Leicestershire County Council

Meeting: **Health and Wellbeing Board**

Date/Time: **Thursday, 24 February 2022 at 2.00 pm**

Location: **Council Chamber, County Hall, Glenfield**

Contact: **Mr. Matthew Hand (Tel: 0116 305 2583)**

Email: **matthew.hand@leics.gov.uk**

Membership

Mrs H. L. Richardson CC (Chairman)

Gemma Barrow	Mark Wightman
Edd de Coverly	Mike Sandys
Sarah Prema	Dr Mayur Lakhani
Rupert Matthews	Jon Wilson
Mark Powell	John Sinnott
Cllr Cheryl Cashmore	Cllr. J. Kaufman
Hayley Jackson	Mrs. C. M. Radford CC
Harsha Kotecha	Andy Williams
Jane Moore	Mrs D. Taylor CC
Ch. Supt Adam Streets	Rachna Vyas
Dr. Vivek Varakantam	

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 25 November 2021.		(Pages 3 - 10)
2.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
3.	Declarations of interest in respect of items on the agenda.		
4.	Position Statement by the Chairman.		

5.	Leicestershire Joint Health and Wellbeing Strategy 2022-2032.	Director of Public Health and Executive Director, Strategy and Planning LLR CCGs	(Pages 11 - 116)
6.	Health and Wellbeing Board Governance.	Director of Public Health	(Pages 117 - 142)
7.	Better Care Fund Plan Update.	Director of Adults and Communities	(Pages 143 - 152)
8.	Better Care Fund Section 75 Agreement - Approval and Assurance	Director of Adults and Communities	(Pages 153 - 266)
9.	Pharmaceutical Needs Assessment 2022.	Director of Public Health	(Pages 267 - 280)
10.	Joint Strategic Needs Assessment - Dementia.	Director of Public Health	(Pages 281 - 286)
11.	Family Hubs Model Implementation and Bid.	Director of Children and Family Services	(Pages 287 - 290)
12.	Technology Enabled Care.	Director of Adults and Communities	(Pages 291 - 298)
13.	Leicestershire Children and Families Partnership Plan: Progress Update.	Director of Children and Family Services	(Pages 299 - 326)
14.	Any other items which the Chairman has decided to take as urgent.		
15.	Date of next meeting. The next meeting of the Health and Wellbeing Board will be held on 26 May 2022 at 2.00pm.		

Agenda Item 1

Minutes of a meeting of the Health and Wellbeing Board held at County Hall, Glenfield on Thursday, 25 November 2021.

PRESENT

Mrs H. L. Richardson CC (in the Chair)

Jane Moore
Mike Sandys
Dr Mayur Lakhani
Nigel Thomas
Kam Mistry
Cllr. J. Kaufman
Mrs D. Taylor CC
Caroline Trevithick
Dr. N. Mahatma

Apologies

Sarah Prema, Rupert Matthews, Mark Powell, Cllr Cheryl Cashmore, Hayley Jackson, Harsha Kotecha, Ch. Supt Adam Streets, Dr. Vivek Varakantam, Jon Wilson, John Sinnott, Andy Williams and Rachna Vyas

In attendance

Fay Bayliss, Edd de Coverly, Mukesh Barot

21. Minutes of the previous meeting.

The minutes of the meeting held on 8 July 2021 were taken as read, confirmed and signed.

22. Urgent items.

There were no urgent items for consideration.

23. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Cllr. J. Kaufman declared a personal interest in regard to the substantive items on the agenda as his son worked for the NHS.

24. Position Statement by the Chairman.

The Chairman presented a position statement on the following matters:-

- The crucial work being undertaken by health, social care and community partners during the ongoing coronavirus pandemic.
- The development of a new Pharmaceutical Needs Assessment

- Joint Strategic Needs Assessments
- The County Council's draft Strategic Plan
- The ongoing media campaign which had seen partners work together to produce a range of communications to encouraging residents to play their part in controlling the spread of coronavirus.

A copy of the position statement is filed with these minutes.

25. Leicestershire Better Care Fund Plan 2021/22.

The Board considered a report of the Director of Adults and Communities which presented the final Leicestershire Better Care Fund (BCF) Plan for 2021/22. A copy of the report, marked 'Agenda Item 5', is filed with these minutes.

The Director said that the BCF documentation was published on the 30th September with a deadline of submission to NHS England of the 16th November 2021. Due to there not being a meeting of the Health and Wellbeing Board until after NHS England's submission deadline, the Chief Executive, following consultation with the Chairman of the Health and Wellbeing Board, took urgent action to submit the BCF Plan for 2021/22. The Board was asked to approve its contents retrospectively.

RESOLVED:

a) That the urgent action taken by the Chief Executive using his delegated powers, to submit the Leicestershire Better Care Fund (BCF) Plan 2021/22 to NHS England by the deadline of the 16 November 2021, be noted;

b) That the contents of the Leicestershire BCF submission, including the Planning Template and Narrative for 2021/22 which includes the proposed ambitions associated with the five BCF metrics, as detailed in the Executive Summary section of the narrative document included as Appendix A, be approved.

26. Draft Leicestershire Joint Health and Wellbeing Strategy 2022 - 2032.

The Board considered a report of the Director of Public Health and Executive Director, Strategy and Planning, Leicester and Leicestershire and Rutland CC which presented the draft Joint Health and Wellbeing Strategy (JHWS) 2022 – 2032 for approval to consult. A copy of the report, marked 'Agenda Item 6', is filed with these minutes.

Arising from discussion the following points were noted;

- The JHWS would set the strategic vision and priorities for Health and Wellbeing across Leicestershire for the next 10 years. The Strategy would act as the place based plan for the County.

- A delivery plan and performance dashboard would be developed to help partners ensure that priorities set out in the Strategy were delivered upon and progress was continuously monitored. A review of the Health and Wellbeing Board's Terms of Reference and membership would also be undertaken to ensure the Board was best placed to be able to oversee its delivery.

- The proposed eight week consultation, beginning on the 29 November 2021, would help shape the JHWS and clarify that the priorities identified represented the needs of Leicestershire residents and communities. Whilst the consultation would be undertaken over the Christmas period, officers were confident there was sufficient opportunity to engage with residents and the appropriate partners/stakeholders.

- The detailed consultation plan set out how engagement with key stakeholders would be undertaken, including presentations at partnership meetings such as the Board's sub-groups, the Council's Health Overview and Scrutiny Committee, Leicestershire Challenge and Equalities Group and the NHS Integrated Care System design groups. Whilst the consultation would be framed around the online questionnaire, there was the ability for officers to meet with specific groups such as carers and community and equalities groups. Local Area Co-ordinators would be asked to facilitate conversations and workshops with residents and communities.

- The draft Strategy would benefit from strengthening the importance of a transformative approach to health and wellbeing and service delivery, particularly post pandemic. The Strategy should encourage the population to take charge of their own health and wellbeing via a citizen activation approach.

- It was suggested that the final Strategy could promote the use of a global measure of wellbeing which could be used to track the wellbeing of the local population.

- Delivery of the priorities set out in the Strategy would be a joint responsibility of health partners. Staffing and resourcing would be constantly monitored In order to ensure there was sufficient capacity within the system.

- It was suggested that the term 'industrialising prevention' which was included within the draft Strategy could be re-phrased.

- The final Strategy would include detail as to how it aligned to the recently formed Integrated Care System.

- The proposal for the alignment of the Strategy's priorities with those identified in Primary Care Network (PCN) and neighbourhood plans was welcomed. This would help ensure the work being undertaken in localities would feed into the County wide (Place) work. To compliment this approach, work was already taking place to strengthen integrated neighbourhood working across health and social care via the PCN and the healthy partnership work at district level.

- Board members were asked to promote the consultation document within their own organisations.

RESOLVED:

a) That the draft Joint Health and Wellbeing Strategy (JHWS) 2022-2032, attached as appendix A to the report, be approved for consultation;

b) That it be noted that a Delivery Plan and associated dashboard will be developed to support the delivery of the JHWS;

c) That it be noted that a report detailing the outcome of the consultation exercise and presenting the final JHWS for approval would be considered by the Board at its next meeting in February 22.

27. Safeguarding Children Partnership Annual Report 2020/21 and Business Plan 2021/22.

The Board considered a report of the Safeguarding Children Partnership which presented the Annual Report of the Leicestershire and Rutland Local Safeguarding Children Partnership (LRSCP) for 2020/21 and the Business Plan of the LRSCP for 2021/22. A copy of the report, marked 'Agenda Item 7' is filed with these minutes.

It was noted that partnership working in relation to the safeguarding of children remained strong despite the challenging circumstances as a result of the pandemic. The safeguarding of babies was a notable emerging concern during the pandemic and a number of workstreams were in place to improve the position.

The introduction of a rotating Chair of the Partnership Board had enabled the Independent Advisor to step away from that role and focus on scrutinising the work of the Partnership.

In response to questions concerning the level of referrals received during the pandemic, it was recognised that whilst there was a drop in early help referrals during the height of the pandemic, a consistent level concerning child protection matters was received. The Partnership remained confident the level of referrals concerning safeguarding remained consistent however there was a concern that a period of early intervention was missed which would have otherwise been addressed. As a result an increase in the complexity of referrals was now being experienced.

RESOLVED:

That the Annual Report 2020/21 and Business Plan for 2021/22 for the Leicestershire and Rutland Safeguarding Children Partnership and the key points of relevance relating to health and wellbeing, be noted.

28. Safeguarding Adult Board Annual Report 2020/21 and Business Plan 2021/22.

The Board considered a report of the Leicestershire and Rutland Safeguarding Adults Board which presented the Annual Report of the Leicestershire and Rutland Safeguarding Adult Board (LRSAB) for 2020/21, and the Business Plan of the LRSAB for 2021/22. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

It was noted that the LRSAB's Business Plan for 2021/22 consisted of three priorities, including a shared one with the LRSCP concerning the support pathways available to children and young people who had been exploited.

RESOLVED:

That the Annual Report 2020/21 and Business Plan for 2021/22 for the Leicestershire and Rutland Safeguarding Adult Board and the key points of relevance relating to health and wellbeing, be noted.

29. Leicestershire County Council's Strategic Plan 2022-2026

The Board considered a report of the Chief Executive, the purpose of which was to seek the Board's views on the draft Strategic Plan (2022 – 26) as part of the 12-week public consultation period which commenced on 1 November 2021. A copy of the report marked, 'Agenda Item 9', is filed with these minutes.

Arising from discussion the following points were noted:

- Partners (including district councils) would play a key part in assisting the Council to deliver the priorities set out in the Strategic Plan and the document would therefore benefit from additional detail which set out exactly who the partners were.

- The 'Strong Economy' outcome identified the need to ensure developer contributions were secured. The section could be strengthened to include the need for service provision (such as health) to match the level of housing growth. It was noted that work to ensure such provision was accounted for when new housing developments were built was being undertaken via the Integrated Care System and was referenced in community health and wellbeing plans.

- In response to concerns that not all the proposed priorities set out in the Strategic Plan aligned, such as the commitment to support the expansion of economic growth and infrastructure whilst also committing to protect the environment, it was noted the Plan's actions set out further detail as to how certain priorities could be achieved whilst not having a negative impact on the delivery of others. It was acknowledged that further clarity as to how this would be achieved was needed within the document.

- It was suggested that the Strategic Plan could commit to the 'Anchor Institute' approach which promoted the joint use of public sector assets to create stronger communities and improve the long-term health of the community.

- Following the adoption of the Strategic Plan, regular update reports would be produced which detailed progress in delivering the Strategy's priorities. It was noted that the Health and Wellbeing Board and health partners would be particularly interested in the progress in relation to the health outcomes and wider determinants of health and how it linked with work being undertaken elsewhere.

- Whilst the Strategic Plan focused on the importance of the first 1000 days of a person's life and the support available to help people live well, it would benefit from the recognition of the importance of partnership working to support people during the last 1000 days of their life as part of a dying well approach.

RESOLVED:

That the Health and Wellbeing Board's comments concerning Leicestershire County Council's draft Strategic Plan (2022 – 2026) be noted.

30. Leicester, Leicestershire and Rutland Suicide Prevention Strategy Update.

The Board considered a report of the Director of Public Health which provided the Board with an update on Suicide Prevention work across the County delivered by the County Council's Public Health Department and its Partnership Group, the Leicester, Leicestershire, and Rutland Suicide Audit and Prevention Group. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

Members welcomed the progress that had been made across LLR to address the priority areas set out in the Suicide Prevention Strategy and the commitment to engage with private sector organisations to raise awareness of the suicide prevention agenda and provide training where required.

It was noted that the Integrated Care Partnership, which comprised of senior leaders from across the Health and Care system, would benefit from an update on the matter.

RESOLVED:

That the co-ordinated suicide prevention work being undertaken across the Leicester, Leicestershire and Rutland area be supported.

31. Commissioning and Procurement of Home Care Services.

The Board considered a report of the Director of Adults and communities which summarised the outcome of the recent tender exercise for integrated home care services to create a new framework of providers. A copy of the report, marked 'Agenda Item 11', is filed with these minutes.

In response to questions concerning the number of providers within each of the 14 zones which made up the framework, the Director said the County had been split into geographical zones based on various factors, including the ability of providers to deliver homecare across the whole zone, which was difficult in some rural areas. It was therefore understandable that the heavily populated zones would attract a greater number of providers.

RESOLVED:

That the work undertaken by the County Council in partnership with Leicestershire Clinical Commissioning Groups to commission and procure home care services, be noted.

32. Date of future meetings.

RESOLVED:

That future meetings of the Health and Wellbeing Board will be held at 2.00pm on the following dates:-

Thursday 24 February 2022
Thursday 26 May 2022
Thursday 22 September 2022
Thursday 1 December 2022

2.00 - 4.15 pm CHAIRMAN
25 November 2021

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Agenda Item 5

Leicestershire County Council

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS

HEALTH AND WELLBEING BOARD: 24 FEBRUARY 2022

REPORT OF THE DIRECTOR OF PUBLIC HEALTH AND EXECUTIVE DIRECTOR, STRATEGY AND PLANNING, LEICESTER, LEICESTERSHIRE AND RUTLAND CCGS

LEICESTERSHIRE JOINT HEALTH AND WELLBEING STRATEGY 2022 – 2032

Purpose of report

1. The purpose of this report is to advise the Health and Wellbeing Board of the outcome of the consultation on the Leicestershire Joint Health and Wellbeing Strategy (JHWS) 2022 – 2032 and seek approval for the final Strategy.

Link to the local Health and Care System

2. The development of a JHWS is a statutory requirement of the Health and Wellbeing Board (HWB) which will set out the strategic vision and priorities for Health and Wellbeing across Leicestershire over the next 10 years. The Strategy is aligned with the Integrated Care System's requirement for the development of a Place Based Plan.

Recommendation

3. It is recommended that:

    a) The outcome of the public consultation exercise on the draft Joint Health and Wellbeing Strategy be noted;

    b) The Joint Health and Wellbeing Strategy 2022 – 2032 be approved;

    c) The Joint Health and Wellbeing Strategy Delivery Plan be noted.

    d) The indicator set used to monitor the performance of the Strategy, be approved

Policy Framework and Previous Decisions

4. At its meeting on the 8 July 2021, the HWB approved the development of the JHWS. The 10 year draft Strategy was subsequently presented at the 24th November 2021 meeting where the Board approved the draft Strategy for consultation.

Background

5. The overall vision for the JHWS is, 'Giving everyone in Leicestershire the opportunity to thrive and live happy, healthy lives,' with the strategic priorities aligning to the life course Integrated Care System (ICS) transformational priorities as approved at the July HWB, which are

    - Best Start For Life
    - Staying Healthy Safe and Well
    - Living and Supported Well
    - Dying Well.

6. It is acknowledged that there are key workstreams covering the whole life course and these are part of a cross-cutting element of the Strategy with the aim of improving mental health, reducing health inequalities and considering the impact of Covid-19. Key principles and enablers are also suggested in the Strategy (attached as Appendix A) to support its implementation.

Developing the Joint Health and Wellbeing Strategy 2022 – 2032

7. Considerable collaboration and partnership efforts have driven the development of the JHWS through a Project Board and subgroups (Needs Assessment, HWB Development Day and Consultation & Engagement groups).

8. The HWB's Development Session was held virtually on the 23 September 2021 to consider the data, engagement activity, current linked strategies from across the partnership and the inequalities and challenges local communities faced. HWB members and invited colleagues engaged in discussions based on the needs assessment pre-read covering the life course approach and cross cutting themes. Colleagues worked together to shape the specific priorities under each outcome, and at its meeting in November 2021, the Board approved the Draft JHWS for an eight week consultation period.

JHWS Consultation

9. The draft Strategy was the subject of an eight-week consultation exercise which took place from 29th November 2021 – 23 January 2022. Members of the public and key stakeholders were consulted in a variety of ways outlined in full in the report attached as Appendix B, with a summary below.

10. The consultation survey accompanied by the draft Strategy document was hosted on the County Council's 'Have your Say' website with an 'easy read' version and paper copies available. The main part of the survey consisted of a range of multiple-choice and open-ended questions. All the documents (draft Strategy and consultation questionnaire) were available in different formats and languages upon request.

11. Targeted notifications were sent to Board members, the Project Board, associated working groups and other key stakeholders alerting them to the consultation. The draft Strategy has been presented to key stakeholder meetings including the Health Overview Scrutiny Committee, the Health and Wellbeing Board's Sub-groups, and meetings across the wider NHS ICS footprint as outlined within the Consultation report. The working group progressing communication and engagement element focussed on those digitally excluded.

12. Social media played a key part in promoting the consultation, with over 16,000 impressions across Facebook, LinkedIn and Twitter and 610 engagements. 144 people clicked directly from these posts into the consultation landing page.

13. There were 98 responses to the online survey, 72 facilitated conversations, 1 paper response and significant feedback from partnership meetings that have all helped to shape the final Strategy.

14. Of the 99 online survey respondents, 80 % of those who responded did so as a resident of Leicestershire, 8% an interested member of the public, 6% a Public Sector organisation, 3% a voluntary organisation, charity or social enterprise and 3% were classified as 'other'. An overwhelming majority of the respondents supported the vision, priorities and outcomes, with 92% agreeing with the vision 'Giving everyone in Leicestershire the opportunity to thrive and live happy, healthy lives'.

15. The survey specifically invited respondents to focus on the following priorities across the life course:

- Best Start For Life : There was strong support for this life course stage, with 90% of online respondents agreeing with the priorities and commitments:
    i. First 1001 Critical Days
    ii. School Readiness
    iii. Preparing for Life

- Staying Healthy, Safe and Well: Again strong support with 85% of online respondents agreeing with the priorities and commitments:
    i. Building Strong Foundations
    ii. Enabling healthy choices and environments

- Living and Supported Well: Another positive response with 86% agreeing with the priorities and commitments:
    i. Industrialising prevention and self-care
    ii. Effective management of frailty and complex care

- Dying Well: In this life course stage 87% of respondents agreed with the priorities and commitments:
    i. Understanding the need
    ii. Normalising end of life planning
    iii. Effective transitions

- 85% of online respondents agreed with the priorities and commitments in the cross cutting themes of improved Mental Health, reduced health inequalities and Covid impact.

16. The majority of online comments received were supportive/confirmative comments (121). A further 118 comments made suggestions for additions or amendments covering a wide range of areas and a further 33 comments highlighted something already covered by the Strategy, highlighting its importance. 31 comments requested more detail about how partners would deliver, monitor and measure success. A small number of respondents disagreed with specific elements of the Strategy although there was no common theme and these sometimes went against the tide of positive responses on the same issue.

17. The Local Area Coordinator team facilitated additional feedback within local communities. The face-to-face conversations with 72 members of the public again highlighted the strength of support for the Strategy with people particularly welcoming the focus on all life stages, mental health, Covid recovery and prevention. Feedback received mirrored points raised online with comments about complexity of the Strategy and language, requests for more detail on how the commitments would be achieved and comments about integrating services, knowing what services are available and how to access them.

18. More detail about the feedback received including key themes is available in the summary at Appendix B.

19. It is acknowledged that the consultation started a conversation with partners, residents and communities on the understanding that this would be progressed to ensure the JHWS continues to reflect experiences. The HWB Communications and Engagement Strategy is also on the agenda for this meeting and highlights how this is evolving. The consultation survey allowed respondents to supply their contact details and be included in the ongoing conversation.

<u>Amendments to the final Strategy</u>

20. As a result of feedback and comments received through the consultation, a number of amendments have been made to the final strategy, outlined in full on slides 7 and 8 in the consultation report. Areas that have been strengthened include;

- Best Start for Life, the importance of working with Children with Special Educational Needs has been reinforced, and keeping children safe from harm,
- Staying Healthy Safe and Well, choice is strengthened under Healthy Choices and Environments
- Living and Supported Well further clarity has been provided regarding Long Term Conditions also referring to disability, increasing knowledge about access and support including economic prosperity, inclusion of the Adults and Communities Investment Strategy and strengthening the relationship between the HWB and LLR Carers Board. Also 'Industrialising Prevention and Self Care has been amended to 'Up scaling prevention and self care'

21. The majority of comments received focussed on Mental Health, in particular funding and the integration of pathways. The Strategy has been strengthened to provide clarity on understanding the health inequalities across Leicestershire following the pandemic, including inclusion of the LGBT+ community.

22. Amendments have been made to the terminology used in order to reduce jargon where this has been highlighted. Further consideration will be given to providing a summary version offering and quick and easy read for the general public to understand.

Monitoring performance of the Strategy

23. To enable the Board to monitor progress against the outcomes, approval was given at its meeting in November 2021 for the development of a Delivery Plan. This is a working document, owned across the partnership and as result, will be constantly changing. The high-level Delivery Plan (attached as Appendix C) showcases to the Board the breadth of work involved in progressing actions to deliver on the Strategy. The Strategy adopts a 'Do, Sponsor, Watch' approach to prioritising the work of the HWB, while supporting the wider partnership.

24. The Board will receive quarterly progress reports against the Delivery Plan framed by the indicator set attached in Appendix D. This is supported by colleagues from across the partnership and led by the County Council's Public Health Business Intelligence Partner. Revisions will be made to reflect progress against the priorities and evolution of the Strategy over the 10 year period.

25. An iterative approach has been taken to the drafting of the JHWS and initial high level Delivery Plan and this will be maintained throughout the duration of the Strategy so that the Board can ensure it adapts and responds to the changing policy landscape. It is acknowledged the HWB subgroups will support delivery of specific life course areas and will therefore add further detail to the Delivery Plan including timescales, leads and ensuring objectives

are SMART. The Strategy and Delivery Plan will be subject to an annual review of progress and a more in depth review every three years. This will enable it to stay relevant and will support the Board in its aim to complement and contribute to the wider health and care system across LLR. The HWB is also reviewing it's terms of reference and subgroups to ensure effective and efficient delivery of the JHWS. These are described in the accompanying paper to the Board.

The Equalities and Human Rights Impact Assessment

26. The Strategy has a cross cutting theme to reduce health inequalities and is linked into the wider LLR Health inequalities framework. A full Equality and Human Rights Impact Assessment has been presented to the Public Health Equalities Group and is attached as Appendix E. The results from this impact assessment have been incorporated into the final version of the Strategy and a review of the EHRIA will be completed on an annual basis to align with the annual review of the Delivery Plan.

Resource Implications

27. There are no specific additional resources allocated to the delivery of the Strategy. Delivery will be completed through current budgets across the Leicestershire HWB partnership. It is acknowledged that any changes to funding and commissioning of services will need to be approved by the respective organisation's governing body.

Background papers

Report to the Health and Wellbeing Board – 8 July 2021: Joint Health and Wellbeing Strategy Refresh

http://politics.leics.gov.uk/documents/s162246/JHWS%20Refresh%20paper%20-%20July%20HWB.pdf

Report to the Health and Wellbeing Board – 25th November 2021: Draft Leicestershire Joint Health and Wellbeing Strategy 2022 - 2032

https://politics.leics.gov.uk/documents/s165094/HWB%20Draft%20JHWS%20Report.pdf

Officers to Contact

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List of Appendices

Appendix A - The Joint Health and Wellbeing Strategy 2022 – 2032

Appendix B - Consultation Report

Appendix C - Joint Health and Wellbeing Strategy High-Level Delivery Plan

Appendix D - Indicators for performance monitoring

Appendix E - Equalities and Human Rights Impact Assessment

Relevant Impact Assessments

Crime and Disorder Implications

28. To ensure crime and disorder implications are considered, links to the Leicestershire Safer Communities Strategy Board and wider Office of the Police and Crime Commissioner have been made through the attendance at the JHWS Project Board and working groups. The Staying Healthy, Safe and Well priority will ensure the health considerations of the Leicestershire Safer Communities Strategy Board are linked into the HWB.

Environmental Implications

29. The JHWS strategy uses the Dahlgren and Whitehead (2006) social model of health to recognise the importance of the wider determinants on health on our health and wellbeing. This includes the importance of the impact of the environment in which we are born, live and grow. To ensure environmental implications are considered, links to the County Council Environment and Transport department and Public Health department have been made through attendance at the JHWS Project Board and working groups. Key priorities have been identified such as air quality, access to green space, active transport and having healthy places.

Partnership Working and associated issues

30. Success of the JHWS and HWB development is dependent on high quality, trusted partnership working and ownership. Through developing an alliance approach to the JHWS and HWB, it is hoped that further progress can be made across multiagency boundaries to improve the health and wellbeing of the Leicestershire population. The JHWS has been developed and owned across the partnership with significant progress across the sub-groups to align

workstreams and delivery. The multiagency JHWS Project Board has also been a key enabler in ensuring this happens.

Risk Assessment

31. The JHWS has been developed during a challenging period including the Covid-19 pandemic, winter pressures and national, local and organisational changing priorities. The key risk moving forward is maintaining the ongoing stakeholder support through the implementation of the 10 year strategy. The County Council's Transformation Unit have provided regular project management support to monitor the risks and issues associated with the programme of work and will continue to programme manage the implementation of delivery moving forward. This will allow early identification and mitigation of risks as needed.

Appendix A

Leicestershire Joint Health and Wellbeing Strategy 2022-2032

Contents

Glossary

Abbreviation	Definition
FSM	Free School Meals
HWB	Health & Wellbeing Board
ICS	Integrated Care System (Leicester, Leicestershire and Rutland)
LLR	Leicester, Leicestershire and Rutland
NEET	Not in Education, Employment or Training
SEND	Special Educational Needs and Disability
PCN's	Primary Care Networks
BCF	Better Care Fund
JSNA	Joint Strategic Needs Assessment
ACEs	Adverse Childhood Experiences
LTC	Long term condition

Foreword

As chair of the Leicestershire Health and Wellbeing Board, I am honoured to be part of an ambitious and motivated forum of health and care system leaders, who have the responsibility of coming together to improve health and wellbeing and reduce health inequalities across Leicestershire.

Health and Wellbeing is important to all of us and a healthy population is one of our most important assets, supporting positive social and economic outcomes both for the individual and society as a whole. As we start to rebuild communities and reset services as part of our recovery from the Covid-19 pandemic, even more importance needs to be placed on tackling inequalities in health and creating engaged and cohesive communities. Across the country, the health and care system and other public services are experiencing increasing demand and financial challenges with the population continuing to grow and a need to ensure a good quality of life.

It is recognised that health and wellbeing is generally good in Leicestershire compared with England overall, however there are significant inequalities and challenges in certain communities. Health inequalities are underpinned by social determinants of health, or the circumstances in which people are born, live, work and grow, and evidence suggests that people from affluent communities in Leicestershire live over 8 years longer for men and 5.4 years longer for women than those living in the most deprived. It is also expected for the population of Leicestershire to grow by 20.7% by 2043 with the biggest increase expected in the 60+ age group.

Working together in collaboration we are evolving to face the challenges of the future and opportunities of the developing Integrated Care System. A focus on preventable ill health and early intervention being critical to the long-term sustainability of our health and care system.

Creating the conditions for good health and wellbeing cannot be achieved overnight and this strategy recognises that to truly see an improvement and notice a difference, a more longer-term vision is required. My thanks to Health and Wellbeing Board members who have created this aspirational strategy collectively. We have a clear and ambitious plan outlined below which we are committed to delivering together, and our challenge is to work in partnership and identify what we as individuals, as communities and as organisations can do to improve health and wellbeing in Leicestershire.

Mrs Richardson

Lead Member for Health

Chair of the Health and Wellbeing Board

Leicestershire County Council

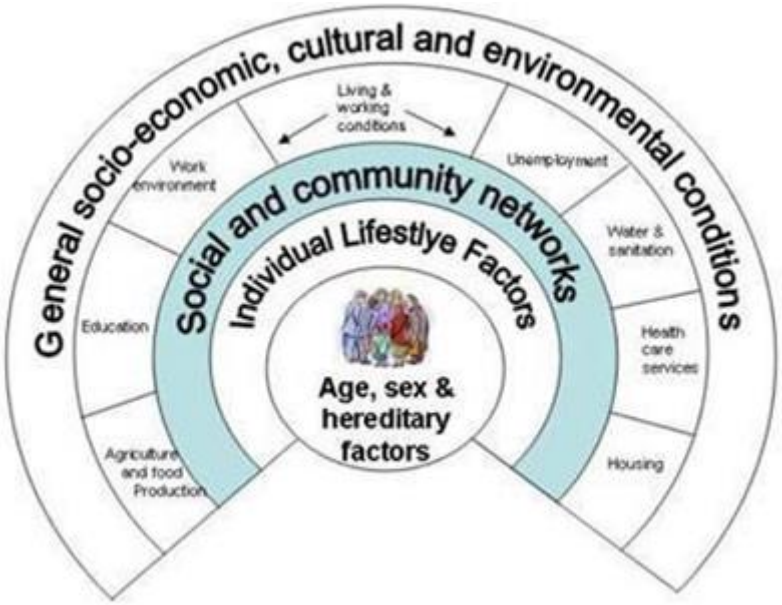
1. Introduction

1.1. Background

Health can be defined as: "*a state of wellbeing with physical, cultural, psychosocial, economic and spiritual attributes, not simply the absence of illness*"[i] (Marks, 2005). This recognises the social model of health (as defined by Dahlgren and Whitehead (2006)[ii]) and identifies all but age, sex and hereditary factors as modifiable to change and therefore lying within the scope of this strategy, particularly in relation to primary prevention.

Figure 1 summarises this model and highlights the wider determinants of health including social, economic and environmental factors which influence people's mental and physical health. Systematic variation in these factors constitutes social inequality, an important driver of health disparities. Therefore on a population level, improving the wider determinants of health (the "causes of the causes") will have a much greater effect on reducing inequities in health compared to NHS interventions alone. Hence this strategy will embed the social model of health and include priorities across the wider Health and Wellbeing Board (HWB) partnership which include the wider determinants of health.

Figure 1 A Social Model of Health, Dahlgren & Whitehead (2006)[ii]



1.2. National Context

The NHS Long Term Plan (NHS England, 2019)[iii] created Integrated Care Systems (ICS's), giving a platform for partnership working and integration at a system level, bringing together local authorities, the voluntary and community sector, NHS bodies and others to look collectively at the needs of the population they serve.

Alongside this, the Long Term Plan created Primary Care Networks (PCN's) which brought together general practices to form new collective contracts, enabling different funding routes and an expectation on these PCN's to take a proactive approach to managing population health, assessing needs, and targeting support.

In January 2021, the Department for Health and Social Care published the white paper Integration and innovation: working together to improve health and social care for all (DoHSC, 2021)[iv]. This put ICS's on a statutory footing and created an ICS Health and Social Care partnership. This partnership is responsible for developing a plan to meet the populations health, prevention, and social care needs. This system level plan should develop from an understanding of the needs of the population of Leicestershire (along with Leicester City and Rutland), gained through the Joint Strategic Needs Assessment and collectively addressed in this Joint Health and Wellbeing Strategy which sets out the Leicestershire approach to addressing need.

One of the ways that key agencies have been working together for some time is through the Better Care Fund (BCF) which provides a pooled budget for delivering health and care functions through an integrated approach. This budget is spent in accordance with a joint, local plan to deliver health and care services that delay or prevent people from needing hospital care, reduce the length of time spent in hospital or that improves outcomes for people being discharged from hospital. These plans and this work continue in Leicestershire but become part of the wider strategy for health and wellbeing.

The ICS for LLR was approved in April 2021 in shadow form, coming into full existence in April 2022. Whilst many relationships were established long before the ICS, this still represents a change in function and responsibility for many of the partners involved. Our partnership working will be established across system (LLR collectively), place (Leicester, Leicestershire and Rutland separately) and neighbourhood (at locality level).

The development of the ICSs has also introduced neighbourhood/ locality level Community Health and Wellbeing Plans to understand more detailed local need in relation to health and wellbeing. It is important to consider how the priorities emerging from the Community Health and Wellbeing Plans and links to Integrated Neighbourhood Teams align across the place and furthermore how the Leicestershire strategic vision is translated into deliverables and accountability at system and neighbourhood/locality level.

1.3. Leicestershire's Current Health and Wellbeing

Leicestershire is a predominantly rural County and comprises of seven local authority districts, each with its own distinctive character. Just under 70.0% of the population of Leicestershire live in areas classed as Urban City and Town, while 20.1% live in Rural Town and Fringe and the remaining 10.6% live in areas classed as Rural Village and Dispersed.

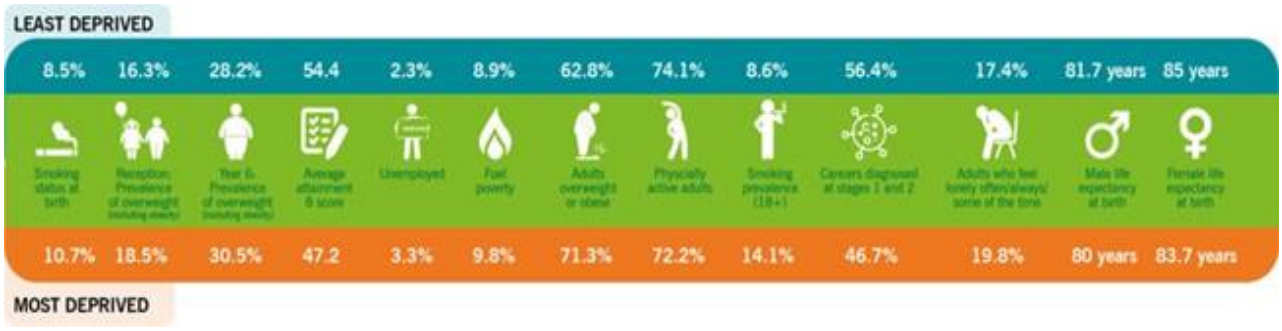
The total resident population of Leicestershire in 2020 was 713,085. The highest proportion of residents were in the 40-59 age group (26.9%), followed by the 60+ age group (26.6%), 20-39 age group (24.0%) and 0-19 age group (22.5%).

Leicestershire County faces the challenge of an ageing population. The population in Leicestershire is expected to grow by 20.3% (145,501 people) between 2020 and 2043 with the biggest increase expected in the 60+ age group (38.9%), followed by the 0-19 age group (15.3%), 40-59 age group (13.1%) and 20-39 age group (12.6%). With our ageing population we need to consider what plans that need to be put in place to manage future health and care needs and demands in the longer term, with a focus on preventable ill health, particularly in working age adults. Health needs are likely to increase with age due to the increased the risk of developing multiple chronic conditions. Therefore, without significant prevention interventions, there will be more older people with complex needs who will require input from all parts of the health and social care system.

Even though Leicestershire is a relatively affluent County, pockets of significant deprivation exist, with some neighbourhoods in Loughborough and Coalville falling into the 10% most deprived neighbourhoods in England. The Education, Skills and Training deprivation domain and Barriers to Housing and Services deprivation domain for Leicestershire have a higher number of neighbourhoods in the top 10% deprived nationally compared to some of the other deprivation domains.

According to the Leicestershire County Council Community Insight Survey (2017-2021), 82.7% of respondents reported being in good/very good health, whilst 3.5% reported being in bad/very bad health. Life Expectancy at birth in Leicestershire has remained significantly better than the England average since 2001-03. Healthy life expectancy (HLE) at birth in Leicestershire for males (63.5 years and females (63.6 years) is similar to the national average in 2017-19. For males, HLE has decreased since 2015-17 and for females, HLE has decreased since 2014-16. There is an eight year difference in life expectancy at birth between males in the most deprived decile and least deprived decile of the population. The equivalent figure for females is 5.4 years. Figure 2 below shows the difference in health inequalities that exist between the most and least deprived districts within Leicestershire over the life course. In order to reduce this inequality, more focus needs to be toward those in greatest need and working together to reduce any factors that may have a negative influence on their health.

Figure 2 Health Inequalities across Leicestershire



Source: Public Health England, Fingertips, 2021.

Note: Please note this data is based on data available at district level and based on IMD score for most and least deprived districts in Leicestershire. Most deprived area data reflects North West Leicestershire and least deprived area data reflects Harborough.

Figure 3 Overview of Health and Wellbeing in Leicestershire (The following Statistics will be converted to an infographic)

Indicator	Time period	Leicestershire value	Unit	Leicestershire RAG	England value
General Fertility Rate	2019	53.5	Per 1,000 live births	Lower	57.7
Year 6: Prevalence of overweight (including obesity)	2019/20	30.6	%	Better	35.2
Admission episodes for alcohol-specific conditions (Persons)	2019/20	407.0	per 100,000	Better	644.0
Smoking Prevalence in adults (18+) - current smokers (APS)	2019	12.0	%	Similar	13.9
Percentage of physically active	2019/20	67.6	%	Similar	66.4

adults					
Life Expectancy at birth-Males	2017-19	80.9	Years	Better	79.8
Life Expectancy at birth-Females	2017-19	84.3	Years	Better	83.4
Depression recorded prevalence (aged 18+)	2019/20	13.3	%	Higher	11.6
Estimated dementia diagnosis rate (aged 65 and over)	2021	61.2	%	Worse	61.6
Hip fractures in people aged 65 and over	2019/20	800.0	per 100,000	Worse	572.0

For further information and evidence for some of the priorities in the Joint Health and Wellbeing Strategy 2022-2032, please see Leicestershire's Joint Strategic Needs Assessment (2018-2021) accessed via the following link:

https://www.lsr-online.org/leicestershire-2018-2021-jsna.html

2. Overall Vision

Our overall vision is;

'Giving everyone in Leicestershire the opportunity to thrive and live happy, healthy lives'

We want to ensure the communities of Leicestershire have the opportunity to have the best health and wellbeing they can across the life course. This includes putting equal weight on their mental and physical health and ensuring we have healthy places, cultures and environments to support this. We want to embed a strength-based approach to allow individuals, families and communities to support each other, aim high and thrive.

We know that not everyone achieves the same level of health and wellbeing across Leicestershire and there is a gradient of health and wellbeing outcomes linked to deprivation and specific characteristics or communities. We will work to 'level up' this gradient and ensure everyone has an equitable opportunity to support their health and wellbeing. To do this we must use the social model of health (Figure 1) and consider the impacts of the wider determinants of health as well as access to health and care services.

A life course approach has been used to identify high level strategic, multi-organisational priorities for the next 10 years and provide clear accountability to the Leicestershire health and wellbeing board. These are summarised in figure 4 below. Further detail on the actions associated with each priority are discussed in section 6.

Figure 4 Summary of the Joint Health and Wellbeing Strategy

To allow everyone across Leicestershire the best opportunity to live long, good quality, happy lives we will where possible, embed the following principles in our priorities and actions;

- **Providing person centred care and support.** We want to ensure that this strategy and delivery plan is built around and for all individuals across Leicestershire. We will build and strengthen the engagement with local people, listening and reflecting their views and experiences as the strategy evolves and develops. We will co-design services wherever possible.
- **Embedding prevention in all that we do**. We know that if we can prevent individuals developing risk factors and disease in the first place this will improve their longer term health and wellbeing outcomes and reduce costs across the system.
- **Enabling independence and self care** to support those that have chronic conditions to manage them effectively, stop or delay disease progression and prevent development of further multimorbidity.
- **Health and equity in all policies approach.** This will ensure that inequalities and health and wellbeing are systematically considered by partners across a range of wider determinants of health.
- **Prioritising mental and physical health equally.** Mental health issues will affect at least one in four people at some point in their life. We know that to have good health and wellbeing both your physical and mental health needs must be supported and met.
- **Supporting Covid-19 pandemic recovery.** The Covid-19 pandemic has been a long and difficult period for many of us, and will continue to impact on our health and wellbeing for some time. Throughout the strategy we will acknowledge the population's loss and will continue to strengthen the innovation that has emerged.
- **Trauma informed approach.** Evidence suggests that trauma is felt throughout lives, especially in the early years, and can have long term impacts on our health and wellbeing. Therefore, we must ensure the four phases (aware, sensitive, responsive, informed)) of trauma informed practice are carefully considered through the delivery of our services.

To allow the strategy to have the best chance of success there are a number of enablers that will support progressing the work. These include;

- **Partnership and collaboration.** Working together where we can add value or reduce duplication through a joint approach. We will work to build an alliance across Leicestershire that provides a supportive and constructive culture the drives innovation, change and outcomes and acknowledges the value and strength of the voluntary and community sector.
- **A strong, skilled and supported workforce.** Our workforce is a key asset to drive the implementation of the strategy. We need to support our health and care workforce to grow and flourish, acknowledging the strength they have shown through the pandemic and the need to ensure Leicestershire is seen as great place to work and develop.
- **Digital improvement.** The pandemic has shown the breadth of innovation, access and efficiency that can be delivered through harnessing digital technology. We want to further embed a digital offer across our services, whilst avoiding digital exclusion.
- **Effective communication and engagement.** This strategy is a partnership across partners of Health and Wellbeing Board (HWB), but also without local communities. We will start the conversation through the development of the strategy but aim to ensure all Leicestershire stakeholders (residents and staff) are able to see how they fit into the wider vision. We will ensure our approach is aligned with Leicestershire Communities collaboration vision, 'Our Communities Approach 2022 – 26.'

- **Anchor institutions**. Collectively HWB partners hold a significant amount of assets across Leicestershire, whether these are cultures, people or estates. We will utilise this resource to ensure organisations are clear on their ask to improve the health and wellbeing of Leicestershire.
- **Population health management** is an important tool to support embedding a population approach to health and care planning and delivery. It also ensures we consider the wider determinants of health.
- **Data gathering, sharing and insight** is an important way in which we build a picture both of an individual and their needs, but also the needs of our population. Data sharing can help to reduce the burden on a person telling their story over again to each agency they work with but must be carefully managed to put the person in control of how their data is used. Embedding an insight driven population health management approach across Leicestershire will also ensure implementation of the strategy is built on a strong evidence base.

3. Strategic Priorities Across the Life Course

3.1. Best Start for Life

We want to give our children the best start for a happy, healthy, long life. We want them to fulfil their potential, allowing them to have positive educational attainment, strong emotional wellbeing and resilience, life skills, contribute to their community and thrive. We know that the families, communities and environments that we are born, grow and develop have a significant impact on health and wellbeing outcomes in later life. This is especially important in the first 1001 critical days (from conception to aged two years) where there is significant neurological brain development that influences lifelong outcomes for the child[vvi][i].

To give our children to have the best start for life we will prioritise a range of actions covering the broader children's age range of 0-19years (or 0-25 years for Special Educational Needs and Disability (SEND)). The key priorities are detailed below.

3.1.1. First 1001 Critical days

We know the building blocks for lifelong emotional health and wellbeing are developed in the first 1001 critical days i.e. from conception to the age of two. This is due to the underdevelopment of human babies at birth who cannot walk or fend for themselves until they are approaching two years of age. The human brain is also only partially formed at birth and becomes hard wired by early childhood experiences including those in pregnancy, which impact across the life course. For example, we know children with secure attachment to their parents and carers develop into resilient adults, build strong relationships at home and work, and are well equipped to raise their own children. This is due to early social and emotional experiences that build baby brains[v]. On the flip side of this, people who lack nurture from one or more caring adults in the first 1001 days of their lives achieve less in education and in the workplace; are more likely to behave anti-socially, and are less healthy, physically and mentally, than individuals who were given a better start. Furthermore, the harm done to them is likely to be perpetuated in an inter-generational cycle when they have children of their own[vii].[2] We also know that those children living in 'disadvantaged' families due to income, deprivation or vulnerability are likely to have poorer health and wellbeing outcomes. For example, those with special educational needs or disabilities (SEND) or living in a household of poor mental health, domestic or substance abuse may require additional support. We therefore aim to develop Leicestershire as a place where every baby and family is nurtured to fulfil their potential. This will embed a society of strong emotional health and wellbeing, employment potential and community cooperation, which will in the longer term will generate savings across the health and care system.

Where are we now?

Leicestershire performs similarly or better than the England average for a number of Best Start for Life indicators. However, Leicestershire performs significantly worse than England for the proportion of New Born Visits completed within 14 days and the percentage of caesarean section births. With regards to immunisations, Leicestershire performs significantly better than the benchmark (>95%) for most indicators. However over the last five years the trend for population vaccination coverage for Dtap/IPV/Hib (1 year old and 2 year old boosters) has been decreasing and getting worse. Over the last five years, the rate of A&E attendances in 0-4 year olds/under 1 year olds and admissions of babies under 14 days has been significantly increasing and getting worse. Breastfeeding rates in Leicestershire significantly decline from birth to discharge and from 10-14 days to 6-8 weeks.

What does success look like?

- Increase in breastfeeding initiation and continuation rates.

- Increase in immunisation rates, especially for the boosters at age 1 and 2years.
- Improvement in maternal mental health.
- Reduction in proportion of caesarean births.
- Positive local feedback from families confirming that they feel supported, through a range of integrated start for life services to develop their babies in the first 1,001 critical days.

Our commitments to Leicestershire

- We will embed the Governments vision for 'The best start for life. A vision for the 1,001 critical days' through a local 1001 Critical Days Children's Manifesto and communication campaign.
- We will have joined up, accessible pre -school services, family hubs, an empowered workforce and clear local and national direction, vision and service improvement. This will include an integrated Early Years Pathway to identify and support vulnerable children.
- Embed the additional 3-4month and 3.5 year checks into our public health nursing service.
- We will invest in evidenced based breastfeeding support for mothers across Leicestershire. Supporting them to initiate and continue breastfeeding for as long as they choose. Support will be prioritised for those in white other ethnic groups and younger mothers.
- We will work to further increase uptake of childhood immunisations programmes especially boosters due at age 1 and 2years.
- We will empower families to feel confident and supported to develop and grow . This will include support to access the most appropriate services for emotional health and wellbeing, minor aliments (including gastro, respiratory/ bronchitis and head injuries) and home safety.

3.1.2. School Readiness

Preparing our children for school is an important transition in their lives, to allow 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. To do this we need to ensure they have the opportunity to develop their communication, gross motor, fine motor, problem solving and personal-social skills at their 2-2.5year checks.

Where are we now?

Leicestershire performs significantly worse than England for the child development indicators, however it should be noted that there are concerns with data quality for these indicators. School readiness in those children accessing free school meals (FSM) in Leicestershire, is also significantly worse than England, however, the trend over the last five year indicates that performance is increasing and getting better.

What does success look like?

- Increase in the proportion of children achieving a good level of development at 2-2.5years and foundation stage across all development areas (fine and gross motor, communication)
- Reduce the gradient in developmental outcomes in those from disadvantaged backgrounds as compared to those in the most advantaged (i.e. split by deprivation, FSM and SEND).
- Family feedback that services are working in more integrated and collaborative ways to support pre-school children and their families.
- Families are clear on what good development in foundation looks like and what support is available to support their children to achieve this.

Our commitments to Leicestershire

- We will take a proportionate universalism approach and focus on narrowing the development gaps that affect children and families who are at the greatest disadvantage (e.g. those who access FSM, live in poverty or have a poor home environment, have SENDs and/or are in our care).
- We will support parents and families to build on their understanding of children's needs so that they are able to understand what good looks like and get their children off to a good development start.
- We will provide support to embed physical activity into young children's lives through interventions that improve fine and gross motor skills.
- We will ensure access to support early development of speech, language and communication.
- We want to help families access free high-quality childcare and early education that is fully inclusive and accessible.
- We will support improving maternal mental health and physical activity to allow parents and carers to be in the best position they can be to support their children.

3.1.3. Preparing for Life

Children today are our adults of tomorrow. We need to ensure they are equipped to navigate and thrive in society. This may be through good education, employment and training, understanding how to survive independently, stay safe and maintain good health and emotional wellbeing. We therefore want to support our young people to transition seamlessly from children into young and prosperous adults. We have a great educational infrastructure which is driving good educational outcomes in key stages 1-4, however children in care, those with SEND, disability or FSM and A-levels results are consistently achieving poorer outcomes than comparators. We know that health and wellbeing outcomes for children in care are poorer than the wider children population and our numbers of children in care are increasing.

The Covid-19 pandemic has had a huge impact on the education, health and emotional wellbeing of our young people. We will therefore need to support our schools and young people to manage the varying demands of the pandemic, build their physical and emotional resilience and enjoy being back.

Where are we now?

As of 2018/19, Leicestershire had a higher proportion of primary and secondary schools rated either good or outstanding than the national average, however educational outcomes for children in care, those with SEND or FSM and A-levels results are poorer than our comparators. Although below the England average, the rate of looked after children in Leicestershire is increasing, like nationally. There has been a 39% increase in numbers of children in care between 2015 and 2020 (from 471 to 654.)

With regards to health, the most recent data shows that Leicestershire performs significantly worse than England for HPV (Human papillomavirus) vaccination coverage for males, and prevalence of underweight Year 6 pupils. People with a learning disability are more likely to be either underweight or overweight. Over the last five years, the HPV vaccination coverage for females has been significantly decreasing and getting worse. A&E attendances in under 18s in Leicestershire are significantly worse than the England average. Over the last five years the trend for A&E attendances has been significantly increasing and getting worse. Nationally we know that 1 in 5 children have 4+

Adverse Childhood Experiences (ACEs), suggesting that significant proportions of Leicestershire children are likely to have ACEs[viii].

What does success look like?

- High uptake of Covid vaccination in 12-17year olds
- Increase uptake of HPV vaccination in males and females
- Stabilising numbers and rates of looked after children
- Reduction in A&E attendances in under 18's, including those caused by self harm
- Increased proportion of children at a healthy weight (not under or overweight/ obese, especially in SEND)
- Increased proportion of young people reporting strong emotional health and wellbeing
- Reduction in Adverse Childhood Experiences risk factors and increased proportion of young people that have a trusted adult in their life.

Our commitments to Leicestershire

- We will work with young people, partners, parents and schools in increase HPV and Covid-19 vaccination uptake
- We will investigate the causes of the increasing levels of children in care and work with families to prevent this whenever possible.
- We will ensure there are opportunities for all 16-17 years olds to gain education, employment and training.
- We will develop the Healthy Schools and secondary school children's public health service to help build informed, healthy, resilient young people that have skills to stay safe from harm and are ready to enter the adult world.
- We will ensure there is appropriate emotional and mental health support for children and young people as part of the Covid recovery.
- We will ensure that children and young people have access to the services they need to gain and maintain an active lifestyle and healthy weight.
- We will support the workforce to embed a Trauma Informed Approach to reduce the impact of Adverse Childhood Experiences on later life.
- We will ensure that children with SEND and learning disabilities have access to the support they need and a seamless transition into adult services.

4. Staying Healthy, Safe and Well

Prevention is always better than cure, and good health and wellbeing is an asset to individuals, communities and the wider population. It improves health and care outcomes and saves money across the whole system. Therefore, we want to give everyone in Leicestershire the opportunity to live happy, healthy, long lives without illness or disease for as long as possible. However, to achieve this we must consider the social model of health (Figure 1) which confirms the importance of strong communities, health behaviour and the wider determinants of health (housing, work, education and skills, built and natural environment, income and transport) and that all factors are modifiable apart from age, sex and hereditary factors. Evidence shows us that clinical care only contributes towards 20% of health outcomes (see Figure 5)[ix], therefore improving the wider determinants of health (the "causes of the causes") will have a much greater effect on improving health outcomes and reducing inequities in health compared to NHS interventions alone.

Modifying these risk factors will take time to evolve and improve, however having a 10 year strategy allows Leicestershire to be bold in ambition and make true, sustainable action to improve the 'cause

of the causes', which will transform the population's health and help break cycles of intergenerational inequality. Key priorities to drive this change are detailed below.

Figure 5 Contributors to health outcomes

4.1.1. Building strong foundations

We want to support people of Leicestershire to have strong foundations so they can build, develop and thrive. We recognise people and communities have influence and assets which can shape their health and wellbeing. We want to develop a strengths-based approach to the strategy working with our community on areas that are important to help them flourish. We know this is dependent on having secure building blocks such as good work and economic growth, financial stability, good homes, accessible transport and a safe and healthy environment.

Where are we now?

Leicestershire generally performs well compared to England for employment rates (80.1% in 2020 compared to 75.7% for England). We have diverse employment industries with varying health and wellbeing risks and needs. The largest sector is Manufacturing (12.5%), followed by Professional, Scientific & Technical (11.5%) Industry and Retail (8.7%) / Education (8.7%) having the highest proportion of employees in Leicestershire. However due to the Covid pandemic there was a 6% (7% nationally) take up of the Furlough scheme at the end of June 2021 especially in the 'accommodation and food services' and 'arts, entertainment and recreation' sectors.

Although these sectors are starting to return, the pandemic has hit many businesses across Leicestershire and claimants for Job Seekers Allowance or Universal Credit have significantly risen (with 13,865 claimants in July 2021). Leicestershire performs significantly worse than England for sickness absence and performs less well for adults with mental health conditions in employment or living independently.

The Leicestershire population is expected to grow by 147,533 or 20.7% between 2020 and 2043, with the biggest increase expected in the 60+ age group which is expected to increase by 39.7%.

Therefore at least 63,667 additional homes are expected to be built by 2036. On top of this in September 2021, 141 single and 110 family households were homeless across Leicestershire.

Leicestershire performs significantly worse or lower than England for the percentage of adults walking for travel 3x per week, access to travel (disabilities or no car) and use of park and ride. We also have variation in air pollution impacts on health and who can access green space within a 10minutes walk across the County.

Although overall crime numbers are generally low across Leicestershire, an increase (57.6%) in hate incidents (specifically racially motivated incidents) has been witnessed over a 12 month period (to June 2021) compared to the previous year.

What does success look like?

- Maintaining and increasing the employment rate. Specially for those with adult mental health.
- Improvement in sickness absence rate.
- Reduction in the number of homeless single and family households and an increase in the number of households where homelessness was prevented
- Improved numbers of adults with mental health living independently.
- Health and Equity in all policies approach embedded across the Leicestershire HWB partners.
- Ensure the appropriate, equitable infrastructure (including health services) is in place for the planned housing growth addressing health inequality through design and use of health impact assessments.
- Increasing access and uptake of active travel.
- Increased proportion of Leicestershire residents who have access to green space within 10minutes walk.
- Improvement in air quality and its impact on health and health inequalities across Leicestershire.
- Maintain low levels of crime especially violent and hate crime.
- Reduction in fear of crime.
- Reduction in the proportion of Leicestershire residents that experience fuel poverty.

Our commitments to Leicestershire

- We will work with partners to deliver the Leicestershire wider determinants action plan, this will include a Health and Equity in all Policies approach to all we do.
- We will further grow Leicestershire's economy and support recovery from the Covid pandemic including work with the Leicester and Leicestershire Enterprise Partnership, Levelling Up and having economic growth for all. We will support those in poverty to access the support to gain employment and eligible benefits and hardship.
- We will work to ensure everyone has 'good work' for them. Supporting people to enter and maintain good employment/ skills and support those with health and care needs to keep their jobs, with particular attention to sickness absence (due to musculoskeletal and mental health conditions) and an aging workforce. We will also consider the role of workplaces in supporting health and wellbeing
- We want everyone to have access to a good home. We will work with partners to ensure high quality new and current housing that has access to green space and supports good health and wellbeing. We will also work to collaboratively prevent homelessness whenever possible.

- We will work with system partners to support adults with mental health challenges to live independently.
- We will effectively and equitably plan for our growing and older population to ensure everyone has access the services, transport and infrastructure they need.
- We will work with Community Safety Partnerships to maintain low levels of crime and support community cohesion including work to reduce domestic violence and implement the Domestic Abuse Act 2021
- We will implement the Air Quality and Health action plan.
- We will collaborate with the Leicestershire planning system and developers to explore a new approach to the design of our residential, employment and town centre environments to increases active travel, green infrastructure and reduction in motorised transport.
- We will support families out of fuel poverty and into affordable warmth.
- We will review the health impacts of climate change to support wider environmental workstreams to embed a health lens into their approach.

4.1.2. Enabling Healthy Choices and Environments

Everyday we make choices about what we eat, drink or how we spend our time. These choices impact on our health and wellbeing, with health behaviours (including smoking, diet, exercise, alcohol use or poor sexual health) contributing towards 30% of our health outcomes. However, making these choices is not straightforward and are heavily influenced by our social connections and the environment that we live in. Research suggests that ease of access to formal and informal green space and active travel significantly improves physical and mental health. By building social capital, community resilience and creating opportunity for people to help their own communities, Leicestershire can support each other to advance their health outcomes. Therefore, we want to encourage and enable people and communities to make healthier choices, creating an environment to empower them to do so and to respond proactively to any barriers that may exist. We need to connect and collaborate with those services and providers who design and develop our built environment to ensure that the physical and mental health of residents is more central to what is designed and developed.

Where are we now?

Leicestershire performs either significantly better than or statistically similar to England across a range of health behaviour indicators including smoking and substance misuse. Although the percentage of physically active/inactive adults and adults who are overweight/obese in Leicestershire are similar to the national average, these have historically been an area of lower performance compared to other county areas and these have a direct impact on general health and wellbeing. With regards to sexual health, rates of STI's diagnosis (particularly chlamydia detection and HIV testing) are relatively poor in comparison to England. The trend for total abortions and abortions in over 25s is significantly increasing and getting worse as seen nationally. According to the Active Lives Survey, in Leicestershire, 21% of adults reported feeling lonely often/always or some of the time.

In terms of immunisation and screening, Leicestershire performs significantly worse than the benchmark for Flu vaccination coverage (<75% in 2019/20) and Shingles vaccination coverage (<50% in 2018/19). However, over the last five years the trend in flu vaccination has improved, and the Shingles vaccination indicator is new due to changes in vaccination coverage collection. Leicestershire performs significantly worse than England for the percentage of eligible population who received an NHS Health check, at 31.7% in comparison to the national average of 33.4%. Cancer

screening coverage for breast and cervical cancer is significantly better than the national average at 77.6% and 79.4% respectively, over the last five years the trend is decreasing and getting worse.

What does success look like?

- Maintain and improve performance on smoking prevalence and substance misuse.
- Reduced proportion of overweight/ obese adults and increased proportion of physical activity.
- Improved access and uptake of five fruit and vegetables a day.
- Increased proportion of Leicestershire residents who have access to green space within 10minutes walk.
- Improved Chlamydia detection and HIV testing rate.
- Levelling and reversing the increasing trend in abortions for over 25's.
- Reduction in loneliness, improvement in community cohesion and resilience.
- Improved vaccination rates for Flu and Shingles, that are comparable to the areas with the best uptake rates in England.
- Reversing the decline in cancer screening rates and more cancers diagnosed at Stages 1 and 2
- Health Check coverage is on par with our ONS comparators in England.
- Qualitative feedback that residents have improved knowledge and access to prevention services.

Our commitments to Leicestershire

- We will increase knowledge and access to prevention services through embedding Making Every Contact Count training and a social prescribing approach across our collective workforce.
- We will deliver targeted, effective and consistent health and wellbeing communications to empower Leicestershire to make healthy choices, including how to access services.
- We will work with partners to deliver the Leicestershire Healthy Weight strategy, Food Plan and Active Together Partnership Physical Activity Framework
- Through the Leicestershire Sexual Health Strategy, we will improve sexual health outcomes including chlamydia detection, HIV testing and combatting the increasing levels of abortion.
- We will further develop the ABCD, strength-based approach to build social capital and strong, connected and resilient communities.
- We will work with businesses to support enabling healthy choices through their shop/ supermarket.
- We will work to further develop active travel across Leicestershire including a review of connected and walkable neighbourhoods and rural connectivity to understand how these impacts on healthy behaviour and environments.
- We will work with planners and licensing officers to further build a healthy environment across Leicestershire reviewing fast food outlet and alcohol premise density.
- We will invest in improving vaccination and screening rates (including cancer and health check coverage). This will include understanding the reasons for the decline in cancer screening rates and a targeted approach for those populations most at risk of premature mortality from cancers.

5. Living and Supported Well

As people age, become unwell or develop one or more Long Term Conditions (LTCs), it is important that they are supported to live as independently as possible, for as long as possible while maximising their quality of life. We know the more LTCs people have (rather than age), the greater amount of health and social care support they will need, and that this can be progressive. With a targeted population health management approach, we can focus on supporting those with disabilities and multiple LTCs (at any age), to help them live as well as possible for as long as possible and prevent or slow further decline into ill health.

5.1. Up Scaling Prevention and Self Care

As people age, develop disability, chronic illnesses or require additional support to remain independent, we want to help them to feel more in control of their condition by equipping them with knowledge and skills around how to stay as active and well as possible and minimise the impact of their health. In addition, if we can encourage people to be more proactive about their health and wellbeing and focus on preventing deterioration by staying healthy and well, then people will live healthier lives for longer.

We understand that no one understands a person's condition, like themselves. Approaches that help patients learn new skills and gain confidence to manage their condition(s) better have been shown to increase feelings of support, confidence and control, while improving health outcomes and quality of life. As more and more people have access to technology at home and the market for assistive technology continues to grow, we want to utilise new ways of helping people to stay independent and well for longer. Whilst support in person will always be important, it will also be crucial to ensure that we want to use developing technologies to assist with prevention, self-care, and independence.

Where are we now?

Leicestershire performs significantly worse than the benchmark (<66.7%) for estimated dementia diagnosis rate at 61.2% (2021).

We need to ensure that we make the best use of universal services such as libraries, museums and learning. These services deliver a range of activities that can play a role in preventing or delaying people's progress to more resource-intensive care arrangements. The appropriate identification and commissioning of services within available resources will ensure that our universal services are used to their full effect.

We have a responsibility to ensure that people have access to appropriate information, advice and guidance as their support needs develop. Customer feedback suggests that this is an area for improvement across all channels.

What does success look like?

- Slowing the number of people who progress from living with 1 or 2 LTC's to 5 or more
- Qualitative feedback that suggests multi-disciplinary, holistic care planning and self-management support packages that enable people to live well with long term conditions for longer, with less need for acute care
- An asset-based approach is taken to recognise and build on the strengths of individuals, families and communities
- Reduction in rates of falls across Leicestershire for people aged 65+, being on a par with the best performing authorities
- Reduction in rates of hip fractures across Leicestershire

Our commitments to Leicestershire

- We will empower patients to self-manage their long-term condition(s) through a variety of routes for different needs, including the use of expert patient programmes, social prescribing, digital approaches, assistive technology, accessible diagnostics and support.
- We will deliver the Adults and Communities strategy including building asset-based approaches and social prescribing to work with and for people and communities.
- We will reduce the number of falls that people over 65 experience, including people in residential and nursing care homes
- We will support the Adults and Communities Accommodation Strategies and Investment Prospectus to ensure people living with disability and long term conditions have access to the right housing, care and support.
- We will work to improve access to health and care services including primary care and appropriate funding support.

5.2. Effective management of frailty and complex care

We know that people with poorer health and multiple LTC's are the biggest users of health and social care resources. If we can utilise a Population Health Management approach to identify those at greatest risk of hospitalisation and deterioration of their health, we will be more able to introduce care planning and interventions early, which will help prevent or minimise episodes of acute health and social care required. This will include work to understand barriers to those with multiple LTC's undertaking physical activity, as maintaining and improving physical condition can have a positive impact upon stopping further decline in health and admissions.

We want to further strengthen this approach by embedding effective care planning across the system, linking different parts of the health and social care network together to plan support more holistically for the people of Leicestershire. By supporting staff to manage a defined level of risk in settings other than hospital (i.e. in the community, care homes, primary care etc), and ensuring effective and timely discharge from hospital with appropriate care packages in place, people will be supported to live independently for as long as possible, even when episodes of acute care are required.

Across Leicester, Leicestershire and Rutland unpaid carers contribute around £2 billion worth of support every year, which has a significant positive impact on demand experienced across the health and social care sector. However, carers can experience some negative consequences associated with their role, such as strain, physical injury or other impacts upon their own health and wellbeing. It is crucial that we support and recognise carer's contribution to the health and social care sector, and the vital role they play in the quality of life experienced by those they care for.

Where are we now?

Leicestershire performs significantly worse than England for hip fractures in those aged 65+, and over the last five years the trend is significantly increasing and getting worse. The rate of emergency hospital admissions for Chronic Obstructive Pulmonary Disease (COPD) is significantly better than England, but the trend over the last five years shows the rate is significantly increasing and getting worse. Over the last five years, GP practices' Quality & Outcomes Framework disease registers show prevalence for Diabetes and Stroke is significantly increasing, most likely due to better case finding and coding of patients, whilst for coronary heart disease, the trend is significantly decreasing.

It is increasing numbers of long-term conditions (LTCs) rather than age that drive health and care costs. In Leicestershire, there are 51,101 people who have 5 or more LTC and 15,802 people with 8 or more. People with 5 LTC will, on average, use 7 times more elective care than those with 1

chronic condition; for those with 8 LTCs, this will increase to an average of 14 times the amount of secondary care activity, on average.

Census data (2011) tells us that there are over 105,000 unpaid carers across Leicester Leicestershire and Rutland (LLR).

What does success look like?

- Early identification of patients at high risk of hospitalisation and social care needs using a Population Health Management approach.
- Reduced numbers of hospital admissions for hip fractures and COPD.
- Reduction in emergency bed days for those with 5 or more Long Term Conditions
- 95% of people identified as vulnerable have a co-produced care plan, which takes into account their wider needs e.g., multiple LTC's, social/psychological elements and carer arrangements
- Improved performance on the Better Care Fund metrics: reduced permanent admissions to residential and nursing care, increases in the number of people (aged 65+) still at home 91 days after discharge into rehabilitation/reablement services, reduction in delayed transfers of care from hospital and reduced non-elective admissions into hospital.
- Improved patient satisfaction and coordination in complex care pathway and care coordination across the system especially for those with multimorbidity (5+ chronic conditions)
- Improved quality of life for carers
- Improved identification of people with moderate or severe frailty in the short term, followed by a reduction in the number of people with moderate or severe frailty as a result of proactive action.

Our commitments to Leicestershire

- We will build on the LLR Population Health Management framework and development programme, translating implications to Leicestershire to identify those at greatest risk of poor health outcomes including multiple hospital admissions.
- We will provide joined up services that support people and carers to live independently for as long as possible, including those with dementia. Supported by integrated health and social care workforce this will ensure that the patient sees the right person for your problem at the right time.
- We will deliver an effective health and care integration programme that will deliver the Home First step up and step down approach for Leicestershire.
- We will seek to develop a more qualitative, holistic approach to care planning and risk management, exploring ways in which this could be delivered by a wider range of professionals across Leicestershire through Integrated Neighbourhood Teams.
- We will improve the quality and coverage of joined up care planning for the most vulnerable including strengthening care planning links across primary and secondary care to achieve 95% of the vulnerable population having a care plan in place.
- We will continue to implement the LLR Carers strategy for Leicestershire and strengthen links with the LLR Carers Board.
- We will work to measure and reduce the number of emergency bed days people with Long Term Conditions experience.
- We will offer a two hour crisis response for people that may otherwise need to attend hospital (target 80% by April 2022).

- We will reduce the number of permanent admissions to residential and nursing homes.
- We will ensure eligible people receive reablement within 2 days of discharge.

6. Dying Well

End of life is an inevitable part of the life course, but we know that it is a difficult subject for many people to openly acknowledge and discuss. We want to support Leicestershire 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.

It is important for us to understand the kinds of support people would like at this stage of life, whether this is accessing practical advice about financial affairs, knowing what bereavement support is available for friends and family to access, or care planning as an option for all. We can then work with people to inform and support them in end-of-life planning.

For many people, the transition from living with one or many conditions into planning for the end of life can occur gradually. This chapter focusses on this transition and seeks to understand and respond to the needs of people and carers through this final phase.

6.1. Understanding the need

We would like to better understand the holistic needs of people nearing the end of life and the needs of those that love and care for them. We already have a strong set of services and ambitions for end-of-life care in Leicestershire, but we want ensure these reflect of the latest data and views of the people of Leicestershire.

Where are we now?

We know that good quality communication is key for people nearing end of life. Dignity and respect, consistency and continuity, speed and access were key themes for the people that have shared views with us along with the need for people to be treated with empathy. We also know that some people report a gap between expectations and services available and that people can feel ‘done to’ rather than empowered to make choices about their care.

We know that many people would prefer to die at home or in their care home than in hospital. Leicestershire performs significantly lower than England for the percentage of deaths occurring in hospital (all ages) and over the last five years, the trend is significantly decreasing. The LLR target is to reduce deaths in hospital to 35% (for adults aged 18+).

What does success look like?

- Reduction in the percentage of deaths occurring inside of hospital, aiming to achieve LLR target of a maximum of 35% in adults aged 18 and over.
- Clear qualitative understanding of what ‘dying well’ looks like across Leicestershire and what support is needed to ensure this happens.

Our commitments to Leicestershire

- We will carry out a Joint Strategic Needs Assessment chapter looking at end of life specifically
- We will seek to gather views from people to understand what dying well means to them and how this could be achieved.

6.2. Effective transitions

We want to support people through the transition from living with a long-term condition(s) or frailty into dying well. This often means informing people about what might happen, and about the choices they have before they reach this stage. It also provides an opportunity for conversations about people's fears and concerns and allows time for people to take action or make decisions to ensure their wishes are respected at the end of life.

Where are we now?

Many people make this transition in an informed way, but we know that not all people have this experience. We'd like to know more about the advice and support people already get, what people would like to know about or be prepared for and about gaps in information or advice available.

What does success look like?

- Increased proportion of people planning for late stages and end of life at a time when they are still able.
- Qualitative feedback that people know and have support on what to expect and what choices are available to them. They have the time to consider and plan for these decisions and to discuss them with family, friends and carers should they wish.

Our commitments to Leicestershire

- We will seek your views on what planning and services for late and end of life should look like and how you should be informed about your choices.
- We will ensure there is a clear transition in care planning from living with long term conditions into the later and end of life.
- We will ensure there is appropriate support for carers following the bereavement of a loved one so they can have a supportive transition into the next stage of their lives.

6.3. Normalising end of life planning

We would like to create a system that normalises end of life planning with people that wish to plan. For some this can mean practical planning for finances and wills, for others this will mean making choices about the care they receive and their treatment choices in advance.

Many people with poor health or in need of support, agree a care plan with their health and care professionals and we would like to increase the number of people with care plans in place. The ReSPECT process allows for conversations between people nearing the end of life or those with complex health needs, their families and carers and health or care professionals. It enables people to discuss and record some key decisions about their care and treatment including decisions about whether resuscitation should be attempted if they wish. We want to continue to support people with setting out their care and treatment choices and are keen to normalise planning for all aspects of end of life where people tell us there is a need.

Where are we now?

The majority of vulnerable people in Leicestershire have a care plan in place, but we know there are some that do not. This is a similar position for ReSPECT plans. Whilst some people may not wish to have a care or ReSPECT plan, we would like to offer this to everyone with opt out as a choice. We know that the numbers of people with a care or ReSPECT plan in place has fallen during the pandemic.

We know there is advice and guidance in our wider system and in communities that helps people with broader aspects of end-of-life planning. We would like to understand the demand for support that goes beyond care and ReSPECT planning and what this might look like.

What does success look like?

- Care plans offered to all vulnerable people that may benefit from having one with a target of 95%, this should include a ReSPECT plan.
- High levels of take up with people specifically opting out of having a plan in place rather than being missed from the offer of one.
- Qualitative feedback that Leicestershire feels comfortable and supported to plan for the end of life.
- End of life as everyone's business – an educated and compassionate workforce that can support people at end of life.
- Care co-ordination for people in the last days and weeks of life operates well.

Our commitments to Leicestershire

- We will offer care plans and ReSPECT plans to all vulnerable people, with a take up target of 95%.
- We will use our better understanding of needs through the JSNA chapter to consider other aspects of end-of-life planning.
- We will develop a social marketing campaign based on insight to normalise end of life planning.
- We will educate our workforce so that everyone understands how to support people at end of life
- We will improve co-ordination of care at end of life, as measured through patient feedback

7. Cross Cutting Priorities

7.1. Improved Mental Health

Good mental health is an important part of our overall health, and the impacts of poor mental health are wide reaching including lower employment, reduced social contributions and reduced life expectancy. The NHS 5 year forward view for mental health and recently the NHS Long-term plan[iii] have highlighted that mental health has been proportionally under-funded and had insufficient focus through statutory services[x].

The national strategies set out a commitment to achieve parity of esteem of funding and outcomes between what has traditionally been framed as offers to meet mental health needs in comparison to physical health needs. A sizeable investment programme was put in place for enhancing and increasing offers targeting mental health needs including:

- Accessible mental health self-management, guidance and support
- Joining up mental health, physical health, wider care, voluntary sector around local geographical areas
- Increasing access and strengthening offers for children and young people, and for women and families before, during and after pregnancy.
- Earlier intervention for people presenting with early signs of psychosis
- Psychological offers for the full range of defined mental health conditions
- Increasing retention and attainment of employment for people with mental health illness

The LLR vision for mental health of both children and adults across the system is '*We will deliver the right care to meet the needs of individual patients at the right time. We will integrate with health and social care partners to care for people when they feel they have mental health needs*.' In Leicestershire, we are keen to support this system work whilst being clear on the mental health and wellbeing needs of those living in Leicestershire specifically in order to champion their needs and support delivery of high quality prevention, care and treatment that improves their outcomes and experiences.

Where are we now?

The estimated number of children and young people aged 5-17 years with mental disorders in Leicestershire is 12,440. Leicestershire performs significantly better than England for percentage of school pupils (secondary and primary age) with social, emotional and mental health needs and children in care (<18 years), however, over the last five years the trend is increasing and getting worse.

The estimated proportion of the population aged 16 & over who have a common mental disorder in Leicestershire is 13.7% which equates to 77,698 people and 8.6% for those aged 65 and over, which equates to 11,997 people. Leicestershire performs significantly worse than England for the gap in the employment rate for those in contact with secondary mental health services and the overall employment rate. Leicestershire also falls short of the NHS England dementia diagnosis target of 67%, achieving 61.2% in 2021. LCC Adult Social Care experienced increased demand for mental health support amongst working age adults in 2020/21: contacts with the Council increased by 19% on the previous year whilst those in receipt of long-term services increased by 4%.

There has been significant engagement with the Leicestershire population as part of the 'Step up To Great Mental Health' consultation in 2021. This highlighted common themes such as highlighting experience of patients being bounced between service offers, difficulties accessing specialist service

offers for mental health (both in location of services and in long waits), insufficient support for carers and services not working together or centred on individual needs.

What does success look like?

- Increased proportions of Leicestershire experiencing good mental health and wellbeing.
- Qualitative feedback that good emotional health and wellbeing is actively promoted and supported across the county including for carers and that services are joined up and meeting patient's needs at the right time and place.
- Reduction in the proportion of people with mental health challenges that need intensive and specialist offers.
- Maintain suicide rates that are lower than the national average.
- Increase dementia diagnosis rates to meet NHSE target of 67% and clear links made between healthy lifestyle and the risk of dementia.
- To increase the proportions of people with mental health challenges that:
    - Access and take up high quality advice, support and access to local amenities, including activities and groups to strengthen mental health and wellbeing
    - Live as independently as possible
    - Be supported around their individual recovery goals
    - Access to education, employment, training and housing and are supported by their employer/ institution
    - Have easy and timely access to the right, local, coordinated service
    - Have their physical health needs monitored and key health / lifestyle needs supported
    - Have their carers and families caring and mental health needs identified and supported

Our commitments to Leicestershire

- We will prioritise Mental Health on an equal basis to physical health in plans, investment and focus also considering the links between physical activity and good mental health and how mental health is linked to other conditions.
- We will seek to co-produce a Prevention Concordat for Better Mental health for Leicestershire to align organisations to further support mental health and wellbeing and prevent poor mental health.
- We will continue to focus on maintaining low rates of suicide and impact of suicide, supporting work of the LLR Suicide Strategy
- We will continue to support the system work on children and young people's emotional health and well being.
- We will listen and respond to the Leicestershire population in the 'Step up to Great Mental Health' consultation and propose (consultation results) to deliver a variety of changes for our population through the LLR and Leicestershire specific Step up to Great Mental Health programme and associated Mental Health investment.
- We would support key recommendations of the Dementia JSNA Chapter and LLR Dementia Strategy (due to be reviewed in 2022). This will include improving dementia diagnosis rates and ensuring clear links between healthy lifestyle and risk of dementia through MECC Plus and Health Checks.

7.2. Reducing Health Inequalities

"Health inequalities are the **preventable, unfair and unjust differences** in health status between groups, populations or individuals that **arise from the unequal distribution of social, environmental and economic** conditions within societies" (NHS England, 2021)[xi]

Overall Leicestershire is an affluent county, that generally performs well in terms of health and wellbeing. However, not everyone enjoys the same prospects or opportunities for good health and wellbeing. As discussed above, health inequalities are underpinned by social determinants of health, or the circumstances in which people are born, live, work and grow. Evidence suggests that those living in the most deprived areas of the county often have poorer health outcomes, as do some ethnic minority groups and vulnerable/socially excluded people. In addition, the most disadvantaged are not only more likely to get ill, but less likely to access services when they are unwell. This is known as the inverse care law.

We know that health inequalities have been further exposed by the Covid-19 pandemic, which has taken a disproportionate toll on groups already facing the worst health outcomes. For example, nationally the mortality rate from Covid-19 in the most deprived areas has been more than double that of the least deprived. In addition, some ethnic minority communities and people with disabilities have seen significantly higher Covid-19 mortality rates than the rest of the population. The economic and social consequences the pandemic response have worsened these inequalities further, with young people, informal carers, those in crowded housing, on low wage, unstable and frontline work experiencing a greater burden and transmission of the virus. We also know that older and more clinically vulnerable people have experienced extended periods of physical deconditioning through limited activity, and also social isolation, both of which may have longer term impacts on their health and wellbeing.

To help reduce these inequities the five NHS priorities for reducing health inequalities include;

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

The aim of these approaches is to achieve equitable access, excellent experiences and optimal outcomes for all across Leicestershire.

Where are we now?

Inequality in life expectancy is estimated using a summary measure called the slope index of inequality (SII). The higher the value of the SII, the greater the inequality within an area. Nationally, the inequality in life expectancy at birth is 9.4 years in males and 7.6 years in females in 2017-19. The SII for males and female life expectancy in Leicestershire in 2017-19 was 6.4 years and 5.0 years respectively. From 2016-18 to 2017-19, the slope index of inequality decreased by 0.1 years for males and has remained the same for females.

In males life expectancy in the least deprived decile has increased from 82.1 years in 2010-12 to 84.0 years in 2017-19. For the same time period, in the most deprived decile, life expectancy at birth in males has remained at 76.0 years. In females life expectancy in the least deprived decile has

increased from 85.4 years in 2010-12 to 86.2 years in 2017-19. In the same time period in the most deprived decile life expectancy at birth in females has increased from 80.5 years to 80.8 years. Hence showing that inequalities in life expectancy are growing across Leicestershire, with increases in life expectancy growing at a fast rate in the least deprived deciles as compared to those in the most deprived deciles.

What does success look like?

- Reduction in the slope index of inequality or 'levelling up' of the social gradient
- A greater rate of improvement in life and health life expectancy in the most deprived communities and vulnerable groups across Leicestershire (including those from specific ethnic or vulnerable groups and disabilities.)

Our commitments to Leicestershire

- We want equitable access, excellent experiences and optimal outcomes for all those using health and care services across Leicestershire. To do this we will embrace a proportionate universalism' approach where interventions are targeted to enable a 'levelling up' of the gradient in health outcomes. This means that although there will be a universal offer of services to all, there will be justifiable variation in services in response to differences in need within and between groups of people, that will aim to bring those experiencing poorer outcomes the opportunity to 'level up' to those achieving the best outcomes. (I.e. developing the national CORE20PLUS5 initiative.)
- We will translate the Leicester, Leicestershire and Rutland Health Inequalities framework for Leicestershire. This will include embedding a Health and Equity in all policies approach, utilising anchor institutions, training our leaders on health inequalities and ensuring we are collating data to analyse health inequalities effectively.
- Within the NHS we will also prioritise the five key clinical areas of health inequalities including early cancer diagnosis (screening & early referral), hypertension case finding, chronic respiratory disease (driving Covid & Flu vaccination uptake), annual health checks for people with serious mental illness and continuity of maternity carer plans[xii].
- We will review the health inequalities across Leicestershire in particular understanding the impact of Covid-19 on our most disadvantaged populations including those living in the most deprived areas or groups (including military and veterans, carers, those with a disability and LGBT+)

7.3. Covid-19 Recovery

The Covid-19 pandemic has and will continue to have a significant direct and indirect impact the health and wellbeing of residents in Leicestershire. The Joint Health and Wellbeing Strategy acknowledges the population's loss and will continue to strengthen the innovation that has emerged through this difficult time.

Where are we now?

The weekly Covid-19 rates in Leicestershire have followed a similar trend to the national rates throughout the pandemic. During the 2nd national lockdown, the Leicestershire rates rose above the national average, whilst in the 3rd lockdown the Leicestershire rates dropped below the national rate. From early August 2021 the Leicestershire rates have increased above the national rate.

The age standardised mortality rate for deaths involving Covid-19 (2020/21) for all persons in Leicestershire was 154.6 (per 100,000 population), this is significantly lower than the national rate of 181.7 (per 100,000 population).

Since the beginning of the pandemic to week 34, 2021 (27th August) there have been 1,600 death occurrences mentioning Covid-19 in Leicestershire and 3,434 hospital admissions in Leicestershire residents. Since implementation of the Covid-19 vaccination programme significant reductions in Covid-19 related hospitalisations and deaths have been seen across Leicestershire. However, no vaccine is 100% effective and we need to continue to work with our communities to support them to live with Covid-19 in the longer term.

What does success look like?

- High uptake of the Covid-19 vaccination
- Reduction in hospitalisations and deaths due to Covid-19
- Reduction in settings based outbreaks due to Covid-19
- Patient feedback that health and care services are equipped to manage the Covid-19 in the longer term
- Numbers of people accessing support for Long Covid

Our commitments to Leicestershire

- We will support our population to get timely access to the Covid-19 vaccinations that are appropriate to them.
- We will ensure our health and care services are equipped to manage the impact of Covid-19 directly and indirectly for the longer term.
- We will use the results from the Covid-19 Impact Assessment to target specific interventions and vulnerable groups throughout the wider strategy implementation.
- We will support Leicestershire to live with Covid-19 circulating within our population in the longer term.
- We will ensure we maintain a collaborative health protection approach and response ready for future Covid-19 surges or other future pandemics.

8. Next Steps

8.1. Evolution of the HWB

We want to ensure we have the correct mechanisms in place to monitor and evaluate the progress against the priorities discussed above to ensure we are making a true difference to improving health and wellbeing outcomes for Leicestershire. The HWBs is a statutory Board that is crucial in making this happen across Leicestershire as a place. It is a key forum established with collaborative decision makers, and commissioning leads from across the County Council, Borough and District Councils and the NHS, informed by the views of patients, people who use services and other partners who bring expert knowledge of the local community to enhance the JSNA and Joint Health and Wellbeing Strategy (JHWS).

Membership of the Leicestershire HWB include:

- Leicestershire County Council
- Clinical Commissioning Groups/ Integrated Care System
- Elected Members
- Lead District Officer for Health and Housing
- Healthwatch
- NHS England
- University Hospitals of Leicester
- Leicestershire Partnership Trust
- Leicestershire Police
- Office of Police and Crime Commissioner

The HWB acknowledges that partners across the system make a significant contribution to improving the health and wellbeing of the Leicestershire population both individually and collectively. Therefore, the HWB will evolve a 'partnership pf partnerships' approach with other key boards, and have agreed to evolve and ensure that the JHWS priorities have ownership and are accountable. As a result, the approved approach is 'do, sponsor, and watch' to allow the board to proactively set the agenda around key integration and partnership priority areas, whilst allowing partners to continue to deliver and drive change through their subgroups and organisations without blockages across the system. The approach is summarised below:

- **Do** – The JHWS will identify 1-2 key priorities for action in each of the life course stages. The HWB will ensure there is the appropriate spotlight on these areas to ensure effective and efficient multiagency delivery and accountability for progress on these priorities. Therefore, each priority will have a named Senior Responsible Officer, with appropriate metrics and action plans developed. The HWB agenda will ensure adequate, dedicated time is allocated throughout the priorities development and implementation to ensure all HWB partners are clear about their role and accountability in progressing the specific priority.
- **Sponsor** – Additional key work streams including from the HWB Sub-groups and LLR ICS Design Groups, will be supported by a sponsor from the HWB who is accountable to ensure outcomes are delivered on. These workstreams will have clear objectives and would not be routinely discussed by the board unless the sponsor highlights the need for this to happen. A highlight report will be submitted to the board on an annual basis and the list of 'sponsor' workstreams will be reviewed on an annual basis.
- **Watch** – Workstreams including specific health pathways, organisational service reviews, support for carers and dementia etc that are still important to prevention and reducing health inequalities, but are more aligned to a single organisation. This is business as usual

and may include areas that are already ongoing, only escalating to the HWB when required. Again the 'watch' list will be reviewed on an annual basis and each workstream will have a Board link to ensure escalation to the Board is made as needed.

8.2. How will we know we have made a difference?

The key to getting things right is embedded in leadership and accountability. The best way of knowing if this strategy has made a difference is to ensure effective and regular monitoring of the actions that address the identified priorities, highlight any gaps and continue the conversation with residents, communities and partners through the JHWS Engagement Strategy. The aim is to regularly check in with residents to see if the priorities reflect the local experiences of health and wellbeing, and that our actions are making a true difference to the local population. The HWB will receive progress reports against the JHWS delivery plan at every meeting. The delivery plan sets out the specific change we would expect to see and the actions that will be taken. Following the approach outlined above, HWB members will be required as a sponsor for priorities to be held accountable and identified as a point of contact for organisations to explore actions being taken.

To ensure the strategy remains relevant, major review and evaluation gateways will take place on a 3-year cycle (aligning with the neighbourhood level Community Health and Wellbeing Plans) along with minor reviews and progress updates on an annual basis reflecting both stakeholder, residents and communities feedback. The JHWS will be tailored and operationalised to reflect varying locality need and this will feed up to shape the wider LLR ICS vision at system and neighbourhood Community Health and Wellbeing Plans. This will enable the JHWS to stay relevant and will support the HWB in its aim to improve health and wellbeing outcomes across Leicestershire, while complementing and contributing to the wider health and care system across LLR.

9. References

[i] D. Marks, M. Murray and E. Estacio, Health Psychology: Theory, research and practice (5th Edition), London: SAGE, 2018.

[ii] Dahlgren and Whitehead (2006) European strategies for tackling social inequities in health: Levelling up Part 2, WHO, Denmark. [Available online at https://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf] [Accessed on 04.11.21].

[iii] NHS England (2019) The NHS Long Term Plan, NHS England. [Available at https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf] [Accessed on 04.11.21].

[iv] Department of Health and Social Care (2021) Policy paper
Integration and innovation: working together to improve health and social care for all, DHSC [Available at https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version] [Accessed on 19.10.2021]

[v] HM Government (2021) The Best Start for Life. A Vision for the 1,0001 Critical Days. HM Government, UK. [Available online at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf] [Accessed on 19.10.2021].

[vi] Belsky, J. & de Haan, M. (2011) Annual Research Review: Parenting and children's brain development: The end of the beginning. Journal of Child Psychology and Psychiatry, 54, (4), 409-428.

[vii] Champagne, F.A. (2015) Epigenetics of the developing brain. Zero to Three, 35, (3) 2-8

[viii] ADD ACES national reference

[ix] Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status.

[x] NHS England (2016) The Five Year Forward View for Mental Health, NHS England. [Available online at https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf] [Accessed on 04.11.2021].

[xi] NHS England, “Reducing health inequalities resources,” [Online]. Available: https://www.england.nhs.uk/about/equality/equality-hub/resources/ [Accessed February 2021].

[xii] Dodge I., Owolabi B.(2021) Tackling Inequalities in NHS care. NHS England and NHS Improvement Board meetings held in common. [Available online at https://www.england.nhs.uk/wp-content/uploads/2021/06/240621-board-meeting-item-9-tackling-inequalities-in-nhs-care.pdf]] [Accessed on 28.10.2021]

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Joint Health and Wellbeing Strategy

CONSULTATION FEEDBACK FEBRUARY 22

The consultation exercise

Gained public and wider professional input to the approach, priorities and commitments set out in the draft JHWS

Asked whether people agreed or disagreed (on a scale) with the overall approach and with the commitments in each life stage

Ran from 29th November 2021 to 23rd January 2022

Used an online survey as the main engagement approach

Was promoted and shared by partners

Was presented to key groups, boards and meetings

The survey

ON-LINE AND PAPER COPIES

Who took part?

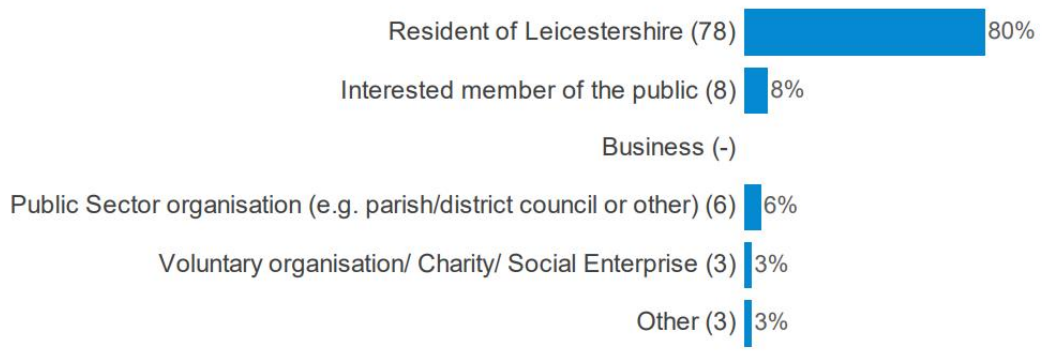
99 People responded to the survey about the JHWS

The majority were residents of Leicestershire (80%)

35% worked for Leicestershire County Council

Your role

Q1 - In which role(s) are you responding to this survey?



District	Count
Blaby	25
Charnwood	12
Harborough	8
Hinckley & Bosworth	5
Leicester City	6
NW Leicestershire	8
Oadby & Wigston	2
Outside of LLR	1
Missing postcodes	32

What did people say?

The majority of people said they either strongly agree or tend to agree with the vision, priorities and commitments

Very few people said they strongly or tend to disagree (between 1% and 6% ticked these boxes throughout the survey)

Many comments received were supportive/confirmative comments (121)

118 comments were received requesting an addition or amendment to the strategy

33 comments highlighted something already contained in the strategy (showing how important this was to them)

18 comments suggested we ought to give more priority or funding to a particular service or area of work

31 people asked for more detail: how we will achieve, fund or measure these commitments

7 comments were from people stating a specific point or approach that they disagreed with in the strategy

- although some of the points made in other categories may also have been negative e.g. 'I agree but it's a bit vague' was categorised as a request for more detail but could also be viewed as a negative response

General themes to feedback

Look/accessibility of strategy
- Infographics
- easy read
- more detail
- less jargon
- too long

Request for more detail
- how will we do this
- how will it be funded
- where will the workforce come from
- which things should we prioritise (with views often offered)

Comments about access:
- knowing what's available and how to access it/find information etc
- difficulties in accessing GP and other health services & getting their 'buy in'
- travel and transport barriers

Lack of money as a barrier to accessing services e.g., leisure, transport, adult social care etc.

Loss of green space/level of feeling about housing growth is a consistent theme

Support for increased integration
- health and social care working together
- Schools, GP's, district councils as examples of key partners
- The link with other strategies e.g., digital strategy, housing strategies etc.

Workforce
- co-ordinate our approaches across partners
- the need to ensure we have enough people to deliver
- training, personalised approaches, attitude etc.

More for specific protected characteristic groups
- LGBT+
- people with a disability

The role of carers and the support required for them (including financial) as well as the huge impact of the work they undertake

The need for community approaches/work with local people to really make a difference and local support networks

The need for a personalised approach – one size does not fit all

Note: the points reflected in this, and the next slide are a summary of common themes, not a detailed account of every point made

Feedback by life course

Best start

- requests for more support with parenting skills/education
- SEND provision – improvements to diagnosis, support, transition
- improved health visiting and other early years services, especially services re-starting following the pandemic
- children's mental health and the need to reduce waiting/improve access and availability, offer early intervention etc.
- access to green space

Living healthy, safe and well

- counselling to support weight loss
- schools and education as partners
- workplace health and the need to ensure businesses take responsibilities seriously
- transport as a barrier to access and the need to increase active travel/remove barriers
- Some objections to the use of 'choice' as some people's circumstances limits choice, however there were also supportive comments given for use of this approach
- Green spaces & physical activity considered important

Feedback by life course continued…

Living and supported well

- Need to have the right sort of housing to enable people to stay at home e.g. more warden assisted etc.
- Access – transport, alternative to digital, knowing how to access services and what's available
- Importance of physical activity
- Workforce – key area for living and supported well
- Recognition that funding is a key issue at this life stage – some wanting it prioritised, increased, is a barrier to sucess

Dying well

- Housing – needs to be right for people in need of support/reaching end of life
- Carer support – including after a person has died e.g. return to work etc.
- Palliative support – comments on pathway, funding and access

Cross cutting

- Most comments received were about mental health – need to prevent, personalise, re-prioritise, waiting times, improve access, early intervention etc.
- Interplay between mental health and other conditions e.g. ADHD or autism
- Physical activity to prevent/improve mental health
- Importance of re-opening services as part of Covid recovery

What did people disagree with?

1 person disagreed with the falls prevention commitment as they could not see how we could do anything about this

1 person disagreed with the idea of supporting people to remain in their own homes for as long as possible (requesting a personalised approach instead)

1 person felt dying well was a family issue, not something that 'government' should be involved with

1 person disagreed with end of life discussions happening towards end of life, feeling they should be had throughout life

1 person felt that something was an 'overblown issue' – unsure of which cross cutting issue this relates to

1 person disagreed with Covid as a cross cutting theme, stressing the need to return to life without an emphasis on Covid

As before, there were more negative comments received about the strategy, but these have been included in other categories

- e.g. a response about needing to offer more financial support for carers has been categorised as a request for an addition/amendment, a response about it being 'too vague' has been categorised as a request for more detail etc.

Conversations with local people

Summary of feedback

Local area co-ordinators spoke to 72 people across a range of ages and venues, often as they took part in local sessions such as crafting, support and friendship groups.

Comments were positive with people particularly welcoming the focus on all life stages, mental health, covid recovery and prevention

Feedback was similar to that received online:

- Request for more detail on how this would be achieved
- Some found it complex with complicated language
- Importance of integrating services
- Request for more information about what services are out there and how to access them
- A comment was made about transport and the difficulties of getting around by bus
- A comment was made about the importance of local communities playing a part in achieving these goals

Feedback from groups, boards and meetings

Which meetings was this presented at?

System
- Integrated Care Board
- UHL Strategic Board
- LPT Board
- Dementia Programme Board
- Info circulated to design groups
- Primary Care Cell

Place
- Health and Wellbeing Board
- Health & Overview Scrutiny Commission
- Safer communities Strategy Board
- District Health Leads meeting

H&WB Subgroups
- Integration Executive (& IDG)
- Unified Prevention Board (Staying Healthy Partnership)
- Children and Families Partnership Board

LCC meetings
- CMT
- Engagement hub
- LECG
- Joint DMT (children, adults and public health)
- Public Health DMT & SLT
- Adults and Communities SLT
- Environment and Transport DMT
- Corporate Resource DMT

What was the feedback?

Support overall for the draft Strategy

How can we ensure integration is a common theme through all life stages and ICS (at system, place and neighbourhood)?

Some requests for a change in language 'industrialising prevention' and 'choices' (due to the issue of some people having much more limited choices than others)

A detailed submission of feedback was received from the districts collaboratively, supporting the approach taken and requesting some amendments and/or considerations going forwards

Action in response

What action has been taken in response?

Strengthening many of the life course sections in line with the feedback received, particularly where points were made by more than one person or group

Strengthen links between the Carers Board and HWB as carers needs were a strong theme from the consultation

Added a statement about needing to better understand where health inequalities are occurring across Leicestershire which may include protected characteristics of disability or LGBT+ people

Strengthened the emphasis on integration with recognition that more may come through further development of the delivery plan

Some amendments where jargon or complex text has been identified

More detail will come with delivery plan and indicator set

Final copy will include easy read and summary version of the strategy

Next steps

This is just the start of the conversation on health and wellbeing

HWB are developing a Communication and Engagement Strategy

Some people have given their details as part of the consultation response so that we can stay connected and seek their views on other pieces of work

Some organisations have provided ideas for how they could be engaged and support the work going forwards

We will continue to use these findings and to work with partners and people to deliver this strategy

As much money should be spent on prevention rather than just reacting to chronic health in old age

I think there should be an emphasis on people helping themselves to take ownership and improve their own health, follow the medical advice they have given, and make better choices.

Nice to see us all in there

Working well - how Leicestershire companies uphold the wellbeing of their staff and address work/life balance

Mental Health is a very important part of all our lives

More hands on experiences and opportunities for SEND young people to make a positive contribution through volunteering etc

Interesting to see the 'how' ?

We need to support each other We need our green open spaces, woods and forests to promote healthy living for mental and physical wellbeing

Like that a plan to join things up is here

A Good Death is important for both the person & their loved ones. The trauma of seeing someone going through a bad death & feeling helpless can stay with you & have an ongoing impact for the rest of your life. Grief should not be underestimated or dismissed.

In every stage access to services is important. They need to be local and accessible by public transport

Best Start for Life	Indicators for dashboard	Ref	Commitment	What does success look like	Actions
First 1001 Critical Days	1. Smoking status at time of delivery 2. Infant Mortality 3. Low birth weight of term babies 4. New Birth Visits completed in 14 days 5. Caesarean Section? 6. A&E attendances - under 1 year? 7. babies first breast milk? 8. breastfeeding at 6-8 weeks? 9. Vaccination coverage - dtap/ipv/hib - 1 yr old	A.1	We will embed the Governments vision for 'The best start for life. A vision for the 1,001 critical days' through a local 1001 Critical Days Children's Manifesto and communication campaign	Positive local feedback from families confirming that they feel supported, through a range of integrated start for life services to develop their babies in the first 1,001 critical days -- Family feedback that services are working in more integrated and collaborative ways to support pre-school children and their families -- Increase in breastfeeding initiation and continuation rates --- Increase in immunisation rates, especially for the boosters at age 1 and 2years. --- Reduction in proportion of caesarean births	A.1.1 C&FPP Priority 1 (available at https://www.leicestershire.gov.uk/sites/default/files/field/pdf/2018/9/17/Partnership_plan.pdf) A.1.2 Saving Babies Lives V2 Priority 4 (available at https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf) A.1.3 NHS Long Term Plan TDP Priority 4 (Available at https://www.longtermplan.nhs.uk/) A.1.4 NHS Patient Safety Strategy priority 4 (available at https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/#patient-safety-strategy) A.1.5 Saving Babies Lives V2 Priority 1
		A.2	We will have joined up, accessible pre -school services, family hubs, an empowered workforce and clear local and national direction, vision and service improvement. This will include an integrated Early Years Pathway to identify and support vulnerable children.		A.2.1 C&FPP Integrated pathway Priority 1 A.2.2 NHS Long Term Plan TDP Priority 4 A.2.3 Saving Babies Lives V2 Priority 4 A.2.4 NHS Patient Safety Strategy priority 4
		A.3	Embed the additional 3-4month and 3.5 year checks into our public health nursing service.		A.3.1 NHS Long Term Plan TDP Priority 4 A.3.2 Saving Babies Lives V2 Priority 4 A.3.3 NHS Patient Safety Strategy priority 4 A.3.4 Recommissioning of the 0-11 public health children services
		A4	We will invest in evidenced based breastfeeding support for mothers across Leicestershire. Supporting them to initiate and continue breastfeeding for as long as they choose. Support will be prioritised for those in white other ethnic groups and younger mothers.		A.4.1 C&FPP Priority 5 See A.1 and A.3.4.
		A5	We will work to further increase uptake of childhood immunisations programmes especially boosters due at age 1 and 2years		See A.1 and A.3.4. A.5.1 Implementation of caesarian birth Nice guidance 192. A.5.2 Work with NHS E&I, CCG and PCN colleagues re uptake of the routine childhood Immunisation programme, potential health equity audits. Pilot in Charnwood see E.9.1.
		A6	We will empower families to feel confident and supported develop and grow. This will include support to access the most appropriate services for emotional health and wellbeing, minor aliments (including gastro, respiratory/ bronchitis and head injuries) and home safety.		A.6.1 EH - CFPP Supporting families to be resilient - Priority 3 A.6.2 CFPP Priority 5 - implementation of Trauma informed approach and reduction to children's A&E admissions. A.6.3. Review aapid access to jaundice clinics See A.1 and A.3.4.
School Readiness	10. School readiness: percentage of children achieving a good level of development at the end of Reception 11. School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception 12. Child development: percentage of children achieving a good level of development at 2-2½ years Proportion - % 13. Child development: percentage of children achieving the expected level in communication skills at 2-2½ years 14. Child development: percentage of children achieving the expected level in personal-social skills at 2-2½ years New data 15. Percentage of 2 year old children benefitting from funded early education		We will take a proportionate universalism approach and focus on narrowing the development gaps that affect children and families who are at the greatest disadvantage (e.g. those who access FSM, live in poverty or have a poor home environment, have SENDs and/or are in our care)	Reduce the gradient in developmental outcomes in those from disadvantaged backgrounds as compared to those in the most advantaged (i.e. split by deprivation, FSM and SEND). --- Families are clear on what good development in foundation looks like and what support is available to support their children to achieve this. --- Increase in the proportion of children achieving a good level of development at 2-2.5years and foundation stage across all development areas (fine and gross motor, communication) --- Improvement in maternal mental health	
		B1	We will support parents and families to build on their understanding of children's needs so that they are able to understand what good looks like and get their children off to a good development start		B.1.1 CFPP Priority 1
		B2	We will provide support to embed physical activity into young children's lives through interventions that improve fine and gross motor skills.		B.2.1 CFPP Priority 1
		B3	We will ensure access to support early development of speech, language and communication		B.3.1 CFPP Priority 1
		B4	We want to help families access free high-quality childcare and early education that is fully inclusive and accessible.		B.4.1 CFPP Priority 1
		B5	We will support improving maternal mental health and physical activity to allow parents and carers to be in the best position they can be to support their children		B.5.1 CFPP Priority 1
		B6			B.6.1 CFPP Perinatal MH Priority 5
Preparing for Life	16. Vaccination coverage - HPV Males 17. Vaccination coverage - HPV Females 18. Covid vaccination uptake 12-17 year olds 19. Children in care 20. 16-17 year olds NEET 21. School pupils with social, emotional and mental health needs 22. hospital admissions as a result of self harm (10-24) 23. Percentage of pupils with SEN or EHC Plan		We will work with young people, partners, parents and schools in increase HPV and Covid-19 vaccination uptake	High uptake of Covid vaccination in 12-17year olds --- Increase uptake of HPV vaccination in males and females --- Stabilising numbers and rates of looked after children --- Increased proportion of young people reporting strong emotional health and wellbeing --- Increased proportion of children at a healthy weight (not under or overweight/ obese, especially in SEND) --- Reduction in Adverse Childhood Experiences risk factors and increased proportion of young people that have a trusted adult in their life --- Reduction in A&E attendances in under 18's, including those caused by self harm	
		C1	We will investigate the causes of the increasing levels of children in care and work with families to prevent this whenever possible		C.1.1 Update trajectories following impact of Omicron variant on staffing numbers
		C2	We will ensure there are opportunities for all 16-17 years olds to gain education, employment and training		C.2.1 CFPP Priority 4
		C3			C.3.1. Recommissioning of 11+ children's public health services. C.3.2. Ensuring children get the correct support they need to consider options education, employment and training opportunities following

C4	We will develop the Healthy Schools and secondary school children's public health service to help build informed, healthy, resilient young people that have skills to stay safe from harm and are ready to enter the adult world	C.4.1 Ensure strategic and operational links to Mental Health Support Teams in Schools (MHSTs) See C.3.1. Recommissioning of 11+ children's public health services C.4.2. CFPP Priority 2 Link to children's mental health priority K4.
C5	We will ensure there is appropriate emotional and mental health support for children and young people as part of the Covid recovery	See C.3.1. Recommissioning of 11+ children's public health services
C6	We will ensure that children and young people have access to the services they need to gain and maintain an active lifestyle and healthy weight.	C.6.1 Further develop Healthy Schools and Healthy Tots programmes across Leicestershire. C.6.2 Coordinate actions through the Weight Management Sub Group See E3 linking to wider Healthy Weight and Physical Activity strategies
C7	We will support the workforce to embed a Trauma Informed Approach to reduce the impact of Adverse Childhood Experiences on later life	C.7.1 CFPP VRN Priority 5 C.7.2 Understand and share how uptake of Trauma Informed Approach is being monitored in provider workforces.
C8	We will ensure that children with SEND and learning disabilities have access to the support they need and a seamless transition into adult services.	C.8.1 CFPP Priority 4

Staying Healthy, Safe and Well	Indicators for dashboard	Ref	Commitment	What does success look like	Actions
Building Strong Foundations	1. Employment rate 2. Gap in employment rate for those in contact with secondary mental health services and the overall employment rate 3. Sickness absence 4. Homelessness 5. Proportion of adults in contact with secondary mental health services who live independently, with or without support 6. Violent Crime rate 7. Hate incidents recorded 8. Air pollution 9. Percentage of adults walking for travel, 3 days a week 10. Percentage of adults cycling for travel, 3 days a week 11. Air pollution	D1	We will work with partners to deliver the Leicestershire wider determinants action plan, this will include a Health and Equity in all Policies approach to all we do	Maintaining and increasing the employment rate. Specially for those with adult mental health. -- Improvement in sickness absence rate -- Reduction in the number of homeless single and family households and number of households where homelessness was prevented -- Improved numbers of adults with mental health living independently. -- Health and Equity in all policies approach embedded across the Leicestershire HWB partners. -- Ensure the appropriate, equitable infrastructure (including health services) is in place for the planned housing growth addressing health inequality through design and use of health impact assessments. -- Increasing access and uptake of active travel -- Increased proportion of Leicestershire residents who have access to green space within 10minutes walk. -- Improvement in air quality and its impact on health and health inequalities across Leicestershire -- Maintain low levels of crime especially violent and hate crime -- Reduction in fear of crime -- Reduction in the proportion of Leicestershire residents that experience fuel poverty	D.1.1 Populated Wider Determinants Action Plan (WDAP) agreed with partners. Delivery of the WD Action Plan against these SMART objectives.
					D.1.2 Training around Wider Determinants of Health, Health and Equity All Policies and health impact assessment for all levels across partners at Place.
					D.1.3 Agreement at Place on process to embed health and equity in all policies approach to key decision making.
		D2	We will further grow Leicestershire's economy and support recovery from the Covid pandemic including work with the Leicester and Leicestershire Enterprise Partnership, Levelling Up and having economic growth for all. We will support those in poverty to access the support to gain employment and eligible benefits and hardship.		D.2.1 Links to LLEP Recovery Plan https://llep.org.uk/app/uploads/2020/12/Economic-Recovery-Action-Plan-COVID-19-FOR-web.pdf
					D.2.2 Links to Strategic Growth Plan https://www.llstrategicgrowthplan.org.uk/wp-content/uploads/2019/01/Final-LL-SGP-December-2018-1.pdf weaknesses on page 3 might influence what does success look like
					D.2.3 Consider strengthening links between the WDAP to include growth that includes health considerations around employment needs.
					D.2.4. Deliver the Work and Slills Leicestershire programme through Adult Learning services
		D3	We will work to ensure everyone has 'good work' for them. Supporting people to enter and maintain good employment/ skills and support those with health and care needs to keep their jobs, with particular attention to sickness absence (due to musculoskeletal and mental health conditions) and considering an aging workforce. . Work will also consider the role of workplaces in supporting health and wellbeing.		D.3.1 Creation of an expanded and integrated workplace Health offer, based on evidence of need post Covid for our working age population. Particular focus on development around the Musculoskeletal and mental health elements of the offer with a development of clear pathways for employers.
					D.3.2 Delivery of a range of Adult Learning courses provide opportunities to help individuals develop skills improving prosperity and life chances. Including the delivery of Leicestershire Work and Skills programme.
		D4	We want everyone to have access to a good home. We will work with partners to ensure high quality new and current housing that has access to green space and supports good health and wellbeing. We will also work collaboratively to prevent homelessness whenever possible.		D.4.1 A common, approved approach to embedding health and care considerations within the planning process on Leicestershire, informed by pilot work with NWL, Blaby and the TCPA. Link to actions in WDAP.
					D.4.2 Pilot and promote use of health place making portal with Planners and Developers.
					D.4.3 Complete Housing health needs assessment pilot for Charnwood
					D.4.4. Investigate the quality of current social housing stock and consider recommendations for improving this.
					D.4.5. Develop innovation in the use of adaptations and technology in homes that support people to live independently for longer in their own homes, including links to Lightbulb.
		D5	We will work with system partners to support adults with mental health challenges to live independently		D.5.1 Set up subgroup of Chief Housing Officers Group to review mental health considerations.
					See mental health priorities K.
		D6	We will effectively and equitably plan for our growing and older population to ensure everyone has access the services, transport and infrastructure they need		See D.4. actions.
					D.6.1. Deliver Home Care for Leicestershire framework.
					D.6.2. Consider links between Leicestershire Transport Plan and health and wellbeing.
		D7	We will work with Community Safety Partnerships to maintain low levels of crime and support community cohesion including work to reduce domestic violence and implement the Domestic Abuse Act 2021.		D.7.1 Develop links with Community Safety Partnerships and how the HWB can support the domestic violence agenda.
		D8			D.8.1 Ascertain contributors to and those unequally impacted by air pollution within Leicestershire
					D.8.2 Plan and deliver an informed engagement exercise with these target groups, communicating key messages around health risk, prevention and mitigation of harm.

			We will implement the Air Quality and Health action plan		D.8.3 Deliver an annual campaign around Clean Air Day to our population
					D.8.4 Investigate the relationship between air pollution and Children's hospital admissions within the county
					D.8.5 Upskill clinicians around the wider determinants of health and their impacts on respiratory/coronary health outcomes and health inequality
					See D1.3.
		D9	We will collaborate with the Leicestershire planning system and developers to explore a new approach to the design of our residential, employment and town centre environments to increases active travel, green infrastructure and reduction in motorised transport.		See D.4.1. Health and equity in all policies.
					See F4.
		D10	We will support families out of fuel poverty and into affordable warmth		D.10.1 Increase awareness of the First Contact Plus to ensure residents access the housing and fuel support they are eligible for.
					D.11.2 Consider links to Chief Housing Officers Group on fuel poverty.
		D11	We will review the health impacts of climate change to support wider environmental workstreams to embed a health lens into their approach.		D.11.1 Work with the National Institute of Health Research looking at creating a framework to capture co-benefits between Environment and Transport work and their outcomes and Public Health.
					D.12.2 Support work relating to Carbon Zero.
					D.12.3 develop link to biodiversity net gain work and requirement for consideration in planning approvals.
					See D.4.1.
Enabling healthy choices and environments	12. Smoking prevalence 13. successful completion of drug treatment - opiate users 14. Percentage of physically active adults 15. Percentage of adults classified as overweight or obese 16. Proportion of people eating 5 fruits and vegetables a day 17. Chlamydia detection rate 18. HIV Testing Coverage 19. Over 25 abortion rate 20. Percentage of adults who feel lonely often/always or some of the time 21. Fast food outlet density? 22. Cancer Screening - Breast Cancer 23. Cancer Screening - Cervical Cancer 24. Cancer Screening - Bowel Cancer 25. Percentage of cancers diagnosed at stages 1 and 2 26. Vaccination coverage - 27. Vaccination coverage - Flu aged 65+	E1	We will increase knowledge and access to prevention services through embedding Making Every Contact Count training and social prescribing approach across our collective workforce	Maintain and improve performance on smoking prevalence and substance misuse --- Reduced proportion of overweight/ obese adults and increased proportion of physical activity --- Improved access and uptake of five fruit and vegetables a day --- Improved Chlamydia detection and HIV testing rate --- Levelling and reversing the increasing trend in abortions for over 25's --- Reduction in loneliness, improvement in community cohesion and resilience Improved vaccination rates for Flu and Shingles, that are comparable to the areas with the best uptake rates in England --- Reversing the decline in cancer screening rates and more cancers diagnosed at Stages 1 and 2 --- Health Check coverage is on par with our ONS comparators in England --- Qualitative feedback that residents have improved knowledge and access to prevention services.	E.1.1 Embed MECC training across Leicestershire also to be delivered to support the Health and Equity in all policies work.
					E.1.2. Develop 3 conversations model across Adults and Communities linked to asset based commissioning.
					E.1.3. Continue to deliver active signposting training across primary care.
		E2	We will deliver targeted, effective and consistent health and wellbeing communications to empower Leicestershire to make healthy choices, including how to access services.		E.2.1. Maintain coordinated communication campaigns across Leicestershire to support healthy choices.
					E.2.2. Communication campaign regarding access to prevention services.
					E.2.3 Communicate with businesses as part of the development of the wider workplace health offer.
		E3	We will work with partners to deliver the Leicestershire Healthy Weight strategy, Food Plan and Active Together Partnership Physical Activity Framework		E.3.1 Support implementation of Leicestershire Healthy Weight and Food Plan including piloting a fast food policy.
					E.3.2. Support delivery of Active Together Partnership Physical Activity Framework
		E4	Through the Leicestershire Sexual Health Strategy, we will improve sexual health outcomes including chlamydia detection, HIV testing and combatting the increasing levels of abortion		E.4.1. Support implementation of the Leicestershire Sexual Health Strategy
					E.4.2. Investigate the reasons behind the trends in chlamydia detection rate and HIV testing with integrated sexual health provider.
					E.4.3. Review the increasing levels of abortion and termination of pregnancy pathway.
		E5	We will further develop the ABCD, strength-based approach to build social capital and strong, connected and resilient communities		E.5.1 TBC
					See D.4.
		E6	We will work with businesses to support enabling healthy choices through their shop/ supermarket		E.6.1 TBC
					See D.4.1. Health and equity in all policies.
		E7	We will work to further develop active travel across Leicestershire including a review of connected and walkable neighbourhoods and		E7.1 Develop stronger links between Environment and transport and public health to progress plans on connected, walkable, rural communities. (Links to 30minute neighbourhoods.)
					E7.2 Consider Healthy Schools Programme role in increasing active travel in children and young people.

	28. NHS Health checks		rural connectivity to understand how these impacts on healthy behaviour and environments		See D4.
					See E.3.2. Support delivery of Active Together Partnership Physical Activity Framework
		E8	We will work with planners and licensing officers to further build a healthy environment across Leicestershire reviewing fast food outlet and alcohol premise density		E.8.1 Develop link to Strategic Planning Group, Environmental Health and Licensing to progress discussion re fast food and alcohol licensing policy.
					See D.4.1. Health and equity in all policies.
		E9	We will invest in improving vaccination and screening rates (including cancer and health check coverage). This will include understanding the reasons for the decline in cancer screening rates and a targeted approach for those populations most at risk of premature		E.9.1 Review vaccination and screening uptake across Place and at neighbourhood level through Community Health and Wellbeing plan. Pilot completed with Charnwood PCN.
					E.9.2. Link to wider system work regarding vaccination and screening uptake, including health equity audits.
					E.9.3. Reviewing delivery of health checks across Leicestershire.

Living and Supported Well	Indicators for dashboard	Ref	Commitment	What does success look like?	Actions
Up Scaling Prevention and Self Care	1. Frailty collaborative measure: falls for people aged 65+ and falls in care homes 2. Fingertips hip fracture measures 3. BCF indicator/NHS OF: unplanned hospital admissions for chronic ambulatory care sensitive conditions 4: NHS OF: emergency admissions for acute conditions that should not require hospital admission Lucy Hulls to see if there is anything else from falls group that could be used here Christine Collingwood to see if there is a way to measure some of the asset based work in ASC John to advise on a measure looking at no. of people with 2 or less LTC's progressing into 5 or more	F1	We will empower patients to self-manage their long-term condition(s) through a variety of routes for different needs, including the use of expert patient programmes, social prescribing, digital approaches, assistive technology, accessible diagnostics and support.	Slowing the number of people who progress from living with 1 or 2 LTC's to 5 or more --- Qualitative feedback suggests multi-disciplinary, holistic care planning and self-management support packages that enable people to live well with long term conditions for longer, with less need for acute care --- An asset-based approach is taken to recognise and build on the strengths of individuals, families and communities --- Reduction in rates of falls across Leicestershire for people aged 65+, being on a par with the best performing authorities Reduction in rates of hip fractures across Leicestershire	F.1.1 Strengthen links between the HWB and frailty collaborative to support implementation of Leicestershire specific actions. F.1.2 Delivery of the Adults and Communities Strategy. See F2. F.1.3 Evolution of Integrated Neighbourhood Teams and role of care coordinators proactively identifying patients who require Care Plans as part of multidisciplinary working. F.1.4 Embedding different options for assistive technology including work through the Lightbulb such as assistive technology pilots to support individuals with a new diagnosis of dementia. F.1.5. Implement Technology Enabled Care (TEC) service across adult social care in Leicestershire County Council.
		F2	We will deliver the Adults and Communities strategy including building asset-based approaches to working with people and communities		F.2.1 Delivery of the Adults and Communities Strategy Including the development of asset based commissioning and the communities and wellbeing volunteering offer. F.2.2 Strengthen Carers Support Services. F.2.3 Review volunteering and voluntary sector support to building asset based approaches across Leicestershire. F.2.4. Deliver the adult and community learning programme through LALS. See E.1.2. Implement 3 conversations model across adults social Care in Leicestershire
		F3	We will reduce the number of falls that people over 65 experience, including people in residential and nursing care homes		F.3.1 Complete a mini needs assessment to look in more depth at the rates of hip fractures, causes for this and possible preventative measures. F.3.2 Scoping a self assessment tool for falls risk for 60+ with onward signposting and app to help manage balance F.3.3 Piloting of a falls crisis response service F.3.4 Reviewing Assistive technology services to support Falls Risk See F.1.
		F4	We will support the Adults and Communities Accommodation Strategies and Investment Strategy Prospectus to ensure people living with disability and long term conditions have access to the right housing, care and support		F.4.1. Implementation of the Adults and Communities Accommodation Strategies and Investment Prospectus. See F.1.4
		F5	We will work to improve access to health and care services including primary care and appropriate funding support		F.5.1. Support LLR action to improve access to primary care (system wide) and translate specifi
Effective management of frailty and complex care	5. BCF indicator/NHS OF: Unplanned admissions for chronic ambulatory care sensitive conditions 6. BCF indicator/NHS OF: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into rehab/reablement 7. BCF indicator: % of people discharged from acute to normal place of residence 8. BCF indicator: % of patients who have been an inpatient in acute for more than 14 and 21 days 9. Home First outcome: To ensure 95% of patients who are identified as vulnerable (eol, care home, frailty flag) have an agreed care plan by Dec 21	G1	We will build on the LLR Population Health Management framework and development programme, translating implications to Leicestershire to identify those at greatest risk of poor health outcomes including multiple hospital admissions	Early identification of patients at high risk of hospitalisation and social care needs using a Population Health Management approach --- Reduced numbers of hospital admissions for hip fractures and COPD -- Reduction in emergency bed days for those with 5 or more Long Term Conditions -- 95% of people identified as vulnerable have a co-produced care plan, which takes into account their wider needs e.g. multiple LTC's, social/psychological elements and carer arrangements --- Improved performance on the Better Care Fund metrics: reduced permanent admissions to residential and nursing care, increases in the number of people (aged 65+) still at home 91 days after discharge into rehabilitation/reablement services, reduction in delayed transfers of care from hospital	G.1.1 The care co-ordination service will work proactively with GP surgeries and PCN's. The service will fund co-ordinators (one for each PCN), using risk stratification data to identify those at highest risk of emergency admission in the next 18 months, frailty score of 5+ or those with 5 or more co morbidities and disabilities. G.1.2 Development of a frailty training strategy that will effect a cultural change in how we approach frailty more proactively. G1.3 Work to address Tier 1 of frailty toolkit (patients, carers, domiciliary care, care homes) to develop practical education aimed at enabling them to understand frailty, how to identify it, how to address it and who to approach for support. This is being developed via Carers delivery group and care homes sub group. G.1.4. Further development of MDT Framework and wider Integrated Neighbourhood Team (INT) working (operational elements of population health management.) G.1.5. Development of the strategic approach to population health management at neighbourhood level, aligning strategic work of the INT with the Community Health and Wellbeing Plans.

	10. Home First Outcome: to stabilise ED attends for complex patients at 19/20 levels 11. Home First Outcome: To increase 2 hour urgent community response compliance to 80% across all providers by April 22 12. BCF indicator: Res and nursing admissions: planned rate of 519 = 3% reductions from 19/20 rate of 536 13. Home First target: to increase 2 day reablement compliance to 80% across all providers by April 2022 John considering whether we can get a measure for reduction in emergency bed days for 5 or more LTC's	**G2** We will provide joined up services that support people and carers to live independently for as long as possible, including those with dementia. Supported by integrated health and social care workforce this will ensure that the patient sees the right person for your problem at the right time	services, reduction in delayed transfers of care from hospital and reduced non-elective admissions into hospital -- Improved patient satisfaction and coordination in complex care pathway and care coordination across the system especially for those with multimorbidity (5+ chronic conditions) --- Improved quality of life for carers --- Improved identification of people with moderate or severe frailty in the short term, followed by a reduction in the number of people with moderate or severe frailty as a result of proactive action	G.2.1 Annual review of f BCF schemes that are funded across CCG's and LCC Adult Social Care to ensure co-ordinated care and support is available to keep people living independently as long as possible. This includes services such as: care co-ordinators, home care, community response and reablement, integrated discharge hub and case management, the housing enablement scheme and therapy led D2A beds. G.2.4. Support delivery of the wider LLR workforce strategies such as the NHS People Plan, A&C strategy to ensure we have the capacity and capability in the health and care workforce to meet current and future needs. G.2.3 Delivery Transforming Care programme See F.2.2. regarding Carers services and E.1.2. re 3 conversation model in adult social care.
		G3 We will deliver an effective health and care integration programme that will deliver the Home First step up and step down approach for Leicestershire		G.3.1 Delivery of the Home First model of care including integrated teams for hospital discharge and reablement, operating on a "home first" philosophy that provides immediate support in the community and assesses ongoing need. The service will support people to step down after a stay in hospital or step up care at home when needs change or there is a G.3.2 Delivery of Joint Commissioning bed framework with Midlands and Lancashire. G.3.3 Delivery of Discharge to Access (D2A) Therapy beds. G.3.4 Increase the numbers or people able to benefit from reablement via HART Reablement. Key performance indicator is 87 starts per week. G.3.5 Increase in workforce within our Crisis Response Service G.3.6 Delivery of Community Hospital Link Workers
		G4 We will seek to develop a more qualitative, holistic approach to care planning and risk management, exploring ways in which this could be delivered by a wider range of professionals across Leicestershire through Integrated Neighbourhood Teams.		G.4.1 Holistic approach in case management function for adults social care. Links to G.1.1. G.4.2 Revision of Integrated personalised care framework. G.4.3. Implement Shared Care Record across health and social care in LLR. See G.1.1. Re care planning.
		G5 We will improve the quality and coverage of joined up care planning for the most vulnerable including strengthening care planning links across primary and secondary care to achieve 95% of the vulnerable population having a care plan in place		G.5.1 Delivery of several priority schemes are defined under the Home First Programme see G.3.1. G.5.2 Implementation of Integrated Case Management Function. Link to Shared Care Record G.4.3. See G.1.1. Re care planning.
		G6 We will continue to implement the LLR Carers strategy for Leicestershire and strengthen links with the LLR Carers Board.		G.6.1 Support implementation of the Leicestershire elements of the LLR Carers strategy. G.6.2. Strength links between the LLR Carers Board and Leicestershire HWB. G.6.3. Ensure health and wellbeing needs of carers are prioritised across the system. See L.2.4. Auditing the number of carers across key LLR anchor institutions.
		G7 We will work to measure and reduce the number of emergency bed days people with Long Term Conditions experience		See G.3.1 and G.5.1. re delivery of Home First. See G.1.1. and G.4.1. Re care planning and operational population health management. In particular patients that have 5-7 co morbidities.
		G8 We will offer a two hour crisis response for people that may otherwise need to attend hospital (target 80% by April 2022).		See G.3.1 and G.5.1. re delivery of Home First. G.8.2 Improved data reporting to reflect 2 hr response activity including implementation of new form and staff training G.8.3 Submit data through CSDS to NHS Digital for national reporting G.8.4 Workforce recruitment campaigns to increase the Crisis Response Service

		G9 We will reduce the number of permanent admissions to residential and nursing homes.	See G.2.1. RE BCF programmes. G.9.1 Increased brokerage resource for quicker point of care (POC) starts G.9.2 Maintain HC4L framework to improve access to care packages particularly within rural areas. G.9.3 Continued business analysis on the increase in demand for domiciliary care ensuring that this demand can be reached effectively within the community. See F.1.4. re housing adaptations and F.1.5. Implement Technology Enabled care (TEC) service
		G1 We will ensure eligible people receive reablement within 2 days of discharge	G.10.1 15% increase in HART service, funded through BCF. G.10.2 Target operating model implemented within HART to increase the numbers able to benefit from reablement to 87 starts per week. G.10.3 Ongoing recruitment campaigns to support increase in staffing numbers into reablement services - increasing overall capacity by circa 15%. Link to G.8.4. G.10.4 Reduce % of inappropriate patients referred to reablement services with improved triaging G.10.5 Effective use of Multi-Disciplinary Team approach to reablement, involving health and therapy partners to maximise independence and sustainability of individual progress. Link to G.1.1.

Dying Well	Indicators for dashboard	Ref	Commitment	What does success look like?	Actions
Understanding the need		H1	We will carry out a Joint Strategic Needs Assessment chapter looking at end of life specifically	Reduction in the percentage of deaths occurring inside of hospital, aiming to achieve LLR target of a maximum of 35% in adults aged 18 and over. -- Clear qualitative understanding of what 'dying well' looks like across Leicestershire and what support is needed to ensure this happens.	H.1.1 JSNA undertaken
		H2	We will seek to gather views from people to understand what dying well means to them and how this could be achieved		H.2.1 Engagement undertaken to understand people's views of what dying well looks like and how this could happen.
Effective transitions	1. Home First Outcome: To ensure 95% of patients who are identified as vulnerable (eol, care home, frailty flag) have an agreed care plan by Dec 21 2. No. of ReSPECT plans in place	I1	We will seek your views on what planning and services for late and end of life should look like and how you should be informed about your choices	Increased proportion of people planning for late stages and end of life at a time when they are still able. -- Qualitative feedback that people know and have support on what to expect and what choices are available to them. They have the time to consider and plan for these decisions and to discuss them with family, friends and carers should they wish.	See H.2.1. Engagement
		I2	We will ensure there is a clear transition in care planning from living with long term conditions into the later and end of life		I.1.2. Consider the roles of cemeteries, crematoriums and public health burials in wider end of life pathways. I.2.1 Ensure effective transition between living with several long term conditions and end of life. See G.1.1. re care planning and G.1.4. re MDT working.
		I3	We will ensure there is appropriate support for carers following the bereavement of a loved one so they can have a supportive transition into the next stage of their lives		I.3.1 To be informed by the new carers strategy (under development) and the JSNA on dying well. Link to H.1.1. and G6.
Normalising end of life planning	3. Home First Outcome: To ensure 95% of patients who are identified as vulnerable (eol, care home, frailty flag) have an agreed care plan by Dec 21 4. No. of ReSPECT plans in place 5. Home First Measure: to reduce deaths in hospital from 40% to 35% by April 2022 6. Place of death measure (i.e. home, hospital or residential care) Do we have any workforce measures we could use here? E.g. no of training places provided?	J1	We will offer care plans and ReSPECT plans to all vulnerable people with a take up target of 95%	Care plans offered to all vulnerable people that may benefit from having one with a target of 95%, this should include a ReSPECT plan -- High levels of take up with people specifically opting out of having a plan in place rather than being missed from the offer of one --	J.1.1. Workforce training to support care planning at the end of life to meet 95% take up of a care ReSPECT plan. Link to I.2.1.
		J2	We will use our better understanding of needs through the JSNA chapter to consider other aspects of end-of-life planning	Qualitative feedback that Leicestershire feels comfortable and supported to plan for the end of life.	J.2.1 Once the engagement activity has completed, we will consider the findings of this and the JSNA and produce an action plan for improvement if this is necessary.
		J3	We will develop a social marketing campaign based on insight to normalise end of life planning	End of life as everyone's business - an educated and compassionate workforce that can support people at the end of life. Care co-ordination for people in the last days and weeks of life operates well.	J.3.1 This will be considered once more is known about what people want from end of life planning and how they would like to receive communication (i.e. following the engagement)
		J4	We will educate our workforce so that everyone understands how to support people at end of life		J.4.1 Workforce training to support conversations regarding end of life planning and decision making.
		J5	We will improve co-ordination of care at end of life, as measured through patient feedback		J.5.1 Review end of life pathway following results of JSNA chapter and regularly review feedback to see if outcomes and coordination have been improved.

Reducing Health Inequalities	Indicators for dashboard	Ref	Commitment	What does success look like	Actions
	1. Healthy Life Expectancy - Males 2. Healthy Life Expectancy - Females 3. Life Expectancy at birth - Males 4. Life Expectancy at birth - Females 5. Inequality in Life Expectancy at birth - Males 6. Inequality at Life Expectancy at birth - Females 7. Any indicators suitable from health inequalities dashboard?	L1	We want equitable access, excellent experiences and optimal outcomes for all those using health and care services across Leicestershire. To do this we will embrace a proportionate universalism' approach where interventions are targeted to enable a 'levelling up' of the gradient in health outcomes. This means that although there will be a universal offer of services to all, there will be justifiable variation in services in response to differences in need within and between groups of people, that will aim to bring those experiencing poorer outcomes the opportunity to 'level up' to those achieving the best outcomes. (I.e. developing the national CORE20PLUS5 initiative.)		L.1.1. All services to consider a proportionate universalism approach tailored to the local need as appropriate, including regular Equalities Impact Assessments and Health Equity Audits on L.1.2 See actions L2 below L.1.3 See actions in L3 below. L.1.4. Review the specific needs of the military and veteran populations across LLR and identify recommendations to support delivery of the military Covenant.
		L2	We will translate the Leicester, Leicestershire and Rutland Health Inequalities framework for Leicestershire. This will include embedding a Health and Equity in all policies approach, utilising anchor institutions, training our leaders on health inequalities and ensuring we are collating data to analyse health inequalities effectively	Reduction in the slope index of inequality or 'levelling up' of the social gradient -- A greater rate of improvement in life and health life expectancy in the most deprived communities and vulnerable groups across Leicestershire (including those from specific ethnic or vulnerable groups and disabilities.)	L.2.1 Embed Health and Equity in all polices approach across Leicestershire to ensure health and inequalities are considered for all key strategic decisions across Leicestershire. See D.4.1. L.2.2 Implement Health inequalities training (including the LLR Inclusive Decision Making Framework) for all senior managers across Leicestershire. L.2.3 Support key public sector organisations to collect accurate data on the protected characteristics including ethnicity and disability. L.2.4. Key organisations to understand the scope and role of being anchor institutions in relations to reducing health inequalities and climate change. This may include an audit of carers across the L.2.5 Development of a LLR Health Inequalities Unit/ Population Health Management Unit.
		L3	Within the NHS we will also prioritise the five key clinical areas of health inequalities including early cancer diagnosis (screening & early referral), hypertension case finding, chronic respiratory disease (driving Covid & Flu vaccination uptake), annual health checks for people with serious mental illness and continuity of maternity carer plans .		L.3.1 Implementation of the CORE20PLUS5. Including specific interventions to reduce health inequalities aligned to the national priority areas of maternity, severe mental health, chronic respiratory illness, early cancer diagnosis and hypertension case L.3.2 Review of obesity pathway including the adult tier 3 weight management services across LLR. L.3.3 Further implementation of the CURE project to support stopping smoking during a hospital admission in LPT and UHL. L.3.4 Review of Health Check delivery model. See E.9.3.
		L4	We will review the health inequalities across Leicestershire in particular understanding the impact of Covid-19 on our most disadvantaged populations including those living in the most deprived areas or groups (including military and veterans, carers, those with a disability and LGBT+)		L4.1.1. Review of key health inequalities across Leicestershire following Covid -19 pandemic.

Improved Mental Health	Indicators for dashboard	Ref	Commitment	What does success look like	Actions
	1. Estimated prevalence of common mental disorders - 16+ 2. Estimated prevalence of common mental disorders - 65+ 3. Gap in employment rate for those in contact with secondary mental health services and the overall employment rate 4. Adults in contact with secondary mental health services who live in stable and appropriate accommodation 5. Loneliness: percentage of adults who feel lonley often/always or some of the time 6. Self reported wellbeing - people with a high anxiety score 7. Suicide rates 8. Hospital admissions for mental health conditions - under 18 years 9. Hospital admissions for as a result of self harm - 10-24 years 10. Estimated number of children and young people with mental disorders - aged 5-17 11. School pupils with social, emotional and mental helath needs - school age 12. Percentage of looked after children whose emotional wellbeing is a cause of concern - aged 5-16 13. Estimated Dementia diagnosis rate (65+)	K1	We will prioritise Mental Health on an equal basis to physical health in plans, investment and focus also considering the links between physical activity and good mental health and how mental health is linked to other conditions.	Increased proportions of Leicestershire experiencing good mental health and wellbeing. -- Qualitative feedback that good emotional health and wellbeing is actively promoted and supported across the county including for carers and that services are joined up and meeting patient's needs at the right time and place. -- Reduction in the proportion of people with mental health challenges that need intensive and specialist offers. -- Maintain rate suicide rates that are lower than the national average. -- Increase dementia diagnosis rates to meet NHSE target of 67% and clear links made between healthy lifestyle and the risk of dementia. -- To increase the proportions of people with mental health challenges that: o Access and take up high quality advice, support and access to local amenities, including activities and groups to strengthen mental health and wellbeing o Live as independently as possible o Be supported around their individual recovery goals o Access to education, employment, training and housing and are supported by their employer/ institution o Have easy and timely access to the right, local, coordinated service o Have their physical health needs monitored and key health / lifestyle needs supported o Have their carers and families caring and mental health needs identified and supported	K.1.1 - Joint commissioning of LLR Mental Health Wellbeing and recovery support service K.1.2 - Place Based Mental Health Multi-agency group to be established with the goal of providing cross-agency collaboration on mental health objectives K.1.3. Identifying the links between good mental health and physical activity. See E3.
		K2	We will seek to co-produce a Prevention Concordat for Better Mental health for Leicestershire to align organisations to further support mental health and wellbeing and prevent poor mental health		K.2.1 - Draft and implement a Prevention Concordat for Better Mental Health across Leicestershire
		K3	We will continue to focus on maintaining low rates of suicide and impact of suicide, supporting work of the LLR Suicide Strategy.		K.3.1 Implementation of the LLR suicide prevention strategy, translating and implementing the specific actions for Leicestershire. Link to Suicide Audit Prevention Group (SAPG).
		K4	We will continue to support the system work on children and young people's emotional health and well being		K.4.1 Implement the LLR Trauma Informed Practice Strategy K.4.2 Piloting Wellbeing App in secondary schools K.4.3 Implementation of emotional health and resilience elements of Healthy Schools work. K.4.4 Delivery of youth engagement activators programme K.4.5 Determine youth counselling/peer engagement programme of work
		K5	We will listen and respond to the Leicestershire population in the 'Step up to Great Mental Health' consultation and propose to deliver a variety of changes for our population through the LLR and Leicestershire specific Step up to Great Mental Health		K.5.1 Translate Leicestershire specific elements of feedback into JHWS delivery plan and also neighbourhood level community health and wellbeing plans. K.5.2 Establish Leicestershire specific mental health subgroup.
		K6	We would support key recommendations of the Dementia JSNA Chapter and LLR Dementia Strategy (due to be reviewed in 2022). This will include improving dementia diagnosis rates and ensuring clear links between healthy lifestyle and risk of dementia through MECC Plus and Health Checks		K.6.1 Support implementation of the Dementia JSNA chapter as part of the wider LLR Dementia Strategy

COVID-19 Recovery	Indicators for dashboard	Ref	Commitment	What does success look like	Actions
	1. Covid vaccination rates for D1, D2 and Boosters? 2.Hospital Admissions linked with Covid 3. Deaths due to Covid 4. ·No. of settings based outbreaks due to Covid 5.Long Covid numbers	M1	We will support our population to get timely access to the Covid-19 vaccinations that are appropriate to them	High uptake of the Covid-19 vaccination -- Reduction in hospitalisations and deaths due to Covid-19 -- Reduction in settings based outbreaks due to Covid-19 -- Numbers of people accessing support for Long Covid -- Patient feedback that health and care services are equipped to manage the Covid-19 in the longer term	M.1.1 Delivery of LLR Covid vaccination programme. Targeted work to meet the needs of MSOAs and groups with low uptake. M.1.2 Targeted communication campaigns to support increase in uptake and reduce myths about vaccination. M.1.3
		M2	We will ensure our health and care services are equipped to manage the impact of Covid-19 directly and indirectly for the longer term.		M.2.1 Services to regularly review business continuity plans in relation to Covid-19 pandemic including impact on the workforce. M.2.2 Services to consider the impact of the Covid pandemic, how services reopen and recovery in the longer term model of service delivery. Services recommissioned and redesigned as appropriate. M.2.3 Services supported by upper and lower tier local authorities through Covid funding as available and appropriate.
		M3	We will use the results from the Covid-19 Impact Assessment to target specific interventions and vulnerable groups throughout the wider		M.3.1 Review the results of the Covid-19 impact assessment and implement specific interventions and support as needed.
		M4	We will support Leicestershire to live with Covid-19 circulating within our population in the longer term.		M.4.1 See M.2.2. M.4.2 Understand the impact of long Covid-19 and review services available to support people living with long Covid-19.
		M5	We will ensure we maintain a collaborative health protection approach and response ready for future Covid-19 surges or other future pandemics.		M.5.1 Establishment and maintenance of partnership working through Outbreak Control Meetings and Incident Management Team as needed to respond to Covid-19 and future health protection incidents. This includes linking into organisation recovery groups and LLR Prepared cells. M.5.2 Regular review and update of Local Outbreak Management Plan

Appendix D

Leicestershire Joint Health and Wellbeing Strategy

(2022-2032)

Performance Dashboards

Updated: February 2022

For more information, please contact Public Health Intelligence on phi@leics.gov.uk
Produced by Business Intelligence Service
Updated February 2022

Leicestershire Joint Health and Wellbeing Strategy - Best Start for Life (1)

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

	Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
	E01 - Infant mortality rate	P	<1 yr	2018 - 20	3.3	6/15	1.9	5.1	3.9	▬	●
1001 Critical Days	A&E attendances (under 1 year)	P	<1 yr	2018/19	1,162.1	16/16	499.0	1,162.1	957.4	▲	●
		F	<1 yr	2018/19	1,061.5	16/16	443.9	1,061.5	873.0	▬	●
		M	<1 yr	2018/19	1,251.7	16/16	550.8	1,251.7	1,028.8	▬	●
	C04 - Low birth weight of term babies	P	>=37 weeks g..	2020	2.2	6/16	2.0	2.9	2.9	▶	●
	C06 - Smoking status at time of delivery	F	All ages	2020/21	10.5	9/16	6.8	13.8	9.6	▶	●
	C07 - Proportion of New Birth Visits (NBVs) completed within ..	P	<14 days	2020/21	86.8	11/16	97.3	78.2	88.0	▬	●
	Caesarean section %	F	All ages	2019/20	31.8	13/16	25.2	32.5	30.1	▬	●
	D03c - Population vaccination coverage - Dtap / IPV / Hib (1 ye..	P	1 yr	2020/21	96.3	2/16	96.3	93.8	92.0	▼	●
	Neonatal mortality and stillbirth rate	P	<28 days	2019	5.8	12/16	3.9	9.9	6.6	▶	●
School Readiness	B02a - School readiness: percentage of children achieving a good level of development at the end of Reception	P	5 yrs	2018/19	72.1	6/16	77.0	70.5	71.8	▲	●
		F	5 yrs	2018/19	78.6	8/16	83.1	77.3	78.4	▲	●
		M	5 yrs	2018/19	65.7	8/16	71.2	62.7	65.5	▲	●
	B02a - School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception	P	5 yrs	2018/19	48.7	15/16	57.6	47.5	56.5	▲	●
		F	5 yrs	2018/19	57.5	13/16	65.4	56.0	64.5	▶	●
		M	5 yrs	2018/19	40.1	14/16	50.7	37.9	48.9	▶	●
	C08a - Child development: percentage of children achieving a ..	P	2-2.5 yrs	2020/21	70.3	15/15	91.6	70.3	82.9	▬	●
	C09a - Reception: Prevalence of overweight (including obesity)	P	4-5 yrs	2019/20	19.0	3/15	18.6	26.1	23.0	▼	●
	C09b - Year 6: Prevalence of overweight (including obesity)	P	10-11 yrs	2019/20	30.6	4/15	28.8	33.8	35.2	▶	●
	C08b - Child development: percentage of children achieving th..	P	2-2.5 yrs	2020/21	78.3	14/15	95.4	74.0	86.8	▬	●
	C08c - Child development: percentage of children achieving th..	P	2-2.5 yrs	2020/21	78.8	14/14	97.1	78.8	90.2	▬	●

Statistical Significance compared to England or Benchmark: Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel: Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

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Leicestershire Joint Health and Wellbeing Strategy - Best Start for Life (2)

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

	Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Preparing for Life	28 - Average Attainment 8 score	P	15-16 yrs	2019/20	50.7	7/16	52.5	48.5	50.2	▬	●
	A&E attendances (<18)	P	<18 yrs	2018/19	435.8	15/16	277.3	478.1	422.2	▲	●
		F	<18 yrs	2018/19	413.1	15/16	263.7	458.4	395.8	▬	●
		M	<18 yrs	2018/19	457.1	14/16	290.4	497.0	442.1	▬	●
	A&E attendances aged under 5 years old, crude rate	P	0-4 yrs	2017/18 - 19/..	683.2	15/15	383.2	683.2	642.5	▬	●
	B05 - 16-17 year olds not in education, employment or training (NEET) or whose activity is not known	P	16-17 yrs	2020	4.7	9/16	3.2	13.8	5.5	▶	●
		F	16-17 yrs	2020	3.3	5/16	2.4	11.7	4.6	▶	●
		M	16-17 yrs	2020	4.6	7/16	3.6	13.8	6.3	▶	●
	C02a - Under 18s conception rate / 1,000	F	<18 yrs	2019	13.3	9/15	10.0	16.1	15.7	▶	●
	Children in care	P	<18 yrs	2020	46.0	3/16	34.0	72.0	67.0	▲	●
	Hospital admissions as a result of self-harm (10-24 years)	P	10-24 yrs	2019/20	255.7	1/16	255.7	905.7	439.2	▼	●
		F	10-24 yrs	2019/20	404.7	1/16	404.7	1,466.7	694.8	▶	●
		M	10-24 yrs	2019/20	120.5	1/16	120.5	387.1	196.6	▶	●
	School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs	P	Primary schoo..	2020	2.3	7/16	1.6	3.1	2.4	▲	●
			School age	2020	2.2	3/16	1.9	3.3	2.7	▲	●
			Secondary sch..	2020	2.1	3/16	1.7	3.4	2.7	▲	●
	D04e - Population vaccination coverage - HPV vaccination coverage for one dose (12-13 years old)	F	12-13 yrs	2019/20	84.7	4/16	94.8	2.6	59.2	▼	●
		M	12-13 yrs	2019/20	78.7	5/16	88.5	2.0	54.4	▬	●

Statistical Significance compared to England or Benchmark: Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel: Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated February 2022

Leicestershire Joint Health and Wellbeing Strategy - Best Start For Life (3)

Priority	Indicator	Time period	Polarity	Leicestershire value	National or benchmark value	Unit	Comments	Direction of travel since last time period
School readiness	Percentage of 2 year old children benefitting from funded early education	Dec-21	High	77.6	Null	%	Null	↑
	Percentage of pupils with SEN or EHC Plan (Primary)	2021	Low	2.2	2.1	%	Higher than national	↑
Preparing for Life	Covid vaccination uptake 12-15 year olds - Dose 1	Jan-22	High	59.9	53.8	%	Higher than national	●
	Covid vaccination uptake 16-17 year olds - Dose 1	Jan-22	High	76.5	66.6	%	Higher than national	●
	Emergency admissions for children with lower respiratory tract infections (LRTIs)	19/20	Low	375.5	504.7	rate per 100,000 pop	Lower than national	↓
	Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under	19/20	Low	29	388.0	rate per 100,000 pop	Lower than national	↑
	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	19/20	Low	209.5	269.8	rate per 100,000 pop	Lower than national	↑

Direction of travel Key:

- ↓ Decrease
- ↑ Increase
- ● N/A

Produced by Business Intelligence Service. Updated February 2022.

Leicestershire Joint Health and Wellbeing Strategy - Staying Healthy, Safe and Well (1)

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

	Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Building Strong Foundations	B06b - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	P	18-69 yrs	2020/21	46.0	12/15	81.0	25.0	58.0	–	Worse
		F	18-69 yrs	2020/21	48.0	12/15	83.0	25.0	59.0	–	Worse
		M	18-69 yrs	2020/21	45.0	12/15	78.0	25.0	56.0	–	Worse
	B09b - Sickness absence - the percentage of working days lost due to sickness absence	P	16+ yrs	2018 - 20	1.0	9/16	0.6	1.5	1.0	–	Similar
	B15a - Homelessness - households owed a duty under the Homelessness Reduction Act	P	Not applicable	2020/21	6.8	4/15	4.6	13.3	11.3	–	Better
	Child Poverty, Income deprivation affecting children index (IDACI)	P	<16 yrs	2019	10.6	4/15	9.9	15.5	17.1	–	Better
	Percentage of adults walking for travel at least three days per week	P	16+ yrs	2019/20	11.7	10/16	15.4	10.4	15.1	–	Worse
	Air pollution: fine particulate matter	N/A	Not applicable	2020	6.5	9/16	4.9	7.3	6.9	–	Not compared
Building Strong Foundations	B08c - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	P	18-69 yrs	2019/20	74.5	14/16	45.9	75.4	67.2	–	Worse
		F	18-69 yrs	2019/20	70.7	15/16	40.4	71.5	61.2	–	Worse
		M	18-69 yrs	2019/20	77.4	13/16	51.7	79.5	72.2	–	Worse
	B08d - Percentage of people in employment	P	16-64 yrs	2020/21	76.9	7/15	79.3	72.6	75.1	▶	Similar
		F	16-64 yrs	2020/21	74.2	7/15	78.5	68.6	71.8	▶	Similar
		M	16-64 yrs	2020/21	79.5	10/15	84.7	75.0	78.5	▶	Similar
	B12b - Violent crime - violence offences per 1,000 population	P	All ages	2020/21	22.3	9/15	18.7	33.6	29.5	▲	Not compared
	B17 - Fuel poverty (low income, high cost methodology)	N/A	Not applicable	2018	9.4	6/16	6.8	10.7	10.3	▶	Not compared
	Percentage of adults cycling for travel at least three days per ..	P	16+ yrs	2019/20	2.3	4/16	7.4	1.0	2.3	–	Similar

Statistical Significance compared to England or Benchmark: Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel: ▼ Decreasing, ▼ Decreasing and getting better, ▼ Decreasing and getting worse, ▲ Increasing, ▲ Increasing and getting better, ▲ Increasing and getting worse, ▶ No significant change, – Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated February 2022

Leicestershire Joint Health and Wellbeing Strategy - Staying Healthy, Safe and Well (2)

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

	Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
	C19a - Successful completion of drug treatment - opiate users	P	18+ yrs	2020	6.7	3/16	9.5	4.0	4.7	▶	●
	C24a - Cancer screening coverage - breast cancer	F	53-70 yrs	2021	64.9	11/15	73.1	58.7	64.1	▼	●
	C26b - Cumulative percentage of the eligible population aged ..	P	40-74 yrs	2016/17 - 20/..	49.8	5/16	62.2	33.2	46.5	–	●
	Over 25s abortion rate / 1000	F	25+ yrs	2020	14.1	6/16	12.1	19.2	17.6	▲	●
Enabling Healthy Choices and Environments	B19 - Loneliness: Percentage of adults who feel lonely often / ..	P	16+ yrs	2019/20	21.1	8/15	17.0	24.2	22.3	–	●
	C15 - Proportion of the population meeting the recommended ..	P	16+ yrs	2019/20	57.0	10/15	61.3	53.2	55.4	–	●
	C16 - Percentage of adults (aged 18+) classified as overweigh..	P	18+ yrs	2019/20	62.7	8/15	56.3	66.8	62.8	–	●
	C17a - Percentage of physically active adults	P	19+ yrs	2019/20	67.6	12/15	73.0	66.1	66.4	–	●
	C18 - Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition)	P	18+ yrs	2020	9.3	2/15	8.0	13.7	12.1	–	●
		F	18+ yrs	2020	7.1	2/15	6.7	12.9	10.4	–	●
		M	18+ yrs	2020	11.5	3/15	9.4	15.7	13.8	–	●
	C21 - Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published.	P	All ages	2020/21	403.7	5/14	343.3	586.7	455.9	▶	●
		F	All ages	2020/21	318.1	6/14	223.7	515.0	321.9	▶	●
		M	All ages	2020/21	500.4	3/14	476.0	712.4	603.2	▶	●
	C24b - Cancer screening coverage - cervical cancer (aged 25 to ..	F	25-49 yrs	2021	74.2	5/15	78.2	66.2	68.0	▶	●
	C24d - Cancer screening coverage - bowel cancer	P	60-74 yrs	2021	70.4	3/15	71.1	62.2	65.2	▲	●
	D02a - Chlamydia detection rate / 100,000 aged 15 to 24	P	15-24 yrs	2020	1,129.9	9/15	1,583.5	588.2	1,408.4	▼	●
	D06a - Population vaccination coverage - Flu (aged 65+)	P	65+ yrs	2020/21	83.5	11/16	85.4	80.1	80.9	▲	●
	D06c - Population vaccination coverage – Shingles vaccination..	P	71	2019/20	48.8	11/16	56.7	41.7	48.2	–	●
	HIV testing coverage, total (%)	P	All ages	2020	42.6	5/15	61.2	22.1	46.0	▶	●

Statistical Significance compared to England or Benchmark: Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel: Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated February 2022

Leicestershire Joint Health and Wellbeing Strategy - Staying Healthy, Safe and Well (3)

Priority	Indicator	Time period	Polarity	Leicestershire value	National or benchmark value	Unit	Comments	Direction of travel since last time period
Building Strong Foundations	Hate Incidents recorded	Nov 20 to Dec 21	Low	1492	Null	Null	Null	
Enabling Healthy Choices and Environments	Vaccination coverage - Covid - 12+ Booster and Dose 3	Jan-22	High	66.9	64.5	%	Higher than national	
	Vaccination coverage - Covid - 12+ Dose 1	Jan-22	High	87	91.0	%	Lower than national	
	Vaccination coverage - Covid - 12+ Dose 2	Jan-22	High	82	83.9	%	Lower than national	

Direction of travel Key:

Produced by Business Intelligence Service. Updated February 2022.

Leicestershire Joint Health and Wellbeing Strategy - Living and Supported Well (1)

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Up Scaling Prevention and Self Care										
C29 - Emergency hospital admissions due to falls in people aged 65 and over	P	65+ yrs	2020/21	1,640.6	1/15	1,640.6	2,279.8	2,023.0	▶	
	F	65+ yrs	2020/21	1,864.3	1/15	1,864.3	2,595.6	2,284.8	▶	
	M	65+ yrs	2020/21	1,366.9	2/15	1,342.3	1,865.4	1,667.3	▶	
E13 - Hip fractures in people aged 65 and over	P	65+ yrs	2020/21	671.8	14/15	472.7	686.7	528.7	▶	
	F	65+ yrs	2020/21	804.2	14/15	567.9	842.3	638.0	▶	
	M	65+ yrs	2020/21	483.1	15/15	329.3	483.1	378.9	▶	
E14 - Excess winter deaths index	P	All ages	Aug 2019 - Jul 2020	17.4	12/15	12.6	24.7	17.4	▬	
	F	All ages	Aug 2019 - Jul 2020	17.4	10/15	8.8	25.3	17.3	▬	
	M	All ages	Aug 2019 - Jul 2020	17.3	9/15	12.0	26.4	17.5	▬	

Statistical Significance compared to England or Benchmark: Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel: Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated February 2022

Leicestershire Joint Health and Wellbeing Strategy - Living and Supported Well (2)

Priority	Indicator	Time period	Polarity	Leicestershire value	National or benchmark value	Unit	Comments	Direction of travel since last time period
Up Scaling Prevention and Self Care	emergency admissions for acute conditions that should not require hospital admission	19/20	Low	1193.8	1409.4	rate per 100,000 pop	Lower than national	↓
	Number of people with 1-4 LTC's registered with a practice situated in the County	Jan-22	N/a	299807	Null	Count	Null	●
	Number of people with 5 or more LTC's registered with a practice situated in the County	Jan-22	Low	68088	Null	Count	Null	●
	Number of people with no LTC's registered with a practice situated in the County	Jan-22	High	317739	Null	Count	Any change will be long term	●
Effective management of frailty and complex care	BCF indicator: Res and nursing admissions of people aged 65+	2020/21	N/a	528.7	498.2	rate per 100,000 pop	Null	●
	BCF indicator/NHS OF: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into rehab/reablement	2020/21	High	84.7	79.0	%	Null	●
	Home First Outcome: 2 hour urgent community response compliance	Y2D Apr-Nov 2021/22	High	69.3	80.0	%	Value for LLR, not Leicestershire County	↑
	Home First target: 2 day reablement compliance	Y2D Apr-Nov 2021/22	High	83.2	80.0	%	Value for LLR, not Leicestershire County	↑

Direction of travel Key:

↓ Decrease

↑ Increase

● N/A

Produced by Business Intelligence Service. Updated February 2022.

Leicestershire Joint Health and Wellbeing Strategy - Dying Well

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Normalising end of life care plan										
Percentage of deaths that occur at home	P	All ages	2020	30.2	14/15	24.7	32.0	27.4	▲	
Percentage of deaths that occur in care homes	P	All ages	2020	24.0	4/15	21.2	31.2	23.7	▶	
Percentage of deaths that occur in hospital	P	All ages	2020	39.7	10/15	34.0	46.6	41.9	▼	

Statistical Significance compared to England or Benchmark:
Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel:
Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated February 2022

Leicestershire Joint Health and Wellbeing Strategy - Cross Cutting Theme: Mental Health

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
B06b - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	P	18-69 yrs	2019/20	48.0	11/16	81.0	30.0	58.0	▬	
	F	18-69 yrs	2020/21	48.0	13/16	83.0	25.0	59.0	▬	
	M	18-69 yrs	2020/21	45.0	13/16	78.0	25.0	56.0	▬	
B08c - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	P	18-69 yrs	2019/20	74.5	14/16	45.9	75.4	67.2	▬	
	F	18-69 yrs	2019/20	70.7	15/16	40.4	71.5	61.2	▬	
	M	18-69 yrs	2019/20	77.4	13/16	51.7	79.5	72.2	▬	
B19 - Loneliness: Percentage of adults who feel lonely often / ..	P	16+ yrs	2019/20	21.1	8/15	17.0	24.2	22.3	▬	
C12 - Percentage of looked after children whose emotional we..	P	5-16 yrs	2019/20	35.9	4/16	25.8	52.7	37.4	▼	
C28d - Self-reported wellbeing - people with a high anxiety sco..	P	16+ yrs	2020/21	22.5	8/15	20.4	26.3	24.2	▬	
E10 - Suicide rate	P	10+ yrs	2018 - 20	8.4	1/15	8.4	14.3	10.4	▬	
	F	10+ yrs	2018 - 20	4.7	6/15	3.6	7.1	5.0	▬	
	M	10+ yrs	2018 - 20	12.2	1/15	12.2	22.6	15.9	▬	
E15 - Estimated dementia diagnosis rate (aged 65 and over)	P	65+ yrs	2021	61.2	5/16	67.7	50.5	61.6	▶	
Estimated number of children and young people with mental d..	P	5-17 yrs	2017/18	12,440..	7/16	9,914.4	27,062.5	Null	▬	
Estimated prevalence of common mental disorders: % of popu..	P	16+ yrs	2017	13.7	2/16	13.5	16.2	16.9	▬	
Estimated prevalence of common mental disorders: % of popu..	P	65+ yrs	2017	8.6	3/16	8.5	10.2	10.2	▬	
Hospital admissions for mental health conditions	P	<18 yrs	2019/20	109.3	13/16	51.3	139.4	89.5	▲	
	F	<18 yrs	2019/20	138.1	12/16	52.9	184.0	111.2	▲	
	M	<18 yrs	2019/20	82.1	13/16	49.6	96.7	68.7	▲	
School pupils with social, emotional and mental health needs: ..	P	School age	2020	2.2	3/16	1.9	3.3	2.7	▲	
Hospital admissions as a result of self-harm (10-24 years)	P	10-24 yrs	2019/20	255.7	1/16	255.7	905.7	439.2	▼	
	F	10-24 yrs	2019/20	404.7	1/16	404.7	1,466.7	694.8	▶	
	M	10-24 yrs	2019/20	120.5	1/16	120.5	387.1	196.6	▶	

Statistical Significance compared to England or Benchmark:
Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel:
▼ Decreasing, ▼ Decreasing and getting better, ▼ Decreasing and getting worse, ▲ Increasing, ▲ Increasing and getting better, ▲ Increasing and getting worse, ▶ No significant change, ▬ Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated February 2022

Leicestershire Joint Health and Wellbeing Strategy - Cross Cutting Theme: Health Inequalities

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
A01a - Healthy life expectancy at birth	F	All ages	2017 - 19	63.6	12/16	69.4	61.3	63.5		
	M	All ages	2017 - 19	63.5	11/16	68.2	61.1	63.2		
A01b - Life expectancy at birth	F	All ages	2018 - 20	84.1	8/15	84.9	82.6	83.1		
	M	All ages	2018 - 20	80.5	6/15	81.5	79.2	79.4		
A02a - Inequality in life expectancy at birth	F	All ages	2018 - 20	4.9	3/15	4.3	7.8	7.9		
	M	All ages	2018 - 20	6.0	2/15	5.7	9.3	9.7		

Statistical Significance compared to England or Benchmark: Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel: Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated February 2022

Leicestershire Joint Health and Wellbeing Strategy - Cross Cutting Theme: COVID Recovery

Priority	Indicator	Time period	Polarity	Leicestershire value	National or benchmark value	Unit	Comments	Direction of travel since last time period
Covid Recovery	Covid Vaccination Uptake - Dose 1 age 12+	Jan-22	High	87	91.0	%	Lower than national	
	Covid Vaccination Uptake - Dose 2 age 12+	Jan-22	High	82	83.9	%	Lower than national	
	Covid Vaccination Uptake - Boosters age 12+	Jan-22	High	66.9	64.5	%	Higher than national	
	Percentage worried about their economic wellbeing - Community Insight Survey	Q3 2021 to Q2 2022	Low	34.9	Null	%	Null	
	Total deaths due to covid since start of pandemic	Week 3 2022	Low	1823	135509.0	Count	Null	
	Total Excess deaths (occurrences) since start of pandemic	Week 3 2022	Low	1494	113527.0	Count	Null	
	Total Hopital Admissons since start of pandemic	Week 3 2022	Low	4585	595998.0	Count	Null	

Direction of travel Key:

Produced by Business Intelligence Service. Updated February 2022.

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Appendix E

Equality & Human Rights Impact Assessment (EHRIA)

This Equality and Human Rights Impact Assessment (EHRIA) will enable you to assess the **new, proposed or significantly changed** policy/ practice/ procedure/ function/ service** for equality and human rights implications.

Undertaking this assessment will help you to identify whether or not this policy/ practice/ procedure/ function/ service** may have an adverse impact on a particular community or group of people. It will ultimately ensure that, as an Authority, we do not discriminate and we are able to promote equality, diversity and human rights.

Please refer to the EHRIA guidance before completing this form. If you need any further information about undertaking and completing the assessment, contact your Departmental Equalities Group or equality@leics.gov.uk

***Please note: The term 'policy' will be used throughout this assessment as shorthand for policy, practice, procedure, function or service.*

Key Details	
Name of policy being assessed:	Leicestershire Joint Health and Wellbeing Strategy
Department and section:	Public Health – Partnership Strategy led by Health and Wellbeing Board
Name of lead officer/ job title and others completing this assessment:	Vivienne Robbins – Public Health Consultant Sally Vallance – Senior Planning Manager Leicester, Leicestershire and Rutland CCG's Jo Hewitt – Health and Wellbeing Board Manager
Contact telephone numbers:	0116 3055384
Name of officer/s responsible for implementing this policy:	Leicestershire Health and Wellbeing Board Members and partner organisations
Date EHRIA assessment started:	December 2021

Date EHRIA assessment completed:	

Section 1: Defining the policy

Section 1: Defining the policy
You should begin this assessment by defining and outlining the scope of the policy. You should consider the impact or likely impact of the policy in relation to all areas of equality, diversity and human rights as outlined in Leicestershire County Council's Equality Strategy.

1	*What is new or changed in the policy? What has changed and why?* The Leicestershire Joint Health and Wellbeing Strategy (JHWS) is a statutory responsibility of the local authority and clinical commissioning group as part of the work of the Health and Wellbeing Board (HWB). The current strategy is due to expire in 2022 and as a result work to prepare the new strategy is underway. The timeframe has been brought forward align with the Integrated Care Systems (ICS) responsibilities for a 'Place Led Plan' which examines the health needs of the County population and allows development of one clear vision for Leicestershire. The strategy is being developed through a review of need, using quantitative data, engagement findings and service feedback to identify where the greatest need, weaker performance and health inequalities exist. It also takes account of the policy framework and priorities locally and nationally as part of the ICS. These will all help to inform the priorities selected in the strategy. As a 10 year strategy, it goes on to propose a set of strategic commitments to address these priorities. It is likely that the strategy will influence changes to a range of health and care services, resource allocation and policy over the next 10years. As these are planned for, an EHRIA will be completed by the lead agency for the specific change as necessary.
2	*Does this relate to any other policy within your department, the Council or with other partner organisations? If yes, please reference the relevant policy or EHRIA. If unknown, further investigation may be required.* The JHWS is an umbrella strategy that makes reference to and draws from other strategies within the Council and partner organisations. No changes to these are occurring at this time but changes are expected in the future, influenced by the JHWS. As these changes occur, an EHRIA will be completed if necessary.
3	*Who are the people/ groups (target groups) affected and what is the intended*

	change or outcome for them? The new strategy will have a potential impact on all people living in Leicestershire as it looks at need during all life stages (from pre-birth through to death). This will include people from all the protected characteristics and geographical areas across Leicestershire. The intention of the strategy is to 'give everyone in Leicestershire the opportunity to thrive and live happy, health lives.' Some of the actions to achieve this will be applicable to all residents of Leicestershire whilst others will be targeted at specific cohorts where they have poorer outcomes. The intention will be to reduce health inequalities and to improve the quality of health for all Leicestershire residents. A proportionate universalism approach is proposed as part of the cross cutting theme to reduce health inequalities across Leicestershire. Due to the finite resources across the health and care system, it is possible that the strategy will lead to other changes (commissioning/decommissioning decisions, changes in policy or practice and re-allocation of resources). It is possible that these changes could draw focus, service or funds away from existing causes and towards the new priorities depending on the evidence base and local need. Where this is the case, an EHRIA would be undertaken to inform the decision at the time. Collaboration and engagement with the local population will also be a key element of the strategy delivery and work of the evolving HWB.
4	Will the policy meet the Equality Act 2010 requirements to have due regard to the need to meet any of the following aspects? **(Please tick and explain how)**

	Yes	**No**	**How?**
Eliminate unlawful discrimination, harassment and victimisation	Yes		It is possible that health inequalities are arising as a result of unlawful discrimination, harassment and victimisation. If this is identified as part of the work to develop or implement the strategy, then this will be highlighted, and action taken as necessary.
Advance equality of opportunity between different groups	Yes		The strategy has a clear cross cutting theme to improve healthy life expectancy and reduce health inequalities between different groups across Leicestershire. Through identifying where inequality is occurring, the strategy will then focus key partners on addressing this through specific actions in the delivery plan. The partnership approach allows for the sharing of knowledge, information and successes and provides a focused approach to tackling some of the harder issues to address. The delivery plan will also be regularly reviewed and evaluated throughout the life span of the strategy.
Foster good relations	Yes		Much of the work identified in the strategy involves communities, neighbourhoods,

	between different groups			existing services and volunteers. These are all vital in fostering good relationships between different groups and the collective focus on addressing health inequalities should be embedded in the promotion of good relationships and community support for all, with a proportionate universalism approach ensuring additional support is provided for those most in need. There are also clear commitments within the strategy regarding building strong communities, resilience and social capital amongst communities.

Section 2: Equality and Human Rights Impact Assessment (EHRIA) Screening

Section 2: Equality and Human Rights Impact Assessment Screening
The purpose of this section of the assessment is to help you decide if a full EHRIA is required.

If you have already identified that a full EHRIA is needed for a policy/ practice/ procedure/ function/ service, either via service planning processes or other means, then please go straight to Section 3 on Page 7 of this document.

Section 2 **A: Research and Consultation**			
5.	Have the target groups been consulted about the following?	**Yes**	**No ***
	a) their current needs and aspirations and what is important to them;	**Yes**	
	b) any potential impact of this change on them (positive and negative, intended and unintended);		**No**
	c) potential barriers they may face		**No**
6.	If the target groups have not been consulted directly, have representatives been consulted or research explored (e.g. Equality Mapping)? Eg carers equalities meeting	**Yes**	
7.	Have other stakeholder groups/ secondary groups (e.g. carers of service users) been explored in terms of potential unintended impacts?	**Yes**	
8.	*If you answered 'no' to the questions above, please use the space below to outline either what consultation you are planning to undertake or why you do not consider it to be necessary.		

	The draft JHWS was approved for formal consultation at the HWB in November 2021. This consultation will remain open until the 23rd January 2022 is available at the link below. https://www.leicestershire.gov.uk/have-your-say/current-engagement/joint-health-and-wellbeing-strategy As part of this consultation demographic data on the person's characteristics are reported and used to review the communication approach for the consultation. (For example, targeting more males and younger people or those from specific ethnic minorities to reply.) Further support is also available for in terms of an easy read version, video introduction and access to a paper copy of the survey. The survey has been shared with over 150 partners for further discussion with the staff and wider organisations. To reach our local communities the survey has been published on social media and the Local Area Coordinators across Leicestershire are also proactively taking the consultation out to local seldom heard communities. The strategy will also be presented at some wider stakeholder meetings such as the LLR Carers Group and Leicestershire Equalities Challenge Group.

Section 2 **B: Monitoring Impact**			
9.	Are there systems set up to:	**Yes**	**No**
	a) monitor impact (positive and negative, intended and unintended) for different groups;	**Yes**	
	b) enable open feedback and suggestions from different communities	**Yes**	
Note: If no to Question 9, you will need to ensure that monitoring systems are established to check for impact on the protected characteristics.			

Section 2 **C: Potential Impact**				
10.	Use the table below to specify if any individuals or community groups who identify with any of the 'protected characteristics' may ***potentially*** be affected by the policy and describe any positive and negative impacts, including any barriers.			
		Yes	**No**	**Comments**
	Age	**Yes**		The strategy talks about different life stages which often (not always) reflects different age groups. It also uses some indicators which are reflective of certain ages e.g. hip fractures in over 65's. The commitments differ according to these life stages and therefore the impact will be different according to which life stage you are at. However, the overall outcome of the strategy is to improve health life expectancy and reduce health inequalities for all people of all ages in Leicestershire.

	Disability	**Yes**		The strategy makes reference to people with long term conditions (LTC's), some of which will be the cause of a disability. The strategy makes commitments to people with LTC's to improve the way we prevent deterioration, support and treatment throughout our system. The strategy also makes reference to CYP with a learning disability where we understand there is a need to provide additional support as they transition into adulthood. Evidence has also shown that people with learning disabilities have worse outcomes than the general population with regards to life expectancy and Covid related hospitalisations and deaths and that targeted work is therefore required to address this inequality.
	Gender Reassignment	**Yes**		As the strategy affects all people in Leicestershire, there will be people with this protected characteristic that are impacted by the strategy. No specific impact is identified for this group, but further detail may be found through specific service EHRIA throughout the strategy.
	Marriage and Civil Partnership	**Yes**		As the strategy affects all people in Leicestershire, there will be people with this protected characteristic that are impacted by the strategy. No specific impact is identified for this group.
	Pregnancy and Maternity	**Yes**		The strategy makes specific reference to pregnancy and maternity in the 'Best Start for Life' priority 1,001 critical days. It will therefore be examining areas for improvement in health outcomes and making commitments to this group to take the priorities forward for example supporting maternal mental health, breastfeeding support etc.
	Race	**Yes**		Although the strategy does not directly refer to specific racial groups, we do know that some inequalities and health issues are more prevalent in certain racial groups. There is also evidence that some of these inequalities have been exasperated through the Covid-19 pandemic, for example poorer health outcomes have been seen in the Black and Asian ethnic groups. It is likely therefore that targeted work on certain conditions as highlighted through commitments in this strategy will lead to a re-focus of service delivery that will impact on racial groups differently. As services are reconfigured/re-commissioned, EHRIA's will be completed as necessary to identify the specific impact involved and mitigate any negative impacts where possible.
	Religion or Belief	**Yes**		As the strategy affects all people in Leicestershire, there will be people with this protected characteristic that are impacted by the strategy. No specific impact is identified for this group.
	Sex	**Yes**		Although the strategy does not directly refer to sex (other than when linked to pregnancy and maternity), we do know that some inequalities and health issues are more prevalent in one sex than another. It is likely therefore that targeted work on certain conditions as highlighted through commitments in this strategy will lead to a re-

				focus of service that will impact on sexes differently. A proportionate universalism approach will be applied as needed, for example to increase access to males for primary care or screening programmes. As services are reconfigured/re-commissioned, EHRIA's will be completed as necessary to identify the specific impact involved.
	Sexual Orientation	**Yes**		As the strategy affects all people in Leicestershire, there will be people with this protected characteristic that are impacted by the strategy. No specific impact is identified for this group, but it will be reviewed through future EHRIAs
	Other groups e.g. rural isolation, deprivation, health inequality, carers, asylum seeker and refugee communities, looked after children, deprived or disadvantaged communities	**Yes**		Evidence shows us that that many of the inequalities experienced and identified are more prevalent within deprived or disadvantaged communities. This strategy identifies reducing health inequalities as a key cross cutting theme. These may be geographical inequalities relating to deprivation or the rural nature of Leicestershire or specific vulnerable groups. A proportionate universalism approach will be embedded across the strategy to ensure an equitable approach to service delivery and actions. Within the strategy specific reference and priority actions are also made to looked after children, those with free school meals, learning disabilities, long term conditions and carers. This strategy should therefore have a positive impact for many of these groups.
	Community Cohesion	**Yes**		Much of the work identified in the strategy involves developing cohesive and resilient communities, asset based approaches, neighbourhoods, existing services and volunteers. The strategy will also use the 'Our communities approach 2022-2025' as an enabler to ensure true local engagement and collaboration with our communities. These elements of the strategy should bring about a positive impact across our local communities.

11.

Are the human rights of individuals ***potentially*** affected by this proposal? Could there be an impact on human rights for any of the protected characteristics? **(Please tick)**

Explain why you consider that any particular article in the Human Rights Act may apply to the policy/ practice/ function or procedure and how the human rights of individuals are likely to be affected below: [NB: include positive and negative impacts as well as barriers in benefiting from the above proposal]

	Yes	**No**	**Comments**
Part 1: The Convention- Rights and Freedoms			
Article 2: Right to life	**Yes**		Whilst the strategy does not directly address this issue, it does

				examine health inequalities which can ultimately affect life expectancy. There are also services relating to termination of pregnancy that would be included within the scope of the strategy.
	Article 3: Right not to be tortured or treated in an inhuman or degrading way		**No**	
	Article 4: Right not to be subjected to slavery/ forced labour	**Yes**		The strategy does support a priority area about support Leicestershire residents to have 'good work' that supports their health and wellbeing**.**
	Article 5: Right to liberty and security		**No**	
	Article 6: Right to a fair trial		**No**	
	Article 7: No punishment without law		**No**	
	Article 8: Right to respect for private and family life	**Yes**		The strategy will aim to give every child the best start for life This will include further developing strong, informed and supportive families**.**
	Article 9: Right to freedom of thought, conscience and religion		**No**	
	Article 10: Right to freedom of expression	**Yes**		As part of the wider HWB evolution we will aim to engage with the local population more proactively to ensure we accurately hear their views on their health and wellbeing.
	Article 11: Right to freedom of assembly and association		**No**	
	Article 12: Right to marry		**No**	
	Article 14: Right not to be discriminated against	**Yes**		Whilst the strategy does not directly examine whether people are being discriminated against, it is possible that some health inequality is caused by discrimination and that this would be uncovered and addressed through the strategy.
	Part 2: The First Protocol			
	Article 1: Protection of property/ peaceful enjoyment		**No**	

	Article 2: Right to education	**Yes**		The strategy will support a best start for life for children and good work which will include ensuring they have access to education, employment and training as appropriate to the person's age.
	Article 3: Right to free elections		**No**	

Section 2
D: Decision

13.	Is there evidence or any other reason to suggest that: a) the policy could have a different affect or adverse impact on any section of the community; b) any section of the community may face barriers in benefiting from the proposal	**Yes**	**No**	**Unknown**
				Yes
				Yes

13.	Based on the answers to the questions above, what is the likely impact of the policy			
	No Impact ☐	**Positive Impact** ☐	Neutral Impact ☐	☒ **Negative Impact or Impact Unknown**

Note: If the decision is 'Negative Impact' or 'Impact Not Known', an EHRIA Report is required.

14.	Is an EHRIA report required?	**Yes** ☒	No ☐

Section 2: Completion of EHRIA Screening

Upon completion of the screening section of this assessment, you should have identified whether an EHRIA Report is requried for further investigation of the impacts of this policy.

Option 1: If you identified that an EHRIA Report ***is required***, continue to Section 3 on Page 7 of this document.

Option 2: If there are no equality, diversity or human rights impacts identified and an EHRIA report ***is not required***, continue to Section 4 on Page 14 of this document.

Section 3: Equality and Human Rights Impact Assessment (EHRIA) Report

Section 3: Equality and Human Rights Impact Assessment Report

This part of the assessment will help you to think ***thoroughly*** about the impact of the policy and to critically examine whether it is ***likely*** to have a positive or negative impact on different groups within our diverse communities. It should also identify any barriers that may adversely affect under-represented communities or groups that may be disadvantaged by the way in which we carry out our business.

Using the information gathered either within the EHRIA Screening or independently of this process, this EHRIA Report should be used to consider the impact or likely impact of the policy in relation to all areas of equality, diversity and human rights as outlined in Leicestershire County Council's Equality Strategy.

Section 3
A: Research and Consultation

When considering the target groups, it is important to think about whether new data needs to be collected or whether there is any existing research that can be utilised.

15.	Based on the gaps identified either in the EHRIA Screening or independently of this process, ***how*** have you now explored the following and ***what*** does this information/ data tell you about each of the diverse groups? a) current needs and aspirations and what is important to individuals and community groups (including human rights); b) likely impacts (positive and negative, intended and unintended) to individuals and community groups (including human rights); c) likely barriers that individuals and community groups may face (including human rights)

A) In order to develop the strategy, a range of stakeholder engagement over the previous 3 years was gathered and reviewed. This contributed to the development of the proposals. In addition, consultation on the vision and priorities was carried out during winter 2021/22. Consultation responses will be collated and interpreted to understand the views of specific community and vulnerable groups

B) No direct negative impacts have been assessed as a result of this strategy. However, it is possible that by setting priorities, the strategy will begin to drive changes in services commissioned, resource allocation and partner focus. This would inevitably need to be balanced by decommissioning and resource disinvestment in non-priority areas. There is the potential for loss of provision or funds in the non-priority areas and therefore a negative impact on the populations currently accessing those services. It is not possible to know at this stage what these negative impacts would be but an EHRIA should be undertaken on future decisions of this nature. The strategy also takes a proportionate universalism approach to minimise the impact on vulnerable groups and ensure services and resource are allocated according to local need.

C) As the strategy is so wide ranging, there are numerous barriers that could be faced by different communities and individuals as we try to implement it. It will be important for the agencies and partnerships to consider these potential barriers as they plan for the work, using a co-production approach whenever possible. Again, the EHRIA process should help to guide as we begin to translate these priorities into action and we start to initiate service changes or take funding decisions.	
16.	Is any further research, data collection or evidence required to fill any gaps in your understanding of the potential or known affects of the policy on target groups?
It will be important for the delivery plan leads to consider this question as they start to plan for and implement actions. This will be reported to the Health and Wellbeing board on a quarterly basis, which a more thorough review on an annual and three yearly term. There are some aspects of the strategy where we have identified a need to better understand something through a JSNA chapter or needs assessment e.g. dying well and what people may want from this. This better understanding will include the perspective of different groups. The HWB is also developing a communication and engagement strategy that will support an ongoing conversation and evaluation of the strategy with our local population and specific vulnerable groups. For other priorities, we already have a good understanding of prevalence within or impact on different groups. In these instances, we will need to consider how to use this knowledge to inform our actions. As before, we will continue to review our knowledge base and impacts of any changes through the EHRIA process as required.	
When considering who is affected by this proposed policy, it is important to think about consulting with and involving a range of service users, staff or other stakeholders who may be affected as part of the proposal.	
17.	Based on the gaps identified either in the EHRIA Screening or independently of this process, ***how*** have you further consulted with those affected on the likely impact and ***what*** does this consultation tell you about each of the diverse groups?
The strategy covers all residents of Leicestershire and therefore has the potential to impact on all protected characteristics. A formal consultation exercise is currently underway, and the strategy will be amended as needed following these responses. The HWB is also developing a communication and engagement strategy that will support an ongoing conversation and evaluation of the strategy with our local population and specific vulnerable groups.	
18.	Is any further consultation required to fill any gaps in your understanding of the potential or known effects of the policy on target groups?
	Yes. Some of these groups are already identified in the strategy e.g. people's views on what dying well means to them. For other groups, we may not have identified a gap yet but may uncover this as we do more work e.g. investigations into hip fractures may uncover a need to understand how this varies across

	genders etc. Due to the nature of the 10 year strategy it is anticipated that priorities and actions will evolve over time. As this occurs the strategy will be reviewed in line with the latest evidence and JSNA chapters which include qualitative feedback from our local communities.

Section 3 **B: Recognised Impact**		
19.	Based on any evidence and findings, use the table below to specify if any individuals or community groups who identify with any 'protected characteristics' are ***likely*** to be affected by this policy. Describe any positive and negative impacts, including what barriers these individuals or groups may face.	
		Comments
	Age	The strategy talks about different life stages which often (not always) reflects different age groups. It also uses some indicators which are reflective of certain ages e.g. hip fractures in over 65's. The commitments differ according to these life stages and therefore the impact will be different according to which priority or commitment detailed and which life stage you are at. However the overall outcome of the strategy is to improve health life expectancy and reduce health inequalities for all in Leicestershire.
	Disability	The strategy makes reference to people with long term conditions (LTC's), some of which will be the cause of a disability. The strategy makes some commitments to people with LTC's to improve the way we prevent deterioration, support and treatment throughout our system. The strategy also makes reference to CYP with a learning disability where we understand there is a need to provide additional support as they transition into adulthood. Evidence has also shown that people with learning disabilities have worse outcomes than the general population with regards to life expectancy and Covid related hospitalisations and deaths.
	Gender Reassignment	As the strategy affects all people in Leicestershire, there will be people with this protected characteristic that are impacted by the strategy. No specific impact is identified for this group, but further detail may be found through specific service EHRIA throughout the strategy
	Marriage and Civil Partnership	As the strategy affects all people in Leicestershire, there will be people with this protected characteristic that are impacted by the strategy. No specific impact is identified for this group.
	Pregnancy and Maternity	The strategy makes specific reference to pregnancy and maternity in the 'Best Start for Life' priority 1,001 critical days. It will therefore be examining areas for improvement in health outcomes and making commitments to this group to take the priorities forward for example supporting maternal mental health, breastfeeding support etc.

	Race	Although the strategy does not directly refer to specific racial groups, we do know that some inequalities and health issues are more prevalent in certain racial/ ethnic groups. There is also evidence that some of these inequalities have been exasperated through the Covid-19 pandemic, for example poorer health outcomes have been seen in the Black and Asian ethnic groups. It is likely therefore that targeted work on certain conditions as highlighted through commitments in this strategy will lead to a re-focus of service delivery that will impact on racial groups differently. As services are reconfigured/re-commissioned, EHRIA's will be completed as necessary to identify the specific impact involved and mitigate any negative impacts. The strategy takes a proportionate universalism approach to ensure all action and service provision is based on local need.
	Religion or Belief	As the strategy affects all people in Leicestershire, there will be people with this protected characteristic that are impacted by the strategy. No specific impact is identified for this group, but individual service EHRIAs may identify issues which will be mitigated wherever possible.
	Sex	Although the strategy does not directly refer to sex (other than when linked to pregnancy and maternity), we do know that some inequalities and health issues are more prevalent in one sex or gender than another. It is likely therefore that targeted work on certain conditions as highlighted through commitments in this strategy will lead to a re-focus of service that will impact on sexes differently. A proportionate universalism approach will be applied as needed, for example to increase access to males for primary care or screening programmes. As services are reconfigured/re-commissioned, EHRIA's will be completed as necessary to identify the specific impact involved.
	Sexual Orientation	As the strategy affects all people in Leicestershire, there will be people with this protected characteristic that are impacted by the strategy. No specific impact is identified for this group, but it will be reviewed through future EHRIAs
	Other groups e.g. rural isolation, deprivation, health inequality, carers, asylum seeker and refugee communities, looked after children, deprived or	Evidence shows us that that many of the inequalities experienced and identified are more prevalent within deprived or disadvantaged communities. This strategy identifies reducing health inequalities as a key cross cutting theme. These may be geographical inequalities relating to deprivation or the rural nature of Leicestershire or specific vulnerable groups. A proportionate universalism approach will be embedded across the strategy to ensure an equitable approach to service delivery and actions. Within the strategy specific reference and priority actions are also made to looked after children, those with free school meals, learning disabilities, long term conditions and carers. This strategy should therefore have a positive impact for many of these groups.

	disadvantaged communities	
	Community Cohesion	Much of the work identified in the strategy involves developing cohesive and resilient communities, asset based approaches, neighbourhoods, existing services and volunteers. The strategy will also use the 'Our communities approach 2022-2025' as an enabler to ensure true local engagement and collaboration with our communities. These elements of the strategy should bring about a positive impact across our local communities.

20. Based on any evidence and findings, use the table below to specify if any particular Articles in the Human Rights Act are ***likely*** to apply to the policy. Are the human rights of any individuals or community groups affected by this proposal? Is there an impact on human rights for any of the protected characteristics?

	Comments
Part 1: The Convention- Rights and Freedoms	
Article 2: Right to life	Whilst the strategy does not directly address this issue, it does examine health inequalities which can ultimately affect life expectancy. There are also services relating to termination of pregnancy that would be included within the scope of the strategy.
Article 3: Right not to be tortured or treated in an inhuman or degrading way	
Article 4: Right not to be subjected to slavery/ forced labour	
Article 5: Right to liberty and security	
Article 6: Right to a fair trial	
Article 7: No punishment without law	
Article 8: Right to respect for private and family life	
Article 9: Right to freedom of thought, conscience and religion	
Article 10: Right to freedom of expression	As part of the wider HWB evolution we will aim to engage with the local population more proactively

		to ensure we accurately hear their views on their health and wellbeing.
	Article 11: Right to freedom of assembly and association	
	Article 12: Right to marry	
	Article 14: Right not to be discriminated against	
	Part 2: The First Protocol	
	Article 1: Protection of property/ peaceful enjoyment	
	Article 2: Right to education	The strategy will support a best start for life for children and good work which will include ensuring they have access to education, employment and training as appropriate to the person's age.
	Article 3: Right to free elections	

Section 3 **C: Mitigating and Assessing the Impact**	
Taking into account the research, data, consultation and information you have reviewed and/ or carried out as part of this EHRIA, it is now essential to assess the impact of the policy.	
21.	If you consider there to be actual or potential adverse impact or discrimination, please outline this below. State whether it is justifiable or legitimate and give reasons.
We do not anticipate there will be adverse impact or discrimination of the overall JHWS. However, implementation of the specific commitments and actions in the delivery plans may impact on different parts of the local community differently. We will therefore ensure that all significant service change/ reconfiguration etc completed separate EHRIAs to understanding and mitigate the impacts of the commitment. These will be considered and reviewed in the annual performance report that is submitted to the HWB.	
NB: i) If you have identified adverse impact or discrimination that is ***illegal***, you are required to take action to remedy this immediately. ii) If you have identified adverse impact or discrimination that is ***justifiable or legitimate***, you will need to consider what actions can be taken to mitigate its effect on those groups of people.	
22.	Where there are potential barriers, negative impacts identified and/ or barriers or impacts are unknown, please outline how you propose to minimise all negative impact or discrimination. a) include any relevant research and consultation findings which highlight the

	best way in which to minimise negative impact or discrimination b) consider what barriers you can remove, whether reasonable adjustments may be necessary and how any unmet needs that you have identified can be addressed c) if you are not addressing any negative impacts (including human rights) or potential barriers identified for a particular group, please explain why
We do not anticipate there will be potential barriers or negative impacts of the overall JHWS itself. However implementation of the specific commitments and actions in the delivery plans may impact on different parts of the local community differently, that may create barriers or unforeseen negative impacts. We will therefore ensure that all significant service change/ reconfiguration etc completed separate EHRIAs to understanding and mitigate the barriers or negative impacts of the commitment. These will be considered and reviewed in the annual performance report that is submitted to the HWB.	
Section 3 **D: Making a decision**	
23.	Summarise your findings and give an overview as to whether the policy will meet Leicestershire County Council's responsibilities in relation to equality, diversity, community cohesion and human rights.
The overall aim of the Leicestershire JHWS is 'Giving everyone in Leicestershire the opportunity to thrive and live happy, healthy lives' This includes aiming to improve healthy life expectancy and reduce health inequalities across Leicestershire. Therefore the overall strategy itself aims to improve outcomes for the whole Leicestershire population. However it is acknowledged that implementation of this high level strategy is likely to result in changes to commissioning of services, service redesign and potentially decommissioning of services. An EHRIA will be completed for each specific service change to ensure any negative impacts are mitigated against.	

Section 3 **E: Monitoring, evaluation & review of the policy**	
24.	*Are there processes in place to review the findings of this EHRIA and make appropriate changes? In particular, how will you monitor potential barriers and any positive/ negative impact?* The EHRIA will be reviewed on an annual basis as part of the annual JHWS performance report. This will be considered and discussed at the HWB. Further EHRIAs will be completed as part of the implementation of the JHWS and these will be picked up through individual organisations and commissioning and project management arrangements. There will also be quarterly performance reports on the progress of the JHWS that will show any specific EHRIA issues as they emerge through the output and outcome data. When the JHWS completed a more thorough evaluation every 3years the overall EHRIA will be reviewed and updated as necessary.

25.	How will the recommendations of this assessment be built into wider planning and review processes? *e.g. policy reviews, annual plans and use of performance management systems* The recommendations from this EHRIA will be considered as part of the development of the JHWS, delivery plan and programme management approach. The EHRIA recommendations will be reviewed on an annual basis as part of the annual JHWS performance report. This will be considered and discussed at the HWB. Further EHRIAs will be completed as part of the implementation of the JHWS and these will be picked up through individual organisations and commissioning and project management arrangements. When the JHWS completed a more thorough review every 3years the overall EHRIA will be reviewed and updated as necessary.

Section 3:
F: Equality and human rights improvement plan

Please list all the equality objectives, actions and targets that result from the Equality and Human Rights Impact Assessment (EHRIA) (continue on separate sheets as necessary). These now need to be included in the relevant service plan for mainstreaming and performance management purposes.

Equality Objective	Action	Target	Officer Responsible	By when
Ensure equality and human rights are considered throughout implementation of the JHWS.	Ensure EHRIAs are completed and mitigating actions implemented for all significant service redesigns or changes that are implemented as part of the overall JHWS.	100% EHRIA completed for all significant service redesigns in accordance with the lead agencies responsibilities and policies on this	Senior responsible officer for each priority area/ commitment.	As part of the planning for any significant service redesign or change.
	Ensure the EHRIA and recommendations are reviewed on annual basis as part of the JHWS annual performance report to the HWB.	Annual review of EHRIA and update to HWB.	Vivienne Robbins/ Jo Hewitt	April 2023
	More thorough review of the EHRIAs as part of the three-year evaluation of the JHWS and review of its priorities.	Refresh EHRIA as part of JHWS refresh.	Vivienne Robbins/ Jo Hewitt	April 2025

Section 4: Sign off and scrutiny

Upon completion, the Lead Officer completing this assessment is required to sign the document in the section below.

It is required that this Equality and Human Rights Impact Assessment (EHRIA) is scrutinised by your Departmental Equalities Group and signed off by the Chair of the Group.

Once scrutiny and sign off has taken place, a depersonalised version of this EHRIA should be published on Leicestershire County Council's website. Please send a copy of this form to the Digital Services Team via web@leics.gov.uk for publishing.

Section 4
A: Sign Off and Scrutiny

Confirm, as appropriate, which elements of the EHRIA have been completed and are required for sign off and scrutiny.

Equality and Human Rights Assessment Screening ☐

Equality and Human Rights Assessment Report ☐

1st Authorised Signature (EHRIA Lead Officer): ……

Date: ……

2nd Authorised Signature (DEG Chair): … 
…….

Date: 3rd February 2022……

Agenda Item 6

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 24 FEBRUARY 2022

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

HEALTH AND WELLBEING BOARD GOVERNANCE

Purpose of report

1. The purpose of this report is to seek the Health and Wellbeing Board's approval for revised Terms of Reference for the Board and to redefine one of the Board's sub-group, the Unified Prevention Board, into the Staying Healthy Partnership Board.

2. The report also details the development of an Engagement and Communication Strategy to raise the profile of the Health and Wellbeing Board and to support delivery of the Joint Health and Wellbeing Strategy.

Link to the Local Health and Care System

3. The Health and Wellbeing Board leads and directs work to improve the health and wellbeing of the population of Leicestershire through the development of effective, high quality integrated health and social care services

Recommendations

4. It is recommended that:

   a) The revised Terms of Reference for the Health and Wellbeing Board be approved;

   b) The redefinition of the Unified Prevention Board to the Staying Healthy Partnership Board, be approved;

   c) Subject to b) above, the Terms of Reference for the Staying Healthy Partnership Board be approved;

   d) The Health and Wellbeing Board governance structure be noted;

   e) The Health and Wellbeing Board Engagement and Consultation Strategy be approved.

Policy Framework and Previous Decisions

5. The current Terms of Reference for the Board were approved by the Health and Wellbeing Board at its meeting on the 26 November 2020. Since that date there have been a number of changes regarding the health and care landscape and arrangements, including further development of the Integrated Care System (ICS) and consideration of Leicestershire's role in leading 'place'.

6. At the meeting on the 8 July 2021, the Board supported the development of a Health and Wellbeing Board Communication and Engagement Strategy Plan to support evolution of the Health and Wellbeing Board, it's relationship with the local population and the delivery of the revised Joint Health and Wellbeing Strategy.

Background

Health and Wellbeing Board Terms of Reference

7. At its meeting in July 2021, the Health and Wellbeing Board approved a review of the Terms of Reference, acknowledging that the Board must evolve to become the place-based Board for health and care including agreeing and overseeing JHWS priorities concerning health and care integration, health protection, prevention and health inequalities (including the wider determinants of health). Partners agreed to provide appropriate representation to allow for strategic leadership, accountability and decision making across Leicestershire

8. The revised Terms of Reference for the Board are attached at Appendix A. These have been amended to take account of the refreshed Joint Health and Wellbeing Strategy, and the considerable changes across the health and care landscape as a result of the developing ICS, ensuring the Board's work is aligned across the ICS, between system, place and neighbourhood including Primary Care network representation.

Staying Healthy Partnership Board

9. The Health and Wellbeing Board approved the draft Joint Health and Wellbeing Strategy for consultation at its meeting in November 2021, which is based on a life course approach, framed using the LLR ICS life course transformational priorities. As a result, considerable partnership work has been undertaken to progress the Strategy which is being presented for final approval as part of a separate item on this agenda. The Best Start for Life element of the approach will be captured through the work of the Children and Family Partnership Board and the Living and Supported Well and Dying well elements are picked up through a refreshed approach from the Integration Executive, both of which are subgroups of the Health and Wellbeing Board. The Staying Healthy, Safe and Well elements require a link into the Board's governance structure that is broader than the existing Unified Prevention Board sub-group, to be able to offer a strategic approach to prevention and increasing the scope to cover areas such as wider determinants of health. It is therefore proposed that the Staying Healthy Partnership Board be established, replacing the Unified Prevention Board. The Terms of Reference for the new Staying Healthy Partnership Board are attached at Appendix B.

10. There is a requirement of the ICS to develop Community Health and Wellbeing Plans at neighbourhood level. Whilst the plans will be owned by local neighbourhood level partnerships, overall place themes will feed into the Staying Healthy Partnership Board. The Staying Healthy Partnership Board will be one of three sub-groups to the Health and Wellbeing Board (along with the Children and Family Partnership Board and Integration Executive) and the draft structure is attached at Appendix C. As changes and developments are progressed with ICS partners, further adaptations of this document will be presented to the Board.

Communication and Engagement Strategy

11. At its meeting on the 8 July 2021, the Board noted the development of the Communication and Engagement Strategy to ensure a sustainable programme of active engagement continued through the Board's work. A long-term Strategy has been developed to consider how awareness of the Board can be raised, understanding and visibility increased, progressed reported and continual feedback collated to inform priorities and delivery of the Strategy.

12. The Communications and Engagement Strategy will support the delivery of the JHWS along with the Health and Wellbeing Board's objectives, to regularly communicate with residents and communities and ensure that the JHWS is reflective of their experiences.

Resource Implications

13. The proposed establishment of the Staying Healthy Partnership will be undertaken using existing budgets and resources. To support the evolution of the Health and Wellbeing Board and deliver the communication and engagement plan an engagement officer will be recruited within the Public Health Department to work with partners across Leicestershire.

Equality and Human Rights Implications

14. None arising from this report. Individual service changes that result from the work of the Health and Wellbeing Board and subgroups will complete Equality and Human Rights Impact Assessments as appropriate.

Background papers

Report of Leicestershire County Council Chief Executive – Board Governance
https://politics.leics.gov.uk/documents/s158088/Board%20Governance.pdf

Appendices

Appendix A - Revised HWB Terms of Reference
Appendix B - Staying Healthy Partnership Board Terms of Reference
Appendix C –System, Place and Neighbourhood Governance structure
Appendix D – HWB Communication and Engagement Strategy

Officers to Contact

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Appendix A

Leicestershire Health and Wellbeing Board

Terms of Reference

Introduction

The Health and Wellbeing Board has been appointed by the County Council as a subcommittee of the Executive to: -

- Discharge directly the functions conferred on the County Council by Section 194 of the Health and Social Care Act 2012, or such other legislation as may be in force for the time being
- Carry out such other functions as the County Council's Executive may permit.

[Note: The County Council's executive function of approving the Better Care Fund and Plans arising from its use has been delegated to the Health and Wellbeing Board.]

Terms of Reference

The Health and Wellbeing Board shall have the following general role and function: -

To lead and direct work to improve the health and wellbeing of the population of Leicestershire through the development of improved and integrated health and social care services. The Board is responsible for:-

- Preparing and publishing the Leicestershire Joint Strategic Needs Assessment in order to identify the needs and priorities across Leicestershire so that future commissioning/policy decisions and priorities are based on evidence.

- Preparing and publishing a Joint Health and Wellbeing Strategy (JHWS) and associated Plan on behalf of the County Council and its partners.

- Approving the Better Care Fund Plan.

- Publishing and refreshing the Pharmaceutical Needs Assessment to assess the need for pharmaceutical services in Leicestershire and providing an evidence base for future policy and commissioning decisions.

- In conjunction with all partners, communicating and engaging with local people on how they can achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing.

- Having oversight of the use of relevant public sector resources to identify opportunities for the further integration of health and social care services.

The Work of the Board

<u>Identifying Needs and Priorities</u>

The Health and Wellbeing Board will take a key role in identifying future needs and priorities in Leicestershire to ensure that its work is based on evidence of needs. The Board will: -

- Ensure that the JSNA and Pharmaceutical Needs Assessment are refreshed, using a variety of tools, evidence and data, including user experience, to support this process.

- Reach a shared understanding of the health needs, inequalities and risk factors in local populations, based on the JSNA and other evidence, and demonstrate how this evidence has been applied to the Board's decisions and strategic priorities.

- Reach a shared understanding of how improvements in outcomes will be monitored and measured, including the benefits of improving integration.

- Ensure that all partners collaborate to use the JSNA and embed a population health management approach across the system to support the delivery of improved outcomes.

- Provide high-level guidance on the development and achievement of Leicestershire's strategic health and wellbeing priorities and outcomes across the Place.

- Adopt a proactive, collaborative approach to the JHWS priorities and delivery plan, setting the agenda around key integration and partnership priority areas, whilst allowing partners to continue to deliver and drive change through the Board's subgroups and partner organisations.

- Consider how wider Leicester, Leicestershire and Rutland (LLR) ICS system health and care priorities are translated and implemented at Leicestershire place and neighbourhood level.

<u>Strategy</u>

The Health and Wellbeing Board will develop, publish and review a Joint Health and Wellbeing Strategy which is developed and owned by all Integrated Care System (ICS) partners. The Strategy will set out key priorities and health and wellbeing outcomes for the Place. The JHWS will act as the Place led plan as required by the ICS to enable one clear vision and create alignment across Place.

The Board will:

- Proactively seek assurance on delivery of the priorities and outcomes set out in the Strategy, including via the Health and Wellbeing Board's sub-groups.

- Monitor the impact of the Strategy through the delivery plan, collectively supporting and constructively challenging progress and performance, taking action as necessary.

- Take account of the recommendations of the Director of Public Health's Annual Report, considering how recommendations are implemented across place.

- Focus collective efforts and resources on the agreed set of strategic priorities for health and wellbeing, as determined from the JHWS recognising the contributions of the wider determinants of health.

- Ensure the work of the Board develops in tandem with other local and national policy developments, dependencies and legislation.

- Establish strong links with the Integrated Care Board and Partnership to ensure both have regard to the Leicestershire JSNA and JHWS.

Integrated Working

The Health and Wellbeing Board will approve and implement plans aligned with the JHWS which will set out how wider determinants of health, care, housing services and prevention will be transformed to provide the people of Leicestershire with better integrated care and support. In addition the Board will:-

- Ensure the Board's work is aligned across the ICS, between system, place and neighbourhood.

- Ensure the Better Care Fund pooled budget and associated Plan is developed in accordance with national guidelines and local priorities.

- Ensure that appropriate partnership agreements, financial protocols, monitoring and risk management arrangements are in place to facilitate the use of the Better Care Fund and other areas of integrated commissioning.

- Ensure that an integrated approach is taken to improving health and wellbeing, including through the wider determinants of health, preventative services and developing asset-based approaches.

- Identify other service areas where place-based and/or pooled budgets would support improvement in outcomes and financial sustainability.

- Make recommendations on the priority of projects and allocation of resources to service providers and/or localities including implementing a preventative approach and reducing health inequalities as appropriate, in order to achieve jointly agreed objectives, noting where appropriate that organisational resource allocation and formal decision making will need to be agreed via the appropriate governance processes.

- Advise on a place based response to service redesign and transformation and operational delivery at system and neighbourhood level which may involve services across Leicester, Leicestershire and Rutland.

Communication and Engagement

The Health and Wellbeing Board will, in conjunction with partners, communicate and engage with local people on how they can achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing. In support of this, the Board will:-

- Develop and implement a Communications and Engagement Strategy which will focus on how the work of the Board will be influenced by partners and the public, including seldom heard groups, and how the Board will support the specific duties with respect to consultation and engagement on service changes. The Communications and Engagement Strategy will align with and support the delivery of the Joint Health and Wellbeing Strategy.

Standing Orders

The Access to Information Procedure Rules and Meeting Procedure Rules (Standing Orders) laid down by the County Council will apply with any necessary modifications including the following:-

The Chairman will be an elected member of Leicestershire County Council's Cabinet.

The quorum for a meeting shall be a quarter of the membership including at least one elected member from the County Council and one representative of the CCGs and/or health equivalent in the new Integrated Care System.

Membership

The Board will keep its membership under review and make such changes as it feels necessary in accordance with Regulations:

County Council Lead Member for Health

County Council Lead Member for Adult Social Care

County Council Lead Member for Children & Young People

Count Council Chief Executive

County Council Director of Public Health

County Council Director of Adults & Communities

County Council Director of Children & Family Services

Two Clinical representatives of the Clinical Commissioning Groups or health equivalent in the new Integrated Care System including Primary Care Networks.

Three non- clinical representatives of the CCGs and or health equivalent in the new Integrated Care System

Two representatives of the Local Healthwatch

Two elected representatives of the District Councils

The Lead District Officer for Health and Housing

One representative from Regional NHSEI

One representative of the Leicestershire Police

One representative of the Office of the Police and Crime Commissioner

One representative of the Leicestershire Partnership NHS Trust

One representative of the University Hospitals of Leicester NHS Trust

One representative from the Office of Health Improvement and Disparities

Appendix B

November 2021

Staying Healthy Partnership Board

Terms of Reference

The Staying Healthy Partnership Board is one of a number of sub-groups of the Leicestershire Health and Wellbeing Board (HWB). Together the sub-groups align with the life course approach set out within the refreshed Joint Health and Wellbeing Strategy.

Purpose

The Staying Healthy Partnership Board is the lead partnership body for the Staying Healthy, Safe and Well life course stage, reporting directly to the HWB. The Board is responsible for action and progress to achieve the Joint Health and Wellbeing Strategic Staying Healthy priorities of: creating healthy foundations, homes, communities and places, promoting healthy behaviours, advocating choice, reducing health inequalities and addressing the wider determinants of health. The Board will have focus on primary prevention and the 'cause of the causes' across Leicestershire.

Role and responsibilities

The Staying Healthy Partnership Board establishes a mechanism through which partners can collaborate to develop a strategic and system-led perspective, to ensure Leicestershire residents and communities stay healthy, safe and well, whilst addressing inequalities and the wider determinants of health. It will also focus on driving health and care improvement through a primary prevention approach across Leicestershire, working to reduce the likelihood of local people developing risk factors and disease that could impact on their health and wellbeing.

This will be achieved through the following key objectives:

- To provide leadership, support and direction for progressing primary prevention initiatives and services across Leicestershire as a Place. This will include regular reporting on the Staying Healthy Delivery Plan and Outcomes Framework, with escalation to the HWB as needed to enable wider system consideration, collaboration and resolution. The Board will adopt the Do, Sponsor, Watch approach to the delivery plan as agreed at the HWB. This will be reviewed on an annual basis.

- To provide a forum for strategic discussions and collective responsibility around system leadership, collaborative working, service integration, commissioning and delivery for primary prevention and the wider determinants of health across Place.

- To provide a forum of influence to enable the wider determinants work plan to be achieved along with other health improvement areas to enable the effective realisation of the Joint Health and Wellbeing Strategy

- To work collaboratively as a partnership to address the staying healthy priorities identified in the Strategy and any primary prevention cross cutting themes (including improved mental health, reduction in health inequalities and Covid recovery) along with enablers.

- To help co-ordinate and influence the activities of the associated thematic delivery groups with a view to identifying primary prevention areas of collaboration and to maximise impact across the Place and wider system.

- To work collaboratively with other HWB subgroups (Children and Families Partnership Board and the Integration Executive) to ensure the Staying Healthy agenda is picked up across the life course as needed. This will include a bi-annual update across the subgroups.

- To provide the link between neighbourhood level Community Health and Wellbeing Plans into the wider delivery of the JHWS and HWB.

- To ensure that Staying Healthy is reflected / embedded in other relevant agendas (such as community safety, economic growth, climate and environment).

Membership of the Staying Healthy Partnership Board

The Board will include but is not limited to strategic representatives from the following:-

Organisation/Department
LCC Representatives
LCC Public Health
LCC Adult and Communities
LCC Children and Families
LCC Chief Executives
LCC Environment and Transport
Growth Service
Air Quality Chair
District Representatives
District Health and Housing Lead Officer
District Health Leads/Lightbulb Representative
Chief Housing Officers Group Chair
Communities Group Chair
Strategic Planning Group Chair
Partner Representatives
OPCC
Violence Reduction Network Partnership
LLEP
Healthwatch
Leicestershire Police
Leicestershire Fire and Rescue Service
Voluntary Action Leicestershire
Active Together
NHS ICS
NHS ICS Strategy and Planning
NHS ICS Integration and Transformation
NHS Provider: Primary Care Network
NHS Provider: University Hospitals Leicestershire
NHS Provider: Leicestershire Partnership Trust

The core membership of the Board will be regularly reviewed in order to ensure it remains fit for purpose, and programme leads etc will be invited for appropriate agenda items.

Substitutes can be provided in the absence of any members.

November 2021

Governance

Meeting Frequency

The Staying Healthy Partnership Board will meet on a quarterly basis and follow the HWB pattern to ensure that relevant discussion points and actions raised by the HWB can be formally considered and actioned.

The HWB will be provided with a quarterly update on the work of the Board along with an annual report demonstrating progress, impact, learning and to advise on future opportunities or areas of focus. The HWB's other sub-groups (Children and Families Partnership Board and the Integration Executive) will be updated bi-annually.

Chair and administration

The Staying Healthy Partnership Board will be jointly chaired by the Director of Public Health and the Lead District Officer for Health and Housing or deputised officers as required.

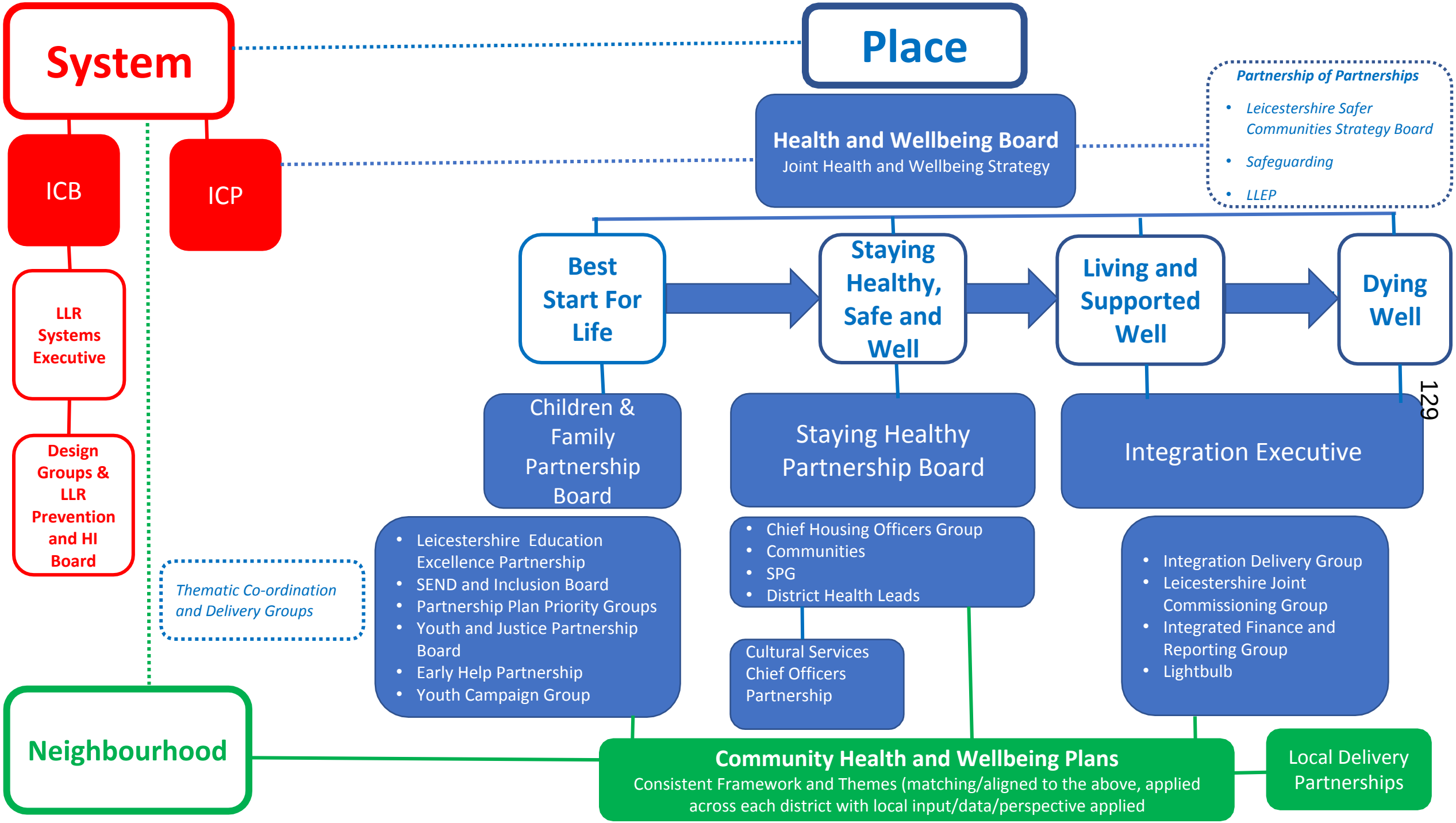
Meetings will be administered by Democratic Services at Leicestershire County Council. The Standing Orders (Meeting Procedure Rules) of the County Council will be applied to meetings of the Board.

The agenda and papers will be issued no later than 4 working days in advance unless later circulation has been authorised by the Chairs (exceptional circumstances).

Quoracy

In order to meet and conduct business, six members must be present of which at least:

- One must be an ICS representative
- One must be a Leicestershire County Council representative
- One must be District Council representative


System
ICB
ICP
LLR Systems Executive
Design Groups & LLR Prevention and HI Board
Thematic Co-ordination and Delivery Groups
Neighbourhood
Place
Health and Wellbeing Board
Joint Health and Wellbeing Strategy
Partnership of Partnerships
Leicestershire Safer Communities Strategy Board
Safeguarding
LLEP
Best Start For Life
Staying Healthy, Safe and Well
Living and Supported Well
Dying Well
Children & Family Partnership Board
Staying Healthy Partnership Board
Integration Executive
Leicestershire Education Excellence Partnership
SEND and Inclusion Board
Partnership Plan Priority Groups
Youth and Justice Partnership Board
Early Help Partnership
Youth Campaign Group
Chief Housing Officers Group
Communities
SPG
District Health Leads
Cultural Services Chief Officers Partnership
Integration Delivery Group
Leicestershire Joint Commissioning Group
Integrated Finance and Reporting Group
Lightbulb
Community Health and Wellbeing Plans
Consistent Framework and Themes (matching/aligned to the above, applied across each district with local input/data/perspective applied
Local Delivery Partnerships

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Appendix D

Health and Wellbeing Board

Leicestershire Health and Wellbeing Strategy 2022-2032

Communications plan

Contents

Background

The creation of statutory Health and Wellbeing Boards (HWB) was a central feature of the Health & Social Care Act 2012. The role of the HWB is to lead and direct work to improve the health and wellbeing of the population of Leicestershire through the development of improved and integrated health and social care services.

The board is responsible for:

- Preparing and publishing the Leicestershire Joint Strategic Needs Assessment to identify the needs and priorities across Leicestershire so that future commissioning/policy decisions and priorities are based on evidence
- Preparing and publishing a Joint Health and Wellbeing Strategy (JHWS) and associated plan on behalf of the County Council and its Integrated Care System partners
- Publishing and refreshing the Pharmaceutical Needs Assessment to assess the need for pharmaceutical services in Leicestershire and providing an evidence base for future policy and commissioning decisions
- In conjunction with all partners, communicating and engaging with local people on how they can achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing

Scope

The HWB aim to communicate or engage with 2 key audiences:

- **Residents of Leicestershire** – to understand need and how to make a positive impact on health and wellbeing, to communicate information e.g. about services or self-care and to influence behaviour. To support coproduction of services where appropriate.
- **Stakeholder agencies and partners** – to ensure people are informed, engaged and working together to achieve improved health and wellbeing and reduced health inequalities across Leicestershire

The HWB Communications and Engagement Strategy will support the delivery of the JHWS along with the Health and Wellbeing Board's wider objectives. It will support regular check in with residents and communities to ensure that the JHWS is reflective of their experiences and what matters to them.

The strategy and delivery plan will be revised, according to the shape and focus for the board and its partners – and will therefore remain a live, working document and outputs and outcomes will be monitored and reported back into the HWB on a quarterly basis together with a performance report.

An annual review of the strategy progress and delivery plan will be undertaken to ensure that resource is targeted appropriately, working effectively, and helping the board to achieve its aims. A more thorough review of the Strategy will take place every three years to ensure it is still reflective of the overarching health and care needs of Leicestershire.

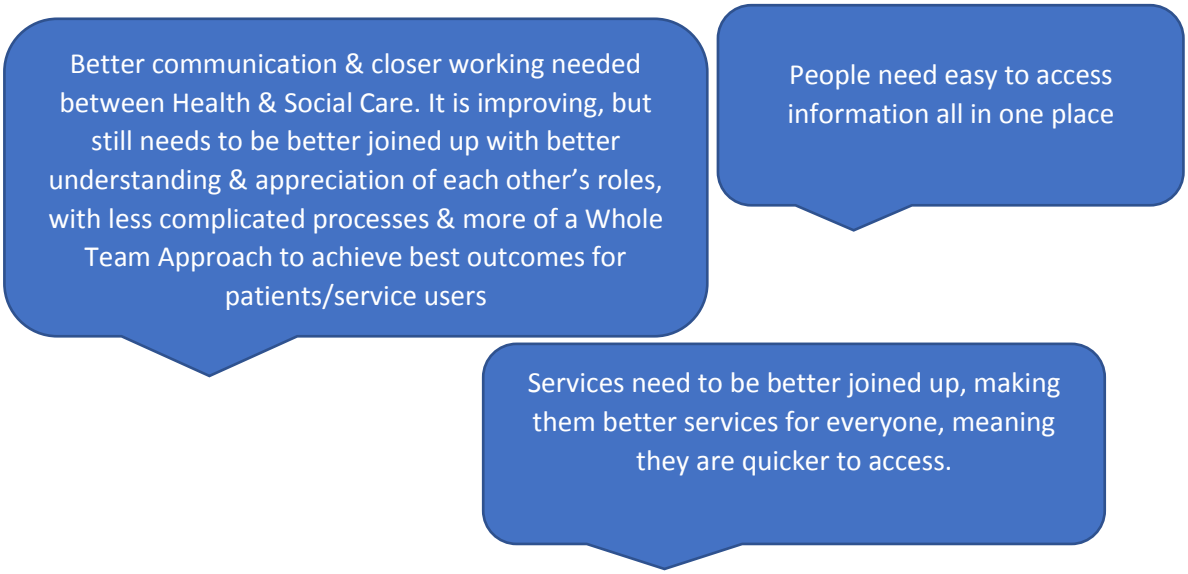
Effective communication

The HWB is a public forum shaped by the experiences of residents and communities and requirements of partners, and as a result it is vital that we understand the context in which we are attempting to engage our target audiences. Knowing how best to communicate with and engage our audiences will help us influence and create meaningful dialogue and service change.

A range of existing communication and engagement activities take place. Some examples of this include the below:

- The JSNA is published and publicly available for partners and the local population to view at: https://www.lsr-online.org/leicestershire-2018-2021-jsna.html ensuring JSNA information is transparent and accessible. Contact details are included on the website to enable people to find out more.
- The JHWS is also influenced by the views of local residents, communities and partners in Leicestershire through the broad consultation approach undertaken during November 2021 – January 2022. This consultation approach included the draft strategy being presented at key partnership meetings and Public Health Local Area Coordinators facilitating conversations and workshops with members of the public.
- In addition to the above activities, the Board also enables the voices of residents to be heard through the membership of the Board. Two representatives of Healthwatch Leicestershire are members of the Board, with Healthwatch having a specific remit around understanding the needs and experiences of local health and care users and speaking out on their behalf. This is in addition to elected members on the Board, including in their roles as community spokespeople, having been elected to represent local people.
- Meetings of the Health and Wellbeing Board are also public meetings, with provision for local people to attend the Board or watch via the County Council YouTube channel.
- Social media
    - Health and wellbeing Board Twitter 1,123 followers
    - Leicestershire County Council Twitter 21,500 followers, Facebook 7,751 followers, Instagram 2,610 followers, LinkedIn 12,782 followers
    - NHS (CCG, LPT and UHL combined) Twitter 42,907 followers, Facebook 27,940 followers, LinkedIn 13,986 followers, Instagram, 8,448 followers
    - Healthwatch Twitter 2414 followers, Facebook 779 friends and 345 followers, Instagram 680 followers
    - Leicestershire Police Twitter 121,097 followers, Facebook 138,307 followers, Instagram 24,400 followers, LinkedIn 6,527 followers
    - District councils across Leicestershire Twitter 38,753 followers, Facebook 48,337 followers, Instagram 1,666 followers, LinkedIn 2,800 followers

- Organisations represented on the Board have individual channels to communicate with stakeholders, including:
    - Leicestershire Matters (Leicestershire County Council)
    - NHS Citizens' Panel, LPT People's Council and UHL Patient Partners (CCG, UHL, LPT), GP practice patient participation groups
    - A range of focus groups and steering groups
    - Individual organisation websites
    - Organisational newsletters
- What are the best approaches to communicating with residents of Leicestershire:
    - Communications tailored to their needs and access requirements
    - the different services to talk to one another and for us to be more 'joined up' across the system
    - reliable and relevant information about prevention, self-care and support
    - Information that's easily accessible and all in one place



QUOTES TAKEN FROM THE HEALTH AND WELLBEING STRATEGY CONSULTATION 2022

- We are already aware that in Leicestershire…
    - BBC TV East Midlands Today regional 6.30pm slot is the most-watched half-hour on the BBC
    - 12,000 copies of the Leicester Mercury are sold daily, with 13 million monthly views to their website
    - 13,000 weekly papers are sold
    - 70.9% of people find out about local news from Tv, 45.4% from local papers and 32.9% from the Leicester Mercury

Aims of the Health and Wellbeing Board

The main responsibilities of the Health and Wellbeing Board requiring involvement of the local population are:

- Producing the JSNA (which looks at the current and future health and care needs of the local population to inform the planning of local health and care services).
- Producing the JHWS (a framework for improving local health and wellbeing). Leicestershire County Council and Integrated Care System partners are jointly responsible for this.
- Producing the PNA (which looks at pharmaceutical current and future needs, to inform future planning.)

Communications Objectives

The objectives of this communications plan are to raise awareness, understanding and increase visibility of the Health and Wellbeing Board, to inform residents and communities in Leicestershire and take continual feedback to inform priorities:

- Improve understanding of the HWBs purpose, benefits and successes – highlighting how the board is adding value to the work of partners
- To have a greater understanding of the local communities across Leicestershire and the health and wellbeing challenges that they face
- To inform people of services and self-care options across Leicestershire
- To bring about changes in behaviour and influence wider determinants that can have a positive impact on people's health and wellbeing
- To co-ordinate and integrate our activity across partners to improve the experience and outcomes for local people
- To demonstrate the work of the HWB and the impact this has on individuals and communities

Communications should explicitly support the Joint Health and Wellbeing Strategy for improving health and wellbeing in Leicestershire.

Audience

how we want them to feel

Internal	External
Board members	Patient participation groups
Organisations represented on the board	Community groups
Elected members	Equality groups
Children and family partnership board	Sports clubs and associations
Staying healthy partnership board	Residents
LLR board for health protection	Taxpayers
Substance misuse board	Children and young people
	Families with young children

Partner organisations not represented by HWB Board	Elderly
Leicester City Council	Males
Rutland Council	Social care users
Parish councils	Patients of health services
Schools/colleges	Carers
Universities	Travelling families
Active Together	BME groups
Voluntary Action Leicester	LGBT groups

Strategy

The Health and Wellbeing Board will communicate and engage with its audiences in the context of the wider strategy for health and care in Leicestershire.

- The board will need to target a range of stakeholders – including professionals working in different sectors – so we will need to tailor our communications and make it meaningful. We are also likely to have a variety of contact points within an organisation – at both a strategic and operational levels. Our narrative must be consistent, but our communications will need to be tailored.
- We will gather feedback at every opportunity, where appropriate to do so, maintaining two-way communication with all stakeholder groups.
- We will engage our partners and audiences via established networks using email updates or briefings. Contact with partners and stakeholders will be mapped to avoid inconsistency of message.
- We will demonstrate how we are working together helping to reshape and improve care and health services. Through media work, social media and stakeholder engagement we will seek to improve our reputation and seek to influence policy decisions and other issues at the national and local levels.
- Internally within the board, we will communicate clearly and regularly, ensuring that we equip spokespeople with key messages, and we maintain – making the most of low-cost digital communications.
- We will work with volunteers to champion messages when engaging with residents and communities about health and wellbeing linking in with the Leicestershire communities' approach which focuses on prevention, engagement and catalysts.
- Local Area Coordinators will be an important link into the community to understand local issues and liaise with those hard to reach audiences.
- We will continue to strengthen our social media to reach stakeholders – including the media, via Twitter @leicshealthwellbeing and share through social media accounts of all organisations represented on the Board to promote positive news and encourage debate where appropriate.

- We will look to introduce a newsletter representing the board to reach stakeholders and keep partners/wider stakeholders informed.
- Wider health promotional campaigns will be identified from organisations represented on the board and will be included in engagement throughout the year.
- Our media relations will be proactive as well as responsive to national or local news stories. For example, we will scan for national and local media coverage which we can lever for the benefit of the board.
- Key spokespeople for campaigns will be Mrs Richardson, Chairman of the Health and Wellbeing Board and Dr Vivek Varakantam, Chairman of the Integration Executive. The HWB will actively promote key spokespeople and will be active on social media. Other 'subject matter experts' will be fielded as appropriate from the board's membership.

Messaging and style

- Our key messages will be tailored according to the purpose of communication.
- Engagement with seldom heard groups will be tailored according to the purpose of the communication.
- Our style of communication will be clear, transparent, and direct.
- Case studies will be used to bring examples to life. Complex financial information will be distilled – using graphics where needed to illustrate key points.
- We will always avoid jargon – explaining terms simply and using plain English.
- We will improve our web offering to ensure we have a central hub to communicate messages making it easier for stakeholders to source information.
- We will explore making board papers more accessible for the range of diverse audiences.
-
- The Joint Health and Wellbeing strategy focuses on a life course approach and is split out into four stage:

    - **Best start for life**: To allow our children to have the best start for life, we will prioritise a range of actions covering the broader children's age range of 0-19 years (or 0-25 years for Special Educational Needs and Disability).

    - **Staying healthy, safe and well**: Prevention is always better than cure, and good health and wellbeing is an asset to individuals, communities and the wider population. Therefore, we want to give everyone in Leicestershire the opportunity to live happy, healthy, safe and long lives without illness or disease for as long as possible.

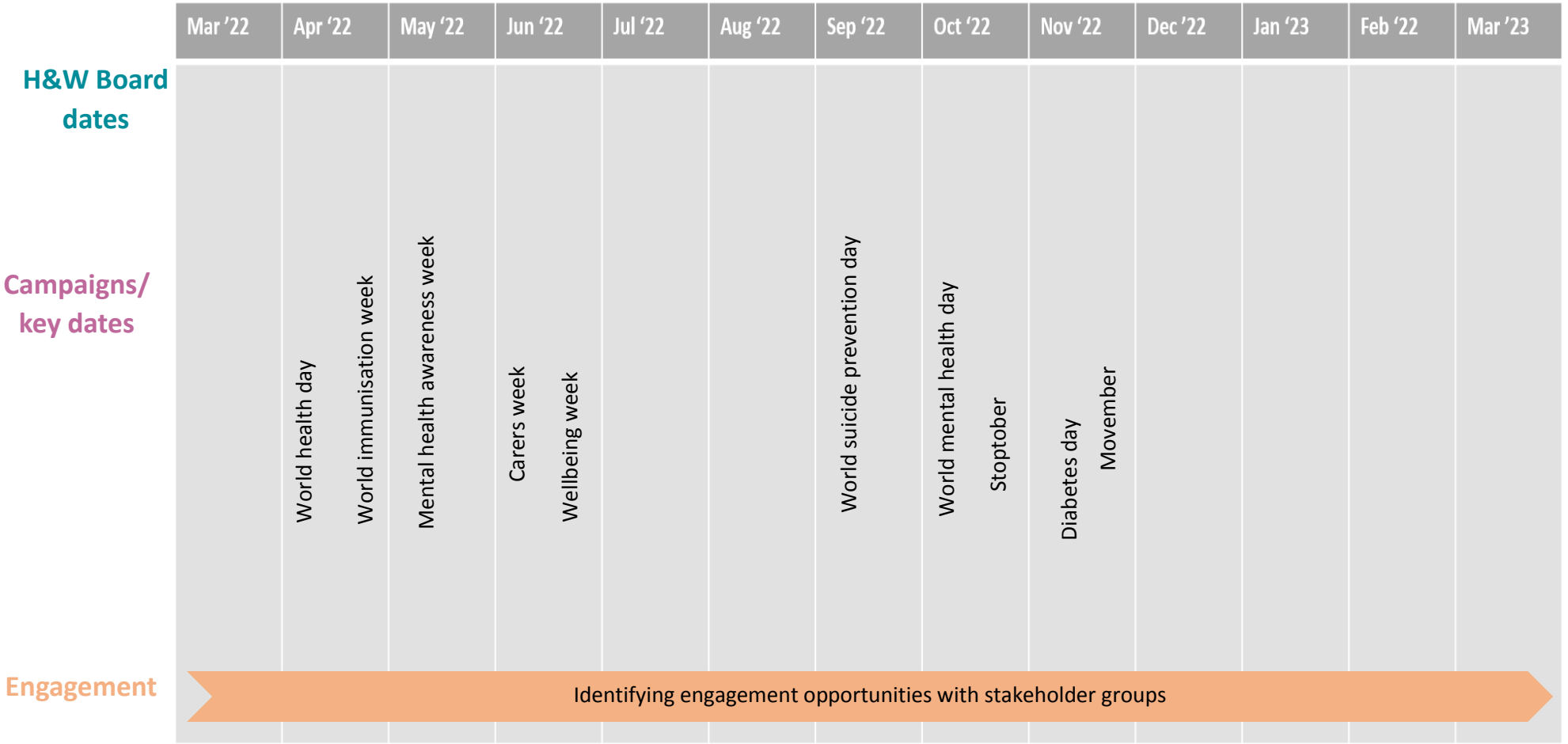
    - **Living and supported well**: As people age, become unwell or develop one or more Long Term Conditions, it is important that they are supported to live as independently as possible, for as long as possible while maximising their

quality of life. We will help them live as well as possible for as long as possible.

- **Dying well**: End of life is an inevitable part of the life course, but we know that it is a difficult subject for many people to openly acknowledge and discuss. We want to support Leicestershire 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 life course approach will provide a key theme throughout communications to stakeholders.

High-level implementation



A detailed implementation plan will sit underneath the high-level plan and will be fed back on quarterly at each Health and Wellbeing Board, showing progress made and evaluating campaigns.

Evaluation

	Target/measure	Outputs
Awareness	Website visits Social media traffic Media coverage	Analytics from social media content Number of website visits
Action	Number of attendees at events Level of participation from internal stakeholders Social media engagement – views, click throughs, comments	Number of responses for event attendance Number of internal stakeholders present at events Social media engagement linked to events
Feedback	Evaluation from engagement sessions Survey/consultation results Social media comments/messages	

The communication and engagement strategy will be reviewed as part of the annual strategy and delivery plan review that is presented to the HWB.

Agenda Item 7

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 24 FEBRUARY 2022

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

BETTER CARE FUND PLAN UPDATE

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board with an overview of the progress against delivery of the 2021/22 Better Care Fund (BCF) Plan.

Recommendation

2. It is recommended that the progress against the delivery of the 2021/22 Better Care Fund Plan be noted.

Policy Framework and Previous Decisions

3. Nationally, the BCF plan for 2021/22 for Leicestershire was officially approved by NHSE in January 2022.

4. The national BCF team has confirmed that as BCF policy guidance and framework was not published until October, 2021, there would not be the usual quarterly returns required until after approval.

5. National reviews and consultation on the BCF planning and assurance processes are beginning in early February 2022, with a series of engagement events and workshops across regions. These sessions will look back on the previous planning rounds and consider lessons for 2022-23. They will also aim to understand the types of system level governance changes already underway. E.g. ICS development.

6. In the meantime, government have given an indication that the BCF policy is likely to continue for a further two years through to 2023/24, although the content of the policy framework over this period is not yet determined.

7. The Health and Wellbeing Board approved the BCF Plan for 2021/22 at its meeting on 25th November 2021.

Current Position

8. Work commenced locally in January 2022 to refresh the BCF expenditure plan for 2022/23 in line with the annual planning arrangements for the CCGs and local authority

9. The focus of the refresh has been to ensure that each scheme funded in the BCF is meeting a series of key lines of enquiry (KLOE's) to meet value for money and desired integration outcomes.

10. The expenditure plan, is also under review, ensuring it keeps pace with commissioning intentions of partners in relation to the next phase of the transformation of health and care, for example changes to community response service or the introduction of care coordination as part of neighbourhood teams.

11. A working session with County Council and CCG partners to review and make recommendations against the expenditure plan, the scheme reviews taken place so far and to consider options and priorities for the unallocated spend arising from the annual uplift to the allocations as set out by government (see BCF income section below), will take place during early March.

12. The Integration Finance and Performance Group, which includes Finance and Strategy Leads from the County Council and the CCGs, reviewed the current forecast underspend at its meeting of the 19th January, 2022 and considered and proposed options and priorities for the unallocated spend. This will be presented to the March working session.

13. It is anticipated that later in 2022/23, NHS England will request a formal submission of the BCF plan. In previous years this has entailed the expenditure plan, supporting narrative, an overview of the BCF metrics. These elements will be brought to the Board for consideration in line with the national timescale, once known.

Update against national conditions for the 2021/22 Plan

National condition 2 – Social Care Maintenance

14. National condition 2 (1 being a joined up BCF submission) focuses on Social Care Maintenance and ensuring that CCG contributions to social care spend continue to match or exceed the minimum required.

15. Finance leads between organisations regularly review social care costs and have worked with CCG colleagues to secure additional in year funding to support increased demand for social care services.

16. In addition, system headroom funding bids have been submitted to support social care expenditure on community services e.g. brokerage and review teams.

National condition 3 – NHS Commissioned out of hospital services

17. During the re-emergence of the pandemic, we have continued to commission care and services with our health partners in the community.

18. Key activity commissioned in the last six months includes:
    - Discharge to recover therapy-led beds
    - Care co-ordination
    - Interim bed contracted framework
    - Complex patient case-management function
    - Support to provider market over winter pressures to expand staffing availability

National condition 4 – Plan for improving outcomes for people being discharged from hospital

19. The BCF plan submitted in November 2021, included robust plans to enable safe and timely discharge for patients across Leicestershire.

20. The regional team have requested an update for NHSE to briefly describe in bullet points, some of the actions that have taken place over the winter period in each HWBB area.

21. Below is the Leicestershire update:

- The discharge hub has developed further and includes all staff utilising Systm1. This includes real-time information on out of county and community hospital patients and enables the system to better understand our system performance against key metrics.
- Community Response Service is now up to 50% recruited to (20 out of 40) for home care assistants. The case management function that compliments this is being developed as part of the ASC restructure and due to come on-line from 1st April. This includes Community hospital and out of county hospital link-workers.
- Partners have re-commissioned therapy-led beds and interim beds (15 and 25 respectively) to ensure that safe and timely discharges remained. Around 50% of patients that are discharged to therapy beds have a reduced package of care and around 90% patients return home with either improved mobility prior to hospital or the same level of mobility.
- UHL and LPT Multi-agency discharge events (MADE) which include focused daily discharge meetings across health and social care to jointly discuss and agree all elements of a persons' discharge plan.
- The commissioning of home care provision has now been completed within the county. The framework has now been re-opened to further increase the amount of capacity available.
- ASC staff work with non-covid wards to co-triage patients with health staff to identify appropriate requirements for discharge. This includes a care co-ordinator and an Assistive Technology officer in support to maximise the use of community and equipment to increase the number of patients that are discharged with no further care requirements.
- Case management for complex nursing patients has been commissioned with Mids and Lancs. This includes a specialist nurse that works with wards on the complex case management and decision making.
- A review of commissioning for D2A residential placements is taking place in February across City and County.

BCF Income and expenditure

22. The increases for the WLCCG and ELRCCG minimum contributions for 2021/22 were 5.8% and 5.4% respectively. The BCF Plan for 2021/22 was submitted to

NHSE/I in November and totalled £65.3m. The funding breakdown is shown in the table below:

BCF Approved Budget	WLCCG	ELRCCG	LCC/DC	Total
CCG Minimum Contributions	24,985	18,681		43,666
Disabled Facilities Grants (DFG)			4,447	4,447
Improved BCF Autumn 2015			11,353	11,353
Improved BCF Spring 2017			3,403	3,403
Winter Pressures			2,414	2,414
Total Funding	**24,985**	**18,681**	**21,617**	**65,283**

2021/22 Forecast Outturn – Quarter 3

23. The overall forecast outturn for the financial year is £65.1m, representing a small underspend of circa £174,000.

	Overall Financial Position				Forecast Position by Organisation		
	Allocation £'000	Forecast £'000	Variance £'000		WLCCG £'000	ELRCCG £'000	LCC / DC £'000
BCF WLCCG	10,236	10,236	0		10,236		
BCF ELRCCG	7,348	7,348	0			7,348	
BCF LCC	26,082	25,908	174				25,908
Total BCF	**43,666**	**43492**	**174**		**10,236**	**7,348**	**25,908**
DFG	4,447	4,447	0				4,447
IBCF	17,170	17,170	0				17,170
Total BCF Plan	**65,283**	**65,109**	**174**		**10,236**	**7,348**	**47,525**

24. The above financial position was reported to the Integrated Finance and Performance Group and Joint Commissioning Group (subgroups of the Integration Executive) at it's meeting of the 19 January, 2022.

25. It was agreed, as previously stated, the underspend would be offset against the current overspend within the Community Response Service (120,000) and that the remainder would be set aside to further support the expansion and increased staffing of Home Care Assistants to support this service.

IBCF

26. The Improved Better Care Fund (IBCF) allocation for 2021/22 consists of funding announced in the 2015 Autumn Statement which amounts to £11.4m for

Leicestershire, in addition to funding announced in the Spring 2017 Budget of £3.4m and Winter Pressures funding of £2.4m.

27. The £11.4m from the Autumn 2015 announcement is recurrent and has been used to offset growth pressures experienced in demand led commissioned services due to demographic changes.

28. The £3.4m is non-recurrent and has been used to fund a range of transformational work and short-term schemes. Winter Pressures Funding of £2.4m is also non-recurrent and will be used to fund schemes which focus on specific winter pressures, and support new ways of working

BCF Metrics

29. The below table shows the BCF metrics for this financial year and the targets that we committed to as part of the submitted BCF plan:

Metric	Target
Unplanned admissions for chronic ambulatory care-sensitive conditions.	7% reduction on 2019/20 (831.5 to 775)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85% an increase of 0.3% on 2020/21 data of 84.7%
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (excluding RIP)	93.10%. This represents an increase of 1.5% on 2020/21 data and an increase of 1% on 19/20 data
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more	Weighted data = 14+ days = 10% 21+ days = 4.6% Maintaining current figures to meet national targets
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Planned rate of 519 = 3% reduction from 19/20 rate of 536

30. Attached to this report as Appendix A, is an updated dashboard summary of performance against the BCF metrics. Refreshed data for December 2021 is not yet available.

31. This dashboard is reported monthly to the Integration Delivery Group and bi-monthly to the Joint Commissioning Group.

Next Steps

32. The BCF schemes and associated funding will be reviewed by a working group of the County Council and CCG colleagues for 2022/23 expenditure.

33. An updated BCF expenditure plan will be produced in draft for April 2022. This will await the minimum contribution and allocation national guidance.

34. Any further policy and planning template timelines will be adhered to once they are known for the next financial year.

Circulation under the Local Issues Alert Procedure

None

Officer to Contact

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Tracy Ward – Assistant Director of Integration, Access and Prevention
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Appendix

BCF Metric Performance Dashboard

Background Papers

BCF Policy Framework 2021/22
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2021-to-2022/2021-to-2022-better-care-fund-policy-framework#:~:text=The%202021%20to%202022%20Better,system%20recovery%20from%20the%20pandemic.

BCF Planning Requirements 2021/22
https://www.england.nhs.uk/wp-content/uploads/2021/09/B0898-300921-Better-Care-Fund-Planning-Requirements.pdf

BCF Report to the Board – 25th November 2021
Agenda for Health and Wellbeing Board on Thursday, 25 November 2021, 2.00 pm - Leicestershire County Council (leics.gov.uk)

Relevant Impact Assessments

Equality and Human Rights Implications

35. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

36. An equalities and human rights impact assessment has been undertaken which is provided at http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf. This finds that the BCF will have a neutral impact on equalities and human rights.

37. A review of the assessment was undertaken as part of the BCF submission for 2021.

Partnership Working and associated issues

38. The delivery of the BCF plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

39. Day to day oversight of delivery is via the Integration Executive through the scheme of delegation agreed via the Integration Executive's terms of reference which have been approved by the Health and Wellbeing Board.

40. The delivery of the Leicestershire BCF ensures that several key integrated services are in place and contributing to the system wide changes being implemented through the five-year plan to transform health and care in Leicestershire, known as the Sustainability and Transformation Partnerships http://www.bettercareleicester.nhs.uk/

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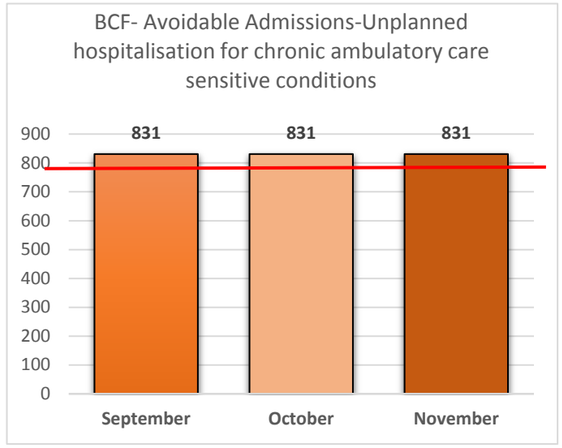
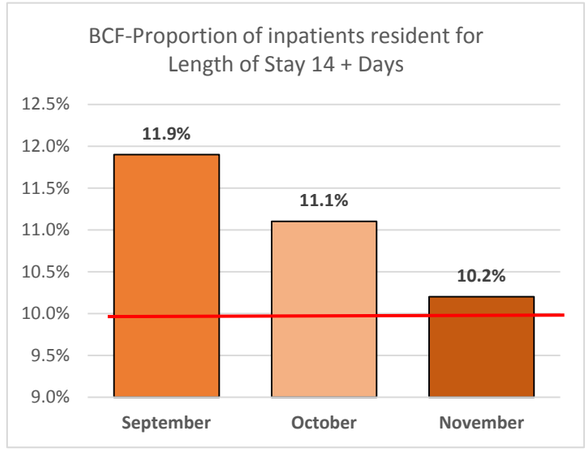
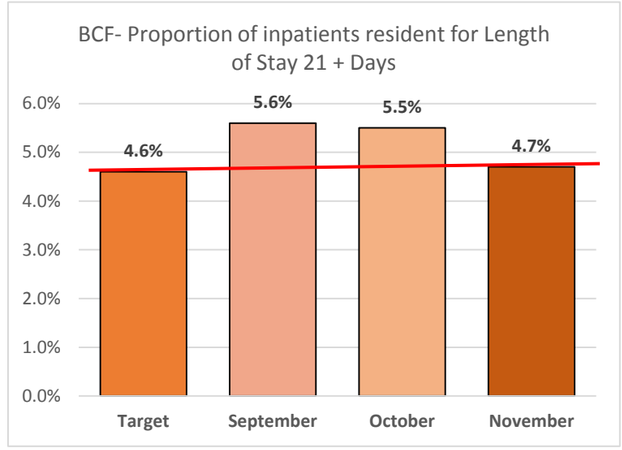
BCF Data Snapshot

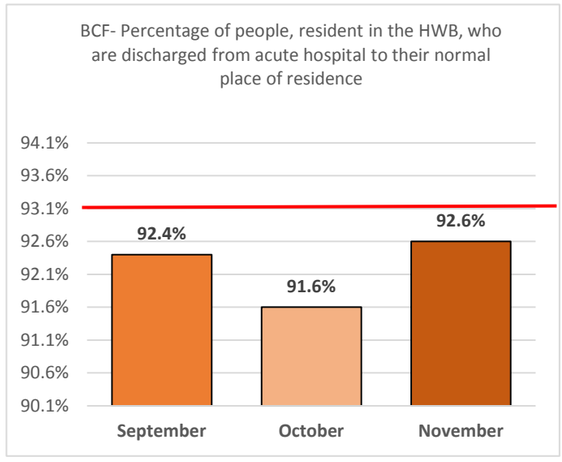
Appendix

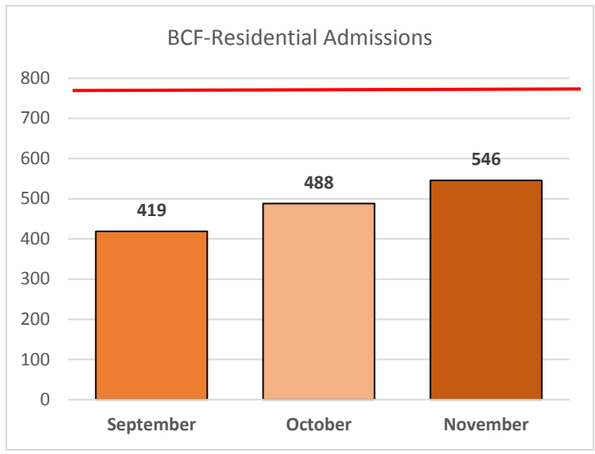
BCF

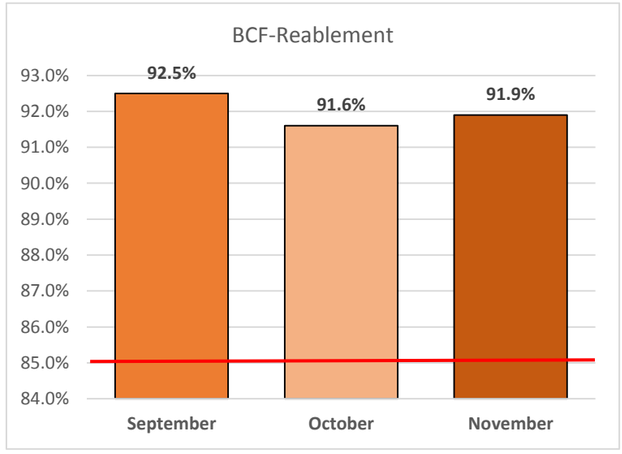












Comments: Better Care Fund Metrics, all or specific commisoning activity will contribute towards us meeting our BCF Targets. Sitting slighly above target of 775 for avoidable admissions. For length of stay we are under 1% above our target set and hope to meet by April 22. People discharged to their normal place of residence has seen a slight increase in Nov 21 but still 0.5% short of meeting our target of 93.1%. Our residential admissions are showing a decrease since Nov 21, to reach our target a maximum of 780 admissions is needed which we look set to meet if the decreasing trend can be sustained. Currently our Reablement service is proving effective exceeding our target set of 85.1%

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Agenda Item 8

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 24 FEBRUARY 2022

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

BETTER CARE FUND SECTION 75 AGREEMENT - APPROVAL AND ASSURANCE

Purpose of the report

1. The purpose of this report is to provide the Health and Wellbeing Board with an update concerning the refresh of the Leicestershire Better Care Fund (BCF) section 75 (s75) agreement for 2021/22 and to seek approval to continue with the pooled budget arrangements.

Recommendation

2. It is recommended that:

   a. The work undertaken to refresh the Section 75 (s75) pooled budget agreement for the Better Care Fund be noted;

   b. That the continuation of s75 pooled budget arrangements between Leicestershire County Council, East Leicestershire and Rutland and West Leicestershire Clinical Commissioning Groups (CCGs) be approved.

Policy Framework and Previous Decisions

3. The BCF Policy framework was introduced by the Government in 2014, with the first year of BCF plan delivery being 2015/16. The County Council's Cabinet in February 2014 authorised the Health and Wellbeing Board to approve the BCF Plan and plans arising from its use.

4. In July 2014 the County Council's Cabinet approved the negotiation and completion of a joint commissioning agreement under s75 of the National Health Service Act 2006 with NHS East Leicestershire and Rutland and West Leicestershire CCGs, along with any other legal agreements necessary for the joint administration of the BCF, including setting up a pooled fund to be managed by the County Council.

5. The original s75 agreement was developed and approved in March 2015 for the 2015/16 financial year. It was written on a rolling-agreement basis to be reviewed and updated each year. The s75 agreement has been reviewed and updated for

the subsequent years, with the most recent version covering 2020-21 having been approved by the Health and Wellbeing Board in January 2021.

Background

6. The Department of Health and Social Care has made it a condition that the operation of the BCF is subject to a s75 pooled budget arrangement where joint governance arrangements between the County Council and the two Leicestershire CCGs will apply.

7. The s75 agreement facilitates the commissioning and provision of services in the BCF Plan and sets out:

   a. The financial contributions and the operation and management of the pooled budget.

   b. The eligible service users included in the agreement.

   c. The County Council and CCGs' respective roles and responsibilities to be exercised in the joint-working arrangements.

   d. The scope of the services that are provided in partnership, including the County Council's functions and the CCGs' functions.

   e. Review and governance arrangements.

8. The BCF Policy Framework for 2021-22 states that;

   a. The BCF is one of the government's national vehicles for driving health and social care integration. It requires clinical commissioning groups (CCGs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under s75 of the NHS Act (2006)

Furthermore, the BCF Planning Guidance for 2021-22, states that:

   b. National condition 1 requires that a plan for spending all funding elements is jointly agreed by local authority and CCG partners and placed into a pooled fund, governed by an agreement under s75 of the NHS Act 2006. Plans will need to confirm that individual elements of the mandatory funding have been used in accordance with their purpose as set out in the BCF Policy Framework, relevant grant conditions and these planning requirements.

2021/22 BCF Section 75 Agreement

9. The s75 agreement has been reviewed to ensure that it still meets national BCF conditions and the governance requirements of all parties. It covers 2021/22 to align with the current BCF Plan and will supersede the 2020-21 agreement. A copy of the BCF s75 agreement is attached as the Appendix A to the report.

10. As part of the above review it has been determined that a s75 Variation Agreement for Covid19 Discharge Requirements is still required for 2021-22 and this is also attached as Appendix B to the report.

11. The updated agreement continues to have focus on financial risk sharing, with a default position that the BCF will continue to operate within its own resources and not place additional financial pressures to either Leicestershire County Council or the Leicestershire CCGs.

12. Key changes to previous plans are detailed below:

a) The BCF expenditure plan has been updated to reflect the 2021/22 position.
b) The plans include targets for the five key performance indicators:
   - Unplanned admissions for chronic ambulatory care-sensitive conditions.
   - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
   - Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (excluding RIP)
   - Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for:
     i) 14 days or more
     ii) 21 days or more
   - Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population

c) Updated, where applicable, legislation and local processes.

Resource Implications

13. The BCF expenditure plan for Leicestershire totals £65.3m in 2021/22 which includes a Disabled Facilities Grant of £4,447,227. The table below provides a summary of the Leicestershire BCF allocations:

Better Care Fund Funding 2021/22 Funding Source	
	£000
CCG Minimum Contributions	
East Leicestershire & Rutland CCG	18,681
West Leicestershire CCG	24,985
	43,666
MHCLG Funding	
Disabled Facilities Grants	4,447
IBCF (Comprehensive Spending Review **–** Autumn 2015)	11,353
IBCF (Adult Social Care Grant Spring Budget 2017)	3,404
Winter Pressure Grant	2,414

	21,618
Total BCF Funding	**£65,284**

14. The BCF budget is hosted by Leicestershire County Council.

Circulation under the Local Issues Alert Procedure

None

Officer to Contact

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0116 305 7454 jon.wilson@leics.gov.uk

Appendices

Appendix A - Leicestershire BCF Section 75 Agreement
Appendix B - Covid19 Discharge Requirements Section 75 Variation Agreement

Background Papers

Better Care Fund Policy Framework 2021/22
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2021-to-2022/2021-to-2022-better-care-fund-policy-framework#:~:text=The%202021%20to%202022%20Better,system%20recovery%20from%20the%20pandemic.

Report to the Health and Wellbeing Board – 28 January 2021 – Better Care Fund Section 75 Agreement Approval and Assurance.
https://politics.leics.gov.uk/documents/s159339/BCF%20s75%20Agreement%202020-21.pdf

Relevant Impact Assessments

Equality and Human Rights Implications

15. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

16. An equalities and human rights impact assessment has previously been undertaken which is provided at http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf.

    This found that the BCF will have a neutral impact on equalities and human rights.

Partnership Working and associated issues

17. The delivery of the BCF Plan and the governance of the assocatied pool budget is managed in partnership through the collaboration of commissioner and provicers in Leicestershire.

18. Day to day oversight of delivery is undertaken by the Integration Executive through the scheme of delegation agreed via the Integration Executive's terms of reference which have been approved by the Health and Wellbeing Board.

19. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the five-year plan to transform health and care in Leicestershire, known as the Sustainability and Transformation Partnerships http://www.bettercareleicester.nhs.uk/

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APPENDIX A

Dated **2020**

LEICESTERSHIRE COUNTY COUNCIL

and

NHS WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

and

NHS EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES

Contents

THIS AGREEMENT is made on day of

PARTIES

(1) **LEICESTERSHIRE COUNTY COUNCIL** of County Hall, Glenfield. Leicestershire (**"**the **Council**");

(2) **NHS WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP** of 55 Woodgate, Loughborough, Leicestershire, LE11 2TZ ("**WLCCG**"); and

(3) **NHS EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP** of Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB (**"ELRCCG**")**,**

WLCCG and ELRCCG together referred to as the "**CCGs**"

The Council and the CCGs, together referred to as the "**Partners**"

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services, and certain health related services, on behalf of the population of the administrative area of Leicestershire County Council.

(B) The CCGs have the responsibility for commissioning health services pursuant to the 2006 Act in the administrative areas of Leicestershire and Rutland.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and local objectives. It is a requirement of the Better Care Fund that the CCGs and the Council establish a pooled fund for this purpose. The Partners wish to extend the use of pooled funds to include funding streams from outside of the Better Care Fund.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead, integrated or joint (aligned) commissioning arrangements. It also provides means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering into this Agreement are to:

a) improve the quality and efficiency of the Services through improvements in integrated care and support;

b) meet the National Conditions outlined in the BCF Policy Framework 2021-22 in that the contribution to social care from the CCG via the BCF is agreed and meets or exceeds the minimum expectation as well as the local objectives;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services in order to sustain integration within the local health and social care economy on an ongoing basis; and

d) increase capacity and capability of integrated community services so that more care can be delivered in the community in the future.

(G) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

(H) This Agreement supersedes a prior s75 agreement between the Partners and which governed delivery of the Better Care Fund between 1 April 2020 and 31 March 2021.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

2018 Act means the Data Protection Act 2018.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

Annual Report means the annual report produced by the Partners in accordance with Clause 20 (Review).

Approved Expenditure means any expenditure approved by the Partners at meetings of the Partnership Board or as set out in the Scheme Specification in relation to an Individual Service above any Contract Price, Permitted Expenditure or agreed Third Party Costs.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement, details of which are more particularly set out in Clause 29.

BCF Quarterly Report means the quarterly report produced by the Partners and provided to the Health and Wellbeing Board.

BCF 2021-22 Agreement means the agreement between the Partners in respect of the Better Care Fund for the period commencing 1 April 2021.

Better Care Fund means the Better Care Fund as described in NHS England Publications as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 5 setting out the Partners' plan for the delivery and use of the Better Care Fund.

Better Care Fund Requirements means any and all requirements on the CCGs and Council in relation to the Better Care Fund set out in Law and guidance published by the Department of Health and NHS England.

CCGs' Statutory Duties means the duties of the CCGs pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the Commencement Date;

Commencement Date means 1 April 2021;

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or their treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Services Contract as consideration for the provision of goods, equipment or services as required as part of the Services and which, for the avoidance of doubt, does not include any Default Liability.

Data Protection Legislation means until the GDPR is no longer directly applicable in the UK the GDPR and any national implementing laws, regulations and secondary legislation, as amended or updated from time to time in the UK and including the 2018 Act; and then any successor legislation to the GDPR and/or UK law governing the processing of personal data

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Partner(s) as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under a Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are liable, under the terms of the relevant Services Contract.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(f) any form of contamination or virus outbreak; and

(g) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief.

Functions means the NHS Functions and the Health Related Functions;

GDPR means the General Data Protection Regulation (EU) 2016/679

HART Services means the Homecare Assessment and Reablement Team Services that are more particularly described in the Individual Scheme set out in the Scheme Specification at Schedule 1 part 3A to this Agreement.

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund and for any Non Pooled Fund the Partner that will host the Non Pooled Fund.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which has been agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Initial Term means the period commencing on the Commencement Date and ending at 00.00 hours on the 31st March 2021.

Integration Executive means a body which both advises the Health and Wellbeing Board on matters relating to the management of the Better Care Fund and delivers the health and care integration programme on behalf of the Health and Wellbeing Board.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an Individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Health Related Functions.

Lead Partner means the Partner responsible for commissioning a Service as part of a Lead Commissioning Arrangement.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Menorrhagia Service means the services that are more particularly described in the Individual Scheme set out in the Scheme Specification at Schedule 1 part 3B to this Agreement.

Month means a calendar month.

National Conditions mean the national conditions as set out in the National Guidance as are amended or replaced from time to time.

National Guidance means the Better Care Fund Policy Framework as issued from to time to time by, the Ministry of Housing, Communities and Local Government, and any relevant guidance issued by NHS England, the Department of Health and Social Care, or the Local Government Association either collectively or separately.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCGs as are relevant to the commissioning of the Services and which may be further described in each Scheme Specification.

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification.

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 10.5 and Schedule 3.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCGs and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board means the partnership board known as the Integration Finance and Performance Group responsible for review of performance and oversight of this Agreement whose terms of reference are set out in Schedule 2.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by Data Protection Legislation

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations.

Pooled Fund Manager means such officer of the Host Partner as is nominated by the Host Partner from time to time to manage the Pooled Fund.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement including the Council where the Council is a provider of any Services.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement and to which the arrangements set out in Part 1 of Schedule 1 to this Agreement shall apply (unless an Individual Scheme expressly states that alternative arrangements apply in whole or part to that Individual Scheme).

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement (and more specifically defined in each Scheme Specification, including the arrangements common to each Scheme Specification (which are more particularly set out in Schedule 1)).

Services Contract means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of the Services in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health and Social Care.

Term means the term of this Agreement as more particularly set out in Clause 2.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as the Partnership Board shall agree in advance may be incurred by a Partner in the proper performance of its obligations under this Agreement.

Underspend means the funds from Financial Contributions that remain in the Pooled Fund at the end of the Financial Year and which have not been spent or committed to be spent.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date and, subject to the provisions of this Clause 2 and Clause 22, shall continue for the Initial Term.

2.2 The Partners may extend this Agreement beyond the Initial Term for a period or periods and on varied terms as may be agreed between them and as approved by the Partners provided that the agreed period or periods of extension and the varied terms are recorded in the minutes of the meeting of the Integration Executive and such minutes are attached as memoranda to this Agreement, which shall constitute a variation pursuant to Clause 30.

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification or if not set out, for the duration of this Agreement unless otherwise agreed by the Partners through the Partnership Board.

2.4 This Agreement supersedes the BCF 2019-20 Agreement without prejudice to the rights and liabilities of the Partners under the BCF 2019-20 Agreement and the Partners agree that the BCF 2019-20 Agreement shall terminate (notwithstanding such of its provisions which expressly or impliedly survive termination), immediately prior to the Commencement Date.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function; or

3.1.3 the powers of the Council to set, administer and collect charges for any Council Health-Related Function; or

3.1.4 the Council's power to determine and apply eligibility criteria for the purposes of assessment under the Community Care Act 1990; or

3.1.5 the rights and powers, duties and obligations of the Partners in the exercise of their functions as public bodies or in any other capacity

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme Specification.

3.4 No changes to the budget or operational arrangements for any Individual Scheme or Financial Contributions will be made without the prior approval of the Partnership Board and such arrangements shall be recorded in the minutes of Partnership Board meetings.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to commission services. This may include one or more of the following mechanisms:

4.1.1 Lead Commissioning Arrangements;

4.1.2 Integrated Commissioning;

4.1.3 Joint (Aligned) Commissioning; and

4.1.4 the establishment of one or more Pooled Funds,

in relation to Individual Schemes (the "Flexibilities")

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such Functions as shall be agreed from time to time by the Partners as are necessary to commission the Services in accordance with their obligations under this Agreement.

5.3 The Partners may add new Individual Schemes to this Agreement provided that the provisions of Schedule 1 Part 1 shall apply to each new Individual Scheme unless otherwise agreed between the Partners. Such an addition of a new Individual Scheme shall constitute a variation pursuant to Clause 30 and the Partners shall complete a Scheme Specification in the form set out in Part 2 of Schedule 1 in respect of that Individual Scheme. The initial Individual Schemes which will commence on the Commencement Date are listed at Schedule 1 part 3. The initial Individual Schemes are not in the form set out in Part 2 of Schedule 1 rather the terms of Part 1 of Schedule 1 apply to them. The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.4 The introduction of any Individual Scheme will be subject to business case approval by the Partners and the Integration Executive.

6 COMMISSIONING ARRANGEMENTS

General

6.1 The Partners shall comply with the arrangements in respect of any Lead, Integrated or Joint (Aligned) Commissioning as set out in the relevant Scheme Specification

6.2 Each Partner shall keep the other Partners, the Integration Finance and Performance Group and the Integration Executive regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non-Pooled Fund.

6.3 The Partnership Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

6.4 Where there are Integrated Commissioning or Lead Commissioning Arrangements in respect of an Individual Scheme then prior to any new Services Contract being entered into the Partners shall agree in writing:

6.4.1 how the liability under each Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme; and

6.4.2 whether the Services Contract should give rights to third parties (and in particular if a Partner is not a party to the Services Contract to that Partner, the Partners shall consider whether or not the Partner that is not to be a party to the Services Contract should be afforded any rights to enforce any terms of the Services Contract under the Contracts (Rights of Third Parties) Act 1999 and if it is agreed that such rights should be afforded the Partner entering the Services Contract shall ensure as far as is reasonably possible that such rights that have been agreed are included in the Services Contract and shall establish how liability under the Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme.)

6.5 Where the Council is itself the Provider of Services, the Council; agrees that it shall report to the Partnership Board in respect of the delivery of those Services and shall comply with the performance arrangements for the relevant Services, as are set out in Schedule 6.

Integrated Commissioning

6.6 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme:

6.6.1 the Partners shall work in cooperation and shall endeavour to ensure that Services in fulfilment of the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.6.2 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

Appointment of a Lead Partner

6.7 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Partner shall:

6.7.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.7.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.7.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.7.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partner;

6.7.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.7.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.7.7 undertake performance management and contract monitoring of all Service Contracts including (without limitation) the use of contract notices, enforcement action and all other means deemed appropriate by the Lead Partner where Services fail to deliver contracted requirements;

6.7.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and

6.7.9 keep the other Partner and Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 Subject to Clause 7.4, it is agreed that the monies held in a Pooled Fund may only be expended on the following:

7.3.1 the Contract Price;

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Partnership Board:

7.3.4 Approved Expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance and recorded in the minutes of the Partnership Board: and

7.3.5 Management costs associated with the hosting and management of the Pooled Fund (including the costs of engaging the Pooled Fund Manager) as agreed in advance in writing and recorded in the minutes of the Partnership Board,

("Permitted Expenditure").

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure where both the approval of the Partnership Board and the express written agreement of each Partner has been provided.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners in accordance with Clause 7.4.

7.6 Pursuant to this Agreement, the Partners agree to appoint the Council as Host Partner for each of the Pooled Funds set out in the Scheme Specifications save where the Partners expressly agree through the Partnership Board that a Partner other than the Host Partner shall be the Host Partner for specific Individual Schemes. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund;

7.6.3 appointing the Pooled Fund Manager; and

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund (across the Individual Schemes and their composite Services);

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the Partnership Board as required by the Partnership Board and the relevant Scheme Specification;

8.2.6 ensuring action is taken to manage any projected Underspends or Overspends relating to the Pooled Fund in accordance with this Agreement;

8.2.7 preparing and submitting to the Partnership Board, Partnership Board Quarterly Reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met including (without limitation) comply with any reporting requirements as may be required by relevant National Guidance;

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as may be required by it and any relevant National Guidance including (without limitation) supplying Quarterly Reports referred to in Clause 8.2.7 above to the Health and Wellbeing Board.

8.3 In carrying out their responsibilities as provided under Clause 8.2, the Pooled Fund Manager shall:

8.3.1 have regard to National Guidance and the recommendations of the Partnership Board and shall be accountable to the Partners.

8.4 Unless otherwise agreed by the Partnership Board, there shall be no viring of funds between Pooled Funds or between Financial Contributions which are made in respect of Individual Schemes.

8.5 Upon request from either organisation, there should be total transparency around cost breakdown, service provisions and delivery against expected and agreed outcomes.

9 NON POOLED FUNDS

9.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

9.2 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

9.2.1 which Partner if any shall host the Non-Pooled Fund; and

9.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 The Partners shall ensure that any Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification.

9.5 Where there are Joint (Aligned) Commissioning arrangements, the Partners shall work in cooperation and shall endeavour to ensure that:

9.5.1 the NHS Functions funded from a Non Pooled Fund are carried out within the relevant CCG's Financial Contribution to the Non Pooled Fund for the relevant Service in each Financial Year; and

9.5.2 the Health Related Functions funded from a Non Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCGs and the Council to any Pooled Fund or Non Pooled Fund for the first Financial Year of the Term are set out in Schedule 3.

10.2 The Financial Contributions of the respective Partners to any Pooled Fund or Non Pooled Fund for each subsequent Financial Years will be as agreed by the Partners prior to the start of each Financial Year.

10.3 Financial Contributions will be agreed as follows:-

10.3.1 to reflect the resources required to deliver the agreed service models for the Services; and

10.3.2 to reflect the National Guidance (including any funding requirements set out therein).

10.4 Financial Contributions will be paid as set out in Schedule 3.

10.5 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non Recurrent Payments to a Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non Recurrent Payments shall be explicitly recorded in Partnership Board minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS

11.1 Schedule 3 shall set out any non financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Service Contracts and the Pooled Fund).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in Schedule 3, which provide for risk share arrangements arising within the commissioning of services from the Pooled Funds as set out in National Guidance.

12.2 Subject to Clause 12.3, the Host Partner for of the relevant Pooled Fund shall manage its expenditure on the Individual Schemes within the Financial Contributions allocated to them, and shall ensure that the expenditure is limited to Permitted Expenditure. The Host Partner shall report its expenditure of Financial Contributions to the Pooled Fund Manager and shall notify the Pooled Fund Manager of potential and actual Overspends and Underspends.

12.3 The Pooled Fund Manager shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 12.4.

12.4 In the event that the Pooled Fund Manager identifies or is notified of an actual or projected Overspend in relation to any Individual Scheme or Service, the Pooled Fund Manager must ensure that the Partnership Board is informed as soon as reasonably possible and the provisions of Schedule 3 shall apply.

Overspends in Non Pooled Funds

12.5 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an Overspend in relation to a Partner's Financial Contribution to a Non Pooled Fund that Partner shall as soon as reasonably practicable inform the other Partners and the Partnership Board.

12.6 Where there is a Lead Commissioning Arrangement the Lead Partner is responsible for the management of the Non Pooled Fund. The Lead Partner shall as soon as reasonably practicable inform the other Partner and the Partnership Board.

Underspend

12.7 In the event that expenditure (including monies committed to be spent) from any Pooled Fund or any Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the surplus monies shall be spent, in accordance with Schedule 3. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13 CAPITAL EXPENDITURE

13.1 Neither Pooled Funds nor Non-Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

13.2 The Partners agree that capital expenditure may be made from Pooled Funds where this is in accordance with National Guidance.

14 VAT

14.1 The Partners shall implement the required treatment of each Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

14.2 Subject to Clause 14.1, Services commissioned by the Council will be subject the VAT regime of the Council and Services commissioned by the CCGs will be subject to the VAT regime of the National Health Service.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the appropriate person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Where possible, any access that is required, shall be on reasonable notice to the Partners, however access may be at any time without notice, provided there is good cause for requiring access without notice.

15.3 The Partners shall comply with relevant NHS finance and accounting obligations as required by relevant Law and/or National Guidance.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement (including a Loss arising under an Individual Scheme or Services Contract) as a consequence of any act or omission of another Partner or Partners ("Other Partner(s)") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or any Services Contract then the Other Partner(s) shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner or Partners contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner or Partners acting in accordance with the instructions or requests of the First Partner or the Partnership Board.

16.3 If any third party makes a claim or intimates an intention to make a claim against a Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16, the Partner that may claim against the other indemnifying Partner(s) will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner or Partners specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner or Partners (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner or Partners and its/their professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that it maintains policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement and in the event of Losses shall seek to recover such Loss through the relevant policy of insurance (or equivalent arrangement).

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

Conduct of Claims

16.6 In respect of the indemnities given in this Clause 0:

16.6.1 the indemnified Partner shall give written notice to the indemnifying Partner as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

16.6.2 the indemnifying Partner shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the indemnified Partner, the indemnifying Partner shall consult with the indemnified Partner about the conduct and/or settlement of such claims and proceedings and shall at all times keep the indemnified Partner informed of all material matters.

16.6.3 the indemnifying and indemnified Partners shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners' respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCGs are subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled are therefore subject to ensuring compliance with the CCGs' Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

18.1 The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 7 and with any statutory obligations applicable to any of the Partners (for example but not limited to statutory obligations of the CCGs pursuant to Clause 14O of the National Health Service Act 2006 and statutory guidance issued thereunder).

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the Partners is vested in the Health and Wellbeing Board. The Integration Executive shall make recommendations to the Partners on behalf of the instructions of Health and Wellbeing Board and as to any action it considers necessary.

19.2 The Partners have established a Partnership Board (known as the Integration Finance and Performance Group) whose terms of reference and remit are set out in Schedule 2 (Governance).

19.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

19.4 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.5 The Health and Wellbeing Board is responsible for leading and directing work to improve the health and wellbeing of the population of Leicestershire through the development of improved and integrated health and social care services including the Better Care Fund.

19.7 The Partnership Board shall be responsible for ensuring that the Better Care Fund Plan achieves its aims and outcomes within the Financial Contributions agreed by the Partners and shall operate in accordance with Schedule 2.

19.6 Each Individual Scheme shall be overseen and reported upon in accordance with the governance arrangements set out in this Agreement except where alternative governance arrangements are specified in the relevant Scheme Specification.

20 REVIEW

20.1 The Partners shall produce a BCF Quarterly Report which shall be provided to the Health and Wellbeing Board in such form and setting out such information as required by National Guidance and any additional information required by the Health and Wellbeing Board or National Health Service Commissioning Board (NHS England).

20.2 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake:

20.2.1 a review, at least annually of the operation of this Agreement;

20.2.2 a Quarterly review of Pooled Funds, and Non Pooled Funds; and

20.2.3 a review of the provision of the Services within 3 Months of the end of each Financial Year.

20.3 Subject to any variations to the review process required by the Partnership Board, reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.4 The Partners shall within 20 Working Days of an annual review prepare a joint Annual Report documenting the matters referred to in this Clause 20. A copy of the Annual Report shall be provided to the Partnership Board and the Integration Executive.

20.5 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

21.1 The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

21.2 In deciding which Partner should deal with a complaint, the following should be taken into consideration:

21.2.1 where a complaint wholly relates to one or more of the Council's Health Related Functions it shall be dealt with in accordance with the statutory complaints procedure of the Council;

21.2.2 where a complaint wholly relates to one or more of the CCG's NHS Functions, it shall be dealt with in accordance with the statutory complaints procedure of the relevant CCG;

21.2.3 where a complaint relates partly to one or more of the Council's Health Related Functions and partly to one or more of the CCG's NHS Functions then a joint response will be made to the complaint by the Council and the relevant CCG, in line with the local joint protocol;

21.2.4 where a complaint cannot be handled in any way described above or relates to the operation of the arrangements made pursuant to this Agreement or the content of this Agreement, then the Partnership Board will set up a complaints subgroup to examine the

complaint and recommend remedies. All complaints shall be reported to the Partnership Board.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 12 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and any terms of this Agreement that expressly or by implication survive termination of this Agreement.

22.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

22.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to Service Users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.6.2 where either Partner has entered into a Service Contract in order to fulfil its obligations, pursuant to this Agreement, the term of which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed Financial Contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.6.3 the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing, provided that the Lead Partner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

22.6.4 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows, the other Partner may request that the Lead Partner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract;

22.6.5 the Partnership Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.7 Termination of this Agreement shall have no effect on the liability or any rights or remedies of the Partners already accrued, prior to the date upon which such termination takes effect.

22.8 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, a Partner may serve written notice of the dispute on any one or more of the other Partners, setting out full details of the dispute. For the avoidance of doubt, if one of the Partners is not involved in the dispute, that Partner shall also be required to be provided with a copy of the dispute notice and to be party to any dispute resolution proceedings under this Clause 23.

23.2 The Authorised Officers of all of the Partners shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Director of Adults & Communities for the Council and the Managing Directors of the respective CCGs or their nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect a Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 No Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by another Partner or incur any liability to another Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs, and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partners as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the

effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than [sixty (60) days], a Partner shall have the right to terminate the Agreement by giving [fourteen (14) days] written notice of termination to the other Partners. For the avoidance of doubt, no compensation shall be payable by any Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained from a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners will comply with the Information Sharing Protocol set out in Schedule 8, and in so doing will ensure that the operation of this Agreement complies with the Law, in particular the 2018 Act**.**

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

29.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient informing the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to The Director of Adults and Communities, County Hall, Glenfield. Leicestershire ;

Tel: 0116 2323232
Fax: 0116 3057440
E.Mail: jon.wilson@leics.gov.uk

29.3.2 if to WLCCG, addressed to The Chief Executive, 55 Woodgate, Loughborough, Leicestershire, LE11 2TZ;

Tel: 01509 567700

29.3.3 if to ELRCCG, addressed to The Chief Executive, Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB.

Tel: 0116 2955105

29.4 The post holders set out in clauses 29.3.1, 29.3.2 and 29.3.3 shall be the Authorised Officers for the purposes of this Agreement, unless the Partners notify the other Partners in writing that they wish to change the designation of their Authorised Officer. Such notification shall constitute a variation pursuant to Clause 30.1 and shall be agreed by the Partners in writing.

30 VARIATION

30.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the Partners.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE CORPORATE SEAL of **LEICESTERSHIRE COUNTY COUNCIL** was hereunto affixed in the presence of:	)))

Executed as a deed for on behalf of **WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

Executed as a deed for on behalf of **EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

SCHEDULE 1- PART 1 ARRANGEMENTS COMMON TO ALL INDIVIDUAL SCHEMES

Unless the context otherwise requires, the defined terms used in this Part 1 shall have the meanings set out in the Agreement.

The following will apply to the Scheme Specifications listed in Schedule 1 part 3, being the Individual Schemes set out in the Better Care Fund Plan 2019/20 except where alternative arrangements have been expressly set out in a particular Scheme Specification.

1 FUNDING

Individual Schemes shall be funded from Financial Contributions made to the Pooled Fund in accordance with the terms of this Agreement, provided that alternative funding arrangements may be put in place for an Individual Scheme if such alternative arrangements are expressly set out in the relevant Scheme Specification or agreed between the Partners.

2 AIMS AND OUTCOMES

Each Individual Scheme will specify the aims and outcomes for that Individual Scheme each of which, will need to be developed based on evidence/intelligence and deliver a shared version of the truth.

3 THE ARRANGEMENTS

Unless otherwise expressly stated in an Individual Scheme, the Service will be commissioned by the Partner that has statutory responsibility for providing the Services which are the subject of the Individual Scheme and will be funded from Financial Contributions made to the Pooled Fund.

4 FUNCTIONS

The Health Related Functions or NHS Functions relevant to each Individual Scheme will be identified in that Scheme Specification. Unless otherwise expressly stated, there will be no delegation of functions for the commissioning of Services in accordance with an Individual Scheme.

5 SERVICES

Where new Services are being commissioned they will be procured in accordance with procurement Law and regulations and in accordance with the rules and standing orders of the Partner who is commissioning those Services.

6 ASSURANCE AND MONITORING

The assurance framework and performance measures in relation to each Individual Scheme will be as specified in that Individual Scheme.

Performance of Individual Schemes will be monitored and reported in accordance with Schedule 5.

7 STAFF

Where Council staff are to be made available to a CCG or vice versa in relation to an Individual Scheme the terms on which such staff will be made available will be as specified in that Individual Scheme

8 INFORMATION SHARING AND COMMUNICATION

The Partners will comply with the terms of the Information Sharing Protocol in Schedule 8 and will enter into information sharing agreements in respect of each Individual Scheme as appropriate.

9 DURATION AND EXIT STRATEGY

9.1 The contractual arrangements for the variation or termination of Individual Schemes will include arrangements for:

(a) maintaining continuity of Services;

(b) allocation and/or disposal of any equipment relating to the Individual Scheme;

(c) responsibility for debts and on-going contracts;

9.2 No Partner will terminate an Individual Scheme without gaining prior approval from the other Partners. No Partner will make any variations to an Individual Scheme that may have an impact on the health and care integration programme of the Better Care Fund Plan, without the prior agreement of the other Partners and prior consultation with the Integration Executive.

9.3 Upon termination of the Individual Service, unless otherwise expressly stated in the Individual Scheme:

(a) responsibility for any termination of contractual arrangements with Service Providers as a result of the termination of the Individual Scheme and the consequences of such termination shall be the responsibility of the Partner or Partners who commissioned the Individual Scheme unless otherwise agreed by the other Partners;

(b) the responsibility for liabilities arising in relation to or out of or in connection with the termination of the Individual Scheme shall lie with the Partners or Partners with the responsibility for commissioning the Services.

PART 2 TEMPLATE SCHEME SPECIFICATION

THIS TEMPLATE SHALL BE USED TO SET OUT THE TERMS OF ANY NEW INDIVIDUAL SCHEMES AGREED IN ACCORDANCE WITH CLAUSE 5.3 OF THE AGREEMENT

TEMPLATE SCHEME SPECIFICATION

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

10 OVERVIEW OF INDIVIDUAL SCHEME

Insert details including:

(a) **Name** *of the Individual Scheme*
(b) *Relevant context and background information*
(c) *Whether there are Pooled Funds:*

The Host Partner for Pooled Fund X is [ ] and the Pooled Fund Manager, being an officer of the Host Partner is [ ]

11 AIMS AND OUTCOMES

Insert agreed aims of the Individual Scheme

12 THE ARRANGEMENTS

Set out which of the following applies in relation to the Individual Scheme:

(1) Lead Commissioning;
(2) Integrated Commissioning*;*
(3) Joint (Aligned) Commissioning;
(4) the establishment of one or more Pooled Funds and/or Non Pooled Funds as may be required.

13 FUNCTIONS

Set out the Council's Functions and the CCG's Functions which are the subject of the Individual Scheme including where appropriate the delegation of such functions for the commissioning of the relevant service.

Consider whether there are any exclusions from the standard functions included (see definition of NHS Functions and Council Health Related Functions)

14 SERVICES

What Services are going to be provided within this Scheme. Are there contracts already in place?
Are there any plans or agreed actions to change the Services?
Who are the beneficiaries of the Services? [1]

1 This may be limited by service line ─i.e. individuals with a diagnosis of dementia. There is also a significant issue around individuals who are the responsibility of the local authority but not the CCG and Vice versa

15 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Set out what arrangements will be in place in relation to Lead Commissioning/Joint (Aligned) commissioning. How will these arrangements work?

Contracting Arrangements
Insert the following information about the Individual Scheme:

(a) relevant contracts

(b) arrangements for contracting. Will terms be agreed by both partners or will the Lead Commissioner have authority to agree terms

what contract management arrangements have been agreed?
What happens if the Agreement terminates? Can the partner terminate the Contract in full/part?
Can the Contract be assigned in full/part to the other Partner?

Access
Set out details of the Service Users to whom the Individual Scheme relates. How will individuals be assessed as eligible.

16 FINANCIAL CONTRIBUTIONS

Financial Year 201.. ../201

	CCG contribution	Council Contribution
Non-Pooled Fund A		
Non-Pooled Fund B		
Non-Pooled Fund C		
Pooled Fund X		
Pooled Fund Y		

Financial Year 201.. ../201

	CCG contribution	Council Contribution
Non-Pooled Fund A		
Non-Pooled Fund B		
Non-Pooled Fund C		
Pooled Fund X		
Pooled Fund Y		

Financial resources in subsequent years to be determined in accordance with the Agreement.

17 FINANCIAL GOVERNANCE ARRANGEMENTS

[(1) As in the Agreement with the following changes:

(2) Management *of the Pooled Fund*

Are any amendments required to the Agreement in relation to the management of Pooled Fund?
Have the levels of contributions been agreed?
How will changes to the levels of contributions be implemented?
Have eligibility criteria been established?
What are the rules about access to the pooled budget?
Does the pooled fund manager require training?
Have the pooled fund managers delegated powers been determined?
Is there a protocol for disputes?

(4) ***(3)*** **Audit Arrangements**

What Audit arrangements are needed?
Has an internal auditor been appointed?
Who will liaise with/manage the auditors?
Whose external audit regime will apply?

(4) Financial Management

Which financial systems will be used?
What monitoring arrangements are in place?
Who will produce monitoring reports?
Has the scale of contributions to the pool been agreed?
What is the frequency of monitoring reports?
What are the rules for managing overspends?
Do budget managers have delegated powers to overspend?
Will delegated powers allow underspends recurring or non-recurring, to be transferred between budgets?
How will overspends and underspends be treated at year end?
Will there be a facility to carry forward funds?
How will pay and non pay inflation be financed?
Will a contingency reserve be maintained, and if so by whom?
How will efficiency savings be managed?
How will revenue and capital investment be managed?
Who is responsible for means testing?
Who will own capital assets?
How will capital investments be financed?
What management costs can legitimately be charged to pool?
What re the arrangement for overheads?
What will happen to the existing capital programme?
What will happen on transfer where if resources exceed current liability (i.e. commitments exceed budget) immediate overspend secure?
Has the calculation methodology for recharges been defined?
What closure of accounts arrangement need to be applied?

18 VAT

Set out details of the treatment of VAT in respect of the Individual Service consider the following:

- *Which partner's VAT regime will apply?*
- *Is one partner acting as 'agent' for another?*
- *Have partners confirmed the format of documentation, reporting and*
- *accounting to be used?*

19 GOVERNANCE ARRANGEMENTS FOR THE INDIVIDUAL SCHEME

Will there be a relevant Committee/Board/Group that reviews this Individual Scheme?
Who does that group report to?
Who will report to that Group?

Pending arrangements agreed in the Partnership Agreement, including the role of the Health & Wellbeing Board, Partners to confirm any bespoke management arrangements for the Individual Scheme

20 NON FINANCIAL RESOURCES

Council contribution

	Details	Charging arrangements	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

CCG Contribution

	Details	Charging arrangements	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

21 STAFF

Consider:

- *Who will employ the staff in the partnership?*
- *Is a TUPE transfer secondment required?*
- *How will staff increments be managed?*
- *Have pension arrangements been considered?*

Council staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the CCG.

If the staff are being seconded to the CCG this should be made clear

CCG staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the Council.

If the staff are being seconded to the Council this should be made clear.

22 ASSURANCE AND MONITORING

Set out the assurance framework in relation to the Individual Scheme. What are the arrangements for the management of performance? Will this be through the agreed performance measures in relation to the Individual Scheme.
In relation to the Better Care Fund you will need to include the relevant performance outcomes. Consider the following:

- *What is the overarching assurance framework in relation to the Individual Scheme?*
- *Has a risk management strategy been drawn up?*
- *Have performance measures been set up?*
- *Who will monitor performance?*
- *Have the form and frequency of monitoring information been agreed?*
- *Who will provide the monitoring information? Who will receive it?*

23 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council					
CCG					

24 INTERNAL APPROVALS

- *Consider the levels of authority from the Council's Constitution and the CCG's standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme;*
- *Consider the scope of authority of the Pool Manager and the Lead Officers*
- *Has an agreement been approved by cabinet bodies and signed?*

25 RISK AND BENEFIT SHARE ARRANGEMENTS

Has a risk management strategy been drawn up?
Set out arrangements, if any, for the sharing of risk and benefit in relation to the Individual Scheme.

26 REGULATORY REQUIREMENTS

Are there any regulatory requirements that should be noted in respect of this particular Individual Scheme?

27 INFORMATION SHARING AND COMMUNICATION

What are the information/data sharing *arrangements?*

How will charges be managed (which should be referred to in Part 2 above)
What data systems will be used?

- *Consultation – staff, people* supported by *the Partners, unions, providers, public*, other *agency*

Printed stationary

28 DURATION AND EXIT STRATEGY

What are the arrangements for the variation or termination of the Individual Scheme.
Can part/all of the Individual Scheme be terminated on notice by a party? Can part/all of the Individual Scheme be terminated as a result of breach by either Partner?
What is the duration of these arrangements?

Set out what arrangements will apply upon termination of the *Individual Service, including without limitation the* following *matters addressed in* the *main body* of *the* Agreement

i) (1) maintaining continuity of Services;

ii) (2) allocation and/or disposal of any equipment relating to the Individual Scheme;

iii) (3) responsibility for debts and on-going contracts;

iv) (4) responsibility for the continuance of contract arrangements with Service Providers (subject to the agreement of any Partner to continue contributing to the costs of the contract arrangements);

v) (5) where appropriate, the responsibility for the sharing of the liabilities incurred by the Partners with the responsibility for commissioning the Services and/or the Host Partners.

- *Consider also* arrangements *for dealing* with *premises, records, information sharing (and the connection* with *staffing provisions set out in the Agreement.*

29 OTHER PROVISIONS

Consider, for example:

- Any *variations to the provisions of the Agreement*
- *Bespoke arrangements for the treatment of records*
- *Safeguarding arrangements*

PART 3 AGREED INDVIDUAL SCHEMES

BCF Expenditure Plan 2021-22 v4.xlsx

PART 3A – SCHEME SPECIFICATION FOR HART SERVICES

SCHEME SPECIFICATION- HART SERVICES

30 OVERVIEW OF INDIVIDUAL SERVICE

HART is a Homecare Assessment and Reablement Team Service which is provided on an in house basis by the Council. The Council will provide the HART Services to the CCGs in accordance with this Scheme Specification and as such is referred to as the "provider" of those services.

DEFINED TERMS

The following definitions apply in this Scheme Specification:

Assigned IPRs: all Intellectual Property Rights (being Intellectual Property Rights other than Retained IPRs) developed by or on behalf of the Council in the provision of the Services.

Business Day: a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business.

Health Case Manager: means a person authorised by the CCGs to act as a Referrer and Assessor of Service Users on Pathway 2 to the HART Services as further defined in the HART Service Specification.

Charges: the payments made from the Permitted Budget for the HART Services which shall be calculated in accordance with the provisions of the Finance Protocol (set out in Schedule 3 of this Agreement).

HART Reablement Screening Tool: means the screening tool to be completed by the Health Case Manager or other health professional which will inform whether it is appropriate to Refer a patient to the HART team for receipt of the Services. The screening tool may be replaced by another tool developed by the Partners from time to time, provided that the replacement of the tool and the details thereof have been agreed by the Partners in writing and signed by the Authorised Officers on behalf of the Partners to record their agreement.

HART Staff: all persons employed or engaged by the Council or any of its Sub-contractors (included volunteers, agency workers, locums, casual or seconded staff) in the provision of the HART Services or any activity related to or connected with the provision of the HART Services.

Health & Social Care Protocol: means the Leicester, Leicestershire and Rutland Health and Social Care Protocol (Revised 2014) as it might be amended or superseded from time to time.

HART Services: short term intensive reablement support in Service Users' homes delivered by the Council HART Staff and as more particularly described in this Scheme Specification and which are the subject of an Order placed by the CCGs with the Council.

Intellectual Property Rights: all patents, rights to inventions, utility models, copyright and related rights, trademarks, service marks, trade, business and domain names, rights in trade dress or getup, rights in goodwill or to sue for passing off, unfair competition rights, rights in designs, rights in computer software, database rights, topography rights, rights in confidential information (including know-how and trade secrets) and any other intellectual property rights, in each case whether

registered or unregistered and including all applications for, and renewals or extensions of, such rights, and all similar or equivalent rights or forms of protection in any part of the world.

Local Healthwatch: an organisation established under section 222 of the Local Government and Public Involvement in Health Act 2007.

NHS: the National Health Service in England.

NICE Technology Appraisals: technology appraisals conducted by NICE in order to make recommendations on the use of drugs and other health technologies within the NHS.

Ordinary Residence: has the meaning given to it in the Care Act 2014 and associated guidance and "Ordinarily Resident" or "Ordinarily Resident" shall be construed accordingly.

Permitted Budget: means the Financial Contributions to the HART Services as set out in the Finance Protocol (at Schedule 3 of this Agreement).

Reablement Plan: means the reablement Support Plan agreed

Referral Process: means the process by which Service Users are referred by each of the CCGs to the Council's HART Staff pursuant to a Reablement Plan and Referred and Referral shall be construed accordingly. The Referral Process is more particularly set out in the service specification embedded at paragraph 5 below.

Regulatory or Supervisory Body: any statutory or other body having authority to issue guidance, standards or recommendations with which the parties or any of them must comply or to which they must or should have regard, including as applicable:

The Care Quality Commission;

the corporate body known as Monitor provided by section 61 of the Health and Social Care Act 2012;

the Special Health Authority known as the National Health Service Trust Development Authority established under the NHS Trust Development Authority (Establishment and Constitution) Order 2012 (NHSTDA);

The National Health Service Commissioning Board established by section 1H of the National Health Service Act 2006, also known as NHS England;

the Department of Health and Social Care or such other body superseding or replacing it;

the National Institute for Health and Care Excellence (NICE);

Healthwatch England.

Retained IPRs: all Intellectual Property Rights either owned by the Council or its third party licensors before the commencement of the provision of the HART Services by the Council or subsequently developed by or on behalf of the Council after the commencement of the provision of the HART Services by the Council other than in the provision of the Services except that such Intellectual Property Rights shall be Assigned IPRs where used by the Council in the provision of the HART Services.

Service User: A person resident in the administrative area of the county of Leicestershire who has been Referred to the Council by the CCGs.

Support Plan: means the support plan prepared by the CCGs which specifies the Services required for a Service User as it may from time to time be reviewed and revised to reflect changes to the Service User's needs.

31 AIMS AND OUTCOMES

The Aims and Outcomes for the HART Services are set out on page 3 of the service specification embedded at paragraph 5 below.

32 THE ARRANGEMENTS

The Council shall act as provider of the HART Services which are commissioned by the CCG in exercise of NHS Functions related to continuing health care in a domiciliary setting.

33 FUNCTIONS

The HART Services are commissioned in exercise of the NHS Functions set out in Regulation 5 of the Regulations. There is no delegation of Functions from the CCGs to the Council.

34 SERVICES

In addition to the obligations set out at Clause 17 of the Agreement in respect of Standards of Conduct and Service, the Partners agree, in view that the Council is the in house provider of the HART Services, that the Council shall comply with the following provisions:

5.1 Council Obligations

5.1.1 In supplying the HART Services, the Council shall (and in accordance with the embedded service specification in this paragraph 5):

(a) Ensure that the provision of the HART Services is consistent with the Service User's needs as identified in the Referral Process;

(b) perform the HART Services with the highest level of care, skill and diligence in accordance with best practice and appropriate clinical standards;

(c) co-operate with the CCGs in all matters relating to the HART Services, and comply with all reasonable instructions of the CCGs;

(d) use personnel who are suitably and appropriately registered, qualified, skilled, competent, experienced and appropriately trained in the application to the Service of the Health & Social Care Protocol and where revalidation is required by the appropriate professional regulatory body this is completed to perform tasks assigned to them, and in sufficient number to ensure that the Council's obligations are fulfilled and are covered by the Council's (and/or any subcontractor that is approved by the CCGs) indemnity arrangements for the provision of the HART Services;

(e) ensure that it obtains, and maintains all consents, licences and permissions (statutory, regulatory, contractual or otherwise) it may require and which are necessary to enable it to comply with its obligations;

(f) comply where applicable with the registration and regulatory compliance guidance of any relevant Regulatory or Supervisory Body and any standards and recommendations issued from time to time by any such Body;

(g) comply with the standards and recommendations issued from time to time by any relevant professional body and agreed in writing between the CCGs and the Council;

(h) comply, where applicable, with the recommendations contained in the NICE Technology Appraisals and have regard to other guidance issued by NICE from time to time;

(i) respond to any reports and recommendations made by Local Healthwatch;

(j) ensure that the HART Services conform with all descriptions and specifications set out in this Scheme Specification;

(k) ensure that the Services are carried out so as to meet the Service User's outcomes as identified in the Service User's Reablement Plan;

(l) provide all equipment, tools, vehicles and other items required to provide the Services;

(m) ensure that all staff using equipment in the delivery of the HART Services and all Service Users and carers using equipment independently as part of the Service User's care or treatment have received appropriate and adequate training and have been assessed as competent in the use of that equipment;

(n) ensure that all goods, materials, standards and techniques used in providing the HART Services are of an acceptable standard;

(o) observe all health and safety rules and regulations and any other reasonable security requirements that apply in respect of the HART Services;

(p) not knowingly do or omit to do anything which may cause the CCGs to lose any licence, authority, consent or permission on which they rely for the purposes of conducting their business;

(q) not knowingly do or omit to do anything which may constitute, cause or contribute to any breach by the CCGs of any licence or contract binding on the CCGs; and

(r) comply with the CCGs' policies on the use of their logo and branding and where applicable comply with the applicable NHS Branding Guidance which is available at www.nhsidentity.nhs.uk.

5.1.2 The Council shall comply with such of the CCGs' policies and procedures as are relevant and are specifically brought to the attention of the Council in the provision of the HART Services and with any relevant statute, regulations, circulars or guidance made under any relevant statute. In particular, the Council shall:

(s) comply with the Health and Safety at Work Act 1974 and of any other Acts Regulations or Orders pertaining to the health and safety of employees;

(t) comply with the Environmental Protection Act 1990 and the Water Resources Act 1991 and other environmental legislation;

(u) use reasonable endeavours to reduce the environmental impact of the HART Services and will implement and maintain systems deigned to ensure good environmental practice including compliance with any relevant British Standards or European equivalents;

(v) have regard at all times to the welfare of children and vulnerable members of society;

(w) comply with the Council's policies relating to the protection of children and vulnerable members of society;

(x) comply with relevant provisions of the Mental Capacity Act 2005 and the Health & Social Care Act 2008 (including but not limited to the duty of candour);

(y) have regard to and do all that is reasonable to prevent crime and disorder in the community;

(z) comply with the Public Interest Disclosure Act 1998 and develop a whistle blowing policy for its staff to encourage them to report any incidents of malpractice within the Service; and

(aa) comply with relevant legislation concerning the use of vehicles on the public highway.

5.1.3 The Council shall develop and continuously review Business Continuity Plans to minimise the impact of unforeseen events in connection with the HART Services including in respect of:

(bb) damage by fire;

(cc) the effects of extreme weather conditions;

(dd) the effects of pandemic illness on staff or Service Users;

(ee) other failures affecting buildings, utilities or equipment (including ICT equipment).

5.1.4 Where the provision of the HART Services requires the operation of vehicles the Council shall ensure that it complies with all relevant legislation. It shall also ensure that all vehicles used in the provision of the Services (whether or not they are owned by the Council) are adequately serviced and maintained and that management, monitoring and risk management procedures are in place in order to guarantee safe working practices.

5.1.5 The Council shall ensure that all staff and volunteers providing the HART Services are aware of the provisions of the Human Rights Act 1998(as amended) and shall take all reasonable steps and precautions to ensure that it does not infringe the human rights of any person (including Service Users) in the provision of the Services.

5.1.6 The Council shall co-operate fully with the authorised representative of the relevant Healthwatch who from time to time may wish to visit the Council in the exercise of its powers under the Local Government and Public Involvement in Health Act 2007 as amended and the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

The CCGs agree that they shall comply with the following provisions in order to assist the Council with the delivery of the HART Services:

5.5 . The CCGs' Obligations

5.5.1 The CCGs shall cooperate with the Council and provide such information and assistance to the Council's Staff as the Council may reasonably request in order to facilitate the smooth implementation of Reablement Plans.

5.5.2 The CCGs shall provide such access to their data, and other facilities as may reasonably be requested by the Council and agreed with the CCGs in writing in advance, for the purposes of the Services;

5.5.3 The CCGs shall inform the Council of all health and safety rules and regulations and any other reasonable security requirements that apply in respect of any Referral.

5.5.4 The CCGs shall ensure that any person making a Referral is trained to use the HART Reablement Screening Tool and uses it appropriately as part of the Referral process.

5.5.5 The CCGs shall ensure that each Service User to be Referred is assigned a named Health Case Manager who is responsible for liaising with HART Staff and who is authorised to take responsibility for clinical matters.

5.5.6 The CCGs shall monitor the number of hours of care Referred to ensure that the cost of Referrals does not exceed the Financial Contributions of ELRCCG or WLCCG.

35 COMMISSIONING, CONTRACTING, ACCESS

The CCGs will commission the HART Services from the Council who shall act as in house provider of the HART Services in accordance with the terms of this Scheme Specification. Further details of access for the HART Services are set out in the specification embedded at paragraph 5 above.

ELR CCG will act as co-ordinating commissioner on behalf of WL CCG in respect of the HART

Services. **Access**

A Referrals Process has been agreed and signed by the Authorised Officers on behalf of the Partners to record their agreement to them

The following provisions will apply in respect of Service Users who are not already resident in the administrative area of Leicestershire:

The CCGs may from time to time seek to Refer a Service User who is not Ordinarily Resident in the administrative area of Leicestershire. In those circumstances, the provisions relating to 'population' set out in paragraph 5 of the HART Service Specification (embedded at paragraph 5 above) shall apply and the Council may accept or decline such Referral provided that in determining whether to accept the Referral the Council will have regard to the following principles:

(ff) All Service Users who are Ordinarily Resident in the administrative areas of Leicestershire, Leicester City or Rutland (LLR) who require the Services should receive an effective and timely response

(gg) The Council and the CCGs should work together to ensure that Service Users' health and social care needs are addressed during the period of reablement.

(hh) Arrangements for accessing reablement should be broadly consistent across LLR

(ii) Responsibilities for which organisation commissions reablement services should be clear and straightforward, so that hospital staff know who should be referred, when they should be referred and where referrals should be made.

(jj) No Service User should be denied a service because of disputes about which local authority or CCG is responsible for paying for care.

36 FINANCIAL CONTRIBUTIONS

Please refer to the Finance Protocol at Schedule 3 of the Agreement in respect of the HART Services.

Costs where CCG Financial Contributions exceeded:

If the cost of Referrals (as defined in the specification embedded at paragraph 5 above) referable to either ELRCCG or WLCCG in any Financial Year exceeds that CCG's Financial Contribution, the Council is not obliged to accept any further Referrals in that Financial Year of Service Users for whom the overspent CCG is responsible.

37 FINANCIAL GOVERNANCE ARRANGEMENTS

Please refer to the Finance Protocol at Schedule 3 of the Agreement in respect of the HART Services.

38 VAT

All amounts payable by the CCGs to the Council in respect of HART Services are exclusive of amounts in respect of value added tax chargeable for the time being (VAT). Where any taxable supply for VAT purposes is made under an order by the Council to the CCGs, the CCGs shall, on receipt of a valid VAT invoice from the Council, pay to the Council such additional amounts in respect of VAT as are chargeable on the supply of the HART Services at the same time as payment is due for the supply of the HART Services

39 GOVERNANCE ARRANGEMENTS

The terms of reference in [Schedule 2] shall apply to the HART Services

40 NON FINANCIAL RESOURCES

Details of Non Financial Resources to be committed to the HART Services are set out in the service specification embedded at paragraph 5 above.

41 STAFF

12.1 The Council shall operate policies on personnel matters for both staff and volunteers. These shall include appropriate arrangements for recruitment, checks for suitability, levels of qualification and/or experience for specific posts, registration requirements, appraisals, training and development, and supervisory (managerially and professionally), disciplinary and grievance procedures, having regard to the nature of the Services, copies of which must be provided to the CCGs on request. The Council shall ensure itself and its Staff and any subcontractors meet the obligations as detailed in these policies.

12.2 Before the Council engages or employs any person in the provision of the Services, or in any activity related to, or connected with, the provision of the Services, the Council must without limitation, complete:

(kk) **the Employment Checks; and**

(ll) **such other checks as required by the DBS.**

12.3 The Council must have policies and procedures which acknowledge and provide for ongoing monitoring of Staff DBS status.

12.4 The Council shall comply with the Public Interest Disclosure Act 1998 (as if such Act applied to the Council) and shall establish and where necessary update from time to time a procedure for its personnel encouraging personnel to report to the Council any incidents of malpractice within the Council or the CCGs. In this context "malpractice" shall include any fraud or financial irregularity, corruption, criminal offences, failure to comply with any legal or regulatory obligation, endangering the health or safety of any individual, endangering the environment, serious misconduct or serious financial maladministration.

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42 ASSURANCE AND MONITORING

Details of the assurance and monitoring for the HART Services are set out in the specification embedded at paragraph 5 above.

43 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Council	Claire Jones	County Hall	0116 305773	Claire.Jones@leics.gov.uk
ELR CCG	Simon Pizzey (Head of Strategy and Planning)	G30, Pen Lloyd, County Council, Glenfield	0116 2953405	Simon.Pizzey@eastleicestershireandrutlandccg.nhs.uk
WL CCG	Arlene Neville	55 Woodgate, Loughborough, Leicestershire, LE11 2TZ	01509 567720	Arlene.Neville@westleicestershireandrutlandccg.nhs.uk

44 INTERNAL APPROVALS

This Individual Scheme has been approved in accordance with the lines of accountability described in the Agreement and in accordance with the Governance Arrangements.

45 RISK AND BENEFIT SHARE ARRANGEMENTS

[The Schedule 3] Financial Protocol shall apply to the HART Services.

46 REGULATORY REQUIREMENTS

Regulatory Requirements are set out in the specification embedded at paragraph 5 above.

47 INFORMATION SHARING AND COMMUNICATION

[The Protocol at Schedule 8] of this Agreement will apply to the HART Services. The Parties will comply with the requirements of the Information Sharing Agreement (and the requirement to have an Information Sharing Agreement in place), in respect of the HART Services.

48 DURATION AND EXIT STRATEGY

The provisions at [Clause 22] of the agreement will apply to the HART services.

In the event of the termination of the HART Services, howsoever arising (including expiry), the Council shall be required to agree a Succession Plan with the CCGs.

In addition to the obligations set out at [Clause 22.6] of the Agreement, the Partners agree that 6 months' notice shall be given by the Council or the CCGs in the event that they wish or require to terminate the provision/commissioning (as appropriate) of the HART Services (except in the case of Force Majeure).

49 OTHER PROVISIONS

49.1 The Council shall not be permitted to sub contract its obligations to deliver the HART Services without the express written agreement of the CCGs.

20.2 Unless otherwise specified, the Council shall retain ownership of all Retained IPRs and the CCGs shall own all Assigned IPRs (and the CCGs shall determine between themselves whether the title, rights and interests in the Assigned IPRs shall continue to be held by them jointly or shall be allocated between them, and shall determine any such allocation of the title, rights and interests between themselves) and shall grant to the Council an irrevocable, unrestricted royalty-free licence to use the Assigned IPRs.

PART 3B – SCHEME SPECIFICTATION FOR MENORRHAGIA SERVICES

Gynaecology Section 75 Schedule SCHEME SPECIFICATION

Part 1 – Template Services Schedule

TEMPLATE SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1. OVERVIEW OF INDIVIDUAL SERVICE

(a) Provision, review and subsequent removal, of Levonorgestrel Intrauterine System (LNG-IUS) for gynaecological (non-contraceptive) purposes including management of menorrhagia and hormone replacement therapy (HRT)

(b) Local authority commissions provision of LNG-IUS fitting, review and removal on behalf of the Clinical Commissioning Group (CCG).

The Section 75 service has zero value pooled budget, the CCG will pay on a cost per case basis for each IUS fitted, reviewed or removed following a quarterly invoice from the local authority.

2. AIMS AND OUTCOMES

This agreement aims to provide the fitting and removal element of LNG-IUS for women requiring Levonorgestrel intrauterine system LNG-IUS fitting as management of menorrhagia or other gynecological purpose such as HRT, endometriosis etc. where clinically relevant, thus reducing the requirement for hysterectomy.

BACKGROUND

The (LNG-IUS) is an intrauterine, long-term progestogen-only method of contraception licensed for 5 years of use. The effects of the LNG-IUS are local and hormonal, including prevention of endometrial proliferation and thickening of cervical mucus and suppression of ovulation in a small minority of women. The system has to be fitted and removed by a qualified practitioner. As well as being licensed as a contraceptive device, the LNG-IUS is also licensed for the management of idiopathic menorrhagia.

Menorrhagia / Heavy menstrual bleeding is defined as excessive menstrual blood loss which interferes with the woman's physical, emotional, social and material quality of life, and which can occur alone or in combination with other symptoms. Any intervention should aim to improve quality of life measures. The Levonorgestrel-releasing intrauterine system (LNG-IUS) is recommended as first line treatment for women with heavy menstrual bleeding and no underlying pathology (dysfunctional uterine bleeding) and in some women with heavy menstrual bleeding and identified benign pathology such as small fibroids (less than 3 cm in diameter which are causing no distortion of the uterine cavity) provided that long-term use is anticipated (at least 12 months). The LNG-IUS may also be recommended, following gynaecological investigation, for the management of conditions such as endometriosis. [2]

Evidence from two systematic reviews and one subsequent publication shows that LNG-IUS produces a clinically relevant reduction in menstrual blood loss in women complaining of heavy menstrual bleeding. https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-womenover40-jul-2010/

Local defined outcomes

- Reduction in secondary care referrals to gynecology (in particular for menorrhagia)
- Reduction in number of hysterectomies
- Improved uptake of long-acting reversible contraception (LARC)

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2 Heavy menstrual bleeding: assessment and management. Clinical guideline. National Institute for Health and Care Excellence. 2007. Last updated August 2016.

- Reduction in unplanned pregnancies
- Improved quality of life for women receiving the LNG-IUS
- Locally convenient service with improved access to care and reduced waiting times for LNG-IUS fitting
- Improved quality of care

3. THE ARRANGEMENTS

Leicestershire County Council will provide a lead commissioning arrangement for the CCGs, ensuring access to the service within the integrated sexual health service and community based contracts.

4. FUNCTIONS

The 2012 Health and Social Care Act created fragmentation across the sexual health commissioning system. Local Authorities are responsible for commissioning coils (intrauterine devices (IUDs) and intrauterine systems (IUSs) for contraceptive purposes and CCGs are responsible for commissioning IUS for non-contraceptive/gynaecological purposes such as for menorrhagia.

The fitting of IUSs for either purpose must be delivered within the same clinical guidelines, quality and service standards, including insertion by appropriately trained/qualified practitioners. Therefore, the CCGs will delegate the function for IUS fitting, review and removal for gynaecological, non-contraceptive purposes to Local Authorities to deliver as combined contraceptive and non-contraceptive services. This enables better use of resources and improved access for women.

Contract management and clinical governance arrangements will be led by the local authority as part of their existing contracts. Performance and financial monitoring of this schedule will be undertaken through the quarterly Integrated Finance and Performance meetings which are part of the Integration Executive's governance arrangements. CCGs will be provided with quarterly performance reports, results of the annual LARC audits and informed of any clinical governance issues/ risks relating to the service as required. CCGs will be required to pay for the reconciled quarterly activity on a cost per case basis within 30 days of receiving the invoice.

5. SERVICES

To deliver the delegated service, contract variations are needed to extend the Local Authority commissioned integrated sexual health service and community-based services for IUS to include provision of IUS for non-contraceptive purposes. (Current services are only commissioned to provide IUS's for contraceptive use.)

The Service(s) will be required to:

- **Ensure all clinicians delivering the service are fully qualified** including having up to date Letter of Competencies in IUD/S fitting.
- **Fit, review and remove LNG-IUS as appropriate** for the management of menorrhagia or other gynecological purposes. This includes confirming the woman is not pregnant at time of IUS fitting.
- **Maintain an up-to-date register of patients fitted with an LNG-IUS.** This will include the name of the clinician and details of the device fitted. This is to be used for the annual audit purposes as well as call and recall.
- **Provide adequate equipment**. Certain special equipment is required for fitting and removal. This includes an appropriate treatment room fitted with a couch and with adequate space, emergency equipment and drugs for resuscitation. For LNG-IUS fittings, a variety of vaginal specula, (and if skills allow cervical dilators, and equipment for cervical anaesthesia) need to be available and meet sterilisation requirements. Women should be informed about the availability of local anaesthesia and offered where possible. An appropriately trained assistant also needs to be present in the building to support the patient and assist the doctor during LNG-IUS procedures if required.
- **Undertake a risk assessment**. To assess the need for sexually transmitted infection (STI) or HIV testing and advice.
- **Assessment and follow up** in accordance with national clinical guidelines.
- **Wait times.** Patients will be seen within 6 weeks of referral. Patients seen outside of this timescale to be reported to the contract manager by exception. GPs of patients who cannot be seen within the 6 week period should be notified.

Follow-up arrangements:
Patient information and follow-up arrangements include:

- Appropriate verbal and written information, about the effectiveness, duration of use and side effects of all options for the management of menorrhagia, should be provided at the time of counselling and reinforced at fitting with information on follow up, effectiveness, duration of use, side effects and those symptoms that require urgent assessment.

- All women should be advised to seek immediate medical advice if they develop symptoms of fever, pelvic pain, irregular bleeding or vaginal discharge which might indicate infection. Arrangements should be in place to review patients experiencing problems in a timely fashion and to provide information and treatment.

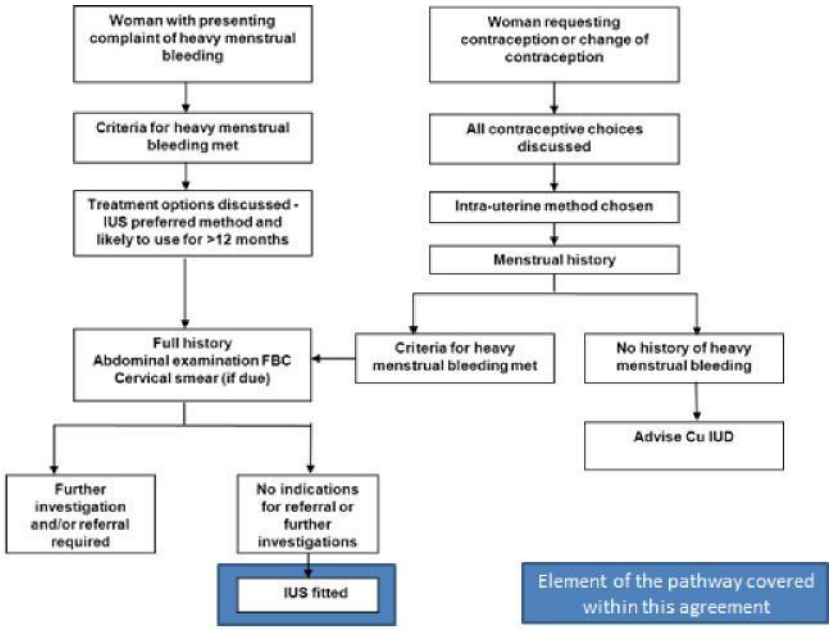
- All women should be advised to seek medical advice if threads are not palpable or they can feel the stem of the IUS.

- A routine follow up visit can be advised after the first menses following insertion of LNG-IUS, or 3-6 weeks later. However, this is not essential and it is more important to advise women as to signs and symptoms of infection, perforation and expulsion, returning if they have any problems relating specifically to the intrauterine method.

- Follow up that does not relate specifically to the insertion of the LNG-IUS i.e. related to the overall gynecological condition is not included in this agreement. This remains part of the general GMS/PMS contract.

All the above should be recorded in the patient record.

Algorithm for use of LNG-IUS for management of gynaecological conditions such as menorrhagia



Applicable national standards

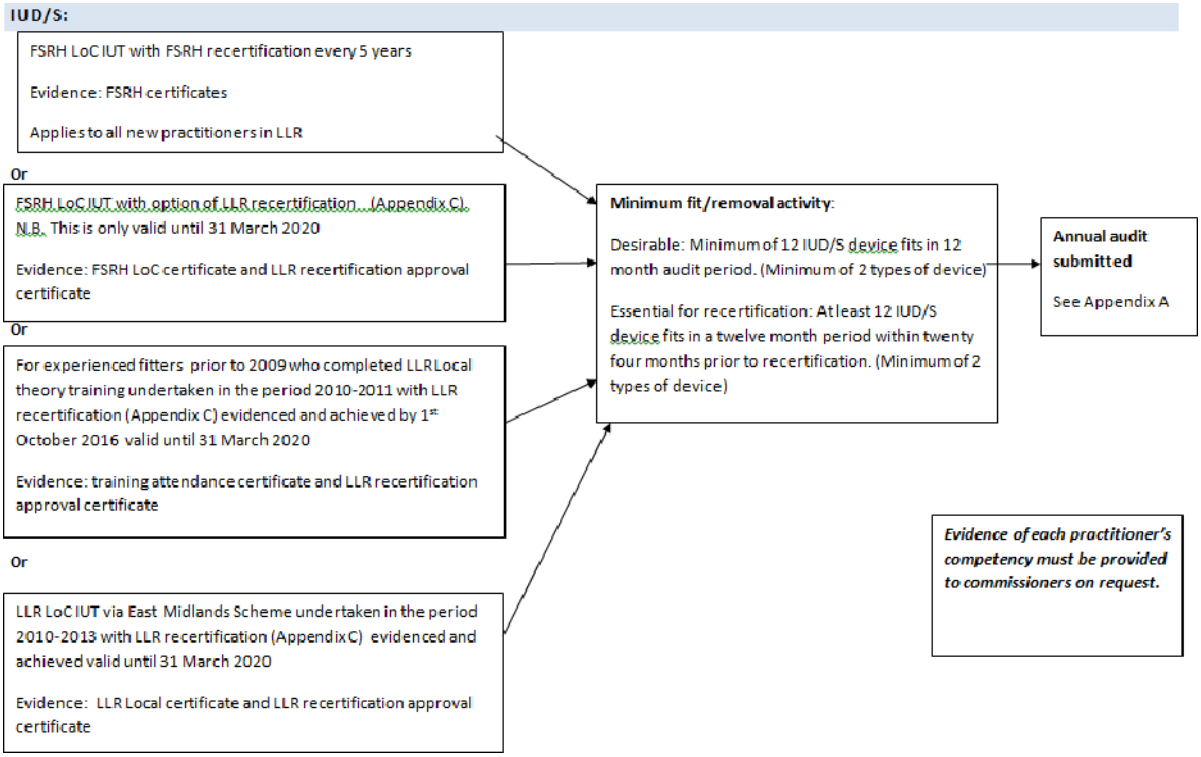
- NICE clinical guideline 44 (January 2007. Last updated August 2016) *Heavy Menstrual Bleeding: assessment and management.*
- Referral guidelines for suspected cancer – gynecological cancers (Implemented Oct 2000 DOH)
- NICE (2005a) *Referral guidelines for suspected cancer: quick reference guide.* Clinical guideline 27. National Institute for Health and Clinical Excellence.
- NICE (2005b) *Long-acting reversible contraception (NICE guideline).* National Institute for Health and Clinical Excellence.

> NICE (2007a) *Heavy menstrual bleeding: understanding NICE guidance.* National Institute for Health and Clinical Excellence.
> NICE (2007b) *Audit criteria: heavy menstrual bleeding.* National Institute for Health and Clinical Excellence.
> RCOG (1998) *The initial management of menorrhagia.* Evidence-based clinical guidelines no.1. Royal College of Obstetricians and Gynecologists.
> FSRH (2009) *UK medical eligibility criteria for contraceptive use [Superseded].* Faculty of Family Planning and Reproductive Health Care.
> NICE *support for commissioning for heavy menstrual bleeding*. (September 2013) > FSRH CEU Clinical Guidance *Intrauterine Contraception*. (2015)

Applicable local standards

The Provider shall demonstrate compliance with the following standards:

- Healthcare professions providing the service must hold membership of an approved professional body and be approved and eligible to practice in a setting that is appropriate to deliver this service as detailed in the specification, including DBS check.
- Device shall be inserted by appropriately trained/qualified practitioner as detailed in flowchart below.
- Standards relevant to premises requirements including:
  - Appropriate CQC registrations must be in place
  - A procedure for cleaning of the environment must be in place based on national guidance and audited
  - Hand hygiene training of staff involved
  - Equipment cleaning protocol based on national guidance must be in place
- The Provider shall cooperate in any announced and unannounced quality visits by the Commissioner.
- Provider must meet all standards of overarching existing contracts. **Summary of training requirements for practitioners delivering IUS fitting/removal service.**



Quality and Monitoring Requirements:

Quarterly reporting (in arrears) of:

- Number IUS inserted for
  - contraceptive purpose

- gynecological purposes
- joint contraception/gynecological purposes

Annual reporting of:

- Numbers of complex patients further referred from community based service providers onto gynaecology or integrated sexual health service. (based on audit returns)
- Numbers of serious complications in community based services: e.g. perforations at time of insertion (based on audit returns)
- Patient satisfaction surveys (Generic information in relation to the integrated sexual health service)
- LARC audit for community based services practitioner providers.

Beneficiaries:
Beneficiaries are women residing or registered in Leicestershire and Rutland that require IUS insertion for gynaecological, non-contraceptive purposes such as menorrhagia.

6. COMMISSIONING, CONTRACTING, ACCESS
Commissioning Arrangements

Leicestershire County Council will provide a lead commissioning arrangement for the CCGs, ensuring access to the service within the integrated sexual health service and community based contracts.

Contracting Arrangements
Leicestershire County Council and Rutland County Council already commission IUD/S provision for contraceptive purposes from:

a) General practices in their respective localities via community based contracts, including opportunity to deliver at Federation and Primary Care Network level and
b)The Integrated Sexual Health Service was re-procured to ensure continuity of sexual health service provision and the service specification includes IUS. The provider from 1st January 2019 is Midlands Partnership NHS Foundation Trust.

Contract management and clinical governance arrangements will be led by the local authority as part of their existing contracts. Performance and financial monitoring of this schedule will be undertaken through the quarterly Integrated Finance and Performance meetings which are part of the Integration Executive's governance arrangements. CCGs will be provided with quarterly performance reports, results of the annual LARC audits and informed of any clinical governance issues/ risks relating to the service as required. CCGs will be required to pay for the reconciled quarterly activity on a cost per case basis within 30 days of receiving the invoice.
Either party can terminate the contract in full by providing 12 months formal written notice to the other party. All activity relating to this notice period would be invoiced by the local authority and need to be paid by the CCGs. Local Authorities would need to implement contract variations with the relevant providers within 10 working days of receiving the notice.

Access

Referral will be via General Practice in order to ensure assessment and ongoing management of gynaecological issues which will not be included in this agreement.

7. FINANCIAL CONTRIBUTIONS
This schedule of the Section 75 has zero (£0) value, instead the CCG will pay on a cost per case basis for each IUS fitted, reviewed or removed following a quarterly invoice (in arrears) from the local authority. No pooled budget will be established between the CCG and local authority.
The CCG will reimburse the local authority for IUS services for gynaecological purposes such as menorrhagia with costs split as follows:

- IUS fitted for gynaecological purposes such as menorrhagia only are funded by East Leicestershire and Rutland CCG/ West Leicestershire CCG for patients registered /residing in their CCG locality.

- IUD/S fitted for contraception only are funded by Leicestershire County Council (for patients resident in Leicestershire) and Rutland County Council (for patients resident in Rutland).
- IUS fitted for joint gynaecological purposes (such as menorrhagia) and contraception purposes are funded on a 50/50 split between the CCG of residence/registered patient and Leicestershire County Council (for Leicestershire residents) and Rutland County Council (for patients resident in Rutland)..

The cost of each IUS fitting will be aligned with the local authority existing payment structures for the integrated sexual health service and community-based service. CCGs will be informed of these on an annual basis. Current costs for 21/22 are:	**Community Based Service (CBS) Contract**	**Specialist Sexual Health Service Contract from 1st January 2019**
IUS Fit	£80.00	£138.13
IUS post-fitting review (if required in accordance with FSRH guidance)	Included in CBS IUS Fit payment.	£63.16
Device cost (LNG-IUS)	Cost reimbursed by practice prescribing route.	Included in unit price of fit
IUS Removal	£20.00	Part of SRH standard tariff
Complex fit/removal. (SRH Complex Tariff)	N/A	£207.93

The local authority will not charge the CCG for existing contract management, new quarterly performance reports and invoices. If additional work is needed this would need specific negotiation between the two parties.
Activity to date suggests that the cost to each CCG would not exceed £50,000 per annum. However, exact figures will be determined once the service is established.

Financial resources in subsequent years to be determined in accordance with the Agreement

8. FINANCIAL GOVERNANCE ARRANGEMENTS
There will be a zero based pooled fund for this schedule. The CCG will be charged on a cost per case basis on a quarterly basis in arrears following completion of the activity.

Audit Arrangements

The Public Health department within the local authority will provide:

- Quarterly performance report detailing the number of IUS fits, reviews and removals by individual provider, the split of the cost (i.e. 100% or 50% CCG depending if also for contraception)
- Quarterly invoice for the activity in the previous quarter
- Annual LARC audit summary report for CBS service providers detailing the number of LARC fitters, their qualifications, complication rates and action taken. (Dependent on timely submission of completed audits from CBS providers)

These reports will be reported via the quarterly Integrated Finance and Performance meetings which are part of the Integration Executive's governance arrangements.

9. VAT
The local authority VAT regime will apply.

10. GOVERNANCE ARRANGEMENTS

The schedule will be managed through the quarterly Integrated Finance and Performance meetings which are part of the Integration Executive's governance arrangements. Lead officers are named in Section 14.

11. NON FINANCIAL RESOURCES

Council contribution

	Details	Charging arrangements[3]	Comments
Premises			
Assets and equipment			
Contracts	Integrated sexual health service Community based contracts for IUD/S and SDI	Recharge on cost per case basis as described in 7. Recharge on cost per case basis as described in 7.	New service was re-procured for January 2019. The previous section 75 arrangement are applicable to any new sexual health provider (Midland Partnership Foundation NHS Trust).
Central support services	Contract management, development of standardised quarterly performance report, invoice and copy of annual LARC audit.	No charge. Will be absorbed within existing Public Health contract management process for the sexual health services.	Additional work above these details would need to be individually negotiated with the local authority.

CCG Contribution

	Details	Charging arrangements[4]	Comments
Premises			
Assets and equipment			
Contracts			
Central support services	Commissioning support is required from the CCG to develop the		

3 Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources

4 Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources

	Details	Charging arrangements[4]	Comments
	section 75 and monitor progress.		

12. STAFF

No staff will be transferring from either organisation. Representatives from each organisation are required to develop and maintain the performance monitoring arrangements of this schedule.

13. ASSURANCE AND MONITORING

Contract and assurance monitoring will be extended to include IUS fitting for menorrhagia/gynaecological purposes within the existing processes for the Public Health Community Based Contract and Specialist Integrated Sexual Health Service contracts.

14. LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Mike Sandys	Leicestershire County Council, County Hall, Glenfield, LE3 8TB	0116 305 4259	mike.sandys@leics.gov.uk	0116 305 3795
CCG					

15. INTERNAL APPROVALS

Developing a more coordinated approach to sexual health commissioning has already been approved at Leicestershire County Cabinet as part of the Sexual Health Strategy 2016-19 in April 2016. Papers available at http://politics.leics.gov.uk/ieListDocuments.aspx?CId=135&MId=4601&Ver=4

16. RISK AND BENEFIT SHARE ARRANGEMENTS

Majority of the risks are managed as part of the existing local authority core public health business, due to the statutory responsibility to provide an open access sexual health service. The key risk is to the CCGs if activity levels are higher than predicted. This will be monitored on a quarterly basis and CCGs have the ability to provide the local authority 12 months' notice if they wish to cease the arrangement.

17. REGULATORY REQUIREMENTS

All clinician's providing the service must have an up to date letter of competency in IUS/D fitting, as detailed in the flowchart in section 5 above. This is managed as part of existing public health contract management.

18. INFORMATION SHARING AND COMMUNICATION

A four week stakeholder consultation (including CCGs, integrated sexual health provider, GPs, UHL gynaecology etc.) was completed from 13th February to the 13th March 2017, this suggested overall support for the schedule development. A summary of the consultation responses is available on request.

Data reports will be developed using the existing provider structures (Pathway analytics for the integrated sexual health service and the community based service portal for primary care.)

19. DURATION AND EXIT STRATEGY

Either party can terminate the contract in full by providing 12 months formal written notice to the other party. All activity relating to this notice period would be invoiced by the local authority and need to be paid by the CCGs. Local Authorities would need to implement contract variations with the relevant providers within 10 working days of receiving the notice. The schedule will be reviewed on an annual basis.

SCHEDULE 2– GOVERNANCE

Part 1 – TERMS OF REFERENCE OF THE PARTNERSHIP BOARD

Partnership Board

The membership of the Partnership Board will be as follows:

the Chief Finance Officer for the time being of NHS East Leicestershire and Rutland Clinical Commissioning Group;

or a deputy to be notified to the Partners in advance of any meeting;

the Chief Commissioning and Performance Officer (or equivalent) of NHS East Leicestershire and Rutland Clinical Commissioning Group:

or deputy to be notified to the Partners in advance of any meeting;

the Chief Finance Officer for the time being of NHS West Leicestershire Clinical Commissioning Group;

or a deputy to be notified to the Partners in advance of any meeting;

the Head of Service Integration and Delivery (or equivalent) of NHS West Leicestershire Clinical Commissioning Group;

or deputy to be notified to the Partners in advance of any meeting;

the Section 151 Officer for the time being of the Council:

or a deputy to be notified to the Partners in advance of any meeting;

the Assistant Director for Strategy and Commissioning (adults and communities) of Leicestershire County Council;

or a deputy to be notified to the Partners in advance of any meeting;

At the first meeting of the Partnership Board the members will elect from their number, by unanimous agreement, a Chairperson. Thereafter, there will be a re-election at the next meeting following each anniversary of the first meeting of the Partnership Board. The Chairperson may vote but will not have a casting vote.

To distinguish between the role of the Partnership Board and other health and social care integration groups, the Partnership Board will be more commonly referred to as the Integration Finance and Performance Group.

Role of Partnership Board

The Partnership Board shall:

Receive financial and activity information regarding the performance of the Individual Schemes in the Better Care Fund Plan on a quarterly basis or at a frequency otherwise agreed between the Partners, and shall take decisions on the delivery of the Individual Schemes based on that information, provided that, no decision shall be taken or acted upon without prior consultation with the Integration Executive where such decision could have an impact on the delivery of the health and care integration programme as set out in the Better Care Fund Plan.

Receive financial, performance and activity information regarding the joint commissioning areas within the plan on a quarterly basis, or at a frequency otherwise agreed between the Partners.

Receive financial and activity information regarding the Learning Disabilities Pooled budget on a quarterly basis, or at a frequency otherwise agreed between the Partners.

Receive financial and activity information regarding the Menorrhagia Services budget on a quarterly basis, or at a frequency otherwise agreed between the Partners.

Review the operation of Agreements under Section 75 of the NHS Act 2006 under the remit of the Partnership Board (such Agreements being listed at Schedule 1 to this Part) and make variations where appropriate, subject to any implications that would have an impact on the health and care integration programme being reported to the Integration Executive;

Review and agree at least annually a financial risk assessment in relation to services operated under a section 75 agreement and submit a report to the Integration Executive;

Agree such protocols and guidance as it may consider necessary in order to enable each Pooled Fund Manager to approve expenditure from a Pooled Fund;

Receive reports from and consider any recommendations from the Integration

Executive. **Accountability**

The Partnership Board shall operate within the lines of accountability set out in Part 2 of Schedule 2 of this Agreement.

Partnership Board Support

The Partnership Board will be supported by officers from the Partners' organisations, as may be agreed by the Partners from time to time.

Meetings

The Partnership Board will meet quarterly each year at a time to be agreed by the Partners.

The quorum for meetings of the Partnership Board shall be a minimum of one representative from each of the Partner organisations.

Decisions of the Partnership Board shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Partnership Board. If no unanimity is reached on the second occasion it is discussed then the matter shall be escalated to the Authorised Officers. If no agreement can be reached following escalation to the Authorised Officers, any Partner may invoke the Dispute Resolution procedure of the relevant section 75 Agreement.

A meeting of the Partnership Board cannot take place unless it is quorate. In the event of inquoracy the Partners shall procure that the meeting will be re-convened within one month of the date of the inquoracy.

Minutes of all decisions shall be kept by the Chairperson and copied to the Authorised Officers within seven (7)] days of every meeting.

Delegated Authority

Each member of the Partnership Board will have delegated authority from his/her Partner, through that Partner's own governance structure and schemes of delegation, to take decisions relating to the management of the Individual Schemes and Pooled Fund. These include, but are not limited to, determining commitments which exceed or are reasonably likely to result in an Overspend provided that

the members of the Partnership Board can only authorise commitments in accordance with the risk sharing arrangements set out in the relevant Agreement.

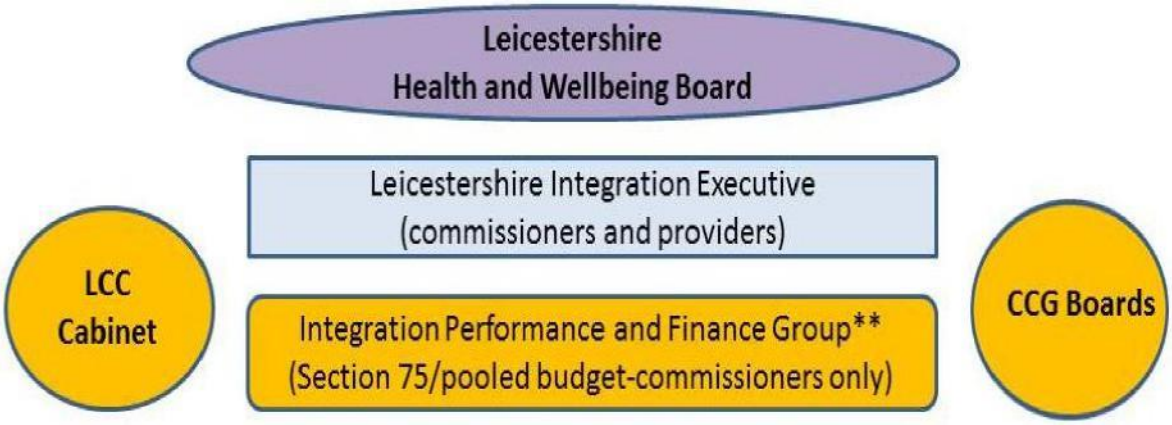
Information and Reports

The Pooled Fund Manager shall supply to the Partnership Board on a quarterly basis with the financial and activity information required under the Agreement in relation to the operation of the Individual Schemes and the Pooled Fund.

Post-termination

The Partnership Board shall unless otherwise agreed by the Partners in writing continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any Service Contracts are received by the Partners in the same proportions as their respective contributions at the date of termination.

Part 2 to Schedule 2 – Lines of Accountability of Partnership Board



	Role	Responsible
1	To lead and direct work to improve the health and wellbeing of the population of Leicestershire through the development of improved and integrated health and social care services including the Better Care Fund	Health and Wellbeing Board
2	To provide leadership, direction and assurance on behalf of Leicestershire Health and Wellbeing Board so that the vision for integrated health and care in Leicestershire is delivered, in line with national policy and local priorities including the management of Individual Schemes and services.	Integration Executive
3	To ensure that the Better Care Fund Plan achieves its aims and outcomes within the Financial Contributions agreed by the Partners and operating in accordance with its Terms of Reference	Partnership Board
4	To ensure that the Help to Live at Home Service achieves its aims and outcomes within the Financial Contributions agreed by Partners and operating in accordance with its Terms of Reference.	Partnership Board

SCHEDULE 3 – FINANCE PROTOCOL

Part 1

Statement on Financial Arrangements

The Better Care Fund Plan will be enabled by a Pooled Fund.

The Council will manage the Pooled Fund acting as Host Partner and engaging the Pooled Fund Manager in accordance with the terms of this Agreement.

The Financial Contributions to the Pooled Fund shall be made from the following funding streams and any other funding streams that may be made available to the Partners or any of them from time to time:

- CCG Revenue Funding for the Better Care Fund
- Disabled Facilities Grants
- MHCLG Funding for the Improved Better Care Fund

Financial Contributions for 2021/22

The Financial Contributions of each of the Partners for the Initial Term are more particularly set out in Table 1 below:

Table 1 Financial Contributions for 2021/22

	NHS East Leicestershire and Rutland CCG	NHS West Leicestershire CCG	Leicestershire County Council	Total
CCG Minimum allocation	£18,680,875	£24,984,683	Nil	£43,665,558
Disabled Facilities Grant	Nil	Nil	£4,447,227	£4,447,227
IBCF (Comprehensive Spending Review 2015)	Nil	Nil	£11,352,700	£11,352,700
IBCF (Additional Adult Social Care Allocation Spring Budget 2017)	Nil	Nil	£3,403,556	£3,403,556
ASC Winter Pressures Grant	Nil	Nil	£2,414,247	£2,414,247
Total BCF Funding	**£18,680,875**	**£24,984,683**	**£21,617,730**	**£65,283,288**

Financial Contributions for subsequent Financial Years will be agreed between the Partners in accordance with Clause 10 of the Agreement.

Payments in respect of all Individual Schemes commissioned by the Partners from the Better Care Fund shall be made in accordance with the Agreement and this Schedule 3.

The cost of the operation of the Pooled Fund will be as identified by the Council and as agreed by the Partners. Pooled Fund operational costs and how they will be met will be set out in the Better Care Fund Spending Plan.

The Pooled Fund Manager will be responsible for the day-to-day management of the Pooled Fund. At the date of this Agreement the Pooled Fund Manager is:

Helen Moran
Finance Analyst
Leicestershire County Council
E-mail - Helen.Moran@leics.gov.uk
Telephone - 0116 3057609

The Council undertakes to inform the CCGs if the identity of the Pooled Fund Manager is to change during the Term.

Budget Setting

The key budget setting deadlines for each Financial Year during the Term are set out below. The timings are intended to ensure the strategic development of health and social care integration and that Individual Schemes are procured and signed off in a timely manner.

October	Financial Modelling to be undertaken to predict future financial commitments to be funded from the Better Care Fund.
November	Proposed Better Care Fund spending plan to be discussed and agreed by the Partnership Board.
January	Better Care Fund Plans to Cabinet / Scrutiny committees (Council) Better Care Fund Plans to CCG Boards Better Care Fund Plan to the Integration Executive and the Leicestershire Health and Wellbeing Board
February	Final Council approval Final CCG approval

The above timeline shows where actions will take place and how recommendations on strategic development and investment from the Partnership Board will need to feed into the financial planning and processes of the CCGs and the Council.

Each Partner will need to confirm the level of investment available for the Better Care Fund in each Financial Year of the Term. The Partner responsible for commissioning each Individual Scheme will receive from the Pooled Fund the amount agreed for that Individual Scheme in the Better Care Fund Spending Plan, which will be used to procure the relevant Services as appropriate.

The Better Care Fund Plan will include details of Individual Schemes that will be funded from the Better Care Fund. Each Individual Scheme will be allocated a maximum budget within which Partners must work. The Better Care Fund Plan will include analysis of the cost per Individual Scheme.

Should the Partners agree not to continue to fund an Individual Scheme any liabilities or costs associated with its termination will be the liability of the Partner responsible for commissioning that Individual Scheme unless otherwise agreed by the Partnership Board.

Inflationary pressures will be identified by the commissioning organisation and reported to the Pooled Fund Manager for inclusion into the Better Care Fund Spending Plan.

If any Partner receives an allocation or grant part or all of which is specific to an Individual Scheme identified in this Agreement, the relevant Partner will pay the relevant part or all of those allocations or grants as appropriate to the Pooled Fund in addition to the sums that make up their agreed Financial Contributions to the Pooled Fund.

Non-recurrent Payments will be recognised as such and the commitments against them highlighted. This is to reduce the risk of Non-recurrent budgets funding recurrent commitments and should this happen that all Partners are aware of the risk.

Budgetary Control and Reporting

The Pooled Fund Manager will administer the Pooled Fund in accordance with the budgetary control systems and other applicable financial procedures of the Council. The relevant governance documents of the Council as Host Partner will be applied, save that the Council will only vire funds out of the Pooled Fund into its own funds with the prior agreement of all of the other Partners (for example but not limited to: in the circumstances where the Council is acting as a provider of Services pursuant to a Scheme Specification).

The financial systems of the Council will be used to record and monitor income and expenditure. Financial and relevant budget reports will be provided to each Partner by the Council in respect of the Pooled Fund and the Individual Schemes in a format such that each of the other Partners is able to maintain and complete their financial records in accordance with the accounting and statutory requirements to which that Partner is subject. The co-ordination of this information will be arranged by the Council with all Partners continuing to maintain records and supply detail as required in order to assist with completion of any Pooled Fund reports required pursuant to the Agreement.

The content and frequency of Pooled Fund reports presented to the Partnership Board will be in accordance with Schedule 5.

The Pooled Fund Manager will draw any actual or projected Under or Overspend to the attention of the Partners as soon as reasonably possible, with reasons for the occurrence and options for the Partnership Board to consider. Under and Overspends will be dealt with in accordance with this Schedule 3

The Council will be responsible for the internal audit of the Pooled Fund. Internal Auditors appointed by the CCGs will undertake reviews as part of an agreed annual work programme. The Council's external auditors will audit the operation of the Pooled Fund as part of their ongoing work programme.

An annual memorandum of Account must be produced by the Council in accordance with Section 75 of the NHS Act 2006. This will need to be incorporated into each Partner's final accounts and fit with individual final accounts timetables. The audit of the Memorandum of Account will be undertaken by the Council's external auditors.

Financial Risk Management and Sharing

Only services included in the Better Care Fund Plan are subject to the financial risk management and sharing protocol.

Financial Risk

With the exception of the HART service and the Menorrhagia Service, overspends on each Individual Scheme included in the Better Care Fund Plan are the responsibility of the Partner responsible for commissioning that Individual Scheme and will not be funded from the Pooled Fund, unless agreed by all the Partners.

Where Overspends on Individual Schemes have been agreed, these shall be funded from:

1. Current Financial Year Underspend on other Individual Schemes funded through the Better Care Fund, or if there is no such Underspend;

2. Agreed additional partner contributions at the time individual scheme overspends are agreed by Partnership Board.

The management of overspends relating to the HART service and the Menorrhagia Service is detailed in Part 2 of this Schedule 3.

With the exception of the HART service and the Menorrhagia Service, underspends in respect of Individual Schemes from a Financial Year will:

1. Be used to offset Overspends in other Individual Schemes where all Partners agree (unless the Underspend is as a result of a delay in the commencement of the provision of Services which will result in a financial commitment in the next Financial Year in respect of that Individual Scheme).

Be returned to partners in proportions as agreed by Partnership Board and in accordance with National Guidance.

The management of underspends in the HART service and the Menorrhagia Service is detailed in Part 2 of this Schedule 3.

Payment of Pooled Fund Contributions

The Council will invoice the CCGs for their contribution to the Pooled Fund in accordance with an agreement made at the beginning of each financial year for the amounts identified in the Better Care Fund Spending Plan. The CCGs will each invoice the Council for sums due from the Pooled Fund which are to be paid to the CCGs to deliver the Individual Schemes for which they are respectively responsible as per the agreement. Any changes to invoicing arrangements shall be agreed by the Partnership Board

Part 2 - Financial Risk Management and Risk Sharing of the HART Service

Overarching Principles

1. The following principles apply in relation to the management of the Pooled Fund for HART Services:

I. The HART Service will be paid for from the Pooled Fund. Payments will be calculated based on fixed percentages for each party of the actual costs.

. **The Council's Medium Term Financial Strategy and the CCGs'** QIPP efficiency savings will not operate under a risk sharing basis, each Partner will manage this risk individually.

Contributions to the Pooled Fund

2. Contributions to the Pooled Fund in 2021/22 will be as set out in table 1 below:

Table HART Reablement 2021/22	NHS West Leicestershire Clinical Commissioning Group	NHS East Leicestershire & Rutland Clinical Commissioning Group	Leicestershire County Council	Total
Forecast Cost	**£435,659**	**£325,743**	**£4,538,955**	**£5,300,357**
Percentage Contribution	**8.22%**	**6.15%**	**85.63%**	**100%**

2. Partner's contributions into the Pooled Fund shall be reviewed and, where necessary, adjusted annually on 1St April or at a later date as agreed by the Partnership Board

3. In order to manage costs effectively, and to ensure that there are no inappropriate Referrals into the HART Services, the CCGs will consistently apply the eligibility criteria (as set out in the Hospital Discharge Screening Tool) for the HART Services.

4. The hourly rates used in calculating costs will be the actual cost of the Services.

5. In 2021/22 the cost of the HART Services for WLCCG and ELRCCG respectively will be funded from the Better Care Fund. The indicative contribution from the BCF will be:

BCF funded cost of step down reablement services			
Financial Year	NHS West Leicestershire Clinical Commissioning Group	NHS East Leicestershire & Rutland Clinical Commissioning Group	Total
2020/21	£435,659	£325,743	£761,402

6. Financial monitoring will be undertaken by the Council throughout the financial year and will report to CCGs details of:
   -
   - Actual expenditure.
   - Forecast for the financial year based on trends.
   - Any forecast overspend or underspend in the reablement pool.
   - Outcomes of assessment following the reablement episode.

17. At the end of a financial year a reconciliation of expenditure in the Pooled Fund will be undertaken by the Council. Unless otherwise agreed by all Partners, any overspends or underspends will be shared by Partners on the basis of their proportional contribution into the Pooled Fund as outlined in table 1.

18. Each Partner will advise the other Partners at the earliest opportunity of any issues that will impact on the cost and/or volume of activity in the Pooled Fund.

Financial Governance

19. Financial aspects of the HART Services will be presented to and jointly assured by the Integration Finance and Performance Group.

Financial Risk Management and Risk Sharing of the Menorrhagia Service

20. The financial arrangements relating to the Menorrhagia Service will be separate from the BCF pool and the HART Risk Sharing Arrangements. The CCGs shall make payment for the Menorrhagia Services within [30] days of receipt of invoices from the County Council's Public Health Directorate for the activity delivered in the previous quarter for the Menorrhagia Service. The rates for the Menorrhagia Service will be as identified in the Scheme Specification for Menorrhagia Services set out in Schedule 1 Part 3B to this Agreement as they may be amended from time to time.

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Contract save where this Agreement or the context requires otherwise.

Where Lead Commissioning Arrangements are in place in respect of an Individual Scheme, the Partners shall agree which of provisions in Part 1 and Part 2 of this Schedule shall apply to that Individual Scheme and may agree further provisions.

Where Lead Commissioning Arrangements are not in place in respect of an Individual Scheme, the provisions in Part 3 of this Schedule shall apply.

– LEAD COMMISSIONER OBLIGATIONS

1 The Lead Commissioner shall notify the other Partners if it receives or serves:

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports

and provide copies of the same.

2 The Lead Commissioner shall unless otherwise agreed provide the other Partners with copies of any and all:

2.1 CQUIN Performance Reports;

2.2 Monthly Activity Reports;

2.3 Review Records; and

2.4 Remedial Action Plans;

2.5 JI Reports;

2.6 Service Quality Performance Report;

3 The Lead Commissioner shall consult with the other Partners before attending:

3.1 an Activity Management Meeting;

3.2 Contract Management Meeting;

3.3 Review Meeting;

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

4 The Lead Commissioner shall not:

4.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

4.2 vary any Provider Plans (excluding Remedial Action Plans);

4.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

4.4 give any approvals under the Service Contract;

4.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

4.6 suspend all or part of the Services;

4.7 serve any notice to terminate the Service Contract (in whole or in part);

4.8 serve any notice;

4.9 agree (or vary) the terms of a Succession Plan;

without the prior approval of the other Partners (acting through the [JCB]) such approval not to be unreasonably withheld or delayed.

5 The Lead Commissioner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

6 The Lead Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

7 The Lead Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports)

8 [INSERT]

– OBLIGATIONS OF THE OTHER PARTNER

9 Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

9.1 resolve disputes pursuant to a Service Contract;

9.2 comply with its obligations pursuant to a Service Contract and this Agreement;

9.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

10 No Partner shall unreasonably withhold or delay consent requested by the Lead Commissioner.

11 Each Partner (other than the Lead Commissioner) shall:

11.1 comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

11.2 notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

12 [INSERT]

Part 2– OBLIGATIONS OF THE PARTNERS (GENERAL)

1 Each Partner shall (at its own cost):

1.1 resolve disputes pursuant to a Service Contract to which it is a party;

1.2 comply with its obligations pursuant to a Service Contract and this Agreement;

1.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

PART 3 – PERFORMANCE ARRANGMENTS

Part 1 - Statement on Performance Arrangements

All Partners recognise the need for a robust performance framework to monitor and measure delivery of the Better Care Fund Plan (BCF).

The performance framework will ensure that Partners have visibility and assurance relating to local progress in delivering BCF priorities and the impact on national metrics and local Key Performance Indicators (KPIs). The framework will also provide assurance to any regional or national scrutiny.

No national performance targets were set for 2020/21 so this section has been removed for this year.

SCHEDULE 5– BETTER CARE FUND PLAN

The Better Care Fund Plan for 2020-21 can be viewed at Leicestershire's Health and Wellbeing Board pages on the Democracy and Decision-Making pages of the Leicestershire County Council website. A link to where the report can be accessed can be found below:

http://politics.leics.gov.uk/mgCommitteeDetails.aspx?ID=1038

SCHEDULE 6– POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

1. The Partners will adhere to the Code of Conduct for the Council's Health and Wellbeing Board for Co-opted Members and Integration Executive (attached as Parts 1 to this Schedule 7)

2. The Partners will each ensure that their employees, agents and representatives complete and keep updated in accordance with paragraph 4.12 of the Register of Interests the form attached as Part 2 to this Schedule 7 in relation to their duties as members of the Health and Wellbeing Board, the Integration Executive and the Partnership Board.

3. The Partners will each ensure that their employees, agents or representatives comply with the statutory obligations of the relevant Partner relating to conflicts of interest when they are acting as commissioners of Services pursuant to Individual Schemes under this Agreement.

Part 1

Code of Conduct
for Coopted Membe

Part 2

Register of
Interests Form 2013.

SCHEDULE 8 – INFORMATION SHARING AGREEMENT AND PROTOCOL

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PART A

INFORMATION SHARING AGREEMENT (the ISA)

The Partners agree that they will comply with the following terms in relation to the sharing of information in connection with the Agreement:

1. **Purpose and Definitions**

1.1 **Purpose**

This Information Sharing Agreement (ISA) is supplementary to the Information Sharing Protocol attached as Part B to this Schedule 8. The ISA will support the smooth running of the Pooled Fund arrangements in respect of the Services commissioned pursuant to the Agreement (as defined below).

Specifically information is shared to achieve

- the efficient delivery of the Better Care Fund Plan
- effective performance monitoring of the Individual Schemes included with the Agreement
- an effective process for ensuring that services commissioned provide value for money and meet service user outcomes

The ISA will ensure the transfer of information in accordance with Data Protection Legislation

1.2 **Definitions**

In the ISA:

WLCCG and ELRCCG will be referred to collectively where the context allows as the CCGs and all the parties together will be referred to as the Partners

Agreement means the agreement to which the ISA is a Schedule.

Data means all data generated, held, utilised or accessed by or on behalf of the Parties prior to the Commencement Date in respect of the Services including all data processed from time to time for the purpose of this Agreement

Records means (i) all Data; and (ii) all files, records, documents, notebooks, books and accounts, statistics, surveys, blueprints, designs, drawings and specifications including any such information recorded or stored in writing or upon magnetic tape or disc or otherwise recorded or stored for reproduction whether by mechanical or electronic means and whether or not such reproduction shall result in a permanent record being made which are held and used by the Partners prior to the Commencement Date of the Agreement in connection with the Agreement, and any Records which are created by the Partners in connection with the Agreement throughout its Term

Other defined terms where the context allows have the meanings given to them in the Agreement

2. Legal Basis

The information to be shared in accordance with the ISA is governed by section 75 of the NHS Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 2000/617 as amended)

3. Duration

The ISA will apply for the duration of the Agreement and will expire automatically on termination or expiry of the Agreement

4. Extent and Type of Information to be Shared

4.1 The Partners agree to share such information and data as is necessary to enable the efficient administration, audit and monitoring of the Pooled Fund and the Individual Schemes commissioned pursuant to the Agreement

4.2 Wherever possible information relating to expenditure from the Pooled Fund will be anonymised.

4.3 While it is envisaged that very little of the information shared in relation to the administration, audit and monitoring of the Pooled Fund will be Personal Data, any such data shall be processed in accordance with the provisions of Data Protection Legislation and the Freedom of Information Act 2000 (FOIA)

5 Information Sharing

5.1 All requests for information about the Pooled Fund from the CCGs to the Council will be sent to the Pooled Fund Manager for the time being

5.2 Subject Access Request

5.2.1 Where a Subject Access Request under Data Protection Legislation is made to any Partner in relation to the Agreement or services commissioned under it and one of the other Partners may hold additional and separate records relevant to the said Subject Access Request the receiving Partner will inform the Service User of that and provide details on how the Service User might obtain those records.

5.3 ***Access*** to Records by the Partners

5.3.1 The Partners will provide to each other such copies of Data and Records relating to the Agreement which may reasonably be requested of the relevant Partner's Records Manager in order to facilitate:

- Audit
- Investigation of complaints
- Clinical Governance
- Investigation of care e.g. an inquiry

5.3.2 Copies of Data and/or Records will be transferred in an appropriately secure format and confirmation of receipt by the Records Manager of the receiving Partner will be provided to the Records Manager of the Partner providing the Data and/or Records.

5.3.3 Copies of Records or Data transferred under this clause 5.3 will be retained by the relevant Partner until the completion of the relevant process and then for the purposes of Data Protection Legislation will be securely disposed of in accordance with the relevant Partner's destruction policy.

5.3.4 Records held by any of the Partners include commissioning data and Service Provider data.

6. How information may be used

6.1 The primary purpose for keeping personal records is to support the planning, delivery and continuation of care to a Service User. The Partners may use personal information from Records for different purposes for example:

- monitoring and protecting public health
- managing and planning Services;
- contracting for Services

- auditing accounts
- Assuring and improving the quality of care and treatment performance
- risk Management
- investigation of complaints and notified of potential legal claims
- monitoring performance, including internally and to the Government
- clinical governance
- investigation of care e.g. an Inquiry

6.2 Additional conditions need to be met for some uses of personal information e.g. research may require Research Ethics approval before Records may be collected. If any non-anonymised Records that have been collected and supplied by a Partner are to be used for research by another Partner then the Caldicott Guardian of the Partner who has supplied the information must provide written consent. The only exemption to this is where a specific data exchange agreement or other agreement has been signed for this purpose.

6.3 Information will be shared with Service Providers in the private, voluntary and state sectors in accordance with the terms of Agreement and the provisions of the Scheme Specifications made under it to the extent necessary to be able to procure the Individual Services included in the Better Care Fund Plan including:

- Basic demographics
- Any details required enabling the Service Provider to undertake appropriate risk assessments, including health and medical information.
- Care Plans
- Commissioning requirements
- Carer arrangement and demographics
- Risks Assessments and Risk factors

6.4 Confidential personal information must only be used for the purposes specified at the time of disclosure and it is a condition of access that it must not be used for any other purpose without meeting the requirements of Data Protection Legislation. Information provided by any Partner to any other Partner for specific purposes, must not be provided to a third party or used for a different purpose unless in accordance of the requirements of Data Protection Legislation.

7. Appropriate Security Levels

7.1 Email between nhs.uk and gov.uk are secured to national standards therefore normal email accounts to transfer information under this Information Security Agreement is appropriate. .

7.4 Security and robustness of the Link and virus control procedures will be managed in line with the CCGs standards and will be confirmed by the Leicestershire Health Informatics Service (LHIS) Network Manager on behalf of the CCGs.

7.5 Each Partner will maintain Personal Data or confidential information received, in strictest confidence. Unless specifically stated in the conditions of release, the Partners will not share such data with any other organisation or agency unless required to do so by law.

7.6 Each Partner will ensure that their members of staff are informed that they have an obligation to request proof of identity from recipient members of staff of another Partner before confidential personal information is passed on.

7.7 Each Partner will ensure that their members of staff are informed that they are personally responsible for taking precautions to ensure the security of confidential personal information whilst it is in their possession and when it is being transferred from one person or organisation to another.

7.8 Recommended procedures to be followed by the Partners to ensure the safe transfer of information:

- Envelopes should be securely sealed, clearly addressed to a known contact and marked 'confidential' and 'addressee only'. A return to sender address should also be marked on the envelope.

- Telephone validation, or 'call back' procedures should be followed before disclosing information to someone not known to a Party to confirm their identity and authorisation. Fax transfer is not safe and should be avoided wherever possible. Where it is necessary 'Safe Haven' procedures should be followed.

- Data held on any removable electronic storage device or disk should be password protected and the physical security of the electronic storage device or disk should be protected i.e. kept under lock and key.

- Confidential information relating to a Service User must not be transmitted via the Internet or via e-mail unless a specific separate data exchange agreement is in place.

8. Breach of Confidentiality

8.1 The objective of reporting security incidents and weaknesses is to minimise damage from security incidents and, by learning from such incidents, reduce the risk that they will happen again. Breaches of security (including any breach of confidentiality) will be reported in line with existing security incident procedures. Security incidents at the CCGs are reported to the HIS Helpdesk (and in some circumstances to the line manager), and escalated to the IM&T Lead or a deputy and to East Midlands Internal Audit Services where appropriate.

8.2 Within the Council all staff have a responsibility to report immediately any security incident or weakness they observe to their manager. Staff should not try to deal with any such incidents personally. All managers have a responsibility to take immediate and appropriate action to respond to all security reports they receive from staff. If the investigation of a security incident or weakness results in the possibility of disciplinary action against an employee, then the Council's relevant Human Resources Section must be consulted before any action is progressed. If necessary, the Council's Information Manager should be contacted for advice.

8.3 Any breaches or issues concerning the ISA by the Partners or a third-party organisation processing data on their behalf must be reported to all relevant Partners as described above:

- CCGs Contact – Relevant Caldicott Guardians

- Council Contact – Adults and Communities Information Manager, who will inform the Caldicott Guardian

8.4 Both requesting and providing Partners must carry out a full investigation of any breach of this ISA, with the assistance of an independent agency if required.

8.5 Once the investigations have been concluded then a report will be taken to the Caldicott Guardians or their nominated representatives from the affected Parties, who will review the findings and make recommendations. In the case of the Council, the Council's Information Management Team will decide if the matter should be referred to the Information Commissioner.

8.6 Priority 1 incidents (ref. LHIS Security Incident Procedures) reported within the CCGs should be brought to the attention of the Head of Information.

8.7 All Staff within the Council are bound by the Council's policies and procedures, specifically the ICT Security and Information policies and procedures.

9. **Indemnity**

Each Partner will keep each of the other Partners fully indemnified against any and all costs, expenses and claims arising out of any breach of this ISA and in particular, but without limitation, the unauthorized or unlawful access, loss, theft, use, destruction or disclosure by the offending Partner or its sub-

contractors, employees, agents or any other person within the control of the offending Partner of any information obtained in connection with this ISA

10. **Release of Third Party Information**

Information provided by one agency must not be given to another agency or used for a different purpose without informing and obtaining the consent of the original provider unless an exemption under the DPA applies or unless specifically authorised under this or another agreement.

11 Standards for Information Use

11.1 The Partners agree to ensure that there is an adequate support facility available to members of their staff involved in the provision of the Services. This includes the following as a minimum:

- Appropriate training on Data Protection Legislation
- Appropriate training on Information Sharing
- Training in the use of this ISA
- Training of all staff in permissible use of NHS Number
- A named Data Protection Officer who can offer advice and guidance in Data Protection Legislation and Information Security
- Records of training will be made available to each Partner on request.

11.2 Monitoring, implementation and distribution of this ISA will be carried out by the relevant Partner's operational management team.

11.3 The ISA is not exempt under the Freedom of Information Act 2000.

12. Appropriate Signatories

12.1 The lead for each Partner for the ISA is the relevant Caldicott Guardian of:

- East Leics and Rutland CCG
- West Leics CCG and
- Leicestershire County Council

12.2 Each Partner's Caldicott Guardian will be responsible for:

- The implementation of the ISA within their respective organization.
- Ensuring compliance to the standards within the ISA.
- Ensuring mechanisms are in place to monitor the operation of the ISA.
- Authorising access levels to personal information covered by the ISA.
- Providing advice and guidance on adherence to the ISA.
- Acting as a point of contact for other Partners or organisations affected by the ISA.
- Ensuring incidents are investigated and appropriate action is taken.
- Agreeing amendments to the ISA

12.3 The role of Records Manager for each Partner is assigned to the following post holders:

- East Leics & Rutland CCG's Team Manager (Information Governance)
- West Leicestershire CCG's Team Manager (Information Governance)
- Leicestershire County Council's Adult Social Care and Health Service's IT and Information Manager

12.4 The role of Information Governance lead for each Partner is assigned to the following post holders:

- East Leics and Rutland CCG
- West Leics CCG
- Leicestershire County Council

13. Review of the ISA

13.1 The ISA will be reviewed annually, on or within two weeks of the anniversary of the Commencement Date of the Agreement unless legislative or organisational changes necessitate a prior review.

13.2 The ISA may be reviewed at any time at the request of any of the Partners' Caldicott Guardians.

14 **Suspension of this Information Sharing Agreement**

14.1 Any Partner may suspend this ISA for 45 days if security has been seriously breached. Notification of suspension should be given in writing to the other Partners and should provide reasons for the suspension, plus evidence of any incidents prompting the decision to suspend.

14.2 Any suspension will be subject to a Risk Assessment and Resolution meeting, the panel of which will be made up of nominated representatives of the Parties. The meeting to take place within 14 days of any suspension.

15 Termination of the ISA

15.1 The ISA can only be terminated during the period when the Agreement is in place with the agreement of all the Partners and always provided that suitable alternative information sharing arrangements are put into place for the duration of the Agreement prior to the ISA being terminated.

15.2 Termination of the ISA shall be without prejudice to the rights and remedies of the Partners accrued before such termination and nothing in the ISA or the Agreement shall prejudice the right of any Partner to recover any amount outstanding as at the date of such termination

Leicester Leicestershire and Rutland

Information Sharing Protocol

Version 6.0

17 July 2019

Document Control

Control Details

Author: Stephen Curtis

Owner: Kevin Turner

Document Amendment Record

Issue	Amendment Detail	Author	Date	Approved
4.9	First draft of version 5.0	SC	15 Jan 13	
4.94	Amendment proposals following consultation	LW	29 Nov 13	
5.0	Final published version	SC/LW	06 Feb 14	
5.1	Reviewed for GDPR & DPA 2018	KT	01 Apr 19	
6	Final published version	KT	17 Jul 19	SIMG

Document Sign-off

Organisation	Chief Officer (Job Title)	Signature

Context

This protocol defines the framework for the sharing of information by agencies operating within Leicester, Leicestershire and Rutland. Partners in Leicestershire have supported an ISP since 2009. This review covers General Data Protection Regulation (GDPR) and the Data Protection Act 2018.

This protocol seeks commitment to put in place the arrangements required to ensure secure and appropriate sharing of information and data, whilst maintaining the controls (largely through agreements) that give assurance and accountability and respects the right to privacy.

The information sharing framework has a number several tiers. Governance arrangements are indicated in brackets for each tier.

- National framework for sharing information – legislation and codes of practice (National Government / ICO)
- Commitments contained in this Information Sharing Protocol v 6.0 (Chief Officers, Partnership Boards)
- Guidance, training, tools (Strategic Information Management Group - SIMG, Organisational governance frameworks)
- Information sharing agreements (Managers, organisational governance frameworks)

Protocol

This Information Sharing Protocol provides a commitment by the signatories to ensure that a framework is in place that facilitates the sharing of information between partners and respects the individual's right to privacy. Information sharing is increasingly important in the provision of services to our communities.

To this end, the signatories commit to:

- Sharing information within a framework where it supports the provision of better services to our service users, patients, customers and communities.
- Ensuring that a Data Protection Impact Assessment (DPIA) is undertaken for any proposed sharing arrangement
- Ensuring that in sharing information:
    - There is a legal basis for the proposed sharing
    - The sharing is fair and covered by an appropriate privacy/fair processing notice (Transparent)
    - There is a clearly defined and agreed purpose for the sharing
    - It accords with GDPR, and the Data Protection Act 2018 (DPA 2018)
    - Only appropriate information is shared,
- Ensuring that written information sharing agreements are developed and monitored for regular sharing of information and data.
- Working with partners to develop guidance / tools (technical and non-technical) to support good information sharing.
- Putting in place governance that ensures that managers and staff are aware of their responsibilities and recognise the need to work with partners.
- Training staff on information sharing and management.
- Communicating the importance of appropriate information sharing to staff.
- Ensuring early consideration of information issues in service developments. Privacy by Default and Design
- Being transparent with service users about how their personal data is going to be used and respecting their privacy.
- Ensuring adherence, where appropriate to:
    - The ICO's Data Sharing Code of Practice.

- **Department of Health guidance on information sharing e.g. 'Striking the Balance'**
- The Caldicott Principles
- NHS guidance on information sharing

When sharing information, each signatory will commit to:

a) Ensuring that when acting as the Data Controller for information they will apply the conditions set out in the Information Sharing Agreement (ISA) and assume responsibility under the DPA.

b) Ensuring any new ISA will set out the purpose, use and scope of the data to be shared, the point at which responsibility moves from one Data Controller to another or the circumstances where the role of Data Controller is exercised together and the responsibilities of each agency signing this ISA

c) Ensuring that any new ISA will be specific and clearly identify only the data that needs to be shared.

Information security is important, both for the interests and privacy of individuals, and also for the reputation of our organisations. Signatories will drive the development of a culture in which their organisations work together to investigate incidents and put in place measures to reduce the risk of repetition. This partnership culture is central to facilitating information sharing.

The Strategic Information Management Group will support the delivery of the partnership aspects of these commitments. Signatories will commit to supporting the work of SIMG as it relates to this protocol. The partnership aspects include (for example):

- Aligned policy across partners, where relevant
- Shared guidance
- Shared training
- A coordinated register of information sharing agreements
- Shared operational arrangements such as information security incident handling
- Aligned communications

Developing these partnership aspects requires signatories to ensure that appropriate resources are made available from within their organisations.

Agreement: We the undersigned do hereby agree to implement the terms and conditions of this Protocol.

Name .....

Title .....

Signature .....

Organisation .....

Date .....

Schedule 7

2021-22 Section 75
Schedule Menorraghi

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Appendix B

brownejacobson LLP

Dated **2021**

(1) Leicestershire County Council

(2) NHS East Leicestershire and Rutland Clinical Commissioning Group NHS West Leicestershire Clinical Commissioning Group

Variation to Framework Partnership Agreement Relating to the Commissioning of Health and Social Care Services

GUIDANCE NOTES

1. *This template variation deed is provided as a template to assist CCGs and local authorities in preparing a variation to one of their section 75 agreements or BCF agreement in response to the requirements of the Covid-19 Hospital Discharge Services Requirements.*

2. *This template variation deed has been prepared based on the approach put forward in the Covid-19 Hospital Discharge Services Requirements namely that one of the partners will act as the Lead Commissioner and the funding which is coming via the NHS to pay for the enhanced discharge packages of care is put in a pooled budget alongside planned local authority spending on discharge support Local authorities have also been allocated grant funding to support their response to COVID-19, this funding is not to pay for these hospital discharge requirements.. If local arrangements are proposing an alternative approach this template variation deed will need amending.*

3. *Please take care to read all the footnotes which provide drafting notes for consideration when using this deed of variation.*

4. *This deed of variation should not be executed in its current form and requires further work. You are advised to seek your own legal advice if necessary.*

5. *This deed of variation can be amended to be executed as a simple agreement. If you wish to execute this as an agreement you will need to make the necessary drafting changes and amend the execution provisions.*

6. *The annex contains a template Scheme Specification which can be used as a starting point or Partners can develop their own.*

Contents

THIS DEED OF VARIATION is made on day of

PARTIES

(1) **LEICESTERSHIRE COUNTY COUNCIL** of County Hall, Glenfield, Leicestershire, LE3 8RA (the "**Council**");

(2) **NHS EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP** of Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicestershire, LE3 8TB (**"ELRCCG"**); and

(3) **NHS WEST LEICESTERSHIRE CLINICAL COMMISSIONING** Group of 55 Woodgate, Loughborough, Leicestershire, LE11 2TZ (**"WLCCG"**)

ELRCCG and WLCCG are together referred to as the **"CCGs"**

The Council and the CCGs are together referred to as the **"Partners"**

BACKGROUND

(A) The Partners entered into a Framework Partnership Agreement relating to the commissioning of health and social care services on 2022 in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable (the "**Partnership Agreement**").

(B) As part of the NHS and wider public sector's response to the global Covid-19 pandemic the Government issued the Covid-19 Hospital Discharge Programme Requirements (the "**Discharge Requirements**") on March 19th, 2020. Several guidance updates have been issued since that date. The current requirements were issued on 19th October in the document at https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model

(C) The Discharge Requirements have been introduced to ensure that where it is clinically safe to discharge patients from an acute or community hospital those patients are discharged in accordance with the new 'Discharge to Assess' model.

(D) To support the new Discharge Requirements a range of measures have been introduced including, amongst others:

a) a temporary suspension of the obligation of the need to carry out Continuing Healthcare assessments for patients on the acute hospital discharge pathway and in community settings during the Enhanced Discharge Services Period;

b) a commitment that the NHS will fully fund the cost for up to six weeks of new or additional elements of existing out of hospital health and social care

support packages commencing between 1st April 2021 and 30th June 2021 to facilitate discharge from, or to prevent admission to, hospital as set out in the Discharge Requirements Scheme 2; and for up to four weeks for packages commencing from 1st July 2021 up to 31st March 2022. The funding will cease on 31st March 2022.

d) a suspension of the usual patient eligibility criteria during the Enhanced Discharge Services Period.

(E) In accordance with the Discharge Requirements, the Partners have considered the most appropriate model through which to commission the enhanced discharge service and admissions avoidance services and agreed that **Leicestershire County Council** shall act as the lead commissioner for enhanced discharged service and shall make recharges as appropriate to Partners in this Deed for the purpose of funding this service.

(F) The Partners have agreed to vary the terms of the Partnership Agreement as set out in this Deed of Variation.

AGREED TERMS

1 Defined terms and interpretation

1.1 In this Deed, expressions defined in the Partnership Agreement and used in this Agreement have the meaning set out in the Partnership Agreement.

1.2 Subject to clause 1.1 of this Deed, the following words and expressions shall have the following meanings:

Covid-19 Hospital Discharge Programme	means the scheme as set out in the Annex to this Deed which implements the Covid-19 Hospital Discharge Programme Requirements on a local level.
Deed	means this Deed of Variation including any schedules and appendices.
Discharge Requirements	means the Covid-19 Hospital Discharge Programme Requirements and subsequent updates published by HM Government and the NHS.
Effective Date	means the date of this Deed.
Funded Packages	means new or extended out-of-hospital health and social care support packages referred to in the Discharge Requirements and more specifically set out in Annex A of the Covid-19 Financial Reporting Guidance; and

- provided to patients on or after the 1st April 2021 and on or before the 31st March 2022.

Future Discharge Requirements

means any subsequent directions and or guidance issued by HM Government and or the NHS in relation to the continuation, variation or cessation of the Discharge Requirements.

1.3 The rules of interpretation set out in the Partnership Agreement apply to this Deed.

2 Variation

2.1 The Partners acknowledge agree and confirm that in accordance with clause 30 (Variation) of the Partnership Agreement (which provides that any variation shall be recorded in writing and signed for and on behalf of each of the Partners) that the Partnership Agreement shall be amended on the Effective Date as follows:

2.1.1 [The Partnership Agreement shall be varied in accordance with Schedule 1 of this Deed[1]].

2.1.2 The Partners have agreed to amend [Part 2 of] Schedule 1 (Agreed Scheme Specifications) to the Partnership Agreement to include a new Scheme Specification for the Covid-19 Hospital Discharge Programme as set out in Schedule 2 (Amendments to Existing Scheme Specifications) of this Deed.

2.1.3 The Partners have agreed to vary Schedule 2 (Governance) to the Partnership Agreement as set out in Schedule 3 (Governance) of this Deed].

2.1.4 The Partners have reviewed the financial arrangements contained in the Partnership Agreement and have agreed that the Schedule [3] (Financial Protocol) to the Partnership

[1] This should be used if the Partners want to make any amends to the main body of the underlying section 75/BCF Agreement. If such amendments are required this Schedule should set out any clauses that will be amended and how they will be amended. It is not, however, expected that there will need to be any amendments to address the requirements of the Discharge Requirements.

Agreement shall not apply in respect of the Covid-19 Hospital Discharge Programme. The financial arrangements in respect of the Covid-19 Hospital Discharge Programme shall be as set out in Scheme Specification[2];

2.1.5 [The Partnership Agreement shall be varied as set out in Schedule 4 (Other Amendments) of this Deed][3].

2.2 Except as amended by this Deed and as set out in clauses 2.1.1 to 2.1.5 above and the Schedules of this Deed, the Partnership Agreement shall continue in full force and effect and this Deed shall not release or lessen any accrued rights, obligations or liability of any of the Partners under the Partnership Agreement.

3 Term

The Partners acknowledge agree and confirm that the variations set out in Clause 2 shall take effect as from the Operational Date and shall continue in effect until the Covid-19 Hospital Discharge Programme is terminated or varied in accordance with the provisions set out in Schedule 2 to this Deed to reflect future arrangements following the end of the Enhanced Discharge Services Period.

4 General

The provisions of the following clauses of the Partnership Agreement shall apply, mutatis mutandis, to this Deed: clause [15] (Audit and Access Rights), clause [23] (Dispute Resolution Procedure), clause [25] (Confidentiality) clause [26] (Freedom of Information and Environmental Protection Regulations), clause [29] (Notices) and clause [34] (Assignment and Sub-Contracting).

5 Severance

If any provision of this Deed, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Deed shall not thereby be affected.

6 Third party rights

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Deed pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

7 Entire agreement

7.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation

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2 NB: the impact of this is to disapply all the standard financial provisions relating to all schemes in the underlying section 75/BCF agreement and allow for bespoke arrangements as set out in the Scheme Specification.

3 Schedule 4 can be used to set out any other locally agreed amendments to the section 75/BCF agreement, which are not captured by the suggested amendments referred to in the preceding Schedules of this Deed.

promise or condition not incorporated herein shall not be binding on any Partner.

7.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the Partners.

8 Counterparts

This Deed may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Deed for all purposes.

9 Governing law and jurisdiction

9.1 This Deed and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

9.2 Subject to clause 23 (Dispute Resolution) of the Partnership Agreement, the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arise out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Deed has been executed by the Partners on the date of this Deed[4]

THE CORPORATE SEAL of **THE COUNCIL OF [□]**
was hereunto affixed in the presence of:

4 Partners to confirm execution blocks.

Signed for on behalf of **[.]**
WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP[5]

_____
Authorised Signatory
Signed by the authorised signatory of

Signed for on behalf of **[.]**
EAST LEICESTERSHIRE & RUTLAND CLINICAL COMMISSIONING GROUP[6]

_____
Authorised Signatory
Signed by the authorised signatory of

5 NB: the Parties executing this Deed will need to be the Partners as existing at the date of execution.
6 NB: the Parties executing this Deed will need to be the Partners as existing at the date of execution.

Schedule 1 Amendments to the Partnership Agreement[7]

[To be populated where the Partners have agreed changes to the main body of the Partnership Agreement.]

7 This Schedule should be used if the Partners are making any changes to the main body of the section 75/BCF Agreement. The Partners should set out what, if any, drafting is being deleted and what is being inserted. For example:

Clause 12.1 shall be deleted and replaced by the following "*The Partners have agreed risk share arrangements as set out in schedule 3 which provide for financial risks arising within the commissioning of services from the Pooled Funds as set out in National Guidance"*.

Changes may be relevant where the section 75/BCF agreement itself sets out provisions which apply to all Schemes but will not apply to this Scheme. To vary this position the following drafting can be included:

The provisions of [*insert clause or schedule*] relating to [*insert nature of provisions*] shall not apply to the Covid-19 Hospital Discharge Scheme. The [*insert nature of provisions*] for the Covid-19 Hospital Discharge Services shall be as set out in Schedule 2 to this Deed.

Schedule 2 Individual Scheme Specifications

The Partners have agreed the following new Individual Schemes and agreed the Scheme Specification as annexed to this Schedule:

- Covid-19 Hospital Discharge Programme.

Schedule 3 Governance

1. The Partners agree that the provisions[8] of Schedule 2 of Partnership Agreement (excluding Paragraphs 10 and 13) do not apply to the Covid-19 Hospital Discharge Programme and that the governance arrangements relating to that Scheme are as set out in the Scheme Specification.

[8] If it is not all provisions specify which it is.

Schedule 4 Other Amendments

[Include here any amendments to any other Schedules that the Partners have agreed. Where general positions are to be overridden wording such as that in Schedule 3 above can be used and tailored as relevant.]

ANNEX – COVID-19 HOSPITAL DISCHARGE PROGRAMME SPECIFICATION

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 This Service shall be known as the Covid-19 Hospital Discharge Programme.

1.2 The Service is being introduced in response to the global Covid-19 pandemic and more specifically the Government's Discharge Requirements guidance to reduce pressure on those hospitals providing acute services.

1.3 The Partners have reviewed the Discharge Requirements and determined that the arrangements as set out in this Scheme Specification will permit them to implement the Discharge Requirements.

1.4 **Leicestershire County Council** will be the lead commissioner for this Service and shall comply with the requirements of this Scheme Specification.

1.5 A monthly reimbursement process will be established whereby the Lead Commissioner will identify total expenditure on the Service to date and the level of contributions to be made by each of the Partners. Invoices will be raised to the CCGs to facilitate the transfer of funds. for this Service.

2 AIMS AND OUTCOMES

Insert agreed aims of the Individual Scheme e.g. consider reference to:

- *facilitating quick discharge of patients who are clinically suitable for discharge;*
- *facilitating rapid mobilisation of care and support packages;*
- *maintaining capacity in acute and community hospitals for the care of patients with Covid-19 who require hospitalisation;*
- *implementing the revised funding model for care and support packages in the Enhanced Discharge Services period.*

3 THE ARRANGEMENTS

3.1 The Partners have agreed to implement the following arrangements in relation to the Covid-19 Hospital Discharge Programme:

3.1.1 lead commissioning; and

3.1.2 the recharge process to Partners has been established and is summarised below;

Timing/Invoicing

- Information will be provided on discharge costs monthly, but calculated on a weekly basis.
- Information will be sent over by the end of the first full week after month end.

- Separate invoices to be raised for each CCG
- To agree the amounts with Health prior to raising the invoice

Identification of recharge

- Packages which are either COVID hospital avoidance or COVID hospital discharge are being entered on the system with a new type of funding arrangement (ELRCCG, WLCCG and OtherCCG)
- Actual costs will be used to recharge Health
- The amount recharged will be the net of the new COVID package less any existing provision
- The report will identify cumulative cost to date of all (netted off) COVID packages and then deduct amounts previously invoiced – to take account of late loading of data and payment of actuals (up to 7 weeks delay for Home Care provider payments)
- The last full week of service prior to a COVID funding arrangement will be used as the value of the "pre-COVID" package – going back a maximum of 10 weeks.

4 FUNCTIONS

This Paragraph sets out the Council's Functions and the CCG's Functions which are the subject of the Individual Scheme including where appropriate the delegation of such functions for the commissioning of the relevant service.

Consider whether there are any exclusions from the standard functions included (see definition of NHS Functions and Council Health Related Functions).

e.g. the following can be used/adapted as relevant:

4.1 For the purposes of implementing this Scheme the CCG delegates to the Council its functions under:

4.1.1 section 3(1)(b) of the 2006 Act of arranging for the provision of other accommodation for the purpose of any service provided under the 2006 Act;

4.1.2 section 3(1)(e) of the 2006 Act of arranging for the provision of such other services or facilities for the prevention of illness, the care of persons suffering from illness, and the after-care of persons who have suffered from illness as are appropriate as part of the health service; [and

4.1.3][9].

In each case in so far as the Council considers such services/provision to be necessary to meet the requirements of the person for whom the care and support is provided.

4.2 The Partners agree that the above delegation from the CCG to the Council will:

9 Ensure reference is made to the specific functions being delegated. The drafting here is an example and should be checked it aligns with locally agreed arrangements or otherwise amended/supplemented.

4.2.1 likely lead to an improvement in the way in which these functions are discharged during the Covid-19 pandemic; and

4.2.2 improve health and well-being. [10]

5 SERVICES

Consider the following when drafting this paragraph:
What Services are going to be provided within this Scheme. Are there contracts already in place?
Are there any plans or agreed actions to change the Services?
Who are the beneficiaries of the Services? [11]

5.1 The Council shall arrange for the provision of the following services[12]:

5.1.1 Enhanced Discharge Support Services.

5.2 The Council shall arrange the provision of the Enhanced Discharge Support Services for the benefit of:

5.2.1 those persons the CCG has responsibility to provide services for under Sections 3(1A) and 3(1B) of the 2006 Act; and

5.2.2 those persons the Council has responsibility to provide services for

and whose requirement for a Funded Package arises during the Enhanced Discharge Services Period.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

Set out what arrangements will be in place in relation to Lead Commissioning e.g. the use of existing service contracts/call-off of services under existing framework agreements/letting of new services contracts. How will these arrangements work? The drafting below is in addition to setting out this information.

6.1.1 The Council shall ensure that when commissioning Funded Packages, it makes the patient and their families and/or carers aware that following the end of the Enhanced Discharge Services Period the patient may be required to pay for all or some of their future care needs.[13]

6.2 Contracting Arrangements

---

10 It will also be necessary to include any limitations on the delegation and these should be set out here.

11 This should be considered in the context of the Discharge Service Requirements. There is also a significant issue around individuals who are the responsibility of the local authority but not the CCG and vice versa this should be considered and reference to how it is addressed in the underlying section 75/BCF agreement.

12 NB: this should include high level description or name of services. The services falling within this Scheme that it would ordinarily fall to either/both the Council and the CCG to provide.

13 This has been included as a link through to the Discharge Requirements.

Insert the following information about the Individual Scheme:

(a) relevant contracts

(b) arrangements for contracting. Will terms be agreed by both Partners or will the Lead Partner have authority to agree terms maintaining public standards for the efficient use of public funds.

What contract management arrangements have been agreed? What happens if the Agreement terminates? Can the partner terminate the Contract in full/part? Can the Contract be assigned in full/part to the other Partner? Is the lead commissioner liable for any liabilities arising out of the service contracts other than the costs of the care packages?

6.2.1 The Council shall ensure that it reimburses those providers providing the Enhanced Discharge Support Services in a timely fashion paying particular attention to the financial pressures on providers during the Covid-19 pandemic. In complying with this obligation, the Council shall refer to guidance issued by the Local Government Association, ADASS, and the Care Provider Alliance on social care provider resilience during Covid-19.[14]

6.3 Access

6.3.1 The Programme is specifically for service users being discharged from acute or community hospitals or to avoid admission to one such hospital and excludes mental health discharges.

7 FINANCIAL CONTRIBUTIONS[15]

7.1 The Covid-19 Hospital Discharge Programme is being implemented in response to the Covid-19 pandemic and to give effect to the Discharge Requirements.

7.2 During the Enhanced Discharge Services Period there will no eligibility assessments for beneficiaries of the services provided under the Covid-19 Hospital Discharge Programme and the cost of care packages or enhancements to existing packages under the Covid-19 Hospital Discharge Programme shall be fully funded from central funding provided to the CCG by NHS England & Improvement. [However, the Council is making contributions to the Pooled Fund as set out in paragraphs 7.6 and 7.7 below][16].

7.3 The Partners shall:

7.3.1 comply with any requirements and any guidance issued by HM Government and/or the NHS relating to the funding of the Covid-19

[14] This drafting should be included along with other relevant drafting in this section to give effect to the requirements of the Discharge Requirements.

[15] This section needs to be tailored to reflect the contributions the CCG will be making to the pooled fund. The Council may or may not be making any contributions but if so, this should be set out here. Where the exact allocation is unknown at this time the section should describe how the allocations will be paid/determined.

[16] Delete if not relevant.

Hospital Discharge Programme after the end of the Enhanced Discharge Services Period; and

7.3.2 work together in good faith to give effect to any such requirements and/or guidance.

7.4 The exact level of the CCG's contribution to Scheme is not known at this time. The CCG's contribution will be based on the monthly expenditure submissions to NHS E&I and completed by the CCG and the Council.

7.5 The CCG shall transfer their contributions to the Council within 30 days following receipt of the Invoice.

7.6 The Partners shall in reaching agreement on the level of Council funding to be provided take into account the cost of new and enhanced packages of care and other relevant costs as agreed between the Partners and support that the Council would ordinarily have expected to fund during this period.

7.7 Information on the level of County Council contributions to the packages put in place as a result of the Programme will be provided to Partners

8 FINANCIAL GOVERNANCE ARRANGEMENTS

8.1 The financial governance arrangements for Individual Schemes as set out in the Partnership Agreement shall not apply to the Covid-19 Hospital Discharge Programme. The financial arrangements for the Covid-19 Hospital Discharge Programme are as follows:

8.2

8.3 Audit Arrangements

All Partners shall promote a culture of probity and sound financial discipline and control. The Council shall arrange for the audit of the accounts of the revenue expenditure by a suitably qualified independent auditor.

All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

8.4 Financial Management[17]

The Council shall ensure that:

[17] Please note this will need to set out the specific requirements in relation to the monitoring required for this funding as set out in the Discharge Requirements and any other guidance issued by HM Government and/or the NHS. This drafting should be reviewed and amended/supplemented where necessary.

8.4.1 all support provided under the Covid-19 Hospital Discharge Programme is recorded at individual level;

8.4.2 all agreed budgets funded through the Covid-19 Hospital Discharge Programme are recorded at individual level;

8.4.3 any local authority funding, whether existing or new, is separately identifiable and the support purchased with it is separately recorded;

8.4.4 existing systems will be used by the Council to record the support put in place and expenditure incurred at an individual level on the Service;

8.4.5 the process to be followed to identify recharges to Partners and raise invoices will be agreed in advance of any financial information or documentation being issued

8.4.6all monitoring and/or reporting information required by the CCG to report to NHSE&I or the Department of Health and Social Care is provided to the CCG promptly. In order to comply with CCG and NHSE/I reporting deadlines, this monthly information must be supplied to CCGs by close of play on the 5th working day of the following month. In practice this may require a cut off date within the local authority for extracting data from relevant systems ahead of the calendar month end being claimed for. Any resultant data lag leading to incomplete data will be included in the following month's data and supported by the CCGs.

9 VAT

THE PARTNERS SHALL AGREE THE TREATMENT OF THE REVENUE EXPENDITURE FOR VAT PURPOSES IN ACCORDANCE WITH ANY RELEVANT GUIDANCE FROM HM CUSTOMS AND EXCISE.

13.2 SUBJECT TO THE CLAUSE ABOVE THE PARTNERS AGREE TO ADOPT "PARTNERSHIP STRUCTURE (A)" AS DESCRIBED IN THE VAT GUIDANCE THROUGH WHICH THE PARTNERS AGREE THAT GOODS AND SERVICES WILL BE PURCHASED IN ACCORDANCE WITH THE COUNCIL'S VAT REGIME

10 GOVERNANCE ARRANGEMENTS

10.1 Governance will be discharged by the Integration Finance and Performance Group and the Discharge Cell to be confirmed.

This section should detail:

- *Is there a Scheme Lead?*
- *Will there be a relevant Committee/Board/Group that reviews this Individual Scheme?*
- *Who does that group report to?*
- *Who will report to that Group?*

11 NON FINANCIAL RESOURCES[18]

Council contribution

	Details	Charging arrangements[19]	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

CCG Contribution

	Details	Charging arrangements[20]	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

12 STAFF[21]

Consider:

- *Who will employ the staff in the Partnership?*
- *Is a TUPE transfer secondment required?*
- *How will staff increments be managed?*
- *Have pension arrangements been considered?*

Council staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the CCG.

If the staff are being seconded to the CCG this should be made clear.

CCG staff to be made available to the arrangements

18 This can be deleted where there are no non-financial resources.
19 Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources.
20 Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources.
21 Consider and detail in this section any staffing arrangements which are being put in place to deliver this Individual Scheme.

Please make it clear if these are staff that are transferring under TUPE to the Council. If

the staff are being seconded to the Council this should be made clear.

13 ASSURANCE AND MONITORING[22]

Roles of the Discharge Cell and the IFPG to be confirmed.

Set out the assurance framework in relation to the Individual Scheme. What are the arrangements for the management of performance? Will this be through the agreed performance measures in relation to the Individual Scheme.

Consider the following:

- *What is the overarching assurance framework in relation to the Individual Scheme?*
- *Has a risk management strategy been drawn up?*
- *Have performance measures been set up?*
- *Who will monitor performance?*
- *Have the form and frequency of monitoring information been agreed?*
- *Who will provide the monitoring information? Who will receive it?*

14 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council					
CCG					

15 INTERNAL APPROVALS

- *Consider the levels of authority from the Council's Constitution and the CCG's standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme.*
- *Consider the scope of authority of the Pool Manager and the Lead Officers.*
- *Has an agreement been approved by cabinet bodies and signed?*

16 RISK AND BENEFIT SHARE ARRANGEMENTS[23]

16.1 The cost of new and extended packages under the Scheme will be met by the CCGs and therefore no risk sharing arrangements are required.

22 This is likely to be different to what the Partners ordinarily include given the nature of the Individual Scheme but should be included as relevant in any event.
23 This is unlikely to be relevant as the costs of the care packages under the Individual Scheme are being fully funded by health.

16.2 Under Scheme2 of the Programme the risk to the CCGs is limited to a maximum of six weeks funding for each service user receiving a new or enhanced package of care.

17 REGULATORY REQUIREMENTS

Are there any regulatory requirements that should be noted in respect of this particular Individual Scheme?

18 INFORMATION SHARING AND COMMUNICATION

The Information Sharing Agreement (ISA) in the main Section 75 shall apply.

19 DURATION AND EXIT STRATEGY

This Paragraph should include: the arrangements for the variation or termination of the Individual Scheme; whether part/all of the Individual Scheme be terminated on notice by a party; whether part/all of the Individual Scheme be terminated as a result of breach by either Partner; and the duration of these arrangements? See outline drafting below which can be adapted for local circumstances.

19.1 The arrangements for the Covid-19 Hospital Discharge Programme may only be varied:

19.1.1 in accordance with the variation provisions in the Partnership Agreement; and

19.1.2 where such variation complies with the requirements of the Discharge Requirements and/or any Future Discharge Requirements.

19.2 This Scheme may not be terminated otherwise than in accordance with paragraph 10.3.

19.3 The Covid-19 Hospital Discharge Programme shall, unless varied to give effect to Future Discharge Requirements, terminate on the date on which the Discharge Requirements cease to apply.

See outline drafting which can be amended locally to suit arrangements noting at this stage it may not be possible for the Partners to specify with any great certainty what those exit arrangements shall be.

19.4 The Partners acknowledge that as at the date of this Agreement they are not in a position to determine all the exit arrangement for the Covid-19 Hospital Discharge Programme. The Partners agree that except as otherwise set out in this clause 10 they shall:

19.4.1 keep under review the Discharge Requirements and any Future Discharge Requirements;

19.4.2 consider how to give effect to the requirements of any Future Discharge Requirements, where relevant; and

19.4.3 develop and agree an transfer plan in relation to the variation of the Enhanced Discharge Services Scheme no later than 31st March 2021 which shall take into account and identify, where relevant,:

(a) appropriate mechanisms for maintaining service provision;

(b) allocation and/or disposal of equipment;

(c) responsibilities for debts and ongoing service contracts;

(d) responsibility for any liabilities which have been accrued by the Host Partner/Lead Commissioner;

(e) premises arrangements;

(f) record keeping arrangements;

(g) information sharing arrangements and requirements;

(h) staffing arrangements[24];

(i) appropriate processes to be initiated in the run up to and following the end of the Enhanced Discharge Services Period.

19.5 The Partners further agree that they shall within [30] days[25] of being notified of the end date for the Enhanced Discharge Support Service the Partners shall [meet to]:

19.5.1 implement any agreed transfer plan or in the absence of an agreed transfer plan agree and implement such a plan which shall include, as a minimum, arrangements to transfer to the existing Funded Packages onto the future funding arrangements; and

19.5.2 consider the need for any other Individual Schemes to be introduced as a result of this termination of this Individual Scheme.

19.6

20 OTHER PROVISIONS

Consider, for example:

- *Bespoke arrangements for the treatment of records*
- *Safeguarding arrangements*

24 Note this is not an exhaustive list and the Partners should consider all relevant issues.
25 Insert what is considered to be a reasonable timescale.

Agenda Item 9

LEICESTERSHIRE HEALTH AND WELLBEING BOARD: 24 FEBRUARY 2022

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PHARMACEUTICAL NEEDS ASSESSMENT 2022

Purpose of Report

1. The purpose of this report is to inform the Health and Wellbeing Board of the timescale associated with the development and publication of the Leicestershire Pharmaceutical Needs Assessment (PNA) and to seek approval of the proposed governance arrangements to enable production of the PNA.

Recommendations

2. It is recommended that

    a) The associated timescales for the development and publication of the Leicestershire Pharmaceutical Needs Assessment (PNA), be noted;

    b) The proposal to form an interagency LLR wide reference group to develop the PNA, be approved;

    c) It be noted that the draft PNA will be presented to the Health and Wellbeing Board for approval to consult at its meeting on the 26 May 2022.

Background

3. The Health and Wellbeing Board has a statutory responsibility to prepare a PNA for Leicestershire and publish it by 1st October 2022.

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

5. The last PNA for Leicestershire was produced in 2018 and can be accessed at: http://www.lsr-online.org/pharmaceutical-needs-assessment.html.

6. The responsibility for producing the PNA rests with Health and Wellbeing Boards in the general reforms embodied in the Health and Social Care Act (2012). The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (amended) sets out the minimum information that must be contained within a PNA and outlines the process that must be followed in its development and can be found at: https://www.legislation.gov.uk/uksi/2013/349/contents

7. In October 2021, the Department of Health and Social Care published a pharmaceutical needs assessment information pack for local authority health and wellbeing boards to support in the developing and updating of PNAs. The PNA guidance can be accessed via the following link: https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

8. The PNA is a statutory document that is used by NHS England to agree changes to the commissioning of local pharmaceutical services. As such, if NHS England receives a legal challenge to the services they commission based on the PNA, the local authority could also be part of that legal challenge. It is essential that the process that is followed meets the legislation that is set out and that the PNA is a robust document.

Governance

9. As many of the relationships required for the PNA are Leicester, Leicestershire and Rutland (LLR) wide – involving representation from NHS England, the Leicestershire Pharmaceutical Committee, Local Professional Network for Pharmacists and the Leicester, Leicestershire and Rutland Local Medical Committee, it is proposed that a PNA Reference Group be established. Due to the tight timescales for this project, a shadow Reference Group has already met in order to start to progress the PNA work. The Reference Group will support PNA work across the three Health and Wellbeing Boards, identify any economies of scale that can be delivered through joint work and ensure that there is an effective process for consultation on the PNAs. However, there will be separate PNA documents for Leicester, Leicestershire and Rutland and each will require approval by the respective Health and Wellbeing Board.

10. Draft terms of reference and membership for the PNA Reference Group are attached as Appendix A.

Development of the revised PNA

11. Approval of the Health and Wellbeing Board will be sought for the pre-consultation draft version and the final version of the Leicestershire PNA. The PNA reference group will develop the pre-consultation draft PNA which will be presented to the Health and Wellbeing Board for approval to consult

in May 2022. Following consultation, the final draft of the PNA will be submitted for approval in September 2022, allowing publication towards the beginning of October 2022. The PNA Reference Group will also provide assurance to the Health and Wellbeing Board that the final PNA is an accurate reflection of the pharmaceutical needs of the population and has been developed using robust processes.

12. The principal resourcing for the development of the Leicestershire PNA is provided by the Leicestershire County Council Business Intelligence Service, with information and advice provided through the PNA Reference Group by NHS England, the LPC, CCGs and other partners.

Engagement and formal Consultation

13. To gather additional intelligence for the development of the draft PNA, it is proposed that two surveys will run throughout the spring. One survey will ask service users for their views on the current pharmaceutical provision and the second will gather data on services provided, opening times etc from pharmaceutical professionals. The findings from these two survey exercises will be incorporated into the initial draft PNA document. Work is currently being undertaken to finalise the content and arrangements for conducting these surveys along with any alternative methodologies.

14. In addition, the draft PNA will be subject to a 60-day statutory consultation period which will start at the beginning of June 2022. Regulation 8 of the Pharmaceutical Services Regulations specifies that the Health and Wellbeing Board must consult with the following:-

- the Local Pharmaceutical Committee
- the Local Medical Committee
- any persons on the pharmaceutical lists and any dispensing doctors list for its area
- any LPS chemist in its area with whom NHS England has made arrangements for the provision of any local pharmaceutical services
- Healthwatch, and any other patient, consumer or community group in its area which in the view of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in its area;
- any NHS trust or NHS foundation trust in its area
- NHS England
- any neighbouring HWB.

15. Health and Wellbeing Boards must consult the above at least once during the process of developing the PNA. Those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

16. The draft PNA will be published on the Leicestershire County Council website and the views of the statutory consultees and other stakeholders will be actively sought. Further detail concerning the consultation approach will be presented to the Health and Wellbeing Board when the draft PNA is presented for approval to consult at its meeting in May.

Content and Timescales

17. The regulations and guidance documents provide information on the PNA content. This has been reflected in the overview of proposed content of the PNA provided in Appendix B. It is proposed that a similar approach be taken to that used in the 2018 PNA but may seek more innovative ways to present and visualise the data.

18. Since the last PNA the Government's policy document of "Community pharmacy in 2016/17 and beyond" has been implemented. The impact of these changes and an assessment of the new and emergent system should be examined to understand the implications for the PNA 2022.

19. The project plan is tight with respect to delivering a signed off PNA by 1st October 2022. The impact of the COVID-19 pandemic could also impact on timescales. The PNA Reference Group will monitor this and escalate any issues of concern to the Health and Wellbeing Board. The current timescale are:
    - 26 May - pre-consultation draft PNA submitted to the Health and Wellbeing Board for approval to consult
    - June – July – formal 60 day consultation undertaken
    - 22 September – final PNA submitted to the Health and Wellbeing Board for approval
    - 1 October 2022 – Publication of the PNA

Equality Impact Assessment

20. The PNA will be subject to an Equality and Human Rights Impact Assessment which will be completed as part of its initial development.

Appendices

Appendix A - Pharmaceutical Needs Assessment Reference Group Terms of Reference
Appendix B - Pharmaceutical Needs Assessment – Working Outline

Officers to Contact

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APPENDIX A

LEICESTERSHIRE COUNTY COUNCIL, RUTLAND COUNTY COUNCIL AND LEICESTER CITY COUNCIL

PHARMACEUTICAL NEEDS ASSESSMENT REFERENCE GROUP

TERMS OF REFERENCE

Purpose:

The Pharmaceutical Needs Assessment (PNA) is a legal duty of the Health and Wellbeing Board (HWB) and each HWB will need to publish its own revised PNA for its area by 1st October 2022.

The purpose of this reference group is to oversee the development of the PNA for Leicestershire, the PNA for Rutland and the PNA for Leicester City.

The team will set the timetable for the development of the PNA, agree the format and content of the PNA and ensure that each PNA fulfils statutory duties around consultation for the PNA.

The team will be a task and finish group, meeting between December 2021 and September 2022.

Key responsibilities:

- To oversee the PNA process
- To ensure that the development of the PNA meets the statutory duties of the HWBs
- To ensure active engagement from all stakeholders
- To communicate to a wider audience how the PNA is being developed
- To ensure that the PNA addresses issues of provision and identifies need
- To map current provision of pharmaceutical services
- To identify any gaps in pharmaceutical provision
- To map any future provision

Governance:

- Leicestershire County Council – the Health and Wellbeing Board will ensure the PNA is conducted according to the legislation.
- Rutland County Council – the Health and Wellbeing Board will ensure the PNA is conducted according to the legislation.
- Leicester City Council - the Health and Wellbeing Board will ensure the PNA is conducted according to the legislation
- The reference group will be chaired by the Public Health Director, Mike Sandys.

PNA Reference Group membership:

Local Authority PNA Leads

- Mike Sandys, Leicestershire County Council, Chair
- Caroline Boucher/Andy Brown, Business Intelligence, Leicestershire County Council
- Vivienne Robbins, Rutland County Council
- Helen Reeve, Leicester City Council

Local Pharmaceutical Committee

- Chief Officer and Secretary, Rajshri Owen

Clinical Commissioning Group

- Gillian Stead, Medicines Management lead, LLR CCG
- Amit Sammi, Head of Strategy and Planning, LLR CCG

HealthWatch

- Harsha Kotecha, Leicester and Leicestershire
- Janet Underwood, Rutland

NHS England

- Dianne Wells, Commissioning Manager

UHL

- Claire Ellwood, Chief Pharmacist, UHL and ICS

Public Health Intelligence Leads

- Kajal Lad, Leicestershire County Council
- Victoria Rice, Rutland County Council
- Helen Reeve, Leicester City Council

Local Medical Committee

- Charlotte Woods

Voluntary Action LeicesterShire

- Kevin Allen-Khimani - TBC

Leicestershire Equalities Challenge Group

- Matthew Hulbert

District Council Representative

- TBC

NB: Membership will be reviewed regularly and may be extended by agreement of the Reference Group members

Frequency of meetings: five meetings have been arranged – December 2021, February 2022, March 2022, May 2022, August 2022.
Additional meetings may be required between January 2022 and May 2022 as this will be the main development phase of the PNA.

Support arrangements:
The minutes of the meetings will be taken by admin support at by Leicestershire County Council.

Confidentiality
An undertaking of confidentiality will be signed by all members of the Reference Group.

During the period of membership of the Reference Group, members may have access to information designated by the Local Authorities or other members as being of a confidential nature and which must not be divulged, published or disclosed without prior written consent. Improper use of or disclosure of confidential information will be regarded as a serious disciplinary matter and will be referred back to the employing organisation. For the avoidance of doubt as to whether an agenda item is confidential all papers will be marked as confidential before circulation to the group members.

Declarations of Interest
Where there is an item to be discussed, where a member could have a commercial or financial interest, the interest is to be declared and formally recorded in the minutes of the meeting.

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APPENDIX B

PHARMACEUTICAL NEEDS ASSESSMENT – WORKING OUTLINE

Purpose

1. To support local commissioners in deciding on the provision of NHS funded services through community pharmacies in Leicestershire. These services are part of the local healthcare provision and affect NHS and Local Authority budgets.

2. To support NHS England in the determination of market entry decisions.

3. To provide a robust governance framework should a market entry decision are contested or challenged legally by an applicant or by existing NHS contractors.

4. To provide a source of relevant reference to Leicester, Leicestershire and Rutland local authorities, clinical commissioning groups and NHS England for the commissioning of any future local pharmaceutical services.

Publication Outline

The PNA will review and include:

- Existing pharmacy provision and services including dispensing, health care and lifestyle advice, medicines reviews and information and implementation of public health messages and services.

- Dispensing by GP surgeries.

- Services available in neighbouring Health and Wellbeing Board areas that could affect the need for services.

- Demographics of the relevant population shown as a whole and more specifically by locality with clear indication of needs specific to each area.

- Gaps in the provision of services, taking into account future requirements that could be met by providing more pharmacies or pharmacy services.

- Local area maps locating pharmacies and pharmaceutical services.

- Impact of “The Community Pharmacy Contractual Framework for 2019/20 to 2023/24: supporting delivery for the NHS Long Term Plan” document.

- Commentary about increased use of online pharmacy services (with data if available) and the potential impact this is having, plus any concerns about digital exclusion.

- Commentary about services that pharmacies could potentially offer in the future to support the ICS (sourced from survey of pharmacies).

The PNA will not include:

- Prison pharmaceutical services;

- Hospital pharmacies.

The published document will cover the following key areas of review (this list is a guide and will evolve alongside the development of the report and subject to advice from the wider Reference Group):

1. Context for the Pharmaceutical Needs Assessment

2. Description of current services
    2.1. Essential Services
        - Dispensing
        - Repeat Dispensing
        - Disposal of Unwanted Medication
        - Promotion of Healthy Lifestyles
        - Sign Posting
        - Support for Self Care
        - Clinical Governance

    2.2. Advanced Services – these are optional services that are commissioned nationally by NHS England through the core contract
        - Medicine Use Review and Prescription Intervention Service (MUR) Activity
        - New Medicines Services (NMS)
        - Appliance use reviews (AUR)
        - Stoma Appliance Customisation Service
        - Community Pharmacist Consultation Service (CPCS) Activity
        - Hepatitis C Antibody Testing Service Activity **– no data made available yet**
        - FLU Vaccinations
        - Seasonal Influenza Vaccination Advances Service (FLU) Income
        - Discharge Medicine Service Income
        - Covid Vaccination Service Activity

    2.3. Enhanced Services which are locally commissioned (list is an example)
        - Out of Hours Services
        - Supply of Palliative Care Drugs
        - Minor Ailment Scheme
        - Advice and Support to Care Homes

- Emergency Hormonal Contraception (EHC)
- Stop Smoking Services
- Supervised Consumption
- Needle Exchange
- Healthy living pharmacies

2.4. Pharmacies facilities
- Wheelchair access
- Access to disabled car parking within 100m
- Private consultation rooms
- Customer toilets
- IT facilities
- Foreign languages spoken
- Electronic prescription service

2.5. Different types of pharmacy contract
- Internet/distance selling
- 100 hour dispensing
- Dispensing practices
- Dispensing appliance contractors
- Cross-border pharmacies affecting local population
- Hospital pharmacy discharge medication arrangements
- Rurality

2.6. Potential to offer additional services to support the ICS

3. Each local authority will produce an overarching health needs document as part of their JSNA process which will inform the PNA.

3.1. Local Health Needs
- This will be the section that identifies the health needs that need to inform the commissioning of the pharmaceutical needs assessment – so the interpretation of the health needs document into the services that can be commissioned through community pharmacy
- For example, mapping of teenage pregnancy hotspot wards to EHC provision.
- Include a review of patients that are not within a 10-minute drive time or a 20 minute walk time of a pharmacy
- Leicestershire and Rutland need to include a section on rurality and the changes to the areas designated as rural linked to the existing PNA

4. Changes to demography, services, etc. that will affect pharmaceutical needs
- Demographic changes

- Planning intentions and housing developments
- Care homes and retirement villages
- Issues such as the impact of the co-operative pharmacy plans
- Increased use of online services

5. Key Strategic Priorities
    - Local Authority JHWS
    - NHS England Primary Care Strategy
    - NHS Long Term Plan
6. Neighbouring and Regional Services
7. Engagement
8. Conclusions
9. Recommendations
10. Equality Impact Assessment
11. Table of Abbreviations/Glossary
12. Appendices

Agenda Item 10

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 24 FEBRUARY 2022

JOINT STRATEGIC NEEDS ASSESSMENT – DEMENTIA

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Purpose of report

1. The purpose of this report is to provide to the Health and Wellbeing Board a summary of the recommendations that have arisen from the Joint Strategic Needs Assessment (JSNA) Dementia chapter.

Link to the local Health and Care System

2. The local authority and clinical commissioning groups (CCGs) have equal and joint statutory responsibility to prepare a JSNA for Leicestershire, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs.

3. JSNAs are a continuous process and are an integral part of CCG and local authority commissioning cycles. Health and Wellbeing boards need to decide for themselves when to update or refresh JSNAs or undertake a fresh process to ensure that they are able to inform local commissioning plans over time.

4. The purpose of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages. It should be viewed as a continuous process of strategic assessment and planning with the aim to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities.

5. The JSNA will be used to help to determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.

6. The local authority, CCGs and NHS England's plans for commissioning services will be expected to be informed by the JSNA. Where plans are not in line with the JSNA, the local authority, CCGs and NHS England must be able to explain why.

7. The JSNA is a statutory document that is used by many organisations to evidence changes to the commissioning of local services. As such, if any organisation receives a legal challenge to the services, they commission based on the JSNA, the local authority could also be part of that legal challenge. It is essential that the process that is followed meets the legislation that is set out and that the JSNA is a robust document.

Recommendation

8. It is recommended that the Health and Wellbeing Board supports the recommendations of the Joint Strategic Needs Assessment concerning Dementia.

Policy Framework and Previous Decisions

9. The Health and Wellbeing Board received a paper in January 2018 which proposed that the JSNA would be published in subject-specific chapters throughout a three-year time period on an iterative basis, in line with CCG and local authority commissioning cycles. This approach was supported with the JSNA outputs agreed as:

    - Subject-specific chapters of an assessment of current and future health and social care needs.
    - Infographic summary of each chapter
    - A data dashboard that is updated on a quarterly basis to allow users to self-serve high level data requests

10. The JSNA chapters published to date can be viewed via the Leicester, Leicestershire and Rutland Statistics and Research website using the following link

    https://www.lsr-online.org/jsna.html

Background

11. The JSNA Dementia chapter will be published alongside the other JSNA chapters (see link above) following its consideration by the Board. A summary of the recommendations arising from the chapter is provided below.

Summary of Recommendations JSNA - Dementia

12. The Dementia JSNA chapter has provided an overview of the data on Dementia. The chapter also considers the relevant national and local policy and guidance context.

13. A set of recommendations have been developed in relation to Dementia with the aim of preventing Dementia (where possible) and improving help, support and quality of life for people affected by Dementia in Leicestershire. The recommendations are:

    Prevention

    - People accessing behaviour change interventions and programmes in mid-life are advised that the risk of developing dementia can be reduced by making lifestyle changes as follows:

        - Integrate dementia prevention messages into other disease prevention strategies focussed on behaviour health improvement.

        - Integrate dementia prevention messages into health behaviour programmes related to smoking, alcohol, physical activity and healthy eating.

        - Improve NHS health check uptake to help ensure that key dementia related messages are aimed at those in mid-life.

Diagnosis

- Call to action: improve dementia diagnosis rate to meet NHSE target (67%) – explore opportunities to address variations in diagnosis rates across the county building on GP training and other measures underway pre-COVID to support primary care in improving diagnosis rates.

- Encourage GPs to diagnose in care homes using the DiaDem tool or gain advice via advice and guidance, this needs to be evaluated and promoted to increase dementia diagnosis rates.

- Consider opportunity to ask dementia screening questions in settings other than GP consultations e.g. nurse led clinics with patients at increased risk (diabetes and hypertension clinics).

- Ongoing capacity and demand work underway by Leicestershire Partnership Trust (LPT) needs to be completed and shared with commissioners on the basis that a 6 week referral to treatment (RTT) service is considered for commissioning. Alongside this there would be a need for the pathway around brain imaging and treatment to be reviewed to determine if the pathway can be reconfigured to enable the 6 week target to be met.

- Consider addressing shortfalls in Memory assessment services to meet NICE standards, recognising challenges in workforce recruitment.

Support services

- Variations in access to dementia related support services across county should be addressed.
- Explore opportunities to ensure a consistent level of funding for dementia related support services is available across the county e.g. where reliance on voluntary sector provision.

Carers

- Explore further challenges and issues for families, carers, and other informal carers. Consider use of advocates to support carers (or individuals affected) to secure access to support/funding.

COVID impact

- Work with care providers to develop guidance/support specific to needs of those with dementia. This should include areas such as Infection, Prevention and Control (IPC) and safeguarding. Consider ensuring that staff have training/awareness of the needs of this specific group.

- Implement Dementia Training provision for key workers including adult social care – link with Dementia Training Standards Framework. Develop joint

approach across Leicester, Leicestershire, and Rutland (LLR) and statutory organisations in relation to dementia learning and development.

- Seek to address maintenance of social contact for people with dementia through situations like COVID.

Living well

- Explore opportunities to improve frequency of care plan reviews in line with guidance (annually).

- Re-instigate quality improvement scheme exploring a joint approach to quality within care settings, in relation to supporting people with dementia.

- Consideration of accommodation provision for those with dementia including those with complex needs – support existing business case.

- Support further development of 'dementia friendly communities' in Leicestershire and explore links with evolving neighbourhood developments around 'mentally friendly communities' in the County.

Dying Well

- Support adoption of early conversations about future planning including dying well.

- Support adoption of advanced care plans including palliative (health).

- Continue to raise awareness of impact of benefits of putting plans in place at an early stage through post diagnostic service.

- Loros have developed tools to support palliative care with dementia – there is a gold standard tool – consider adoption

- Deprivation of Social Liberties: Implement the guidance when published (April 2022).

Other Considerations

- People with learning difficulties: There is a need to consider additional dementia awareness and training to make sure that specific needs related to dementia can be addressed.

- Raise awareness of dementia in younger people, Veterans, those in prisons and BAME communities.

Background papers

https://www.lsr-online.org/jsna.html

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Relevant Impact Assessments

Equality and Human Rights Implications

14. The JSNA is subject to an EHRIA. This is being conducted on an ongoing basis in consultation with the Council's policy officers. A representative from the Leicestershire Equality Challenge Group (LECG) sits on the JSNA Reference Group and members of the LECG participate in the Task and Finish Groups which oversee the development of each chapter.

Partnership Working and associated issues

15. A range of partner organisations have roles to play in Dementia management and prevention which relate to the recommendations within this report. This includes health and social care providers and the community and voluntary sector. Partner organisations already meet to address the Dementia agenda as part of the LLR Dementia Programme Board Meeting (LLR) and associated strategy.

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Agenda Item 11

HEALTH AND WELLBEING BOARD – 24 FEBRUARY 2022

FAMILY HUBS MODEL IMPLEMENTATION AND BID

REPORT OF THE DIRECTOR OF CHILDREN AND FAMILY SERVICES

Purpose of report

1. The purpose of this report is to inform the Health and Wellbeing Board of the County Council's intention to develop a Family Hubs Model of service delivery in Leicestershire and the recent submission of a bid submitted to the Department for Education (DfE) for funding to develop the model.

2. A Family Hubs Model is a system-wide approach of providing high-quality, whole-family, joined up support service which delivers support from pregnancy, through the child's early years and into early adulthood.

3. In order to meet with DfE deadline, the Chief Executive (using his delegated powers) took urgent action to approve the bid on behalf of the Health and Wellbeing Board, a requirement of its submission.

Recommendation

4. It is recommended that;

   a) The County Council's intention to develop a Family Hubs Model of Service Delivery in Leicestershire, be supported;

   b) The urgent action taken by the Chief Executive to submit the County Council's Family Hubs Model bid to the Department for Education on behalf of the Health and Wellbeing Board, be noted.

Policy Framework and Previous Decisions

5. In October 2021 the Government Spending Review announced the creation of an £82 million fund for the development of Family Hubs in England (the Family Hubs Transformation Fund). Authorities which adopt the Family Hubs model will be able to apply for support from this Fund.

6. The proposal contributes to the following elements of Leicestershire County Council's draft Strategic Plan 2022-2026:

   a. Improving Opportunities:
      i. Every child gets the best start in life
      ii. Every child has access to good quality education
      iii. Families are self-sufficient and enabled to be resilient
      iv. Everyone is able to aim high and reach their full potential.

   b. Keeping People Safe and Well:
      i. People are safe in their daily lives

ii. People at the most risk are protected from harm.

c. Great communities
   i. People participate in service design and delivery.

7. The Children and Family Services Departmental Plan 2020-23 sets out four clear ambitions all of which would be supported through the Family Hubs Model:

- Help every child get the best start in life.
- Help children and their families build strength, resilience, confidence and capacity.
- Help children in Leicestershire to live in safe, stable environments and have secure attachments.
- Help every child to have access to good quality education to ensure they meet their maximum potential.

8. The Family Hubs Model also supports the Government policy paper "The best start for life: a vision for the 1001 critical days" which outlines six areas for action to improve the health outcomes of babies in England.

Timetable for Decisions (including Scrutiny)

9. On the 11 February 2022 the Cabinet approved the principle of a Family Hubs Model of service delivery for services provided by the Children and Family Wellbeing Service and noted that a feasibility study, which would include engagement with families and other stakeholders, would be undertaken in order to inform the new model.

10. The feasibility study will include a period of engagement with partners, parents and carers, which will commence at the end of February and is expected to be concluded by end of April 2022, at which point work will begin to move services to the Family Hubs Model. It is anticipated that the model will be fully operational by March 2024.

11. The bid submitted to the DfE totalled £969, 886 from the initial tranche of transformation funding for Family Hubs. If this bid is successful, the funding would provide project support to implement new ways of working and the transition to the new model. The DfE is due to report on the outcome of applications by end of January 2022 however at the time of writing the outcome was unknown. If the bid is not successful, the implementation will proceed using existing County Council resources.

Background

12. A Family Hubs model is a system-wide model of providing high-quality, whole-family, joined up family support services. Family Hubs deliver support services from pregnancy, through the child's early years and later childhood, and into early adulthood until they reach the age of 19 (or up to 25 for young

people with special educational needs and disabilities (SEND)). The concept of Family Hubs is not new but in the last 12 months has been increasingly prominent in Government thinking and policy.

13. The Anna Freud National Centre for Children and Families (a national children's mental health organisation) was appointed by the DfE to undertake the lead on developing The National Centre for Family Hubs, a learning network that will champion the Hubs and disseminate best practice to Family Hubs providers across England. A model framework has been developed by the DfE with input from the Department for Levelling Up, Housing and Communities, Department for Work and Pensions and the Department for Health and Social Care. The Framework focuses on three key areas for delivery:

    a. Improving access to services – agencies working together to develop clear pathways of support. This will include buildings-based services, outreach, on-line and virtual delivery, web-based information and resources.
    b. Developing connections between agencies, communities, voluntary sector etc to work in partnership with families.
    c. Supporting relationships within families and communities, building resilience, and reducing unresolved conflict in families.

14. The Family Hubs framework is in-line with the agreed Early Help Partnership plan (Priority 3 of the Children and Families Partnership Plan.) The Early Help Partnership has stated a commitment to developing enhanced data sharing to support identification of vulnerability and application of resources as well as a commitment to working with communities to deliver joined up services in a way that makes sense to families. The Partnership has stated a commitment to ensuring parent carer and child voice is central to planned developments.

15. The proposal is to adopt the Family Hubs Model framework as the guiding strategy for the delivery of early help services in Leicestershire, joining up with other County Council teams and departments such as Children's Social Care, Adult Social Care, Libraries. This proposal would make best use of LCC estate to help promote an equality of access to services for families.

DfE bid

16. The Bid was submitted on 17 December 2021 to the initial tranche of Transformation Funding for Family Hubs – if successful the funding will be used to project manage the implementation as well as supporting costs to deliver the following:

    a. A Family Hubs communication strategy which will help explain the concept, how it will support families, and how it is accessed.
    b. A Family Hubs logo or brand.
    c. A website for Family Hubs.
    d. Data sharing arrangements.
    e. An evaluation of the approach.

17. Bids are assessed against a number of qualifying criteria one of which is approval and support of The Health and Wellbeing Board. In order to meet with DfE deadline, the Chief Executive (using his delegated powers) took urgent action to approve the bid on behalf of the Health and Wellbeing Board.

Background Papers

Family Hubs Transformation fund:
https://www.gov.uk/government/publications/family-hubs-transformation-fund

Report to the Cabinet – 11 February 2022 – Developmenet of a Family Hubs Model in Leicestershire.

https://politics.leics.gov.uk/ieListDocuments.aspx?CId=135&MId=6773&Ver=4

Circulation under the Local issues Alert Procedure

18. None

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Equality and Human Rights Implications

19. An equality and Human Rights Impact Assessment will be completed as part of the Feasibility Study. It is anticipated that Family Hubs Model will enhance access to services as the breadth of delivery models will cater to a wider range of needs.

Partnership Working and Associated Issues

20. The Family Hubs Model will require wide partnership support. The co-ordination and development of this will be lead through the Early Help Partnership Board and the Children and Families partnership Board.

Agenda Item 12

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 24 FEBRUARY 2022

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

TECHNOLOGY ENABLED CARE (TEC)

Purpose of report

1. The purpose of this report is to update the Health and Wellbeing Board on progress made with the introduction of a Care Technology (CT) service across Leicestershire's Adult Social Care services. An Appendix is included and forms part of a presentation to be provided to the Board.

Recommendation

2. The Health and Wellbeing Board is asked to note the progress made with the introduction of a Care Technology service across Leicestershire's Adult Social Care services as detailed in the report and Appendix and comment on where there might be wider opportunities to link this work with other digital initiatives.

Link to the local Health and Care System

3. Maximising the use of technology which can assist people in their homes can have a range of benefits. These may be helping people live independently for longer in their own homes, and also financial benefits through avoided cost elsewhere in the organisation.

4. Optimising access to CT in the home for those eligible for social care forms an integral part of the Department's integrated Strategy 'Delivering Wellbeing and Opportunity in Leicestershire: Adults and Communities Department Ambitions and Strategy for 2020–2024'.

Background

5. In October 2020, a diagnostic of the current technology service delivered by an in-house Assistive Technology Team was completed. The diagnostic outlined a compelling case for the transformation of the approach to Care Technology in the County Council, identifying opportunities to enhance support for vulnerable adults and deliver financial benefits to the Council.

6. In early 2021, a Business Case was approved, building on the diagnostic phase by setting out the agreed strategy and preferred option for the future of CT in Leicestershire. The Business Case proposed a transformed service which

mainstreams CT effectively across social care, encouraging practitioners to consider it as part of the 'first offer'.

7. The Council has now entered into the implementation phase, working alongside its strategic partner Hampshire County Council and their commercial partner PA Consulting to transform Leicestershire's CT service offer.

8. The ambition of the service is to:

- Establish CT as part of the first offer for Adult Social Care, in doing so, creating an equitable service designed around service user outcomes;
- Develop a programme of cultural change and engagement that drives high quality referrals, better understanding of care technology amongst practitioners and better outcomes for service users;
- Embed a quality assurance framework into the service model for care technology;
- Enable robust measurement of the financial and non-financial benefits of CT.

9. As the service establishes itself, there may be opportunities to link the offer into other areas of digital health care across a range of stakeholders. It is anticipated, for example, that one area would be the Lightbulb Project, that brings together a range of agencies and support for Leicestershire residents to remain safe and well in their own homes. There will be others and therefore it will be important to ensure that opportunities are identified and developed as the service establishes itself.

Resource Implications

10. The costs of the existing Assistive Technology Team of £755,000 per annum are funded through the improved Better Care Fund (IBCF). It is anticipated that the cost of the new CT service will be higher than that of the existing service due to the costs of transforming the service, expected growth in the number of service users benefiting from CT, and the additional cost of digital equipment. The existing IBCF allocation of £755,000 will be used to partially offset the new service costs for which additional funding is being sought within the Council's Medium Term Financial Strategy.

Timetable for Decisions

11. It is anticipated that the re-modelled service will launch in April 2022.

Circulation under the Local Issues Alert Procedure

12. None.

Officer to Contact

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Appendix

Care Technology (CT) Transformation

Relevant Impact Assessments

Equality and Human Rights Implications

13. The CT service is rooted in being outcome based and should not disproportionately impact on groups with protected characteristics. It is anticipated that it will enhance people's access to services.

Partnership Working and associated issues

14. There will be a range of opportunities in the medium term to explore how the service complements or adds value to other technology related initiatives across the county.

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Care Technology (CT) Transformation

Background and History

1. Diagnostic Phase

In October 2020, a diagnostic of the current service was completed. The diagnostic outlined a compelling case for the transformation of the approach to Care Technology in LCC, identifying opportunities to enhance support for vulnerable adults and deliver financial benefits to the council.

2. Developing the Business Case

In early 2021, a Business Case was approved, building on the diagnostic phase by setting out the agreed strategy and preferred option for the future of care technology in Leicestershire. The BC proposed a transformed service which mainstreams CT effectively across social care, encouraging practitioners to consider it as part of the 'first offer'.

3. Planning, Mobilisation and Implementation

We have now entered into the implementation phase, working alongside Hampshire County Council and PA Consulting to transform Leicestershire's CT service offer. The implementation phase includes a series of workstreams to mobilise the transformation

Our Ambition

LCC's overall objective in working with HCC/PA is to jointly transform the Assistive Technology team, enabling a new CT service to be embedded as part of a transformed social care offer, resulting in the delivery of individual, organisational and systemic benefits.

To achieve this, the CT transformation will:

- Establish care technology as part of the first offer for Adult Social Care, in doing so, creating an equitable service designed around service user outcomes;
- Develop a programme of cultural change and engagement that drives high quality referrals, better understanding of care technology amongst practitioners and better outcomes for service users;
- Embed a quality assurance framework into the service model for care technology;
- Enable robust measurement of the financial and non-financial benefits of CT.

Features of the transformed approach to CT

APPENDIX

Leicestershire County Council

Care Technology (CT) Transformation

The benefits

The new service will positively impact a wide range of stakeholders across the council and across the local health and care system, from care professionals and wider staff, to service users, their carers and family members:

Outcomes for people with care

- Reaching a **broader range** of users
- **Supporting individuals living to manage health and care needs** with a range of support mechanisms
- **Addressing social isolation and independence**
- **Support to younger adults with disabilities**

→ Target to reach ~1,400 people in the service's first year

Outcomes for care practitioners

- **Wider** and **more responsive** service
- Regular and automated **tracking of benefits**
- Full programme of culture change activity including training, case studies and regular engagement to **ensure that the service is responsive to care professionals' needs**

Financial outcomes for LCC

This project **transforms the CT service**, supports a larger number of **younger adults and expands the offer for OP**, leading to increased and measurable benefits. The transformed service is expected to deliver an incremental net benefit in the region of £5m by 2025/26 through the delay, avoidance and reduction of other costlier forms of care.

Example CT Case Study; Evidencing the Positive Impact of CT

Mr Bennett, an NHS worker, has long-term epilepsy. He has recently started having frequent blackouts and seizures and has expressed anxiety about accessing the community and commuting to work.

The CT Service recommended a small personal alarm with a built-in GPS tracker that he can clip to his belt. Since this, Mr Bennett reported an increased sense of safety at home and when travelling to work.

The CT supported Mr Bennett to return to work and regain his independence. The solution also avoided domiciliary care of 3 to 7 hours per week.

In the future service, there will be opportunities to utilise a broader range of monitored equipment and explore opportunities for service innovation and growth. Examples of the potential positive impacts are shown in a series of videos available here.

Governance

Leicestershire County Council

Care Technology (CT) Transformation

Service Potential and Growth

Benefits and service development in Hampshire so far

£14m
Net saving in **6.5** years

Over 2,000
health and **social** care **practitioners** trained and certified

93%
of users surveyed feel that care technology has **increased their feeling of safety and security**

13,000
active service users

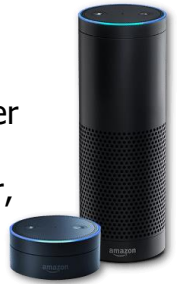
nine out of 10
social workers say Argenti care technology is **"good"** or **"very good"** at **achieving desired user outcomes**

98%
Of users surveys would "recommend the service to others"

full system benefits

Argenti drives wider take up of care technology across **health and social care** working with Councils, CCGs the Police and the third sector

- Cobots help with the physical demands faced by care sector staff – Hampshire County Council and PA
- Touchless interfaces like Amazon Echo are becoming mainstream
- PA / Amazon Web Services Automated Call Service improved customer service while reducing costs with automated contact
- Using care technology with children: managing challenging behaviour, promoting safety and reducing carer strain



Future potential for CT in LCC

What are the key Adult Social Care challenges facing LCC?

What opportunities are there for LCC that technology can help to unlock?

What system partners could the CT service engage with to broaden its impact?

What are the strengths of LCC that the care technology service can tap into to maximise its potential?

Leicestershire County Council

Care Technology (CT) Transformation

Workstreams and their Purpose

Governance: Establishing strong decisive governance structures that operate across Leicestershire to provide inputs at the right level throughout the transformation and ongoing development of the service.

Service Redesign: Establishing and embedding the new operational service model. Pathway and referral form co-design to co-produce new simplified referral pathway and embed service operating procedures.

Benefits: Designing and implementing a robust approach to benefits measurement and realisation that meets the needs of Leicestershire stakeholders, including a benefits dashboard.

Upskilling and delivery transformation: Working with the care technology team to enhance and embed ways of working to support the new service delivery model.

Comms and Engagement: Embedding and delivering sustainable change and benefits. Raising the profile of the service through a programme of activity around culture change and engagement.

L&D: Supporting referrers, commissioners, providers and leadership to have the capacity and capability to use the service and encourage higher rates of take-up.

Workstream Achievements to Date

Governance: Regular meetings of the Operations and Steering Groups involving multiple stakeholders from the relevant LCC teams to agree key decisions required for the transformation.

Service Redesign: Engaged with ~40 staff across all social work / AT / BI and Systems teams to co-design a new referrals pathway and form, resolving key service design questions. Created a user-focussed assessment process and begun development of the underpinning operational procedures.

Benefits: Worked with BI, Finance, Systems and operational teams to develop a set of performance/ financial KPIs and a measurement approach to track them.

Upskilling and delivery transformation: Liaised with the AT team manager and external delivery expertise to begin development of a role specific training plan.

Comms and Engagement: Identification of key channels of communication and messages to be shared, including Leics Matters, a CT Champions network and digital platforms, and creation of content for these channels.

L&D: Recruitment of a Champions network and a network of Trainers to deliver future BAU training and commenced design of a CT section of the LCC learning hub.

Leicestershire County Council

Agenda Item 13

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 24th FEBRUARY 2022

REPORT OF THE DIRECTOR OF CHILDREN AND FAMILY SERVICES

LEICESTERSHIRE CHILDREN AND FAMILIES PARTNERSHIP PLAN: PROGRESS UPDATE

Purpose of the report

1. The purpose of this report is to present to the Health and Wellbeing Board a progress update on the delivery of the Children and Families Partnership Plan 2021-23.

Link to the local Health and Care System

2. The Children and Families Partnership Plan is aligned to the Leicestershire County Council Strategic Plan and focuses on the added value of approaching strategic priorities across the partnership to ensure consistent communication and service delivery to children and families.

Recommendation

3. The Health and Wellbeing Board is asked to note the progress in delivery of the Children and Families Partnership Plan.

Policy Framework and Previous Decisions

4. In November 2016 the Health and Wellbeing Board approved the Terms of Reference for a Children and Families Partnership to replace the Supporting Leicestershire Families Executive as a subgroup of the Health and Wellbeing Board. The expanded remit included oversight of how the priorities for children and families as set out in the Joint Health and Wellbeing Strategy, are delivered.

5. In May 2018, the Health and Wellbeing Board approved the Children and Families Partnership Plan for 2018 – 21 and requested that it received regular progress updates.

6. In November 2020 the Health and Wellbeing Board approved the updated Terms of Reference for a Children and Families Partnership, required to reflect the decision to strategically align the Leicestershire Education Excellence Partnership, SEND and Inclusion Board, Youth and Justice Partnership Board and the Early Help Partnership to the Children and Families Partnership.

7. In November 2020 the Health and Wellbeing Board approved the refreshed Partnership Plan for 2021 - 23. The Partnership agreed that the current five priority areas and key actions were still relevant, and the focus of actions should remain on identifying where improved partnership working would add value.

Background

8. The Children and Families Partnership Plan is a strategic document which sets out the shared vision for children, young people and their families and the priority outcomes that need to be improved. The Plan is not intended to be a detailed description of the individual work of each partner, but rather a summary of key areas of work that are best delivered together to have the biggest impact on the lives of children and young people.

9. The five priorities of the Partnership Plan are:

i. Ensure the best start for life
ii. Keep children safe and free from harm
iii. Support children and families to be resilient
iv. Ensure vulnerable families receive personalised, integrated care and support
v. Enable children to have good physical and mental health

10. The Integrated Care System Children's Design Group, Leicestershire Education Excellence Partnership, SEND and Inclusion Board, Youth and Justice Partnership Board and the Early Help Partnership provide regular reports to the Children and Families Partnership.

Progress update

11. The Partnership Plan for 2021 – 23 has been updated with indicative success measures for each priority, as requested by the Health and Wellbeing Board, which is shown in the appended Partnership Plan.

12. Priority leads have continued to work with partners and other key stakeholders to deliver current action plans. It is important to note that the pace of delivery and progress of actions continues to be affected by Covid-19 due to resources being re-focussed on responding to the pandemic. Key progress includes:

Priority 1 - Ensure the best start for life

Develop an integrated Early Years Pathway to ensure the needs of vulnerable children are identified:

- The universal offer to support parents accessing the two year check has been published on the Two to School webpage.

- Providers and professionals have welcomed the virtual meetings appointment system to receive professional advice to support vulnerable children and feel that children have been better supported as part of the graduated approach. Drop-ins have been planned for the year to provide additional assistance where providers have concerns about children who need further strategies and support.

Develop a shared understanding of the importance of the first 1001 Critical Days and school readiness:

- A communications campaign has been implemented to share key messages around the importance of accessing preschool places and getting school ready.

- Work is being undertaken with the County Council's Communities team to analyse take up of early years provision and localised Middle Super Output Areas (MSOA) of low take up.

- 785 children were identified as having not accessed pre-school prior to starting school in September 2021. A communications plan is now in place around starting school and work is being undertaken with School Admissions and Information Governance teams in the County Council to enable parents to be contacted if their child is not attending pre-school and, in future, to enable parents to opt in to be contacted about starting school and accessing their free early education entitlement.

- Officers from the County Council's Early Years and Inclusion Service have also attended Children's Social Care (CSC) management meetings to raise the importance of supporting vulnerable children to accessing their early education entitlement at 2,3 and 4 years and the support that can be offered.

- Work has been undertaken with health, schools and the early years sector to help understand the impact of the pandemic on school readiness has identified self-regulation skills, gross/fine motor skills, poor core strength and behaviour for learning as key areas. A new action is being developed under this priority to develop support for early years professionals and parents to address developmental areas impacted by Covid 19.

- An e learning module to raise awareness of the importance of the first 1001 critical days is being built by the County Council's Children and Family Services (CFS) and will be piloted with staff in Children and Family Wellbeing Services (CFWS) before sharing wider via the Authority's learning hub. The multi-agency 1001 Critical Days task group are exploring how the module can be shared across partners.

- Workshops on 1001 Critical Days have been delivered to staff from the County Council's CFS, Health and Midwifery and links are being made with colleges around including 1001 Critical Days as part of the training for students on Health and Social Care courses.

- An online 1001 Critical Days event to raise awareness of key messages took place on 10th Nov with 90 attendees from a range of partners across LLR.

- A 1001 Critical Days animation is being developed by the County Council's CFS and has been shared with parent focus groups for feedback. It is anticipated the animation will be launched in spring 2022 as part of a communication campaign, including the refresh of the 1001 Critical Days parent leaflet.

<u>Priority 2 - Keep children safe and free from harm</u>

Develop and embed an integrated model of services to prevent harm to children and young people:

- The Child Criminal Exploitation (CCE) Vulnerability Ops Group continue to meet regularly to progress the delivery plan. Key areas for action include developing a strong model around transitions into adulthood, learning from data and work completed on children who go missing in order to develop a stronger offer, earlier and work around adolescents harmed outside the home.

- A review of partnership data collection has been completed and new performance indicators have been identified to focus on understanding the local landscape, challenges and the targeting of resources. Multi agency review of all high-risk case are in place to determine risk, threat and response.

- Following a successful bid for DFE recovery funding on behalf of the regional response to Child Criminal Exploitation (CCE), Leicestershire is developing a framework to adopt a contextual approach to respond to children at risk of harm outside the home - Extra Familial Harm (EFH). To support the development and integration of this approach, work will be undertaken with the Safer Young Lives Project, Bedfordshire University, including case studies, the oversight of a peer assessment project and work on the implications for practice and policy guidance. Leicestershire will be responsible for the dissemination of learning for LLR, Lincolnshire and Nottinghamshire.

<u>Priority 3 - Support children and families to be resilient</u>

Review Early Help Partnership governance and leadership:

- The County Council's Cabinet approved the development of a Family Hubs model of service delivery at its meeting on the 11 February. This model will provide the framework for an Early Help strategy.

Develop early help data sets:

- The Early Help Partnership data group has been expanded to include City and Rutland to align this group to incorporate the work of Supporting Families national programme and the Violence Reduction Network.

- The LLR Strategic Information Management Group has agreed to take on the role of the LLR EH Data Governance Group. This group will provide strategic direction and will be able to address barriers to data sharing.

- An LLR Early Help Data Sharing Board has been established. The current focus of work is police data and mapping is taking place to understand how data is currently shared between Leicestershire County Council, Leicester City Council and Rutland County Council and police.

Develop shared systems and process for early help:

- A "Phone Fist" pilot was run with Hinckley schools to enable them to phone a dedicated line to discuss possible referrals into the County Council's CFWS before completing a multi-agency referral form (MARF). The scheme has now been rolled out to Harborough and Melton.

- A draft early help assessment is currently being piloted by a small group of schools. This pilot will end early April and next steps will be decided following evaluation.

Develop the early help workforce:

- Home Office funding was secured in July 2021 to support the design and delivery of training around Trauma Informed Practice and Barnardo's have been contracted as a service provider.

- A Design and Delivery group has been established and is meeting regularly and feedback to inform the training is being sought through multi-agency design workshops and consultation with children families.

- Tier 1 and 2a training, targeting front-line staff and managers, has been designed and is being delivered from January to March 2022 with positive feedback from participants to date.

- DWP and Public Health funding was secured to deliver a Reducing Parental Conflict programme on, which will be known locally as Relationships Matter. A Leicestershire Practitioner Toolkit has been developed and will be available to all staff who are trained across the Partnership.

<u>Priority 4 - Ensure vulnerable families receive personalised, integrated care and support</u>

Provide integrated, outcome-based, high quality, cost effective provision:

- Discussions are being held between the County Council and Health partners, as part of the review of the current Complex Care Panel pathway and protocol, to look at a sample of cases and agree plans for future joint commissioning.

Develop a post 16 multi-agency delivery model:

- The multi-agency Joint Housing and Social Care protocol for 16- and 17-year olds at risk of homelessness is being reviewed.

- A working group has been set up to explore options for the extension of CAMHS services to care leavers until they 25. In recognition that this is likely to be a longer-term aspiration, the task group will identify smaller, achievable steps and actions that can be taken in the interim.

- The County Council's Leaving Care team are recruiting to a mental health worker post to help address the lower level mental health concerns of young people. There is also a therapeutic fund which allows access to £2,000 per year for young people who need support in this area.

- The LLR Joint Commissioning Strategy has now been launched, including and action to develop an LLR Pathway to Adulthood Strategy.

<u>Priority 5 - Enable children to have good physical and mental health</u>

Develop a programme of work to implement Trauma Informed Practice aligning to the LLR Trauma Aware workstream:

- Work is on-going to develop a programme of work, including the development of an LLR Trauma Informed Practice strategy

Understand why breastfeeding initiation across Leicestershire are lower than national average:

- Data quality issues were identified and addresses by NHS Digital and now meets validation criteria

- A Maternity Equity Analysis has conducted and has identified areas where additional support is needed around breastfeeding initiation and sustaining.

Reduce A and E attendances for 0-18s across the County:

- Public health are working with the County Council's Environment and Transport on an air pollution campaign. Forty primary schools signed up to the campaign.

Reduce food poverty (including holiday hunger) through further development of the Leicestershire Food Plan:

- A Food Poverty Officer has been appointed to develop a programme of work to address food poverty

- CFS, working with Active Together co-ordinated the delivery of DfE funded Holiday Activities and Food 2021 programme across Leicestershire to target children in receipt of free school meals for free holiday club provision over the Christmas holidays. £105,000 was awarded fund 22 providers to deliver 1500 places at 39 venues across the County and for CFWS to deliver family fun days and food hampers to eligible case load families.

<u>Youth Voice</u>

- Members of Youth Parliament (MYPs) and representatives from County Youth Council for Leicestershire (CYCLe) attended the Board meeting in January to provide an update on activity they have been engaged in from August 2021, including:
    i. The launch of SEND CYCLe and Young Carer CYCLe groups in November 2021
    ii. The launch of a leaflet in October 2021 that highlights common causes of cancers in young people. The leaflet has been shared with schools, governors, LPT and elected members and will be shared with young people engaging in group work with Children and Family Wellbeing Service
    iii. Contributing to the development of a national survey led by the London School of Economics to gain the voice of young people on the impact of Covid 19.
    iv. Involvement in six interview panels for roles within CFS where their views were given equal weighting in the recruitment decisions. CYCLe members who participated have also been involved reviewing the young person's Interview Training Pack created by De Montfort University
    v. Working with LPT to produce a Young Carer short video which was released to GPs across LLR to enhance their knowledge of young carers to increase the recognition of their needs within GP services
    vi. Supporting United against Violence and Abuse (UAVA) in the development of the Healthy Relationship game as part of an LLR project
    vii. Formulating questions for a Q and A session with the Police Crime Commissioner about police, crime and things that affect young people which will be delivered in February 2022 Feb 2022
    viii. Working with Victim Impact and the police on victim support

Future Developments

13. Work over the next six months will include:

- Launch of the 1001 Critical Days animation and 50 Things to Support Your Baby to Thrive by Five video
- Development of a funded project targeting young parents not in education or employment
- Development of a core data set which will support the early help/Supporting Families agenda
- Delivery of 3 workshops in March 2022 for senior leaders and managers across partners in LLR on Becoming a Trauma Informed Organisation
- Delivery of Relationships Matter - Reducing Parental Conflict training to CFS and voluntary sector family workers and inquiry workshops with Police, Education, Health and districts to understand their training requirements around this agenda.
- Joint audit by Children's Social Care and Districts on 16/17 homeless cases and actions taken
- Co-ordination and delivery of the 2022 Holiday Activities and Food Programme over the Easter and Summer holidays to target children eligible for free school meals

Background papers

Report to the Cabinet – 11 February 2022 – Development of a Family Hubs Model In Leicestershire
https://politics.leics.gov.uk/ieListDocuments.aspx?CId=135&MId=6773&Ver=4

Report to the Health and Wellbeing Board – 8 July 2021 – Leicestershire Children and Families Partnership Plan – Update
https://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=6584&Ver=4

Appendix

Leicestershire Children and Families Partnership Plan

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Leicestershire Children and Families Partnership Plan 2021-23

Our Children Our Future

Leicestershire
Children and Families
Partnership

Foreword

Our Children and Families Partnership Plan brings together partners who work closely with our children and young people. Over the past three years we have made great strides in improving the lives of our children and young people, their families and carers in Leicestershire. A partnership approach where the child's voice is at the forefront of all our thinking and action, provides a safe and supportive culture for our children to thrive. This is turn supports our vision that **Children and young people in Leicestershire are safe and living in families where they can achieve their full potential**. We are united as partners and I am incredibly proud to be the Chair of the partnership as we move forward over the next three years.

Cllr Deborah Taylor

Lead Member for Children, Families, Safer Communities and Regulatory Services

Deputy Leader of Leicestershire County Council

Vision

> Children and young people in Leicestershire are safe and living in families where they can achieve their potential and have their health, wellbeing and life chances improved within thriving communities.

Background

Leicestershire Children and Families Partnership was established in 2018 to champion effective partnership working on shared outcomes and priorities that make a real difference to the lives of children and young people.

By working together, the Partnership aims to maximise resources and expertise, be more co-ordinated in the services provided and avoid duplication of effort.

The Partnership is a sub-group of Leicestershire's Health and Wellbeing Board and is made up of the key organisations that work with children, young people and their families across Leicestershire.

The Partnership includes representatives from Leicestershire County Council, District and Borough Councils, Leicestershire Police, Office of the Police and Crime Commissioner, NHS health partners, Schools, Probation Service, Department of Work and Pensions and the Voluntary Sector.

Partnership Plan

The Partnership is tasked with overseeing the delivery of a Children and Families Partnership Plan, addressing the five priorities relating to children and young people identified in Leicestershire's Joint Health and Wellbeing Strategy (2017-22).

Priority 1: Ensure the best start for life

Priority 2: Safe and free from harm

Priority 3: Support families to be self-sufficient and resilient

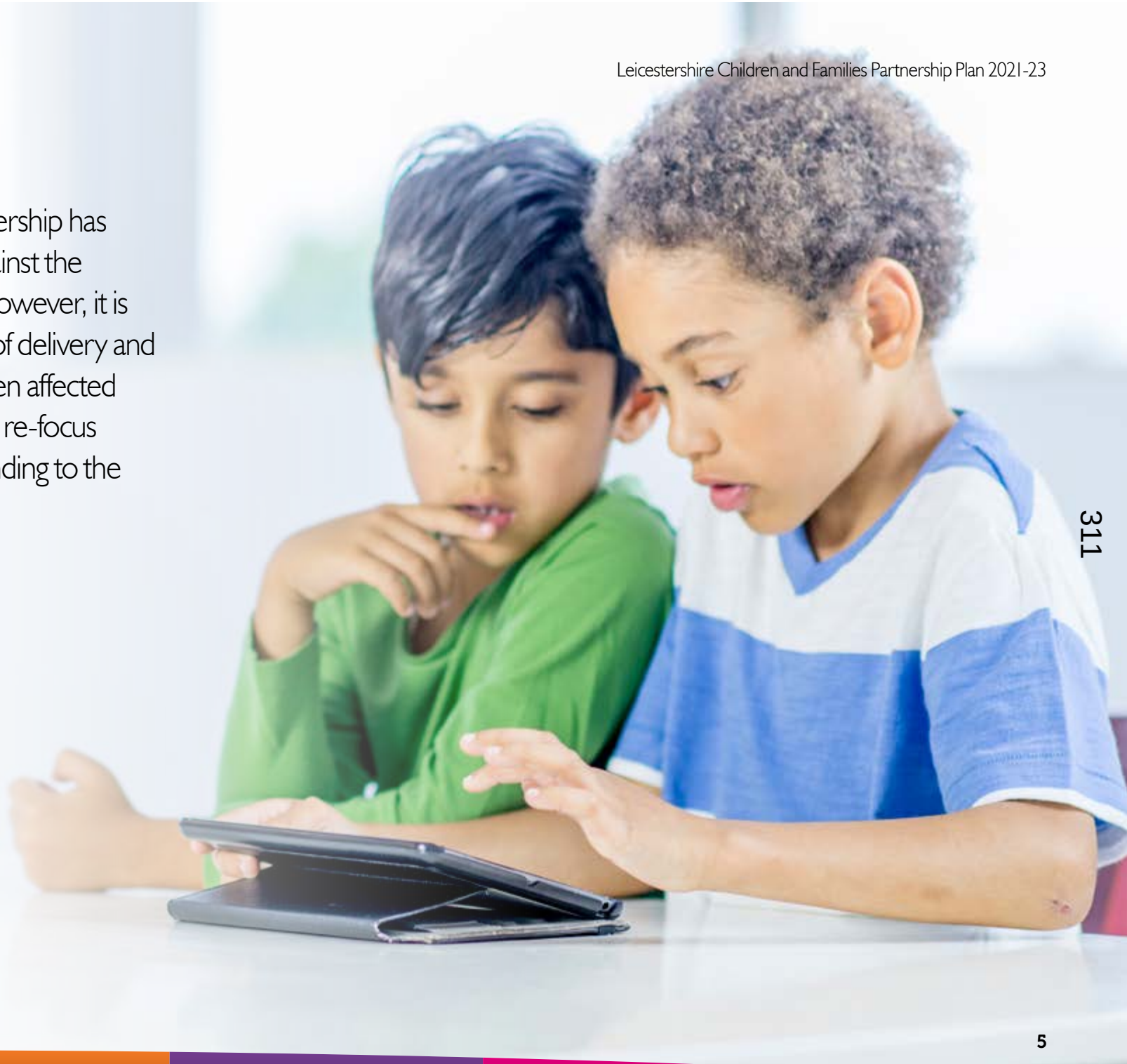
Priority 4: Ensure vulnerable families receive personalised, integrated care and support

Priority 5: Enable children to have good physical and mental health

The Partnership Plan is not a detailed description of the work of each partner individually, but an overview of those actions we know that, by working as partner agencies, we can have the biggest impact on the lives of children and young people.

Achievements

The Children and Families Partnership has celebrated key achievements against the Partnership Plan for 2018 – 21, however, it is important to note that the pace of delivery and progress of some actions has been affected by the Covid-19 and the need to re-focus partnership resources on responding to the pandemic.



Priority 1

Ensure the best start for life

Early Identification

A universal offer has been developed to support children identified as at risk of delay through the 2 year health check.

A "Graduated Approach" has been introduced to assist children at risk of delay being identified early and referred to appropriate services for support. The approach includes an Advice Line, support visits from Area SENCOs, half-termly drop-ins for providers to talk through concerns with a range of professionals and an online toolkit for schools and preschools.

A neo natal support pathway is being developed to help identify families with children who have been born prematurely who may require additional support at home on leaving the neo natal ward.

School Readiness – a shared understanding across Leicestershire

Early years providers, schools, families and 0-5 services all have a shared responsibility to ensure that each individual child is ready to continue their learning journey as they enter school and get off to a flying start. School readiness is about working together for a child ready, family ready, school ready community.

The Partnership have developed a number of resources to promote a shared understanding of school readiness across Leicestershire.

- "Ready for school?" A leaflet to support parents
- "Talking about starting school" A video to support parents
- "School readiness – a shared understanding across Leicestershire" A booklet for professionals.
- School Readiness webpage – for parents, early years providers and schools
- School readiness online toolkit - for early years providers and schools
- School Readiness communications campaign to promote home learning tools and resources and the benefits of early years provision
- School Readiness Campaign - Areas across county with lower take up of free early education entitlement were identified for targeted promotional campaign

The First 1001 Critical Days

The first 1001 days, from conception to age two, is a period of rapid growth and what happens during this time lays the foundations for future development. Positive experiences and good quality parent-infant relationships during this time are associated with the formation of a secure attachment which contributes to good physical and mental health, speech and language development, emotional self-regulation, resilience and wider social and economic advantages throughout the life course.

The Partnership have developed a communication plan and a number of resources to promote a shared understanding of the importance of the First 1001 Critical Days..

- "My first 1001 Days"– A leaflet for parents, distributed to expectant and new parents through key health contacts
- 1001 Critical Days webpage – serves as a one-stop shop for information for new parents
- 1001 Critical Days workshops and roadshows – awareness raising sessions for professionals across the Partnership
- 1001 Critical Days communications plan – including the distribution of leaflets and posters to schools, GP surgeries and public-facing/community buildings around the county and a social media campaign to promote the key messages

Priority 2

Safe and free from harm

Child Criminal Exploitation Delivery Plan

A partnership delivery plan for Child Criminal Exploitation (CCE) is in place. The plan contains 89 actions set to the five P's (pursue, prevent, prepare, protect and partnership) and is being monitored by the Child Vulnerability Operational group.

Child Criminal Exploitation Hub

The well-established, effective, multi-agency Child Sexual Exploitation (CSE) and Missing from Home safeguarding hub has been developed to tackle to the wider issues of the CCE.

- A strong partnership response is in place to all forms of exploitation, enhanced by the co-location of partners from across LLR including health, children's services, education, YOS and the police.
- The Terms of Reference and Strategy for the CCE hub have been updated and a joint data set including all LLR authorities, Police and health data has been compiled.
- Violent Crime Surge funding has been secured to fund posts to support the delivery of CCE work
- County Lines Intensification Week activities have successfully resulted in a number of warrants and arrests, the seizure of controlled drugs, firearms & cash and the identification of vulnerable people

Child Criminal Exploitation Framework

Leicestershire has led in the development of the regional response to tackle CCE and develop improved information sharing across borders, including the development of a CCE pathway to services and resources and have worked with East Midlands regional neighbours to develop a Child Criminal Exploitation Framework to ensure a local and regional response that is effective and coordinated for children and young people at risk of CCE.

Communications

A Communications Strategy, training plan and resources to support professionals in the delivery of safety messages have been developed and rolled out.

- An electronic, partnership newsletter has been developed to ensure all practitioners across the county are up-to-date with the work being undertaken by police and partners and to raise greater awareness of CCE.
- Resources, including posters, have been distributed to professionals across LLR to raise awareness of CCE and county lines
- Breck's Last Game film and resource pack, aimed at protecting children from online grooming, has been rolled out to schools across LLR
- CSE/CCE gangs and county lines training has been delivered to professionals across LLR
- A short video briefing has been developed and shared with all GPs across LLR
- "Are You Listening" social media campaign, targeting parents/carers has been successfully delivered
- Workshops, aimed at children and education professionals, have been delivered to schools across the county

Priority 3

Support families to be self-sufficient and resilient

Joined up information and guidance

The Leicestershire Information and Support Directory (LISD) has been launched and includes a number of new features to enable children, young people and families to be more self-sufficient and navigate services

Progress towards work

Enterprise advisers are now working with every secondary school to link them to employers, help them to deliver careers support and offer employment advice to young people

Early Help

The areas for action under this priority were reviewed during 2019 and in 2020 the focus was shifted to the effective partnership delivery of early help services. Leicestershire's Early Help Partnership have refreshed their terms of reference to include oversight of the delivery of this priority. Shared areas for action and named leads have been identified and work has been undertaken to develop action plans for each workstream.

Priority 4

Ensure vulnerable families receive personalised, integrated care and support

Integrated provision

Work has been undertaken to review partnership processes to ensure they are integrated, outcome-based and meet the needs of children and families

- The Complex Care Panel pathway/ protocol has been reviewed to develop an approach that effectively considers complex needs and solution focused responses. A Joint Solutions Panel has been established to review joint funding arrangements.
- A new LLR SEND Joint Commissioning Strategy has been launched
- Work has been undertaken in relation to the Risk of Admission Register (ROAR) and Care, Education and Treatment Review (CETR) processes to ensure children at risk are identified and more robust processes are in place for the provision of co-ordinated, multi-agency support
- An Inclusions Pathway has been developed and a webpage for the LCC Inclusion Service has been launched

Post 16 multi-agency delivery model

- A 'Promise' to children in care and care leavers has been launched and includes a series of measures to support young people in, or who have left care. The Promise has been agreed by partners including the County Council, all seven district and borough councils, the Office of the Police and Crime Commissioner and the Combined Fire Authority
- A wraparound therapeutic services model has been developed to support step-downs from residential care
- A multi-agency Housing Protocol for 16 and 17 year olds at risk of homelessness is now in place
- Work has been undertaken to review the Pathway to Adulthood for children with SEN and disabilities

Priority 5

Enable children to have good physical and mental health

Maternal and Child Obesity

Work has been undertaken to develop a partnership approach to Maternal and Child Obesity.

- Face to face & online Make Every Contact Count PLUS training modules on maternal obesity have been developed and launched
- Resources for practitioners to use with service users to discuss healthy weight before/ during & post pregnancy have been developed
- Make Your Move for a Healthy Pregnancy leaflet has been launched
- The Active Travel to and from school 'Choose How You Move' programme has been successfully delivered in schools across the county
- Sport England funded "Active Families" project has been delivered to all 7 districts and boroughs

Emotional and mental wellbeing

Work has been undertaken to develop a partnership approach to Adverse Childhood Experiences (ACEs) and Trauma-Informed Practice.

- Multi-agency workshops to raise awareness of ACEs and identify implications for local policy and practice have been delivered, including virtual workshops on 'An Introduction to ACEs and Trauma-Informed Practice' commissioned by the Violence Reduction Network
- The Safeguarding Children Partnership have designed a half-day training session, with 12 local colleagues now trained to deliver this on an on-going basis
- Screenings of the "Resilience" film have been delivered to professionals across the Partnership
- A virtual learning event was organised and delivered by the new Trauma-Informed Schools network
- Consultancy and workforce development support has been delivered to Youth Justice teams by Leicestershire Partnership Trust's ACEs Project
- An e-learning package on trauma-informed practice has been developed by the Violence Reduction Network
- Eight practitioners have been appointed to provide mental health support in schools.

Youth Campaign Group

A Youth Campaign Group (YGC) was developed in November 2018 to involve young people from the County Youth Council and Members of Youth Parliament for Leicestershire in developing and delivering the Leicestershire Children and Families Partnership Plan. The focus of the YCG is on undertaking campaign activity aligned to key issues identified by county young people through the national, annual "Make Your Mark" youth ballot.

Knife crime was identified as the number one issue for 2018/19 and the YCG has been working with partners including the Lord Lieutenant of Leicestershire, the Office of the Police and Crime Commissioner, Leicester City Football Club's Community charity, Public Health and the Home Office-funded Words Over Weapons project on knife crime and awareness raising activity.

YGC and Youth Council members have also engaged in:

- Consultation on the County Council's Environment Strategy
- Q&A sessions with the Violence Reduction Network and the Police and Crime Commissioner
- LLR Self-harm Pathway young people's feedback
- British Youth Council meetings with the Government Office around their messages to young people on Covid-19
- LLR SEND Joint Commissioning Strategy consultation

Children and Families Partnership Plan Refresh 2021-23

In September 2020 the Children and Families Partnership undertook a review of their terms of reference and Partnership Plan for 2018-21. Based on an understanding of the data and the needs of Leicestershire's children and families, the Partnership agreed that the existing five priorities and key areas for actions remained relevant, and the focus of the refreshed Partnership Plan should remain on identifying where improved partnership working would add value.

The Partnership's vision for children and young people has not changed, however we continue to have fewer resources with which to achieve this vision which presents challenges, but also opportunities to do things differently and to be creative in how the resources are harnessed across the Partnership.

In November 2020 the Health and Wellbeing Board approved the refreshed Partnership Plan for 2021-23 and the strategic alignment of the Leicestershire Education Excellence Partnership, SEND and Inclusion Board, Youth and Justice Partnership Board and the Early Help Partnership to the Children and Families Partnership.

An overview of the refreshed Partnership Plan for 2021 - 23 and the updated Children and Families Partnership governance structure is provided in the appendices to this document.

How will we deliver the priorities?

Named leads for each priority continue to work with partners and other key stakeholders to develop and deliver their priority action plans and to provide regular progress reports to the Children and Families Partnership.

How will we know we are making a difference?

The Partnership Plan is a long-term ambition and the identified priorities will require a medium to long term strategic approach and system change to achieve.

The Partnership will identify key performance/success indicators and monitor them over time to help understand how the priority action plans are contributing to delivering change and improving outcomes for children and young people.

Appendix 1:

Children and Families Partnership Plan 2021-23 Priority Actions

Priority 1
Ensure the best start for life

What we want to achieve

- To improve early identification of children's needs
- To promote a shared understanding of "1001 Critical Days"
- To embed a partnership approach to "school readiness"

What we will do

- Develop an integrated Early Years pathway that ensures needs are assessed and appropriate, proportionate interventions are offered
- Deliver and embed support for parents and caregivers throughout the 1001 days to support children to be physically healthy, emotionally capable and resilient
- Deliver a communications campaign to share key messages around school readiness and the support and resources available for children and families to help them to be "school ready"

Indicators of success

To understand the impact of the work undertaken against this priority we will focus on tracking data on narrowing the attainment the gap for vulnerable groups and increasing the proportion of reception children reaching a "good level of development".

Performance/success indicator
% of children reaching expected milestones in all 5 domains of the two year health review
% of children working at expected levels at the end of the foundation stage

Priority 2
Safe and free from harm

What we want to achieve

- To embed an integrated approach to risk of harm and Child Criminal Exploitation (CCE)
- To establish an integrated approach to the promotion of universal safety messages

What we will do

- Identify, implement and align operational responses to Child Criminal Exploitation across Leicester, Leicestershire and Rutland, including the analysis, collection and sharing of intelligence
- Develop a communications strategy that supports partners to deliver universal safety messages (real and virtual world) to children and young people

Indicators of success

To understand the impact of the work undertaken against this priority we will focus on the successful completion of a DfE funded project, being led on by Leicestershire on behalf of the region, to develop an assessment framework for safeguarding adolescents from harm outside the home

Performance/success indicator
Development of a regional assessment framework for safeguarding adolescents from harm outside the home Timeframe by March 2022
Training on agreed model disseminated across partnership, including delivery of regional seminar Timeframe by March 2022

Priority 3

Support families to be self-sufficient and resilient

What we want to achieve

- To develop a partnership approach to Early Help
- To develop Early Help data sets
- To develop shared systems and processes for Early Help
- To develop the Early Help workforce
- To engage communities in Early Help

What we will do

- Develop and implement a shared Early Help Partnership action plan
- Identify relevant data sets from across the partnership to develop an Early Help Partnership dashboard
- Identify principles and protocols for joint agency working and develop a shared system to record and share any Early Help Support
- Develop a training programme across the partnership for the early help workforce around Trauma Informed Practice
- Identify effective means of engaging the voluntary and community sector in Early Help

Indicators of success

To understand the impact of the work undertaken against this priority we will focus on progress made across the Early Help Partnership to improve data sharing and shared systems and processes, as part of the overall Family Hubs approach.

Performance/success indicator
Development of an Early Help Assessment used by schools and other agencies Pilot with a small number of schools from January 2022 10 schools take on the news approach by July 2022
Development of an Early Help Strategy and Charter for Family Hubs. In place by June 2022 Strategy in place and 75% partners signed up to the charter by Oct 2022
Data sharing between LCC, VRN and Police agreed and in operation by August 2022 Vulnerability data set agreed by the LLR Early Help Data Sharing group and dashboard produced - Timeframe by March 2023

Priority 4
Ensure vulnerable families receive personalised, integrated care and support

What we want to achieve

- To provide integrated, outcome-based, high quality, cost-effective provision
- To develop a multi-agency post 16 delivery model

What we will do

- Review the current Complex Care Panel pathway/ protocol and develop an approach that considers complex needs and solution focused responses
- Develop a wraparound therapeutic services model to support step-downs from residential care
- Develop a multi-agency protocol for 16 and 17 year olds at risk of homelessness
- Develop the Care Leaver offer across the partnership
- Review integrated Pathways to Adulthood for children with SEN and disabilities

Indicators of Success

To understand the impact of the work undertaken against this priority we will focus on key partnership work and how , by working across services, we can improve the take up of health assessments for Children in Care and access to appropriate (housing) support for homeless 16/17 year olds

Performance/success indicator
Improvement in the take up of health assessments for Children in Care
Protocol between district housing and Children's Social Care is reviewed and tracking is undertaken to confirm that young people who present as homeless receive appropriate services.

Priority 5

Enable children to have good physical and mental health

What we want to achieve

- To implement Trauma Informed Practice aligning to the Leicester, Leicestershire and Rutland (LLR) Trauma Aware workstream
- To reduce Accident and Emergency (A & E) attendances for 0 -18s across the County
- To reduce food poverty (including holiday hunger) through further development of the Leicestershire Food Plan
- To reduce maternal and child obesity
- To improve perinatal mental health
- To reduce/stop smoking in early pregnancy

What we will do

- Work with the LLR Leadership Group to develop a programme of work and embed a shared vision for Trauma Informed Practice
- Analyse A & E attendance data to understand and address any trends and develop prevention pathways
- Develop and implement a programme of work to address food poverty
- Develop and implement a programme of work to improve maternal health with a focus maternal physical activity and mental health
- Improve access to evidence-based interventions/psychological therapies for women and their partners at an earlier stage
- Deliver training to all midwifery staff and QuitReady intervention programme to identified pregnant smokers

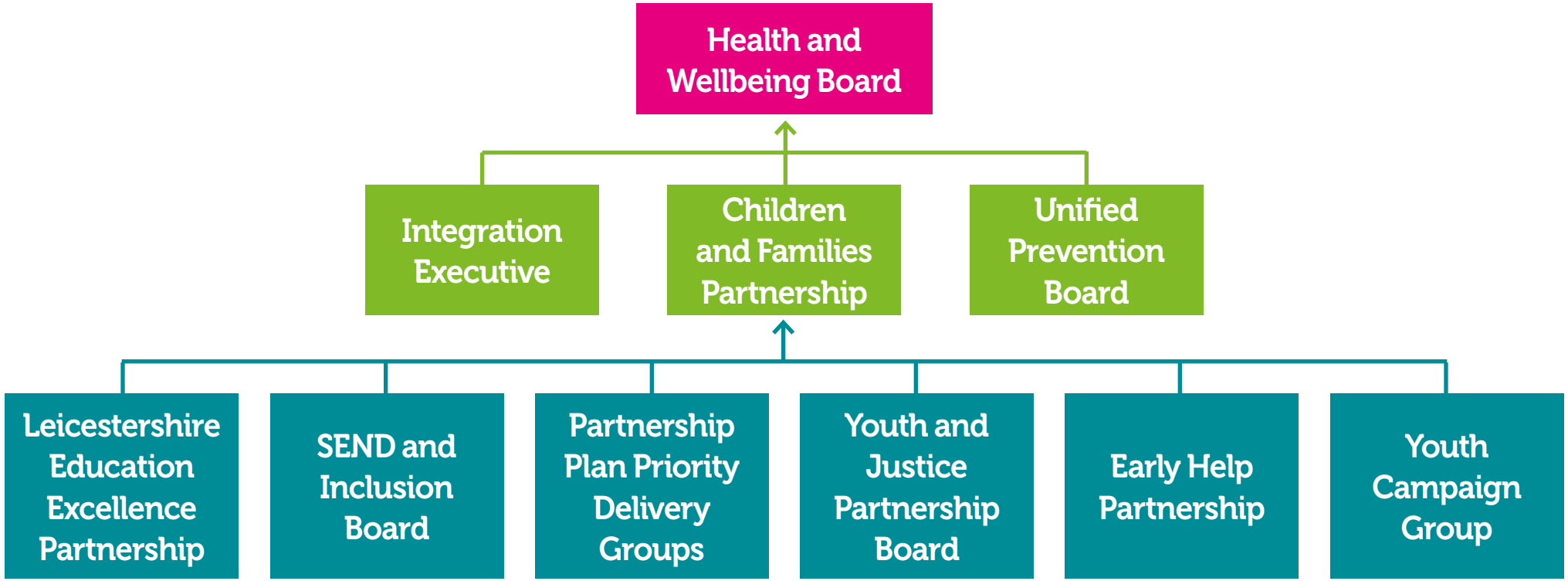
Indicators of success

To understand the impact of the work undertaken against this priority we will focus on gathering baseline data on maternal weight and improving smoking in pregnancy rates.

Performance/success indicator
Reduction in the proportion of children 0-18 attending at emergency departments
Development of county-wide baseline to understand those affected by food poverty
Development of baseline data for women needing support to improve their weight and mental health
Improvement in the % of women who stop smoking at time of delivery
An evidence based programme of work in place to prevent trauma that is aligned to the LLR Trauma Informed Practice strategy

Appendix 2: Governance

Children and Families Partnership Board Governance



Our Children Our Future

Leicestershire
Children and Families
Partnership

Blaby District Council
the heart of Leicestershire

Charnwood

District of Harborough

Hinckley & Bosworth Borough Council
A Borough to be proud of

Melton Borough Council
Helping people. Shaping places

North West Leicestershire District Council

Oadby & Wigston Borough Council

Police & Crime Commissioner for Leicestershire

Voluntary Action LeicesterShire
Helping people change their lives for the better

Leicestershire Police
Protecting our communities

NHS

Leicestershire County Council

Department for Work & Pensions

YOUNG LEICESTERSHIRE
Putting Young People First