IN Partnership

The stakeholder bulletin for the Leicester, Leicestershire and Rutland ICS

November 2021

WELCOME TO IN PARTNERSHIP

Welcome to this second edition of *In Partnership*, providing details of how the Integrated Care System (ICS) in Leicester, Leicestershire and Rutland (LLR) is taking shape.

Our emerging ICS is a partnership of local health and care organisations, including the three upper tier local authorities, that have come together to plan and deliver joined up services and to improve the health and wellbeing of people who live and work in the area. *In Partnership* brings you news, views and updates on partner organisations working together to better integrate care in LLR. We plan to publish this update approximately monthly.

INCLUDED IN THIS ISSUE:

A FOCUS ON RESILIENCE THIS WINTER

Colleagues across health and social care organisations are together working tirelessly and making urgent preparations as we approach what will undoubtedly be a tough winter with pressures on all our services.

The combination of the Covid-19 pandemic, the seasonal rise in respiratory infections, and the aim to recover performance in elective (planned) care, means that locally, and nationally, the NHS and social care faces a particularly challenging period ahead.

Partnership plans are being progressed which will advance our work in key areas such as acute and emergency, non-acute, elective and social and residential care. There is a strong sense in our plans of purpose and determination across all partner organisations – as well as a recognition of the challenges facing individuals and teams.

Andy Williams, the ICS lead for LLR, and Joint Chief Executive for the three local clinical commissioning groups, said: "Typically, in winter, we cope with emergency pressure by scaling down elective care, but this winter as we emerge from the pandemic it's vital that we increase elective activity and cope with winter pressures as well. It's an extraordinarily challenging time, and as such, there's really comprehensive planning underway.

"I'm confident we can have a successful winter, but it is going to be vital that we all work together as one health and care family. All parts of the system have a part to play. And there's no time to lose as demand for services is already ahead of where we would typically expect for this time of year.

"Indeed, I want to acknowledge how incredibly busy it is from primary care to our hospitals, and from mental health to the community. We all have a slightly different experience of this. There are colleagues on the frontline who are feeling the pace acutely on a daily basis, whilst there are others in supportive roles who might be one step removed but it doesn't mean that we're not aware or supportive and trying to play our part.

"If we are to make this winter successful it's vital that we work together as a team, make sure that everyone is pulling in the same direction, and look out for another."

"In that context, I just want to say thank you for the work that all colleagues across health and care are doing. I am incredibly grateful and proud, and I know my senior colleagues elsewhere in the system are too."

EVERYTHING IN THE RIGHT PLACE – DELIVERING HEALTH AT ALL LEVELS

Improving people's health and wellbeing is being carried out at all levels – from strategic planning in boardrooms to local communities devising activities to get friends and neighbours more active and healthier.

Key to achieving health gains is the NHS and local authorities working together at all levels for the benefit of local people. In LLR, this is taking place at system level (the ICS Integrated Care Partnership), place level (at the boundaries of upper tier local authorities via Health and Wellbeing Boards) and neighbourhood/locality level.

Place-based plans are being developed for Leicester City, Leicestershire County and Rutland. The plans are:

- Taking a collaborative approach to health and wellbeing, bringing together a range of partners
- Making a shift to prevention to tackle the causes of poor health and wellbeing as well as treating the symptoms
- Ensuring there is alignment between national targets and local delivery
- Making the best use of community assets and people's own skills; promoting independence
- Ensuring our health and wellbeing services are ready and able to respond to population changes.

All three Health and Wellbeing Boards are currently revising or developing new Joint Health and Wellbeing Strategies to align the health and care strategies and place-based plans to create one clear strategic vision for each place. These draft strategies are due to be presented to Health and Wellbeing Boards in October and November 2021 for agreement and sign-off before April 2022.

Alongside this, work is being completed to review and cross-reference the emerging priorities across each place to provide guidance to system-wide priorities. At neighbourhood/locality level, eight Community Health and Wellbeing Plans are being developed across Leicestershire that will feed up and down to the Leicestershire Joint Health and Wellbeing Strategies and delivery plan.

SETTING OUT THE PRINCIPLES TO TACKLE HEALTH INEQUALITIES

A framework is nearing agreement on a set of principles and key actions that need to be taken in order to address health inequalities in LLR.

Health inequalities are avoidable and unfair differences in health between different groups of people. Health inequalities concern not only people's health but the differences in care they receive and the opportunities they have to lead healthy lives.

Those living in the most disadvantaged areas often have poorer health, as do some ethnic minority groups and vulnerable/ socially excluded people. These inequalities are due to many factors, such as income, education and the general conditions in which people are living. In addition, the most disadvantaged are not only more likely to get ill, but less likely to access services when they are ill.

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

There are always going to be differences in health, some are unavoidable, due to people's age or genetics, but many differences in health are avoidable, unjust and unfair – it is these that we are concerned about and that the framework seeks to address.

The framework sets out how local organisations will plan to take action to not only affect the causes of health inequalities but the 'causes of these causes'. These contributory factors are sometimes known as the wider determinants of health, recognising that the NHS, local authorities and other public bodies all have a part to play.

A number of principles have been set out – with a fundamental principle being that reducing health inequalities is a key factor in all work carried out by the ICS – it is everybody's business. Other principles include a focus on the importance of illness prevention, establishing equity between physical and mental health, and using data to understand our population better.

In addition, the framework sets out a number of actions to help guide strategic commissioning of local services and support. The framework states that ultimately, if these actions are successful, we should expect to see:

- A reduction in health inequities
- An increase in healthy life expectancy
- A reduction in premature mortality
- A workforce that is representative of the local population
- Better use of data.

JOINING UP HEALTH AND CARE DATA

Work is being advanced across the ICS to introduce a shared care record which will enable the safe and secure sharing of an individual's health and care information as they move between different parts of the NHS and social care.

The Shared Care Record programme will ensure that data is made available across local areas to support joined up and safer care on a day-to-day basis.

Shared Care Records will provide a standardised and consolidated view of a person's health and care.

The many benefits include easing patient handovers, reducing the need for repeat tests/scans, and reducing the number of times that someone has to repeat their story to a health and/or care professional.

Our recent experience of the Covid-19 pandemic has shown how important it is for the health and care professionals caring for a person to be able to see their information without delay when needed. The Shared Care Record will make a joined-up approach to health and care much more possible.

In LLR, the Shared Care Record programme team has been working with local project teams connecting clinical and care systems across the area.

When fully established, the Shared Care Record portal will join up health and care records enabling better, safer care and treatments for all our local population, allowing staff members to access real time data held by other services across LLR to support direct care.

The end of September 2021 saw the programme team achieve a technical go live deadline. User journey mapping is now being carried out and pilot testing among select services will take place towards the end of this year as the programme is advanced.

If you want to find out more about Shared Care Records, please email leicspart.llrsharedcarerecord@nhs.net

TWO PROJECTS SHORTLISTED FOR HSJ AWARDS

The work being progressed by partners here within LLR is attracting the attention of national award judges with two projects shortlisted in the finals of the prestigiousHealth Service Journal (HSJ) Awards.

The technology-enabled 'virtual wards' initiative, covered in the first edition of In Partnership, has seen Leicestershire Partnership Trust and University Hospitals of Leicester Trust, supported by the LLR CCGs and Spirit Healthcare, shortlisted in the digitising patient services category.

Technology is being set up across a number of care pathways including heart failure and COPD to help patients self-manage their condition at home while giving them support and reassurance that the monitoring equipment will ensure their clinical teams can act swiftly if their health deteriorates.

Elsewhere, the Building Better Hospitals public consultation, hosted by the three local clinical commissioning groups, which ran from September to December 2020 and attracted more than 5,000 responses, has been shortlisted in the 'communications initiative of the year' category.

The consultation on proposals to transform local hospitals by investing more than £450 million reached a staggering 1.8 million people. It was held during the Covid-19 pandemic which led to many traditional forms of face-to-face engagement being replaced by cutting edge, multi-channel, real time techniques that combined both online and offline.

This was supported by innovative partnership work with the voluntary and community sector to reach out and engage with those communities who might be digitally excluded, as well as though those who typically don't engage with the NHS or other statutory partners. The end result was participation in the consultation that was as close as possible to being demographically representative of the make up of Leicester, Leicestershire and Rutland.

The HSJ awards finals will take place in London on 18 November 2021.

WHAT THE ICS MEANS TO ME

Each month we sit down with someone from across the LLR health and care system to get their reflections on what the ICS means to them. In this second issue of In Partnership, we talk with Mike Sandys, Director of Public Health for Leicestershire County Council and Rutland County Council.

As the public health lead for two of the three unitary/upper tier authorities in LLR and with three decades' experience working in public health, Mike is in a good position to assess how health and local government works together. His public health discipline has been hosted in both the health service and in councils during this time, most recently transferring over to local government as a result of the Health and Social Care Act 2012.

"For a long time, people have asked 'where is the best place for public health? Is it in the NHS? Is it in local government?' And, of course, the answer is that it is a bit of both," says Mike. "If we consider the question 'where does public health fit within the ICS?' I think we need to recognise that over the last eight years that public health has not always featured as strongly as it should do within the NHS. It was a positive change to place public health in local government because it has embedded us closer to where many of the big levers are but equally, in order to focus on inequalities, you need a focus on what the NHS can do, both in terms of service delivery and in its role as an anchor institution. The factor that ties both sides of the equation together is that both local government and the NHS have an ambition – a public health ideal – of wanting to improve people's lives and make people healthier. That is something we can all work together on.

> "The key thing for me is to recognise that despite leaving the NHS, public health never went away; we might not have been as visible to those in the health service, but we're still here.

From a system point of view, the fundamental thing is not starting from scratch - the ICS essentially being a partnership of partnerships, building on what is already here. We have a focus on communities and inequalities, on building up from place-level into a system.

"I think it was Sir David Nicholson, former chief executive of the NHS said, who said in relation to health and social care, that 'two turkeys don't make an eagle'. That is of course unfair on both the NHS and social care but there is something that the ICS has to recognise that there are real difficulties around staffing and money in the two sectors. The ICS has to be collaborative, and has to be able to challenge and work at the appropriate levels to resolve these issues, it has to avoid becoming simply a 'talking shop'. The ICS has to be about actions. It's like when I would play five-a-side football and the captain would say 'let's get some shots in'. And he's right – you can do all your fancy footwork but sooner or later you've got to get some shots in."

Public health and football analogies are nothing new during Covid-19 thanks to the Downing Street press conferences featuring Professor Jonathan Van-Tam, Chief Medical Officer, but how does Mike reflect on the recent experience of having a lead public health role in the pandemic response?

"It feels like it is still probably too soon to reflect on the past couple of years but I don't think I could say when exactly the right time would be. I'm sure myself and Ivan (Browne, Director of Public Health, Leicester City Council) could talk for a long time about dealing with Covid-19, the experiences of being the first place in a local lockdown, the amounts of media we've done, the brilliance of our teams in setting up local test and trace, local contact tracing, and supporting care homes and schools with outbreak and infection prevention and control advice, and many other things.

"The pandemic has touched, tragically, all communities. Had I been 10 years older, I might have been retired and would have missed it, and from a professional viewpoint I would have missed the ultimate public health test for the last 100 years. It's something nobody wanted but, also, I would not have wanted to be anywhere else. That probably says something about professionalism and wanting to help people. All of us have public service in our hearts, and from that point of view, I just look at what my colleagues have done and think 'yes, well played'.

The response to Covid-19, both the direct response and the indirect effect on other local services and support, has dominated health and social care since the beginning of 2020. Many services, projects and strategies have had to be paused while the fight against coronavirus has taken place. How does public health and the ICS intend to re-visit other priorities in the years ahead?

"The short answer is that the focus on other public health measures never went away. Colleagues have still have been providing health improvement services and strategic leadership, on a range of issues such as weight management and substance misuse. It will be interesting to see how the public narrative from Covid-19 plays out. There will be some people who will say that public health has spent two years telling us what to do and they're not going to listen anymore and you can see a bit of that happening now. Elsewhere, you will have some people who will have re-assessed their lives during lockdown – we saw a bit of that with the Prime Minister and his concerns over his weight – and who will be looking to adopt healthier behaviours. The challenge for public health post-Covid will be recognising that we have a much more polarised population, with a section of the population such as the anti-vaxxers, that really does not want to engage."

Elsewhere in this newsletter, we highlight a new framework being advanced by public heath on tackling health inequalities in LLR. This has been an objective of health and local authorities for a long time and while some inequalities have been reduced over the years, some seem as entrenched as ever.

Mike is asked how the ICS might be able to make progress in this area where previous partnerships or initiatives have been frustrated.

"Our focus on trying to reduce health inequalities is nothing new. Trying to understand the pattern of inequalities and focusing our resources on those areas where populations have been under-served has always been an integral part of what we do. I mentioned earlier that it feels like there has been less emphasis on public health and inequalities within the NHS in the last eight years. The ICS provides us with the opportunity to shine a spotlight on this. We can, for example, build in an inequalities' perspective on service re-design, making sure we're really thinking about the needs of under-represented and under-served populations. Due to Covid-19 it's really important that we take an inequalities perspective on reducing waiting lists. We have been doing things like health equity audits for many years but it's nice to have a new focus on this through the ICS. There are issues such as air quality, for example, which have no respect for administrative boundaries so there is a real benefit in bringing partner organisations together across a broader footprint."

There is a benefit too in the expertise and insight that public health can bring to the ICS in terms of understanding the needs of diverse local communities.

Mike explains: "There is a technical aspect to this, working with colleagues within the council and the NHS on understanding both quantitative and qualitative data, which illuminates that rich picture of inequalities and under-representation. The other bit for me is public health being able to open up that discussion with other organisations and bringing them into the fold. We have a role in understanding the inequalities perspective of communities and facilitating discussions regarding how we make best use of our resources."

The ICS, and partner organisations within the ICS, have a number of plans and strategies that embrace public health. One article in this newsletter states how such plans are being advanced at community, place (health and wellbeing board) and ICS strategic levels. But what initiatives would Mike personally like to see advanced – where he would like to see a future focus?

"I think people would expect me to say lifestyle, behaviour and inequalities, and of course all these things are hugely important. I am also very interested in the links into communities. I've never been a community development worker, but I've got a long-standing interest and involvement in community initiatives that build social capital. I would like to see a focus in the ICS on harnessing the power of our communities, about how we develop social capital, and you can see a bit of that taking place in recent years in the NHS with the introduction of social prescribing, and this all builds on the strength of local government.

> My other interest is whereby public health almost starts getting into organisational development territory, in wanting to be part of the solutions and discussions about how we bring different sections of the health and care workforce together. Until we have an understanding of what stops individual staff groups working closely with other staff groups, we will never achieve a fully cohesive system.

EVERYTHING'S GONE GREEN – HOW WE CAN TACKLE CLIMATE CHANGE

The health and care sector, as the biggest employer in this country, is both part of the problem of climate change and part of the solution.

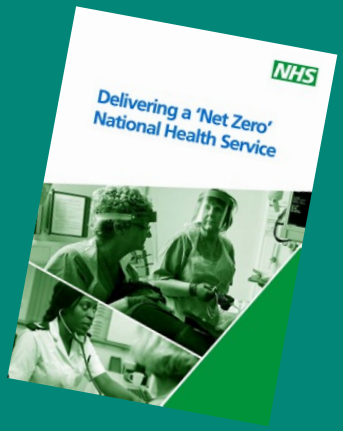
The Delivering a 'Net Zero' National Health Service publication (October 2020) states that if health services across the world were their own country, they would be the fifth-largest emitter on the planet.

This report highlights that if left unabated, climate change will disrupt care, with poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer.

The report sets out trajectories and actions for the entire NHS to reach net zero carbon emissions by 2040 for the emissions it controls directly, and 2045 for those it can influence (such as those embedded within the supply chain).

Locally, we are planning to set up a LLR ICS Green Board which will be tasked with overseeing development and implementation of a Green Plan (by March 2022). University Hospitals of Leicester will lead on development of the Green Plan and establish project capacity.

The Green Board will bring together local authority sustainability leads with their NHS counterparts to identify key local actions on reducing carbon admissions.



National guidance states that as a minimum the Green Plan should set out proposals to reduce carbon, waste and water; improve air quality; and reduce the use of avoidable single-use plastics.

PROMOTING INCLUSIVE DECISION-MAKING

Partner organisations in the ICS have launched a new tool to help embed equality considerations in decision-making.

The Inclusive Decision-Making Framework (IDMF) aims to enhance our decision-making processes, ensure they are not influenced by biases and that we have thoroughly considered the diverse needs of our workforce, public/patients and the wider community.

Inclusive decision-making highlights the importance of equality, diversity and inclusion when we are developing and implementing strategy, plans, programmes, projects, and commissioning and procuring services.

The framework was created to support the embedding of equality, diversity and inclusion in the culture of the ICS as the system embarks on transformation and innovation across LLR.

It has been designed to be used by all staff in their daily work, recognising that we are all leaders in our own right, with a toolkit that has been produced to help implement the framework.

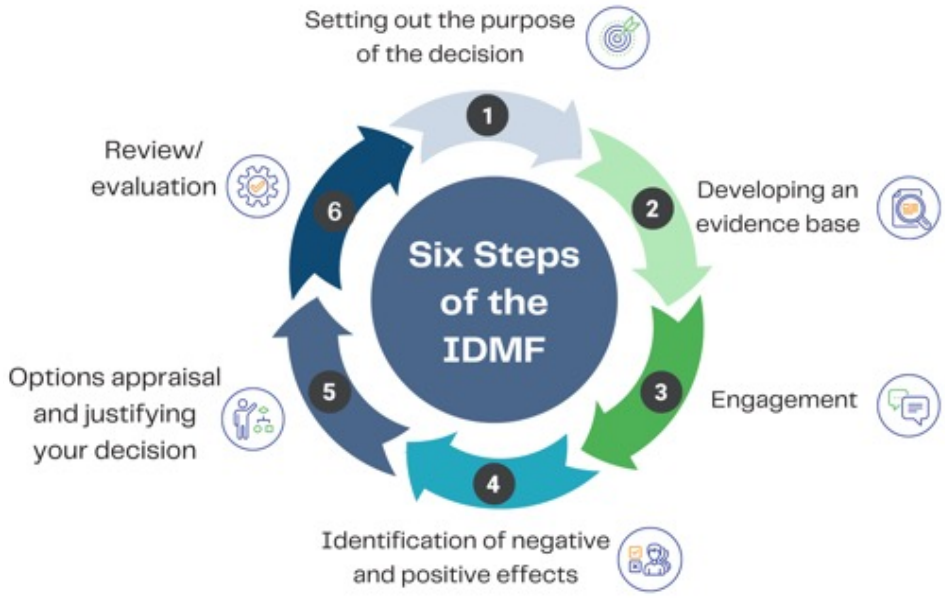
It covers a six-step process, shown in the diagram below, taking the user from the first step of establishing the purpose of the decision, to the final step of reviewing and evaluating the decision.

Successful implementation of the framework will help to:

- Foster a culture of inclusive decision-making across LLR
- Provide a shared equality, diversity and inclusion resource across different system partners
- Provide practical steps to ensure that the needs of different communities and staff are considered in decision-making and plans
- Meet the challenges of delivering the NHS Long Term Plan across LLR, in terms of legal duties on equality, human rights and reducing health inequalities.

Further information is available on the LLR Academy website.

https://llracademy.org/inclusive-decision-making-framework-idmf/



Have an item that you would like including in the next issue of In Partnership, or a case study of integration in practice that could be highlighted?

Please send your thoughts and ideas, as well as any feedback, to: PressOfficeLLRCCGs@leicestershire.nhs.uk.