Leicestershire County Council

Meeting: **Health and Wellbeing Board**

Date/Time: **Thursday, 26 May 2022 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

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

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

Membership

Mrs H. L. Richardson CC (Chairman)

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

AGENDA

Item		Report by
1.	Appointment of Chairman. *To note that the County Council's Lead Member for Health, Mrs. L. Richardson CC, has been appointed Chairman.*	
2.	Minutes of the meeting held on 24 February 2022.	(Pages 3 - 10)
3.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	

4.	Declarations of interest in respect of items on the agenda.		
5.	Position Statement by the Chairman.		
6.	Leicestershire Joint Health and Wellbeing Strategy 2022 - 2032 Progress Update.	Director of Public Health	(Pages 11 - 72)
7.	Better Care Fund 2021/22 Quarter 4 Performance.	Director of Adults and Communities	(Pages 73 - 94)
8.	Pharmaceutical Needs Assessment 2022 - Progress Update and Pre-Consultation Draft.	Director of Public Health	(Pages 95 - 184)
9.	Reducing Health Inequalities - Core20Plus5	Executive Director for Strategy and Planning, LLR CCGS	(Pages 185 - 212)
10.	Proposals for the Role and Format of the Leicester, Leicestershire and Rutland Integrated Care Partnership.	Directors of Public Health for Leicestershire and Leicester City	(Pages 213 - 224)
11.	Community Health and Wellbeing Plans.	Executive Director for Strategy and Planning, LLR CCGS	(Pages 225 - 232)
12.	Date of next meeting. *The next meeting of the Health and Wellbeing Board will be held on Thursday 22 September 2022 at 2.00pm.*		
13.	Any other items which the Chairman has decided to take as urgent.		

Agenda Item 2

Minutes of a meeting of the Health and Wellbeing Board held at County Hall, Glenfield on Thursday, 24 February 2022.

PRESENT

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

Gemma Barrow	Mike Sandys
Sarah Prema	Dr Mayur Lakhani
Cllr Cheryl Cashmore	Jon Wilson
Harsha Kotecha	Mrs. C. M. Radford CC
Jane Moore	Andy Williams
Dr. Vivek Varakantam	Mrs D. Taylor CC
Supt Jonny Starbuck	Julia Smith
Samantha Leak	Ellen Osborne

Apologies

Mark Powell, Hayley Jackson, Ch. Supt Adam Streets, John Sinnott, Cllr. J. Kaufman, Edd de Coverly and Mike Wightman

33. Minutes of the previous meeting.

The minutes of the meeting held on 25 November 2021 were taken as read, confirmed and signed.

34. Urgent items.

There were no urgent items for consideration.

35. Declarations of interest in respect of items on the agenda.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting. No declarations were made.

36. 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 Joint Strategic Needs Assessments Cycle
- Healthwatch's Stakeholder Survey
- The various health related media campaigns being undertaken by the County Council and partners.

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

It was noted that, Jo Hewitt, Health and Wellbeing Board Manager, would be leaving her role in early May. On behalf of the Board, the Chairman thanked Jo for the support she had provided to the Board, specifically in the development of the revised Joint Health and Wellbeing Board Strategy.

RESOLVED:

That the position statement be noted.

37. Change to the Order of Business.

The Chairman, with the consent of the Board, confirmed a change to the order of business to that set out on the agenda.

38. Family Hubs Model Implementation and Bid.

The Board considered a report of the Director of Children and Family Services concerning the County Council's intention to develop a Family Hubs Model of service delivery in Leicestershire and the urgent action taken by the Chief Executive to approve a bid to be submitted to the Department for Education (DfE) for funding to develop the model. A copy of the report marked 'Agenda Item 11' is filed with these minutes.

The Director said that if successful, the funding secured from the bid would be used to project manage the implementation of the new Model, however it was the intention that the Model would be introduced regardless of whether the bid was successful.

In response to a question concerning implementation timescales, the Director said that the DfE had not set any specific deadlines for authorities to introduce the Model. The County Council would complete an options appraisal first to inform how the Model rollout would be undertaken. The Council had also been involved in regional work which had enabled it to explore how delivery of the Model would utilise partnership working.

Mrs Taylor CC urged partners to work with the Council to help develop and rollout the Model in order to create a community wide service to support families.

RESOLVED:

a) That the County Council's intention to develop a Family Hubs Model of Service Delivery in Leicestershire be supported;

b) That 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.

39. Leicestershire Children and Families Partnership Plan: Progress Update.

The Board considered a report of the Director of Children and Family Services which provided a progress update on the Children and Families Partnership Plan 2021-23. A copy of the report, marked 'Agenda Item 13', is filed with these minutes.

It was noted that performance indicators had been added to the Plan to help measure and quantify the impact of the work being undertaken by the Partnership.

RESOLVED:

That progress in the delivery of the Children and Families Partnership Plan be noted.

40. 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, Leicestershire and Rutland CCGs to advise on the outcome of the consultation on the Leicestershire Joint Health and Wellbeing Strategy (JHWS) 2022 – 2032 and to seek approval for the final Strategy. A copy of the report marked 'Agenda Item 5' is filed with these minutes.

Arising from discussion the following points were noted;

- The Strategy, which set out the overall vision of Giving everyone in Leicestershire the opportunity to thrive and live happy healthy lives, also aligned to the life course Integrated Care System (ICS) transformational priorities and therefore acted as the local place led Plan.

- In response to the consultation feedback, changes had been made to the draft Strategy, including strengthening many of the life course sections, formalising the links between the Carers Board and the Health and Wellbeing Board governance structure, the inclusion of a statement to reflect the need to understand where health inequalities were occurring across Leicestershire and strengthening the focus on integration.

- An 'easy read' version of the Strategy would be produced, along with a Communication and Engagement Strategy to help partners to share the Strategy and actively engage with communities, including those groups it had struggled to do so with in the past.

- A draft Delivery Plan had been produced which would evolve as partners worked through the specific actions set out in the Strategy.

- The Health and Wellbeing Board would receive quarterly progress updates on the implementation of the Strategy. Delivery would be measured using an indicator set which would be overseen by the County Council's Public Health Business Intelligence Partner.

- In reference to the do, sponsor, watch approach, a significant proportion of the detail in the Strategy would be addressed and delivered upon via the subgroups of the Board and the Delivery Plan would be used to identify what the 'do' priorities for each of the subgroups were. It was noted that there would also be areas which the Board would have oversight on but would be managed by partners elsewhere in the system.

- The embedding of a trauma informed approach in the Strategy's priorities and actions was particularly welcomed. Evidence suggested that trauma was felt throughout lives, especially in the early years, and could have long term impact on health and wellbeing.

The Chairman thanked partners for their ongoing support and encouraged continued joint working which was critical for the successful delivery of the Strategy.

RESOLVED:

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

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

c) That the Joint Health and Wellbeing Strategy Delivery Plan be noted;

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

41. Health and Wellbeing Board Governance.

The Board considered a report of the Director of Public Health which sought approval for revised Terms of Reference (ToR) for the Health and Wellbeing Board and to redefine one of the Board's sub-groups, the Unified Prevention Board, into the Staying Healthy Partnership Board. The report also detailed 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. A copy of the report marked 'Agenda Item 6' is filed with these minutes.

In reference to the formation of the Staying Healthy Partnership, it was noted that its work, and delivery of the Joint Health and Wellbeing Strategy, would be closely aligned with the Community Health and Wellbeing Plans which were being developed at neighbourhood level.

It was noted that a working group had been formed to oversee the development of the revised ToR for the Board and CCG partners had considered the document ahead of its consideration by the Board. It was acknowledged that there was the potential for changes to the Board's membership following the introduction of the Integrated Care System and further changes could be made to the ToR later in the year if necessary.

It was noted that the Staying Healthy Partnership would have a different role to that of the LLR wide Prevention and Health Inequalities Board, with a focus on work at place level , particularly concerning wider determinants of health. There would however need to be strong links between the two boards to ensure work was not duplicated. The Staying Healthy Partnership would have a key role in delivering elements of the Joint Health and Wellbeing Strategy.

In response to questions from members, it was noted that as part of the development of the Joint Health and Wellbeing Strategy, an Equalities and Human Rights Impact Assessment had been undertaken and the Board's work would continue to reflect the diverse nature of the local population.

RESOLVED:

a) That the revised Terms of Reference for the Health and Wellbeing Board be approved noting that a review of the Board's membership may be required later in 2022 following the establishment of the Integrated Care System;

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

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

d) That the Health and Wellbeing Board governance structure be noted;

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

42. Better Care Fund Plan Update.

The Board considered a report of the Director of Adults and Communities which provided an overview of the progress against delivery of the 2021/22 Better Care Fund (BCF) Plan. A copy of the report marked 'Agenda Item 7' is filed with these minutes.

The Director said that a national review was being undertaken with regard to the long term future of the Better Care Fund, specifically in light of the coronavirus pandemic, and the County Council was expecting further guidance in terms of a future policy framework in the coming months.

Locally work was being undertaken to refresh the BCF and expenditure plan ahead of the finalisation of the 2022/23 Plan.

RESOLVED:

That the progress against the delivery of the 2021/22 Better Care Fund Plan be noted.

43. Better Care Fund Section 75 Agreement - Approval and Assurance

The Board considered a report of the Director of Adults and Communities which sought approval for a revised Leicestershire Better Care Fund (BCF) section 75 (s75) agreement for 2021/22. A copy of the report marked 'Agenda Item 8' is filed with these minutes.

RESOLVED:

a) That 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.

44. Pharmaceutical Needs Assessment 2022.

The Board considered a report of the Director of Public Health concerning the development and publication of the Leicestershire Pharmaceutical Needs Assessment (PNA) and sought approval of the proposed governance arrangements to enable its production. A copy of the report marked 'Agenda Item 9' is filed with these notes.

Arising from discussion the following points were noted;

- The PNA would be developed in line with the projections of housing growth in the County over the next 20 years and there would be a specific chapter dedicated to its expected impact on pharmacy provision.

- Pharmacy services continued to be under strain, a situation which had been exacerbated as a result of the pandemic during which they provided vital support and in some instances were expected to take on additional responsibilities such as undertaking medication reviews and administering vaccines. As a result, sustainability of provision, quality of services and the additional support required would be a key factor to consider as part of the PNA's development.

- The surveys which would be produced to help shape the PNA would be aimed at service users and those who managed pharmacies. It was therefore hoped any concerns relating to the quality of provision and the areas where further support was required would be highlighted as part of the feedback.

- In light of the discussion, the patient questionnaire would be reviewed to ensure it would ascertain responses concerning the satisfaction of the advice received and whether the quality of pharmacy provision was consistent across the County.

RESOLVED:

a) That the associated timescales for the development and publication of the Leicestershire Pharmaceutical Needs Assessment (PNA), be noted;

b) That the proposal to form an interagency LLR wide reference group to develop the PNA, be approved;

c) That 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.

45. Joint Strategic Needs Assessment - Dementia.

The Board considered a report of the Director of Public Health which provided a summary of the recommendations arising from the Joint Strategic Needs Assessment (JSNA) Dementia chapter. A copy of the report marked 'Agenda Item 10' is filed with these minutes.

The Director said that as a result of the JSNA and the resulting recommendations, the LLR Dementia Board and key stakeholders would be reviewing and updating the Dementia Strategy.

It was proposed that a Health and Wellbeing Board development session be held to further consider the matter.

RESOLVED:

That the recommendations of the Joint Strategic Needs Assessment concerning Dementia be supported.

46. Technology Enabled Care.

The Board considered a report of the Director of Adults and Communities concerning progress made with the introduction of a Care Technology (CT) service across Leicestershire's Adult Social Care services. Representatives from the County Council's strategic partner, Hampshire County Council and their commercial partner PA Consulting, joined the Director to present the report. A copy of the report marked 'Agenda Item 12' is filed with these minutes.

Arising from discussion the following points were noted;

- The establishment of the CT Service as a core part of Council's social care offering would enable a wider range of people across the County to access CT and live more independently. As a result, the Authority would be able to make a significant saving by reducing the use of more costly forms of care.

- As the Service developed it would become an area of collaboration between system partners. Work would continue in order to ensure the Service linked with the digital offers already being provided by partners.

- In order to continually develop the Service, the feedback of service users and their careers would be regularly sought and if necessary changes would be made to meet individual needs as part of a personalised approach.

- The pandemic had led to many people embrace technology for the first time. This meant that more individuals receiving adult social care would now be willing to use technological solutions and it was therefore a good time to introduce the Service.

- The ability to save time for practitioners was an important feature of the Service which would enable care workers to spend additional time delivering face to face care where it was most required.

RESOLVED:

That 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 be noted.

48. Date of next meeting

It was noted that the next meeting of the Board would take place on 26 May 2022 at 2.00pm.

2.00 - 3.50 pm CHAIRMAN
24 February 2022

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Agenda Item 6

HEALTH AND WELLBEING BOARD 26th MAY 2022

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

LEICESTERSHIRE JOINT HEALTH AND WELLBEING STRATEGY 2022 – 2032 PROGRESS UPDATE

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board (HWB) with an update on the progress made in the initial stages of delivery of the Leicestershire Joint Health and Wellbeing Strategy (JHWS) 2022-2032, including the establishment of new Governance arrangements, previously approved by the Board, to support its delivery.

2. The JHWS is a 'Do' area of work, identified as a key priority across the Health and Wellbeing Board, partners and sub-groups.

Recommendation

3. It is recommended that the progress made in delivering on the JHWS be noted.

Policy Framework and Previous Decision

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 to the Board at the 24 November 2021 for consultation and the final JHWS was approved by the Board on the 24 February 2022.

5. A revised governance structure which included changes to the Board's sub groups and its Communication and Engagement approach, was also approved by the Board in February 2022.

Governance

6. The Joint Health and Wellbeing Strategy is based on a life course approach, framed using the LLR ICS life course transformational priorities.

7. 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 required a link into the Board's governance structure that was broader than the previous Unified Prevention Board sub-group, to be able to offer a strategic approach to prevention and to increase the scope to cover areas such as wider determinants of health. The Staying Healthy Partnership Board was therefore established. The governance structure is detailed at Appendix A.

JHWS Delivery

8. The JHWS contains a set of priorities and commitments under each life stage. A high-level Action plan was also shared with the HWB at the same time as the Strategy was approved, which provides an outline of some of the actions required but is not exhaustive and will need to evolve as the Strategy develops.

9. The life stages and priorities set out in the JHWS are as follows:

Best start for life

- First 1001 Critical Days
- School Readiness
- Preparing for Life

Staying healthy, safe and well

- Building Strong Foundations
- Enabling healthy choices and environments

Living and supported well

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

Dying well

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

Cross cutting themes

- Improved mental health
- Reducing health inequalities
- Covid -19 recovery

Best Start for Life - Children and Families Partnership Board (C&FP)

10. The C&FP is an established Sub-Group of the HWB, with senior leaders from key agencies across Leicestershire championing effective partnership working

to deliver outcomes that make a real difference to children, young people and their families.

11. The C&FP oversees a Partnership Plan addressing the priorities relating to children and young people from the JHWS. The current plan 2021 - 2023 was recently refreshed prior to the JHWS being approved, and work is now underway to align the current Delivery Plan with the JHWS Best Start for Life Delivery Plan. The intention is that this will be further discussed at a development session for C&FP members to ensure all agencies current actions are captured in the Delivery Plan, that actions adequately address the 'measures of success' set out in the strategy and that gaps are identified (with plans to address).

Staying Healthy, Safe and Well - Staying Healthy Partnership Board

12. The Staying Healthy Partnership Board (SHP) was established in February 2022 as a Sub-Group of the HWB and is responsible for the Staying Healthy, Safe and Well elements of the JHWS, offering a strategic approach to the primary prevention agenda. Although this will be a formal Sub-Group at Place, there will be links with the Community Health and Wellbeing Plans at a neighbourhood level that are a requirement of the Integrated Care System. Whilst these plans will be owned by local neighbourhood level partnerships, overall place themes will feed into the Staying Healthy Partnership Board and then into the HWB as required.

13. The SHP meets on a quarterly basis with a number of thematic groups feeding into it including: Chief Housing Officers Group, Communities Group, Strategic Planning Group, District Health Leads and the Leicestershire Mental Health Group. Discussions have started with the thematic group Chairs on the detail of the Delivery Plan, to ensure the objectives set are clear and any gaps highlighted in preparation for a development session in June to focus on priority setting for 2022 into 2023.

Living well and Dying Well - Integration Executive

14. The Integration Executive (IE) provides leadership, direction and assurance, on behalf of the HWB so that the vision for integrated health and care is delivered and has ownership of the Living and Dying Well stages of the JHWS.

15. The work of the IE includes oversight and delivery of the Better Care Fund (BCF) to ensure delivery and outcomes are achieved. Whilst the BCF activity aligns well with Living and Dying Well, a development session is being held in June to ensure Delivery Plans are robust and capture both the BCF and wider JHWS requirements. This will include identifying whether actions fall under the 'Do' 'Sponsor' or 'Watch' approach.

Cross Cutting Themes

16. All Sub-Groups will have a responsibility for reporting on the cross-cutting themes (improved mental health, reducing health inequalities and Covid -19 recovery.) Further work will be completed as part of the subgroup development sessions to consider how specific elements of the cross cutting themes will be represented and delivered through the subgroups.

Performance Reporting

17. To enable the Board to monitor progress against the outcomes, approval was given by the HWB for the development of a Delivery Plan with quarterly progress reports framed by the agreed indicators. The first of these outcome summary reports is attached at Appendix B.

18. The performance summary presents indicators across each life course stage, allowing Board members to gauge development during these initial stages of the JHWS implementation.

19. Revisions will be made in the dashboard to reflect progress against the priorities and evolution of the Strategy over the 10 year period.

20. 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 defining objectives.

21. 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.

Communication and Engagement

22. At its meeting on the 24 February 2022, the Board approved 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.

23. 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.

24. The County Council's Communication Department is working with Communication leads from across the partnership including the developing ICS Communications and Engagement Strategy to agree a template to report on quarterly and an interim report is attached at Appendix C, to highlight the broad scope of engagement activity across the partnership. The email address HWB@leics.gov.uk has been created to begin communicating with residents, communities and partners and a new look website is also being progressed, with a professionals area and survey section.

25. A new visual identity for the HWB which will be rolled out across documentation and social media and the chosen design (following feedback from members of the Board) will also be incorporated into the Strategy which will be showcased at a future Board meeting. An Easy Read version of the Strategy is attached at Appendix D.

Resource Implications

26. Delivery of the JHWS and the establishment of the Staying Healthy Partnership is being 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 is being recruited within the Public Health Department to work with partners across Leicestershire.

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 – 25 November 2021: Draft Leicestershire Joint Health and Wellbeing Strategy 2022 - 2032
https://politics.leics.gov.uk/documents/s165094/HWB%20Draft%20JHWS%20Report.pdf

Report to the Health and Wellbeing Board – 24 February 2022: Leicestershire Joint Health and Wellbeing Strategy 2022 - 2032
https://politics.leics.gov.uk/documents/s166706/HWB%2024th%20February%20JHWS.pdf

Appendices

Appendix A – HWB Governance Structure

Appendix B – JHWS Outcomes Summary Report

Appendix C – HWB Communication and Engagement Report

Appendix D – JHWS Easy Read version

Relevant Impact Assessments

Equality and Human Rights Implications

27. The JHWS 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 (EHRIA) has been undertaken and the results from this impact assessment have been incorporated into the final version of the Strategy. A review of the EHRIA will be completed on an annual basis to align with the annual review of the Delivery Plan.

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 attendance at the JHWS Project Board and working groups established to progress the JHWS. The Staying Healthy, Safe and Well priority will ensure the health considerations of the Communities Safety Strategy Board are linked into the HWB and colleagues are also represented at the Children and Families Partnership Board.

Environmental Implications

29. The JHWS 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. There will also be Environment and Transport attendance at future Staying Healthy Partnership sub-group. 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 delivery of strategy commitments, is dependent on high quality, trusted partnership working and ownership. Through developing an alliance approach, it is hoped that further progress can be made across multiagency boundaries to improve the health and wellbeing of the Leicestershire population. The aim is for a JHWS that is developed and owned across the partnership.

Officer to contact

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Appendix A

System

ICB

ICP

LLR Systems Executive

Design Groups & LLR Prevention and HI Board

Thematic Co-ordination and Delivery Groups

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

- Leicestershire Education Excellence Partnership
- SEND and Inclusion Board
- Partnership Plan Priority Groups
- Youth and Justice Partnership Board
- Early Help Partnership
- Youth Campaign Group

Staying Healthy Partnership Board

- Chief Housing Officers Group
- Communities
- SPG
- District Health Leads
- Leicestershire Mental Health Group

Cultural Services Chief Officers Partnership

Integration Executive

- Integration Delivery Group
- Leicestershire Joint Commissioning Group
- Integrated Finance and Reporting Group
- Lightbulb

Neighbourhood

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 B

Joint Health and Wellbeing Strategy: Outcomes Summary Report

Leicestershire

May 2022

Business Intelligence Service
Leicestershire County Council

Victoria Rice
Research & Insight Manager-Public Health

Brydon Hurst
Research & Insight Officer

Business Intelligence Service
Chief Executive's Department
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Produced by the Business Intelligence Service at Leicestershire County Council.

Best Start for Life

Performance Summary

- Out of all the comparable indicators presented for best start in life, 11 are red, eight are amber and 24 are green.

- Looking at trend over the last five time periods where presented, two indicators are decreasing and getting worse, six indicators are increasing and getting worse, 14 indicators have no significant change, three indicators are decreasing and getting better, and four indicators are increasing and getting better.

- Of the 24 green indicators, Leicestershire ranks 1st (best performing) when compared to its similar neighbours for the following indicators:

    - Hospital admissions as a result of self-harm (10-24 years) - Persons
    - Hospital admissions as a result of self-harm (10-24 years) - Females
    - Hospital admissions as a result of self-harm (10-24 years) - Males

- There are currently eight indicators where, when compared to similar areas, Leicestershire performs in the bottom three (worse performing):

    - Caesarean section %
    - A&E attendances (Under 1 year) - Persons
    - A&E attendances (Under 1 year) - Males
    - School readiness: Percentage of children with free school meal status achieving a good level of development at the end of reception - Persons
    - School readiness: Percentage of children with free school meal status achieving a good level of development at the end of reception - Males
    - Child development - percentage of children achieving a good level of development at 2-2 ½ years
    - Child development - percentage of children achieving the expected level in communication skills at 2-2 ½ years
    - Child development - percentage of children achieving the expected level in personal-social skills at 2-2 ½ years

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
	Caesarean section %	F	All ages	2020/21	34.3	14/16	27.2	37.4	32.5	▬	🔴
	E01 - Infant mortality rate	P	<1 yr	2018 - 20	3.3	6/15	1.9	5.1	3.9	▬	🟡
	Neonatal mortality and stillbirth rate	P	<28 days	2019	5.8	12/16	3.9	9.9	6.6	▶	🟡
1001 Critical Days	A&E attendances (under 1 year)	P	<1 yr	2019/20	991.0	14/15	547.8	1,020.6	1,000.1	▲	🟡
		F	<1 yr	2019/20	870.0	12/15	490.7	940.7	908.3	▬	🟢
		M	<1 yr	2019/20	1,104.0	15/15	600.7	1,104.0	1,075.0	▬	🟡
	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	▬	🔴
	D03c - Population vaccination coverage - Dtap / IPV / Hib (1 ye..	P	1 yr	2020/21	96.3	2/16	96.3	93.8	92.0	▼	🟢
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/

Produced by Business Intelligence Service
Updated May 2022

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	2020/21	50.9	9/16	53.7	49.0	50.9	▬	●
	A&E attendances (0-4 years)	P	0-4 yrs	2019/20	571.9	9/16	412.3	701.9	659.8	▶	●
		F	0-4 yrs	2019/20	507.4	9/16	367.1	647.0	594.3	▶	●
		M	0-4 yrs	2019/20	631.4	9/16	455.2	754.0	714.3	▲	●
	A&E attendances (<18)	P	<18 yrs	2019/20	323.1	5/15	271.2	457.2	415.6	▶	●
		F	<18 yrs	2019/20	301.8	5/15	254.4	439.1	389.7	▬	●
		M	<18 yrs	2019/20	343.0	4/15	287.1	474.4	435.1	▬	●
	C02a - Under 18s conception rate / 1,000	F	<18 yrs	2020	10.8	5/15	6.5	13.2	13.0	▶	●
	Hospital admissions as a result of self-harm (10-24 years)	P	10-24 yrs	2020/21	245.9	1/16	245.9	783.0	421.9	▼	●
		F	10-24 yrs	2020/21	403.5	1/16	403.5	1,293.7	681.7	▼	●
		M	10-24 yrs	2020/21	101.7	1/16	101.7	306.6	175.2	▶	●
Preparing for Life	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	▶	●
	Children in care	P	<18 yrs	2021	49.0	5/16	34.0	73.0	67.0	▲	●
	D04e - Population vaccination coverage - HPV vaccination coverage for one dose (12-13 year old)	F	12-13 yrs	2020/21	79.3	11/16	92.5	41.7	76.7	▼	●
		M	12-13 yrs	2020/21	70.8	13/16	88.3	39.5	71.0	▬	●
	School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs	P	Primary schoo..	2021	2.2	7/16	1.7	3.1	2.4	▲	●
			School age	2021	2.3	3/16	2.0	3.5	2.8	▲	●
			Secondary sch..	2021	2.4	4/16	1.8	4.0	2.9	▲	●
		F	School age	2021	1.4	7/16	1.1	2.0	1.6	▬	●
		M	School age	2021	3.2	3/16	2.9	4.9	3.9	▬	●

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 May 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	Mar-22	High	76.5	Null	%	Higher than national	↓
	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	Apr-22	High	65	53.8	%	Higher than national	●
	Covid vaccination uptake 16-17 year olds - Dose 1	Apr-22	High	76.2	65.7	%	Higher than national	●
	Emergency admissions for children with lower respiratory tract infections (LRTIs)	20/21	Low	43.9	76.3	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	20/21	Low	Null	161.3	rate per 100,000 pop	Lower than national	↓
	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	20/21	Low	124.7	175.4	rate per 100,000 pop	Lower than national	↓

Direction of travel Key:

- ↓ Decrease
- ↑ Increase
- ● N/A

Produced by Business Intelligence Service. Updated May 2022.

Staying Healthy, Safe and Well

Note: The figures for "Child Poverty, Income deprivation affecting children index (IDACI)" are unavailable and therefore this indicator is not presented.

Performance Summary

- Out of all the comparable indicators presented for staying healthy, safe and well, 10 are red, 11 are amber and 12 are green.
- Looking at trend over the last five time periods where presented, two indicators are decreasing and getting worse, one indicator is increasing and getting worse, 10 indicators have no significant change, two indicators are increasing and getting better, and one indicator is increasing.
- Of the 12 green indicators, Leicestershire did not rank 1st (best performing) when compared to its similar neighbours for any indicators.
- There are currently two indicators where, when compared to similar areas, Leicestershire performs in the bottom three (worse performing):
    - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate - Persons
    - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate - Females

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
	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		
		F	18-69 yrs	2020/21	48.0	12/15	83.0	25.0	59.0		
		M	18-69 yrs	2020/21	45.0	12/15	78.0	25.0	56.0		
	B09b - Sickness absence - the percentage of working days lost..	P	16+ yrs	2018 - 20	1.0	9/16	0.6	1.5	1.0		
	Percentage of adults walking for travel at least three days pe..	P	16+ yrs	2019/20	11.7	10/16	15.4	10.4	15.1		
	Air pollution: fine particulate matter (historic indicator)	N/A	Not applicable	2020	6.5	9/16	4.9	7.3	6.9		
	B15a - Homelessness - households owed a duty under the Ho..	N/A	Not applicable	2020/21	6.8	4/15	4.6	13.3	11.3		
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		
		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		
	B08d - Percentage of people in employment	P	16-64 yrs	2020/21	76.9	7/15	79.3	72.6	75.1	▶	
		F	16-64 yrs	2020/21	74.2	7/15	78.5	68.6	71.8	▶	
		M	16-64 yrs	2020/21	79.5	10/15	84.7	75.0	78.5	▶	
	B12b - Violent crime - violence offences per 1,000 population	P	All ages	2020/21	22.3	9/15	18.7	33.6	29.5	▲	
	B17 - Fuel poverty (low income, high cost methodology)	N/A	Not applicable	2018	9.4	6/16	6.8	10.7	10.3	▶	
	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		

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

Note: The figures for "Child Poverty, Income deprivation affecting children index (IDACI)" are unavailable and therefore this indicator is not presented.

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

Produced by Business Intelligence Service
Updated May 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
	C16 - Percentage of adults (aged 18+) classified as overweigh..	P	18+ yrs	2020/21	64.9	10/15	58.1	69.2	63.5	▬	🟡
	C17a - Percentage of physically active adults	P	19+ yrs	2020/21	66.6	12/15	72.5	65.2	65.9	▬	🟡
	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	▬	🟡
	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 May 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	Feb 21 to Mar 22	Low	1606	Null	Count	Null	
Enabling Healthy Choices and Environments	Vaccination coverage - Covid - 12+ Dose 1	May-22	High	87.4	92.5	%	Lower than national	
	Vaccination coverage - Covid - 12+ Dose 2	May-22	High	84	86.5	%	Lower than national	
	Vaccination coverage - Covid - 12+ Booster and Dose 3	May-22	High	69	67.6	%	Higher than national	

Direction of travel Key:

Produced by Business Intelligence Service. Updated May 2022.

Living and supported well

Performance Summary

- Out of all the comparable indicators presented for living and supported well, three are red, three are amber and three are green.

- Looking at trend over the last five time periods where presented, six indicators have no significant trend.

- Of the three green indicators, Leicestershire ranks 1st (best performing) when compared to its similar neighbours for the following indicators:

    - Emergency Hospital admissions due to falls in people aged 65 and over - Persons
    - Emergency Hospital admissions due to falls in people aged 65 and over - Females

- There are currently three indicators where, when compared to similar areas, Leicestershire performs in the bottom three (worse performing):

    - Hip fractures in people aged 65 and over - Persons
    - Hip fractures in people aged 65 and over - Females
    - Hip fractures in people aged 65 and over - Males

Leicestershire Joint Health and Wellbeing Strategy - Living and Supported 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
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 May 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
Industrialising Prevention and Self Care	Emergency admissions for acute conditions that should not require hospital admission	20/21	Low	711.3	849.9	rate per 100,000 pop	Lower than national	↓
	Number of people with 1-4 LTC's registered with a practice situated in the County	Apr-22	N/a	301799	Null	Count	Null	●
	Number of people with 5 or more LTC's registered with a practice situated in the County	Apr-22	Low	70388	Null	Count	Null	●
	Number of people with no LTC's registered with a practice situated in the County	Apr-22	High	317813	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+	2021/22	N/a	576.1	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	Mar-22	High	89.4	85	%	Null	●
	Home First Outcome: 2 hour urgent community response compliance	Y2D Apr-Feb 2021/22	High	69.8	70	%	Value for LLR, not Leicestershire County	↑
	Home First target: 2 day reablement compliance	Y2D Apr-Feb 2021/22	High	85	80	%	Value for LLR, not Leicestershire County	↑

Direction of travel Key:

↓ Decrease

↑ Increase

● N/A

Produced by Business Intelligence Service. Updated May 2022.

Dying Well

Performance Summary

- Out of all the comparable indicators presented for dying well, one indicator is significantly higher, one indicator is similar, and one indicator is significantly lower.
- Looking at trend over the last five time periods where presented, one indicator is significantly increasing, one indicator is significantly decreasing, and one indicator has no significant trend.

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 May 2022

Cross Cutting Themes:

Mental Health

Performance Summary

Note: The figures for "Estimated number of children and young people with mental disorders - aged 5 to 17" are unavailable and therefore this indicator is not presented.

- Out of all the comparable indicators presented for supporting mental health, seven are red, six are amber and 13 are green.
- Looking at trend over the last five time periods where presented, three indicators are increasing and getting worse, six indicators have no significant trend, and two indicators are decreasing and getting better.
- Of the 13 green indicators, Leicestershire ranks 1st (best performing) when compared to its similar neighbours for the following indicators:
    - Suicide rate - Persons
    - Suicide rate - Males
    - Hospital admissions as a result of self-harm (10-24 years) - Persons
    - Hospital admissions as a result of self-harm (10-24 years) - Females
    - Hospital admissions as a result of self-harm (10-24 years) - Males
    - Hospital admissions for mental health conditions - Females
- There are currently two indicators where, when compared to similar areas, Leicestershire performs in the bottom three (worse performing):
    - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate - Persons
    - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate - Females

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
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	▬	●
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 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	▬	●
B06b - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	P	18-69 yrs	2020/21	46.0	13/16	81.0	25.0	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	▬	●
C12 - Percentage of looked after children whose emotional we..	P	5-16 yrs	2020/21	38.1	5/16	28.2	53.7	36.8	▶	●
Hospital admissions as a result of self-harm (10-24 years)	P	10-24 yrs	2020/21	245.9	1/16	245.9	783.0	421.9	▼	●
	F	10-24 yrs	2020/21	403.5	1/16	403.5	1,293.7	681.7	▼	●
	M	10-24 yrs	2020/21	101.7	1/16	101.7	306.6	175.2	▶	●
Hospital admissions for mental health conditions	P	<18 yrs	2020/21	66.3	3/16	54.5	139.3	87.5	▶	●
	F	<18 yrs	2020/21	79.1	1/16	79.1	211.3	124.3	▶	●
	M	<18 yrs	2020/21	54.2	8/16	28.3	83.3	52.5	▶	●
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs	P	Primary schoo..	2021	2.2	7/16	1.7	3.1	2.4	▲	●
		School age	2021	2.3	3/16	2.0	3.5	2.8	▲	●
		Secondary sch..	2021	2.4	4/16	1.8	4.0	2.9	▲	●
	F	School age	2021	1.4	7/16	1.1	2.0	1.6	▬	●
	M	School age	2021	3.2	3/16	2.9	4.9	3.9	▬	●

Note: The figures for "Estimated number of children and young people with mental disorders - aged 5 to 17" are unavailable and therefore this indicator is not presented.

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 May 2022

Health Inequalities

Performance Summary

- Out of all the comparable indicators presented for health inequalities, two are green and two are amber.

- Of the two green indicators, Leicestershire ranks 8th (best performing) when compared to its similar neighbours for Life expectancy at birth (females) and 6th for Life expectancy at birth (males).

- Of the two amber indicators, Leicestershire ranks 12th (best performing) for both Healthy life expectancy at birth (females) and Healthy life expectancy at birth (males).

- For inequality in life expectancy at birth, Leicestershire ranks 2nd (best performing) when compared to its similar neighbours for males and 3rd for females.

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	2018 - 20	63.6	12/15	69.4	60.0	63.9		
	M	All ages	2018 - 20	62.9	12/15	68.0	61.5	63.1		
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 May 2022

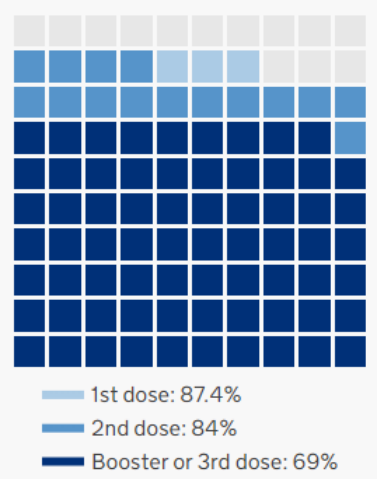
COVID recovery

Performance Summary

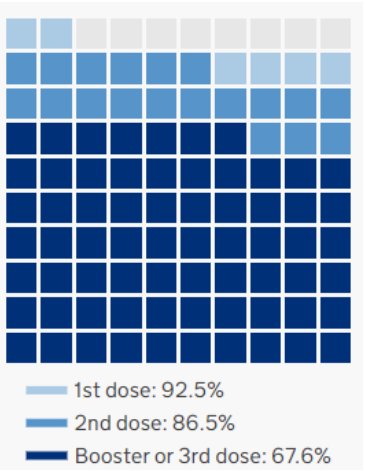
- **COVID-19 vaccinations (% Uptake)**

  The Covid-19 vaccination uptake in Leicestershire is higher than England for Booster/Dose 3 for those aged 12 and over as of 4th May 2022. The percentage uptake for Dose 1 and Dose 2 in Leicestershire is lower in comparison to the national average for those aged 12 and over.

Covid-19 Vaccination Uptake in Leicestershire 12+



Covid-19 Vaccination Uptake in England 12+



Source: Coronavirus (Covid- 19) in the UK dashboard (https://coronavirus.data.gov.uk/)

- **COVID-19 Hospital Admissions at University Hospitals of Leicester (UHL)****

  From March 2020 to April 2022, there have been a total of 5,789 hospital admissions with Covid-19 at UHL from Leicestershire residents since the start of the pandemic. Out of the 5,789 admissions, 70% were in those aged over 60 and 30% were in those aged under 60. It is important to note that Leicestershire residents would also attend other hospitals in other counties.

- **COVID-19 Deaths*****

  As of week 16 in 2022, there have been a total of 1,951 Covid-19 deaths in Leicestershire. Of the total deaths involving Covid-19 in Leicestershire, 1,333 (68.3%) were in a hospital setting and 464 (23.8%) were in a care home setting.

Since the beginning of the pandemic (week 12, 2020) there have been a total of 14,785 deaths (all causes) in Leicestershire.

Based on the average mortality data for 2015-19, we would expect 13,206 deaths in Leicestershire for this period. This reveals an excess of 1,580 deaths from any cause in Leicestershire during this period.

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

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+	May-22	High	87.4	92.5	%	Lower than national	
	Covid Vaccination Uptake - Dose 2 age 12+	May-22	High	84	86.5	%	Lower than national	
	Covid Vaccination Uptake - Boosters age 12+	May-22	High	69	67.6	%	Higher than national	
	Percentage worried about their economic wellbeing - Community Insight Survey	Q3 2022	Low	28.3	Null	%	Null	
	Total Hopital Admissons since start of pandemic	Week 17 2022	Low	5789	Null	Count	Null	
	Total deaths due to covid since start of pandemic	Week 16 2022	Low	1951	Null	Count	Null	
	Total Excess deaths (occurrences) since start of pandemic	Week 16 2022	Low	1580	Null	Count	Null	

Direction of travel Key:

- Decrease
- Increase
- N/A

Produced by Business Intelligence Service. Updated May 2022.

Appendix 1

Similar areas to Leicestershire

The Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbours model seeks to measure similarity between Local Authorities. The nearest neighbours to Leicestershire are listed below.

Nearest CIPFA neighbours to Leicestershire available from fingertips include:

- Worcestershire
- Staffordshire
- Nottinghamshire
- Warwickshire
- Derbyshire
- Somerset
- Hampshire
- Suffolk
- Gloucestershire
- Essex
- North Yorkshire
- Cambridgeshire
- Oxfordshire
- Northamptonshire
- West Sussex

Leicestershire County Council

If you require information contained in this leaflet in another version e.g. large print, Braille, tape or alternative language please telephone: 0116 305 6803, Fax: 0116 305 7271 or Minicom: 0116 305 6160.

જો આપ આ માહિતી આપની ભાષામાં સમજવામાં થોડી મદદ ઇચ્છતાં હો તો 0116 305 6803 નંબર પર ફોન કરશો અને અમે આપને મદદ કરવા વ્યવસ્થા કરીશું.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਵਿਚ ਕੁਝ ਮਦਦ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0116 305 6803 ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਅਸੀਂ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਦਵਾਂਗੇ।

এই তথ্য নিজের ভাষায় বুঝার জন্য আপনার যদি কোন সাহায্যের প্রয়োজন হয়, তবে 0116 305 6803 এই নম্বরে ফোন করলে আমরা উপযুক্ত ব্যক্তির ব্যবস্থা করবো।

اگر آپ کو یہ معلومات سمجھنے میں کچھ مدد درکار ہے تو براہ مہربانی اس نمبر پر کال کریں 0116 305 6803 اور ہم آپ کی مدد کے لئے کسی کا انتظام کر دیں گے۔

假如閣下需要幫助，用你的語言去明白這些資訊，請致電 0116 305 6803，我們會安排有關人員為你提供幫助。

Jeżeli potrzebujesz pomocy w zrozumieniu tej informacji w Twoim języku, zadzwoń pod numer 0116 305 6803, a my Ci dopomożemy.

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Chief Executive's Department
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APPENDIX C

Leicestershire Health and Wellbeing Board

Communications and Engagement

Report

May 2022

Safer sleep week

Organisations represented across the health and wellbeing board shared content across social media channels for safer sleep week. Graphics were used to highlight the important of safe sleep for babies. Channels such as Instagram were used to create two-way communication and encourage engagement.

Self-injury awareness day

Messages were shared with partners and sent to colleagues at a parish and town councils to highlight the support available for self-injury awareness day. The county council have partnered with DistrACT to provide support and self help to those in need. Messages went out across social media, using threads on Twitter and gaining more than one thousand impressions.

Mental health awareness week

Comms campaigns were run throughout Leicestershire highlighting the importance of mental health across Mental Health Awareness Week. The theme this year was loneliness. A toolkit was produced by the Start a Conversation Partnership and partners were offered the use of the toolkit to strengthen the messages across Leicestershire. There was a total of 52 requests for the toolkit.

In Hinckley and Bosworth, a market stall event, exhibitions and workshops took place across the week.

Schools

Healthy Schools team worked in partnership with the South Leicestershire School Sports Partnership (SLSSP), Active Oadby & Wigston, Active Blaby and Active Harborough, to create a week of tutor time activities (inc. myth busting) and the Helpie Selfie Challenge, as well as adding details around the event to the healthy school's website.

Children's and Young Peoples Officers provided mental health and wellbeing workshops targeting primary and secondary classes from individual school requests. A small card was produced with mental health resources and signposting for young people to leave in schools post-delivery.

Suicide prevention

Healthwatch ran a male suicide campaign to understand potential barriers that males face, exploring ways to raise awareness of services available and suggest tools available to help promote services. This work was followed by the 'Get the ball rolling' campaign which has continued to grow since the February launch, and we are exploring options for an event which ties into the world cup later this year.

Physical activity

There are many physical activity initiatives happening across the county on a local level. One group being targeted specifically are older residents who could be at risk of slips, trips or falls. Walk Together in Harborough has 60 participants who attend at multiple locations across the district for one hours walk and in most areas a coffee afterwards.

Leicester City Community Trust Premier Kicks Programme is taking place at Green Towers in Hinckley. Twelve weekly sessions are being held for 11–15-year-olds with an interest in football.

Health champions

A covid champions newsletter was issued by Leicestershire Public Health on a weekly basis during the peak of covid. This has recently converted to Health Champions, and we have 130 champions out in the community who help to spread health messages. Messages included so far have been from both Public Health and partners including the NHS 111 campaign, mental health awareness week, My Turning Point, Mensoar and Workplace Health.

APPENDIX D

LEICESTERSHIRE Health & Wellbeing Board

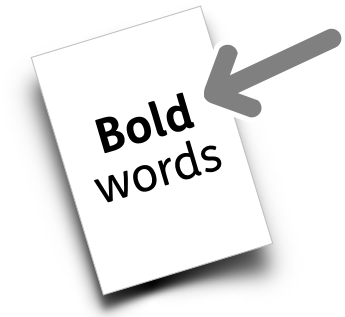
Joint Health and Wellbeing Strategy

2022 to 2032

Giving everyone in Leicestershire the chance to live happy, healthy lives

easy read

Contents



In this easy read document, difficult words are in **bold**. We explain what these words mean in the sentence after they have been used.

Some words are blue and underlined. These are links which will go to another website which has more information.

Introduction

Leicestershire Health and Wellbeing Board has written this **strategy**.

Leicestershire Health and Wellbeing Board is an official committee made up of people from local health and care organisations.

We work to make sure health and care services are right for local people and support them to live happy, healthy lives.

A **strategy** is a plan of things to do over a period of time.

This strategy explains our plans for health and care services for the next 10 years.

Health and wellbeing in Leicestershire

Where people live

Leicestershire is mostly countryside, but most people live in our towns.

Only about 1 in 10 people live in the countryside.

More older people

We expect there to be more older people over the next 10 years.

This is because people are living longer and more people living in Leicestershire.

More older people means that more people will be wanting a health and care service.

Rich and poor

Most people in Leicestershire have enough money to live well.

But there are areas which have people who are very poor.

Poorer people tend to have worse health than other people.

Long lives

On average people in Leicestershire live longer than people in the rest of England.

But men in the poorer areas of Leicestershire live on average for 8 years less than men in other areas of the county.

Women in the poorer areas, on average live 5 years less than women in the other areas of the county.

Long, happy, healthy lives

We want everyone in Leicestershire to live, long, happy, healthy lives.

So, we will do these things:

- Provide care and support that is right for each individual person.

- Help people not to get ill in the first place.

- Help people with long term health conditions to live as independently as possible.

- Make sure that we are fair to everyone in all our work - so that everyone has an equal chance of having good health.

- Help people to have good **mental health** as well as having good **physical health**.

  Physical health is the health of your body.

  Mental health is the health of your mind.

- Help everyone recover from the difficulties we all had with COVID-19.

- Remember to treat people carefully and with respect because we don't know if they have suffered from **trauma** at some time in their lives.

  Trauma is something bad that has happened to you, is difficult to forget and affects your health and wellbeing.

To make these things happen, we will:

- Work together with other organisations.

- Train and support our health and care workers.

- Use equipment, computers and phones in new and better ways.

- Involve, listen to and talk to local communities.

- Build on the services and organisations that are working well.

- Think about the health and wellbeing of everyone in Leicestershire.

- Collect more information about the health and wellbeing of local people so we can plan to have better services.

Best start for life

First 1001 important days

The first few years of your life are very important. They affect how healthy you are for the rest of your life.

We will have services for families and children that are accessible to all, including disabled people, before they go to school.

We will support women to breastfeed their babies.

We will give young children the **vaccinations** they need to keep safe from certain illnesses.

A **vaccination** is an injection or jab that helps to stop you being ill with a certain illness.

Ready for school
We will help families to make sure their children are ready to start school.

We will work to help:

- Children from the poorer communities.

- Children with special educational needs and disabilities (SEND).

We will:

- Help children and families to get used to taking exercise and keeping fit.

- Help any children who are having difficulty with speech and communication.

Preparing for life
We will help children and young people to become healthy adults by:

- Giving children and young people the vaccines that will keep them healthy, including the vaccine against COVID-19.

- Making sure all children and young people can go to school, get a job or some training.

- Helping children and young people to know how to:

  - Stay safe.

  - Look after their own mental health.

  - Keep fit and have a healthy weight.

Staying healthy, safe and well

If people have a healthy lifestyle and live in healthy places, they are more likely to have a long and healthy life.

We will help by:

- Working with local schools, colleges and businesses so people can get good jobs.

- Working with house builders so everyone can get a good place to live.

- Supporting people with mental health conditions to live independently.

- Working with the police and communities to keep everyone safe.

- Reducing pollution and improving the quality of the air we breathe.

- Aiding families who can't afford to keep their homes warm.

Choosing a healthy lifestyle
We will help people to choose a healthy lifestyle by:

- Encouraging people to support each other to be active.

- Giving people information about how to live a healthy lifestyle.

- Working with shops and supermarkets to make sure there is plenty of low cost healthy food for people to buy.

- Improving people's sexual health.

- Making it easier for people to walk and cycle across Leicestershire.

- Checking if people have got cancer.

Living well

We want people to carry on being healthy and living well even if they have long term conditions or disabilities.

Staying independent

As people start with long-term health conditions and disabilities, we will:

- Help people to manage their own health and care at home using new equipment, computers and phones.

- Help people to get support from local communities.

- Reduce the number of older people who have a fall.

- Help people find the right type of housing and support for them.

- Make sure that people can access local health services.

People who are frail or need complex care

Complex means complicated, because they have many different health conditions.

Frail means that someone is weaker and more likely to be hurt.

We will:

- Look out for people who are likely to need hospital treatment at some time.

- Support people and their carers to be as independent as possible for as long as possible.

- Get better at planning so that most **vulnerable** people have a care plan.

  Vulnerable means you might need help and support to stay safe and well.

- Quickly come and see people at home if they have a crisis, so they don’t have to go into hospital.

- Support people to get back home quickly and safely if they have been in hospital.

- Reduce the number of people who have to go into a nursing home.

Dying well

We want people to be able to choose the care and support they get at the end of their life.

We will:

- Ask people what they would like for them at the end of their life.

- Ask people in Leicestershire what services should be like for people at the end of their life.

- Support carers after a loved one has died, so they can move on to the rest of their lives.

- Offer all vulnerable people care plans that include what they want at the end of their lives.

Other priorities

Priorities are the most important things that we will do first.

These priorities affect all parts of our life.

Improved mental health

We will:

- Make mental health services equal to physical health services when we make plans.

- Help people to have good mental health - so they don't become ill.

- Keep the number of people who take their own lives low.

- Carry on working to help children and young people have good mental health.

- Listen to local people by asking them what they want for mental health services.

- Improve our support for people with **dementia**.

  Dementia is a disease in the brain. It affects your memory and behaviour.

Reducing health inequalities

A **health inequality** is where certain people have worse health than others. Often poorer and more vulnerable people have worse health than others.

We will:

- Make sure that everyone has fair access to health services.

- Train our managers so they understand more about the problems of health inequality.

- Make sure everyone gets fair access to:

  - Tests for cancer.

  - Tests for high blood pressure.

  - Vaccinations against flu and COVID-19.

  - Yearly health checks for people with mental health problems.

- Look at how COVID-19 has affected people from poorer communities.

Recovering from COVID-19

Many people and services have suffered because of COVID-19.

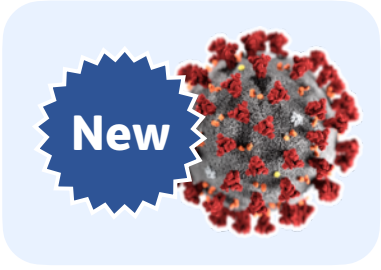
We will:

- Help people to get a vaccination against COVID-19.

- Make sure that services are able to support people who catch COVID-19 in the future.

- Look at how to support vulnerable people so they are safe from COVID-19.

- Help the people of Leicestershire to live with COVID-19 in our county.



- Make sure we are ready if any new disease, like COVID-19, comes along.

Next steps

The Leicestershire Health and Wellbeing Board works with key people from the local councils and health services as well as listening to patients and people who use services.

We also have people from the police at our meetings.

We help people from different organisations:

- Work and make plans together.
- Listen to patients and people who use services.

Next, we will:

- Make sure that services work together on our main priorities.

- Look at other areas of work that may become a priority in the future.

- Watch the general health of people in Leicestershire so we can quickly make plans if we need to.

For more information

You can read the full strategy here:
https://politics.leics.gov.uk/documents/s166738/Appendix%20A%20JHWS.pdf

This Easy Read information has been produced by easy-read-online.co.uk

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 26 MAY 2022

REPORT OF DIRECTOR OF ADULTS AND COMMUNITIES

BETTER CARE FUND Q4 2021/22 PERFORMANCE

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board with an update on the performance of the Better Care Fund (BCF) programme for 2021/22 and the associated national annual year end reporting requirements. The report also seeks approval for the submission of the year end template which sets out income and expenditure, performance against BCF metrics, successes and challenges and statements as to whether the national conditions have been met.

Recommendation

2. It is recommended that:

   a) The performance against the Better Care Fund (BCF) outcome metrics, and the positive progress made in transforming health and care pathways in 2021/22 be noted;

   b) The year-end BCF 2021-22 template, attached as the appendix to the report, be approved for submission to NHS England.

Policy Framework and Previous Decision

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

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

5. National reviews and consultation on future BCF planning and assurance processes began in early February 2022, with a series of engagement events and workshops across regions. These sessions looked back on the previous planning rounds and consider lessons for 2022-23 planning guidance which is yet to be published. Future planning sessions will also aim to understand, system level governance changes already underway. E.g. Integrated Care System (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.

Background

7. The Health and Wellbeing Board approved the BCF Plan for 2021/22 at its meeting on 25th November 2021 with an update on progress received at its meeting on 24th February 2022.

8. On 11th April 2022 the national BCF team published the year end template for reporting the position for the 2021/22 financial year which requires approval by the Health and Wellbeing Board.

9. The aim of the report and template is to inform the HWBB of progress against integration priorities and BCF delivery. BCF quarterly reporting can be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local authorities and service providers).

10. The completed year end template is attached to this report as the Appendix. It must be submitted by the NHSE deadline of the 27 May 2022.

11. The template consists of tabs that update progress against the following:

- Whether the four national conditions detailed in the Better Care Fund planning requirements for 2021-22 continue to be met through the delivery of the plan.
- A confidence assessment on achieving the metric targets for each of the BCF metrics which includes a brief commentary outlining the challenges faced in achieving the target along with any support needs and successes that have been achieved.
- Confirms the level of income received within the HWBB area against actual expenditure and any commentary noting any differences to planned expenditure
- an opportunity to provide feedback on delivering the BCF in 2021-22 through a set of survey questions. These questions are kept consistent from year to year to provide a time series.
- Data on average fees paid by the local authority for social care.

BCF Income and expenditure

12. 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 Outturn

13. The outturn for the financial year is £76.7m. Additional contributions of £11.436m were made by ELR CCG in year. The contributions were used to support social care resilience in light of the increased demand for services during 2021/22.

	Overall Financial Position			Forecast Position by Organisation		
	Allocation £'000	Outturn £'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	37,518	37,518	0	14,749	22,769	
Total BCF	**55,102**	**55,102**	**0**	**24,985**	**30,117**	**0**
DFG	4,447	4,447	0			4,447
IBCF	17,170	17,170	0			17,170
Total BCF Plan	**76,719**	**76,719**	**0**	**24,985**	**30,117**	**21,617**

Adult Social Care (ASC) Fee Rates

14. The ASC fee rates reported a reduction in the reported rates.

15. The average rates reported last year included additional support payments to County providers, as per the guidance. This year however, all of the additional payments made have been "whole market" support – and as such the guidance for the return is clear that they should be excluded.

Improved Better Care Fund (IBCF)

16. The Improved Better Care Fund (IBCF) allocation for 2021/22 consisted 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.

17. 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.

18. 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

19. The below table shows the BCF metrics for this financial year, the targets and projected outturns for the 2021/22 financial year (projections are required as year-end national data has yet to be released):

Metric	**Target**	**Projected outturn**	**Commentary**
Unplanned admissions for chronic ambulatory care-sensitive conditions.	775	735.1	The target for this indicator is projected to have been exceeded by approximately 5%. Therefore, fewer non-planned admissions occurred than predicted.
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85%	89.4%	This metric is on track exceed the target by approximately 4.3%. The focus on reablement in hospital and the community has improved performance against this metric within the financial year. ASC teams have been restructured to maximise the reablement function.
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (excluding RIP)	93.10%.	92.3%	This metric is slightly off target (0.8%). However, it was an ambitious target for post-pandemic recovery. It does, however, represent an improvement on both previous years' 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%	14+ days = 11.2% 21+ days = 5.4%	Both targets have been missed by approximately 1%. With data for 14+ days at 11.2% and 21+ days at 5.4%. This has been reflected on as a system acknowledging a focus on those with more acute needs being in hospital for longer. There will be a review of actions across LLR to impact on this during the 2022/23 BCF planning.
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	574.7 (per 100,000 population)	Currently data suggests that this is not on target and will miss this be approximately 10%. Additional use of residential care settings has led to increased admissions. Support has been requested from health colleagues on the focus on reablement and to ensure that community teams are better placed to case manage people in their own homes with a fully-operational Home First model of care. The population rate has not been published as yet, so this may reduce the rate when known.

Update against national conditions for the 2021/22 Plan

National condition 2 – Social Care Maintenance

20. National condition 2 (1 being a joined up BCF submission – completed Nov 2021) focuses on Social Care Maintenance and ensuring that CCG contributions to social care spend continue to match or exceed the minimum required.

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

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

National condition 3 – NHS Commissioned out of hospital services

23. During the re-emergence of the pandemic, there continued to be commissioning of care and services with health partners in the community.

24. Key activity commissioned over the financial year 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

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

26. In January 2022, the regional team requested an update for NHS England to briefly describe in bullet points, some of the actions that have taken place over the winter period in each HWBB area.

27. This was reported in full to the Health and Wellbeing Board at its meeting in February 2022 and is summarised below:

    - Development of the discharge hub.
    - Expansion of the Community Response Service
    - Re-commissioned therapy-led beds and interim beds
    - UHL and LPT Multi-agency discharge events (MADE
    - The commissioning of home care provision (Home Care for Leicestershire)
    - ASC staff working on wards to co-triage patients
    - Commissioning of case management for complex nursing patients
    - A review of commissioning for D2A residential placements

Next Steps

28. The BCF schemes and associated funding has been reviewed by a working group of the County Council and CCG colleagues for 2022/23 expenditure.

29. An updated BCF expenditure plan is in development. This will be predicted based on the estimated national uplift in minimum CCG contributions of 5.66%. This will await the minimum contribution and allocation national guidance and confirmation.

30. 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

Jon Wilson, Director of Adults and Communities

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

Tracy Ward – Assistant Director of Integration, Access and Prevention

0116 305 7563 Tracy.ward@leics.gov.uk

Appendix

BCF 2021-22 Year End Template

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 Health and Wellbeing Board – 25th November 2021

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

BCF report to the Health and Wellbeing Board – 24 February 2022

https://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=6942&Ver=4

Relevant Impact Assessments

Equality and Human Rights Implications

31. 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.

32. 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 concluded that the BCF will have a neutral impact on equalities and human rights.

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

Partnership Working and associated issues

34. 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.

35. 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.

36. 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/

Better Care Fund 2021-22 Year-end Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2021-22, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Hosusing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local authorities and service providers) for the purposes noted above.

BCF quarterly reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB documents.

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the BCF Team will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the Better Care Exchange (BCEx) prior to publication.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.

2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercaresupport@nhs.net
(please also copy in your respective Better Care Manager)
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2021-22 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2021-22/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to CCG Minimum Contribution
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of hospital stays that are 14 days or over, Proportion of hospital stays that are 14 days or over, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Long length of stay (14 and 21 days) and Dischaege to usual place of residence at a local authority level to assist systems in understanding performance at local authority level.

The metris worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to provide a directional estimate.
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Income and Expenditure

The Better Care Fund 2021-22 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and CCGs. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, and the minimum CCG contribution. A large proportion of areas also planned to pool additional contributions from LA and CCGs.

Income section:
- Please confirm the total HWB level actual BCF pooled income for 2021-22 by reporting any changes to the planned additional contributions by LAs and CCGs as was reported on the BCF planning template.
- The template will automatically pre populate the planned expenditure in 2021-22 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional CCG or LA contributions in 2021-22 in the yellow boxes provided, **NOT** the difference between the planned and actual income.
- Please provide any comments that may be useful for local context for the reported actual income in 20121-22.

Expenditure section:
- Please select from the drop down box to indicate whether the actual expenditure in you BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and expanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2021-22 in the yellow box provided and also enter a short commentary on the reasons for the change.

- Please provide any comments that may be useful for local context for the reported actual expenditure in 2019/20.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2021-22 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 9 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2021-22
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges
This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:
8. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2021-22.
9. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2021-22?

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

7. ASC fee rates

This section collects data on average fees paid by the local authority for social care.

Specific guidance on individual questions can be found on the relevant tab.

HM Government

NHS

Better Care Fund 2021-22 Year-end Template

2. Cover

Version 2.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. Narrative sections of the reports will not be published. However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information, including that provided on local authority fee rates, will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Leicestershire	
Completed by:	Lisa Carter	
E-mail:	Lisa.Carter@leics.gov.uk	
Contact number:	0116 3050786	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Lead Member Health and Wellbeing Board	Yes
Name:	Mrs L. Richardson CC	Yes

Checklist

Complete:

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes
7. ASC fee rates	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Year-end Template

3. National Conditions

Selected Health and Wellbeing Board: Leicestershire

Confirmation of Nation Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2021-22:**
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the BCF policy?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Plan for improving outcomes for people being discharged from hospital	Yes	

Checklist
Complete:
Yes
Yes
Yes
Yes

Better Care Fund 2021-22 Year-end Template

4. Metrics

Selected Health and Wellbeing Board: Leicestershire

National data may like be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2021-22 planning				Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	775.0				On track to meet target	With increasing admissions and attendances, there has been a system focus on the front-door and community support for those at high-risk of admission. Support to left-shift from acute settings has been sought around	The target for this indicator is projected to have been exceeded by approx 5% to 735.1. Therefore, fewer non-planned admissions occured than predicted.	Yes
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	**14 days or more (Q3)**	**14 days or more (Q4)**	**21 days or more (Q3)**	**21 days or more (Q4)**	Not on track to meet target	Both targets have been missed by approx 1%. With data for 14+ days at 11.2% and 21+ days at 5.4%. This has been reflected on as a system acknowledging a focus on those with more acute needs being in hospital for	The targets for Leicestershire for LOS were reflective of pre-pandemic data. This did not include the increase in demand for those that have delayed seeking care over the past 2 years. In spite of this, Leicestershire has	Yes
		10.0%	10.0%	4.6%	4.6%				
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.1%				Not on track to meet target	Increased acuity and demand has led to increased use of D2A bedded solutions (incuding designated settings). This has required additional support from hospital teams to better describe need and include	This metric is slightly off target (0.8%) projected to be 92.3%. However, it was an ambitious target for post-pandemic recovery. It does however, represents an improvement on both previous years data.	Yes
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)	519				Not on track to meet target	Currently data suggests that this is not on target and will miss this by approx 10% (574.7 per 100,000 population). As detailed above, additional use of residential care settings has led to increased admissions.	The achievements made as a system to improve the triage of patients within hospital settings have been embedding within this financial year. This is starting to see a reduction in the use of permanent	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85.1%				On track to meet target	There have been limitations to ASC staff having access to wards to contribute to identifying reablement potential. This has been restarted in year. Staff sickness recruitment and retention within HART	This metric will exceed the target by approx 4.3% to 89.4%. The focus on reablement in hospital and the community has improved performance against this metric within the financial year. ASC teams have been	Yes

* In the absense of 2021-22 population estimates (due to the devolution of North Northamptonshire and West Northamptonshire), the denominator for the Residential Admissions metric is based on 2020-21 estimates

Better Care Fund 2021-22 Year-end Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Leicestershire

Income

	2021-22
Disabled Facilities Grant	£4,447,227
Improved Better Care Fund	£17,170,503
CCG Minimum Fund	£43,665,558
Minimum Sub Total	£65,283,288

	Planned
CCG Additional Funding	£0
LA Additional Funding	£0
Additional Sub Total	£0

Actual		
Do you wish to change your additional actual CCG funding?	Yes	£11,436,470
Do you wish to change your additional actual LA funding?	No	
		£11,436,470

	Planned 21-22	Actual 21-22
Total BCF Pooled Fund	£65,283,288	£76,719,758

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2021-22	Additional voluntary contributions have been made in light of the evolving domiciliary care and residential care landscape in responding to the extraordinary pressures on flow through the acute and community hospitals across Leicestershire, Leicester and Rutland. Includes contributions to Winter Retention Scheme Payments, National Living Wage tariff, Crisis Response Service and

Expenditure

	2021-22
Plan	£65,283,288

Do you wish to change your actual BCF expenditure?	Yes

Actual	£76,719,758

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2021-22	Additional voluntary contributions have been made in light of the evolving domiciliary care and residential care landscape in responding to the extraordinary pressures on flow through the acute and community hospitals across Leicestershire, Leicester and Rutland. Includes contributions to Winter Retention Scheme Payments, National Living Wage tariff, Crisis Response Service and

Checklist

Complete:

Yes

Yes

Yes

Yes

Yes

Yes

Better Care Fund 2021-22 Year-end Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF. Covid-19 had a significant impact on services and schemes delivered on the ground which may have changed the context. However, national BCF partners would value and appreciate local area feedback to understand views and reflections of the progress and challenges faced during 2021-22
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Leicestershire

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	During this post-pandemic recovery year, many aspects of BCF partnership delivery have improved joint working. In particular, the re-introduction of social care staff back into hospitals to work with patients and their families / carers which had been ammended and paused during the covid pandemic. This formed part of the wider ASC restructure to improve case management resources and to extend this to the community. This has successfully extended our Home First offer as part of the BCF programme for 2021/22 and to provide additional resource to cover demand. Other areas of BCF delivery which have contributed to an improved joined up system include: •Care co-ordinators collaborating with their PCN's / INT's to identify residents within their communities who require care planning and MDT working •Re-focussing on reablement potential both in the community and on discharge from hospital •Agreeing a risk share with partners to support people who require additional funding for care beyond the D2A requirements •Jointly commissioning therapy-led discharge to recover beds to reable patients with ongoing health needs to return to their own homes - maximising the use of community therapy staff to meet as many individuals needs as possible. The above enabled us to work more effectively together to deliver services as per guidance. In particular, the ability to be flexible with staffing to respond to the needs of the health and social care system.	Yes
2. Our BCF schemes were implemented as planned in 2021-22	Agree	In 2021/22 many of the BCF schemes were implemented or maintained as described in the BCF plan. During the pandemic many staff were redeployed to support frontline services which shifted the focus from some of the planned BCF schemes, however, during this financial year we have returned to delivering plans as described particularly taking learning from the pandemic period into account. BCF schemes such as care coordination have returned to working with PCN's and INT's whilst ensuring that we flex the workforce to continue to support patients in hospital with lower-level needs for discharge. The first phase of the re-commissioning of domicilairy care in Leics was completed in Nov 2021. This saw a reduction in waits for care from around 300 people at the maximum to around 50. This significantly minimised the requirements for interim beds and also resources needed to bridge care in the commmunity. Some areas of delay remain, including the recruitment of positions that support delivery of our community response service. This provides care to all patients leaving hospital within the first 48 to 72 hours on pathway one. To support this, we worked with colleagues across our care system to help bridge the	Yes

3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality	Agree	Delivery of the plan has had a positive impact on joined up working between our newly restructured clinical commissioning group and Leicestershire County Council particularly in respect of public health and adult social care services. Governance reporting has been streamlined and there are now clear definitive outcomes associated with the delivery of the BCF and how this links to the delivery of the Joint Health and Wellbeing Strategy life course priorities. This has also been mapped to the four focus areas of the emerging ICS. Partnerships have developed rapidly over the last 12 months and the continued development of place-based delivery has insured join up between our primary care colleagues, housing and community response services along with the development of place-led plans.	Yes

Part 2: Successes and Challenges
Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing. Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	6. Good quality and sustainable provider market that can meet demand	Completion of the re-commissioning of Domicilliary Care contracts took place during 2021/22. The process was completed in Nov with a new framework covering Leicestershire. The new framework allowed for zonal pricing to ensure care availability in traditionally more rural areas. This gave wider scope for timely and cost effective delivery. The new framework dramatically improved care wait times, reducing the amount of people awaiting care from around 300 to 50 within a few weeks. This helped to restore confidence in the market and ensured reduced discharge delays. The pick-up timescales reduced from around 10 days to 2-3 days within the same time period. Care availability was assessed after the first commissioning exercise and a re-opening of the framework began in Jan 22 to cover areas of Leics that would benefit from further care availibility. This was completed in conjunction with Health Colleagues in a joint exercise and has allowed for greater flexibility and more sustainable provision.	Yes
Success 2	2. Strong, system-wide governance and systems leadership	Existing relationships have been particularly vital during 2021/22. Partners have built on this further, ensuring a joined up approach to discharge and case management, bridging and therapy needs. Strong governance and leadership covered all areas responsible for the delivery of various aspects of patient and resident care. The use of community assets and the voluntary sector to support public health, the NHS and social care and hospital governance arrangements provided resource to deliver support to Leicestershire residents, particularly around the delivery of the home first model and therapy -led reablement. Good, existing relationships built since 2017 continue to contribute to joined up governance supporting the ICS and the delivery of the Joint Health and Wellbeing strategy ensuring governance and leadership at place.	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	7. Joined-up regulatory approach	The joined up regulatory response during the covid pandemic, highlighted how well we had driven and progressed integration since 2017. However, the changes within this financial year to ongoing regulation and reform have highlighted gaps and differences in regulation between health and social care. For example, the removal of D2A funding combined with ASC reform has meant that there is increased pressure to ensure that the focus reverts to pre-pandemic processes and structures - particularly for self-funders. Further work on developing risk-share arrangements with health are underway in this financial year to mitigate exessive costs to social care spend.	Yes

Challenge 2	5. Integrated workforce: joint approach to training and upskilling of workforce	One of the key challenges facing our current system arrangements is the ability to recruit and retain appropriate levels of staffing in key areas of delivery. This has led to gaps and challenges around the development of a joined up workforce that could deliver aspects of both health and social care in a timely manner and therefore reducing the need for handoffs between service providers. This challenge is currently being addressed as part of our existing Home First collaboration which is aiming to deliver a joint recruitment strategy including access courses and on the job development of staff, with appropriate funding and leadership committed to addressing this challenge. We have a team of people dedicated to oversee the development and employment of an integrated workforce across LLR both within social care and health and an Integrated Personalised Care Framework that details shared tasks between health and social care. This is due to launch within the first quarter of 2022/23	Yes

Footnotes:

Better Care Fund 2021-22 Year-end Template

7. ASC fee rates

Selected Health and Wellbeing Board: Leicestershire

The iBCF fee rate collection gives us better and more timely insight into the fee rates paid to external care providers, which is a key part of social care reform.
Given the introduction of the Market Sustainability and Fair Cost of Care Fund in 2022-23, we are exploring where best to collect this data in future, but have chosen to collect 2021-22 data through the iBCF for consistency with previous years.

These questions cover average fees paid by your local authority (gross of client contributions/user charges) to external care providers for your local authority's eligible clients. The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

We are interested ONLY in the average fees actually received by external care providers for your local authority's eligible supported clients (gross of client contributions/user charges), reflecting what your local authority is able to afford.

In 2020-21, areas were asked to provide actual average rates (excluding whole market support such as the Infection Control Fund but otherwise, including additional funding to cover cost pressures related to management of the COVID-19 pandemic), as well as a 'counterfactual' rate that would have been paid had the pandemic not occurred. This counterfactual calculation was intended to provide data on the long term costs of providing care to inform policymaking. In 2021-22, areas are only asked to provide the actual rate paid to providers (not the counterfactual), subject to than the exclusions set out below.

Specifically the averages SHOULD therefore:
- EXCLUDE/BE NET OF any amounts that you usually include in reported fee rates but are not paid to care providers e.g. your local authority's own staff costs in managing the commissioning of places.
- EXCLUDE/BE NET OF any amounts that are paid from sources other than eligible local authority funding and client contributions/user charges, i.e. you should EXCLUDE third party top-ups, NHS Funded Nursing Care and full cost paying clients.
- EXCLUDE/BE NET OF whole-market COVID-19 support such as Infection Control Fund payments.
- INCLUDE/BE GROSS OF client contributions /user charges.
- INCLUDE fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.
- EXCLUDE care packages which are part funded by Continuing Health Care funding.

If you only have average fees at a more detailed breakdown level than the three service types of home care, 65+ residential and 65+ nursing requested below (e.g. you have the more detailed categories of 65+ residential without dementia, 65+ residential with dementia) **please calculate for each of the three service types an average weighted by the proportion of clients that receive each detailed category:** 1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age 65+ residential without dementia, age 65+ residential with dementia) by the total number of clients receiving the relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each detailed category.
4. For each service type, sum the resultant detailed category figures from Step 3.

Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

For information - your 2020-21 fee as reported in 2020-21 end of year reporting *	Average 2020/21 fee. If you have newer/better data than End of year 2020/21, enter it below and explain why it differs in the comments. Otherwise enter the end of year 2020-21 value	What was your actual average fee rate per actual user for 2021/22?	Implied Uplift: Actual 2021/22 rates compared to 2020/21 rates

Checklist

Complete:

1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£19.57	£19.57	£19.51	-0.3%		Yes
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£835.00	£835.00	£728.00	-12.8%		Yes
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£820.00	£835.00	£728.00	-12.8%		Yes
4. Please provide additional commentary if your 2020-21 fee is different from that reported in your 2020-21 end of year report. **Please do not use more than 250 characters.**		Q3 an incorrect figure was reported in the 2020-21 return. This should have been £835.00			161 characters remaining	Yes

Footnotes:

* ".." in the column C lookup means that no 2020-21 fee was reported by your council in the 2020-21 EoY report

** For column F, please calculate your fee rate as the expenditure during the year divided by the number of actual client weeks during the year. This will pick up any support that you have provided in terms of occupancy guarantees.
(Occupancy guarantees should result in a higher rate per actual user.)

*** Both North Northamptonshire & West Northamptonshire will pull the same last year figures as reported by the former Northamptonshire County Council.

LEICESTERSHIRE HEALTH AND WELLBEING BOARD
26 MAY 2022

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PHARMACEUTICAL NEEDS ASSESSMENT 2022 - PROGRESS UPDATE AND PRE-CONSULTATION DRAFT

Purpose of Report

1. The purpose of this report is to provide the Health and Wellbeing Board (HWB) with an update on work undertaken to produce the draft Pharmaceutical Needs Assessment (PNA) 2022 and to seek the Board's approval to consult on the draft document.

Recommendation

2. It is recommended that the Health and Wellbeing Board:

    a. Notes the work undertaken to produce the draft Pharmaceutical Needs Assessment (PNA) 2022, which has been developed in line with the findings of public and pharmacy surveys;

    b. Approves the draft PNA for consultation;

    c. Notes that a further report will be considered by the Board at its meeting in September 2022 detailing the outcome of the consultation and seeking approval of the final PNA.

Policy Framework and Previous Decision

3. The HWB has a statutory responsibility to prepare a PNA for Leicestershire and publish it by 1 October 2022. At its meeting on 24 February 2022, the Health and Wellbeing Board noted the timescales and process for the production of the PNA, along with areas of focus, likely structure, governance and consultation arrangements to inform the draft.

4. 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

Background

5. 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.

6. The last PNA for Leicestershire was produced in 2018 and can be accessed at: http://www.lsr-online.org/pharmaceutical-needs-assessment.html.

7. 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.

8. 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

9. A PNA Reference Group has been established to oversee the detailed production of the PNA documents for Leicester, Leicestershire and Rutland to ensure a consistent local approach. Membership of this group includes: local authorities, NHS England, the Leicestershire Pharmaceutical Committee, Local Professional Network for Pharmacists and the Leicester, Leicestershire and Rutland Local Medical Committee, Clinical Commissioning Groups and Healthwatch. Although there is a common approach, there will be separate PNAs for Leicester, Leicestershire and Rutland.

10. 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 Project Team by NHS England, the Leicestershire Pharmaceutical Committee, CCGs and others.

Content

11. The regulations and guidance documents provide information on the PNA content. This has been reflected in the draft PNA appended as Appendix A. Although a similar approach to that taken in the 2018 PNA has been used when developing the PNA content, more innovative ways will be used to present and visualise the 2022 PNA data which will also be regularly updated.

12. 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 has been examined to understand the implications for the PNA 2022.

Progress to Date

13. The PNA Reference Group considered pre-consultation drafts of the Leicestershire and Rutland PNAs at its meeting on 26 April 2022. The document followed a similar format to the 2018 version which met statutory requirements. The views of the Reference Group have now been incorporated into the draft Leicestershire document attached at Appendix A. This draft includes analysis and presentation of available data and also the headline results from a survey of local pharmacies. In light of the relatively low response rate (67 responses) the survey will be re-opened, and the findings will be incorporated into the final Strategy. The Appendices to the PNA form a lengthy addition to the report and hence have been included for reference in the link attached - https://www.lsr-online.org/pna-for-2022.html.

Consultation/Patient and Public Involvement

14. To gather additional intelligence for the development of the draft PNA, two surveys ran throughout the spring. One survey asked service users for their views on the current pharmaceutical provision and the second gathered data on services provided, opening times etc from pharmaceutical professionals. The findings from these two survey exercises have been incorporated into the initial draft PNA document.

15. The PNA is subject to a 60-day statutory consultation period which, subject to approval, will commence in June 2022. The Pharmaceutical Services Regulations specify that the Health and Wellbeing Board must consult with the following: -

- the Local Pharmaceutical Committee (LPC)
- 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.

16. 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.

17. The Reference Group is working with the County Council's Consultation Manager to design an effective consultation process. 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. An easy read version of the PNA will be developed.

Resource Implications

18. Pharmacy Services are core funded through NHS England budgets, but also commissioned for extra services from a range of sources. Any changes in services and provision will impact on those particular budgets. The PNA has been developed within existing business intelligence and public health budgets, including the consultation arrangements.

Timetable for Decisions

19. Appendix B sets out the project timescales. The project plan is tight with respect to delivering an approved PNA by 1 October 2022. The PNA Project Team will monitor this and report any issues of concern to the Health and Wellbeing Board. The current timescales 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

Background Papers

Pharmaceutical Needs Assessment Guidance and Regulations
https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

Circulation under Local Issues Alert Procedure

None

Appendices

Appendix A – Pre-Consultation Draft of Leicestershire PNA
Appendix B - PNA Preparation Timeline
Appendix C – PNA Appendices - https://www.lsr-online.org/pna-for-2022.html

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Relevant Impact Assessments

Equality and Human Rights Implications

The PNA will be subject to an Equality Impact Assessment. The consultation process has sought to obtain and analyse views from the wide range of equalities groups.

Partnership Working and associated issues

The PNA has been produced in partnership with a range of partner agencies who have an interest in continued effective and efficient delivery of pharmacy services in the county and related services.

Risk Assessment

The assessment looks at a wide range of factors related to the adequacy of current pharmacy services in the County and the implications and risks that would arise with inadequate provision.

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Appendix A

Leicestershire County Council

LEICESTERSHIRE PHARMACEUTICAL NEEDS ASSESSMENT

Public Health Intelligence
Business Intelligence Service
Chief Executive's Department
Leicestershire County Council
County Hall, Glenfield
Leicester LE3 8RA

Tel 0116 305 4266
Email phi@leics.gov.uk

Produced by the Business Intelligence Service at Leicestershire County Council.

FOREWORD AND EXECUTIVE SUMMARY

To be completed once document completed.

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BACKGROUND AND INTRODUCTION

1. Introduction

The Health and Social Care Act 2012 established Health and Wellbeing Boards. From April 2013, Health and Wellbeing Boards became responsible for developing and updating pharmaceutical needs assessments. At the same time responsibility for using pharmaceutical needs assessments as the basis for determining market entry to a pharmaceutical list transferred from primary care trusts to NHS England and NHS Improvement.

If a person (a pharmacist, a dispenser of appliances or a GP) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and as of October 2021 are held by NHS England and NHS Improvement. This is commonly known as the NHS "market entry" system.[1]

In order to be included on a relevant pharmaceutical list, the applicant applies by proving they are able to meet a pharmaceutical need as set out in the relevant Pharmaceutical Needs Assessment (PNA). There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance-selling (internet or mail order only) basis.

The latest PNA for Leicestershire was produced in March 2018 by the Leicestershire Health and Wellbeing Board. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 requires all Health and Wellbeing Boards to publish a revised assessment within three years of publication of their first assessment. Due to the ongoing pressures across all sectors in response to the Covid-19 pandemic, the Pharmaceutical Needs Assessment for 2021 was postponed to October 2022. This PNA replaces the 2018 document.

2. Purpose of the PNA

The PNA is the key local tool for understanding the provision of pharmaceutical services in a local area as well as identifying and assessing which pharmaceutical services need to be provided by local community pharmacies and other providers in the future.

PNAs inform commissioning decisions of pharmacy services by local authorities, NHS England and NHS Improvement, Clinical Commissioning Groups, and with their introduction Integrated Care Systems. PNAs also identify which services should be commissioned for local people, within available resources, and where these services should be.

PNAs are aligned to other relevant local assessments and plans for health and social care such as the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy and they examine the local population demographics and services available in neighbouring areas that may affect local service need.

PNAs identify gaps in pharmaceutical service provision and inform decision making in response to applications made to NHS England and NHS Improvement by organisations to provide a new pharmacy. The organisation that will make these decisions is NHS England and NHS Improvement hence the PNA is of particular importance to them.

In summary, the regulations[1] require a series of statements that must be contained in the PNA, such as:

- A statement of pharmaceutical services that the Health and Wellbeing Board has identified as services that are necessary to meet the need for pharmaceutical services
- A statement of pharmaceutical services that have been identified as services that are not provided but which the Health and Wellbeing Board is satisfied need to be provided in order to meet a current or future need for a range of pharmaceutical services or a specific pharmaceutical service
- A statement of pharmaceutical services that the Health and Wellbeing Board has identified as not being necessary to meet the need for pharmaceutical services but have secured improvements or better access
- A statement of the pharmaceutical services that have been identified as services that would secure improvements or better access to a range of pharmaceutical services or a specific pharmaceutical service, either now or in the future
- other NHS services that affect the need for pharmaceutical services or a specific pharmaceutical service.

Other information that will be included or considered within the PNA is:

- how the Health and Wellbeing Board has determined the localities in its area
- how it has taken into account the different needs of the different localities, and the different needs of those who share a protected characteristic
- a report on the consultation
- a map that identifies the premises at which pharmaceutical services are provided
- information on the demography of the area
- whether there is sufficient choice with regard to obtaining pharmaceutical services
- any different needs of the different localities; and
- the provision of pharmaceutical services in neighbouring Health and Wellbeing Board areas.

3. Pharmaceutical Services and Pharmacy Contracts

Pharmaceutical services are defined by reference to the regulations and directions governing pharmaceutical services provided by community pharmacies, dispensing GPs and appliance contractors.

The Community Pharmacy Contractual framework with the NHS (CPCF) outlines three tiers of community pharmaceutical services:

Essential Services – all pharmacies, including distance selling pharmacies, are required to provide essential services as part of the NHS Community Pharmacy Contractual Framework (the pharmacy contract).

Advanced Services – are those services that community pharmacy contractors and dispensing appliance contractors can provide as long as they meet the requirements set out in the Secretary of State's Directions.

Enhanced Services – are the third tier of services that pharmacies may provide, and they can only be commissioned by NHS England and NHS Improvement.

Local Community Services - in addition to these nationally determined services, community pharmacies can also be contracted to provide locally commissioned services by local authorities and Clinical Commissioning Groups.

Quality Assurance:

NHS England and NHS Improvement's local teams monitor the provision of Essential and Advanced Services and the pharmacy contractors' compliance with the terms of the Community Pharmacy Contractual Framework. Each year, every pharmacy must complete a short questionnaire which will determine whether a pharmacy needs visiting.

The General Pharmaceutical Council carry out inspections in all registered pharmacy premises to ensure that they comply with all legal requirements and regulatory standards. The inspector will examine how the pharmacy operates with the aim of securing and promoting the safe and effective practice of pharmacy services.[2]

All pharmacies are required to conduct an annual community pharmacy patient questionnaire (Patient Satisfaction Questionnaire) which allows patients to provide feedback to community pharmacies on the services they provide. Due to the current challenges being experienced by pharmacies and the contribution of the pharmacy workforce to the Covid-19 vaccination programme, the Pharmaceutical Services Negotiating Committee (PSNC) has reached agreement with NHS England and NHS Improvement and the Department of Health and Social Care that contractors will not be required to complete the Community Pharmacy Patient Questionnaire for 2021/2022.[3.]

3.1. Essential Services

As of October 2021, there are eight essential services listed below that are offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework (the 'pharmacy contract').

Table 1: Essential Pharmacy Services

Essential Services	**Description[4]**
Dispensing Medicines and Appliances	The supply of medicines and appliances ordered on NHS prescriptions, together with information and advice, to enable safe and effective use by patients and carers, and maintenance of appropriate records.

Repeat Dispensing/ Electronic Repeat Dispensing (eRD)	The management and dispensing of repeatable NHS prescriptions for medicines and appliances, in partnership with the patient and the prescriber. The service specification for repeat dispensing covers the requirements additional to those for dispensing, such that the pharmacist ascertains the patient's need for a repeat supply and communicates any clinically significant issues to the prescriber.
Discharge Medicines Service (DMS)	This service was introduced in 2021 and aims to reduce the risk of medication problems when a person is discharged from hospital. Patients are digitally referred to their pharmacy after discharge from hospital. Using the information in the referral, pharmacists are able to compare the patient's medicines at discharge to those they were taking before admission to hospital. A check is also made when the first new prescription for the patient is issued in primary care and a consultation with the patient and/or their carer will help to ensure that they understand which medicines the patient should now be using.
Clinical Governance	Pharmacies have an identifiable clinical governance lead and apply clinical governance principles to the delivery of services. This will include use of standard operating procedures; recording, reporting and learning from adverse incidents; participation in continuing professional development and clinical audit; and assessing patient satisfaction.[5]
Promotion of Healthy Lifestyles (Public Health)	The provision of opportunistic healthy lifestyle advice and public health advice to patients receiving prescriptions who appear to have diabetes; or be at risk of coronary heart disease, especially those with high blood pressure; or are overweight; and participating in six health campaigns where requested to do so by NHS England and NHS Improvement.
Disposal of Unwanted Medicines	Acceptance, by community pharmacies, of unwanted medicines by someone living at home, in a children's home or in a residential care home which require safe disposal. Primary Care Organisations will have arrangements for the collection and disposal of waste medicines from pharmacies.
Signposting	The provision of information on other health and social care providers or support organisations to people visiting the pharmacy who require further support, advice or treatment which cannot be provided by the pharmacy.
Support for self-care	The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families.

Source: NHS Community Pharmacy Contractual Framework

3.2. Advanced Services

There are eleven advanced services within the NHS Community Pharmacy Contractual Framework (the 'pharmacy contract'). Community pharmacies can choose to provide any or all of these listed services.

Table 2: Advanced Pharmacy Services

Advanced Services	**Description**[4]
Medicine Use Reviews (MURs)	Accredited pharmacists undertaking structured adherence-centered reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions. National target groups have been agreed in order to guide the selection of patients to whom the service will be offered. The MUR process attempts to establish a picture of the patient's use of their medicines – both prescribed and non-prescribed. The review helps patients understand their therapy and it will identify any problems they are experiencing along with possible solutions. A Prescription Intervention was simply an MUR which was triggered by a significant adherence problem which came to light during the dispensing of a prescription. It was over and above the basic interventions, relating to safety, which a pharmacist makes as part of the dispensing service. An MUR feedback form will be provided to the patient's GP where there is an issue for them to consider. *This service was decommissioned on 31st March 2021.*
New Medicine Service (NMS)	This service was introduced on 1st October 2011. The service provides support for people with long term conditions who have been newly prescribed a medicine to help improve medicines adherence and self-manage their condition. This service is initially focused on particular patient groups and conditions.
Community Pharmacist Consultation Service (CPCS)	Introduced in November 2020 this service replaces the NHS Urgent Medicine Supply service pilot. General practices and NHS 111 can refer patients for minor illness consultation at pharmacies offering CPCS.
Covid-19 Lateral flow Device Distribution	From March 2021 to March 2022, lateral flow device distribution was added to the advanced services available at some community pharmacies. Lateral flow devices were free to collect for members of the public. *This service ceased from 1st April 2022.*

Appliance Use Review (AUR)	This service can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. AURs should improve the patient's knowledge and use of any 'specified appliance' by establishing the way the patient uses the appliance and the patient's experience of such use. This is achieved by identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient, including advising the patient on the safe and appropriate storage of the appliance and advising the patient on the safe and proper disposal of the appliances that are used or unwanted.
Stoma Appliance Customisation (SAC)	The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. The stoma appliances that can be customised are listed in Part IXC of the Drug Tariff. If the pharmacist is unable to provide the prescribed service, they should either refer the patient to another pharmacy or provide the patient with the contact details of at least two pharmacies or providers that are able to supply the service.
Seasonal Influenza (flu) Vaccination	Community pharmacy has been providing flu vaccinations under a nationally commissioned service since September 2015, for patients aged 65 and over and at-risk groups, to support GP services in increasing vaccination rates. Each year from September through to March the NHS runs a seasonal influenza (flu) vaccination campaign aiming to vaccinate all patients who are at risk of developing more serious complications from the virus.
Hepatitis C Testing Service	From September 2020 Hepatitis C testing became available as an advanced service from pharmacies who offer this service. This service is focused on provision of point of care testing for Hepatitis C antibodies to people who inject drugs who haven't yet accepted treatment for their substance use. Those who test positive are referred for further confirmatory testing and treatment. *This service ceased at the end of March 2022.*
Hypertension Case-Finding Service	Also known as the NHS Blood Pressure Check, from October 2021 pharmacies provided clinic blood pressure testing to those aged over 40 to identify those with high blood pressure. Where clinically indicated, patients are then offered 24-hour ambulatory blood pressure monitoring, the results of which are shared with the persons GP.
Pandemic Delivery Service	Originally offered to clinically extremely vulnerable people shielding due to the Covid-19 before being offered to people who have been notified of the need to self-isolate by NHS Test and Trace. Delivery of prescriptions from Pharmacies organized via a variety of methods including volunteer delivery or direct pharmacy delivery. *This service ceased from 5th March 2022.*
Smoking Cessation Service (CSC)	This service enables NHS trusts to refer patients to a community pharmacy of their choice to continue their smoking cessation treatment, including providing medication and support as required. This service only became an advanced service in 2022 and as such no data will be presented.

Source: NHS Community Pharmacy Contractual Framework

3.3. Community Based Services

In addition to the services above, pharmacies can also offer services that are commissioned by local authorities and Clinical Commissioning Groups that have been identified to meet the health needs of their local populations. These services currently include:

Table 3: Community Based Pharmacy Services

Community Based Services	Description
Emergency Hormonal Contraception (EHC)	This is a free service to women up to 25 years of age following unprotected sexual intercourse to prevent unintended pregnancies.
Needle Exchange	A service for intravenous drug users, providing clean needles and so reducing the risk of infection such as hepatitis.
Supervised Consumption	A service for registered drug addicts, providing regular monitored doses of an opiate substitute to support becoming progressively drug free.
Champix Provision	A service to provide Champix (Varenicline) as part of a Patient Group Directive to service users on referral by the Quit Ready Leicestershire Stop Smoking Service. *Currently there has been no provision for the last year due to a manufacturer recall.*
Extended Care Services	The extended care service allows pharmacies to provide treatment for a selection of minor ailments without the patient having to attend a GP or Out of hours service. Advice is also given to reduce the likelihood of repeat need for treatment. The patient must be registered with a GP and may need to be in an eligible group.
Palliative Medicine Supply	Palliative care is aimed at offering the patient the highest possible level of comfort during the last phase of their life. This service aims to facilitate prompt access to palliative care medicines by patients and their representatives. This service also includes provision of urgent antibiotics.
Emergency Supply Service	The Emergency Supply Service allows pharmacists to prescribe prescription only medicines to a patient previously prescribed the requested drug without a prescription. This means a patient can in emergency situations receive a drug without visiting a doctor and is intended to lessen demand for emergency medical care for repeat prescriptions.
Covid-19 Vaccinations	Community pharmacies have been central to the Government's response to Covid-19, by offering and delivering Covid-19 vaccinations.

3.4. Pharmacy Contracts

There are four types of community pharmacy contractors. They are:

Those held on a pharmaceutical list (standard contract) - healthcare professionals working for themselves or as employees who practise in pharmacy: the field of health sciences focusing on safe and effective medicines use.

Dispensing Appliance Contractors – they only dispense prescriptions for appliances. They cannot dispense prescriptions for drugs. Dispensing appliance contractors are not required to have a pharmacist, or a regulatory body and their premises do not have to be registered with the General Pharmaceutical Council. Dispensing appliance contractors tend to operate remotely, receiving prescriptions either via the post or the electronic prescription service, and arranging for dispensed items to be delivered to the patient.

Dispensing Doctors/Practices – GP Practices can dispense medicines and appliances to patients who live in a controlled locality (rural area) and live more than 1.6km from a pharmacy.

Local Pharmaceutical Service (LPS) Contract - allows NHS England and NHS Improvement to commission community pharmaceutical services tailored to specific local requirements. It provides flexibility to include within a single locally negotiated contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements set out in the 2013 Regulations. All LPS contracts must, however, include an element of dispensing.

3.5. Distance Selling Pharmacies

Distance selling pharmacies (e.g., internet pharmacies) are able to provide the full range of essential, advanced and enhanced services to the population, without face-to-face contact. Distance selling pharmacies will receive prescriptions either via the electronic prescription service or through the post, dispense them at the pharmacy and then either deliver them to the patient or arrange for them to be delivered using a courier. They must provide essential services to anyone, anywhere in England, where requested to do so. They may choose to provide advanced services, but when doing so must ensure that they do not provide any element of the essential services whilst the patient is at the pharmacy premises.

4. What is Excluded from the scope of the PNA?

The PNA is set out by regulation to cover the community-based pharmacy services that have been described in Section 3 of this report. There are other providers of pharmaceutical services in Leicestershire that have not been included in the assessment of need. These are set out below:

4.1. Prison Pharmacy

Pharmaceutical services are provided in HMP Gartree prison in Leicestershire. Health services provided within prisons require a pharmaceutical service to support the delivery of healthcare and the supply of medicines. The unique nature of the environment and the predominance of certain clinical services in some prisons, such as substance misuse services, means that these services are provided by contracted providers with a model that is determined to support the prison population safely.

4.2. Hospital Pharmacy

Around 20% of pharmacists work in hospitals and play an essential role in patient care. Working as part of a multidisciplinary team, hospital pharmacists manage caseloads and provide treatment programmes for all hospital patients. In Leicestershire, patients will access acute care from a range of hospital providers, including:

- University Hospitals of Leicester NHS Trust
- Community hospitals in Coalville, Hinckley, Loughborough, Lutterworth, Melton and Market Harborough,
- Out of county providers, such as Nottingham, Derby, Burton, Peterborough, etc.

Whilst in hospital, patients' medicines will be dispensed and managed by hospital pharmacists. Once the patient is discharged to the community their pharmaceutical needs will be met by their community pharmacist.

5. Process followed for developing the PNA

The Health and Wellbeing Board has a statutory responsibility to prepare a PNA for Leicestershire by October 2022. The Board has tasked the Leicester, Leicestershire and Rutland (LLR) PNA Reference Group to oversee and develop the PNA on their behalf.

The inter-agency PNA Reference Group was established because many of the relationships required for the PNA were Leicester, Leicestershire and Rutland (LLR) wide. The group included representation from NHS England and NHS Improvement, the Leicestershire Pharmaceutical Committee and the Local Professional Network for Pharmacists. The group's terms of reference are attached as Appendix A.

The PNA will be subject to a 60-day statutory consultation period running in June and July 2022. A consultation also took place with local pharmaceutical professionals and service users between March to April 2022 to gather evidence to support the PNA. 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 the NHS England and NHS Improvement 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 and NHS Improvement
- any neighbouring Health and Wellbeing Board

The full range of statutory bodies required will be contacted and asked to participate in the consultation. In addition, the consultation will be distributed widely to other groups likely to be interested.

HEALTH NEEDS OF THE POPULATION OF LEICESTERSHIRE

6. Population of Leicestershire

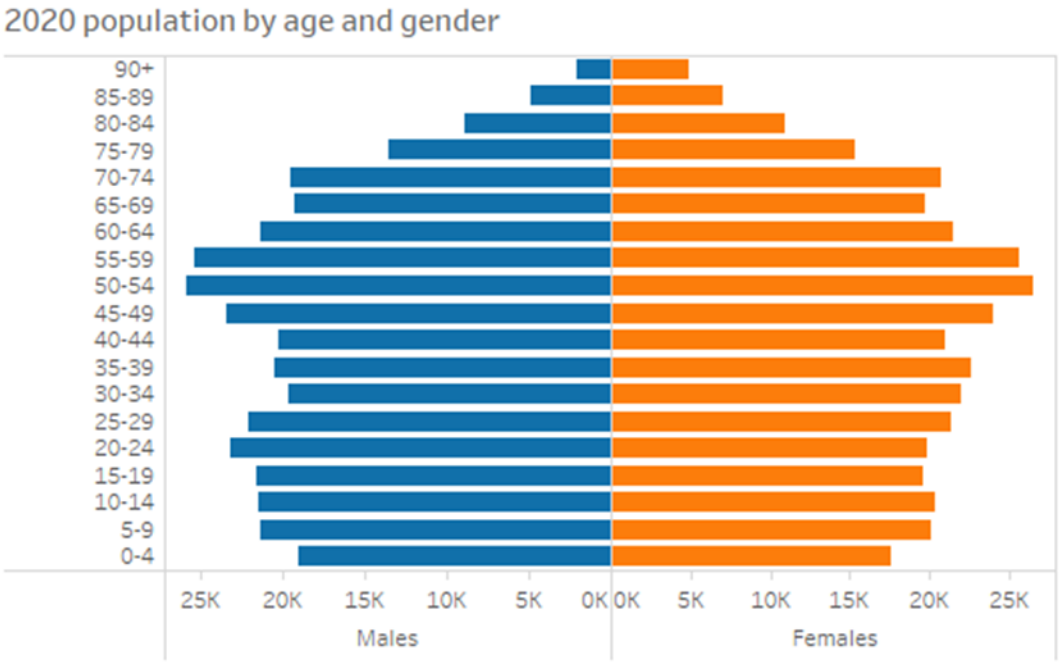
Leicestershire's Joint Strategic Needs Assessment (JSNA) Demography Report was published in 2021.[6]In addition to the publication of the JSNA, additional reports are available to further enrich the evidence base for the health and wellbeing of the population. This includes the Leicestershire Joint Health and Wellbeing Strategy 2022-2032[7] and performance report, the Public Health Outcomes Framework (PHOF) report published for Leicestershire County Council and Local Authority District Profiles, and the Director of Public Health's Annual Reports. The latest Director of Public Health's Annual Report focused on Physical Activity.

These reports are all available from http://www.lsr-online.org/health-and-wellbeing-leicestershire3.html

6.1. Population estimates

In 2020, the population of Leicestershire was estimated to be 713,085 people, including 119,567 children aged 0-14 years (16.8%), 446,843 (62.7%) working age population aged 15-64,127,843 people aged 65-84 years (17.9%) and 18,832 people aged 85 years and over (2.6%).[8]

Figure 1: 2020 Population pyramid[8]



Source: Mid-2020 population estimate, ONS, 2021.

Table 4: 2020 Population estimates for Leicestershire[8]

Age	Male	Female	% of Male Total Population	% of Female Total Population
0-4	18,970	17,543	2.7%	2.4%
5-9	21,249	20,153	3.0%	2.8%
10-14	21,358	20,294	3.0%	2.8%
15-19	21,483	19,639	3.0%	2.7%
20-24	23,133	19,825	3.3%	2.7%
25-29	22,012	21,353	3.1%	3.0%
30-34	19,594	21,974	2.8%	3.0%
35-39	20,405	22,653	2.9%	3.1%
40-44	20,149	20,970	2.9%	2.9%
45-49	23,401	24,059	3.3%	3.3%
50-54	25,844	26,564	3.7%	3.7%
55-59	25,255	25,648	3.6%	3.6%
60-64	21,342	21,540	3.0%	3.0%
65-69	19,210	19,695	2.7%	2.7%
70-74	19,505	20,777	2.8%	2.9%
75-79	13,519	15,326	1.9%	2.1%
80-84	8,926	10,885	1.3%	1.5%
85-89	4,867	7,008	0.7%	1.0%
90+	2,028	4,929	0.3%	0.7%
All Ages	352,250	360,835	50.0%	50.0%

Source: Mid-2020 population estimate, ONS, 2021.

6.2. Deprivation

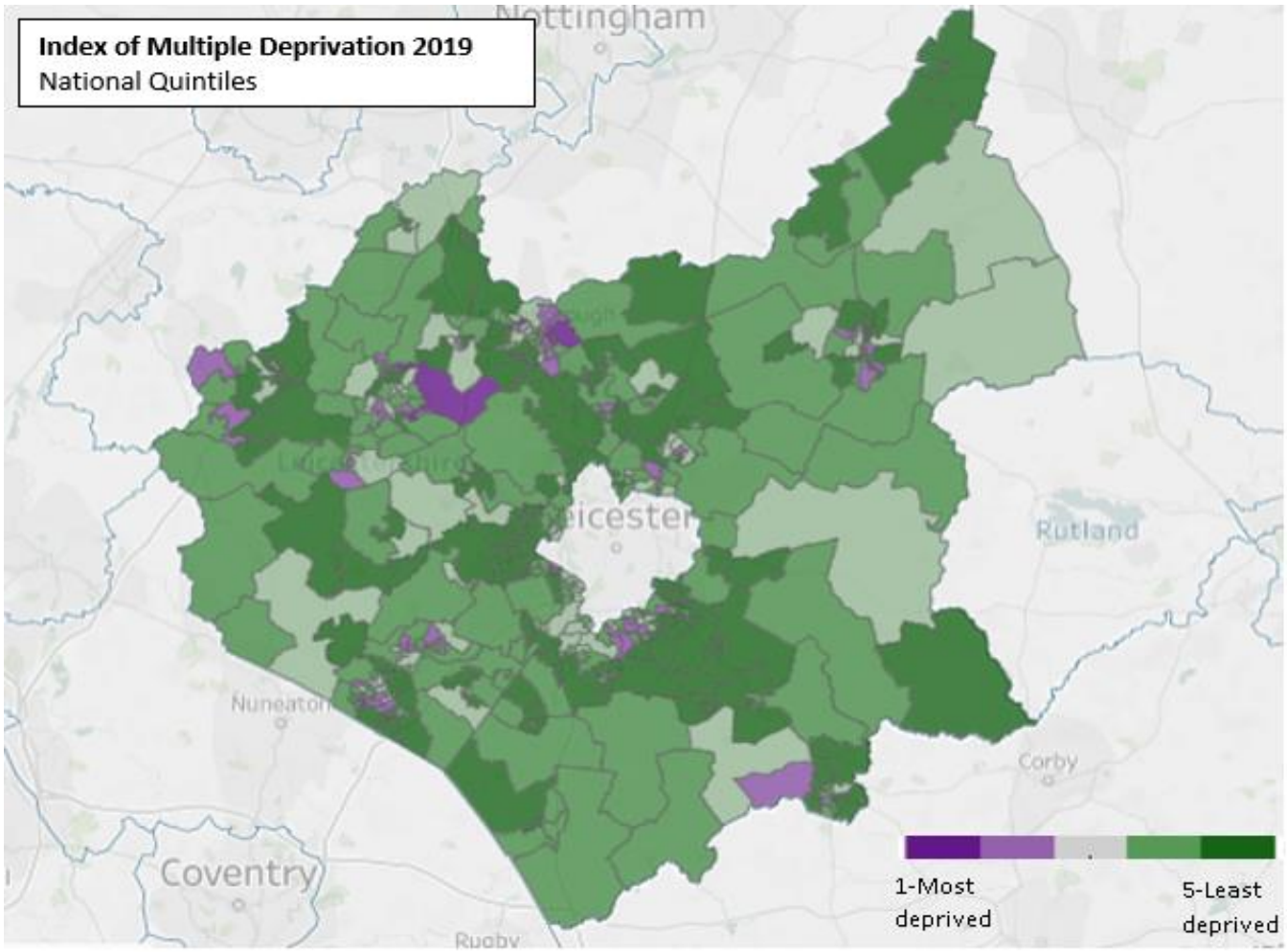
The wider determinants of health are described and measured within the English Indices of Deprivation.[9] These are a group of measures which gauge different aspects of deprivation. Deprivation is a general lack of resources and opportunities, which includes financial poverty and a range of other aspects such as lack of access to education or good quality housing. The measures are combined into an overall measure of the amount of deprivation in an area called the Index of Multiple Deprivation (IMD), which can be used to compare different local areas.[9]

The indices of deprivation use several measures in each of seven "domains":

- Income deprivation, including Income deprivation affecting children (IDACI) and Income deprivation affecting older people (IDAOPI)
- Employment deprivation
- Health deprivation and disability
- Education, skills and training deprivation
- Barriers to housing and services
- Crime; and
- Living environment deprivation.

Figure 2 presents the level of deprivation in different areas of Leicestershire according to the IMD 2019. The data are presented as "quintiles" of deprivation - areas of Leicestershire that fall into the most deprived fifth (20%) of areas in England are quintile 1, those in the second most deprived fifth of areas are quintile 2, and so on, through to quintile 5 which are areas that are within the least deprived fifth (20%) in England.

Figure 2: English Indices of Multiple deprivation 2019 by national quintile for Leicestershire[9]

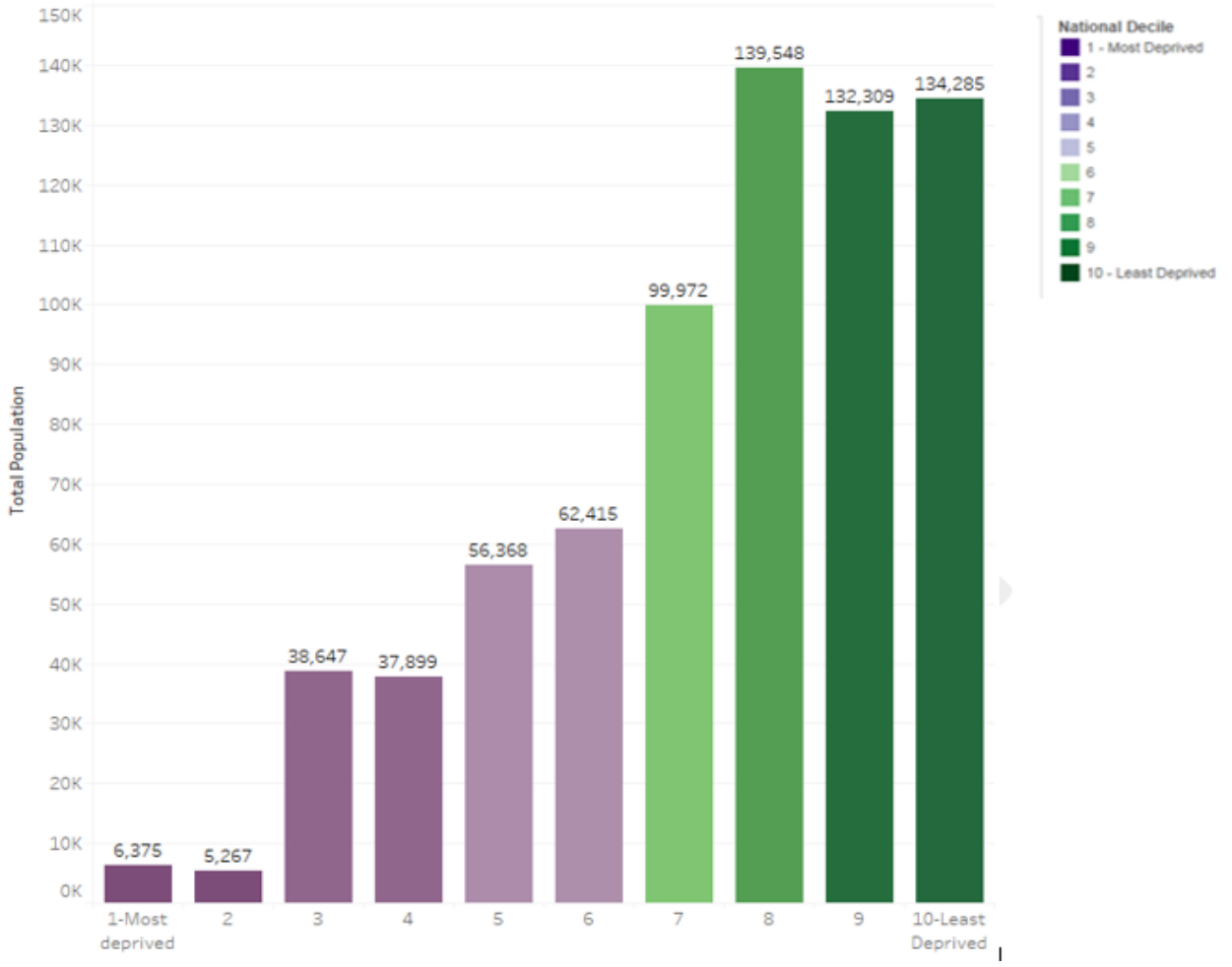


Source: Indices of Deprivation 2019, MHCLG,2019.

Figure 3 shows how much of the population of Leicestershire lives in each deprivation decile (decile 1 represents areas in the most deprived 10% nationally and decile 10 represents areas in the least deprived 10%), and demonstrates that:

- 2% of the population of Leicestershire (11,642) people live in areas categorised within the most deprived 20% (decile 1 and 2) of areas in the country.
- Three districts in Leicestershire; Charnwood, Hinckley and Bosworth and North-West Leicestershire, have areas which are in the most deprived 20% in the country.
- 11% of the Leicestershire population live in deciles 3 and 4 of deprivation (in the most deprived 20-40% of areas in England), accounting for over 76,000 people. All seven districts have people in this category of deprivation.
- Over two-thirds (71%) of the population of Leicestershire live in the least 20% deprived (deciles 9 and 10) and least 20-40% deprived areas in England.

Figure 3: Population by deprivation decile in Leicestershire, 2019[9]



Source: Indices of Deprivation 2019, MHCLG,2019. 2020 Mid-year population estimates, ONS, 2021

6.3. Ethnicity

The 2011 Census reported that 578,432 people in Leicestershire were White British, representing 88.9% of the total population. This is higher than the proportion in England of 79.8%.[10]

The most represented black and minority ethnic group was Asian Indian, with 28,598 people, 4.4% of the total population. This is higher than the proportion in England of 2.6%.[10]

7. Local Health Needs

7.1. Health Profiles

As part of the Public Health Outcomes Framework, health profiles are updated on a quarterly basis by the Office for Health Improvement & Disparities (OHID) and provide a useful snapshot of the health needs of the local population.[11] The health profiles for Leicestershire and the constituent districts are included in Appendix B. The key findings are summarised in this section.

The health of people in Leicestershire is generally better than the England average. Leicestershire's deprivation score (12.3) is lower than the national average (21.7), however about 12.3% (15,580) children live in relatively low-income families. Life expectancy at birth for both men and women are significantly better than the England average and the under 75 mortality rates for all causes, cardiovascular diseases and cancer are significantly better than the England average.[11]

Table 5 shows how people's health in each local authority district across Leicestershire compares to the rest of England. It is clear that Leicestershire performs well in many indicators, with 16 indicators that are significantly better than the England average. However, this is not consistent across all districts in Leicestershire and there is room to improve the overall health of Leicestershire's population.

The table identifies a number of areas where Leicestershire can improve health, through both focusing on areas where the county is significantly worse than the national average and focusing on the areas where Leicestershire's performance is similar to the national average.

There are just two indicators where Leicestershire as a whole performs significantly worse in comparison to the England average, namely smoking status at time of delivery and hip fractures in people aged 65 and over. However, at a district level there are several indicators where performance could be improved. North- West Leicestershire performs significantly worse than the national average for five indicators; Blaby, Charnwood and Hinckley and Bosworth for three indicators; Oadby and Wigston for two indicators, whilst Melton and Harborough each only perform significantly worse than the national average for one indicator. Breast feeding initiation is a priority in most Districts; other indicators such as levels of overweight and obesity, smoking at the time of delivery and lower rates of early cancer diagnosis are also of concern in several areas.

Appendix B - Health Profiles for Leicestershire and the Districts (February 2022)

Table 5: Health Profile Summary[11]

Source: Fingertips, Office for Health Improvement & Disparities, 2022

		Blaby	Charnwood	Harborough	Hinckley and Bosworth	Melton	North West Leicestershire	Oadby and Wigston	Leicestershire
Our Communities	1 Deprivation score (IMD 2019)								
	2 Children in relative low income families (under 16s)								
	3 Homelessness - households owed a duty								
	4 Average Attainment 8 score		#						#
	5 Violent crime - violence offences								
	6 Long-Term Unemployment								
Children's and young people's health	7 Smoking status at time of delivery		$		$				$
	8 Breastfeeding initiation		$	$		$			
	9 Year 6: Prevalence of overweight (including obesity)						#		
	10 Admissions for alcohol-specific conditions (under 18s)	$	#						
	11 Under 18s conception rate	$							
Adult's health and lifestyle	12 Smoking Prevalence in adults (18+) - current smokers								
	13 Percentage of physically active adults			#		#			
	14 Percentage of adults (18+) classified as overweight or obese	$						#	#
Disease and poor health	15 Percentage of cancers diagnosed at stages 1 and 2	$						#	
	16 Emergency Hospital Admissions for Intentional Self-Harm								
	17 Admission episodes for alcohol-specific conditions								
	18 Recorded diabetes								
	19 TB incidence (three year average)								
	20 All new STI diagnosis rate								
	21 Hip fractures in people aged 65 and over	#				#		#	
Life expectancy and mortality	22 Life expectancy at birth (Male, 1 year range)		#		#				
	23 Life expectancy at birth (Female, 1 year range)		#	$				#	
	24 Infant mortality rate								
	25 Killed and seriously injured (KSI) casualties on England's roads								
	26 Suicide rate								
	27 Smoking attributable mortality								
	28 Under 75 mortality rate from all cardiovascular diseases			$	#				
	29 Under 75 mortality rate from cancer			$		$			$
	30 Excess winter deaths index							$	
	Significantly better than the England average								
	Not significantly different from the England average								
	Significantly worse than the England average								
	No significance or not compared								
#	RAG rating has changed from Red to Amber *or* Amber to Green; i.e. performance has improved								
$	RAG rating has changed from Green to Amber *or* Amber to Red; i.e. performance has gotten worse								

7.2. Life Expectancy

Between 2018 and 2020, life expectancy for males in Leicestershire was 80.5 years and for females was 84.1 years. This is significantly better than the England average for both males and females.[11]

Healthy life expectancy for 2017-19 was 63.5 years for males and 63.6 years for females. This is not significantly different to the England average for males or females.[11]

7.3. Lifestyles

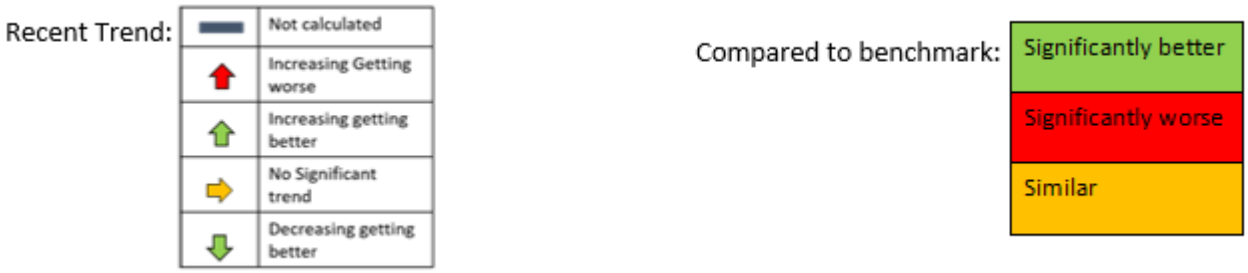
The lifestyle statistics presented below in Table 6 relate to the population of Leicestershire and they are taken from the Public Health Outcomes Framework:[11]

- In 2020, 9.3% of adults smoked. This is significantly better than the England average of 12.1%.
- In 2020/21, the rate of admission episodes for alcohol-related conditions was 404 per 100,000 (2,897 admissions). This is significantly better than the England average of 456 per 100,000 population.
- In 2019/20, 62.7% of adults were classified as overweight or obese. This is not significantly different to the England value of 62.8%.
- In 2019/20, 19.0% of children aged 4-5 years were overweight or obese. This is significantly better than the England value of 23.0%.
- In 2019/20, 30.6% of children aged 10-11 years were overweight or obese. This is significantly better than the England value of 35.2%.
- In 2019/20, 21.9% of adults were physically inactive. This is not significantly different to the England value of 22.9%.
- In 2020/21, 7.7% of people reported a low happiness score for self-reported wellbeing. This is statistically similar to the England average of 9.2%.
- In 2020/21, 22.5% of people reported a high anxiety score for self-reported wellbeing. This is statistically similar to the England average of 24.2%.

Table 6: Lifestyle statistics for Leicestershire

Indicator	Time Period	Leicestershire	England
Smoking Prevalence in adults (18+) – current smokers (APS) (2020 definition)	2020	9.3%	12.1
Admission episodes for alcohol-related conditions (Narrow): New Method (Persons) / 100,000	2020/21	404	456
Percentage of adults (aged 18+) classified as overweight or obese	2019/20	62.7%	62.8%
Reception: Prevalence of overweight (including obesity)	2019/20	19.0%	23.0%
Year 6: Prevalence of overweight (including obesity)	2019/20	30.6%	35.2%
Percentage of physically inactive adults	2019/20	21.9%	22.9%
Self-reported wellbeing – people with a low happiness score	2020/21	7.7%	9.2%
Self-reported wellbeing – people with a high anxiety score	2020/21	22.5%	24.2%

Source: Fingertips, Office for Health Improvement & Disparities, 2022



Note: recent trend is based on the most recent 5 data points

7.4. Burden of Disease in the Population

The 2020/21 Quality and Outcomes Framework Data collected by GPs gives a good indication of the numbers of patients that GPs are seeing with long term conditions.[12] The burden of disease statistics for the population of Leicestershire is presented in Table 7.

In Leicestershire there were:

- 109,966 people on GP hypertension registers, 15.2% of the total population. This is significantly higher than the England prevalence of 13.9%.
- 45,538 people on GP asthma registers, 6.7% of the total population. This is significantly higher than the England prevalence of 6.4%.
- 81,091 people on GP depression registers, 13.9% of the population aged 18 years and over. This is significantly higher than the England prevalence of 12.3%.
- 41,255 people on GP diabetes registers, 7.0% of the population aged 17 years and over. This is significantly lower than the England prevalence of 7.1%.
- 21,607 people on GP coronary heart disease registers, 3.0% of the total population.
- 25,080 people on GP cancer registers, 3.5% of the total population. This is significantly higher than the England prevalence of 3.2%.
- 13,700 people on GP stroke or transient ischaemic attacks registers, 1.9% of the total population. This is significantly higher than the England prevalence of 1.8%.
- 13,140 people on GP COPD registers, 1.8% of the total population. This is significantly lower than the England prevalence of 1.9%.

It is worth noting these are not age adjusted numbers, as such Leicestershire is likely to have higher proportions with age related conditions as the population is older than the national.

Table 7: Burden of disease in the population of Leicestershire[12]

Indicator	Time Period	Leicestershire	England
Hypertension: QOF prevalence	2020-21	15.2%	13.9%
Asthma: QOF prevalence	2020-21	6.7%	6.4%
Depression: QOF prevalence (18+)	2020-21	13.9%	12.3%
Diabetes: QOF prevalence (17+)	2020-21	7.0%	7.1%
Coronary heart disease: QOF prevalence	2020-21	3.0%	3.0%
Cancer: QOF prevalence	2020-21	3.5%	3.2%
Stroke: QOF prevalence	2020-21	1.9%	1.8%
COPD: QOF prevalence	2020-21	1.8%	1.9%

Compared to benchmark:

Significantly Higher than England Average

Significantly Lower than England Average

Source: Quality outcomes framework 2020-21

Appendix C: Quality Outcomes Framework data from Leicestershire County and the districts (2020/21)

8. Leicestershire's Health and Wellbeing Priorities

The Leicestershire Joint Health and Wellbeing Strategy (2022-32) was published in 2022.[7] The Strategy is the Health and Wellbeing Board's response to the health and wellbeing needs identified in the Joint Strategic Needs Assessment.[13] The Strategy is aligned with the Integrated Care System's requirement for the development of a Place Based Plan. A life course approach has been used to identify high level strategic, multi-organisational priorities for the next 10 years that will need to be addressed in order to improve the needs of the population and provide clear accountability to the Leicestershire Health and Wellbeing Board. These are summarised in Figure 4 below:

Figure 4: Summary of the Leicestershire Joint Health and Wellbeing Strategy (2022-32) Priorities

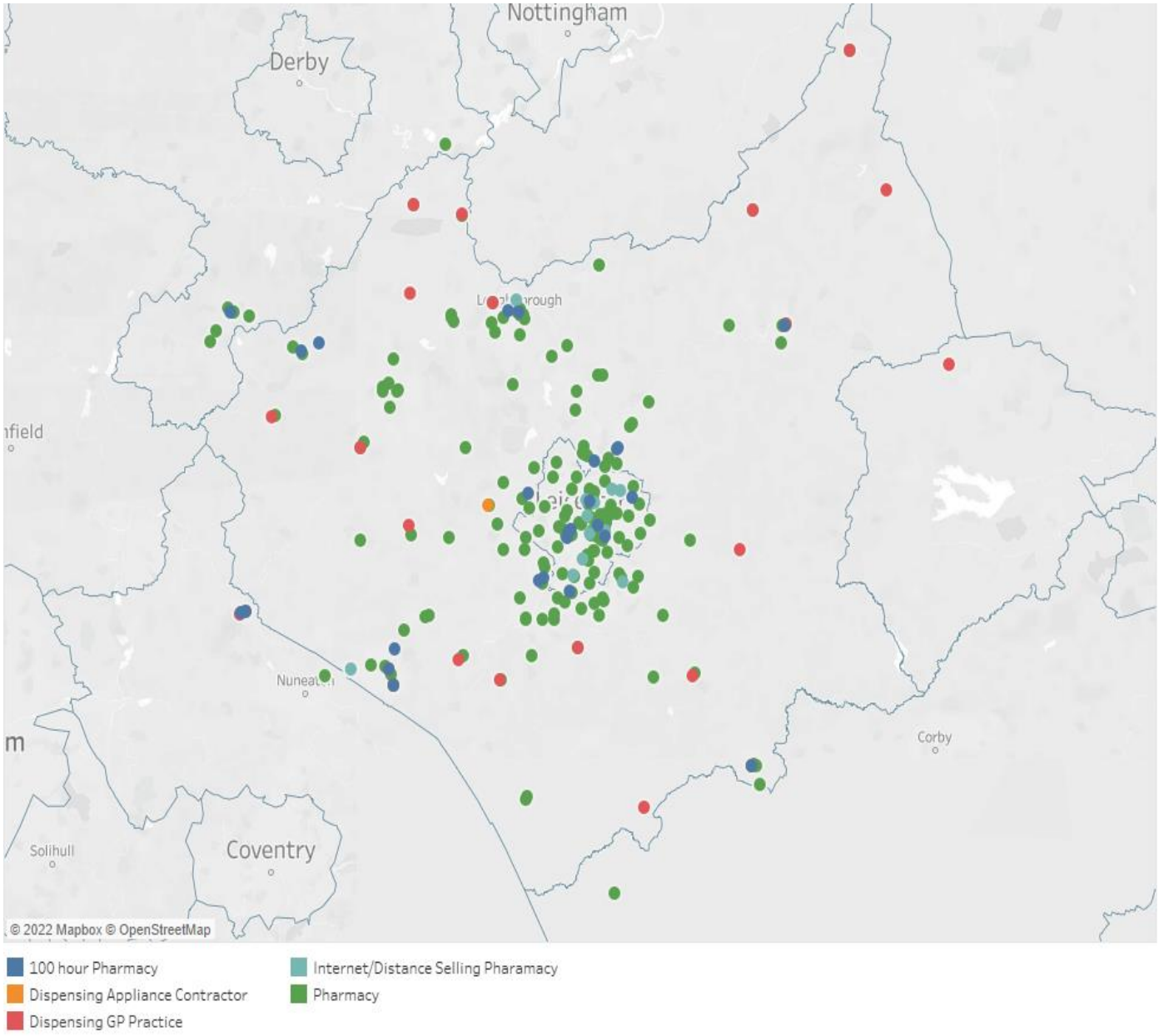
Leicestershire Joint Health and Wellbeing strategy 2022-32

The priorities have all been further developed, with sub-committees of the Health and Wellbeing Board taking these work streams forward. The Health and Wellbeing Board will publish an annual report describing the progress that is being made to deliver the Joint Health and Wellbeing Strategy.

9. Location of Pharmacies

Figure 5 shows the location and type of services in and around Leicestershire. Leicestershire has 132 pharmacies. Out of these, 128 are community pharmacies, 1 is a dispensing appliance contractor and 3 are distance selling pharmacies. There are a total of 18 GP dispensing locations.

Figure 5: Leicestershire pharmaceutical services, as of 31st March 2021



Source: NHS England & NHS Improvement, Pharmaceutical Dataset, Sept 2021

Table 8: Leicestershire Pharmaceutical Services, as of 31st March 2021

Area	Pharmacies	GP Practices with Dispensing Services	Population (Mid-2020)	Pharmacies per 10,000	Pharmacies and Dispensing Premises per 10,000 Population
Blaby	22	2	101,950	2.2	2.4
Charnwood	42	1	188,416	2.2	2.3
Harborough	13	5	95,537	1.4	1.9
Hinckley and Bosworth	19	3	113,666	1.7	1.9
Melton	9	3	51,394	1.8	2.3
North West Leicestershire	16	4	104,809	1.5	1.9
Oadby and Wigston	11	0	57,313	1.9	1.9
Leicestershire	132	18	713,085	1.9	2.1

Source: NHS England & NHS Improvement, Pharmaceutical Dataset, Sept 2021

Overall, Leicestershire has 1.9 pharmacies per 10,000 population. In 2020/21 there were 11,636 pharmacies in England.[14] With a population of 56,550,138 people in 2020,[8] the average number of community pharmacies for England is 2.1 per 10,000 population. Despite Leicestershire being a rural area, the county has a similar overall coverage of pharmacies per 10,000 population as England. This represents a good level of population coverage. The England value here has been used as a guide as there is no set target for pharmacy provision. Since 2018/19, the overall coverage of pharmacies in Leicestershire has remained at 1.9 per 10,000 population.

The coverage of pharmacies is not uniform, ranging from 1.4 pharmacies per 10,000 in Harborough to 2.2 pharmacies per 10,000 in Charnwood and Blaby. The availability of pharmacies in the localities will be driven by the rurality of large parts of Leicestershire and is mitigated by the availability of dispensing GPs. Leicestershire has 18 dispensing GP locations.

Combining community pharmacies (excluding internet pharmacies) and dispensing GPs, as the contractors that are able to provide local residents with dispensing services, gives a better indication of the total population coverage for Leicestershire. In October 2021, there were 1,050 dispensing GPs in England.[15] When combined with the number of pharmacies, this gives an England average of 2.2 contractors per 10,000 population. Leicestershire has 2.1 contractors per 10,000 population, similar to the England average. There is variation across the localities, ranging from the lowest coverage in Harborough, Hinckley and Bosworth, North-West Leicestershire and Oadby and Wigston at 1.9 per 10,000 population to 2.4 per 10,000 in Blaby. The combined provision of core pharmacy services in Leicestershire is similar to the England average and the issues linked to access are discussed further within this report.

9.1. Local Pharmaceutical Service Contract

Currently, as of 31st March 2021, there are no pharmacies in Leicestershire that are contracted by NHS England and Improvement as part of the LPS contract. However, 0.12% of items prescribed in Leicestershire were dispensed by LPS in another local authority.

9.2. Distance Selling Pharmacies

In addition to community pharmacies and dispensing GPs, residents are also able to access pharmacy services from distance selling, or internet, pharmacies both based locally in Leicestershire and further away in other areas. Leicestershire has three distance selling or internet pharmacies: in Charnwood, Hinckley and Bosworth and Oadby & Wigston.

Distance selling pharmacies are able to provide the full range of essential, advanced, and enhanced services to the population. However, a distance selling pharmacy must not provide essential services to a person who is present at the pharmacy, or in the vicinity of it.

The distance selling pharmacies do add to the overall provision in Leicestershire but will also provide services that cover a much wider area than Leicestershire. Because they are not able to provide face to face essential services, they have been excluded from the overall count of pharmacies per 10,000 population. They have not been included in the analysis examining access to services using drive and walk times. Between April 2020 and March 2021, 3.85% of all items prescribed in Leicestershire were dispensed by distance selling pharmacies in another local authority.

10. Services Available in Leicestershire

10.1. Essential Services

Essential services are provided by all pharmacies in Leicestershire, including internet pharmacies, as part of the NHS Community Pharmacy Contractual Framework. These services are managed by NHS England and NHS Improvement. They include dispensing, repeat dispensing, discharge medicines service, clinical governance, promotion of healthy lifestyles, disposal of unwanted medicines, signposting and support for self-care (see Table 1).

10.1.1. Opening hours

Pharmacies have core contractual hours of 40 per week and these are agreed with NHS England & NHS Improvement. Pharmacies across Leicestershire are open at varying times, providing a service somewhere in the county at almost all times between 6.30am and midnight, Monday to Saturday. The hours of opening for pharmacies in Leicestershire are summarised in

Figure 6 and Table 9.

Figure 6: Leicestershire pharmacies by opening hour category

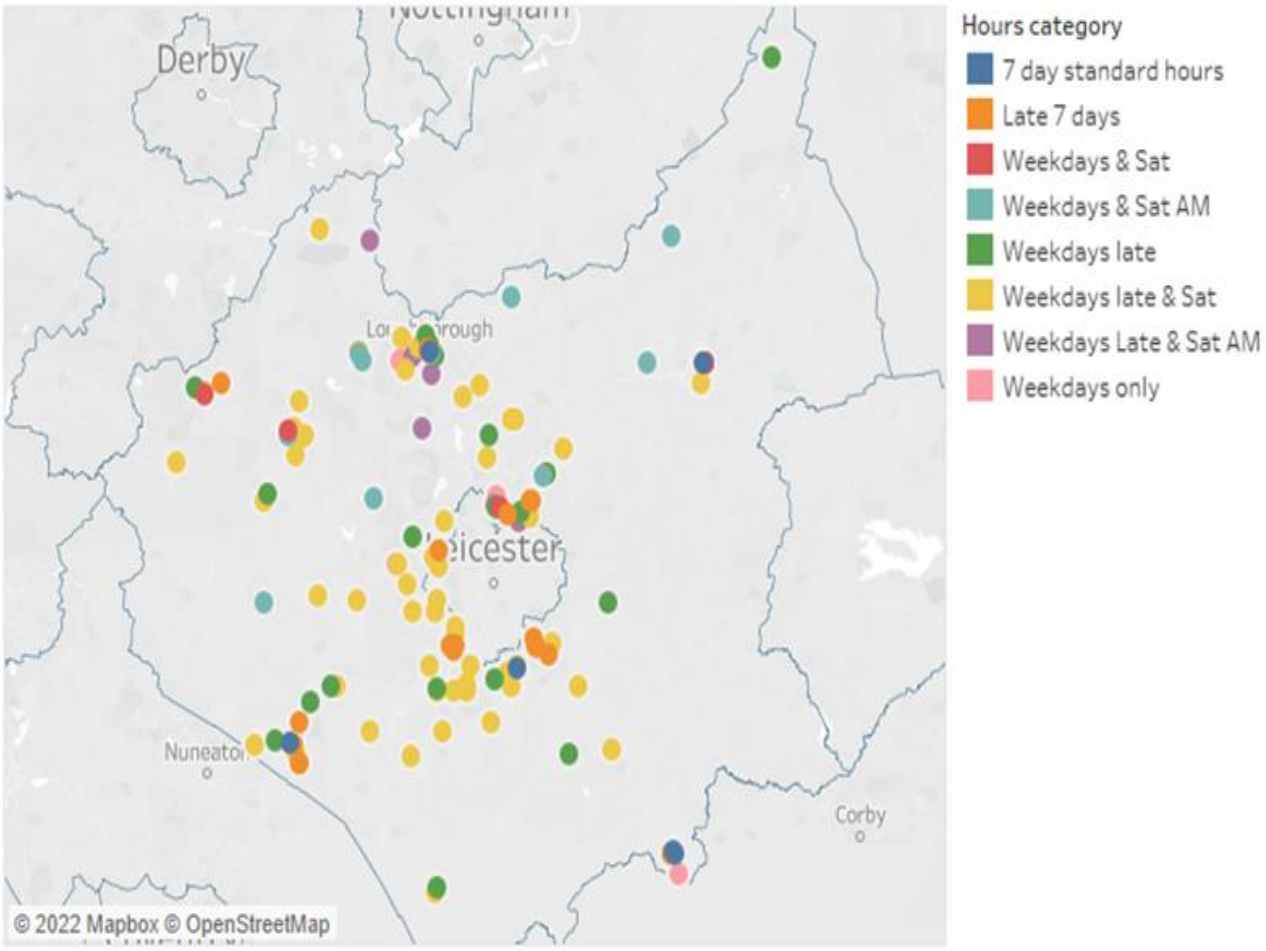


Table 9: Leicestershire pharmacies by opening hour category, 2020/21

	7 day standard hours	Late 7 days	Weekdays & Sat	Weekdays & Sat AM	Weekdays late	Weekdays late & Sat	Weekdays Late & Sat AM	Weekdays only	Grand Total
Blaby		4			1	17			22
Charnwood	1	5	2	5	7	15	5	2	42
Harborough	2	2			4	4		1	13
Hinckley & Bosworth	1	4		2	4	7		1	19
Melton	1		3	2	1	2			9
NW Leicestershire		1	2	1	2	9	1		16
Oadby & Wigston	1	3			1	5		1	11
Grand Total	6	19	7	10	20	59	6	5	132

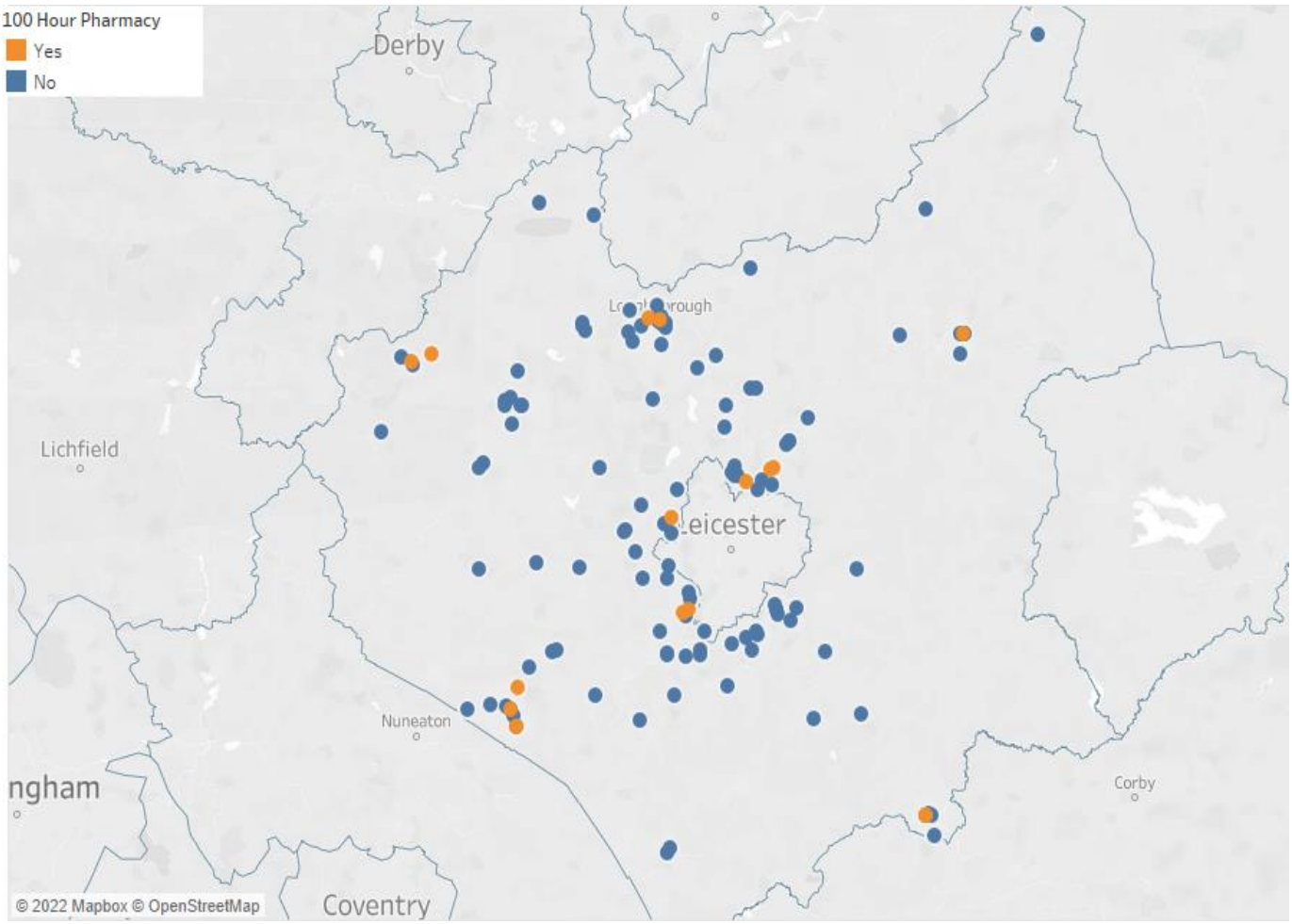
Source: NHS England & NHS Improvement, Pharmaceutical Dataset, Sept 2021

Services are more restricted on Sundays and Bank Holidays, but pharmaceutical provision is available from 8am until 10pm in the county. Across Leicestershire, 18.9% (25) of pharmacies are open 7 days a week (standard and late hours), with Charnwood (6) having the most pharmacies available on a Sunday, whilst Melton and North West Leicestershire each have the least with only one pharmacy open on a Sunday. Out of the 132 pharmacies in Leicestershire, 44.6% (59) are open late during the weekend and on a Saturday, ranging from 17 pharmacies in Blaby to 2 in Melton.

Derbyshire Health United (DHU) Health Care Community Interest Company runs the Clinical Navigation Hub and Home Visiting Service. These services have access, through an on-call pharmacist, to out of hours on call pharmacy provision for Leicestershire which ensures urgent prescriptions are dispensed during the out of hours and bank holiday period.

In Leicestershire, there are 16 pharmacies that are contracted to open for 100 hours per week, as illustrated in Figure 7. Oadby and Wigston is the only district without a 100-hour pharmacy, however, proximity to city pharmacies reduces the impact of this.

Figure 7: Leicestershire 100-hour pharmacies, 2020/21



Source: NHS England & NHS Improvement, Pharmaceutical Dataset, Sept 2021

10.1.2. Prescribing Activity

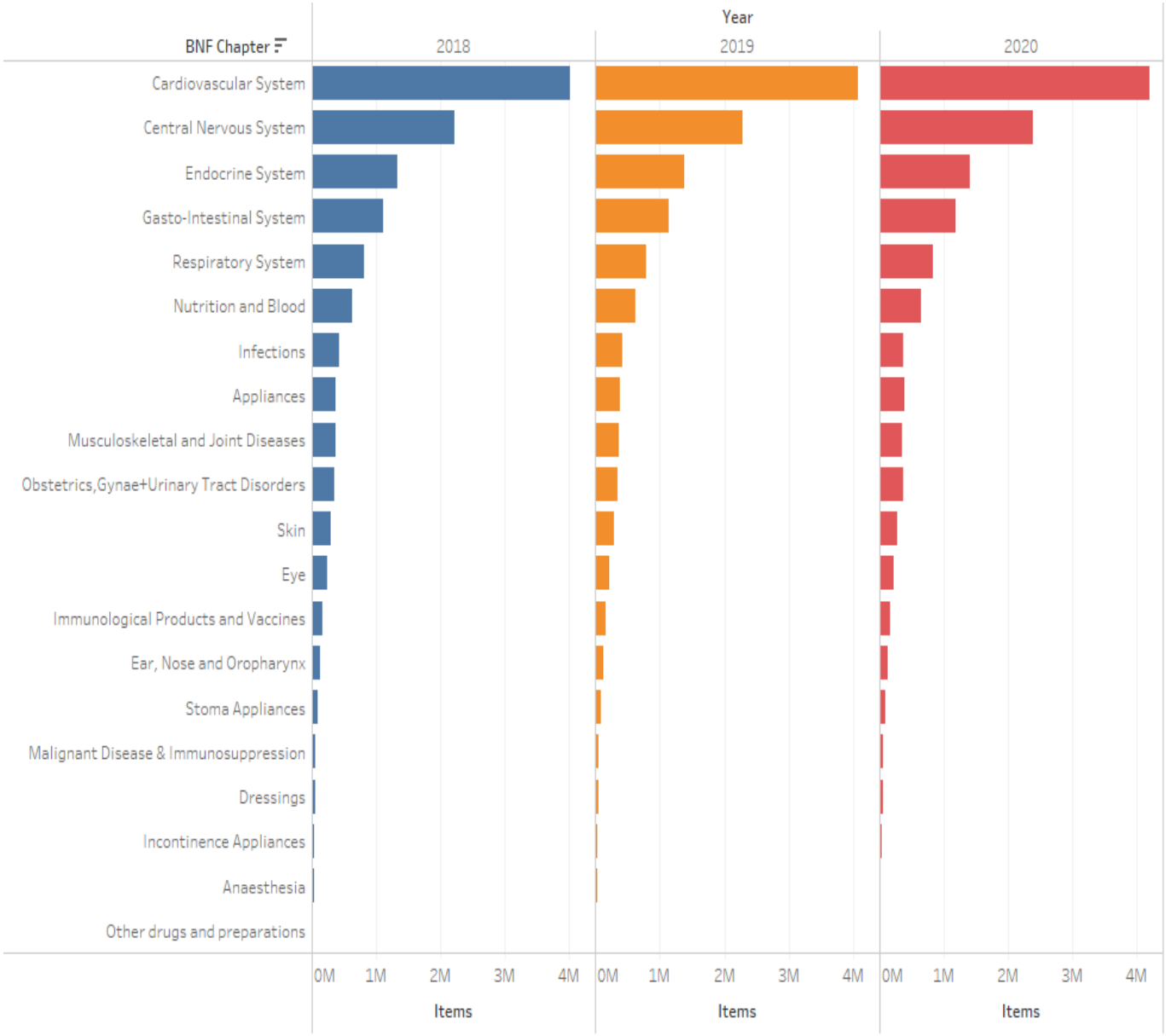
GP practices in Leicestershire prescribed over 13.1 million items in 2020[16]. This is over 18 items per head of the registered population, including repeat prescriptions.[17] Hinckley and Bosworth (22.4) had the highest items prescribed per head of the registered population and Melton had the lowest (13.3). The largest proportions of prescriptions in 2018 to 2020 were drugs for the cardiovascular system which includes treatments for high cholesterol and hypertension. This correlates with the disease prevalence data included in Section 7.4. More details are shown in Table 10 and Figure 8. The prescriptions are dispensed by community pharmacies, internet pharmacies and dispensing GP practices.

Table 10: Number of items prescribed for Leicestershire 2020

Area	Items Prescribed	Registered population (as of December 2020)	Items per head population
Blaby	1,773,470	108,245	16.4
Charnwood	3,339,195	197,616	16.9
Harborough	1,893,003	91,994	20.6
Hinckley and Bosworth	2,431,990	108,585	22.4
Melton	716,784	53,894	13.3
North West Leicestershire	2,027,062	111,491	18.2
Oadby and Wigston	1,012,697	58,924	17.2
Leicestershire	13,185,201	730,749	18.0

Source: GP Prescribing data, 2020. Open Prescribing beta.

Figure 8: Prescribing activity by BNF Chapter for Leicestershire 2018-20



10.1.3. Drive and Walk Time Analysis

Using the Strategic Health Asset Planning and Evaluation (SHAPE) Place tool[18] it is possible to analyse how long it takes to walk or drive from any Lower Super Output Area (LSOA) to the nearest pharmacy or dispensing GP practice location. Pharmacies and dispensing GPs 1.5km outside of the Leicestershire boundary have been included in this analysis. The drive-time map for Leicestershire pharmacies is shown in

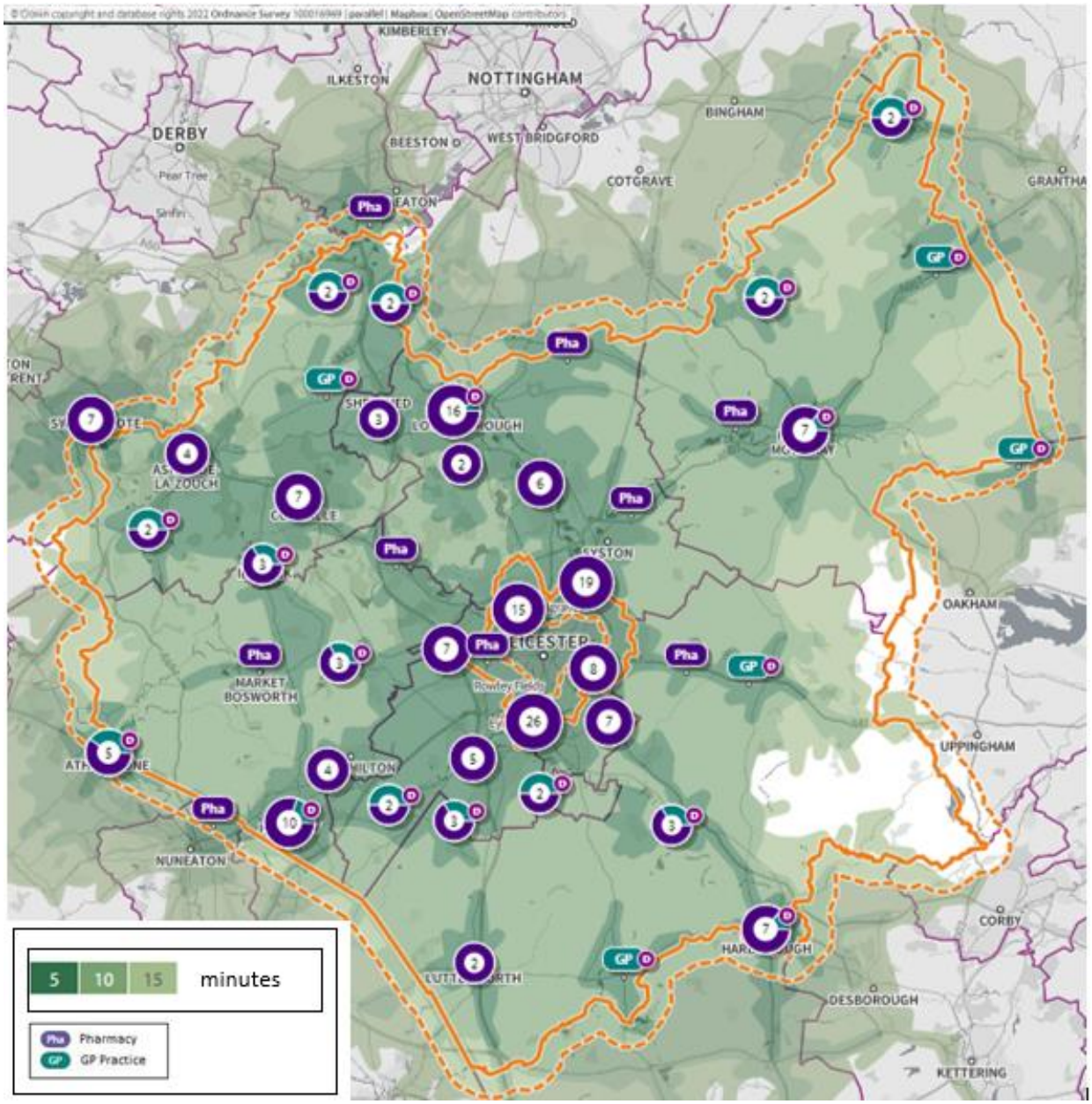
Figure 9. Although some areas of the county appear to be outside of the 15-minute drive boundary, the areas covered have a low proportion of the population of the county, as shown in Table 11.

It is important to note that not everyone will access their nearest pharmacy and may choose to access a pharmacy outside their local area.

Overall, 91.4% of the Leicestershire population live within a five-minute drive time of a pharmacy or dispensing GP practice and 0.3% of the population (2,432 people) live outside of the 15-minute drive time boundary.

All the population outside the 15 minutes' drive live in the district of Harborough with 2.5% of Harborough's population living more than 15 minutes' drive from a pharmacy or dispensing GP. In contrast, the whole population of Oadby and Wigston live within a 5-minute drive of a pharmacy or dispensing GP practice.

Figure 9: Drive time to nearest pharmacy or dispensing GP practice location



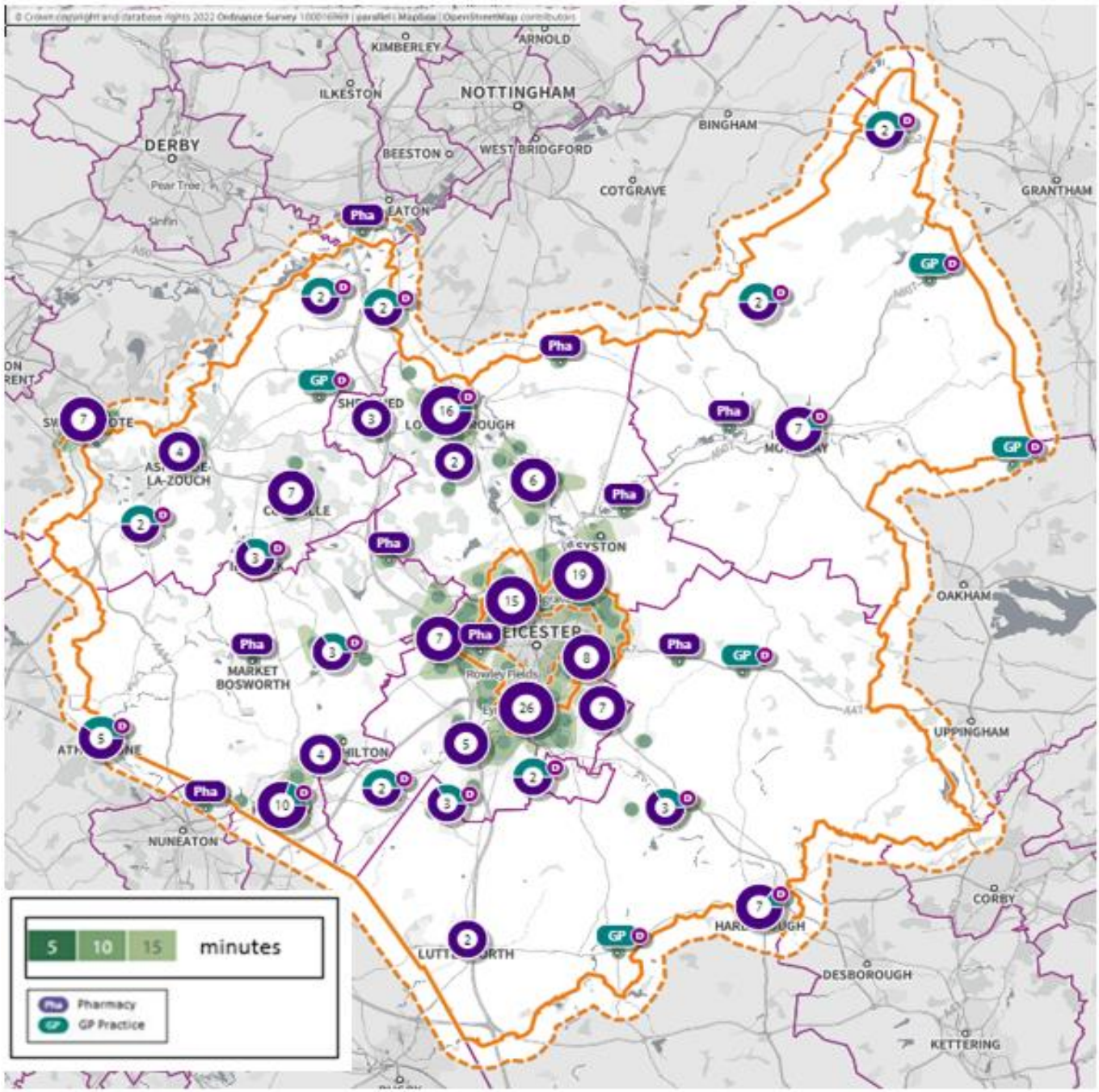
Source: Strategic Health Asset Planning and Evaluation, 2022.

Table 11: Population by drive-time

	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Blaby	100,571	98.6%	1,379	1.4%	0	0.0%	0	0.0%
Charnwood	180,421	95.8%	7,995	4.2%	0	0.0%	0	0.0%
Harborough	81,304	85.1%	11,801	12.4%	0	0.0%	2432	2.5%
Hinckley and Bosworth	99,697	87.7%	12,154	10.7%	1,815	1.6%	0	0.0%
Melton	39,592	77.0%	8,325	16.2%	3,477	6.8%	0	0.0%
North West Leicestershire	92,944	88.7%	11,865	11.3%	0	0.0%	0	0.0%
Oadby & Wigston	57,313	100.0%	0	0.0%	0	0.0%	0	0.0%
Leicestershire	651,842	91.4%	53,519	7.5%	5,292	0.7%	2432	0.3%

Table 12 illustrates the walk time to a pharmacy or dispensing GP surgery. Overall, over a third of the county's population live less than a 5-minute walk from a pharmacy, just under a quarter (24.3%) live between 6- and 10-minutes' walk, over 15 percent (15.5%) live between 11- and 15-minutes' walk, and just over a quarter (25.5%) live over a 15-minute walk time.

Figure 10: Walking time to the nearest pharmacy or dispensing GP surgery



Source: Strategic Health Asset Planning and Evaluation, 2022.

Table 12: Population by walk-time

	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Blaby	46,307	45.4%	23,324	22.9%	18,158	17.8%	14161	13.9%
Charnwood	79,099	42.0%	60,265	32.0%	21,413	11.4%	27639	14.7%
Harborough	19,932	20.9%	24,034	25.2%	16,798	17.6%	34773	36.4%
Hinckley and Bosworth	38,012	33.4%	24,525	21.6%	19,744	17.4%	31385	27.6%
Melton	10,196	19.8%	10,576	20.6%	4,773	9.3%	25849	50.3%
North West Leicestershire	27,239	26.0%	19,576	18.7%	16,630	15.9%	41364	39.5%
Oadby & Wigston	25,987	45.3%	11,220	19.6%	13,104	22.9%	7002	12.2%
Leicestershire	**246,772**	**34.6%**	**173,520**	**24.3%**	**110,620**	**15.5%**	**182173**	**25.5%**

Source: Strategic Health Asset Planning and Evaluation, 2022.

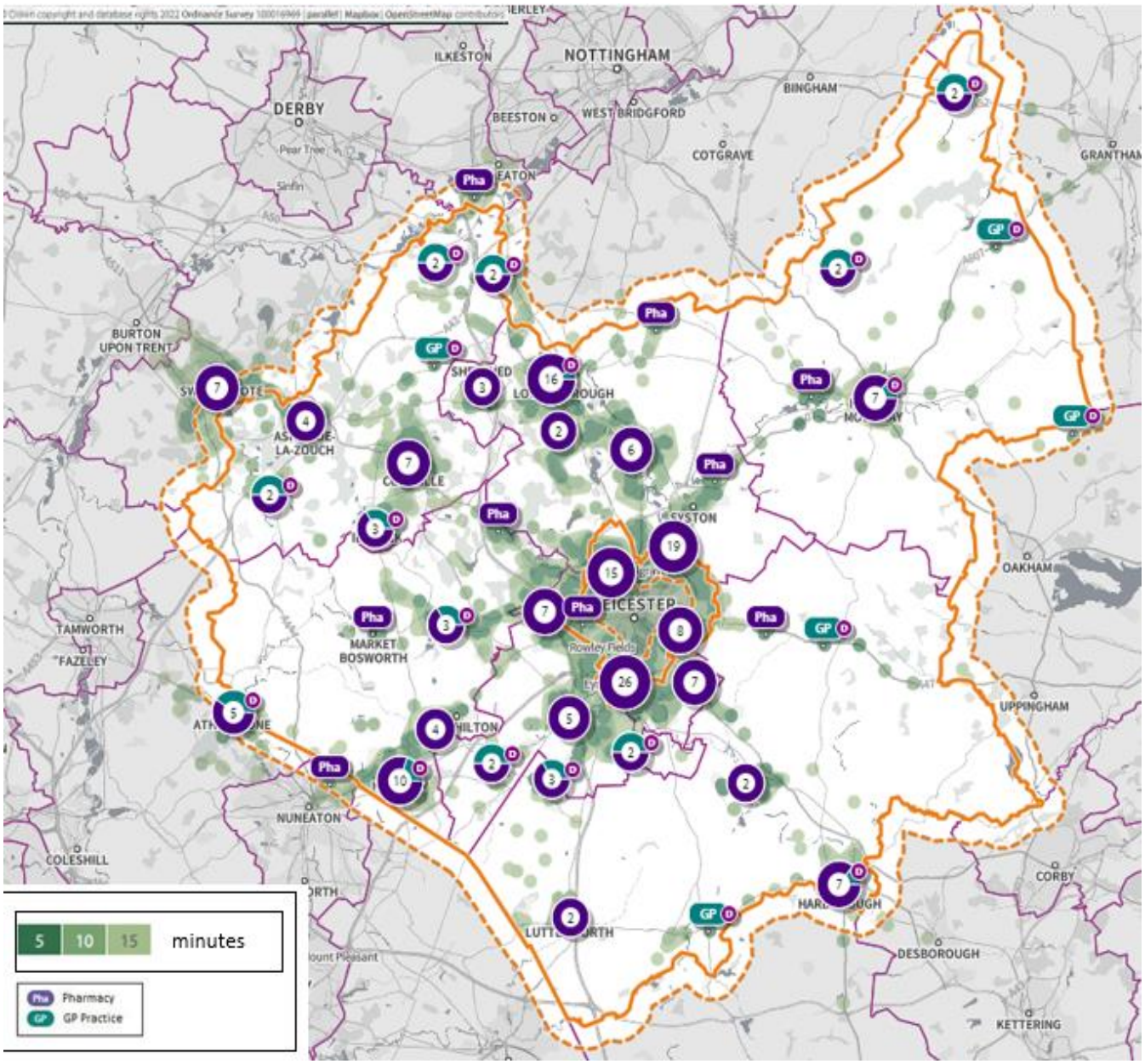
10.1.4. Public Transport

There are a range of public transport services available across the county. These can be viewed at the Leicestershire County Council website: https://www.leicestershire.gov.uk/roads-and-travel/buses-and-public-transport

Using the Strategic Health Asset Planning and Evaluation (SHAPE) Place tool[19] it is possible to analyse how long it takes by public transport on a weekday morning from any Lower Super Output Area (LSOA) to the nearest pharmacy or dispensing GP practice location. Pharmacies and dispensing GPs 1.5km outside of the Leicestershire boundary have been included in this analysis.

Table 13 and Figure 11 illustrate public transport times on a weekday morning to pharmacies in the county and by district. Overall, only 7.8% of the county's population live more than 15-minutes by public transport from a pharmacy or dispensing GP practice on a weekday morning, 10.6% live between 11- and 15-minutes' journey, 36.0% live between 6 and 10 minutes and 45.7% live within a 5-minute journey time. Weekend and afternoon public transport services will present a different percentage of the population within these journey times.

Figure 11: Public transport time to the nearest pharmacy on weekday mornings



Source: Strategic Health Asset Planning and Evaluation, 2022.

Table 13: Population by public transport travel time on weekday mornings

Area	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Blaby	62,447	61.3%	32,660	32.0%	4,361	4.3%	2482	2.4%
Charnwood	107,385	57.0%	66,757	35.4%	11,101	5.9%	3173	1.7%
Harborough	23,369	24.5%	43,272	45.3%	14,815	15.5%	14081	14.7%
Hinckley & Bosworth	46,785	41.2%	41,869	36.8%	14,792	13.0%	10220	9.0%
Melton	13,384	26.0%	13,948	27.1%	13,394	26.1%	10668	20.8%
North West Leicestershire	41,447	39.5%	33,749	32.2%	14,903	14.2%	14710	14.0%
Oadby & Wigston	30,712	53.6%	24,682	43.1%	1,919	3.3%	0	0.0%
Leicestershire	**325,529**	**45.7%**	**256,937**	**36.0%**	**75,285**	**10.6%**	**55334**	**7.8%**

Source: Strategic Health Asset Planning and Evaluation, 2022

10.1.5. Access and populations affected by deprivation

Table 16 14, 15 and 16 show drive, walk and public transport times respectively for the population living in areas classified into local deprivation quintiles.

- 100% of those living in the most deprived areas in Leicestershire are within a 5-minute drive of a pharmacy or dispensing GP practice.
- 0.9% of those living in the least deprived areas are more than a 10-minute drive from a pharmacy or dispensing GP practice.
- 28.9% of people living in Leicestershire's most deprived areas live more than a 15-minute walk from the nearest pharmacy or dispensing GP practice.
- 100% of those living in the most deprived areas in Leicestershire are within a 10-minute public transport journey on a weekday morning of a pharmacy or dispensing GP practice.

Table 14: Estimated population by deprivation quintile and drive times

	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quintile 1- Most Deprived	11642	100.0%	0	0.0%	0	0.0%	0	0.0%
Quintile 2	76546	100.0%	0	0.0%	0	0.0%	0	0.0%
Quintile 3	107600	90.6%	11183	9.4%	0	0.0%	0	0.0%
Quintile 4	206796	86.3%	29101	12.1%	3623	1.5%	0	0.0%
Quintile 5- Least Deprived	249258	93.5%	249258	93.5%	1669	0.6%	2432	0.9%

Source: Strategic Health Asset Planning and Evaluation, 2022

Table 15: Estimated population by deprivation quintile and walking times

	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Quintile 1- Most Deprived	3381	29.0%	2263	19.4%	2631	22.6%	3367	28.9%
Quintile 2	38439	50.2%	22147	28.9%	4381	5.7%	11579	15.1%
Quintile 3	54041	45.5%	30518	25.7%	16426	13.8%	17798	15.0%
Quintile 4	77148	32.2%	47222	19.7%	39374	16.4%	75776	31.6%
Quintile 5- Least Deprived	73763	27.7%	71370	26.8%	47808	17.9%	73653	27.6%

Source: Strategic Health Asset Planning and Evaluation, 2022

Table 16: Estimated population by deprivation quintile and public transport journey time on weekday mornings

	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Quintile 1- Most Deprived	3381	29.0%	8261	71.0%	0	0.0%	0	0.0%
Quintile 2	51537	67.3%	19825	25.9%	3010	3.9%	2174	2.8%
Quintile 3	66605	56.1%	38246	32.2%	1287	1.1%	12645	10.6%
Quintile 4	101979	42.6%	71125	29.7%	39560	16.5%	26856	11.2%
Quintile 5- Least Deprived	102027	38.3%	119480	44.8%	31428	11.8%	13659	5.1%

Source: Strategic Health Asset Planning and Evaluation, 2022

10.1.6. Access and People by Age Profile

Table 17, Table 18 and Table 19 show drive, walk and public transport times respectively for the estimated population belonging to each age band.

- 10.2% of the population aged 65-84 in Leicestershire are more than a 5-minute drive from a pharmacy or dispensing GP practice, compared with 8.6% of the total population.
- Over half (62.8%) of the population aged 15-24 live within a 10-minute walk from their nearest pharmacy or dispensing GP practice, compared with 57.3% of the population aged 65-84 years.
- Although over a quarter half (25.5%) of Leicestershire's population live more than a 15-minute walk from a pharmacy or dispensing GP practice, this proportion is higher for 65–84-year-olds (27.0%).
- Just under half of the population (45.7%) live less than 5 minutes by public transport on weekday mornings from a pharmacy or dispensing GP practice. This proportion is higher for 15–24 year-olds (50.2%).

Table 17: Estimated population by age and drive times

	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
0-14	110,094	92.1%	8,324	7.0%	763	0.6%	386	0.3%
15-24	78,244	93.1%	5,076	6.0%	557	0.7%	203	0.2%
25-64	331,475	91.4%	27,335	7.5%	2710	0.7%	1,243	0.3%
65-84	114,817	89.8%	11,333	8.9%	1151	0.9%	542	0.4%
85+	17,212	91.4%	1,451	7.7%	111	0.6%	58	0.3%

Source: Strategic Health Asset Planning and Evaluation, 2022

Table 18: Estimated population by age and walk times

	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
0-14	40,300	33.7%	29,701	24.8%	18765	15.7%	30,801	25.8%
15-24	33,179	39.5%	19,610	23.3%	12811	15.2%	18,480	22.0%
25-64	124,627	34.4%	88,332	24.3%	55840	15.4%	93,964	25.9%
65-84	41,950	32.8%	31,370	24.5%	20011	15.7%	34,512	27.0%
85+	6,716	35.7%	4,507	23.9%	3193	17.0%	4,416	23.4%

Source: Strategic Health Asset Planning and Evaluation, 2022

Table 19: Estimated population by age and public transport journey time on weekday mornings

	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
0-14	54,454	45.5%	43,510	36.4%	12615	10.6%	8,988	7.5%
15-24	42,192	50.2%	28,880	34.3%	7727	9.2%	5,281	6.3%
25-64	164,841	45.4%	130,524	36.0%	38770	10.7%	28,628	7.9%
65-84	55,477	43.4%	46,954	36.7%	14277	11.2%	11,135	8.7%
85+	8,565	45.5%	7,069	37.5%	1896	10.1%	1,302	6.9%

Source: Strategic Health Asset Planning and Evaluation, 2022

10.1.7. Access and Rurality

Table 20, Table 21 and Table 22 show drive, walk and public transport times respectively for the estimated population by Rural Urban classification.[20] This illustrates that:

- 100% of those living in 'urban city and town' and 'rural town and fringe' areas in Leicestershire are within a 10-minute drive of a pharmacy or dispensing GP practice
- 2.8% of those living in 'rural village and dispersed' areas are more than a 15-minute drive from a pharmacy or dispensing GP practice
- 85% of those living in 'rural village and dispersed' areas in Leicestershire are more than a 15-minute walk from a pharmacy or dispensing GP practice
- 55.6% of those in 'rural village and dispersed' areas in Leicestershire are more than 15-minutes public transport journey on a weekday morning of from a pharmacy or dispensing GP practice.

Table 20: Estimated population by rurality and drive times

	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Rural town and fringe	125750	95.9%	5317	4.1%	0	0.0%	0	0.0%
Rural village and dispersed	30575	35.3%	30575	35.3%	5292	6.1%	2432	2.8%
Urban city and town	495517	100.0%	0	0.0%	0	0.0%	0	0.0%

Source: Strategic Health Asset Planning and Evaluation, 2022

Table 21: Estimated population by rurality and walk times

	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Rural town and fringe	65057	49.6%	24186	18.5%	17211	13.1%	24613	18.8%
Rural village and dispersed	3270	3.8%	3207	3.7%	6487	7.5%	73537	85.0%
Urban city and town	178445	36.0%	146127	29.5%	86922	17.5%	84023	17.0%

Source: Strategic Health Asset Planning and Evaluation, 2022

Table 22: Estimated population by rurality and public transport journey time on weekday mornings

	Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Rural town and fringe	77809	59.4%	41776	31.9%	9308	7.1%	2174	1.7%
Rural village and dispersed	3270	3.8%	11453	13.2%	23659	27.4%	48119	55.6%
Urban city and town	244450	49.3%	203708	41.1%	42318	8.5%	5041	1.0%

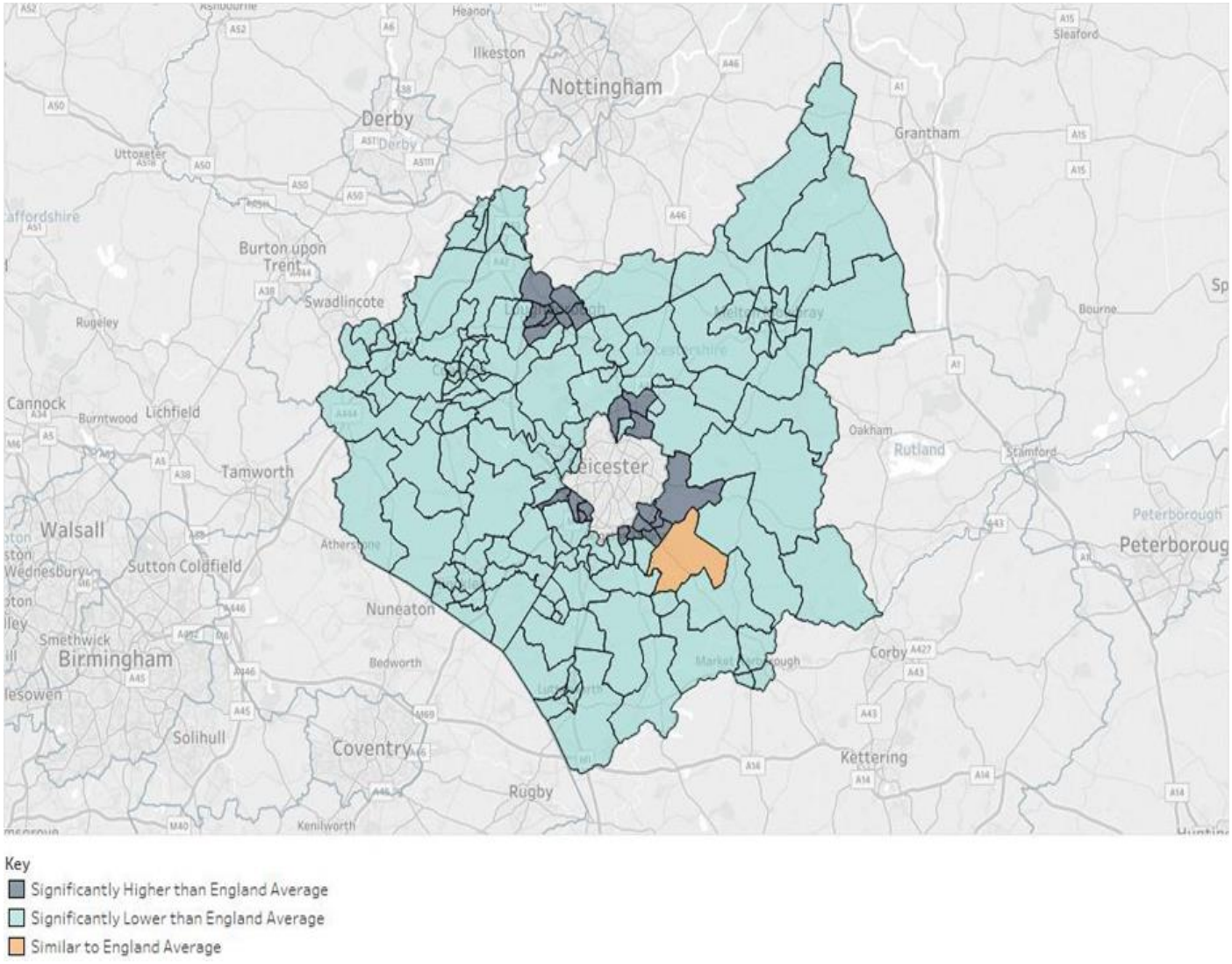
Source: Strategic Health Asset Planning and Evaluation, 2022.

10.1.8. Access and Language

The 2011 Census found that the main language spoken throughout all Middle Super Output Areas (MSOAs) in Leicestershire was English.[10] However, understanding the proficiency of English and other languages spoken by the population of Leicestershire is essential to ensure the population is able to access the appropriate service to treat their health needs.

Figure 12 shows there are multiple areas in the county where the percentage of the population who cannot speak English well or cannot speak English at all is significantly higher than the national average. These areas are Loughborough, Thurmaston, Oadby and areas in Blaby.

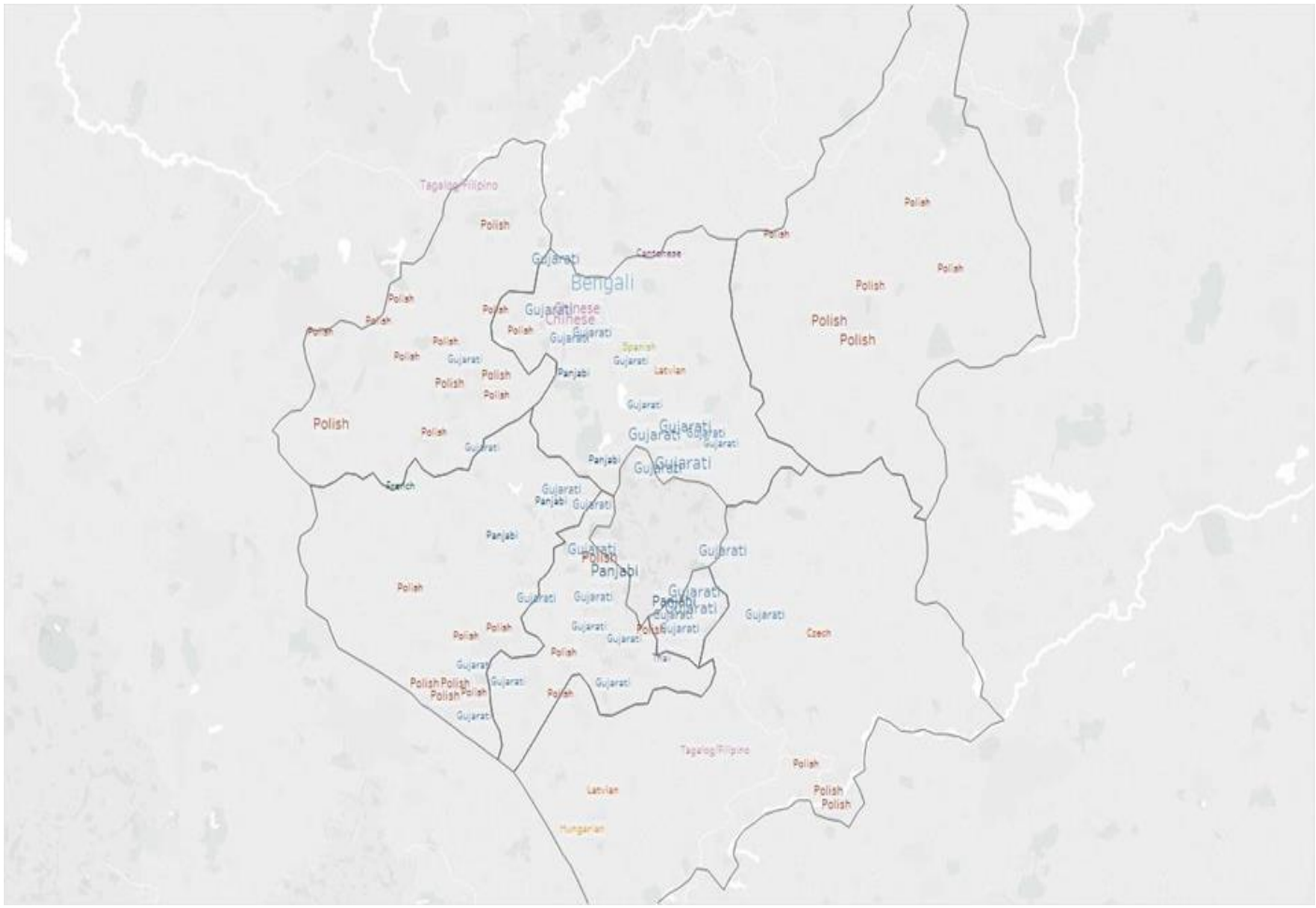
Figure 12: English proficiency (the percentage of people that cannot speak English well or at all) in Leicestershire,2011[10]



Source: 2011 Census, ONS, 2012.

Figure 13 examines the second most prevalent language spoken throughout the MSOAs in Leicestershire. The figure shows that in areas of Blaby, Charnwood and Oadby and Wigston, Gujarati and Punjabi are spoken as the main languages. There is a large population who speak Bengali as their main language in Loughborough and in areas of Hinckley, Melton and North-West Leicestershire, the second most prevalent main language is Polish.

Figure 13: Second most prevalent language spoken in Middle Super Output Areas in Leicestershire[10]



Source: 2011 Census, ONS,2012.

In the PNA engagement activity (described in PNA Professional Results below) responders reported Gujarati was spoken in 53% of pharmacies, Punjabi in 47%, Urdu in 20% and Polish in 12%. Gujarati is spoken by staff in four pharmacies in Blaby, 12 in Charnwood, four in Harborough, two in Hinckley and Bosworth, one in North West Leicestershire and four in Oadby and Wigston. Punjabi is spoken by staff in four pharmacies in Blaby, nine in Charnwood, three in Harborough, two in Hinckley and Bosworth, three in North West Leicestershire and three in Oadby and Wigston. Urdu is spoken by staff in two pharmacies in Blaby, two in Charnwood, one in Harborough, one in Hinckley and Bosworth, two in North West Leicestershire and two in Oadby and Wigston. Polish is spoken in two Pharmacies in Hinckley and Bosworth and one pharmacy each in Charnwood, Melton, North west Leicestershire and Oadby and Wigston. The absence of Polish spoken by staff in Blaby and Harborough potentially represents a barrier to the access of pharmaceutical services for this community. No Pharmacies in Melton reported having speakers of Gujarati, Punjabi or Urdu however from the above map it can be seen this is not a language widely spoken in the district.

It should also be noted the Pharmacy professional survey was not completed by every pharmacy in the county and all questions were optional.

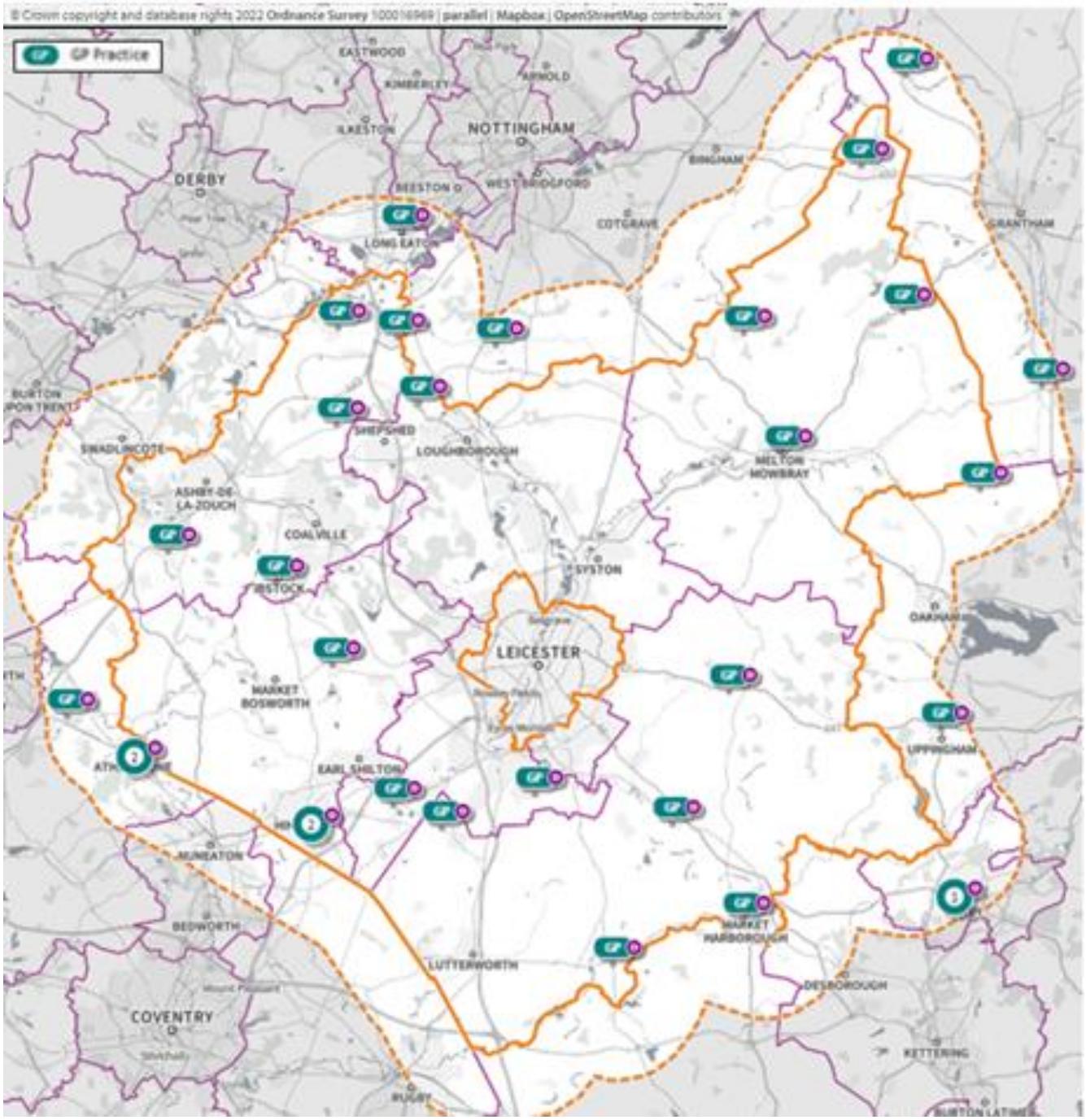
10.1.9. GP Dispensing

Dispensing doctors may generally only provide pharmaceutical services to patients who live in a designated controlled locality and more than 1.6km (1 mile) from a pharmacy. A controlled locality is an area that has been determined, by NHS England and NHS Improvement, a predecessor organisation or on appeal by the NHS Litigation Authority's Family Health Services Appeal Unit (FHSAU), to be 'rural in character'.[2]

Patients may at any time request in writing that their GP practice provides them with pharmaceutical services. The practice should then check that they meet one of the conditions to be designated a dispensing practice. The purpose of GP dispensing is to recognise the difficulties of providing a full range of essential pharmacy services in rural areas and to provide the patients that live in rural areas with an alternative provider for dispensing services. Leicestershire (and surrounding 1.5km) has 20 GP dispensing locations illustrated in Figure 14. Dispensing GPs within 5km of the border with the county are also present in Figure 14. The areas that are designated as rural in Figure 15 represent the controlled localities in Leicestershire.

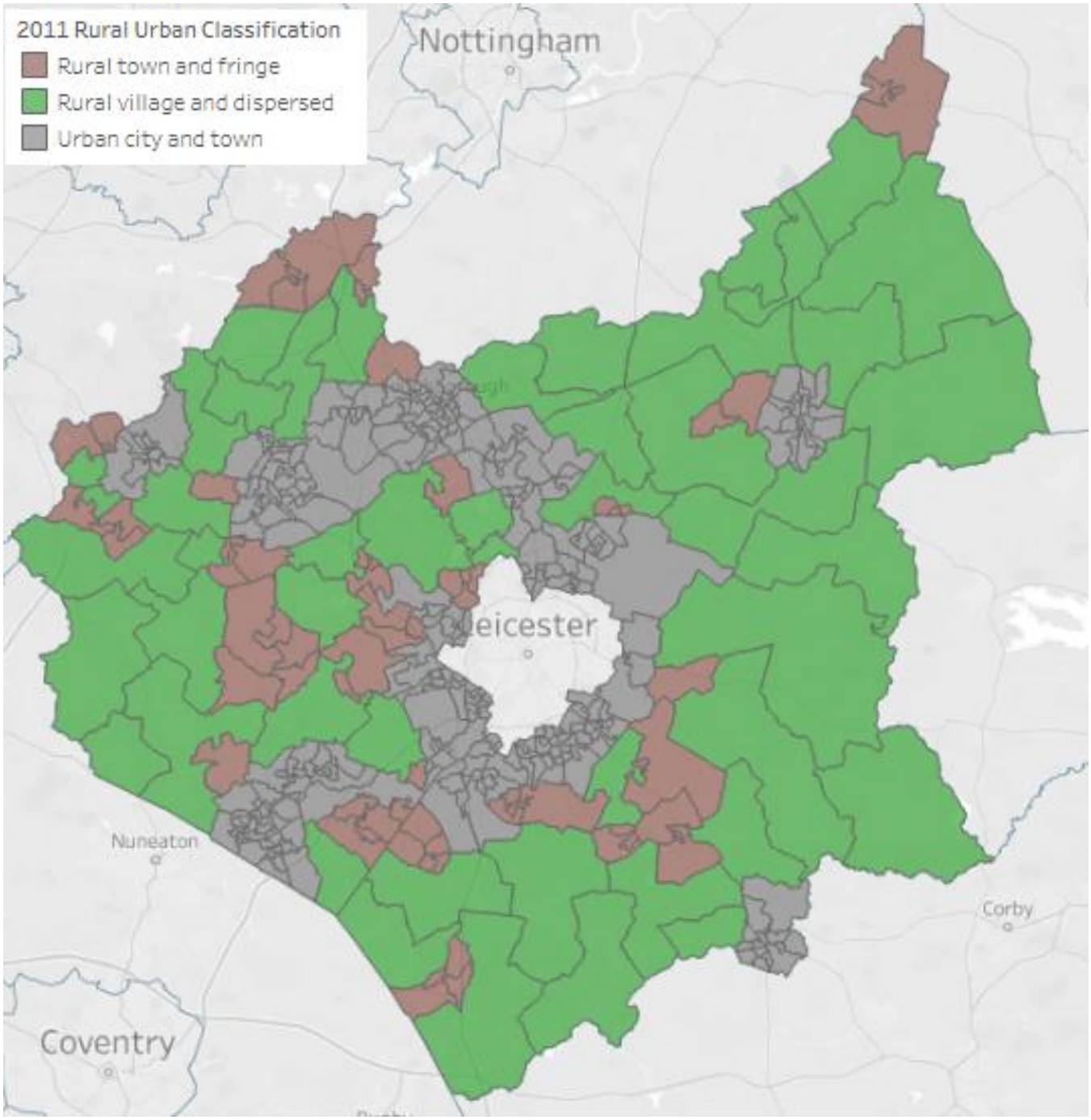
The dispensing GP surgeries are spread across the localities and whilst a patient may live over a 15-minute walk or 20-minute drive time to their nearest pharmacy or dispensing GP surgery, there is a strong correlation between the walk time analysis and the rural area designation. Designated patients in need of dispensing services will be able to access these as part of their GP visit; but the opening times of GP surgeries will restrict this. The drive and walk time analysis within this report includes the time it will take the people of Leicestershire to get to either a community pharmacy or a dispensing GP surgery.

Figure 14: Dispensing GP practices



Source: Strategic Health Asset Planning and Evaluation, 2022.

Figure 15: Urban and Rural areas, Leicestershire



Source: 2011 Census, ONS,2012.

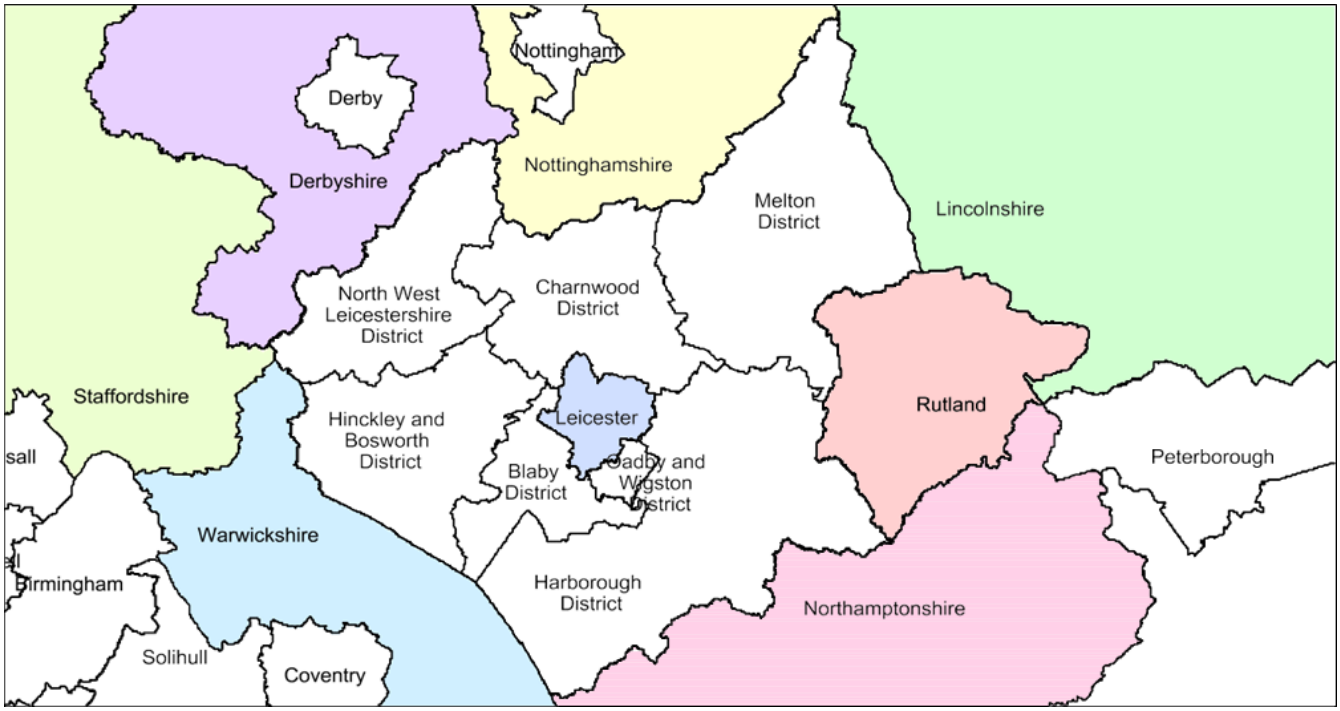
10.1.10. Cross Border Provision

The population of Leicestershire are able to access pharmacy services from any community or distance selling pharmacy that they choose. This means that they can choose to access services that are near their homes but in another county or unitary authority, services that are near their work or, in the case of internet pharmacies, any registered provider. As part of the access analysis

pharmacies and dispensing GPs within 1.5km of the Leicestershire have been considered. The boundaries of Leicestershire are illustrated in Figure 16.

The Health and Wellbeing Board is a statutory consultee for the PNAs developed in these adjoining areas. The most recently published draft PNAs (2022) for each area will be used to assess the impact of neighbouring pharmacy provision on the population of Leicestershire, though these are not yet available but will be included in the final version of the PNA.

Figure 16: Leicestershire neighbouring local authorities



10.2. Advanced Services

Advanced services are commissioned by NHS England and NHS improvement from pharmacies. These are voluntary agreements, and any pharmacy can choose to deliver these services as long as they meet the requirements set out in the Secretary of State's Direction around issues such as premises and staff training.

These services provide an opportunity for community pharmacists to engage with and empower their patients to take greater control of their health through more effective use of their prescribed medication or appliance. This in turn should help prevent their conditions from unnecessarily getting worse and thus contribute towards savings to the NHS. Advanced services can be provided by community pharmacies and by distance selling pharmacies.

There are 10 advanced services:

- New Medicines Service (NMS)
- Stoma Customisation
- Appliance Use Reviews
- Seasonal Influenza (flu) Vaccination Programme

- Community Pharmacist Consultation services (CPCS)
- C-19 Lateral Flow device distribution – **no activity data available.**
- Hepatitis C Testing Service. – *service ceased end of March 2022*
- Hypertension case finding service - **no activity data available.**
- Pandemic delivery service - **no activity data available –** *service ceased March 2022.*
- Smoking Cessation Service (CSC) - **no activity data available.**

Note: Medicines Use Review (MUR) and Prescription Intervention Services were decommissioned on 31st March 2021, however activity data for this service has been presented in this section. Smoking cessation services were commissioned in April 2022, so no data is available.

Table 23 shows the number of community pharmacies offering each service (where activity data was available), by locality as at 2020/21. Of the 132 community pharmacies in Leicestershire, 115 were offering the New Medicines Service, 124 were offering the Community Pharmacist Consultation service, 17 were offering Stoma Customisation, 116 were offering the Seasonal Influenza Vaccination and 120 were offering Medicines Use Review and Prescription Intervention Service. No Pharmacies provided Appliance Reviews or Hepatitis C testing services. In addition to community pharmacy provision, three distance selling/internet pharmacies are located in Leicestershire, one of these offers a new medicine service. There is also one Dispensing Appliance Contractor that offers no advanced services.

Table 23: Advanced Services – Number of community pharmacies providing each service, 2020/21

	Total Pharmacies	New Medicine Service	Stoma Customisation	Seasonal Flu Vaccination	Community Pharmacist Consultation Service	Medicines Use Review and Prescription Intervention Service
Blaby	22	17	3	18	20	19
Charnwood	42	34	6	36	40	37
Harborough	13	12	3	12	12	12
Hinckley & Bosworth	19	17	1	17	17	17
Melton	9	9	1	7	9	9
North-West Leicestershire	16	16	1	16	16	16
Oadby & Wigston	11	10	2	10	10	10
Leicestershire	132	115	17	116	124	120

Source: NHS England & NHS Improvement, Pharmaceutical Dataset, September 2021

10.3. Quality of essential and advanced services

Quality monitoring of essential and advanced services commissioned by NHS England and NHS Improvement is carried out by self-assessment. Targeted visits are undertaken where concerns are raised. In addition, new pharmacies that have opened and existing pharmacies that have relocated are visited.

10.4. Community Based Services

Community based services are additional services that are commissioned by CCGs or by local authorities to meet the health needs of their populations. A number of these services are commissioned from community pharmacies.

The services that are currently commissioned by Leicestershire County Council are:

- Emergency Hormonal Contraception (EHC)
- Needle and syringe exchange for people with drug addictions; (via Turning Point)
- Supervised administration of methadone and other substitutes; (via Turning Point)
- Champix provision to help people who want to stop smoking; this has been paused due to discontinuation of production of the treatment.

Table 24: Number of Pharmacies Offering Local Authority Commissioned Community-Based Services as of 31st March 2021

	EHC	Needle Exchange	Supervised Consumption
Blaby	9	2	7
Charnwood	18	4	22
Harborough	6	2	5
Hinckley and Bosworth	7	4	11
Melton	4	2	3
North West Leicestershire	8	3	13
Oadby and Wigston	9	2	6
Leicestershire	65	19	67

Source: Community Based Service Dataset, Leicestershire County Council and Turning Point Dataset.

The services that are currently commissioned by Leicester, Leicestershire and Rutland CCGs are:

- Extended care services Tier 1- Conjunctivitis and UTI treatment
- Extended care services Tier 2a - Impetigo, Eczema and insect bite treatment
- Palliative medicine supply
- Emergency supply service
- Covid-19 vaccinations

Table 25: CCG Commissioned Community-Based Services 2020-21

Districts	CCG Commissioned Enhanced Service 2020-21						
	Palliative medicines	**Emergency supply service**	**Tier 1- Conjunctivitis**	**Tier 1 - UTI**	**Tier 2a - Impetigo**	**Tier 2a - Insect bites**	**Tier 2a - Eczema**
Blaby	0	10	13	14	12	11	11
Charnwood	0	23	23	23	15	15	15
Harborough	0	11	9	9	6	6	6
Hinckley & Bosworth	0	6	14	14	11	11	11
Melton	0	5	5	5	2	2	2
NW Leicestershire	1	9	10	10	8	8	8
Oadby & Wigston	0	7	6	6	5	5	5
Leicestershire	**1**	**71**	**80**	**81**	**59**	**58**	**58**

Source: NHS England & NHS Improvement CCG commissioned Enhanced services 2020-21

These community-based services are voluntary agreements and pharmacies are not compelled to offer any or all of the services.

10.4.1. Emergency Hormonal Contraception

Following an episode of unprotected sexual intercourse (UPSI), the provision of emergency contraception can help to prevent unplanned pregnancy. Intrauterine devices provide the best method of emergency contraception as they give lasting protection. However, emergency hormonal contraception (EHC) is frequently a preferred method. A public health community-based service contract is currently in place with the aim of reducing unintended conceptions and improving sexual health for young people. In 2020/21, 61 pharmacies delivered the EHC service, including six 100-hour pharmacies. There were 623 pharmacy-based consultations for EHC, and Levonelle (Levonorgestrel) was issued in 193 of these.

Table 26 illustrates that the overall consultation rate in Leicestershire pharmacies was 15.8 consultations per 1,000 females aged 15-24. This varied from a rate of 0.8 per 1,000 females in Melton to 33.6 per 1,000 females in Oadby & Wigston. This indicates that the provision is different in each area of the county, and the public health team needs to ensure that access is equitable across the whole range of EHC providers.

Table 26: Community Based Services activity 2020/21 - Emergency Hormonal Contraception in 2020/21

Locality	Pharmacists providing service	Consultations	Levonelle	2020 Population Female aged 15-24	Consultations per 1,000 female population aged 15-24
Blaby	9	92	37	4851	19.0
Charnwood	18	203	59	13638	14.9
Harborough	6	49	9	4401	11.1
Hinckley and Bosworth	7	70	17	5183	13.5
Melton	4	2	1	2413	0.8
North-West Leicestershire	8	88	21	5434	16.2
Oadby and Wigston	9	119	49	3544	33.6
Leicestershire	65	623	193	39464	15.8

Source: Community Based Service Dataset, Leicestershire County Council

EHC is also provided by the specialist integrated sexual health service, GP practices and by the school nursing service. A new EHC drug, Ulipristal, has been found to have a lower failure rate and is effective for up to five days after UPSI.

10.4.2. Substance Misuse Services

There are currently two community-based services for substance misuse, the **Needle Exchange Service** and the **Supervised Methadone Consumption Service.** The Public Health Team at Leicestershire County Council commissions these services through Turning Point, a national charity that supports and treats people with alcohol and substance misuse problems. Turning Point has been commissioned to manage the whole system for people in Leicestershire with respect to substance misuse, and the pharmacy is a key part of the pathway for community-based services. Turning Point have put in place agreements with pharmacies to deliver needle exchange and supervised methadone consumption to support treatment and harm reduction in the community.

Needle exchange - the overall aim of the Needle Exchange Service is to reduce the rates of equipment sharing amongst injecting drug users, thereby preventing the risks of infection and drug related harm (individual and community). Pharmacies provide access to sterile equipment including needles and syringes, and sharps containers for return of used equipment. Where agreed locally, associated materials, for example condoms, citric acid and swabs, will be provided to promote safe injecting practice and reduce transmission of infections by substance misusers. Pharmacies offer a user-friendly, non-judgmental, client-centred and confidential service.

The Appendix shows the location of pharmacies offering this service in Leicestershire. Overall, 19 of Leicestershire's pharmacies provided the Needle Exchange Service as of 31st March 2021. **Error! Reference source not found.**shows the uptake of the needle exchange service by individuals in 2020-21[21] There were 14,117 recorded transactions for the needle exchange service during the 12-month period. These transactions occurred in 19 pharmacies in Leicestershire. The highest number of transactions occurred in Charnwood. Data has been used with the recognition that there may be data quality issues due to no mechanisms of data quality assurance.

Supervised Methadone Consumption

This service requires the pharmacist to supervise the consumption of methadone or other prescribed drugs at the point of dispensing in the pharmacy ensuring that the dose has been administered to the patient. Pharmacies offer a user-friendly, non-judgmental, client- centred and confidential service. The pharmacy will provide support and advise the patient including referral to primary care or specialist centres where appropriate.

The Appendix illustrates the location of pharmacies providing supervised methadone consumption in Leicestershire. In 2020-21 67 pharmacies provided this service with the highest level of coverage in Charnwood (with 22 pharmacies) and the lowest coverage in Melton with just three pharmacies. Table 27 shows the supervised methadone consumption service by individuals in 2020-21[21].

Table 27 Supervised Methadone consumption service uptake by district (2020-2021)

Area	No. of Pharmacies providing Supervised Methadone	No. of Transactions
Blaby	7	3,437
Charnwood	22	19,206
Harborough	5	2,797
Hinckley and Bosworth	11	10,526
Melton	3	554
North-West Leicestershire	13	4,663
Oadby & Wigston	6	664
Leicestershire	**67**	**41,847**

Source: Turning Point dataset 2020-21

10.4.3. Extended Care Services

The extended care service allows pharmacies to provide treatment for a selection of minor ailments without the patient having to attend a GP or 'Out of hours' service. Advice is also given to reduce the likelihood of repeat need for treatment. The patient must be registered with a GP and may need to be in an eligible group. The scheme is split into tiers and pharmacies are able to just sign up to the tier 1 services or both tier 1 and 2. The conditions treated and eligible groups in tier 1 are Urinary Tract Infection-Females aged 16-65 years old and acute bacterial conjunctivitis-

Children aged 3 months to 2 years old. The conditions treated in tier 2 are Impetigo, Infected Insect bites and Infected Eczema. The number of pharmacies providing these services in Leicestershire are summarised in Table 28-below.

Table 28- Number of Pharmacies Providing Extended Care Services

Districts	CCG Commissioned Enhanced Service 2020-21				
	Tier 1: Conjunctivitis	**Tier 1: UTI**	**Tier 2a: Impetigo**	**Tier 2a: Insect bites**	**Tier 2a: Eczema**
Blaby	13	14	12	11	11
Charnwood	23	23	15	15	15
Harborough	9	9	6	6	6
Hinckley & Bosworth	14	14	11	11	11
Melton	5	5	2	2	2
NW Leicestershire	10	10	8	8	8
Oadby & Wigston	6	6	5	5	5
Leicestershire	**80**	**81**	**59**	**58**	**58**

Source: NHS England & NHS Improvement CCG commissioned Enhanced services 2020-21

10.4.4. Palliative Medicine Supply

The palliative medicine supply service requires pharmacies to keep a supply of an agreed list of palliative care drugs to ensure that when prescribed by healthcare providers the drugs can be supplied quickly to palliative patients to ensure their comfort and maintain a good level of care. Just one Pharmacy in Leicestershire provided this service in 2020-21, this pharmacy is in Castle Donington in North-West Leicestershire.

10.4.5. Emergency Supply Service

The Emergency Supply Service allows pharmacists to prescribe prescription only medicines to a patient previously prescribed the requested drug without a prescription. This means a patient can in emergency situations receive a drug without visiting a doctor and is intended to lessen demand for emergency medical care for repeat prescriptions. In 2020-21 71 Pharmacies provided the emergency supply service the districts of these providers are summarised in Table 29.

Table 29: Pharmacies in Leicestershire providing Emergency supply services

Area	Number of Pharmacies providing Emergency Supply service in 2020-21
Blaby	10
Charnwood	23
Harborough	11
Hinckley & Bosworth	6
Melton	5
North West Leicestershire	9
Oadby & Wigston	7
Leicestershire	**71**

Source: NHS England & NHS Improvement CCG commissioned Enhanced services 2020-21

10.4.6. COVID Vaccinations

The Leicestershire CCGs also commissioned COVID vaccinations through community Pharmacies, unfortunately no data on this service is available.

11. Stakeholder Views

Leicestershire County Council has undertaken a consultation exercise to ask stakeholders of pharmacy services and providers of pharmacy services to tell us their views on the services that they access/provide. The findings will be available in the following appendices and are summarised below.

Appendix D – Professionals Pharmacy Questionnaire

Appendix E – Professionals Pharmacy Questionnaire Summary Report

Appendix F-Public Pharmacy Questionnaire

Appendix G- Public Pharmacy Questionnaire Summary Report

11.1. Leicestershire PNA Pharmacy Professionals Survey - Responses Summary

74 responses were received as at 9/05/22 from the LLR Pharmacy professionals survey.

The majority of pharmacies receive between 1,000 and 25,000 **enquiries** per year. The average number of **consultations** per week range from 2 to 150 (average 23). 100% have a closed consultation area on the premises and 92% have wheelchair access. Over half have **dementia-friendly** space and **large print** material and a range of other adaptations were made to help people access services.

84% use **locum** pharmacists and 69% use **relief** pharmacists, with recruitment difficulties experienced particularly in community pharmacist, dispenser and medicines counter assistant roles. Though 69% feel able to maintain the current level of services with 18% disagreeing.

42% of respondents intend to provide the appliance use review service, with 55% for the hypertension case finding service. Most would be willing to provide NHS and local authority commissioned services with training and/or facilities.

The majority do not provide **stop smoking service** as an LA commissioned service but would be willing to do so with training and/or facilities. 7 out of 20 **non commissioned** services are provided by over half of all respondents, with most indicating that they would provide others with support. Over half of respondents do not provide **non-NHS funded** services but most are willing to with training and/or facilities. 58% plan to expand the business with 29% planning to expand online services

Over 80% of respondents indicate that the **number of pharmacies** and the **location** within a 3-mile radius are ‘excellent’ or ‘good’ and 15% adequate. Ratings for the **range of services** provided within a 3-mile radius are slightly lower, with 71% rating ‘excellent’ or ‘good’ and 19% ‘adequate’.

11.2. Leicestershire PNA Public Survey Responses

336 responses were received as at 25/04/22 with around a third from Leicester and the other two thirds from Leicestershire and Rutland.

In relation to Leicestershire over half **use a car** (54%) to attend their pharmacy with 82% having **less than 15 minutes** travel time, whilst 44% walk. Responses highlight varied frequency of use from a few times per month (19%), once a month (36%) to every 2-3 months (24%). 82% use services during 9am to 6pm weekdays. 73% agree that opening hours meet their needs with 16% disagreeing. 94% found it easy to find a pharmacy open in the day, whilst 33% found it easy in the evening. 53% found it easy at weekends.

The majority (73%) are satisfied with **advice from pharmacies.** Satisfaction with **advice from GP dispensaries** is more varied (40% very/fairly satisfied, 12% neither satisfied nor dissatisfied and 8% dissatisfied) although this includes don't know responses. [1] **Quality of service, availability** of medicines, **private areas** to speak to a pharmacist, physical **accessibility** and **location** are the most important issues for respondents. Vaccinations were also mentioned as important.

The majority (81%) agree that the pharmacy provides a **good service** and provides **clear advice (72%).** Some responses highlight some concerns about speaking to a pharmacist **without being overheard. Access to medicines on time and busy pharmacists** were also raised as issues.

Services with the **lowest levels of awareness** were advice on physical exercise (13%) and healthy eating advice (17%). Access to specialist medicines in stock was quoted as an issue by some.

37% indicate that they have **caring responsibilities** and comments highlight the value of pharmacists having family knowledge/awareness of circumstances. Responses indicated that caring needs were generally met. Generally, people felt that their physical access needs were also met.

10% had delivery by post or pharmacy (and most of these respondents agreed that their pharmacy provides a good service), whilst 90% collected. The majority indicated that they were not likely to use **postal (73%) or online (home delivery) services (64%)** within the next 3 years.

12. Digital Developments

The Electronic Prescription Service (EPS) enables new and repeat prescriptions to be sent electronically from the GP to the patient's nominated pharmacy.

Pharmacies are now able to access an electronic Summary Care Record (SCR) for patients. The NHS SCR is an electronic summary of key clinical information (including medicines, allergies and adverse reactions) about a patient, sourced from the GP record with the patient's consent. SCR was rolled out to pharmacies from March 2016 and helps support safer patient care and treatment. A web-based system called PharmOutcomes[22] collates information on pharmacy

services. Local and national analysis and reporting of PharmOutcomes helps improve the evidence base for more effective community pharmacy services.

12.1. Access and Broadband Availability

An average download speed of 10Mbps is required to carry out basic online tasks, such as email, browsing the internet and online shopping, while 'superfast' speeds of 30Mbps are recommended. Data from ThinkBroadband shows that in April 2022, 98.0% of Leicestershire premises had access to superfast broadband. However not everyone has the necessary digital skills to be able to order medicines online or the necessary technology. The resident survey confirmed that the majority were not likely to use online or home delivery services in the next three years.

13. Projected Future Needs

13.1. Population Projections

The population of Leicestershire is growing and by 2043 the total population is predicted to reach 860,618 people, a total population growth of 23.3% compared with 2018.[23] However, the population is not growing uniformly across the different age bands. In the next 25 years, the population is predicted to grow as follows:[23]

- A 15% increase in children and young people aged 0-24 years (202,122 people to 232,198)
- A 17% increase in the working age population aged 25-64 (from 353,856 people to 414,241)
- A 43% increase in people aged 65-84 (from 124,095 people to 177,149)
- A 104% increase in the oldest population group of people aged 85 years and over (from 18,195 people to 37,030)

Table 30: Leicestershire population projections by age band (in 1,000s) - 2018 to 2043[23]

	2018	2019	2024	2029	2034	2039	2043
0-24	202.1	203.1	210.5	220.9	226.2	228.6	232.2
25-64	353.9	358.8	376.4	383.1	389.5	401.2	414.2
65-84	124.1	126.5	138.4	153.6	165.1	175.1	177.2
85+	18.2	18.6	21.0	24.4	31.8	34.9	37.0
All ages	698.3	706.9	746.2	782.0	812.7	839.8	860.6

Source: 2018-based Subnational Population Projections, Office for National Statistics

Table 31: Estimated projected population growth Projected population (in 1000s)[23]

	2018	2019	2024	2029	2034	2039	2043
Blaby	100.4	102.1	109.6	115.7	120.9	125.6	129.3
Charnwood	182.6	185.2	195.7	205.8	213.9	220.0	224.7
Harborough	92.5	93.6	98.8	103.2	107.2	110.9	113.8
Hinckley and Bosworth	112.4	113.7	120.1	125.8	130.9	135.9	139.6
Melton	51.1	51.2	51.7	52.3	52.8	53.4	53.9
North West Leicestershire	102.1	103.9	112.3	119.9	126.6	132.8	137.2
Oadby And Wigston	57.1	57.2	58.1	59.4	60.4	61.2	62.1
Leicestershire	698.3	706.9	746.2	782.0	812.7	839.8	860.6

Source: 2018-based Subnational Population Projections, Office for National Statistics

Table 32 uses a simple population model to assess how many pharmacies providing essential services will be needed in each locality (using a mix of community pharmacies and dispensing GPs) to maintain this level of access.

Table 32: Estimated pharmacies needed to maintain 2.1 pharmacies and GP dispensing practices per 10,000 population

	Current number of Pharmacies and dispensing GPs	2024	2029	2034	2039	2043
Blaby	**24**	23	24	25	26	27
Charnwood	**43**	41	43	45	46	47
Harborough	**18**	21	22	23	23	24
Hinckley and Bosworth	**22**	25	26	27	29	29
Melton	**12**	11	11	11	11	11
North-West Leicestershire	**20**	24	25	27	28	29
Oadby and Wigston	**11**	12	12	13	13	13
Leicestershire	**150**	157	164	171	176	181

Source: 2018-based Subnational Population Projections, Office for National Statistics
And Source: NHS England and NHS Improvement, Pharmaceutical Dataset, Sep 2021

It is important to note that the national average rate of 2.1 is an aspiration and not a target and the pharmacy coverage available for the Leicestershire population is good for a rural local authority, and further boosted by the availability of GP dispensing services. This is not a nationally recognised standard but a benchmark for the Health and Wellbeing Board to aspire to and not for NHS England and NHS Improvement to use when determining a new pharmacy application under the PNA.

The pharmacy coverage across 3 districts in Leicestershire in particular needs to be kept under review and may need further consideration in the light of actual population and housing growth, to maintain sufficiency for the projected populations to 2024. This is not an indication that there is a need for additional pharmacies in the localities that are affected earliest, but rather a need to ensure that the pharmacy system across Leicestershire continues to meet the needs of the whole population in the way that it is currently doing. The increasing number of distance-selling pharmacies has the potential to increase local pharmacy capacity, for example in performing signposting to services, to ensure that the needs of local people are being met.

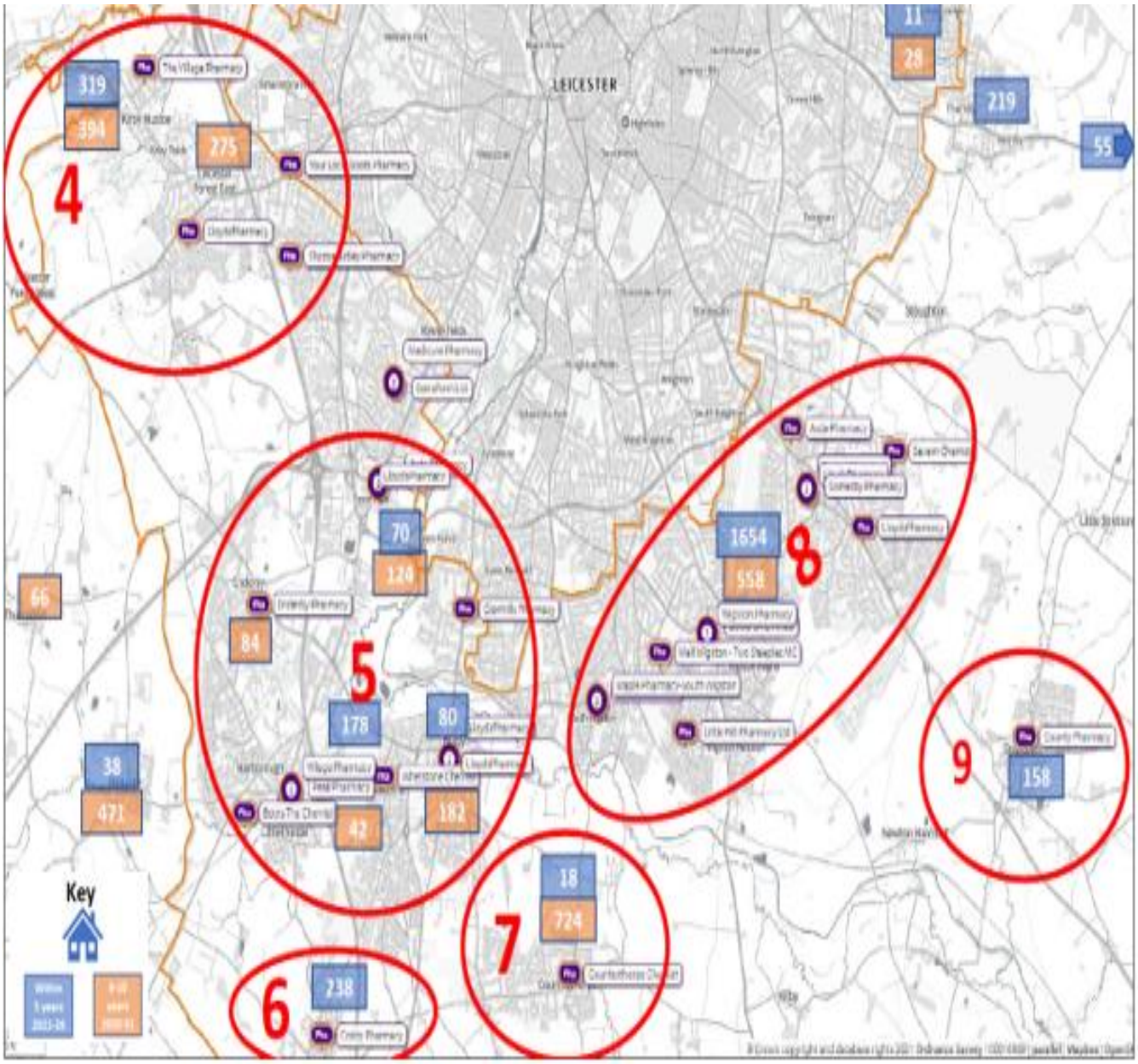
13.2. Future Housing – Potential Locations

The proposed dwellings are split into those predicted to be completed between 2021 and 2026 (Blue boxes on the below maps) and those expected to be completed between 2026 and 2031 (Orange boxes on the below maps). The new housing developments will provide housing for the increase in the population projected by the Office for National Statistics but may also see additional population moving into the area through migration. Population growth linked to plans for housing development are not included in the population projections, but the impact on services will be considered as part of the Health Impact Assessment that is carried out for new developments.

More details are set out in the maps below. The planned dwellings and estimated associated residents expected in Leicestershire up to 2031 are summarised in **Error! Reference source not found.**.

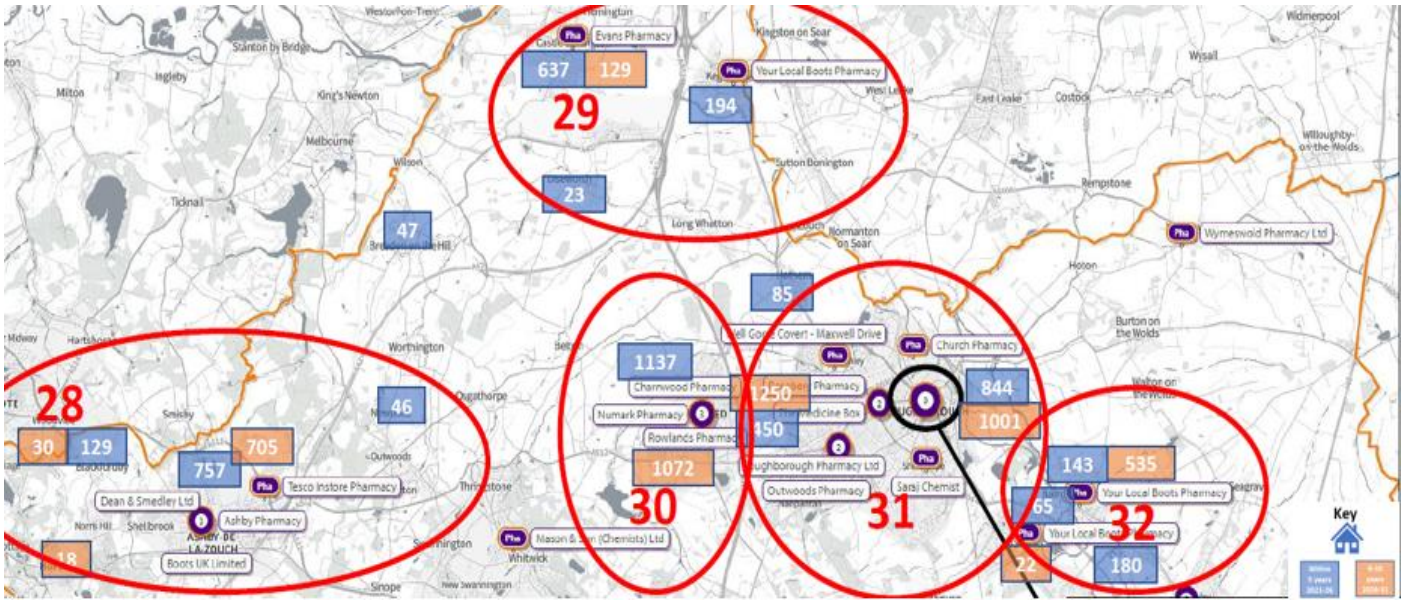
The housing and population forecasts are subject to regular monitoring and review. In particular the release of the latest census information this summer may result in further refinement of the numbers. There may also be some changes in forecast housing numbers as local plans develop and as a result of national planning guidance updates and the work of the local MAG Planning group. So, impact on actual pharmacy services and access will need to be kept under review and also considered as part of Health Impact Assessment for particular developments.

Figure 17: Planned housing developments and pharmacy locations in Blaby and Oadby & Wigston to 2031



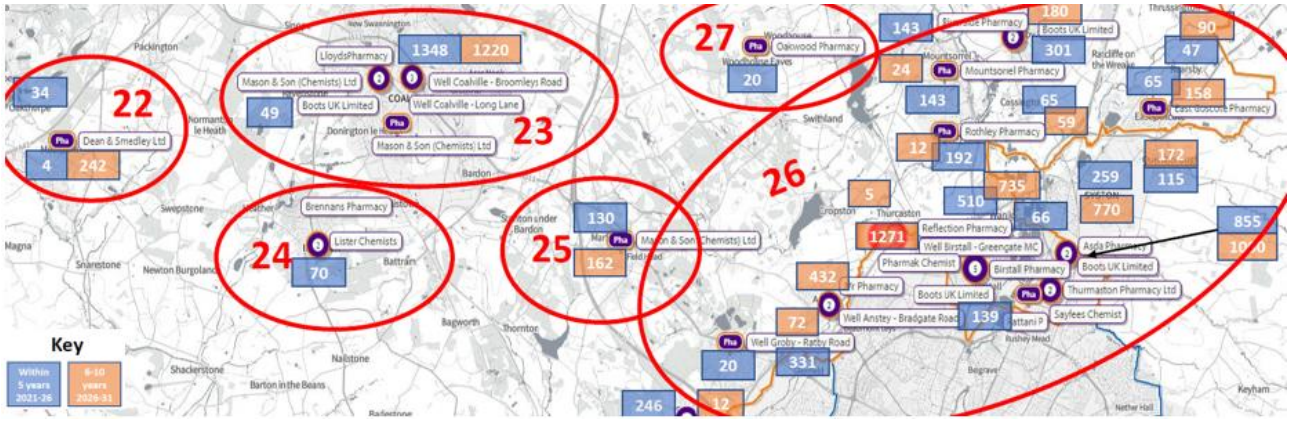
Source: Blaby District Council Strategic Housing and Economic Land Availability Assessment (SHELAA) 2016, Oadby & Wigston District Council Housing Implementation Strategy 2021, Strategic Health Asset Planning and Evaluation, 2022.

Figure 18: Planned housing developments and pharmacy locations in Charnwood and North-West Leicestershire to 2031-1



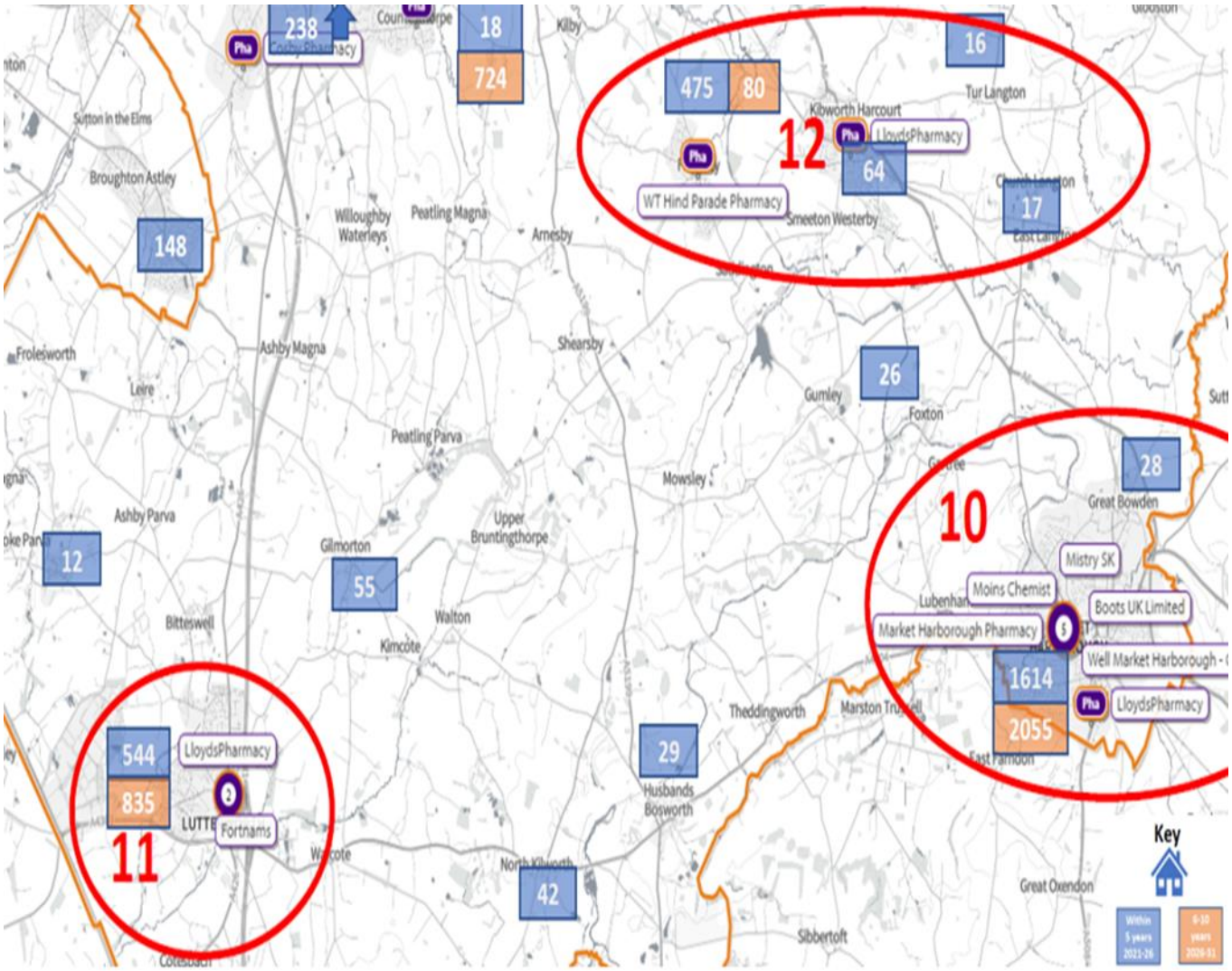
Source: Charnwood District Council Local Plan 2021-37 Draft July 2021, NW Leicestershire Housing Trajectory 2021 Final, Strategic Health Asset Planning and Evaluation, 2022.

Figure 19: Planned housing developments and pharmacy locations in Charnwood and North-West Leicestershire to 2031-2



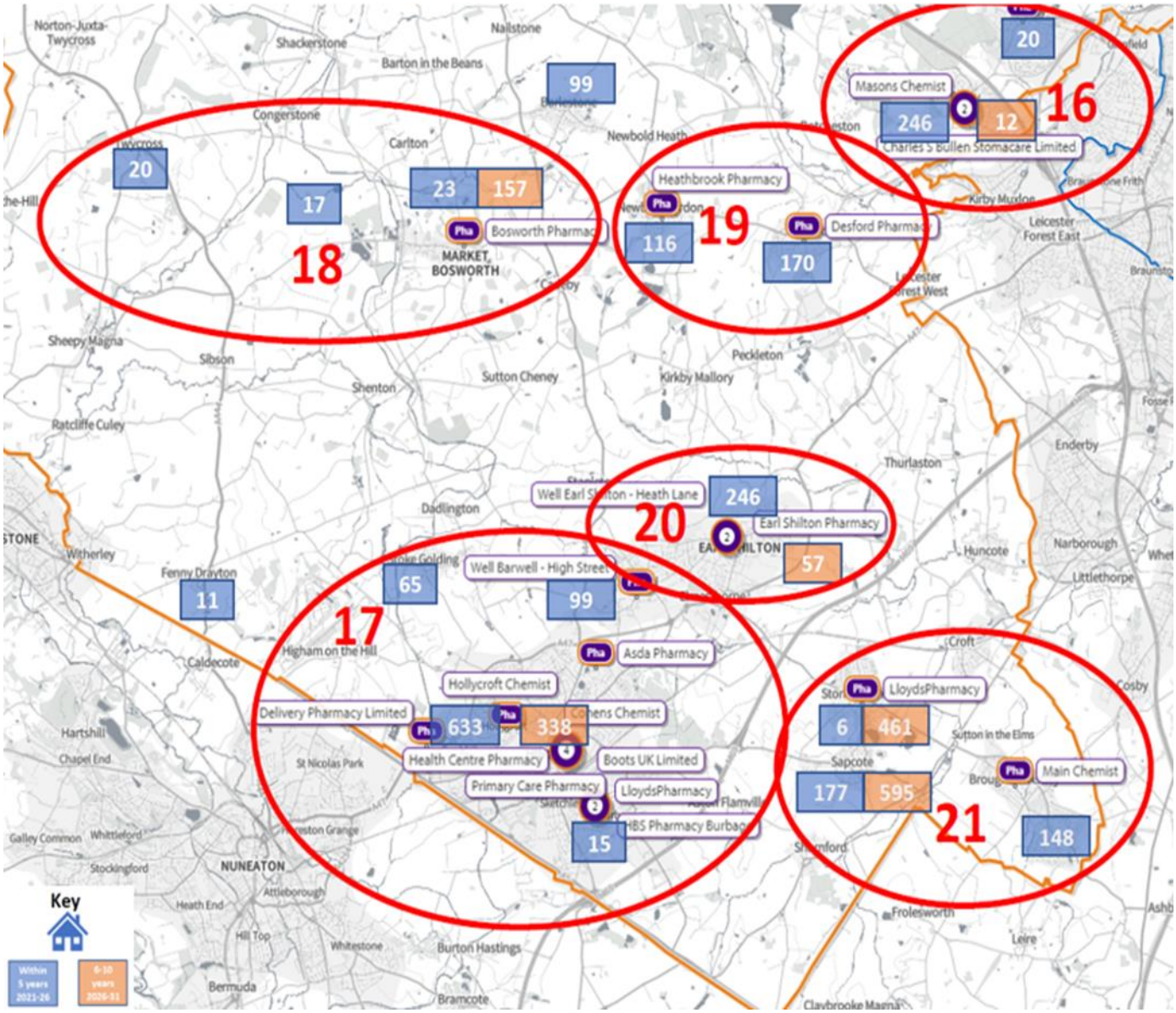
Source: Charnwood District Council Local Plan 2021-37 Draft July 2021, NW Leicestershire Housing Trajectory 2021 Final, Strategic Health Asset Planning and Evaluation, 2022.

Figure 20: Planned housing developments and pharmacy locations in Harborough to 2031



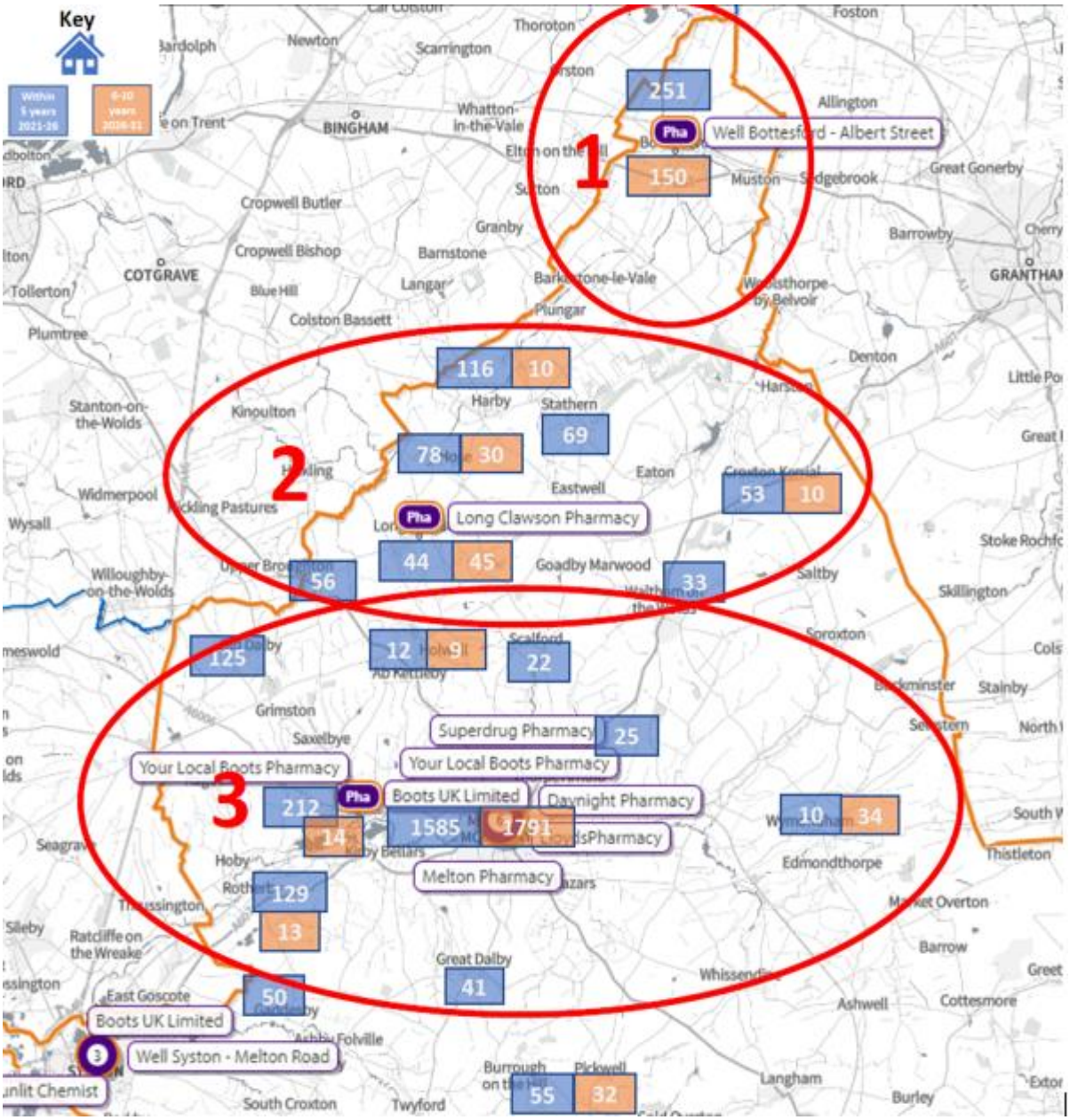
Source: Harborough District Council 5-year Housing Land Supply September 2021, Strategic Health Asset Planning and Evaluation, 2022.

Figure 21: Planned housing developments and pharmacy locations in Hinckley and Bosworth to 2031



Source: Hinckley & Bosworth District Council Residential Land Availability Monitoring Statement 2020-21, Strategic Health Asset Planning and Evaluation, 2022.

Figure 22: Planned housing developments and pharmacy locations in Melton to 2031



Source: Melton District Council Final Housing Trajectory July 2021, Strategic Health Asset Planning and Evaluation, 2022.

	Completion expected between 2021-26		Completion expected between 2026-31	
	No. of dwellings	Estimated residents	No. of dwellings	Estimated residents
Blaby	1,024	2,437	1,488	3,541
Charnwood	6,914	15,833	7,786	17,830
Harborough	2,916	6,940	2,970	7,069
Hinckley & Bosworth	2,001	4,462	1,608	3,586
Melton	2,861	6,866	2,106	5,054
North-West Leicestershire	3,421	8,142	2,506	5,964
Oadby & Wigston	1,654	4,036	558	1,362
Leicestershire	20,791	48,717	19,022	44,406

Table 33: Planned dwellings and estimated residents in Leicestershire to 2031

Source: Blaby District Council Strategic Housing and Economic Land Availability Assessment (SHELAA) 2016, Charnwood District Council Local Plan 2021-37 Draft July 2021, Harborough District Council 5-year Housing Land Supply September 2021, Hinckley & Bosworth District Council Residential Land Availability Monitoring Statement 2020-21, Melton District Council Final Housing Trajectory July 2021, NW Leicestershire Housing Trajectory 2021 Final, Oadby & Wigston District Council Housing Implementation Strategy 2021.

Whilst current access to pharmacy provision is largely good, with the projected increases in population that are anticipated in Leicestershire, the areas of Harborough, Hinckley and Bosworth, and North-West Leicestershire should in particular be kept under review to ensure that the provision remains adequate to meet the future needs of the populations in these areas. The large amount of housing development in the county should also be kept under review and taken into consideration as this may present particular geographical areas of need for further pharmaceutical services.

14. Responses to the 60-Day Statutory Consultation

There is a statutory requirement for each Health and Wellbeing Board to consult a number of bodies about the contents of the Pharmaceutical Needs Assessment for a minimum of 60 days. The consultation period will take place between June 2022 and July 2022. Results will be incorporated into the final PNA. An additional questionnaire also took place with local pharmaceutical professionals between March and June 2022 to gather evidence to support the PNA. The consultation responses from the professional survey are available in Appendix E. A public

questionnaire gathered responses between March and April 2022 and results are found in Appendix G.

Appendix H - Statutory Consultation Questionnaire

Appendix J - Statutory Consultation Easy Read Questionnaire

Appendix K - Statutory Consultation Questionnaire Summary Report

Appendix L - Draft 2022 PNA for Statutory Consultation

In addition, detailed comments were made by members of the Reference Group on the draft PNA 2022.

15. Equality Statement

Appendix M - Equality Statement

16. Gap analysis

16.1. Essential Services

Leicestershire benefits from three different types of providers for essential services; community pharmacies, distance selling pharmacies and dispensing GPs. Combining all three providers for the delivery of essential services, residents of Leicestershire have similar levels of access (providers per 10,000 population) to the England average.

Whilst current access to pharmacy provision is largely good, with the projected increases in population that are anticipated in Leicestershire, the areas of Harborough, Hinckley and Bosworth, and North-West Leicestershire should in particular be kept under review to ensure that the provision remains adequate to meet the future needs of the populations in these areas. The large amount of housing development in the county should also be kept under review and taken into consideration as this may present particular geographical areas of need for further pharmaceutical services.

Access to essential services by car is good with 99% of Leicestershire residents living within a 10-minute drive-time of a pharmacy or dispensing GP surgery. 75% of residents live within a 15-minute walk-time of a pharmacy or dispensing GP surgery. It is worth noting that despite this, of residents in the most rural parts of the county 85% live more than 15 minutes' walk from a pharmacy or dispensing GP surgery. 92% of residents live within a 15-minute public transport journey (weekday AM) of a pharmacy or dispensing GP surgery. Public and community transport is important to support access in certain areas, particularly the rural east of the county.

There is good coverage of pharmacy access across Leicestershire between 6.30 am and midnight Monday to Saturday. There is access to pharmacy services on Sundays and bank holidays across the county, although fewer services are open, and patients may need to travel further. Patients that need to access emergency pharmacy services outside of opening times are able to access an emergency pharmacy service through the out of hours service.

No gaps have been identified in the provision of essential services during normal working hours or outside of normal working areas across the whole Health and Wellbeing Board area. Furthermore, no gaps have been identified in essential services that if provided either now or in the future would secure improvements or better access to essential services across the whole Health and Wellbeing Board area. However, housing and population growth need to be kept under review with a focus on Harborough, Hinckley and Bosworth and North West Leicestershire.

16.2. Advanced Services

Across Leicestershire, the delivery of advanced services is at a higher percentage than the England average, with 94.0% of pharmacies providing Community Pharmacist Consultation Service, 86.4% providing the New Medicines Service, and 87.9% providing the Seasonal Influenza Vaccination. However just 12.9% provide Stoma Customisation.

Appliance Use Reviews and Hepatitis C testing are not provided by community pharmacists in Leicestershire but are services not provided widely nationally. Pharmacies that do not provide this service are able to signpost patients to the appliance contractors who provide this service.

The CPCS and NMS services are two services that are important in helping to support patients to manage their own conditions in the community. It is essential that the opportunities for supporting patients using these services is maximised, by ensuring that patient uptake of both of these services in pharmacies increases where this is low and that the quality of the services offered in pharmacies is consistently high.

No gaps have been identified in the provision of advanced services across the whole Health and Wellbeing Board area. No gaps have been identified in the provision of advanced services at present or in the future that would secure improvements or better access to advanced services across the whole HWB area. Though there should be continued promotional activity to ensure take up of advanced services where these are lower.

16.3. Community Based Services (CBS)

Across Leicestershire a good range of community-based services (CBS) are offered by pharmacies. The CBS schemes provide the CCGs and Local Authorities with an opportunity to increase the role of pharmacies in delivering the primary care and the public health agendas. Pharmacies are very highly valued by the people that use them, and pharmacies have considerable day-to-day accessibility to clients making them an ideal setting for supporting patients and clients to either make informed lifestyle choices or to manage their own health conditions effectively.

The analysis of CBS identified a number of schemes with good population coverage and uptake of services but also some gaps when relating the coverage to health needs. The key findings are summarised below:

- Emergency Hormonal Contraception is a well-developed service provided in all localities with good uptake.
- Substance misuse services are commissioned by the specialist treatment provider, Turning Point, and include needle exchange and supervised methadone consumption services in

Leicestershire. These services have good geographical distribution throughout the county and are part of a wider whole system approach to harm reduction and treatment of people affected by substance misuse.

- Extended care services provide the opportunity for community pharmacies to provide treatments for minor ailments without the need for medical prescribing and help provide preventative advice. There is good coverage in the county for the two tiers of extended care services.

- Palliative medicine supply is only provided by one pharmacy in North West Leicestershire. With the increasingly aging population this service Is likely to become more important and as such may require development to ensure good coverage.

- Emergency supply service provides a patient with emergency provision of prescription only medicines when a prescription is unavailable. This means this service is very useful in reducing demand on out of hours medical facilities for prescription requests. There is good coverage across the county.

Based on current information, no gaps have been identified in the provision of community-based services across the whole Health and Wellbeing Board area, however consideration should be given to the need for enhanced palliative medicine supply. Going forward these services should be monitored and promoted to secure good service coverage across the whole Health and Wellbeing Board area.

17. Recommendations

17.1. Equity of Service

NHS England (and where relevant Leicestershire County Council, Leicestershire CCG/ICS should:

- Keep locations and opening times under review in the light of population and housing growth to assess whether access to pharmacies for essential services is equitable for all Leicestershire residents. In particular for Bank holidays and Sunday.

- Pharmacy service provision should be kept under review, particularly where provision has cross-city and cross-county border use, to ensure that issues of quality and uniformity of access to advanced and community-based services are regularly considered.

- The availability of public, community and voluntary transport provision to pharmacy and GP dispensing locations should also be kept under review

- Keep under review recruitment difficulties for some pharmacies, use of private consultation rooms and timely access to some medicines.

Promote use of pharmacy services in promoting health and healthcare management

NHS England and NHS Improvement (and where relevant Leicestershire County Council, Leicestershire and Rutland CCG/ICS should:

- Ensure the promotion of the healthy lifestyles (Public Health) requirements of the essential services. While NHS England retains responsibility for this area of the pharmacy contract, local campaigns should in future be jointly defined by NHS England, Local Authority Public Health and the Clinical Commissioning Groups.

- Consider the opportunity to include and develop the role of pharmacies in commissioning strategies particularly in relation to providing services which deflect work out of primary care general practice.

- Assess levels of uptake of advanced and community-based services and follow-up low or high performers in order to share best practice.

18. Conclusions

The PNA looks at pharmacy cover across Leicestershire in relation to the health needs of the people who live there. It includes existing services, where they are located, the breadth of services they are providing, and the views of people using them.

Overall, the community-based pharmacies are meeting the current needs of the Leicestershire population for Essential and Advanced services. The consistency and quality of the advanced services should be continually reviewed, and uptake should be increased wherever possible. The provision of Community Based Services across Leicestershire is also reasonable, but more needs to be done to ensure that services across the county are consistent and being used.

The PNA process has highlighted the importance of public, community and voluntary transport to accessing pharmacy provision in east Leicestershire for those without a car and that this should be supported and kept under review. The process has also highlighted that the move to more digital/online provision will take some further time to evolve and there is a risk of digital exclusion for those without technology and skills to use it. The ability for customers to have a confidential conversation in the pharmacy, at times, has also been flagged in the survey and consideration should be given to greater use of confidential meeting spaces.

Pharmacies have successfully extended their offer over recent years and surveys indicate a general willingness to offer more services, if funded and supported to do so. However, feedback has also pointed to pressures on the business and on some pharmacy staff and some recruitment difficulties, which could provide a potential risk to further expansion of services. Timely access to some medicine supplies in stock was also raised through survey responses.

Community pharmacies are the easiest healthcare workers for members of the public to access, and they are highly valued by their customers. Pharmacies will be essential in promoting healthy lifestyles and also supporting health and social care in the future. This will cut down the number of unnecessary admissions to hospital. The landscape of health care in LLR is changing through local and national policy development and the impact on pharmacies should continue to be monitored.

GLOSSARY OF TERMS

ABI	Alcohol Brief Intervention
AUR	Appliance Use Review
CBS	Community Based Services
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
DHU	Derbyshire Health United
DRT	Demand Responsive Transport
EHC	Emergency Hormonal Contraception
ELRCCG	East Leicestershire and Rutland Clinical Commissioning Group
ERMs	Emergency Repeat Medicines Scheme
EPS	Electronic Prescription Service
ESBL	Extended-Spectrum Beta-Lactamase
FSRH	Faculty of Sexual and Reproduction Healthcare
GP	General Practitioner
H. pylori	Helicobacter pylori
HWB	Health and Wellbeing Board
IDACI	Income Deprivation Affecting Children
IDAOPI	Income Deprivation Affecting Older People
IMD	Index of Multiple Deprivation
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LPS	Local Pharmaceutical Services
LPT	Leicestershire Partnership Trust
LSOA	Lower Super Output Area
MSOA	Middle Super Output Area
MUR	Medicines Use Review
NHS	National Health Service
NIAVS	National Influenza Adult Vaccination Service
NMS	New Medicines Service

NRT	Nicotine Replacement Therapy
OHID	Office for Health improvement and Disparities
ONS	Office of National Statistics
OOH	Out of Hours
PGD	Patient Group Directive
PNA	Pharmaceutical Needs Assessment
POPPI	Projecting Older People Population Information System
SCR	Summary Care Record
WLCCG	West Leicestershire Clinical Commissioning Group
UPSI	Unprotected Sexual Intercourse

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જો આપ આ માહિતી આપની ભાષામાં સમજવામાં થોડી મદદ ઇચ્છતાં હો તો 0116 305 6803 નંબર પર ફોન કરશો અને અમે આપને મદદ કરવા વ્યવસ્થા કરીશું.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਵਿਚ ਕੁਝ ਮਦਦ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0116 305 6803 ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਅਸੀਂ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਦਵਾਂਗੇ।

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APPENDIX B - Pharmaceutical Needs Assessment Timetable - 2020/2021

Action	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
PNA Discussion		8th											
PNA Reference Group Meeting 1			**1st**										
PNA Reference Group Meeting 2					22nd								
PNA Working Group Meeting 3				19th									
PNA Reference Group Meeting 4						31st							
PNA Reference Group Meeting 5								email					
PNA Reference Group Meeting 6											11th - TBC		
PNA Reference Group Meeting 7												email?	
Data Gathering and Analysis													
Document development													
Pharmacy Survey													
Consultation Document Preparation													
Consultation - 60 day statutory period													
Analysis of consultation responses													
Document revisions to reflect consultation													
Publish Document													
Leicestershire HWB		**25th**			**24th**			**26th**				**22nd**	
Leicester HWB				**27th**			**28th**			**TBC**			
Rutland HWB				**11th**			**5th**					**TBC**	

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Agenda Item 9

HEALTH AND WELLBEING BOARD 26 MAY 2022

REPORT OF THE EXECUTIVE DIRECTOR FOR STRATEGY & PLANNING, LLR CCGS

REDUCING HEALTH INEQUALITIES – CORE20PLUS5

Purpose of report

1. The purpose of this report is to inform the Health and Wellbeing Board (HWB) of the NHS requirement set by NHS England and NHS Improvement to deliver against the CORE20Plus5 to support wider work to reduce health inequalities across Leicester, Leicestershire and Rutland (LLR).

2. The HWB is required to 'Do' specific Leicestershire place (such as work on the wider determinants of health as led by the Staying Healthy Partnership) and 'Sponsor' wider LLR NHS initiatives that reduce health inequalities in Leicestershire.

Recommendation

3. It is recommended;

    a. That the report be noted;

    b. That it be noted that further work will be undertaken to agree an initial focus on a Leicestershire population cohort(s) who already experience health inequities and this will be a cohort of the Core20Plus5 approach.

Policy Framework and Previous Decision

4. Reports concerning the Core20Plus 5 have been considered by the shadow LLR Integrated Care Board on the 14 April 2022 and he LLR Integrated Care Partnership on the 29 March 2022.

5. Improving population health and healthcare and tackling unequal outcomes and access are two of the four purposes of an ICS.

6. Nationally, Core20Plus5 is the NHSs approach to addressing unequal outcomes and access.

7. LLR Health Inequalities Framework – Better Care For All (attached as the Appendix) was presented to the HWB on 25 March 2021 and approved by the shadow LLR Health and Care Partnership Board on 30 November 2021, is currently being updated to reflect the Core20Plus5 approach.

Background

8. NHS England define health inequalities as 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. Reducing health inequalities is a core priority for the LLR Integrated Care System (ICS) and its programme of work to reduce health inequalities will be guided by the 12 principles within the LLR Health Inequalities Framework (see Appendix) with a focus on addressing the five priorities in the 21/22 & 22/23 NHS Operational Planning Guidance and the Core20Plus5 approach (Figure 1 below). The LLR ICS is aligned to the national vision of 'exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes. Health inequalities exist on a gradient throughout populations, and we are committed to using a proportionate universalism approach to reduce inequity wherever it exists across LLR.

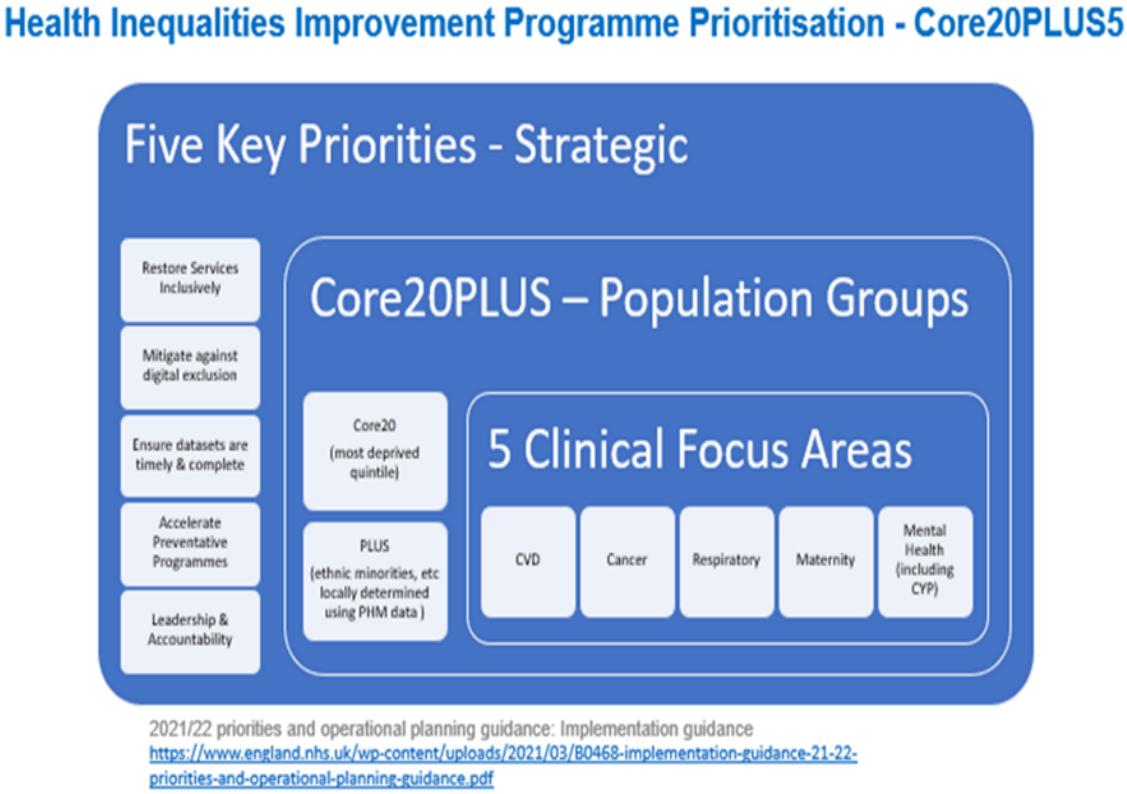

Figure 1*: The five priorities in the 21/22 & 22/23 NHS Operational Planning Guidance and the Core20Plus5 approach*

Core20Plus5 – An approach to reducing health inequalities

9. Core20Plus5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system (LLR) level. The approach defines a target population cohort – the 'Core20PLUS' –

and identifies '5' focus clinical areas requiring accelerated improvement (Figure 2).

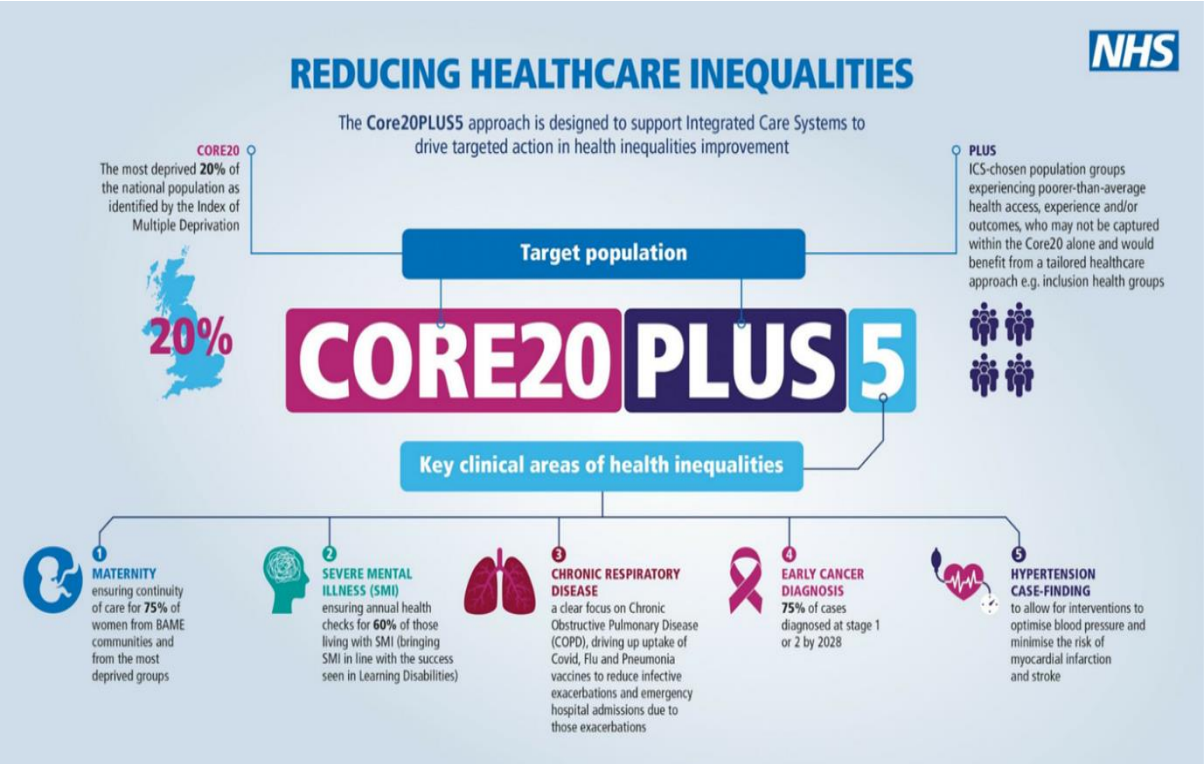

Figure 2: *The Core20Plus5 approach to reducing health inequalities*

Core20

10. The Core 20 refers to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

11. For Leicester, Leicestershire & Rutland (LLR), 153,284 registered patients live in the 20% most deprived neighbourhoods in England (Table1). Our Strategy and system, place and neighbourhood levels of service delivery will be to ensure that we invest resources to ensure that (1) access to services, (2) experience of services, and (3) health and care outcomes are fair and equitable for the people in this group compared to the rest of the population. This means that we will work with partners to make the necessary efforts and investments needed to "level the playing field" for everyone in terms of chances to live a long and healthy life.

Table1*: Summary of the number of registered patients across LLR and those that live in the 20% most deprived areas in England*

	Registered patients living in 20% most deprived areas in England	Total registered patients	%
Leicester	130,794	413,074	31.7%
Leicestershire	22,321	688,401	3.2%
Rutland	169	40,035	0.4%
LLR	153,284	1,141,510	13%

The “PLUS” populations

12. The Plus populations of the Core20Plus5 approach to reducing health inequalities are groups, not specifically covered in the “Core 20”, who may need additional support from system partners in order to have an equitable chance of having the best health and care outcomes. The LLR partners will use national and local data to identify these groups. They may include: ethnic minority communities, people with very poor mental health, protected characteristic groups, people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, military and veteran populations, sex workers, people in contact with the justice system, victims of modern slavery. It also considers those living in very rural areas/ those remote from certain services, and other socially excluded groups.

13. The recently approved Joint Health & Wellbeing Strategy for Leicestershire has health inequalities as a cross cutting theme across all the life course stages (Figure 3 below). To ensure that additional work and resources are aligned to the specific ‘place’ priorities and populations, the ‘Plus’ population groups will be determined in each of our three ‘places’ by the relevant Health & Wellbeing Board.

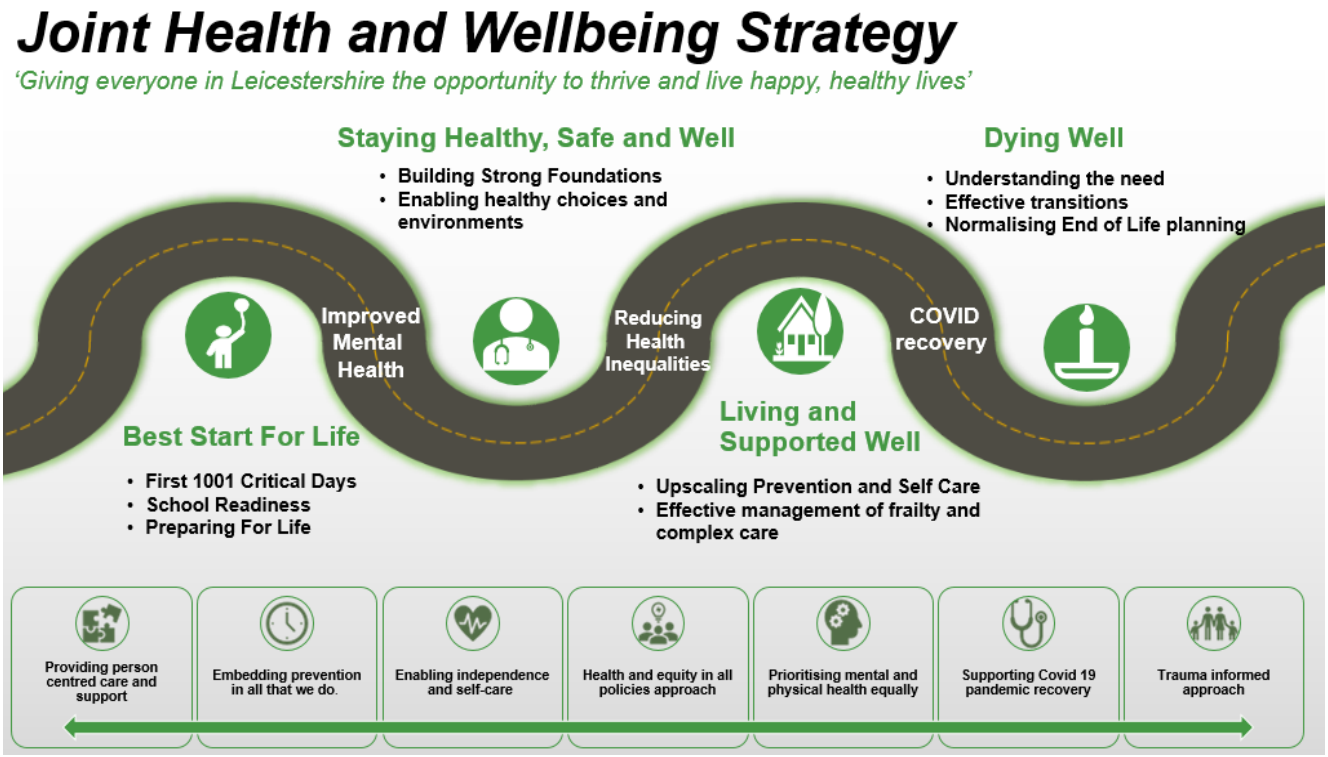

Figure 3: *Example of a life course approach in Leicestershire and health inequalities cross cutting theme.*

"The 5"

14. The final part of the Core20Plus5 framework sets out five clinical areas of specific NHS focus. Governance for these five focus areas sits with national NHS programmes; national and regional teams coordinate local systems to achieve national aims. The five clinical areas include;

    a. **Maternity:** ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the Core 20 part of the population.

    b. **Severe mental illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

    c. **Chronic respiratory disease**: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

    d. **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.

e. **Hypertension case-finding**: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Delivery & Governance

15. The local NHS will collaborate with partners to deliver against Core20Plus5 national targets. Successful programmes to improve access, experience and outcomes requires not just the NHS, but all system partners working together. At system level; reporting on, and governance of actions will be through the LLR Prevention & Health Inequalities Reduction Board and ICB/ICP. At place it will be through the Health and Wellbeing Boards and Directors of Public Health, as outlined in the delivery of the Joint Health and Wellbeing Strategy. At neighbourhood level, it will be through local neighbourhood Community Health and Wellbeing Plans which will include delivery partners such as Primary Care Networks, Integrated Neighbourhood Teams and district and borough councils.

16. Reporting on Health Inequalities will be proportionate to the footprint at which action is taken, with neighbourhood reporting being the most detailed and localised, but aligned to place and system priorities, and overall progress against the NHSEI 5 priority areas and Core20Plus5 metrics for the five clinical areas.

17. The LLR ICS has placed a very high premium on identifying and strengthening leadership and accountability for tackling health inequity at all levels of the system. Health Inequality Leads are now in place at Board level in each large NHS providers, on the NHS system Board, and through formal clinical and management leader roles in different specialities. The LLR Prevention & Health Inequalities Board, chaired by the Director of Public Health for Leicestershire, will oversee the implementation of the LLR Health Inequalities Framework and support action at place and neighbourhood level through a ‘Do, Sponsor, Watch’ approach to delivery.

18. A local LLR health inequalities dashboard has been developed in addition to the national reporting tool to help us measure local progress on reducing health inequalities through the Core20Plus5. Regular reporting against system, place and neighbourhood actions to reduce health inequalities will be presented to the Integrated Care Board, the Integrated Care Partnership and each of the three Health and Wellbeing Boards in LLR.

Consultation/Patient and Public Involvement

19. Health Watch has been a member of the Task and Finish Group responsible for producing the LLR Health Inequalities Framework. This framework is currently being updated to reflect the Core20Plus5 approach. Meaningful engagement with public and patients on health inequalities needs to take place at place level and more locally to be effective in driving effective action

Background papers

https://www.england.nhs.uk/wp-content/uploads/2021/06/240621-board-meeting-item-9-tackling-inequalities-in-nhs-care.pdf

Appendix

LLR Health Inequalities Framework – Better Care For All

Officer to contact

Sarah Prema, Executive Director Strategy & Planning. LLR CCGs

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Email: Sarah.Prema@nhs.net

Relevant Impact Assessments

Equality and Human Rights Implications

20. The CORE20Plus5 is a NHS national framework to reduce health inequalities, it takes into account protected characteristic's as part of it's 'Plus 5' groups.

Partnership Working and associated issues

21. The Core20Plus5 approach provides a framework for how we plan to act, both collectively and through specific organisations to positively impact not just the direct causes, but the "causes of the causes" of these differences. Some work, therefore, will fall to the NHS to do, some to other partners such as local authorities or other public sector bodies, and some as joint working at system, place or neighbourhood. Often this is not something one organisation can do on their own – it requires the system to work together to act as anchor institutions – using their collective resources and working with the voluntary and community sector to make a difference.

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APPENDIX

Leicester, Leicestershire and Rutland Integrated Care System

Better care **for all**

A **framework** to reduce health inequalities in Leicester, Leicestershire and Rutland.

Contents

What are health inequalities?

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

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

Health inequalities have been made worse by the Covid-19 pandemic, which has hit hardest the groups who already do not have the best health. The rate of people dying from the virus has been higher in more deprived areas and among some ethnic minority communities and people with disabilities. People in crowded housing, on low wages, unstable or frontline work have experienced a greater impact from Covid-19.

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

What does it mean for local people?

Health inequalities across Leicester, Leicestershire and Rutland (LLR) are stark.

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

What will this framework seek to achieve?

We want local people to be healthier, with everyone having a fair chance to live a long life in good health. This is why we will aim to 'level up' services and funding, rather than take anything away from areas where outcomes are already good.

This framework sets out how local organisations will plan to take action to not only affect the causes of these health inequalities but the 'causes of these causes'.

Health and wellbeing is not just the concern of the NHS. The health and wellbeing of people is an asset to individuals, to communities, and to wider society. Good mental and physical health is a basic precondition for people to take an active role in family, community and work life. The NHS, local authorities and other public bodies all have a part to play. Often, it will involve a number of different organisations working together to improve all the things that can affect someone's health.

Locally, we have set up an integrated care system (ICS) which brings organisations together to ensure better partnership working, and improvements in people's health and care. By listening and responding to local people, we will achieve a fairer and healthier future for us all.

> The health and wellbeing of people is an asset to individuals, to communities, and to wider society.

What does equity look like?

'Health inequalities' is the commonly used term, however we are actually referring to 'health equity and inequities'.

'Equality' means treating everyone the same or providing everyone with the same resource, whereas 'equity' means providing services relative to need.

We can show what this looks like in the illustration below. **Figure 01** shows, on the top line, four people of different sizes all trying to cycle the same size of bicycle. One person in a wheelchair cannot use the bicycle at all. The second line shows each person happily using a bicycle correctly sized or adapted for their needs.

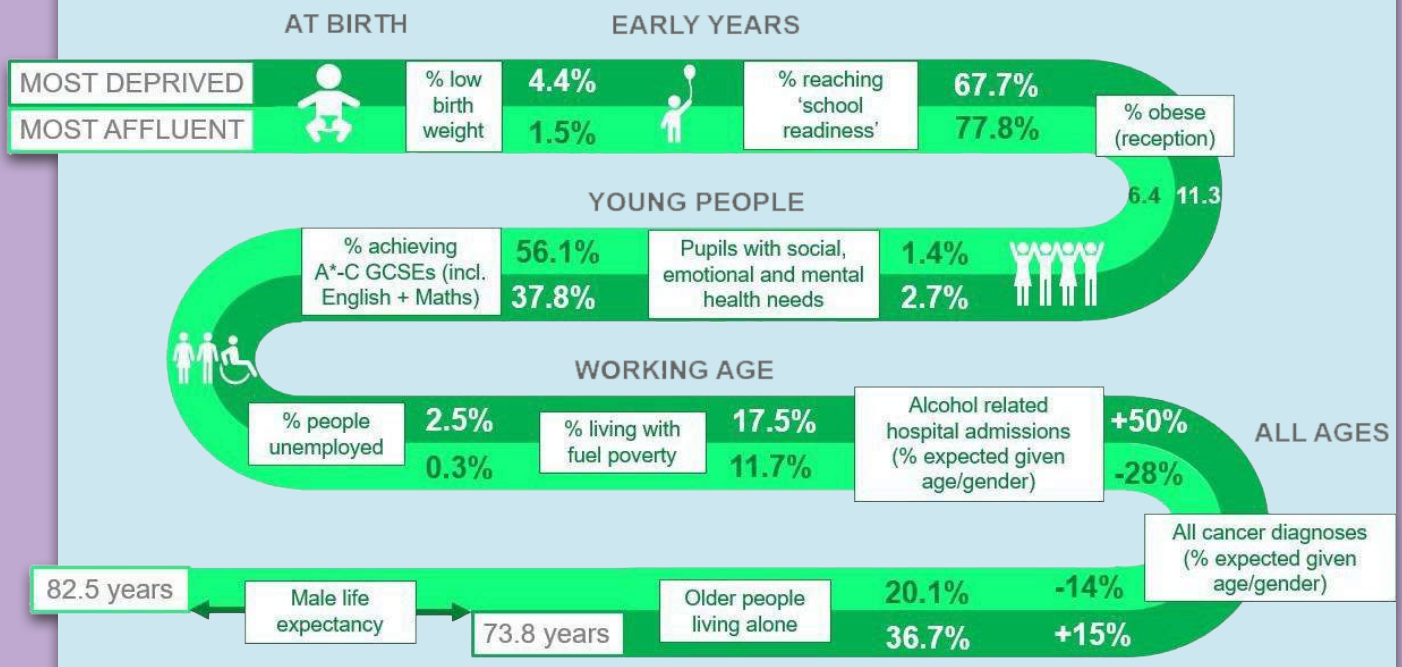
Figure 01 | Representation of equality and equity using adapted bicycle example

Source: Reproduced with authorisation from Robert Wood Johnson Foundation (Better Bike Share, 2017)

Inequalities can be seen as being present from birth, through someone's early years and into later life. At each stage this can result in relatively poorer mental and physical health.

This can be shown in a tale of two babies in **Figure 02** below. While we must recognise that no outcome is set in stone, the story aims to illustrate the different opportunities and difficulties that two babies might encounter throughout their life. The graphic shows two parallel curving lines. One showing outcomes for those from the most deprived areas of LLR and the other showing outcomes for those from the most affluent areas of LLR.

Figure 02 | Difference in health indicators between the most and least deprived local areas of LLR



Source: PHE Fingertips

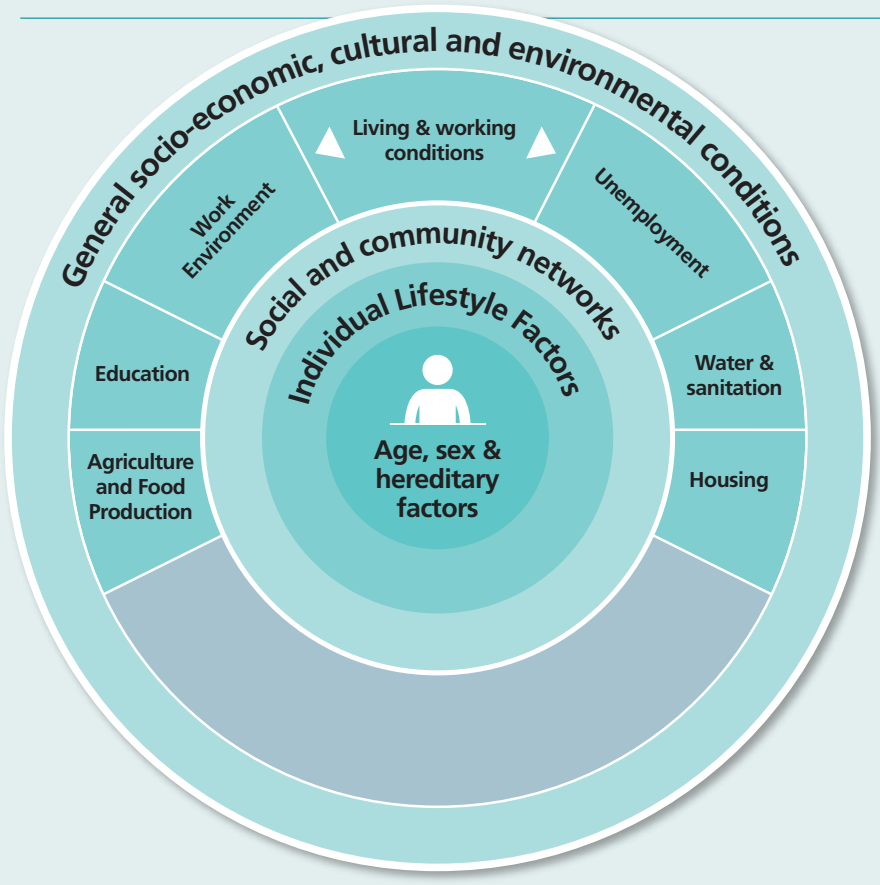
What is 'Health'?

Health has been defined as:
"A state of wellbeing with physical, cultural, psychosocial, economic and spiritual attributes, not simply the absence of illness."

We are using this definition of health in **assessing health inequalities.**

Our work is also based on a **'social model'** of the factors that can influence someone's health. This is shown in **Figure 03** below. It shows that everything but age, sex and hereditary factors can be modified in terms of factors that can influence an individual's health.

Figure 03 | A Social Model of Health



Things like education, housing, transport and clean air are often known as 'wider determinants of health'.

They can also be seen as the 'causes of causes' which we mentioned earlier. It shows the importance of the NHS working with local authorities and other organisations who can influence these factors.

Source: The World Health Organisation

Our Principles
for reducing health inequalities

Reducing health inequalities is a key factor in all work carried out within the ICS – it is everyone's business.

Our work in this area will be guided by the following principles:

Principle 01

Reducing health inequalities

is a key factor in all work carried out within the ICS – it is everyone's business. Reducing health inequalities and improving health equity should run through all our work, at all levels, as a 'golden thread'. Appropriate training and support will be given to enable people to think and act in ways that reduce health inequity.

Principle 02

We will use data and insight

to better understand local health inequalities and how they affect people. We will draw upon the best evidence to take action to reduce inequalities and to evaluate the impact of our services. This is known as 'population health management'. Where services are failing to reduce inequity, or (by accident) are increasing it, the services will be adjusted or changed completely.

Principle 03

We will prioritise prevention,

helping prevent or lessen the impact of illness. This is important in improving health equity as the burden of disease is borne unfairly by those who are more deprived, marginalised or in a minority. Primary prevention includes a focus on and increased investment in reducing inequalities in lifestyle risk factors (such as smoking, diet, exercise or alcohol consumption), mental wellbeing, housing, income, education, working conditions and the wider environment. In these areas, it is critical that the NHS works effectively with local authority partners.

Principle 04

A focus on gaining a fair balance

between mental and physical health - reducing inequalities in mental health will be prioritised to the same extent as reducing inequalities in physical health.

Principle 05

Local public sector organisations

will seek to reduce health inequalities through offering 'social value'. This approach includes efforts to make the workforce more representative of the local population. We will use mentoring, reverse mentoring and apprenticeships to improve opportunities for under-represented groups, support people from less affluent backgrounds to establish a career in the public sector, and seek to tackle racism and prejudice in society. In addition, we will seek to maximise the value of our collective spending on the local economy.

Principle 06

Investment in services

will be proportionate to the needs of people using those services. This means that although there will be a universal offer of services to all, we will vary the provision of services in response to differences in need within, and between, groups of people. In this way we will look to 'level up' the way that services are offered and outcomes achieved.

Principle 07

We will draw on the strengths of communities and individuals

to reduce health inequality and inequity. Our services will aim to focus on 'what matters to people' rather than focusing on 'what is the matter' with them. We will listen to local people with lived experience to shape local priorities and redesign services. As part of strengthening resilience in communities we will work to improve health literacy – the skills, knowledge and understanding that people have to make use of available information and access local services.

Principle 08

We will ensure that all plans

and policies put forward by the ICS partners take into account issues of health equity. This is particularly important in relation to the wider factors that can affect people's health such as housing, education or employment.

Principle 09

We will take effective action

during the key points of a person's life to help reduce health inequality and inequity. This means a specific focus on giving children the best start in life, prevention of ill health and the promotion of wellbeing and resilience.

Principle 10

The ICS is accountable

for delivering on health inequalities across the local health and care system. We acknowledge that organisations within the ICS also have a statutory duty to reduce health inequalities. The work required to reduce health inequalities will tend to take place at a 'place' (or local neighbourhood) level. These places will need to be responsive to the particular needs of local people.

Principle 11

Actions will be undertaken

at the most appropriate level of the ICS where they can be most effectively owned and delivered. This will tend to be determined by the relevant statutory responsibilities of the partner organisations. Housing, education, and licensing rest with local authorities, for example, while commissioning responsibility for most health services sits with the local NHS clinical commissioning groups and their successors.

Principle 12

There is significant potential

to improve people's health through better and more widespread use of digital technologies. Digital technologies are integral to many of the changes envisaged in the NHS Long Term Plan. However, it will also be important to take steps to prevent digital technologies entrenching or widening health inequalities. This means understanding and addressing the issue of digital exclusion and ensuring that people can still receive face-to-face services where required.

Taking steps to reduce health inequalities

Actions to address health inequalities will need to take place at different levels:

System Level

Across the whole LLR area.

Place Level

Across the area covered by the upper tier local authorities (Leicester City Council, Leicestershire County Council, Rutland County Council) and led by Health and Wellbeing Boards.

Neighbourhood or Locality Level

Smaller (though locally meaningful) populations within the wider upper tier boundaries.

Medium to long term priorities will be determined at place level and are likely to include:

- A **focus on the first 1,001 days of life.** Events and people's health during this period often determine outcomes across the whole of someone's life
- **Improving healthy life expectancy** through early intervention and prevention. This will include actions relating to the other factors that can affect someone's health such as education or job opportunities
- **Using the lived experiences of people** to inform our plans and actions
- **Each organisation having their own executive lead for health inequalities** who will be responsible for driving this agenda forward
- An approach which is **Smart, Measurable, Achievable, Realistic and Timed (SMART).**

Shorter term goals are to:

- **Restore NHS services inclusively** (following the impact of Covid-19)
- **Mitigate** against digital exclusion
- Ensure that **our data is accurate** and **providing the necessary insights**
- **Accelerate preventative programmes** that engage those at greatest risk of poor health (management of long-term conditions, annual health checks for people with learning disabilities/serious mental illness, continuity of maternity care for BME women and those from deprived neighbourhoods)
- **Strengthen leadership and accountability.**

Strategic actions

to reduce health inequalities at the ICS level

All decision makers within the ICS will have expertise, skills, insight and understanding of health inequity and how to reduce it.

Action 01

Places will be expected

to apply the principles, outlined in this framework, to their specific populations, in the most appropriate way, that meets their local needs. This is likely to embrace the various factors that can affect people's health (as shown in figure three).

Action 02

The ICS will make investment decisions

for people across LLR that reflect the various needs of different communities. In this way, actions can be universal, but adjusted and made proportionate to the level of disadvantage. The aim of reducing health inequalities will be a high priority. Specifically, we will develop a new strategic long-term model of primary care (GP practice) funding, distribution and investment. This will 'level up' funding based on population need rather than historical allocation.

Action 03

We will establish a defined resource

to review health inequalities at this strategic level. This will be a virtual partnership between the NHS, local authorities and local universities. An enhanced ability to process and analyse data will support a better understanding of inequity across the area. We will gather and share best practice in effective interventions and provide teaching and training to all levels of staff in undertaking health equity audits. We will facilitate local research. Public health teams will deliver, with partners, the health inequalities support function at a place and neighbourhood level. Specifically, a proposal for the establishment of an LLR health inequality resource will be presented to the system executive.

Action 04

All decision makers

within the ICS will have expertise, skills, insight and understanding of health inequity and how to reduce it. Specifically, health inequity and inequality training will be mandatory for all executive decision makers in each organisation. We will work with local and regional partners to develop appropriate and robust training packages relevant to roles.

Action 05

Partner organisations will work together

to understand the impact of Covid-19 on health inequalities across LLR, to allow effective and equitable recovery after the pandemic. We will be looking to:

- Identify groups and communities, across all ages and across protected characteristics, which have been most affected by the pandemic as a result of pre-existing vulnerabilities and disadvantages
- Undertake proportionate additional work to ensure vaccine uptake is equitable
- Include consideration of the role of the wider determinants of health, such as education, employment, housing and poverty
- Promote equal support for mental and physical health to those groups worst affected by the pandemic and the consequences of lockdown.

Action 06

All partners will work

to improve the completeness and consistency of their data to enable a better understanding of health inequity. This mainly relates to data collection on people with 'protected characteristics' under the Equality Act. Specifically, partner organisations will develop an action plan for having ethnicity, accessibility and communication needs of their population appropriately coded in records. In addition, we will make better use of our data sets in order to identify vulnerable groups and individuals to offer proactive, holistic care through Integrated Neighbourhood Teams.

Action 07

At the ICS level,

we will obtain and use data to help us better understand where we can do more work to reduce health inequity. Each organisation will adopt a standard health equity audit tool and put training plans in place to use this tool, so that each 'place' area can compare their performance against other areas.

Action 08

We will undertake health equity audits

to identify health inequalities between different population groups. These will be carried out at the planning stage when we commission, redesign or evaluate services. Action to reduce health inequity will be taken based on audit findings (at a minimum considering the protected characteristics of the Equality Act 2010).

Action 09

The NHS

and public sector partner organisations within the ICS will seek to reduce health inequalities through seeing what we can do together, especially in the areas of work opportunities, use of buildings and purchasing.

How will we know if this work is succeeding?

If this framework is successful in driving effective action, we expect to see the following outcomes:

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

CASE STUDY 01:
Reducing health inequalities – COVID vaccine hesitancy in St Matthews

Our Approach

Our approach to tackling inequalities across LLR is based upon the NHS Race & Health Observatory Covid-19 working group recommendations for communications & engagement:

1. Build trust through community forums
2. Clear, simple and accessible messaging
3. Messages are repeated, consistent and culturally sensitive
4. Engages in proactive social media campaigns
5. Embed delivery within familiar and accessible locations – such as GP practices and community infrastructure
6. Use NHS professionals and other trusted community voices to promote and advocate the programme

What the issue was - i.e. rate prior to intervention

Data from SystmOne via Leicestershire Health Informatics Service includes counts of vaccines administered and population data by age band, sex, ethnic group and geographical area.
By showing vaccination uptake by ethnic group and geographical area, it is possible to see areas of the city with low vaccination uptake for different ethnic communities. Leicester's Somali population had 49% uptake in over 50s at 23/03/21 compared with 78% in the population overall. Over half of the Somali population live in 2 neighbouring areas in the city, St Matthews and St Peters.

Design of intervention in partnership with community

In Reach Pop Up Clinic

- To provide an agile response to the population, we facilitated a vaccination pop up clinic at a local Faith Centre in the City known to the community.

Community Engagement

- Zoom webinars - hosted by a local GP and proactive community leader with support from the Director for Public Health.
- YouTube video curated by a local GP highlighting the vaccination pop up clinic and key details/cascading amongst the local Community via whatsapp.
- Local Radio with BBC Radio Leicester to inform and discuss the vaccination pop up clinic, also interview with the local CCG.
- Communications material sent out to all shops, mosques, schools, and community organisations.
- Information sharing via the COVID helpline, managed by the Women 4 Change Community Organisation who can advocate for the population and signpost queries.
- Information sharing via NHS, LLR CCG websites and social media.

Rate after interventions

537 people attended the pop-up clinics for their vaccination. Overall, 44% of people that attended said that had this not been made available locally then they were not likely to have taken up the vaccine.

Data up to 23/3/21 shows uptake in over 50s Somali population was 49%. Following the In reach intervention with the community and a pop-up vaccination clinic increased vaccination uptake to 60% at 30/03/21.

Data up to 17/08/21 shows currently 78% of over 50s within the Somali population in Leicester have received dose 1 vaccination.

Data up to 23/3/21 in St Matthews & St Peters shows 69%. Data up to 30/3/21 shows an increase to 75%.

Feedback from staff and patients

- Volunteers and vaccinators alike stated they were **"proud to be part of this local initiative"**
- Many volunteers stated they **would like to join the mass vaccination efforts.**
- **The vaccinators felt it had an impact on changing hearts and minds** - individual interactions with the community members enabled them to breakdown a lot of the myths and allay their fears and concerns. Many community members who came to the clinics - partly out of curiosity and others who felt doubtful and came to ask questions - were able to have their vaccines there and then once they were able to have these conversations with the vaccinators.

How we have applied this learning elsewhere

The learning has been applied across various differing settings including Workplace in Reach Clinics. We were asked by Local Authority and Public Health colleagues to contact several large employers within the LLR footprint.

We set up an initial task and finish group with a large organisation where we discussed vaccine hesitancy, the use of the Healthy Conversations Toolkit, support for managers in using this toolkit and also asked for the demographics of the workforce this data showed us that 62% of the workforce were from ethnic minorities, including individuals from Eastern European communities and African communities.

As this large organisation uses a 24-hour shift pattern system. It was agreed that the best time to run the clinics was across the shift change times this gave all employees the opportunity to access the vaccination clinic.

A range of Comms was used for this clinic including internal comms through staff awareness sessions the Healthy Conversations toolkit was also used in these sessions.
The organisation also arranged for their staff to book into the clinics via an internal appointment system this was provided to us allowing us to book individuals into the clinic via the Swift Q system. Use of Swift Q ensured that a second dose trigger was set.

151 people were vaccinated over the two days of the clinic with 32% of those that attended advising that they would not have taken up the vaccine had it not been made available to them on site.

CASE STUDY 02:
Health inequalities - Introduction of new technology to improve care in diabetes

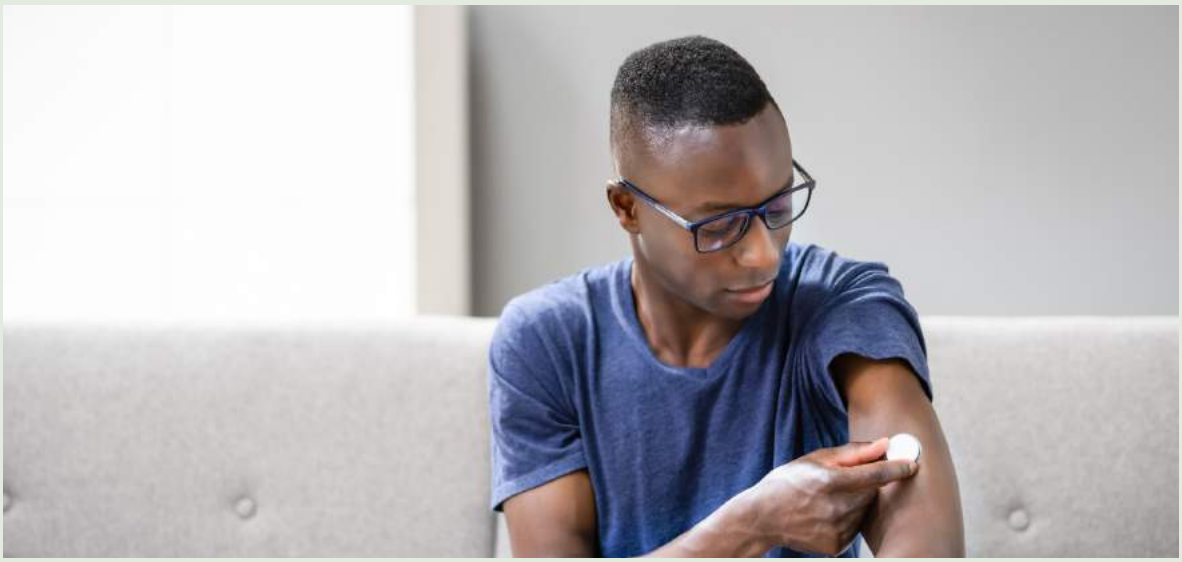
Case study by Professor Azhar Farooqi

Diabetes is one of the most common chronic disorders affecting nearly five million people in the UK. It is a significantly more common condition in people of low socio-economic status and in BME groups. Diabetes is a costly condition, not only in financial terms (more than 10% of the NHS budget), but also in terms of mortality and morbidity. Sufferers lose several years of life and the condition is the biggest cause of acquired blindness, renal failure and amputations.

The evidence that good control of blood glucose improves outcomes for patients and reduces NHS costs is overwhelming. Freestyle Libre (FSL) is a new technology, known as flash glucose monitoring, which allows patients to monitor in real time their blood glucose using a skin patch and a small handheld sensor. It avoids multiple lancet jabs and time-consuming use of glucose strips and machines.

The technology is approved by NICE for patients with type 1 diabetes who normally would test multiple times a day and is likely soon to be extended to patients with type 2 diabetes on insulin and other groups deemed at high risk of hypoglycaemia.

It costs about £500 per patient per year. The real-world impact of this technology has shown significant improvements in blood glucose levels, reduced hospital admissions and paramedic call-outs, less severe hypoglycaemia and improved overall blood glucose control.



How was this technology rolled out?

The prescribing of FSL has been via secondary (hospital) care to eligible patients who have an education session on how to use it. As with all new technologies and treatments, patients learn about the availability of this via media and friends and those most empowered tend to know about it first. The patient benefit is not only in improved diabetes control but also the avoidance of painful finger pricks. It was entirely predictable that the most articulate, informed and persuasive patients would be in a position to demand this technology and persuade their health care professional they are eligible and would benefit. The criteria of existing multiple testing and the education package also favours English speakers, literate patients and those already empowered in looking after their condition - all of which make it less likely that people form deprived backgrounds would either push for this technology or be prioritised for it.

What has been the health inequality?

Type 1 patients in the most deprived area of Leicester, Leicestershire and Rutland had a 29% chance of receiving this technology, compared to 39% in the least deprived area. Only 14% of type 1 patients received FSL in GP practices with the most BME people in their population, whereas this figure was 38% for the practices with fewest BME people.

Why has this happened?

This data was produced by a pharma company, who in effect, 'whistle blew' the problem. The local NHS service provider had no idea of this health inequality. There was no consideration of health inequalities in the introduction of this technology, nor monitoring of uptake by deprivation or socio-economic status. Despite the data, little has changed on the provision of this technology to date. Future provision requires a robust health equity audit to fully understand the potential impact on health inequalities.

Lessons to be learnt

It is important that a full equity impact assessment is carried out when all new technology (or therapies) are introduced. It is important that monitoring of uptake by socio-economic status and BME status, as well as other characteristics, is undertaken, and data reported and shared. It is important to consider if specialist-only provision will worsen health inequalities. Most type 1 patients (60%) and the vast majority of type 2 diabetics (95%) receive care only in general practice. It is likely that appropriate primary care provision will improve wider access to this intervention. Language is likely to be a significant barrier in addressing health inequalities, in particular, when a mandatory education package is only available in English. Specific thought, investment and planning needs to take place to reverse this inequality of provision of FSL.

Where can I find out more?

Public health experts routinely put together assessments of health and health inequalities for local areas. These are known as Joint Strategic Needs Assessments and are available for:

- **Leicester City**
- **Leicestershire**
- **Rutland**

Produced by
Leicester, Leicestershire and Rutland Integrated Care System

Concept & design by Fresh* Communications t: 0116 254 1351 e: alf@freshcom.co.uk

Agenda Item 10

HEALTH AND WELLBEING BOARD 26TH MAY 2022

JOINT REPORT FROM THE DIRECTORS OF PUBLIC HEALTH FOR LEICESTERSHIRE & LEICESTER CITY

PROPOSAL FOR THE ROLE AND FORMAT OF THE LEICESTER, LEICESTERSHIRE AND RUTLAND'S INTEGRATED CARE PARTNERSHIP

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board with information concerning the role, priorities, enablers and format of the Integrated Care Partnerships (ICP), to be locally known as the LLR Health and Wellbeing Partnership, in preparation for the integrated Care System (ICS) becoming statutory in July 2022.

2. The ICP is a 'Sponsor' area of work for the Health and Wellbeing Board and will be key area of focus to ensure system alignment with partners and sub-groups.

Recommendation

3. The Health and Wellbeing Board is asked to note the report.

Policy Framework and Previous Decision

4. As part of the preparation for moving towards a statutory NHS Integrated Care organisation (known as the Integrated Care Board or ICB) and the associated system wide Leicester, Leicestershire and Rutland (LLR) ICP, a working group has been meeting to develop the role of the ICP in LLR. The working group consists of senior officers from the three upper tier local authorities and from NHS commissioning and provider organisations. Until its formal establishment in July 2022, the ICP has been meeting in shadow form as the LLR Health and Care Partnership. Once formally established, the ICP will be known as the LLR Health and Wellbeing Partnership. For the remainder of this report, the Partnership will be referred to as the ICP.

5. It is acknowledged that there will be a need to review this new partnership as it evolves to consider what is working well, what could be improved, and what needs to change to enable the ICP to work well for LLR.

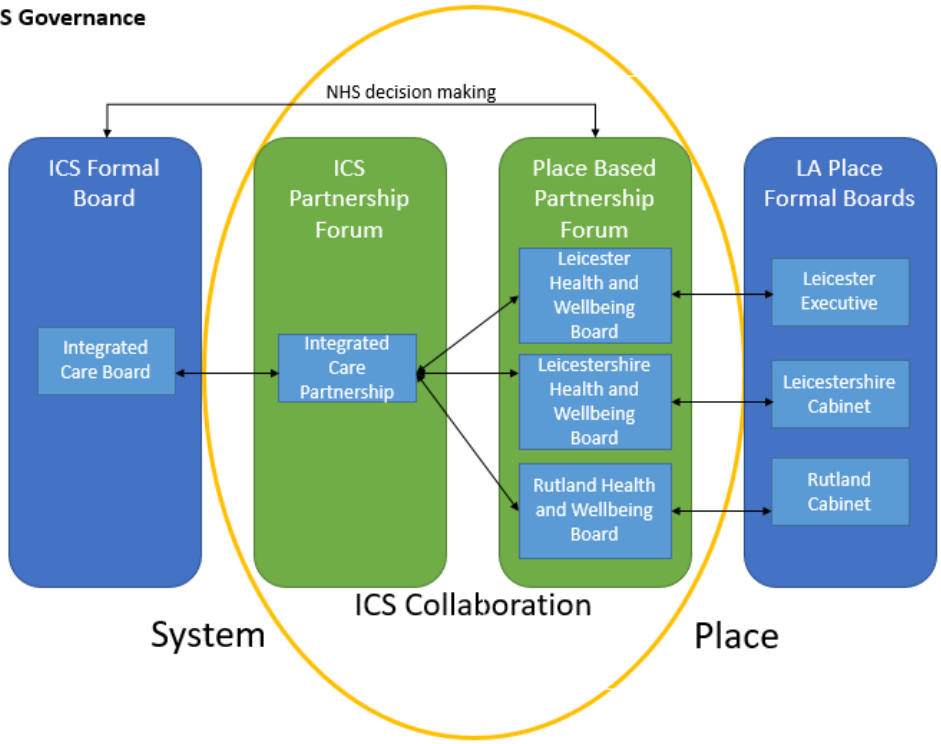
Background and Governance

6. The LLR ICS provides an excellent opportunity to further develop collaboration and joint working on health and care. Figure 1 below summarises the key decision-making boards and partnership forums at system and place across LLR.

7. The ICB will be the formal statutory NHS organisation and operational decision-making board for NHS resources across the system (including place and neighbourhood), whilst Cabinet/ Executive are the decision making boards for the respective local authority resource at place. There is an emerging consensus that the ICP locally should focus on the health, care and wellbeing of the LLR population overall and not be hierarchically 'above' the Health and Wellbeing Boards. Instead, the ICP should be the partnership board that operates on a system or LLR footprint.

8. The Health and Wellbeing Boards (HWBs) are the statutory partnership boards that operate on a place footprint and will have crucial role in bridging the collaborative work between system and place. The Health and Wellbeing Boards also have delegated authority to approve the Better Care Funds for each place.

Figure 1 LLR ICS Governance



9. The ICP is likely to have a statutory requirement to develop an ICS Strategy. It is proposed that the ICP should be a collaborative forum that meets to explore the breadth and depth of complex 'wicked' issues, formulating system action for improvement. Issues raised at the ICP will meet at least one of the following criteria:

   i. The issue can only be tackled at system level and in partnership between a wide range of LLR organisations.

ii. An issue where a system level discussion will add value to work at place level or elsewhere.

10. The ICP will avoid duplicating work that is appropriately being done elsewhere. For example, decisions that are the responsibility of the Integrated Care Board or respective local authority Cabinets/ Executive, or where effective collaborative work is happening through other boards and partnerships such as the Health and Wellbeing Boards at place level.

11. Further work needs to take place to consider how the ICP will link with the County Council's Health Overview and Scrutiny Committee (HOSC) and the LLR Joint Health Overview and Scrutiny Committee and processes across LLR. It is envisaged that the system level work of the ICP will be reviewed and scrutinised by Joint HOSC (which has member representation for all three upper tier local authorities), while place specific issues will remain at the respective place scrutiny committees.

12. Although the Joint HOSC is likely to be the primary committee that the ICS will serve, it is important to remember that the work of the ICS also comes under the remit of other scrutiny committees particularly in relation to adult and children's social care and wider determinants of health (including climate change).

Proposals/Options

13. It is proposed that the ICP has two main priorities for the next 1-2 years. These are:

    i. The role of LLR anchor institutions including workforce.
    ii. Health and wellbeing equity (reducing health and wellbeing inequalities) including equitable access to health and care services and the wider determinants of health at system level. (Acknowledging that health inequalities may be seen across specific vulnerable groups of the population and not just through geographical deprivation, and that much of this work will be driven through the Health and Wellbeing Boards [HWB] at place level.)

14. Anchor institutions are large organisations that have a significant stake in their local area. They are large employers and have sizeable assets that can be used to have a positive effect on their local communities' health and wellbeing. Anchor institutions can contribute to reducing health and wellbeing inequalities and to improving the wider determinants of health such as through meaningful employment and workforce, land use, and procurement processes to name three. Developing the work of collective organisations in this area is likely to have greater impact at system level and fulfils criteria 2 and 3 above.

15. System level approaches to health, care and wellbeing equity and embedding prevention in all we do are crucial for future health and care demand. LLR has a system wide health inequalities framework with sets of principles and actions, which has been approved by the upper tier local authorities and clinical commissioning groups. Action is being taken at a number of levels, but a system partnership approach to support the implementation of the health inequalities framework will improve health and wellbeing equity and therefore health and wellbeing outcomes. Examples include developing a LLR health inequalities/ Population Health Management Unit to understand the impact of the Covid pandemic on LLR health inequalities, improving data quality for protected characteristics, developing inequalities training for senior leaders etc. Other wider examples may be further development of Home First model or development of the LLR health and care workforce. Work in this area is likely to have greater impact when tackled at system level as well as work being done at place. It therefore meets criteria 2.

16. It is recognised that further development work will be required to link in the role and activities of neighbourhoods into the ICP through place governance, to ensure a golden thread between all three levels of the LLR system.

Enablers or underpinning principles of the ICP

17. It is proposed that the following tools or approaches should underpin the work that is undertaken by the ICP to enable the priorities to be achieved:
    - Health and wellbeing equity in all we do
    - Co-production of services and pathways with service users and their families as the norm in all we do
    - Embedding prevention in all we do by implementing Making Every Contact Count Plus (known locally as Healthy Conversations Skills) and upscaling prevention in system level services
    - Utilising a population health management approach
    - Adopting a trauma informed approach
    - A partnership of equals
    - Recognition and appreciation of the primacy of place in an ICS

How the ICP will work

18. The ICP will be a strategic collaborative forum meeting four times a year. Most of its work will in practice be done through system wide development sessions. This discursive approach means that a larger or wider membership is possible compared with the current health and care partnership membership. Therefore, the ICP will be a meeting of the members of the three Health and Wellbeing Boards in LLR. As the NHS structures evolve into an Integrated Care Organisation, the NHS membership of the ICP will be refined and streamlined. It is recognised that membership of the Health and Wellbeing Boards may also need updating to reflect other recent changes. The appendix to this report list the names of members of the shadow ICP and members of upper tier local authority HWBs.

19. Once each year, the ICP will hold an extended formal public meeting, in the form of an AGM. This will review and accept the terms of reference, sign off the annual strategy and other relevant documents, and review progress.

20. In order to remain transparent and accountable, meetings will be held in public, and will be supplemented with development sessions held in private to allow for a space where partners can consider key wicked issues. However, once these development sessions have taken place, a summary of discussions will be received at the next formal meeting of the ICP. It is intended that there will be four meetings held in public and two development sessions per year. The meetings in public will complete formal business of the partnership.

21. Outputs or system solutions from these development sessions would be delegated to time limited task and finish groups or current LLR design groups or workstreams. ICP members will also be expected to gain formal organisational agreement as appropriate for proposed actions developed within the ICP.

22. The three HWB chairs, the ICB/ICP chair and System Executive will meet on a quarterly basis to gain assurance and hold the system to account on agreed LLR system actions and consider the content of future ICP agendas.

Resource Implications

23. The paper highlights the need for the ICP to have dedicated secretariat and officer time which will be supplied through ICS budgets.

Relevant Impact Assessments

Equality and Human Rights Implications

24. The work of the ICP will ensure it gives regards to the Equality Duty through it's enabler regarding 'Heath and Equity' in all policies. Equality Impact Assessments will also be completed on specific pieces of work as necessary.

Partnership Working and associated issues

25. The role of the ICP within the developing ICS, will be dependent on high quality, trusted partnership working and ownership. It is acknowledged that there will be a need to review this new partnership as it evolves to consider what is working well, what could be improved, and what needs to change to enable the ICP to work well for LLR.

Appendix

A Summary of current membership of the shadow ICP (to be known as the LLR Health and Wellbeing Partnership) and members of upper tier local authority HWBs

Officers to contact

(On behalf of the ICP Working Group, March 2022)

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Appendix - Summary of the current membership of the shadow ICP (to be known as the LLR Health and Wellbeing Partnership) and members of upper tier local authority HWBs

Organisation	Name	Job Title	Current LLR ICP	HWB Leicester	HWB Leicestershire	HWB Rutland
Local Authority						
Leicester City Council	Martin Samuels	Strategic Director Social Care and Education				
Leicester City Council	Ivan Browne	Director of Public Health				
Leicestershire County Council	John Sinnott	Chief Executive				
Leicestershire County Council	Jon Wilson	Director of Adult Social Care				
Leicestershire County Council	Jane Moore	Director of Children and Family Services				
Leicestershire County Council	Mike Sandys	Director of Public Health				
Rutland County Council	Jon Morley	Strategic Director for Adults and Health (DASS)				
Rutland County Council	Dawn Godfrey	Strategic Director of Children and Families (DCS)				
Elected Members						
Leicester City Council	Cllr Vi Dempster	Assistant City Mayor Health				
Leicester City Council	Cllr Elly Cutkelvin	Assistant City Mayor - Housing and Education				
Leicester City Council	Cllr Piara Singh Clair	Deputy City Mayor - Culture, Leisure and Sport				
Leicester City Council	Cllr Rita Patel	Assistant City Mayor - Equalities and Special Projects				
Leicester City Council	Cllr Sarah Russell	Deputy City Mayor - Social Care and Anti-Poverty				
Leicestershire County Council	Mrs Louise Richardson	Cabinet Lead Member for Health				
Leicestershire County Council	Mrs Deborah Taylor	Cabinet Lead Member for Children and Family Services				
Leicestershire County Council	Mrs Christine Radford	Cabinet Lead Member for Adult Social Care				
Rutland County Council	Cllr Samantha Harvey	Lead Member for Health, Wellbeing and				

		Adult Care				
Rutland County Council	Cllr David Wilby	Lead Member for Education and Children's Services				
Oadby and Wigston Borough Council	Cllr Jeffrey Kaufman	District Councillor				
Blaby District Council	Cllr Cheryl Cashmore	District Councillor				
CCGs						
LLR ICS	David Sissling	Independent Chair				
LLR CCG	Andy Williams	Chief Executive				
LLR CCG	Sarah Prema	Executive Director of Strategy and Planning				
LLR CCG	Rachna Vyas	Exec Director of Integration & Transformation				
East Leicestershire, and Rutland CCG	Dr Vivek Varakantam	Chair				
West Leicestershire CCG	Professor Mayur Lakhani	Chair				
Leicester City CCG	Dr Avi Prasad	Co-Chair				
Leicester City CCG	Professor Azhar Farooqi	Co-Chair				
LLR CCG	Fay Bayliss	Deputy Director of Integration and Transformation				
LLR CCG	Melanie Thwaites	Associate Director: Children and Families				
The Lead District Officer for Health and Housing						
Melton Borough Council	Edd de Coverly	Chief Executive				
Healthwatch						
Healthwatch Leicester and Leicestershire	Harsha Kotecha	Chair				
Healthwatch Rutland	Dr Janet Underwood	Chair				
NHS England						
NHS England	Frances Shattock	Director of Strategic Transformation				

NHS England	Hayley Jackson	Assistant Director of Strategy and Transformation-LLR				
NHS England	Steve Corton/Wendy Hoult	NHS England – Midlands – BCF Lead				
UHL						
UHL	Richard Mitchell	CEO				
UHL	John MacDonald	Chair				
LPT						
LPT	Angela Hillery	Chief Executive				
LPT	Mark Powell	Deputy CEO				
LPT	Cathy Ellis	Chair				
LPT	TBC	Head of Community Health Services				
LPT	Fiona Myers	Interim Director of Mental Health Services				
Leicestershire Police						
Melton & Rutland	Audrey Danvers	NPA Commander				
Leicestershire Police	Chief Supt Jonny Starbucks	Commander, Local Policing Directorate				
Leicestershire Police	Inspector Lindsey Booth	Inspector				
OPCC						
Police and Crime Commissioner Leicestershire	Rupert Matthews	Police and Crime Commissioner				
Office for the Police & Crime Commissioner	David Peet	Chief Executive				
PCN						
NHS - GP	Dr Hilary Fox	East Leicestershire and Rutland PCN Representative				
NHS- GP	Dr Aruna Garcea	City PCN Representative				
LLR LMC	Dr Anu Rao	Leicestershire PCN Representative				
EMAS						

EMAS	Richard Henderson	Chief Executive				
EMAS	Pauline Tagg	Chair, EMAS				
EMAS NHS Trust	Richard Lyne	General Manager, Leicestershire				
Universities						
Leicester University	Professor Andrew Fry	College Director of Research				
DMU	Professor Bertha Ochieng	Professor of integrated health and social care				
Patient and Public Involvement Assurance Group						
Patient and Public Involvement Assurance Group	Evan Rees	Chair				
Leicestershire Fire and Rescue Service						
Leicestershire Fire and Rescue Service	Callum Faint	Chief Fire Officer				
VCS						
Voluntary Action Leicester	Kevan Liles	Chief Executive				
Citizen's Advice Rutland	Duncan Furey	Chief Operating Officer				
NHSE/I						
NHSE/I Midlands Region	Oliver Newbould	Director of Intensive Support				
Strategic Sports Alliance Group						
Strategic Sports Alliance Group	Kevin Routledge	Leicester Rider's Chairman				
DHU Healthcare						
DHU Health Care	Stephen Bateman	Chief Executive				
DHU Health Care	David Whitney	Chair				
LLEP						
LLEP	Sue Tilley	Head of Business and Innovation				
Other						
Longhurst Group	Louise Platt	Executive Director of Care and Business Partnerships				

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Agenda Item 11

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

NHS

HEALTH AND WELLBEING BOARD: 26 MAY 2022

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

COMMUNITY HEALTH AND WELLBEING PLANS

Purpose of report

1. The purpose of this report is to present to the Health and Wellbeing Board the intended approach for the development of the Community Health and Wellbeing Plans (CHWP's) across Leicestershire.

2. The report also provides an update concerning neighbourhood working and the complexities regarding governance and footprints of the CHWP's.

Recommendation

3. It is recommended that:

    a) The purpose of the Community Health and Wellbeing Plans (CHWP) and the development of seven plans across Leicestershire be noted;

    b) The proposed approaches to governance and footprints of the CHWPs be noted;

    c) The links to the Joint Health and Wellbeing Strategy (JHWS) and other place-based plans and work including the CHWPs be noted.

Background

4. In January 2021, the Department for Health and Social Care (DHSC) published proposals through the White Paper: Integration and Innovation: Working together to improve health and social care for all, to develop the NHS long term plan and bring forward measures for statutory Integrated Care Systems (ICS). The ICS for Leicester, Leicestershire and Rutland (LLR) was approved in April 2021 in shadow form, coming into full existence in July 2022.

5. Partnership working has been established across the system (LLR collectively), place (Leicester, Leicestershire, and Rutland separately) and neighbourhood (at locality level). The NHS long term plan highlights the importance of joint working, and the White Paper outlines a duty for the NHS and Local Authorities to collaborate with the introduction of Health and Care Partnerships to support integration and address health,

public health and social care need with a key responsibility being to support place based joint work.

6. Place based work is being driven through the new Joint Health and Wellbeing Strategy which also serves as the Place Led Plan for Leicestershire. A similar planning approach is proposed on a neighbourhood footprint to support the ICS in identifying variance in health needs and outcomes across different areas of the County.

The purpose and content of CHWP's

7. The purpose of CHWP's are:

    a. To identify solutions to the Primary and Community care infrastructure/services when impacted by housing growth
    b. To understand the local needs in relation to health and wellbeing
    c. To ensure we have plans to drive improvement to the health and wellbeing of local populations
    d. To ensure the NHS is maximising opportunities to bring care closer to home
    e. To both inform the JHWS (through identification of local need) and respond to JHWS priorities at a neighbourhood level where appropriate

8. To do this, partners will:
    - Look at local healthcare services to understand the patterns of access to community hospital, outpatient, elective and day-case procedures
    - Consider housing growth planned for the local area and ensure there are plans in place to support Primary and Community care services to meet rising demand
    - Gather information to help us understand local need, inequity, and outcomes
    - Engage with local communities where appropriate to understand local wants/needs

9. The plans are being developed on a district footprint due to the availability of lower tier local authority data and alignment with lower tier local authority partnerships that focus on health and wellbeing. It is intended that these plans form the strategic picture for health and wellbeing for the neighbourhood area and that other initiatives at neighbourhood level are co-ordinated through these plans.

The fit with other local plans and strategies

10. Many individual organisations have their own plans relating to health and wellbeing for their staff, resources and priorities and some local partnerships have developed their own plans or strategies. This includes examples such as:

    - Local plans developed by district councils to plan to meet physical need in the area (e.g., housing growth)
    - PCN plans to address need or areas of improvement in Primary Care (GP) provision in the area

- Sustainable community strategies and health and wellbeing strategies developed by local partners to oversee improvement, often led by district councils

11. The CHWP's will form an umbrella plan across all of these. Whilst they will not contain the same level of detail, they will reference them and their importance in local health and wellbeing.

12. Some of the linked plans may have a footprint that is at system or place rather than neighbourhood. If these system or place plans relate to a local need, there will be a discussion with the system or place led to see whether neighbourhood work is also required. These discussions are likely to result in one of three outcomes:

    1. Actions will continue to be delivered at system or place with input from neighbourhood partners
    2. Actions will be delivered at both system/place and neighbourhood footprints with partners agreeing who is doing what and what footprint their action relates to
    3. Actions will be best delivered at neighbourhood with some oversight at system/place

13. The CHWPs will adopt a 'Do, Sponsor, Watch' approach to prioritising the work of the plans in line with the JHWB Strategy. This is to ensure clarity upon system, place and neighbourhood accountability.

14. This co-ordination across system, place and neighbourhood will be key in ensuring a 'golden thread' approach to delivering improved outcomes and will avoid duplication or contradictory action.

Timescales for delivery

15. Of the seven plans proposed, three are nearing the prioritisation stage which should be completed by the end of the summer. Three plans are at needs assessment stage whilst development of the other remaining plan will commence in early Autumn 2022.

16. Once agreed, a Delivery Plan will be developed to identify the necessary actions required to impact on the priorities and a dashboard will support the on-going review of progress alongside this.

17. It is anticipated that all of the CHWP's will be in place and approved by the end of 2022/early 2023 with delivery plans in place within 6 months of each plan being approved.

Governance

18. The plans are being developed through local partnerships, often the Integrated Neighbourhood Team (Includes representatives from the GP practices, Adult Social Care, Leicestershire Partnership Trust, Local Authority, VCSE etc) where this is co-terminus with the CHWP footprint or through a task and finish group established specifically to develop the plan.

19. The Governance arrangements for the plans have not been finalised but the proposed structure as set out in the Appendix, provides the basis for discussion with each locality upon the potential governance architecture.

20. It is envisaged that the 'Integrated neighbourhood teams (INT)' will be the delivery arm of the plans noting that specific priorities e.g., health will need to be led by the CCGs/ICB as the decision-maker/commissioner of those services. Each district has a Local Partnership Board, and the proposal is that these boards will have oversight of the plans with regular reporting into the district health leads meeting as well as the Integrated Delivery Group e.g., the Charnwood Partnership Board is changing it's name to the 'Charnwood Community Health and Well-being Board and are updating their Terms of reference to reflect oversight of the plan and regular reporting into both the Integrated Delivery Group (IDG) and the Health and Well-Being board. There will also be a requirement for all plans to report into the Leicestershire Health and Wellbeing Board and IDG to ensure that there is synergy and alignment with the JHWBP.

21. There are complexities with 'neighbourhood working' as footprints for INTs and PCNs are not always co-terminus with the CHWP footprints. Where this is not the case discussions will take place with those INTs/PCNs to request that they are able to drive forward the priorities within the relevant CHWP e.g., the Melton, Syston and Vale INT have agreed that they will provide the delivery arm for the Melton CHWP.

Appendix

Proposed Governance arrangements

Relevant Impact Assessments

Equality and Human Rights Implications

22. The CHWP's will aim to identify and reduce health inequalities and will link with the wider LLR Health inequalities framework.

Crime and Disorder Implications

23. A partnership approach and links to wider strategies such as local sustainable communities strategies will be developed as part of these CHWP's.

Environmental Implications

24. Local needs assessments will form the basis of the plans and will take into account information (where available) such as air quality, access to green space, active transport and having healthy places.

Partnership Working and associated issues

25. CHWP's will take a partnership approach to assessing need, defining and agreeing priorities and agreeing actions to address these. Partnership working is at the core of these plans.

Risk Assessment

26. The key risk the JHWS and HWB development will face is maintaining the ongoing stakeholder support and buy in through the development and implementation of the plans. Partners investment of resource and time may be impacted on by a number of factors including the Covid-19 pandemic, winter pressures and national, local or organisational changing priorities.

Officers to Contact

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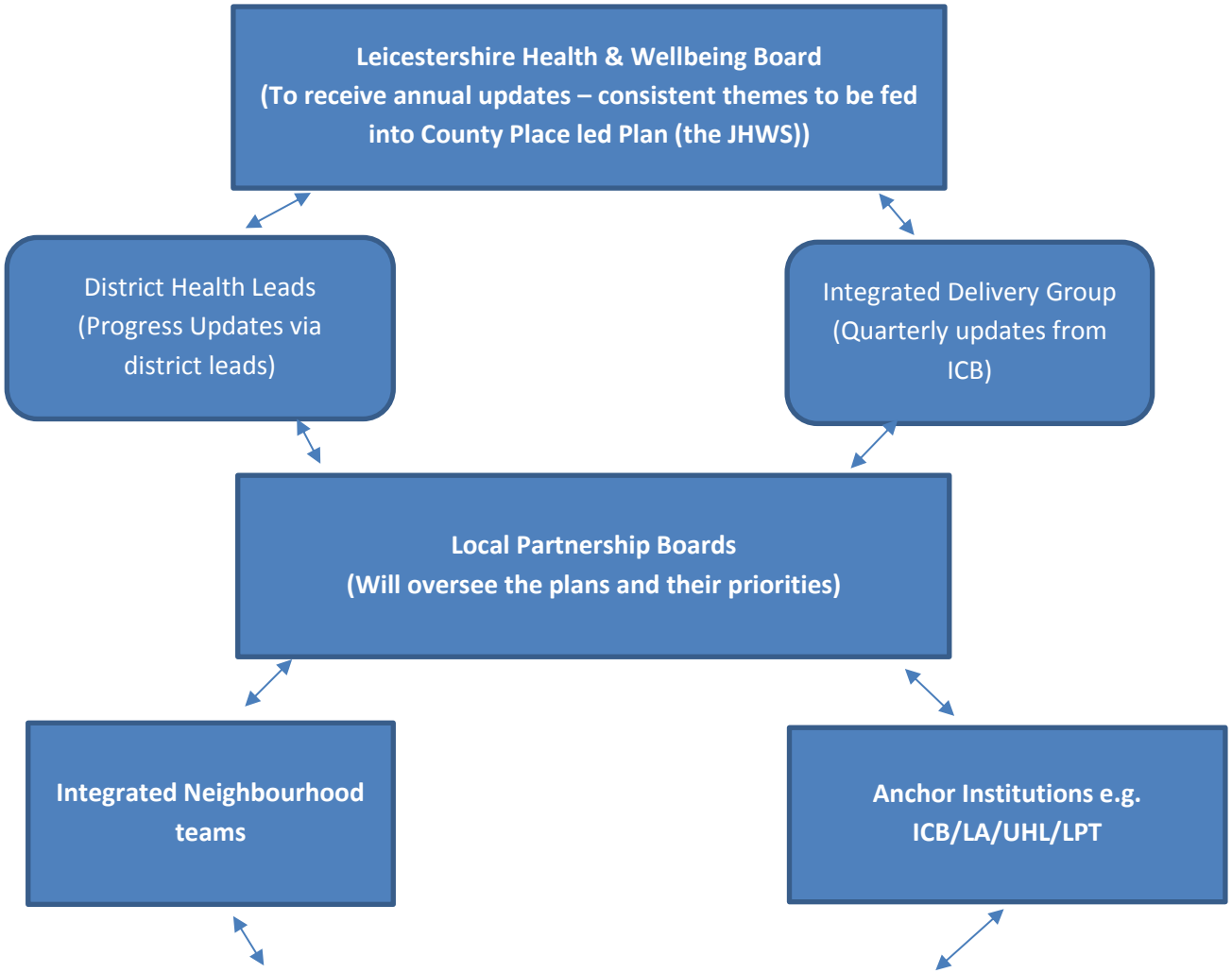

	Potential Priorities in the CHWB plans	(Not a Definitive List)	System/Place/Neighbourhood
Community safety	VCSE	Mental Health	Sponsor
Public health	Housing	Health	Do
Physical health	Employment	CYP	Watch

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