pharmacy faculty; and

- Reduce patient harm from medicines.

Maternity

We will respond to the NHSE Single Delivery Plan for Maternity by listening to our women, growing and supporting our workforce and supporting the positive leadership culture. This will be underpinned by our approach to safety and delivering a personalised, equitable service. Specific focus will be on:

- Improving the Maternity Voices Partnership
- Integrating 1001 days into our maternity transformation programme
- Embedding the learning from national maternity reviews including Ockenden and Kirkup
- Implementing the Saving Babies Lives Care Bundle
- Increasing personalisation and choice
- Improving access to the perinatal mental health service
- Improving the safety culture across our services.

Strategic Commissioning

The planning and delivery of the 5-Year plan and yearly Operational Plans are underpinned by the quality and performance improvement strategy, implementation of quality improvement methodologies and processes that ensure the impact on patients and staff are fully understood and therefore inform decision making, thereby minimising risk and potential harm as a result of competing demands for limited system financial resources.

We will use Equality and Quality Impact Risk Assessment tools and Clinical Prioritisation Frameworks to evaluate any plans and business cases that are developed. By doing so, we ensure that decisions are based on an understanding of the impact on equity, clinical risk and quality, and identification of risk that can be mitigated. The equity focused approach enables us to consider the needs and perspective of all groups, and to address potential health inequalities that may arise.

Our goal is to make informed decisions, promote better health outcomes and a fairer healthcare system for everyone.

Direct Commissioning Delegation

On 1st April 2023, we assumed responsibility for community Pharmacy, Optometry and Dental services (PODS) from NHS England. The aim of delegating POD services is to make it easier for organisations to deliver joined up and responsive care, delivering high quality primary care services for our population. Work is taking place across the East Midlands area to review what this will look like, operationally.

Quality assurance: measuring and monitoring quality

The success of our approach to quality improvement is measured against the three core elements of quality (see Figure 12)

Figure 12: The three core elements of quality

1. Effectiveness

Clear quality improvement priorities based on a sound understanding of quality issues within the context of our local resident's needs, variation and inequalities. This also includes sharing data and intelligence across the system in a transparent and timely way.

2. Patient and Public Experience

Meaningful engagement ensures that people using services, the public and staff shape how services are designed, delivered and co-evaluated. This includes working together in an open way with clear accountabilities for quality decisions, including ownership and management of risks, particularly relating to serious quality issues.

3. Safety

Sharing data and intelligence across the system in a transparent and timely way and moving to a culture of shared learning, review and understanding of care. The safety agenda includes recognising the impact of decisions made at system level given the financial constraints the system may experience. In order to do this effectively LLR is developing a joint equality and quality impact assessment framework to support the assurance of our decision-making which is clinically led.

We have robust quality assurance arrangements in place, the key elements being:

Quality and Safety Committee

Receives intelligence from the System Quality Group and provides assurance to the ICB.

System Quality Group

With membership from across our NHS, primary care and local authority partners, this group has responsibility for sharing quality intelligence, learning, engagement improvement and planning.

Clinical Executive Group

Interdependent, but separate to the ICS quality function, this Group provides clinical leadership to the ICS.

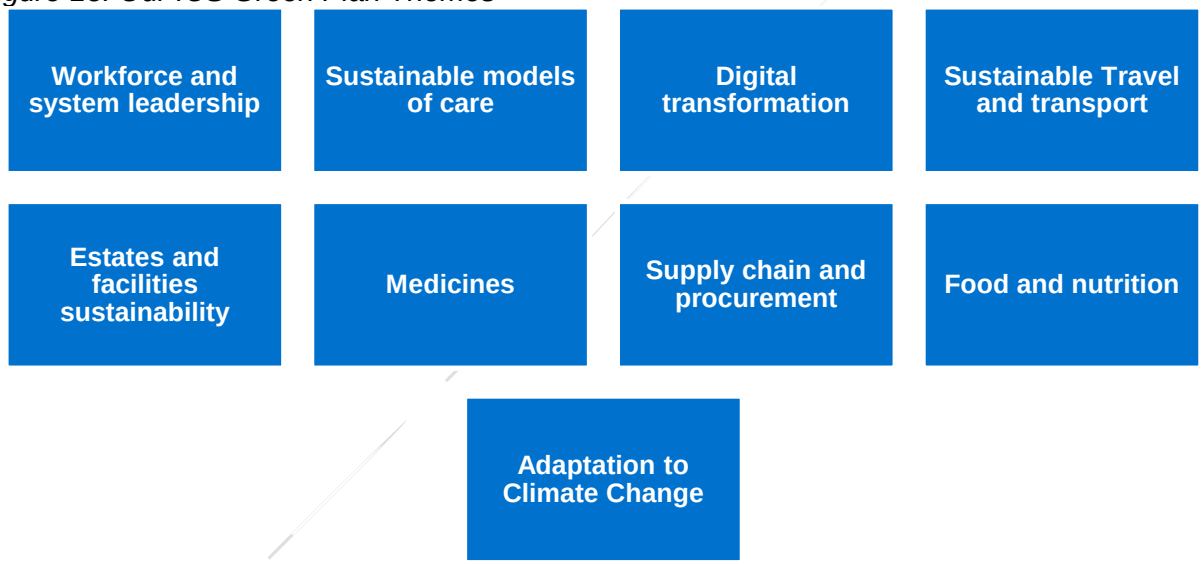
4.4 Delivering a Net Zero NHS

We launched our LLR ICS Green Plan in February 2023 and this sets out how our local NHS:

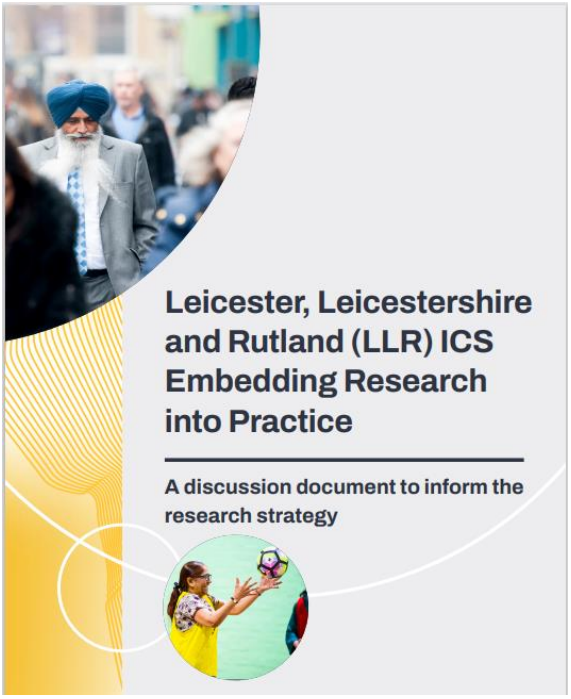
- Plans to deliver against the targets and actions in the Delivering a Net Zero NHS report.
- Supports the NHS-wide ambition to become the world's first healthcare system to reach net zero carbon emissions
- Plans to prioritise interventions which simultaneously improve patient care and community wellbeing while tackling climate change and broader sustainability issues across LLR; and
- Work collaboratively to deliver tangible reductions in emissions and improved outcomes.

The plan articulates where we can lever our collective resources for the widest benefit, including improving health equity. It is structured across nine themes (see Figure 13) each underpinned by a set of key actions.

Figure 13: Our ICS Green Plan Themes



4.5 Research and innovation



Our vision

We will ensure that research and innovation play a central role across our ICS partners. There is already a substantial breadth and scale to research activities across LLR, through our research infrastructure organisations and universities. This work is described in more detail in our discussion document "Embedding Research into Practice"

We have established a Research Strategy Board to steer and oversee the continued development and maturity of our research activities. This Board brings together institutional partners and other stakeholders across the range of health, social care, local authority and higher education institutions. Working with these partners, we will deliver the vision set out in Saving and Improving Lives: The Future of UK Clinical Research Delivery. This will be achieved by building on existing strengths and infrastructure, developing new areas of research and ensuring integration with clinical service and communities.

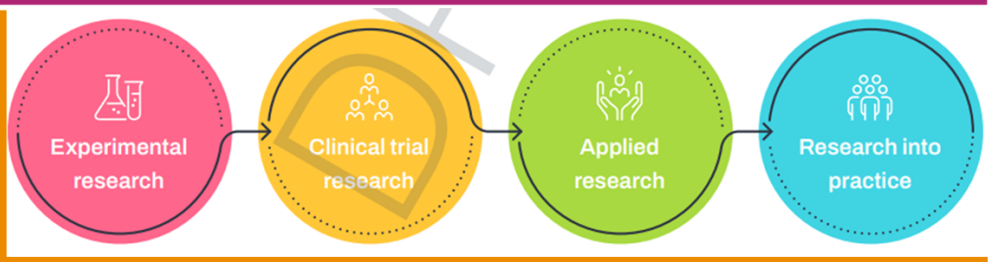
Principles underpinning our ICB research approach:

1. To support research funding applications being made by our academic, health and care partners, where these are relevant to the work of the ICB
2. To support the conduct of research studies undertaken by academic, health and industry partners across the breadth of its work
3. To provide a forum to bring together partners (including research infrastructure such as the Leicester Biomedical Research Centre, Applied Research Collaboration – East Midlands and Leicester Clinical Research Facility) to form productive clinical-academic networks that can work together to respond to specific research calls from national funding bodies (Medical Research Council and National Institute for Health and Care Research) in a timely way
4. Ensure processes are in place to provide robust research governance and quality assurance. We have already taken important steps to achieve this through the integration of our ICB research governance operations with those of UHL
5. Endeavour to facilitate participation in research across all areas of health and social care so that patients are routinely offered participation in research studies as part of their care; and
6. Support (with appropriate data governance) access to clinical data for the purposes of research for our partners.

The ICB is not a research funding body but, where feasible and where resources permit, the ICB will seek to build capacity for research across partners and within the clinical workforce through:

- A focus on promoting and supporting research activity involving primary care and, more generally, into prevention and health inequity
- An ambition to increase the number of non-medical clinicians as participants in our research active communities; and
- Promoting the analysis and utilisation of local clinical and care data through our partnership with academic institutions and research infrastructure, with the purpose of informing service transformation and evaluation, as well as the establishment of new models of care.

Research into practice in LLR



Developing new treatments for cancer – Immunotherapy for mesothelioma

Mesothelioma is a devastating disease caused by asbestos – the only occupation-caused lung cancer. In light of poor treatment options, the National Institute for Health and Care Research (NIHR)-funded James Lind Alliance Mesothelioma priority-setting partnership, identified the top research question as whether boosting the immune system with new immunotherapy agents could improve survival rates. We led a clinical trial called CONFIRM (CheckpOiNt Blockade for Inhibition of Relapsed Mesothelioma) funded by Cancer Research UK & Standup to Cancer. This compared the immunotherapy nivolumab with placebo and received television coverage on Channel 4.

Improved survival was seen and presented as a plenary in the 2021 World Lung Cancer Conference.
Leicester has led at a global level, advances in treatment for mesothelioma. In addition to CONFIRM, the Cancer Research UK funded VIM study, comparing chemotherapy with vinorelbine versus active symptom control, demonstrated benefit and now this drug is used widely in the NHS. Leicester has pioneered therapy for mesothelioma based on the tumour genetic makeup with MIST, the world's first mesothelioma platform trial (funded £3M by the British Lung Foundation). It has demonstrated an improvement in overall survival for patients with relapsed mesothelioma. Nivolumab is now available on the NHS, constituting a change of practice in the UK

4.6 Supporting broader social and economic development (anchor institutions)

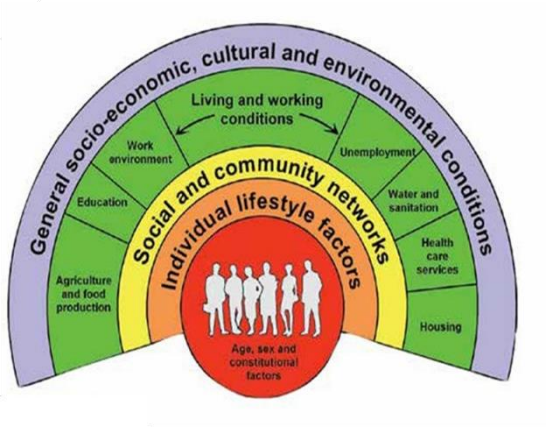
What are anchor institutions?

Anchor institutions are large organisations that are likely to remain in an area and have a significant stake in their local area. They have "sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use".

Our NHS partners are anchor institutes, being large organisations and substantial employers with significant spending power. Fully utilising the opportunities of anchor institutions could result in substantial impact on health and wellbeing equity. This can happen through addressing the wider determinants of health in a way that is appropriate to large health organisations and their broader impact than the clinical health and wellbeing outcomes.

Figure 14 shows the wider determinants of health. It shows the interaction between environmental, social and cultural factors on health and wellbeing. Unemployment and the conditions that people live and work in influence people's health and wellbeing. It is in these areas, plus the general socio-economic outlook of an area, where anchor institutions can play a wider role beyond healthcare delivery.

Figure 14: The Wider Determinants of Health, The Dahlgren-Whitehead rainbow model

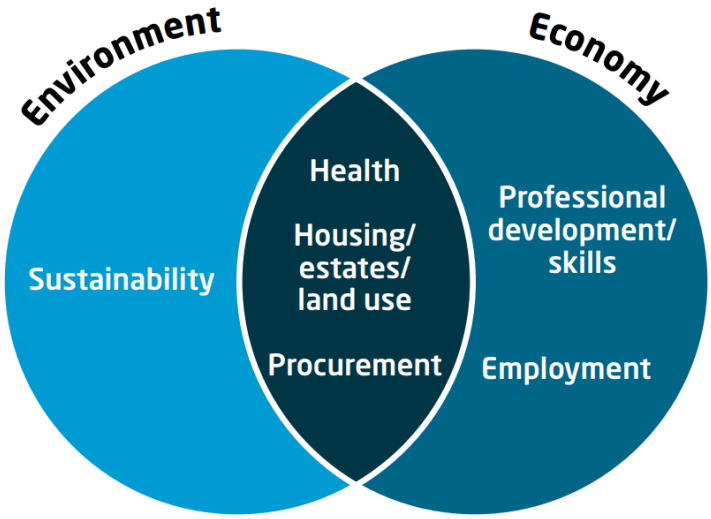


The King's Fund model for anchor institutions considers two broad categories of the environment and the economy (see figure 15). It sets out a possible structure to develop further thinking and action plans for our anchor institutions.

Our current actions and plans for this area inlcude:

- Bring together partners from the NHS, local authority, primary care, independent care providers, third sector and education to support, develop and grow our local health and social care workforce through the LR ICS 'One Workforce' approach. Working in partnership with local communities to make a difference, for example being a good employer and creating opportunities for local communities to develop skills and access jobs in the local health and care sector, particularly aimed at disadvantaged and under-represented communities.
- Through our Estates programme, we will explore opportunities to better harness NHS buildings and spaces to share benefits, co-locate services with our public sector and voluntary sector partners and support our local communities.

Figure 15: The key areas of interest for anchor institutions in the health and social care sector



- Through the revised procurement practices outlined within our LLR ICS Green Plan, we will promote the redirection of investment to support our local suppliers and economy. Adoption of Social Value Model will ensure that economic, social and environmental wellbeing is a key consideration in our supply chain actions.

- Through the LLR Health and Wellbeing Partnership, we will ensure that the ICB works with our local partners beyond health to cascade good and innovative practice, model civic responsibility across our anchor network. We will influence wider economic development and environmental balance, in order to improve people's health and wellbeing and reduce health inequalities.