Leicestershire County Council

Meeting: **Health and Wellbeing Board**

Date/Time: **Thursday, 4 December 2025 at 2.00 pm**

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

Contact: **Euan Walters (Tel: 0116 305 6016)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Mr. M. Squires CC (Chairman)

Barney Thorne	Kevin Allen-Khimani
Edd de Coverly	Fiona Barber
Harsha Kotecha	Siobhan Peters
Jane Moore	Mr. C. Pugsley CC
Mike Sandys	Cllr. J. Kaufman
Jon Wilson	Cllr Cheryl Cashmore
Jean Knight	Toby Sanders
Rachel Dewar	Mr. C. Abbott CC
Simon Pizzey	Matt Gaunt

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 25 September 2025.		(Pages 3 - 12)
2.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
3.	Declarations of interest in respect of items on the agenda.		
4.	Position Statement by the Chairman.		
5.	Mental Health Place-based Sub-group progress update.	Director of Public Health	(Pages 13 - 18)

6.	Leicester, Leicestershire and Rutland Joint Living Well Dementia Strategy.	Director of Adults and Communities	(Pages 19 - 28)
7.	Neighbourhood Models of Care.	Integrated Care Board	(Pages 29 - 38)
8.	Office of the Police and Crime Commissioner.	Police and Crime Commissioner	(Pages 39 - 46)
9.	Better Care Fund - Quarter 2 2025/26.	Director of Adults and Communities	(Pages 47 - 62)
10.	LLR SEND and Inclusion Alliance.	Integrated Care Board	(Pages 63 - 96)
11.	Pandemic Planning	Integrated Care Board	(Pages 97 - 108)
12.	Joint Local Health and Wellbeing Strategy review.	Director of Public Health	(Pages 109 - 174)
13.	Any other items which the Chairman has decided to take as urgent.		
14.	Date of next meeting. The next meeting of the Health and Wellbeing Board will be held on Thursday 26 February 2026 at 2.00pm.		

Agenda Item 1

Minutes of a meeting of the Health and Wellbeing Board held at County Hall, Glenfield on Thursday, 25 September 2025.

PRESENT

Leicestershire County Council

Mr. M. Squires CC (in the Chair)
Mr. C. Pugsley CC
Mike Sandys
Jon Wilson

District Councils

Edd de Coverly

Integrated Care Board

Toby Sanders
Rachel Dewar
Pete Burnett

University Hospitals of Leicester NHS Trust

Simon Pizzey

Leicestershire Partnership NHS Trust

Jean Knight

Office of the Police and Crime Commissioner

Siobhan Peters

Healthwatch Leicester and Leicestershire

Fiona Barber

Voluntary Action Leicestershire

Kevin Allen-Khimani

In attendance

Joshna Mavji – Leicestershire County Council
Abbe Vaughan – Leicestershire County Council
Lisa Carter – Leicestershire County Council
Tracy Ward – Leicestershire County Council
Hanna Blackledge – Leicestershire County Council
Ellie Lowe – Leicestershire County Council

Euan Walters – Leicestershire County Council

Apologies

Mr. C. Abbott CC, Mr. J. Sinnott, Cllr Jeffrey Kaufman, Cllr Cheryl Cashmore, Jane Moore

17. Minutes of the previous meeting.

The minutes of the meeting held on 29 May 2025 were taken as read, confirmed and signed.

18. Urgent items.

There were no urgent items for consideration.

19. 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.

The Chairman himself declared an Other Registerable Interest in all substantive items as he was an agency worker for Leicestershire Partnership NHS Trust. The Chairman clarified that the agenda items did not directly relate to his employment and therefore he would remain in the room throughout the meeting.

No other declarations were made.

20. Position Statement by the Chairman.

The Chairman presented a Position Statement on the following matters:

(i) Health and Wellbeing Board Membership update;
(ii) Adult Social Care;
(iii) NHS;
(iv) Chair's Engagement Activity;
(v) Key Messages.

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

The Chair also reported that he had received a petition from Mr. J. T. Orson CC regarding the potential closure of St Mary's Birth Centre in Melton. The petition had over 3,000 signatures. The Chair stated that he would give consideration to which would be the best way of dealing with the petition.

21. NHS 10 Year Health Plan for England.

The Board considered a report of the Integrated Care Board regarding the main objectives and implications of the Ten-Year Health Plan for England which was published by the government in July 2025. A copy of the report, marked 'Agenda Item 5', is filed with these minutes.

Arising from the report the following discussions took place:

(i) It was noted that a significant part of the plan was to shift care from hospital to the community. The implementation of the Neighbourhood Health Programme in Leicestershire was key to the delivery of the 10 year plan.

(ii) West Leicestershire had been named as one of 43 areas in England which would benefit from improved Neighbourhood Health Services as part of a government scheme. Reassurance was given that Neighbourhood services would be implemented in the rest of Leicestershire as soon as possible and the learning from the national programme would be passed onto the other areas. Further engagement with district councils was required and would take place.

(iii) The way partners worked together was key and the changes which were taking place to the structure of Integrated Care Boards was an opportunity to review the ways of working. The direction of travel for the NHS and local government was to create larger organisations covering a wider geographical footprint. It was therefore emphasised that it was important not to lose the focus on place and neighbourhood.

(iv) The Chair noted that there were issues with staffing, recruitment and retention in Leicestershire and queried whether the resources were available to carry out the proposals set out in the 10 year plan. In response reassurance was given that the 10 Year Health Plan would be accompanied by an NHS 10 Year Workforce Plan which would set out how the NHS would tackle the issues of retention, productivity, training and attrition. The shift from hospital to community would also help with these issues.

(i) It was suggested that the implementation of the 10 year plan would be more effective if communities had 'buy-in' and helped develop the proposals. The level of community resilience was also important.

RESOLVED:

That the information provided in the report be noted and priority actions be supported.

22. Families First Reform Programme

The Board considered a report of the Children and Families Service, Leicestershire County Council which provided an overview of the Families First Partnership Programme (FFPP) which was the delivery mechanism for the Government's reform of children's social care services. A copy of the report, marked 'Agenda Item 6', is filed with these minutes.

As part of discussions the following points were made:

(i) Members praised the work that had gone into the FFPP. The Cabinet Lead Member for Children and Families Mr. C. Pugsley CC emphasised the importance of the partnership work and the potential for it to lead to positive outcomes for families. Other members also advocated the partnership approach particularly the use of the voluntary sector, and in response reassurance was given that the voluntary sector and a wide range of partners were heavily involved. The wider community and networks would play a role in achieving outcomes for children and families. A networking event to bring families and partners together was being organised.

(ii) It was queried what the expected outcomes were and what success looked like. It was emphasised that the children and families themselves needed to have input into what the expected outcomes were. In response it was explained that engagement events were taking place where families could have an input into goal setting.

(iii) There were several different services in Leicestershire which worked with Families run by different organisations, and it was important that the way they linked together was understood and that they complimented each other but did not duplicate work. It was explained that Families First was different to Family Hubs because it was more targeted whereas Family Hubs were universally available. Family Hubs enabled multi-agency working as at the one venue a family could engage with several different partners. As the Neighbourhood Health Programme was implemented an assessment needed to be made of whether all the services aligned with each other.

(iv) The implementation of the Neighbourhood Health Programme was an opportunity to ensure that not only the Families First Programme linked in with the Neighbourhood work, but all the other work with families was aligned as well.

RESOLVED:

That the Board:

(a) Notes the content of the report and shares within agencies;

(b) Participates in partnership briefings and engagement events to support partnership collaboration;

(c) Notes the implications for practice, process and future commissioning.

23. Pharmaceutical Needs Assessment 2025.

The Board considered a report of the Director of Public Health regarding the outcome of the statutory consultation on the draft Pharmaceutical Needs Assessment (PNA) 2025. A copy of the report, marked 'agenda item 7', is filed with these minutes.

Arising from discussions the following points were made and noted:

(i) It was stressed that the PNA needed to take into account of the amount of housing development taking place in Leicestershire and the locations of the extra housing. Local Plans were a useful guide in this regard. In response reassurance was given that housing figures had been received (albeit late in the process) and fed into the assessment.

(ii) A member emphasised the importance of pharmacies being accessible by public transport.

(iii) Community Pharmacies were now playing a much broader role and were able to advise patients on more issues without the patient needing an appointment at the

GP Practice. More work could be carried out to raise public awareness of the services offered by pharmacies.

(iv) A letter had been received from the Integrated Care Board dated 4 August 2025 in response to the consultation, which was broadly supportive of the conclusions and recommendations, and suggested priorities for the work going forward.

RESOLVED:

That the Board:

(a) Notes the report, outcome of the statutory consultation and amendments made to the draft Pharmaceutical Needs Assessment as a result; and

(b) Approves the final Leicestershire Pharmaceutical Needs Assessment to be submitted and published.

24. Joint Local Health and Wellbeing Strategy Review 2022-32

The Board considered a report of the Director of Public Health regarding proposed changes to the Joint Local Health and Wellbeing Strategy (JLHWS) 2022-2032. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

Arising from discussions the following points were noted:

(i) The proposed changes had been considered by the Health Overview and Scrutiny Committee on 3 September 2025. The Committee had gained assurances that issues were not being removed from the Strategy altogether but streamlined in the commitments, with detail retained in accompanying delivery plans that would follow on from the review. Reassurance was also given that the Strategy would address the health and wellbeing of people post-retirement.

(ii) Simplifying the commitments in the JLHWS made the document more accessible and easy to read. Phase 2 of the project work would cover the delivery plans and how progress with the commitments could be measured.

(iii) Whilst the review had originally been intended to be 'light-touch', it became a more in-depth piece of work. Officers were thanked for the thorough and comprehensive nature of their work.

(iv) It was emphasised that to make the Strategy worthwhile it needed to be effectively communicated to wider partners and the public. In response reassurance was given that comms and engagement workstreams were being put in place. Feedback had already been received from the public regarding how the previous Strategy had been perceived by the public.

RESOLVED:

That the Board:

(a) Approves the recommended changes to the current Joint Local Health and Wellbeing Strategy 2022-2032 as part of the current review;

(b) Approves the approach to the next phase of the review including indicative timescales.

25. Healthwatch Leicestershire Annual Report.

The Board considered a report of Healthwatch Leicestershire which presented the organisation's Annual Report for 2024/25. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

Arising from discussions the following points were noted:

(i) University Hospitals of Leicester NHS Trust welcomed the work Healthwatch carried out and thanked them for the insight into services that they provided. Likewise, Leicestershire Partnership NHS Trust valued the work of Healthwatch. It was agreed that where NHS Trusts required further detail on surveys carried out by Healthwatch, that detail could be provided on request.

(ii) Government was proposing that Healthwatch functions related to healthcare be combined with Integrated Care Boards, and Healthwatch functions related to social care transfer to local authorities. However, these proposals required legislation to implement them and therefore in the meantime Healthwatch was taking a 'business as usual' approach. Board members welcomed this approach from Healthwatch.

(iii) The Director of Adults and Communities at Leicestershire County Council invited closer working between Healthwatch and the local authority with regards to adult social care, as the future proposals for Healthwatch became closer to being implemented.

(iv) Voluntary Action Leicestershire (VAL), who held the Healthwatch contract, asked that partner organisations not make any public announcements about the future of Healthwatch without checking with VAL first so as not to upset Healthwatch staff.

(v) One of the reasons why the public felt comfortable engaging with Healthwatch was that they were independent from the service providers. The future proposals for Healthwatch had the potential to curtail this independence but further clarity was required before the full implications could be understood.

(vi) Healthwatch Leicestershire was calling on women and girls of all ages, backgrounds and communities to take part in a new survey about their experiences of health and care services. Partners were asked to help publicise this survey.

RESOLVED:

That the contents of the report be noted.

26. Leicestershire and Rutland Safeguarding Adults Board Annual Report 2024-25 and Business Plan 2025-27.

The Board considered a report of the Independent Chair of the Leicestershire and Rutland Safeguarding Adults Board regarding the Safeguarding Adults Board Annual Report 2024/25, Strategic Plan 2025-2031 and Business Plan for 2025-2027. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

Arising from the report the following discussions took place:

(i) Whilst self-neglect was no longer a business plan priority for 2025 reassurance was given that this did not mean that it was not considered to be important. This issue had already received a lot of focus between 2023 and 2025. Mental Capacity however would continue as a priority despite the extensive work that had already been undertaken around this theme.

(ii) Government had placed a duty on Safeguarding Adults Boards to support individuals that were rough sleeping. It was clarified that this referred to those people sleeping on the streets rather than those that did not have a permanent bed and slept in other people's homes.

(iii) A significant proportion of the safeguarding concerns related to the same individuals therefore it was queried what work took place to tackle the route causes. In response it was explained that some individuals were at risk from various different sources and therefore multiple referrals were required. Safeguarding plans were put in place to protect people.

(iv) Durham University, supported by the Leicestershire Safeguarding Boards, had carried out some research relating to Domestic Abuse against older adults. It was suggested that Leicestershire Police should be linked in with this work and the Director of Adults and Communities agreed to ensure that they were.

(v) The Reserve Fund had been used to manage foreseen costs, however as this fund was limited partner contributions could have to be increased going forward.

RESOLVED:

That the Board notes the Leicestershire and Rutland Safeguarding Adults Board's Annual Report for 2024-2025, the Leicester, Leicestershire and Rutland Safeguarding Adults Boards' Strategic Plan 2025-2031 and Business Plan for 2025-2027, and takes into account the key points of relevance relating to health and wellbeing.

27. Leicestershire and Rutland Safeguarding Children's Board Annual Report 2024-25 and Business Plan 2025-27.

The Board considered a report of the Leicestershire and Rutland Safeguarding Children Partnership which presented its yearly report for 2024-25 and its Business Plan for 2025-27. A copy of the report, marked 'Agenda Item 11', is filed with these minutes.

As nobody from the Partnership was available to present the report, the Chairman informed that any questions would be taken away and answered after the meeting. No questions were submitted.

RESOLVED:

That the Board notes the Leicestershire and Rutland Safeguarding Children Partnership Yearly Report for 2024-25, the Leicester, Leicestershire and Rutland Safeguarding Children Partnerships' Business Plan for 2025-27, and the key points of relevance relating to health and wellbeing.

28. Better Care Fund Quarter 1.

The Board considered a report of the Director of Adults and Communities which presented the quarter 1 2025/26 template report of the Better Care Fund (BCF). A copy of the report, marked 'Agenda Item 12', is filed with these minutes.

Arising from discussions the following points were noted:

(i) The full data for quarter 1 2025/26 was not yet available due to a delay in national reporting therefore data from quarter 4 2024/25 had been used instead to enable comparisons with the previous year to be made. However, some data from July 2025 was currently available. These delays were expected to continue into the future due to the standard NHS England reporting timescales.

(ii) The proportion of adult patients discharged from acute hospitals on their discharge ready date was 84.9% for quarter 4. The Chairman emphasised the importance of increasing domiciliary care capacity in order to help improve discharge rates. He stressed that this was particularly important during the winter months where hospitals faced extreme pressures. In response it was explained that only a relative small proportion of patients discharged from hospital went into domiciliary care therefore increasing domiciliary care capacity would not have a big impact. Furthermore, the current wait times for domiciliary care were almost non-existent and care could usually be provided as soon as it was requested by the hospital. Work was taking place to improve reablement care capacity as this was the best way of getting patients active again. Reassurance was given that the NHS and the County Council were working well together with regards to discharge and improving flow out of the hospital. Work was taking place with the business management consultants Newton Europe to improve the step up and step down processes.

(iii) In response to a question from the Chairman about whether pooling funds was better than spending the money separately, it was explained that pooled funding produced better outcomes. Constant efforts were made to drive value from the Better Care Fund. In-house services were better value for money. Enabling staff from different organisations to share roles was more effective than requiring the patient to wait for a professional from a different organisation to arrive. One of the benefits of pooled funding was that the money was protected for specific purposes and would not be used by organisations for other urgent pressures which arose. In any case pooled funding for Adult Social Care was a statutory requirement under the NHS Act 2006.

RESOLVED:

That the Board notes:

(a) The performance against the Better Care Fund outcome metrics, and the positive progress made in transforming health and care pathways up to quarter 1;

(b) The action taken by the Chief Executive of Leicestershire County Council, to approve the Better Care Fund Quarter 1 report and use of powers of delegation to approve this for the NHS England submission deadline of 15th August 2025.

29. Section 75 Agreement.

The Board considered a report of the Director of Adults and Communities which presented the Section 75 agreement for 2025/26 and sought approval to continue with the pooled budget arrangements. A copy of the report, marked 'Agenda Item 13', is filed with these minutes.

Arising from discussions the following points were noted:

(i) In response to a question from the Chair it was confirmed that there was flexibility within the Section 75 Agreement for funding to be moved and reallocated mid-year for emerging priorities. However, the minimum percentage of allocations to each area was set by government and could not be changed.

(ii) Quarterly updates were brought to the Board regarding spending therefore the Board was regularly kept appraised of any significant changes. Reports were also taken to the Integration Executive regarding variances. In all the time the Better Care Fund had been in operation there had been no significant overspends. Any underspends would be reallocated.

(iii) Whilst Integrated Care Board structures were covering a larger geographical footprint going forward due to the clustering process, there was also an increased focus on neighbourhood health and it was important that shared funding arrangements related specifically to those neighbourhood areas, rather than funding being drawn up to the much larger ICB areas. In doing this the risks and joint benefits needed to be taken into account. The Better Care Fund was already broken down into community services and aligned with the neighbourhood plan and Joint Local Health and Wellbeing Strategy and this approach would be continued.

RESOLVED:

(a) That the Board notes the work undertaken to refresh the Section 75 pooled budget agreement for the Better Care Fund.

(b) That the continuation of Section 75 pooled budget arrangements between Leicestershire County Council and the Leicester, Leicestershire and Rutland Integrated Care Board be approved.

30. Annual Health Protection report.

The Board considered a report of the Director of Public Health which provided an overview of health protection activities in Leicestershire from January to December 2024. A copy of the report, marked 'Agenda Item 14', is filed with these minutes.

The Director of Public Health stated that he was as assured as he could be regarding the Health Protection arrangements in Leicestershire, without being able to predict everything that would happen in the future.

The importance of County Council staff getting vaccinated against flu and Covid-19 was emphasised. To make it easier for staff, and help overcome resistance to vaccines, vaccinations were taking place on Council premises.

RESOLVED:

That the Board:

(a) Notes the annual Health Protection Report 2024;

(b) recognises the specific health protection issues that have arisen locally, the steps taken to deal with them and the areas of focus for the coming year.

31. Dates of future meetings.

RESOLVED:

That future meetings of the Board take place on the following dates all at 2.00pm:

Thursday 4 December 2025;
Thursday 26 February 2026;
Monday 15 June 2026;
Thursday 17 September 2026;
Thursday 10 December 2026.

2.00 - 4.45 pm CHAIRMAN
25 September 2025

Leicestershire County Council

HEALTH AND WELLBEING BOARD:

4TH DECEMBER 2025

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

MENTAL HEALTH PLACE-BASED SUB-GROUP PROGRESS UPDATE

Purpose of report

1. The purpose of this report is to enable the Mental Health Place-based subgroup to update the Health and Wellbeing Board on progress in delivering against the Joint Local Health and Wellbeing Strategy (JLHWS) priorities.

Recommendation

2. The Board is asked to note the progress that has been made over the past 12 months.

3. The Board is asked to support the work of the group including helping to overcome barriers to data sharing, to help facilitate progress in some areas of work.

Policy Framework and Previous Decision

4. The Leicestershire HWB Mental Health Place-based group was established in February 2023. As well as being a HWB sub-group, the group also acts as the place-based group for the Leicester, Leicestershire and Rutland (LLR) Mental Health Collaborative.

5. The Mental Health Place-based group is now well established, with representation from a range of partners including Leicestershire County Council, NHS Leicestershire Partnership Trust (LPT), Integrated Care Board (ICB), the voluntary and community sector, and the district and borough councils.

Background

6. Good mental health and wellbeing is an important part of our overall health, and the impacts of poor mental health and wellbeing are wide reaching. Mental health impacts on our emotional, psychological, and social well-being, and affects how people think, feel, and act. It also helps determine how individuals handle stress, relate to others, and make choices.

7. The priority areas of the Mental Health Place-based group are largely driven by the JLHWS commitments, along with the Mental Health Joint Strategic Needs Assessments (JSNAs) for both Children and Young People (CYP), and adults.

8. A delivery plan has been developed around the priorities for the group based on a life course approach. Key elements of the plan include:

- Development of an all-age **Mental Health Promotion plan** around prevention. This work, led by public health, is underway with a programme of work, including a campaign around the 'Five Ways to Wellbeing' due to be delivered through 2026.

- **Children and Young People (CYP)** – Supporting and enhancing the CYP offer around mental health and wellbeing including the transition from child to adult services. This work is ongoing with partners working together to help understand and promote access and awareness of the different levels of support available for CYP.

- **Health Inequalities - Serious Mental Illness (SMI)** – improving health check uptake and follow up support for people with SMI. This work is led by the ICB, with partners contributing to elements of this including breast cancer uptake screening; and smoking cessation uptake programmes of work (as outlined below). The proportion of county patients, on GP SMI registers, receiving all six health checks is around 67%, this is statistically significantly better than the national average (60%).

- **Health Inequalities - Serious Mental Illness (SMI)** – Improving breast cancer screening uptake in people with SMI. Initiated as a priority in county, this has now been adopted as a health inequalities priority across LLR by the Mental Health Collaborative. A system wide programme of work based on the use of the Health Equity Audit tool is underway (further details below).

- **Suicide Prevention** – supporting the work of the LLR Suicide Audit and Prevention Group (SAPG) and strategy re-fresh.The suicide prevention strategy re-fresh is now complete, and implementation is now underway.

An example of action related to suicide prevention is detailed below in MHFP and clubs.

- **Dementia** – raising awareness of modifiable risk factors and role of lifestyle in relation to Dementia, prevention, and improving dementia diagnosis rates. Implementation of a local plan around Dementia is underway in line with the LLR Dementia strategy, led by local authority Adult & Communities colleagues. Dementia diagnosis rates for the county remain a challenge despite ongoing efforts to address this – though rates are not significantly different to the England average.

  A campaign to raise awareness of modifiable risk factors for Dementia is planned for 2026, led by public health.

  Further detail related to progress in relation to dementia priorities is included in a separate report to the Board for this meeting.

- **Wider Determinants** - addressing the impacts of the wider determinants on mental health and wellbeing; which include employment, housing and gambling harms. District council colleagues are leading on a piece of work, to explore opportunities that will improve the availability of mental health support for those who are affected by homelessness. This also includes those living in temporary accommodation as part of the wider work to target efforts around those with Severe and Multiple Disadvantage (SMD).

Progress made in the last 12 months

9. There has been considerable activity over the last 12 months that has contributed to the delivery of the MH Place-based priorities. Below are a few key highlights of the areas where significant progress has been made:

Supporting People with SMI: Stop Smoking Service

10. Highlighted in both the Leicestershire County Council Adults MH and Health Inequalities JSNA, it is well evidenced that people with Serious Mental Illness (SMI) often die prematurely compared to those who do not have SMI.

11. Smoking prevalence remains disproportionately high among people with SMI, contributing to poor health outcomes and a 15–20-year shorter life expectancy compared to the general population. Locally, referrals into the QuitReady stop smoking service were historically low, with fragmented engagement from mental health professionals and inconsistent pathways into support.

12. To address this inequality a programme of work has been implemented to develop a more visible, appropriate and accessible stop smoking offer for people with SMI across Leicestershire.

13. Key to planning and implementing change to the service has been utilising improved service-level data capture to monitor referrals, engagement, and quit outcomes specifically for people with SMI. The latter has included integrating SMI indicators into QuitReady's data systems to enable better tracking of uptake and outcomes.

14. This has resulted in the following:
    - Strengthening referral pathways through direct engagement with Leicestershire Partnership NHS Trust (LPT) and community providers.
    - Developing a clear process for referrals during SMI Health Checks, supported by secure sharing of patient data.
    - Upskilling QuitReady advisors through training in trauma-informed care and mental health awareness.
    - Improving awareness and confidence of Community Mental Health Facilitators and other frontline staff through Brief Intervention training and information-sharing sessions.
    - Embedding standardised, psychologically informed care planning for SMI clients, including collaborative working with Community Psychiatric Nurses (CPNs).
    - Improving communications to challenge myths, reduce stigma, and make Quit Ready's offer more accessible and inclusive.
    - As a result of this approach, early indications are that service uptake amongst people with SMI is already improving.

Supporting People with SMI: Breast Cancer Screening

15. This is now an LLR system-wide piece of work that was agreed as a priority via the LLR mental health collaborative. A Health Equity Audit is underway using the Health Equity Assessment Tool (HEAT), this process has enabled the identification of key barriers to breast cancer screening among individuals with SMI. This has highlighted four thematic areas for action these are: people-related, system issues, service-related, and wider environmental factors. A targeted plan has been developed to address these barriers and promote effective facilitators for breast screening.

16. Recent achievements include increased awareness of SMI across the integrated care system, enhanced promotion of reasonable adjustments such as the Equality Access Clinic (EAC) and an improved understanding of the local breast screening pathway. The Leicestershire Partnership NHS Trust's mental health directorate has updated its Standard Operating Procedure to include an addendum that will ensure a minimum offer for individuals with SMI to participate in the screening programme. Additionally, engagement with lived experience and peer support has been strengthened, resulting in meaningful improvements in service delivery and accessibility.

Suicide Prevention

17. The completed refresh of the LLR Suicide Prevention strategy identified five priority areas including:
    i) Suicide Bereavement
    ii) High Risk Groups/Locations
    iii) Children and Young People
    iv) Self-harm
    v) Leadership

18. Under the umbrella of the LLR Suicide Audit Prevention Group, actions are now being developed, agreed and implemented in line with priority areas.

Mental Health Friendly Places/Clubs Programme

19. The Mental Health Friendly Places (MHFP) initiative is a partnership project that is led by Leicestershire County Council and Leicester City Council. A MHFP is a public facing organisation that has received training resources and support to confidently navigate conversations around low-level mental health and wellbeing. Upon completing the free training and becoming a MHFP, each organisation will be able to recognise signs and symptoms of poor mental health; ask appropriate questions, listen effectively and signpost to local mental health services to ultimately prevent people from reaching crisis point. Launched in May 2024, it forms part of the wider suicide prevention work. The aim of the MHFP is to support and deliver community-based prevention work throughout LLR. To date there are 77 MHFPs in the County.

20. Due to the success of the MHFP, a pilot project was developed with the Leicestershire and Rutland County FA aimed at supporting men's mental health by delivering football sessions, branded "My Space, My Game". A total of 5 local football clubs signed up to take part in the pilot, to encourage local men in the community to use football to support their wellbeing. Each club received free mental health and suicide awareness training.

21. The feedback received through the "My Space, My Game" pilot highlighted the positive impact the initiative was having on local men. As a result, the Mental Health Friendly Clubs (MHFC) programme was developed. Unlike the "My Space, My Game" project, which focussed specifically on men and football clubs, the MHFC is designed to include other sporting clubs such as cricket, rugby, bowls etc. It is hoped, in the future, to expand this out to non-sporting clubs. To date there are 43 MHFC across the County.

Conclusion

22. Much work has taken place over the last year to progress the priorities in this important area. The group continues to work well and develop as a partnership, despite organisations experiencing challenges in relation to recent and ongoing organisational change. Data sharing within and across organisations is vital to enable some joint projects to progress, and this remains an ongoing challenge at times impacting on our ability to deliver some priorities in an effective and efficient way.

Officer to contact

Mike Sandys, Director for Public Health

Email: Mike.Sandys@leics.gov.uk

Fiona Grant, Consultant in Public Health

Email: Fiona.Grant@leics.gov.uk

Relevant Impact Assessments

Equality Implications

23. There are no equality implications arising from the recommendations in this report.

Human Rights Implications

24. There are no human rights implications arising from the recommendations in this report.

Agenda Item 6

Leicestershire County Council

HEALTH AND WELLBEING BOARD – 4 DECEMBER 2025

REPORT OF DIRECTOR OF ADULTS AND COMMUNITIES LEICESTERSHIRE COUNTY COUNCIL

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT LIVING WELL DEMENTIA STRATEGY UPDATE

Purpose of Report

1. The purpose of this report is to provide an update on the delivery of the Leicestershire, Leicester and Rutland (LLR) Joint Living Well Dementia Strategy 2024-28, including:

   - Progress made since the previous update made to the Board on 27 February 2025;
   - Key achievements and challenges;
   - Plans for future commissioning of dementia services.

Background

2. The LLR Joint Living Well Dementia Strategy 2024–2028 reflects a system-wide commitment to improving outcomes for people affected by dementia. Developed collaboratively across health, social care and the voluntary sector, it aligns with national priorities and focuses on:

   - Prevention and early intervention;
   - Timely diagnosis;
   - Person-centred support throughout the dementia journey.

3. Delivery is co-ordinated through local plans for Leicester City, Leicestershire County, and Rutland, overseen by the LLR Dementia Programme Board.

Recommendation

4. The Board is asked to:

   a) Acknowledge progress made since February 2025;
   b) Endorse continued collaboration to improve diagnosis rates and reduce inequalities;
   c) Support commissioning plans that embed co-production, cultural competence, and carer support, with annual updates.

LLR Joint Living Well Dementia Strategy 2024–2028

5. The Strategy, approved in November 2023, sets out a system-wide commitment to deliver personalised, integrated care from pre-diagnosis through

to end-of-life. Delivery is driven by strong partnerships across Local Authorities, NHS, voluntary, community and social enterprise organisations, and people with lived experience, under the governance of the LLR Dementia Programme Board.

6. Strategic focus areas include:

- Prevention raising programme around prevention planned for 2026 – promoting healthy lifestyles and early intervention;
- Timely Diagnosis and Pathway Redesign – to improve diagnosis rates in the County taking into account the geographical barriers and seldom heard communities;
- Improving access through initiatives such as Memory Clinic pilots;
- Person-Centred Support and Community Engagement – ensuring inclusivity and appropriate care.

7. The Strategy is built around seven pillars: *Preventing Well, Diagnosing Well, Supporting Well, Living Well, Dying Well, Leading Well, and Monitoring Well* - providing a whole-pathway approach from prevention to end-of-life care.

8. As the Strategy approaches the end of its first year of delivery, the partners are reviewing progress against milestones, identifying gaps, and capturing learning to inform next steps.

Joint Strategic Needs Assessment (JSNA)

9. The JSNA highlights:

- Over 10,000 people living with dementia in Leicestershire, including around 300 people aged under 65 years;
- **70%** of older people in care homes and **60%** of home care recipients have dementia;
- Two-thirds of people with dementia live at home;
- The Dementia Support Service (DSS) supports over 2,600 people annually, offering advice, carer learning, and social groups.

The Dementia Support Service (DSS)

10. Age UK are jointly funded to deliver the DSS which is a comprehensive, person-centred support model for people diagnosed with dementia and their carers.

11. The DSS provides the following support and the Pathway Map is attached as an Appendix:

- *Information, Advice and Guidance (IAG)* - Clear, accessible advice on dementia care, rights, and available services;
- *Single Point of Access (SPA)* - A central referral hub for professionals and families to access support quickly;
- *Personalised Support Plans* - Goal-based plans tailored to individual needs, helping people live well with dementia;
- *Post-Diagnosis Support* - Emotional support, practical advice, and signposting immediately after diagnosis;

- *Carer Learning and Resilience Workshops* - Training and resources for informal carers to build confidence and coping strategies;
- *Social Groups and Peer Support* - Activities to reduce isolation and promote community engagement;
- *Co-ordination with Health and Social Care* - Works alongside GPs, Memory Clinics, and Adult Social Care to ensure integrated care;
- *Culturally Appropriate Support* - Outreach to diverse communities and seldom-heard groups.

Key achievements 2024/25

12. The following key achievements within the priority areas are as follows:

a) Monitoring Well – Where appropriate dementia specific practice has been embedded into service specifications (e.g. Care Homes, Extra Care and Home Care) and will form part of new commissioning activity (Day Services).

b) Preventing Well
- Public health campaigns and community outreach promoted risk reduction and awareness;
- Dementia 100 Toolkit (a self-assessment tool designed to assist places to assess their performance and aim towards a consistent approach in supporting people with dementia) has been developed by NHS Midlands and Lancashire Commissioning Support Unit in partnership with the Department of Health and Social Care and is being adopted for system-wide implementation;
- Pilots for one-stop clinics and advanced pathways underway.

c) Diagnosing Well
- Referral pathways streamlined; GP processes reviewed. One-stop clinic trial launched to reduce waiting times. This is currently within a pilot phase with evaluation to take place in November 2025;
- Hospital grant introduced to support carers of loved ones with dementia post-discharge.

d) Supporting Well - The DSS expanded to include personalised plans and proactive outreach. Dementia-friendly practices are embedded across all services. As the joint LLR Carers Strategy concludes in 2025, each local authority across the LLR footprint will develop its own strategy to ensure continuity of support for carers, raise awareness, and sustain impactful training and peer support networks that have proven valuable for carers of people with dementia.

e) Living Well - Delivery plan co-designed with people with lived experience and carers to ensure inclusive, person-centred approaches. This will inform the proposed new DSS including the deliverables and outcomes throughout the contract. Feedback from people with dementia and their carers will also inform the new Leicestershire Carers' Strategy as part of the ongoing engagement currently taking place.

Organisational Contributions to Strategic Objectives

13. The roles of key agencies ensure delivery of the LLR Dementia Strategy across all seven pillars, supports Making Every Contact Count and drives integrated working:

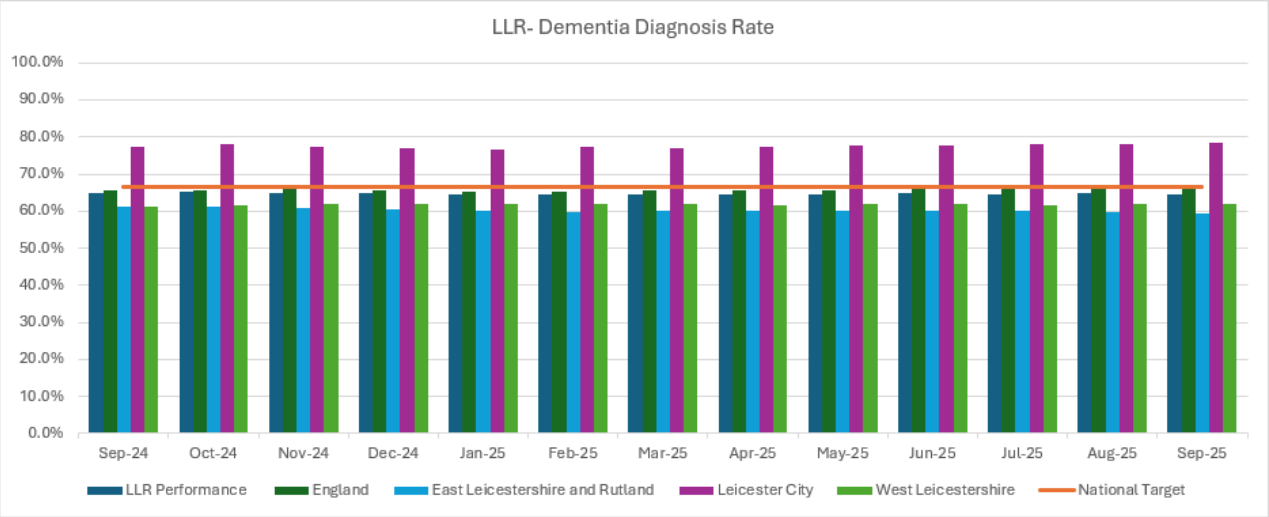
- *Dementia Programme Board and ICB* - System leadership, governance, and performance oversight;
- *Local Authority Adult Social Care Teams* - Commissioning dementia-friendly services, care pathways, and carer support;
- *Primary Care Networks and GP Practices* - Early identification, diagnosis, and referral to Memory Clinics and DSS;
- *Public Health Teams* - Prevention campaigns, risk reduction, and community engagement;
- *Voluntary Sector Partners (Age UK, Alzheimer's Society, Carers UK)* - Post-diagnosis support, carer workshops, and peer groups;
- *Housing Associations* - Dementia-friendly housing and adaptations;
- *Community Organisations (Libraries, Faith Groups*) - Outreach, inclusion, and reducing isolation;
- *Digital Inclusion Teams* - Tackling digital barriers for access to information and support;
- *End-of-Life Care Teams and Hospices (e.g., LOROS)* – Co-ordinating dignified end-of-life care pathways.

Dementia Diagnosis Rate

14. Dementia diagnosis rates in Leicestershire have averaged 64% over the last 12 months. The *national target* is that 66.7% of people with dementia should have a formal diagnosis. This underperformance limits access to timely care and support.

15. In Leicestershire, it is estimated that around 10,500 people are living with dementia. However, only about 6,400 have a formal diagnosis. This means that nearly 4,000 people may have dementia but do not yet have it recorded, which can delay access to support and care.

16. The chart below provides a clear comparison of dementia diagnosis rates across Leicester City, East Leicestershire and Rutland, West Leicestershire, the overall LLR performance and England, against the national target.



17. Leicester City stands out as the strongest performer, consistently achieving rates around 72–73%, which is well above the national target of 66.7%. This indicates that the city has effective systems in place for identifying and diagnosing dementia.

18. In contrast, East Leicestershire and Rutland and West Leicestershire both fall below the national target, with rates hovering around 62–64%. These county areas are underperforming compared to both Leicester City and the national benchmark, suggesting gaps in diagnosis coverage or access to services.

19. England's average is similar to the county areas, reinforcing that the challenge is not unique to LLR but is a wider issue. Strategically, this highlights the need for targeted improvement in rural and county areas, emphasising better case finding, GP engagement, and community outreach.

20. Sharing best practices from Leicester City, such as culturally tailored engagement and streamlined referral pathways, could help raise performance across the region and close the gap to the national target.

Actions in progress

Memory Assessment Clinic (MACs) - One Stop Clinic Trial

21. A one-stop memory assessment clinic trial is being piloted across Leicestershire and Leicester and is designed to deliver all key diagnostic steps in a single visit, rather than across multiple appointments. The model brings together a multidisciplinary team - such as neurologists, psychiatrists, psychologists, and nurses - to provide rapid access to cognitive testing, medical investigations, and a same-day consensus diagnosis.

22. It also includes immediate management planning, post-diagnostic support, and integration with primary care and community services. Key areas of focus include reducing waiting times, improving patient and carer experience, ensuring equity of access, and creating personalized care pathways for conditions like mild cognitive impairment and younger-onset dementia.

23. This approach helps by enabling earlier diagnosis and treatment, reducing system costs, supporting workforce efficiency, and meeting national dementia

targets, while also offering opportunities for research participation and innovation.

Link between MACs and DSS

24. These two services form the essential stages of the dementia care pathway. Memory clinics are primarily responsible for diagnosis and initial assessment, including cognitive testing, medical investigations, and confirming conditions such as dementia or mild cognitive impairment.

25. Once a diagnosis is made, DSS takes over to provide post-diagnostic support**,** which includes education, emotional support, care planning, and connecting patients and carers to community resources and social care services.

26. The MACs and the DSS form a continuous care pathway. Together, they ensure early identification and ongoing support, enabling people to live well with dementia.

Training and Workforce Development – Dementia Care

27. The system has identified a range of training initiatives to support people with dementia and their families. This includes:

a) Strategic Framework
- National Standards: Dementia Training Standards Framework (Awareness, Core Skills, Leadership) and NICE QS184 guide consistent, high-quality dementia care;
- Local Implementation: Birmingham is embedding these standards into contracts and workforce development plans.

b) What We Have Locally
- Alzheimer's Society: Live training, Train the Trainer, and online Learning Hub for care homes and community providers;
- Skills for Care: Dementia qualifications (Levels 2 and 3), resources, and funding support for employers;
- Carers Service: Continuing Professional Development (CPD) accredited courses for professional and unpaid carers, including immersive empathy training;
- DSS: Practical modules on brain health, behaviour changes, wellbeing, and care transitions.

c) What We Are Doing
- Aligning Quality Assurance Frameworks with new contracts to make dementia care a priority.
- Requiring contracted providers to meet dementia training standards;
- Using Improvement Cafés and Provider Forums to share training opportunities and best practice;
- Building staff confidence and competence through targeted CPD.

Engagement and Inclusion

28. Earlier this year, commissioners engaged Age UK with users of their services and carers to understand lived experiences and priorities for dementia support. The outcomes included:

- Joined up working between health and social care is essential;
- Culturally appropriate support must be embedded in service design;
- Inclusion of seldom heard and rural communities to reduce inequalities;
- Recognition of carer loneliness and the need for emotional and practical support;
- Clearer post-diagnosis pathways and timely access to services;
- Alternative communication methods to tackle digital exclusion.

29. This feedback is central to shaping the new DSS ensuring fit-for-purpose services are commissioned across city and county that reflect these priorities.

Monitoring and Evaluation

29. A robust approach will be implemented to measure the impact of the dementia delivery plan and commissioned services. A user led approach will be used to assess progress on a quarterly basis, ensuring that feedback from those with lived experience informs continuous improvement. In addition, clear success metrics to evaluate quality of care, staff competence, accessibility, and carer support outcomes will be developed. These findings will drive ongoing service refinement, contract compliance, and future commissioning decisions, ensuring that dementia services remain effective, inclusive, and responsive to local needs

Equality

30. The Dementia Strategy and delivery plan will be designed to reflect the diverse needs and lived experiences of our communities, ensuring cultural sensitivity, accessibility, and fairness.

31. Insights from recent engagement, including Age UK's work with service users, will inform commissioning decisions so that services are fit for purpose and equitable across both city and county.

32. Additional steps to embed inclusion will involve:

- co-production with people with lived experience to shape and monitor services;
- soft market testing and early engagement with providers to ensure equality requirements are built into service design and delivery.

Resource Implications

33. Delivery will proceed using current resources and budgets and aligned with strategic priorities.

Conclusion

34. The Board is asked to acknowledge the progress made in implementing the LLR Dementia Strategy and endorse continued collaborative efforts to deliver high-quality, inclusive dementia services across the county. This includes embedding national standards, strengthening local engagement, and ensuring equality and accountability throughout commissioning and delivery.

Officers to contact

Jon Wilson, Director of Adults and Communities
Adults and Communities Department
Leicestershire County Council
Email: jon.wilson@leics.gov.uk
Tel: 0116 305 7454

Amina Begum, Senior Strategic Commissioning Adviser
Adults and Communities Department
Leicestershire County Council
Email: Amina.Begum@leics.gov.uk
Tel: 0116 305 6601

Background papers

LLR Joint Living Well with Dementia Strategy 2024-2028
https://resources.leicestershire.gov.uk/adult-social-care-and-health/market-position-statement/dementia

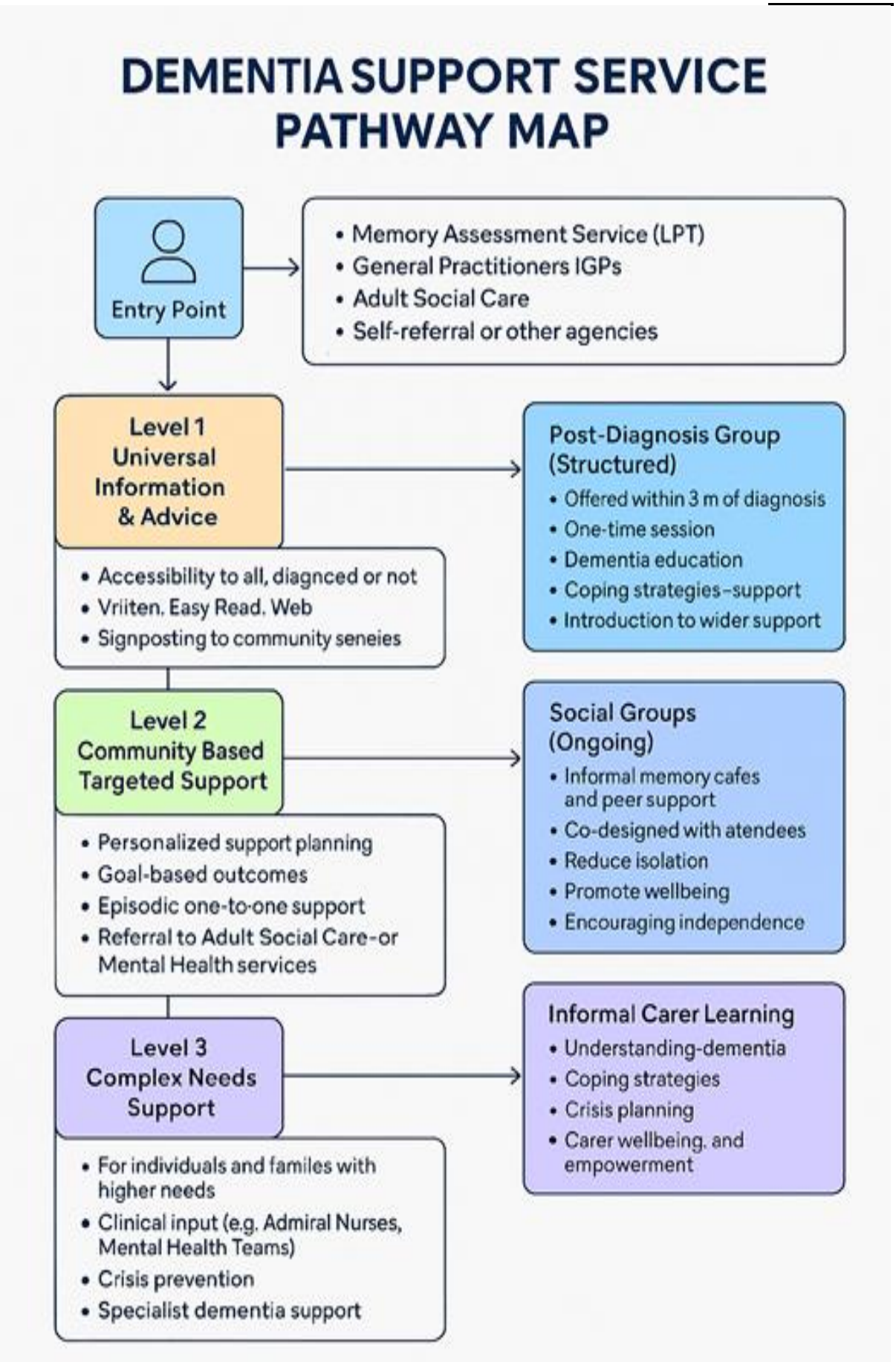
Health and Wellbeing Board: 27 February 2025 – LLR Dementia Strategy update
https://democracy.leics.gov.uk/documents/s188718/6%20Dementia%20Strategy%20HWBB%20Report%2027%20Feb%202025%20v2.pdf

Report to Cabinet: 24 November 2023 – LLR Joint Living Well with Dementia Strategy 2024-28 – Outcome of Consultation
https://cexmodgov01/documents/s179785/LLR%20Dementia%20Strategy.pdf

Appendix

Dementia Support Pathway Map

APPENDIX


DEMENTIA SUPPORT SERVICE PATHWAY MAP
Entry Point
• Memory Assessment Service (LPT)
• General Practitioners IGPs
• Adult Social Care
• Self-referral or other agencies
Level 1 Universal Information & Advice
• Accessibility to all, diagnced or not
• Vriiten. Easy Read. Web
• Signposting to community seneies
Post-Diagnosis Group (Structured)
• Offered within 3 m of diagnosis
• One-time session
• Dementia education
• Coping strategies-support
• Introduction to wider support
Level 2 Community Based Targeted Support
• Personalized support planning
• Goal-based outcomes
• Episodic one-to-one support
• Referral to Adult Social Care-or Mental Health services
Social Groups (Ongoing)
• Informal memory cafes and peer support
• Co-designed with atendees
• Reduce isolation
• Promote wellbeing
• Encouraging independence
Level 3 Complex Needs Support
• For individuals and familes with higher needs
• Clinical input (e.g. Admiral Nurses, Mental Health Teams)
• Crisis prevention
• Specialist dementia support
Informal Carer Learning
• Understanding-dementia
• Coping strategies
• Crisis planning
• Carer wellbeing. and empowerment

This page is intentionally left blank

Agenda Item 7

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Working in partnership with Northamptonshire Integrated Care Board

HEALTH AND WELLBEING BOARD: 4th DECEMBER 2025

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

NEIGHBOURHOOD WORKING UPDATE

(Implementer site progress)

Purpose of report

1. The purpose of this report is to provide an update on the Neighbourhood actions taking place across Leicestershire, Northampton and Rutland (LNR) and to share the Leicestershire respiratory Story, and the work of the National Neighbourhood Health Implementation Programme (NNHIP).

Recommendation

2. The Board is recommended to support the work of the implementer neighbourhood site and recognise the commitment to roll this out across the whole County.

Policy Framework and Previous Decision

3. In 2025 NHS England published Neighbourhood Health Guidelines regarding the need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery.

4. The "Fit for the Future: 10-Year Health Plan for England", published in July 2025, is a comprehensive government strategy aimed at transforming the NHS. It focuses on shifting the NHS from hospital-centric care to community-based care, embracing digital technologies, and prioritizing preventative healthcare.

5. In July 2025 NHS England invited Integrated Care Boards to take part in the National Neighbourhood Health Implementation Programme (NNHIP). The NNHIP seeks to build on success to date and the new approaches set out in the 10 Year Health Plan – taking a test, learn and grow approach – to transform the health and care of neighbourhoods. The aim of this new national programme is to accelerate the work already being carried out or being

planned, by learning together, sharing solutions, tackling challenges and delivering improvement, adapting those solutions to circumstances. It will be working at scale both within Place and alongside Places across the country simultaneously, accelerating the learning.

Background

6. The concept of neighbourhood working is not new, and NHS and partners in Leicestershire have done this in part for some time. The current strengthened approach links to the NHS 10-year plan and the need to consistently do different to support patients in the highest need groups, along with a focus on prevention.

7. In 2025 NHS England launched an implementer site programme to support early impact schemes. LLR submitted an application for the whole of the County area but whilst NHS England supported the application, they felt the County as a whole was too large as a footprint. Therefore, it was later agreed with NHS England that for the national work we would focus on West Leicestershire. The learning and resources from the West Leicestershire implementer programme will be shared with East Leicestershire, Rutland, Leicester City and Northamptonshire, in real time, to support the same progress in developing the neighbourhood model of care being made in these areas.

8. West Leicestershire was one of 43 places chosen from a total of 141 applications. The West Leicestershire footprint includes Hinckley and Bosworth, North West Leicestershire and Charnwood.

9. The programme will bring NHS care closer to home and provide better support for people with complex health conditions, keeping them well and avoiding unnecessary hospital attendances and admissions.

10. This will be achieved with a focus on local engagement and involvement, with health care and support organisations working collaboratively to shape the future of community-based care.

Respiratory illness

11. The appendix to this report provides a short story of why we have focused on respiratory illness for the West Leicestershire implementer programme, the impact respiratory illness has on the system and on individuals and how partners are going to work together to improve outcomes. This story/narrative will evolve as our planning continues. We expect to update it with our progress every 4-6 weeks. We recognise that there are Adult Social Care outcomes related to intermediate care, reduced requirement for discharge reablement, reduced admission to permanent residential care, and we aim to also measure these outcomes within this programme along with wider provider impacts,

including contact with district council services such as housing and voluntary sector organisations contacts.

Consultation/Patient and Public Involvement

12. Voluntary Action Leicestershire and Healthwatch are involved in the County neighbourhood group and are supporting the wider neighbourhood board in developing a patient involvement working group.

Resource Implications

13. There is no funding attached to this programme of work. Resource redistribution as schemes demonstrate impact will be key to expanding neighbourhood work.

Background papers

Fit for the future: 10 Year Health Plan for England - executive summary

NHS England » Neighbourhood health guidelines 2025/26

Report to Health and Wellbeing Board 29 May 2025: https://democracy.leics.gov.uk/documents/s189876/HWB%20Report%20-%20Neighbourhood%20model%20of%20care.pdf

Circulation under the Local Issues Alert Procedure

14. Implementer reporting relates to West Leicestershire therefore members that represent divisions in that area will need to be made aware of this report.

Appendices

Appendix – Respiratory work

Officer to contact

Rachel Dewar, AD Integration and Transformation/System Neighbourhood Lead

Telephone: 07956515100

Email: Rachel.dewar@nhs.net

Relevant Impact Assessments

Equality Implications

15. No Equality Impact Assessment (EIA) is required at this time.

Human Rights Implications

16. There are no human rights implications arising from the recommendations in this report

APPENDIX

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Our respiratory story

Part 1

Nov 2025

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Why respiratory illness is important…..

To the NHS…..

- The leading cause of emergency admissions in England
  - 1 in 8 emergency admissions
  - High readmission rate
- 50-60% spike in winter
- 2.0% of West Leicestershire have COPD (2,030 people) and 13.7% have asthma (56,442 people)
- COPD prevalence is 1.6 times higher in the most deprived than in the least deprived areas of West Leicestershire
- Nearly ½ of West Leicestershire patients with COPD are in PNGs 9-11
- Patients with COPD have other life limiting conditions
- 69% of patients have 5 or more chronic conditions
- 54% have hypertension, 25% have renal failure, 23% have diabetes
- As mobility declines, falls risk increases.
- Proactively addressing health inequity will reduce NHS costs

Breathlessness means…

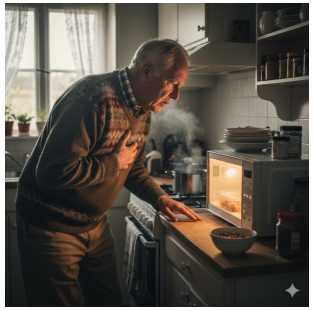
- I can't climb stairs to my bedroom; I sleep in my living room.
- Cooking is hard work I rely on microwaved processed foods.
- I am too scared to leave home; in case I get wheezy and cannot get home
- I can't manage my own shopping anymore
- I don’t walk much now
- I stay at home and don’t go out

The impact of respiratory illness

On the hospital

950 emergency COPD hospital admissions from West Leicestershire in 2023/24 [Readmission rate within 30days data being produced]

On the person



Contributes to falls, frailty osteoporosis and depression.
At least 800 people in West Leicestershire with COPD do not have a care plan.

On society

7,325 patients with COPD (QOF Register in West Leicestershire), using national prevalence there are 3,760 people with potential for COPD not on GP registers

Financial

Each hospital admission costs £1,900-2500 v community treatment £200-300.
Vaccination prevents 30-40% of exacerbations

Measurable

Measurable returns can be seen in 12-24 months

The actions we are taking and the difference it will make

Housebound patients with COPD
(c.481 people in WLeics)

Any COPD patient readmitted to hospital within 30days

System MDT for every patient
GP, Care Coordinator, LPT respiratory/complex care, UHL consultant

Updated care plan

Activated patient, knows what to do when unwell

Increase in flu vaccinations

Increase community support

NHS

Increased joint working between organisations

Our call to action

- Primary care, UHL, LPT & the county council will create a shared MDT
- They will explore DHU's involvement in this process.
- The VCSE, local authority and the ICB will work together to improve flu vaccination uptake this winter
- Community partners, mental health services, primary care, local authorities will work together to promote and connect the physical health solutions to tackling breathlessness
- We all need to access and use the shared care plan and ensure we implement the areas we are responsible for.
- We all need to work together to identify people with COPD and implement early prevention support
- The ICB data team are working with us partners to measure our actions and outcomes
- Making a difference, needs everyone to make a change from what we are doing now.

Who (in West Leicestershire)…..

Leicestershire County Council

healthwatch Leicester and Leicestershire

VAL Helping people change their lives for the better

Hinckley & Bosworth Borough Council

Charnwood GP NETWORK LTD

North West Leicestershire District Council

Charnwood

NHS University Hospitals of Leicester NHS Trust

hinckley & bosworth medical alliance

NHS Leicester, Leicestershire and Rutland

DHU Healthcare

NHS Leicestershire Partnership NHS Trust

Agenda Item 8

POLICE & CRIME COMMISSIONER for Leicester, Leicestershire & Rutland
Your Communities - Your Commission

HEALTH AND WELLBEING BOARD: 4 DECEMBER 2025

REPORT OF THE OFFICE OF THE POLICE & CRIME COMMISSIONER

OPCC UPDATE and 26-27 PRIORITIES

Purpose of report

1. This report provides an overview of health-related activities commissioned, grant-funded or provided as part of the responsibilities of the Office of the Police & Crime Commissioner (OPCC) for Leicester, Leicestershire & Rutland (LLR). Whilst a significant amount of OPCC funded activity is LLR wide, this report will highlight specific, where able, areas of delivery in Leicestershire.

Recommendation

2. The Health and Wellbeing Board is recommended to:
    a. Note the report for information.
    b. In noting the report, identify areas where OPCC delivery links into the wider of partnership of the Health & Wellbeing Board priorities, where joint working could provide greater benefits.
    c. Note that the OPCC commissioning priority for 26/27 is the re-commissioning of Domestic Abuse and Sexual Violence services for commencement April 2027.

Policy Framework and Previous Decision

3. This is the first report to the Health & Wellbeing Board from the OPCC and is presented to the board in the context of the OPCC's statutory responsibilities, which are:
    - To support victims and witnesses – Providing victim support services for all crime types and specialist victim services for victim/survivors of

domestic abuse, serious sexual assault and rape (RASSO). Providing specialist support to secondary victims of indecent images of children crimes. All services provided at age-specific levels for children and adults.

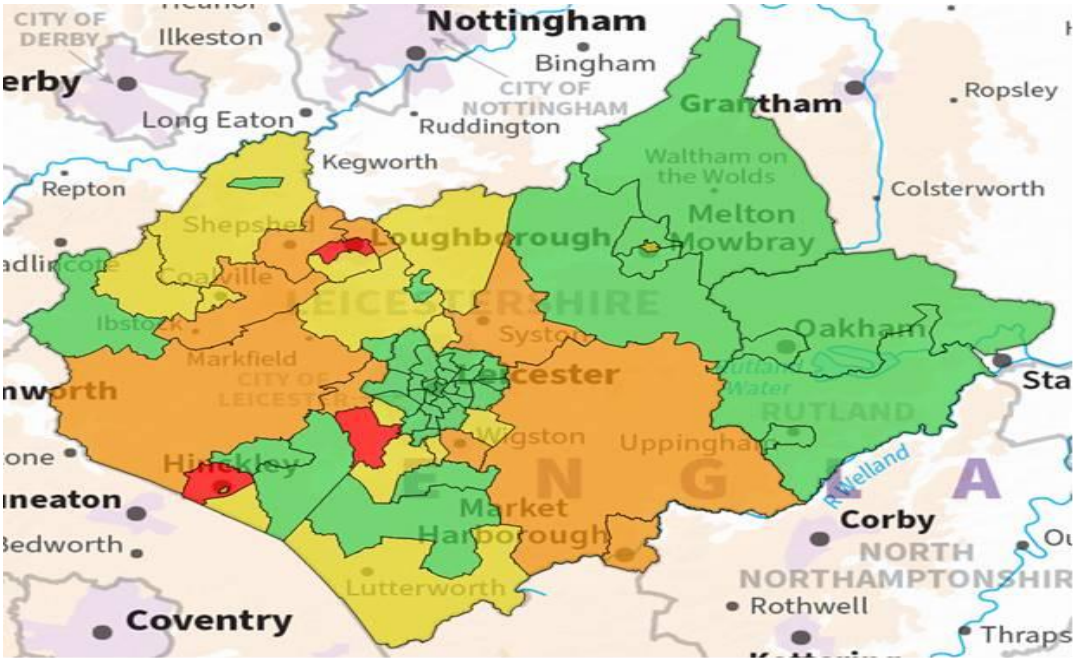
- To prevent and divert from crime – Providing Out of Court Resolutions as an alternative sentencing option, providing crime prevention advice and specific crime-related problem-solving support and grant funding to grass roots organisations to deliver crime prevention and diversionary activities.

Background

4. The report summaries the activity the OPCC commissions that supports or contribute to strategic areas of delivery of the Health & Wellbeing Board.

5. Drugs and Alcohol – The OPCC makes a contribution of £111,856.00 per annum to the county's substance use treatment service (provided by Turning Point). The OPCC additionally funds a Drug Test on Arrest (DToA) facility based in custody suites, whereby offenders presenting with trigger offences (typically acquisitive crimes) are tested by custody officers for use of Class A drugs, and those with a positive result are offered a treatment intervention by Turning Point through the Required Assessment Process.

Acquisitive Crime - Leicestershire Year 24/25* by policing beat:



*Not all acquisitive crime arrests require or result in a DToA, data represents Leicestershire not Leicester city areas.

6. The main county areas for reported acquisitive crime are Enderby & Narborough (Fosse Park), Loughborough Town & Hinckley Greater. The recorded number of police referrals into drug treatment (2024/25) are as follows:
    - 325 Referrals via Drug Testing on Arrest (includes Required Assessments and voluntary referrals);
    - 16 Referrals via Young Persons Community Resolution pathway (those young people who were referred into treatment after police/TP intervention).

7. Youth Justice Boards – The OPCC contributes £77,934.00 to Leicestershire & Rutland Children & Young Peoples Justice Service (CYPJS). The OPCC provides a representative to the local CYPJS Board to act as Victims Lead. There are health and wellbeing implications in youth criminal justice services, the main being provision or lack thereof of Speech, Language & Communication Needs (SLCN). The Royal Society of Speech & Language Therapists identified that over 60% of young people in justice settings have SLCN. City and County CYPJS are working to fund an SLCN post across youth justice services.

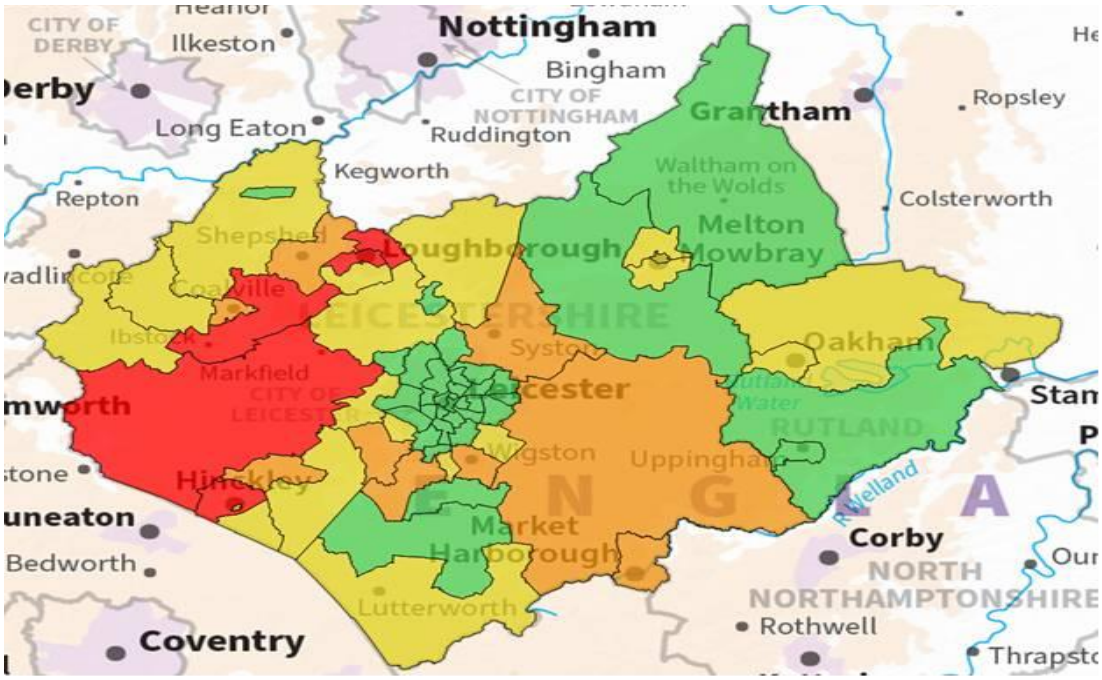
8. Gambling Harms – The OPCC are beginning a piece of work to better understand those who are within the criminal justice system (CJS) due to gambling addiction. The majority of crimes committed by those with gambling harms sit around fraud and embezzlement and are subject to custodial sentences. Gambling harms were, from April 2025, subject to the public health levy – a mandatory fee on gambling operators, to generate significant, ringfenced funding for research, prevention, and treatment of gambling-related harms. It replaces the voluntary industry contribution system and aims to raise over £100 million annually. The funds are to be split, with 50% dedicated to treatment services (like the NHS), 30% to prevention and early intervention, and 20% to research. Gambling harms have a broad impact on the individual, families and communities when considering housing, finances, family breakdowns and the impact of suicide. For every individual gambling at harmful levels, six to ten other people are impacted, which amounts to between 10,500 to 17,600 Leicestershire residents being affected by someone else's gambling. It is also estimated that over 9,500 children live in the same household as an adult who might benefit from gambling treatment and support. (Leicestershire HNA – Gambling Harms August 2024)

9. The OPCC also commissions FreeVa to deliver medium and high-risk support to victim/survivors of domestic abuse and sexual violence. This includes IDVA (Independent Domestic Violence Advocates), ISVA (Independent Sexual Violence Advocates), CHISVA (Childrens Independent Sexual Violence Advocates) support and in the next financial year will introduce ISAC (Independent Stalking Advocacy Caseworker) support. The service works across the general population and includes IDVA/ISVA's with specialisms in

supporting male victims, black and multi-ethnic communities, LGBTQ+ and those with neurodiversity. Domestic Abuse has a significant impact on GP, Emergency Services including A&E and on Mental Health Services. All victim focussed services serve the whole LLR area. Whilst some of the ethnicity demographics are less represented in Leicestershire, the county is more impacted by domestic abuse in rural communities. Domestic abuse lasts, on average, 25% longer in most rural areas – exiting abuse is harder, takes longer and is more complex for rural victims as there are significant additional barriers in rural communities compared to urban areas.

10. Victim First, provided by Catch 22, delivers support to all consenting victims of crime (including standard risk domestic abuse victims) across LLR. The offer of support includes emotional and practical support and is tailored to children, young people and adults as discrete groups. Support is available online, in easy read formats, in multiple languages including British Sign Language, through webchat and face to face. With regards to a health lens, the service supports victims of assault and violence against the person which will have implications on emergency, primary and secondary health providers.

Violence Against the Person 2024-25 (excluding Leicester city)

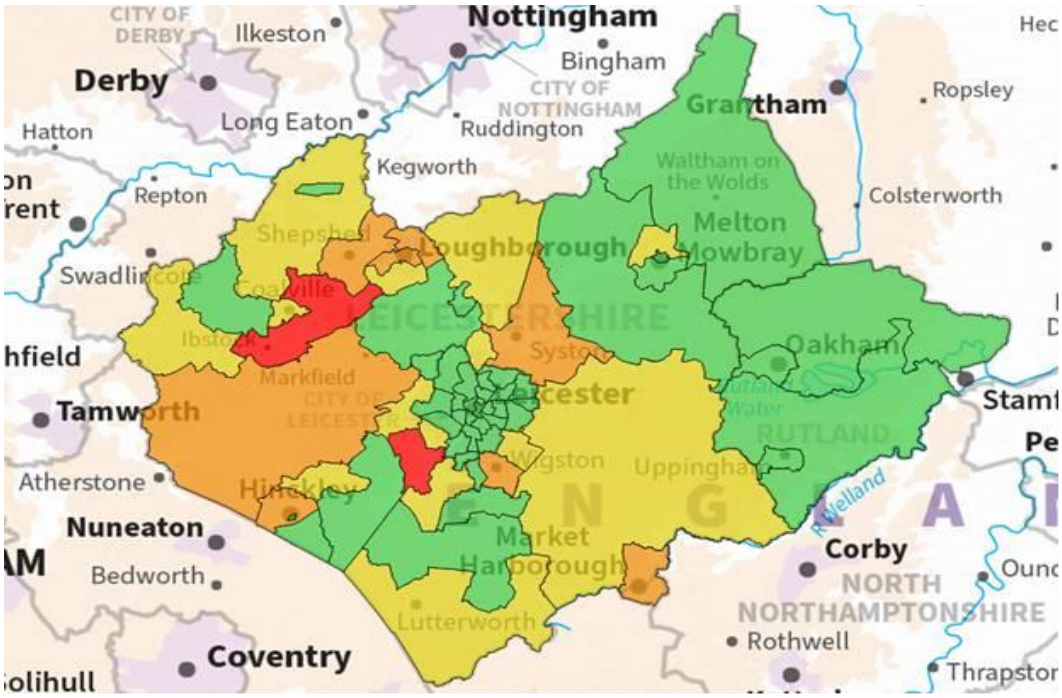


11. The highest number of violence against the person are in Hinckley Greater, Market Bosworth, Whitwick & Ibstock, Loughborough Town & Loughborough North police beats. Across LLR 2024 -25 for all crime types, 10,459 victims were positively contacted, 1397 chose to decline support, and 9062 engaged in some form of support.

12. Sexual Assault Referral Centres (SARC) – The OPCC co-commissions with NHS England, SARC's for both adults and children. The East Midlands Children & Young Peoples SARC (EM CYP SARC) are located in Nottingham and Northampton. Children from Leicestershire in need of specialised forensic SARC services, delivered via a Consultant Paediatrician-led model will usually attend the closet SARC to them. Adult SARC services are delivered from Juniper Lodge (New Parks, Leicester). Juniper Lodge serves the entire LLR area. Data on victim address is protected and therefore cannot be broken down into districts or county. The majority of SARC referrals are female. For the year 25/26, Juniper Lodge:

- Received 341 referrals.
- Conducted 167 forensic examinations.
- Made 96 onward referrals to mental health and/or crisis teams.
- Made 50 onward referrals to substance use treatment services.
- Offered and started 29 cases of HIV PEP (Post exposure prophylaxis).
- Delivered 61 emergency contraception interventions.
- Started 48 Hepatitis B schedules.
- Made 104 onward referrals to Sexual Health services.

Rape & Serious Sexual Assault (RASSO) locality map by policing beat (excluding Leicester city) 2024/2025:



13. Whitwick & Ibstock and Enderby & Narborough are the areas with the highest reports of RASSO, however there is a caveat to this. Leicestershire Police Force Headquarters is located in the Enderby & Narborough beat, and all offences with no known location default to Enderby for recording purposes.

14. The OPCC are progressing the delivery of an animated information booklet regarding sexual violence. This will be in video form with multiple choice home language video voice overs, following advice and learning from Health & Wellbeing partners and Sexual Health Services on better engagement with minority groups. The animation will have choices of English, Gujarati, Punjabi, Polish, Urdu, Hindi and Romanian narration and can be built upon with other languages as required. This will sit alongside our written information which has been co-produced by victim/survivors of rape and sexual assault.

15. The Violence Intervention Project (VIP) run through the Violence Reduction Network, is a tertiary prevention intervention which aims to prevent repeat victimisation and/or offending through offering timely and tailored support to those aged 11 to 25. VIP workers are based in the Emergency Department (ED) at Leicester Royal Infirmary and the custody suite at Euston Street Police Station. The project uses "reachable moments" in these settings to engage with the young person at a critical point in their lives and offer support to assist recovery and/or desistence, and address pressing issues such as safety and emotional wellbeing. The workers will continue to support the young person following discharge/release, offering mentoring and practical assistance to empower them to achieve their goals. Referral to the project is made by ED and custody staff. Further information on VRN projects can be found in the 2024-25 Annual Report linked in the background papers.

16. The OPCC o-commissions with Public Health in the county and the city a Bereaved by Suicide service delivered by the Tomorrow Project. Governance of the service sits with Leicestershire County Council Public Health but serves the entire LLR footprint. The service provides counselling to all those affected by suicide, including family and friends of the deceased. In the first 6-month period of this financial year the service received 79 referrals, of which 57 originated in Leicestershire. On average 86% of those receiving support are White. Of those receiving support, on average 21% are children of the deceased, 20% are parents of the deceased, 20% are the spouse/partner of the deceased and 13% are the parent of the deceased.

Consultation/Patient and Public Involvement

17. Where applicable to the priority the OPCC consults with the public or representatives of the affected demographic/community e.g. the support publication for victim/survivors of RASSO was co-produced with Voices, a lived experience group of victim/survivors of rape.

18. In 2024 the OPCC developed and introduced a Lived Experience Strategy, which includes representation from the public or representative group on all commissioned procurement, including evaluation and award of funding.

Resource Implications

19. There are no resource implications to this paper.

Background papers

OPCC for Leicester, Leicestershire and Rutland Police & Crime Plan

https://www.leics.pcc.police.uk/DOCUMENT-LIBRARY/Planning-and-Money/Police-and-Crime-Plan/2024-2029/Police-and-Crime-Plan-2024-2029.pdf

Violence Reduction Network Annual Report 2024 – 2025

https://democracy.leics.gov.uk/documents/s190051/Appendix%20A%20-%20VRN%20Annual%20Report%202024%20-%202025.pdf

Circulation under the Local Issues Alert Procedure

20. The report does not affect a particular area of the county.

Officer to contact

Siobhan Peters

Director of Strategy, Partnerships & Commissioning - OPCC

0116 229 8980

siobhan.peters@leics.pcc.police.uk

Relevant Impact Assessments

Equality Implications

21. There are no equality implications arising from this report. Equality Impact Assessments are carried out by the OPCC in each individual case of funded activity where required.

Human Rights Implications

22. There are no human rights implications arising from this report.

Crime and Disorder Implications and Environmental Implications

23. There are no crime and disorder and environmental implications from this report. Policing and crime and disorder implications are agreed with Leicestershire Police Force in all relevant OPCC Funding decisions at the time of commissioning and/or grant funding.

Partnership Working and associated issues

24. Partnership working across health, local authorities, police, fire, districts etc. is essential to ensure robust criminal justice health-related initiatives are in place.

Risk Assessment

25. All delivery undertaken by the OPCC is risk assessed through multiple assessment platforms and forums and where appropriate risks are escalated to the OPCC Risk Register.

Agenda Item 9

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 4th DECEMBER, 2025

REPORT OF DIRECTOR OF ADULTS AND COMMUNITIES

BETTER CARE FUND QUARTER 2, 2025/26 RETURN

Purpose of report

1. The purpose of this report is to provide the Board with the quarter 2, 2025/26 template report of the Better Care Fund (BCF). The report sets out performance against BCF metric targets, spend and activity and statements as to whether the national conditions continue to be met.

Recommendation

2. It is recommended that the performance against the Better Care Fund (BCF) outcome metrics, and the positive progress made in transforming health and care pathways up to quarter 2 be noted;

Policy Framework and Previous Decision

3. Nationally, the BCF plan for 2025/26 for Leicestershire was officially approved by NHSE in June, 2025.

4. The Chief Executive of Leicestershire County Council, using powers of delegation, approved the BCF Quarter 2 report for the NHSE submission deadline of 10th November, 2025.

Background

5. In September 2025, the national BCF team published the Quarter 2 template for reporting the position, which requires approval by the Health and Wellbeing Board or it's respective governance.

6. The aim of the report and template is to inform the Board of progress against 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 integrated care boards, local authorities and service providers).

7. The completed Quarter 2 template is attached to this report as Appendix A. The NHSE submission deadline was the 10th November.

8. 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 2025-26 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 any goals met or challenges faced in achieving the target along with any support needs and successes that have been achieved. It also provides an opportunity to revise any targets published in the 2025/26 plan.
- An update against income and expenditure.

Update against national conditions for the 2025/26 Plan

National condition 1

9. This national condition was met in full at the September 25th meeting of the Health and Wellbeing Board where the Section 75 was presented for approval.

10. All other national conditions are being met. These are:
- National Condition 1: A jointly agreed plan
- National Condition 2: Implementing the objectives of the BCF
- National Condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care
- National Condition 4: Complying with oversight and support processes

BCF Metrics

11. The below table shows the BCF metrics for this financial year, the targets and outturns for Quarter 2 where available:

Metric	Target Q2	Actual Q2	Commentary
Indirectly standardised rate (ISR) of admissions per 100,000 population	1617	1622 (Jul - Aug)	The target is currently being met when compared to the monthly target rates for July and Aug (1633). Sept data is not yet available. Year to date we are slightly below the target (variance of 2%).
Average length of discharge delay for all acute adult patients, derived from a combination of: proportion of adult patients discharged from acute hospitals on	0.42 YTD 86.5%	0.6 (Apr - July	Data is only available until end July for this indicator. Against the YTD end of Q2 target we are taking 0.2 days longer than expected.

their discharge ready date (DRD) for those adult patients not discharged on DRD, average number of days from DRD to discharge.	3.38 days	83.6% (July – Aug) 4 days	We are currently performing 2.9% off target for Q2 so far against the projected Q2 target. We were taking 0.62 days longer to discharge delayed patients than the projection for Q2
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	217	213	The plan for Q2 was 217 admissions and actual data shows this to be 213 for the period. YTD performance is 421 against a target of 434.

Updated spend and activity

12. This section updates income and expenditure for the quarter.

13. Information is required on the differing income streams of the BCF and if there have been any changes to this against the published planned income.

14. Expenditure for Quarter 2 has been inputted and is in line with the published plan and equates to 48% of the overall income.

Circulation under the Local Issues Alert Procedure

15. None

Background papers

Better Care Fund Planning Requirements 2025-26:
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#planning-expectations-meeting-national-conditions

Better Care Fund Policy Framework 2025-26:
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026#bcf-objectives

Officers to Contact

Jon Wilson Director of Adults and Communities
Telephone: 0116 3057454
Email: jon.wilson@leics.gov.uk

Lisa Carter Health and Social Care Integration Service Manager
Telephone: 0116 3050786

Email: lisa.carter@leics.gov.uk

List of Appendices

Appendix A – BCF Quarter 2 template 25-26

Relevant Impact Assessments

Equality and Human Rights Implications

16. 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.

17. 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.

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

Partnership Working and associated issues

19. 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.

20. 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.

21. 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 2025-26 Q2 Reporting Template

0

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction

https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any sigificant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF 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 ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

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

Data needs inputting in the cell

Pre-populated cells/Not required

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 row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

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. Once you select your HWB from the drop down list, relevant data on metric goals from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.
2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.
3. 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.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. 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 2025-26 (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/long-read/better-care-fund-planning-requirements-2025-26/

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 for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing the objectives of the BCF
National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) (and section 75 in place)

National condition 4: Complying with oversight and support processes

4. Metrics

The BCF plan includes the following metrics (these are not cumulate/YTD):
1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)
Plans for these metrics were agreed as part of the BCF planning process outlined within 25/26 planning submissions.
Populations are based on 2023 mid year estimates

Within each section, you should set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care.

The bottom section for each metric also captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
The metrics worksheet seeks a short explanation if a goal has not been met - in which case please provide a short explanation, including noting any key mitigating actions. You can also use this section to provide a very brief explanation of overall progress if you wish.

In making the confidence assessment on progress, please utilise the available metric data via the published sources or the DHSC metric dashboard along with any available proxy data.

https://dhexchange.kahootz.com/Discharge_Dashboard/groupHome

5. Expenditure

This section requires confirmation of an update to actual income received in 2025-26 across each fund, as well as spend to date at Q2. If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.

On the 'DFG' row in the 'Source of Funding' table, 'Updated Total Planned Income for 25-26' this should include the total funding from DFG allocations that is available for you to spend on DFG in this financial year 2025-26. 'Q2 Year-to-Date Actual Expenditure' should include total amount that has been spent in Q2, even if the application or approval for the DFG started in a previous quarter or there has been slippage.

The template will automatically pre-populate the planned income in 2025-26 from BCF plans, including additional contributions. Please enter the update amount of income even if it is the same as in the submitted plan.

Please also use this section to provide the aggregate year-to-date spend at Q2. This tab will also display what percentage of planned income this constitutes; [if this is 50% exactly then please provide some context around how accurate this figure is or whether there are limitations.]

Better Care Fund 2025-26 Q2 Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here 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 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:	1163050786
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

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	For further guidance on requirements please refer back to guidance sheet - tab 1.
3. National Conditions	Yes	
4. Metrics	Yes	
5. Expenditure	Yes	

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2025-26 Q2 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Leicestershire

Confirmation of Nation Conditions			Checklist Complete:
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:**	
1) Plans to be jointly agreed	Yes		Yes
2) Implementing the objectives of the BCF	Yes		Yes
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes		Yes
4) Complying with oversight and support processes	Yes		Yes

This page is intentionally left blank

Better Care Fund 2025-26 Q2 Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board: Leicestershire

For metrics time series and more details: BCF dashboard link

For metrics handbook and reporting schedule: BCF 25/26 Metrics Handbook

4.1 Emergency admissions

Plan		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,516.4	1,610.6	1,669.0	1,685.3	1,714.5	1,558.6	1,626.8	1,587.8	1,633.3	1,630.1	1,539.1	1,691.8
	Number of Admissions 65+	2,335	2,480	2,570	2,595	2,640	2,400	2,505	2,445	2,515	2,510	2,370	2,605
	Population of 65+	153,982.0	153,982.0	153,982.0	153,982.0	153,982.0	153,982.0	153,982.0	153,982.0	153,982.0	153,982.0	153,982.0	153,982.0

Assessment of whether goal has been met in Q2:	On track to meet goal
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.	
You can also use this box to provide a very brief explanation of overall progress if you wish.	Data for July and August shows that we have had 5105 admissions (rate of 3244) against a target of 5235 (rate of 3327). For quarter two we are on track to meet the targets set. The population data has been changed to reflect the new DHSC estimations. For the year to date we are slightly off target as there have been 12,895 admissions (rate of 8195) against year to date targets of 12,620 (rate of 8020). This is a variance of just over 2%.

Did you use local data to assess against this headline metric?	No

If yes, which local data sources are being used?	

4.2 Discharge Delays

Original Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	0.45	0.44	0.43	0.42	0.41	0.40	0.38	0.38	0.36	0.35	0.34	0.33
Proportion of adult patients discharged from acute hospitals on their discharge ready date	85.0%	85.4%	85.7%	86.1%	86.5%	86.8%	87.2%	87.5%	87.9%	88.3%	88.6%	89.0%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00

Assessment of whether goal has been met in Q2:	Not on track to meet goal
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.	Currently the system is stepping up the strategic discharge oversight group with actions specifically linked to the data targets for this area of work. This includes ensuring earlier referrals prior to MOFD. This is a multi-partner forum to ensure the mitigating actions resolve areas where improvements are needed most to ensure the target is reached and delays are minimised during the winter months.
You can also use this box to provide a very brief explanation of overall progress if you wish.	Currently the year to date data shows that we are approximately 0.9% off the target set. This we feel is recoverable over the remainder of the year with targeted efforts around pathways 1 and 2 discharges. The target in days for these pathways is 3.5 on average with current performance at 4 days.

Did you use local data to assess against this headline metric?	No

If yes, which local data sources are being used?	

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q2 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	509.8	535.1	140.9	140.9	140.9	140.3
	Number of admissions	785.0	824.0	217.0	217.0	217.0	216.0
	Population of 65+*	153982.0	153982.0	153982.0	153982.0	153982.0	153982.0

This page is intentionally left blank

Better Care Fund 2025-26 Q2 Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board: Leicestershire

Source of Funding	2025-26 Planned Income	Updated Total Plan Income for 25-26	DFG Q2 Year-to-Date Actual Expenditure	Checklist Complete:
DFG	£5,518,288	£5,518,288	£1,353,958	Yes
Minimum NHS Contribution	£57,070,979	£57,070,979		Yes
Local Authority Better Care Grant	£21,824,275	£21,824,275		Yes
Additional LA Contribution	£0	£0		Yes
Additional NHS Contribution	£0	£0		Yes
Total	**£84,413,542**	**£84,413,542**		

	Original	Updated	% variance	
Planned Expenditure	**£84,413,542**	£84,413,542	**0%**	Yes

		% of Planned Income	
Q2 Year-to-Date Actual Expenditure	£40,205,050	**48%**	Yes

If Q2 year to date actual expenditure is exactly 50% of planned expenditure, please confirm this is accurate or if there are limitations with tracking expenditure.		Yes
If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than	N/A	Yes

5% of total BCF expenditure, please use this box to provide a brief summary of the change.	

HEALTH AND WELLBEING BOARD: 4 DECEMBER 2025

REPORT OF LLR SEND AND INCLUSION ALLIANCE

Purpose of report

1. The purpose of this report is to present to the Health & Wellbeing Board a progress update of Phase 2 of the work of the LLR SEND and Inclusion Alliance (SIA): SEND and Alternative Provision Change Programme Partnership (SEND & AP CPP) and the approach to phase 3 and beyond.

Recommendation

2. The Board is asked to:

   (a) Note the progress of Phase 2 of the LLR SEND and Inclusion Alliance (SEND & AP CPP) and the approach to Phase 3 and beyond;

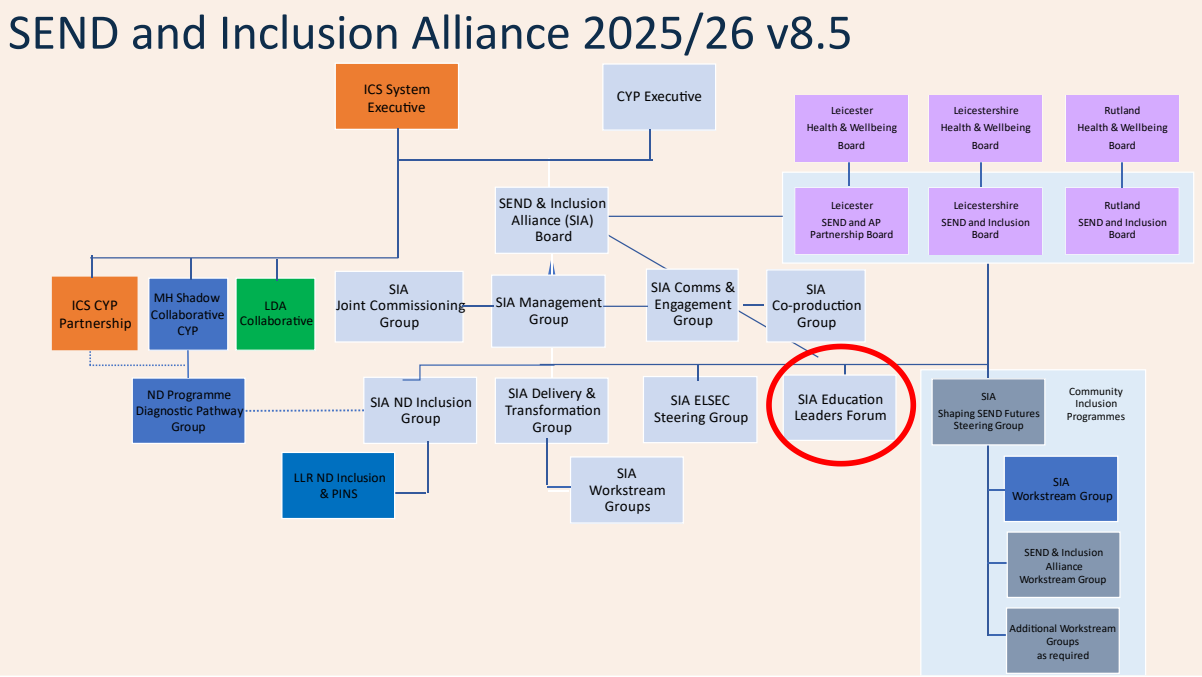
   (b) Continue to support and work in partnership with the LLR SIA;

Policy Framework and Previous Decision

3. Partners have signed the SIA Memorandum of Understanding (in appendix 2) to work in partnership to deliver the expectations of phase 3 of the (SEND & AP CPP) and, in the longer term, improve outcomes and lived experience for children and young people with SEND.

Background

4. LLR are the East Midlands representative for the national (SEND & AP CPP). The governance structure can be viewed below:



5. CPP phase 2 impact – to meet needs at the right time are illustrated below:
   - **a. Alternative provision (Meeting Need):**
     - i. Embedding 3 tier Alternative Provision model
     - ii. Alternative Provision handbook guide (co-produced with school reps) across the city
     - iii. A digital solution is being developed to enable services to monitor and quality assure Alternative Provision placements
   - **b. ELSEC (Speech & Language)**
     - i. Over 400 children with lower-level speech and language needs have been supported.
     - ii. A speech & Language toolkit launched across LLR
     - iii. ELSEC continues with focus on areas of high deprivation
   - **c. PINS (Neurodivergence)**
     - i. 40 LLR Primary Schools participated.
     - ii. Helped bridge gaps in relationships between schools and parents and enabled parents/carers to create support groups with schools
     - iii. E-learning available for all schools
     - iv. Plan to extend to secondary schools
   - **d. Inclusion (Internal Alternative Provision)**
     - i. Lead by Headteacher of Imperial Avenue. Over 64 Leicester primary schools signed up to this new network
     - ii. Providing advice and quality assuring provision
     - iii. As network grows, more schools interested in developing onsite internal Alternative Provision to enhance Mainstream inclusion offer across the city

6. The programme is in the final phase and will conclude in March 2026. LLR Partners have signed a Memorandum of Understanding to form a SEND & Inclusion Alliance, the purpose of which is to continue to embed the positive initiatives piloted through the CPP test and learn process beyond the end of March 2026. It will take a lead on shaping priorities for aligned commissioning, co-production, and community-led inclusion to help children and young people with SEND to thrive.

Proposals/Options

7. It is intended to continue to embed the principes of the SEND & Inclusion Alliance beyond the conclusion of the SEND & AP CPP in March 2026

8. During 2025 and 2026 the Alliance's primary role will be to co-ordinate:

iv. the delivery of the national SEND and Alternative Provision Change Programme Partnership;
v. the delivery of the LLR SEND Joint Commissioning Strategy;
vi. the roll-out of the LLR community inclusion programme to deliver the Local Inclusion Support Offer;
vii. integrated partnership working to improve quality of outcomes and lived experience for children and young people with SEND.

Consultation/Patient and Public Involvement

9. The SEND & Inclusion Alliance vision and strategic priorities beyond the deliverables of the CPP have been co-produced with the LLR Parent Carer Forums and underpinned by Young Researchers Young Voices research (2022-25).

Resource Implications

10. The Alliance has been established through DfE ringfenced Change Programme Partnership funding to deliver the Local Inclusion Support Offer. Funding allocations have been made and need to be spent by the end of March 2026.

Conclusion

11. The purpose of this report is to provide the Health & Wellbeing Board with an update of Phase 2 of the work of the SEND & Inclusion Alliance: SEND and Alternative Provision Change Programme Partnership and seek continued support for the work of the programme during phase 3 and beyond.

Background papers

12. None.

Officer to contact

Fay Bayliss

Director; LLR SEND & Inclusion Alliance

Mobile: 07717 346584

fay.bayliss@nhs.net

APPENDIX 1

SEND & Inclusion Alliance/

Change Programme Partnership (CPP)

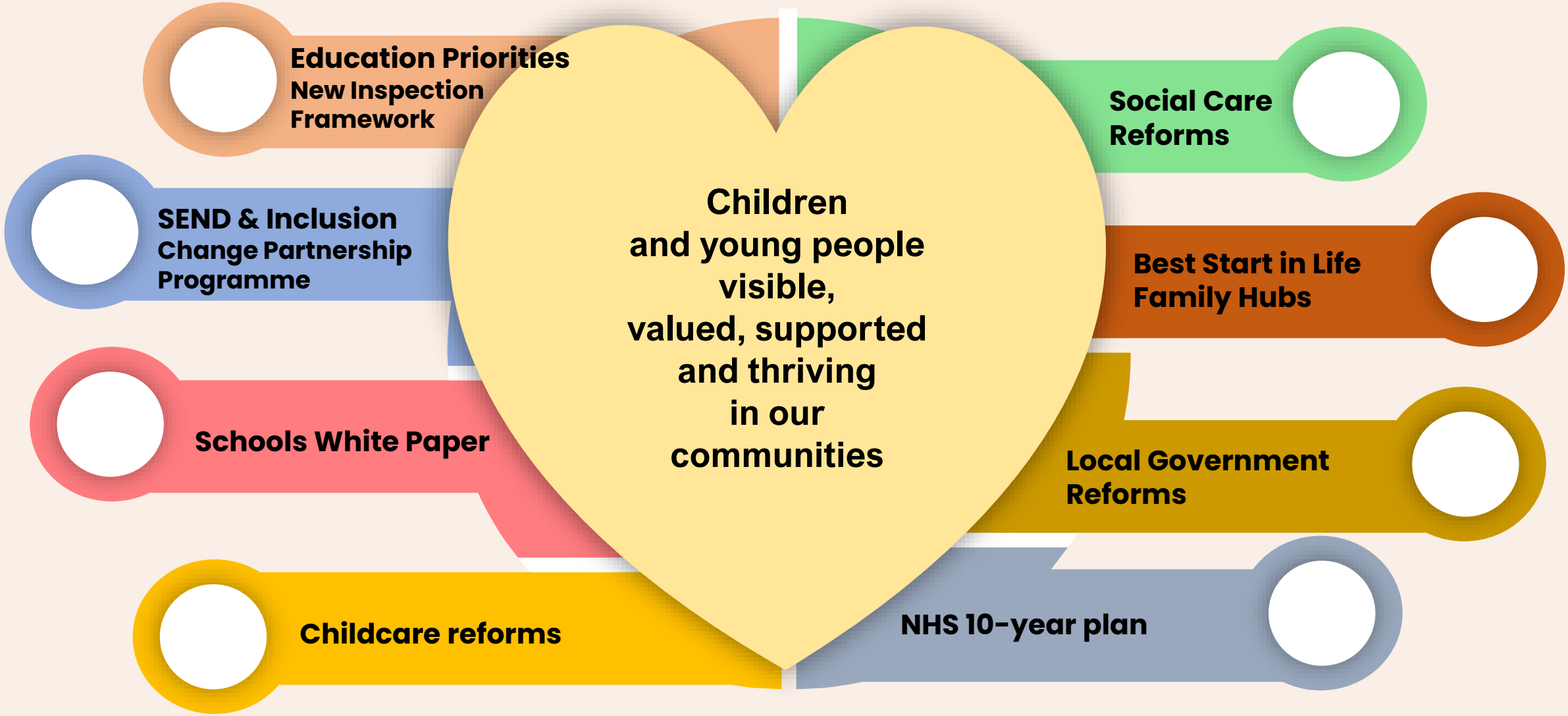
SEND and Inclusion Alliance update
HWBB November 2025

Jane Pierce – Programme Lead

Fay Bayliss – Director
Mark Roberts - Director

Change Programme Partnership LLR
SEND & AP IMPROVEMENT PLAN

National reforms context



LLR SEND & Inclusion Alliance: Change Programme Partnership (CPP) phase 3 and beyond

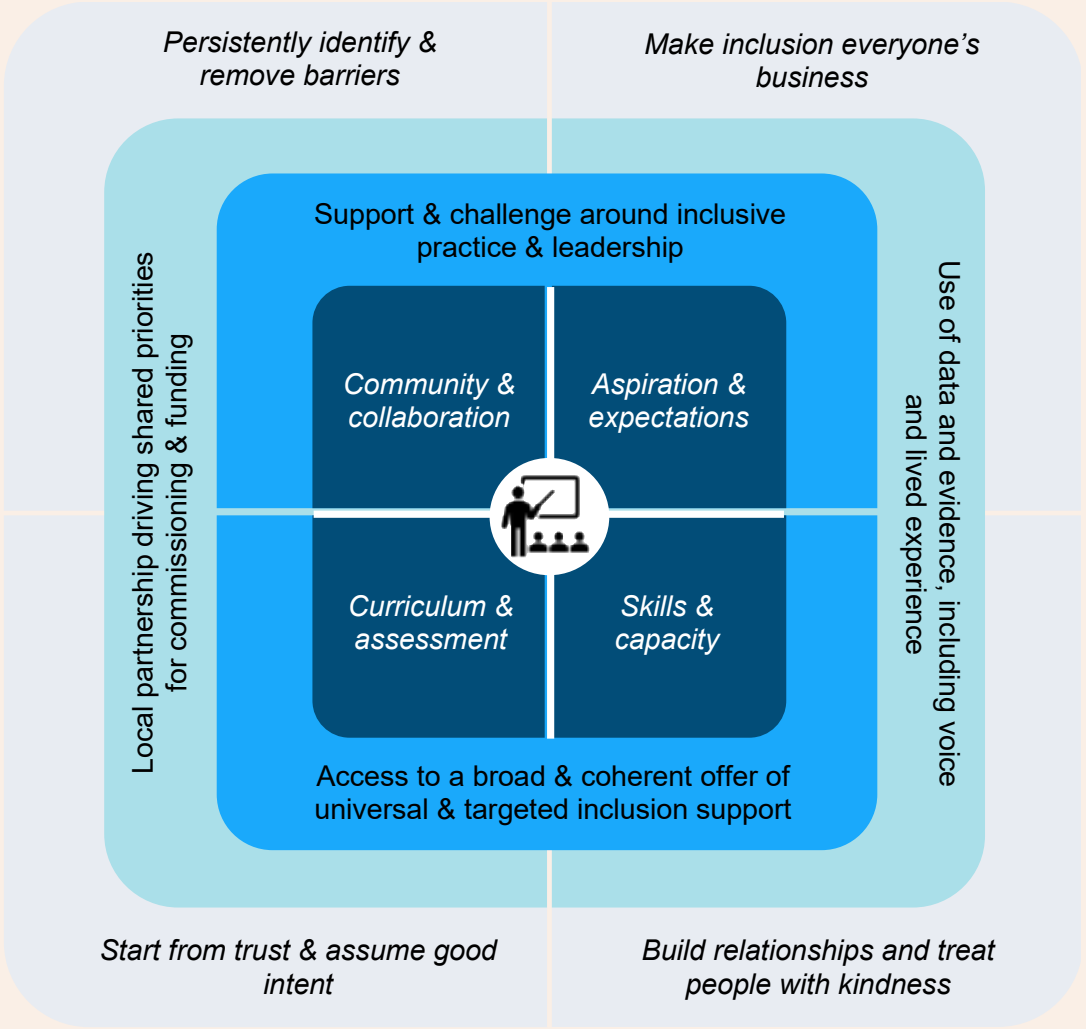
- Co-production is the golden thread that weaves through everything we do
- The Local Inclusion Support Offer is a multi-disciplinary approach to bridge the gap between specialist and mainstream provision
- Our community inclusion programme works with LLR communities to support local cyp with SEND to thrive

Developing our first annual implementation plan of LLR's SEND Joint Commissioning Strategy. First priorities are developing and commissioning a cohesive LISO

- Having these building blocks in place will facilitate collective ownership and strengthen accountability

DfE intention: Building blocks of an inclusive system

‘Working model’ of an inclusive system



Layers of the model:

Inclusive settings & providers – moving all settings and providers towards a shared understanding and consistent practices around inclusion

Structures & services to strengthen inclusion – improving collaboration between settings and with specialist services available locally to build universal and targeted capacity

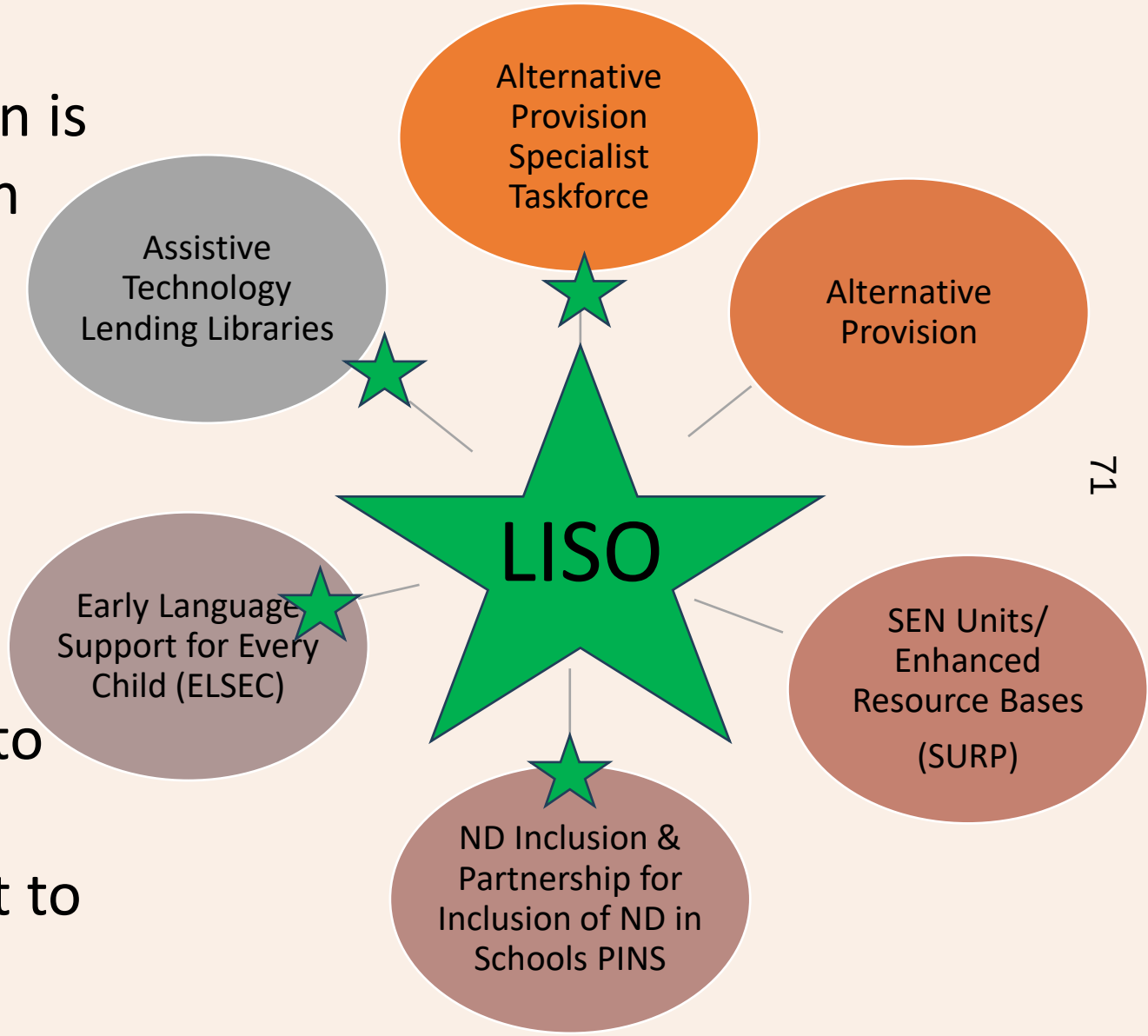
System leadership & local partnership – putting in place the enabling conditions across a local area that ensures planning and provision reflects the local area & is joined up

Consistently inclusive culture & behaviours – shifting mindsets through practical actions and shared accountability towards a system that works for children and families

Change Programme Partnership – LISO at the heart of phase 3

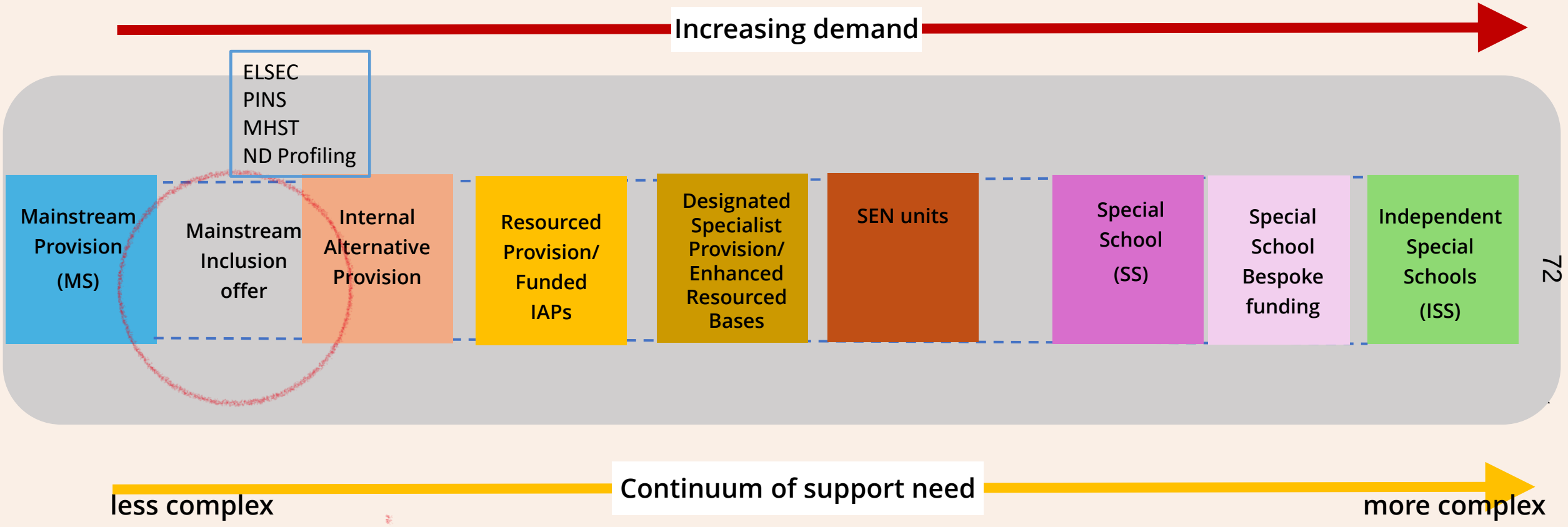
- Local areas are testing how inclusion is strengthened across their education settings through a **Local Inclusion Support Offer** (LISO) around
  - Advice
  - Training
  - Direct Support

★ Funding to test additional themes to inform policy development
- Tight timescales and commitment to spend by end of March 2026



Continuum of SEND Provision

2025 Expanding and Developing



£ MS Funding

£ SS Funding

£ ISS Funding

CPP phase 2 IMPACT – to meet needs at the right time

Alternative Provision

- Embedding 3 tier AP model
- AP handbook guide (co-produced with school reps) across the city
- A digital solution is being developed to enable services to monitor and quality assure AP placements

Meeting need

ELSEC

- Over 400 children with lower-level speech and language needs have been supported.
- A speech & Language toolkit launched across LLR
- ELSEC continues with focus on areas of high deprivation

Speech & Language

PINS

- 40 LLR Primary Schools participated.
- Helped bridge gaps in relationships between schools and parents and enabled parents/carers to create support groups with schools
- E-learning available for all schools
- Plan to extend to secondary schools

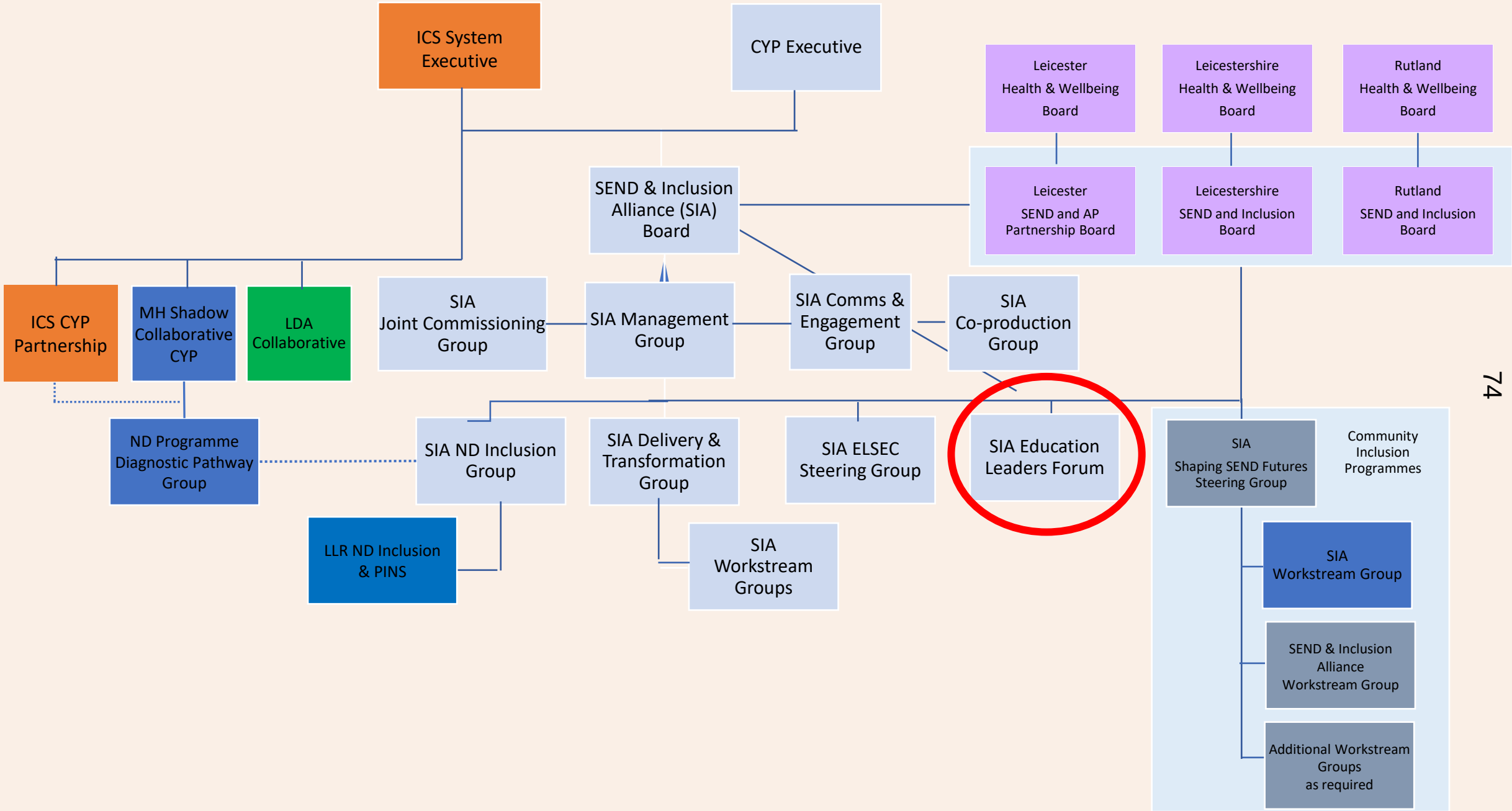
Neurodivergence

Internal Alternative Provision

- Lead by Headteacher of Imperial Avenue. Over 64 Leicester primary schools signed up to this new network
- Providing advice and quality assuring provision
- As network grows, more schools interested in developing onsite internal AP to enhance Mainstream inclusion offer across the city

Inclusion

SEND and Inclusion Alliance 2025/26 v8.5



LLR Co-production Charter

Coproduction involves individual and community voices working together in respectful partnership to improve lives.

We respect and trust everyone in the process

We support and enable everyone to be heard

We are clear on the way forward and act on what has been agreed

We are honest, respect confidentiality and try to understand everyone's circumstances and point of view

We work in partnership

We welcome and value everyone's views

We seek honest and transparent feedback

We understand that our different roles, responsibilities and perspectives are the key to good coproduction

We communicate well

We listen to everyone's views

We feed back to everyone about what we have heard and what we have done

We make sure all communication is simple, accurate and easy to understand

We give everyone the information and support they need to participate

We are inclusive

We make everyone feel welcome, comfortable and that they belong

We give everyone the time and space to be heard

We make sure that everyone can participate – for example meeting venues are accessible, we meet at suitable times, we provide interpreters where we can

Coproduction should happen at all levels:

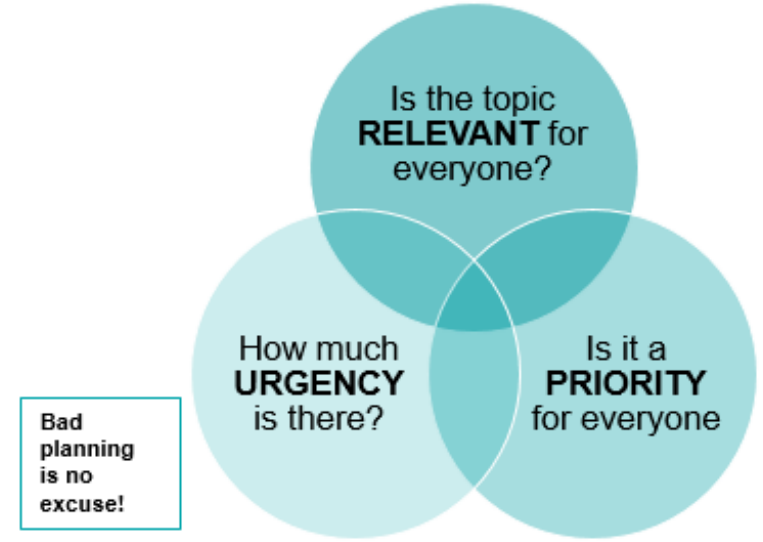
- Individual
- Operational
- Strategic

Coproduction should cover all relationships:

- Practitioners (inc schools) to parents and CYP
- Commissioners to parents and CYP
- Commissioners to practitioners
- Providers to other practitioners
- Parents and CYP with other parents and CYP

75

We seek to coproduce as much as possible but need to consider:



Change Programme Partnership - Test of SEND Local Partnership Maturity Assessment

- A DfE tool designed to support Local SEND and Inclusion partners to evaluate and enhance current practice in a structured way
- There are seven principles putting outcomes of children and young people (CYP) at the heart of strategic planning and commissioning
- Descriptors for each principle help frame partnership arrangements and practices against a scale of maturity, to support a system shift towards inclusion

Local Partnership Maturity Assessment tool

1. Co-production with parents/carers and CYP (p4)
2. Understanding and evidencing the needs of CYP with SEND and those CYP who may need AP (p6)
3. A clear focus on early identification, intervention and inclusion in mainstream settings through improving mainstream inclusion (p9)
4. Creating collaborative relationships with providers of early years, school and FE places, specialist provision, CYP health services for 0-25 and social care services and the local authority (p12)
5. Improving outcomes-based accountability through transparency, communication and trust (p16)
6. Using a range of sources to monitor effectiveness and enable continuous improvement, ensuring a targeted, judicious and sustainable use of resources (p19)
7. Driving strategic decision making at the right level (p17)

- Use of assessment tool supported by REACh (CPP delivery partner)

This page is intentionally left blank

APPENDIX 2

MEMORANDUM OF UNDERSTANDING

Leicester, Leicestershire and Rutland SEND & Inclusion Alliance

v1.1 - 29th July 2025

Review date: 31st March 2027

CONTENTS

1 PARTIES TO THE MEMORANDUM OF UNDERSTANDING

1.1 This Memorandum of Understanding ("**MoU"**) is made on 1st September 2025 to formalise the LLR SEND & Inclusion Alliance (The Alliance) between:

LEICESTER CITY COUNCIL

LEICESTERSHIRE COUNTY COUNCIL

RUTLAND COUNTY COUNCIL

LLR INTEGRATED CARE BOARD

LEICESTERSHIRE PARTNERSHIP NHS TRUST

THE SCHOOL DEVELOPMENT AND SUPPORT AGENCY (SDSA)

LEICESTER CITY PARENT CARER FORUM

LEICESTERSHIRE PARENT CARER FORUM (LEICESTERSHIRE SEND HUB)

RUTLAND PARENT CARER VOICE

together the "**Parties**" and each a "**Party**"

2 STATUS

2.1 The Alliance is not a legal entity in its own right and it is acknowledged that this MOU is not a legally binding agreement. It does not change the statutory roles, responsibilities and accountabilities of any NHS, local authority or other body covered by this MOU.

2.2 During 2025 and 2026 the Alliance's primary role will be to co-ordinate:

2.2.1 the delivery of the Change Programme Partnership

2.2.2 the delivery of the LLR SEND Joint Commissioning Strategy
2.2.3 programmes of work assigned by the parties to it to improve the commissioning and delivery of services
2.2.4 the roll-out of the LLR community inclusion program to deliver the Local Inclusion Support Offer
2.2.5 integrated partnership working to improve quality of outcomes and lived experience for children and young people with SEND

2.3 It is expected that the Alliance will evolve and mature, over time, as will its relationship with each of the local organisations that form it in section 1.1 above. On an annual basis the Alliance will review its accountabilities and document these and this MOU will be superseded by an updated accountability agreement when required.

3 PURPOSE OF THIS DOCUMENT

3.1 This document outlines and formalises the relationship in place between the parties and the Alliance for:

3.1.1 Co-ordinating the system approach to SEND service transformation and addressing challenges

3.1.2 Overseeing the design, commissioning and deployment of programmes and work and new service developments generated by the Alliance with regard to co-production, commissioning, delivery and impact assessment

3.1.3 The evolution of the maturity of the Alliance using an approach to be agreed by the Alliance Board

4 PURPOSE OF THE ALLIANCE

4.1 The SEND Alliance has been established to ensure children, young people and young adults with special educational needs and disabilities and their families and carers can enjoy fulfilling lives and achieve their full potential, and to ensure that they can access impactful support from the right people at the right time.

4.2 The Alliance provides the opportunity for education, health, social care and voluntary and community sector organisations to come together to embrace difference, solve challenges such as unwarranted variation and inequality, as well as to improve resilience. It is expected that all parties will play a full part through commitment and the allocation of resources. The Alliance, along with place-based partnerships, will be a key component of the Integrated Care Systems (ICS), enabling the local system to deliver better health, education, care and efficient use of resources.

5 PRINCIPLES

5.1 The Seven Principles of Public Life (aka the Nolan Principles) underpin the Parties common purpose, relationships and behaviours.

5.1.1 Selflessness
5.1.2 Integrity
5.1.3 Objectivity
5.1.4 Accountability
5.1.5 Openness
5.1.6 Honesty
5.1.7 Leadership

(Ref: The Seven Principles of Public Life - GOV.UK)

5.2 The guiding principles by which the Parties to this MoU will abide are:

5.2.1 Adopting a clear and agreed vision and purpose that supports the priorities for the Parties and National NHS and DfE priorities

5.2.2 Ensuring co-production remains central to all work undertaken in the Alliance

5.2.3 The Alliance will be inclusive, evolutionary and purpose driven. In addition to the Parties, it must draw from the insights, experience and resources of those individuals and organisations necessary to fulfil its vision and purpose, for example: schools, social care; NHS providers; independent sector; primary care; the VCSE sector; carers; service users, etc.;

5.2.4 Operating in the spirit of inclusion, collaboration and partnership, demonstrating positive behaviours and mutual respect;

5.2.5 Including Place leaders and local government to ensure services are designed to meet the needs of the different communities across LLR;

5.2.6 Adopting an approach that delivers the Population Health Management five aims of; Enhanced Experience of Care, Improved Health and Wellbeing of the Population, Addressing and health and care inequalities, Increasing the well-being and engagement of the workforce, reducing costs and improving productivity.

5.2.7 Addressing education, health and care equity/inequalities as a core component of strategic planning and transformational activities.

5.2.8 Takes a whole pathway approach to transformation (including specialised and direct commissioning) and considers the life course approach to ensure services are fit from conception to 25 years;

5.2.9 Ensuring Partners are of equal status and standing;

5.2.10 Making decisions that are focused on the interests and outcomes of Service Users and people in LLR rather than organisational interests;

5.2.11 Supporting each other in achieving the Alliance Objectives;

5.2.12 Is accountable. Takes on, manages and accounts to each other for performance of the respective roles and responsibilities set out in this MoU and consider the wider impact across the LLR ICS;

5.2.13 Improve resilience across providers, particularly in relation to the workforce – with the expectation that the Alliance's work will support workforce development and workforce planning;

5.2.14 Consider where specialisation and consolidation would provide better outcomes and value

5.2.15 Is open, honest and transparent by communicating concerns, issues or opportunities relating to this MoU, subject always to appropriate treatment of Commercially Sensitive Information and Competition Law;

5.2.16 Adhering to statutory requirements and Good Practice. Complies with applicable Law and standards including EU procurement rules, Competition Law, data protection and freedom of information legislation;

5.2.17 Acting in a timely manner. Recognises the time-critical nature of the MoU and respond accordingly to requests;

5.2.18 Making available sufficient and appropriately qualified resources to fulfil the responsibilities set out in this MoU, including its Schedules;

5.2.19 Looking to adopt a collective ownership of risk and reward, including identifying, managing and mitigating all risks in respect of their performance of the obligations under this MoU;

5.2.20 Maintaining flexibility in working together to meet the Alliance Objectives; and

5.2.21 Co-ordinating with and contributing to the development of other local partnerships.

6 ROLES AND RESPONSIBILITIES

6.1 In view of the current maturity level of Alliance, the Parties agree the following roles and responsibilities for the period up to March 2027. Beyond this point, roles and responsibilities will be revised in an updated accountability agreement, to reflect the increased maturity of the Alliance.

6.2 All Alliance Parties will:

6.2.1 Ensure delivery of the Change Programme Partnership and subsequent associated DfE and NHSE funded programmes of work as agreed by the Board

6.2.2 Ensure delivery of the LLR SEND Joint Commissioning Strategy

6.2.3 Deliver an agreed programme of work assigned by the Parties to improve the commissioning and delivery of services; overseeing the design, commissioning and deployment of programmes and work and new service developments generated by the Alliance with due regard to co-production, commissioning, delivery and impact assessment

6.2.4 Co-ordinate wherever possible on a systemwide basis SEND service transformation and the addressing of challenges

6.2.5 Ensure that the maturity of the collaborative is monitored and progressed using an approach agreed by the Alliance Board

6.2.6 Effectively engage with all other Partners and Stakeholders within and outside of the Alliance

6.2.7 Track and monitor the mobilisation and implementation of SEND developments, as well as any remedial/corrective action plans required

6.2.8 Manage the gathering and analysis of key data sets in conjunction with other Alliance Partners.

6.2.9 Ensure communications and engagement activities increase staff awareness and involvement in improvement activity

6.2.10 Ensure sufficient resources are made available to enact the requirements of the Alliance as set out in this MOU.

6.3 The Alliance Board

6.3.1 In addition Alliance Board will have the additional roles, as follows:

6.3.1.1 Assurance that the Alliance is delivering its transformation agenda and addressing the key SEND challenges;

6.3.1.2 Ensuring oversight of financial management, performance, quality and impact of the Alliance's activities

6.3.1.3 Act as the interface between the Alliance and NHS England, the Department for Education and the LLR NHS and Local Authority Executive Teams, ensuring robust lines of communication in both directions

6.3.1.4 Act as the strategic interface between the LD&A Alliance and other LLR partnerships and Boards

7 DURATION AND REVIEW OF MOU

7.1 The MOU will commence on 1 September 2025 and will continue until 31 March 2027. Either party can request that the end date be reviewed and/or amended, with the agreement of both parties.

7.2 During the period of this MoU, all Parties will work together to implement an agreed Maturity Plan. By so doing, a revised accountability agreement will be agreed, for 2027/28 and beyond, to reflect the expected increase in maturity.

7.3 In recognition that 2025/26 is the first year of operation, the Parties will conduct an initial review of the arrangements as set out in the MOU by the 31 March 2026.

8 GOVERNANCE ARRANGEMENTS

8.1 Decision making will be undertaken within the governance arrangements outlined in Appendix 1. It is accepted that the governance arrangements will themselves mature and all Parties will work together to refine the meeting structures, reflecting these in the revised accountability agreement for March 2027 and beyond.

8.2 The Parties recognise that, as an overarching principle during 2025/26, flexibility will be required and they will seek to agree any additional oversight and interaction required to manage key risks and fulfil Alliance functions.

8.3 The Parties recognise the duties in terms of conflicts of interest and have agreed to manage conflicts of interest in line with the ICS's Conflict of Interest Policy, which will include establishing a conflicts of interest register, declaring and effectively managing conflicts of interest as they arise.

9 ACCOUNTABILITY AND MONITORING

9.1 The Alliance Management Team is accountable to the Alliance Board that will be chaired by an Independent Chair supported by lead officers assigned by the Parties' organisations. The Alliance Management team will be led by a Director who will be accountable to the Board for the delivery of the Alliance's functions and responsibilities. In practice, the Director will set out an annual plan and report on progress against this on a quarterly basis.

9.2 The Board will be led by an Independent Chair appointed by the members of the LLR CYP Executive Group.

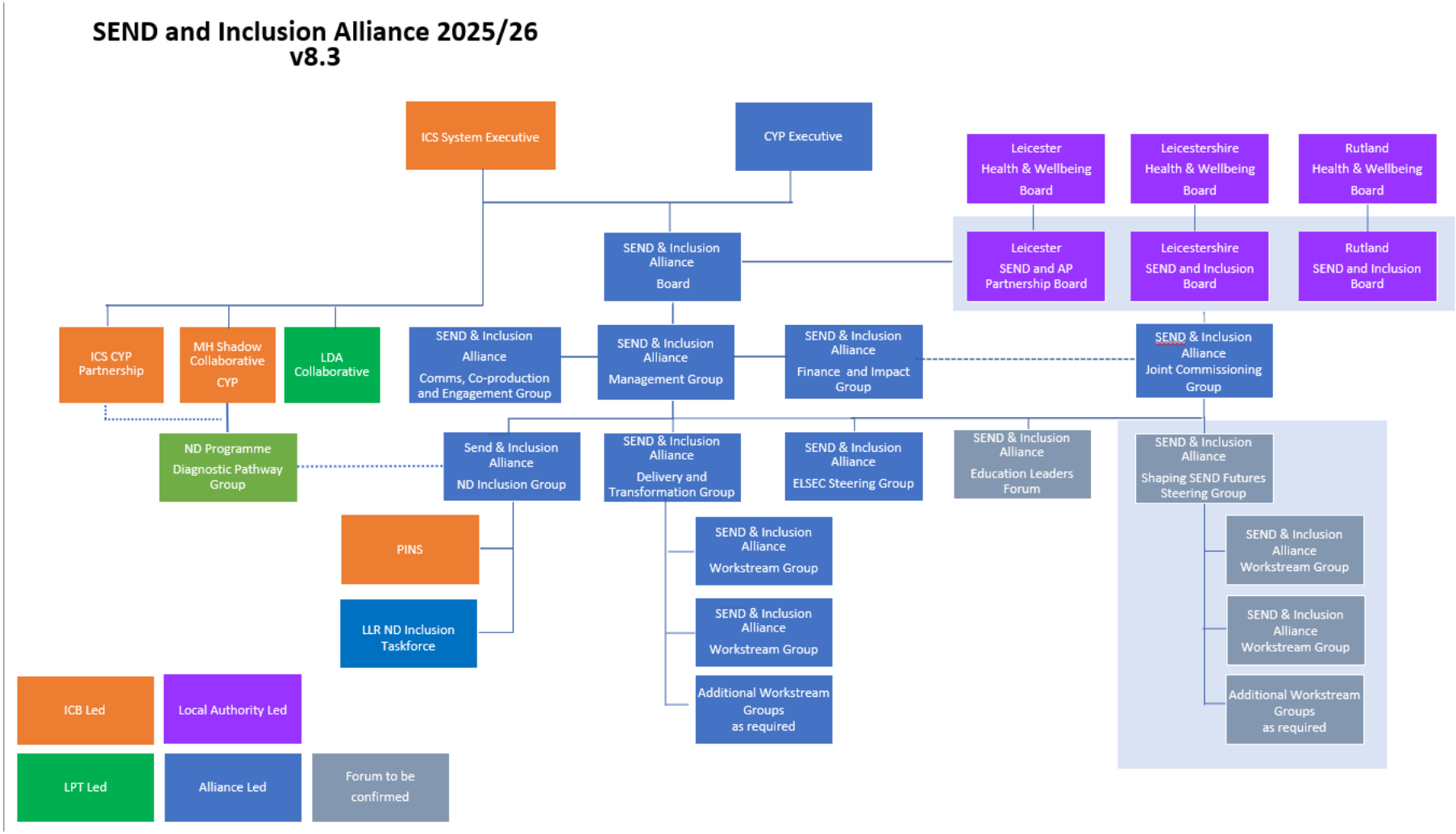
9.3 Through the work of the Independent Chair and the Board the Alliance will regulate its own performance and development. Providing annual reports to the CYP Executive and the ICs System Executive setting out commissioning and operational progress and plans.

9.4 In recognition that 2025/26 is the first year of operation, the Parties will conduct an initial review of the arrangements as set out in the MOU by the 31 March 2026.

10 DISPUTE RESOLUTION

10.1 In the event of disagreement about the oversight arrangements, or any other matter as set out in the MoU, the aggrieved Party shall notify the other Parties and the Parties will seek to resolve the matter with reference to the Dispute Resolution procedures (See appendix 2).

Appendix 1


SEND and Inclusion Alliance 2025/26
v8.3
ICS System Executive
CYP Executive
Leicester Health & Wellbeing Board
Leicestershire Health & Wellbeing Board
Rutland Health & Wellbeing Board
SEND & Inclusion Alliance Board
Leicester SEND and AP Partnership Board
Leicestershire SEND and Inclusion Board
Rutland SEND and Inclusion Board
ICS CYP Partnership
MH Shadow Collaborative CYP
LDA Collaborative
SEND & Inclusion Alliance Comms, Co-production and Engagement Group
SEND & Inclusion Alliance Management Group
SEND & Inclusion Alliance Finance and Impact Group
SEND & Inclusion Alliance Joint Commissioning Group
ND Programme Diagnostic Pathway Group
Send & Inclusion Alliance ND Inclusion Group
SEND & Inclusion Alliance Delivery and Transformation Group
SEND & Inclusion Alliance ELSEC Steering Group
SEND & Inclusion Alliance Education Leaders Forum
SEND & Inclusion Alliance Shaping SEND Futures Steering Group
PINS
LLR ND Inclusion Taskforce
SEND & Inclusion Alliance Workstream Group
SEND & Inclusion Alliance Workstream Group
Additional Workstream Groups as required
SEND & Inclusion Alliance Workstream Group
SEND & Inclusion Alliance Workstream Group
Additional Workstream Groups as required
ICB Led
Local Authority Led
LPT Led
Alliance Led
Forum to be confirmed

Appendix 2– DISPUTE RESOLUTION

1 Avoiding and Solving Disputes

1.1 The Parties commit to working co-operatively to identify and resolve issues to mutual satisfaction to avoid, so far as is possible, dispute or conflict in performing their obligations under this MoU.

1.2 For the avoidance of doubt, disputes relating to operational matters are to be resolved via individual party organisation's dispute resolution procedures.

1.3 The Parties believe that:

1.3.1 by focusing on the LLR SEND Alliance Principles (Clause 5);

1.3.2 taking decisions to tackle health inequalities, collective prioritisation of population needs, and service transformation; and

1.3.3 maximising strategic planning opportunities through a shared decision-making framework;

they will reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with the services they provide.

1.4 The Parties shall promptly notify the Board of any dispute or claim or any potential dispute or claim in relation to this MoU or the operation of the Services (each a "**Dispute**") when it arises.

1.5 The Board shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties.

1.6 The Board shall deal proactively with any Dispute in accordance with this MoU to seek to reach a unanimous decision. If the Board reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice.

1.7 The Parties agree that the Board may determine whatever action it believes is necessary including the following:

1.7.1 if the Board cannot resolve a Dispute, it may select an independent facilitator to assist with resolving the Dispute; and

1.7.2 the independent facilitator shall:

(i) subject to the provisions of this MoU, be provided with any information they request about the Dispute;

(ii) assist the Board to work towards a consensus decision in respect of the Dispute;

(iii) regulate their own procedure and, subject to the terms of this MoU, the procedures of the Parties at such discussions;

(iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and

(v) have its costs and disbursements met by the Parties involved in the Dispute equally or in such other proportions as the independent facilitator shall direct.

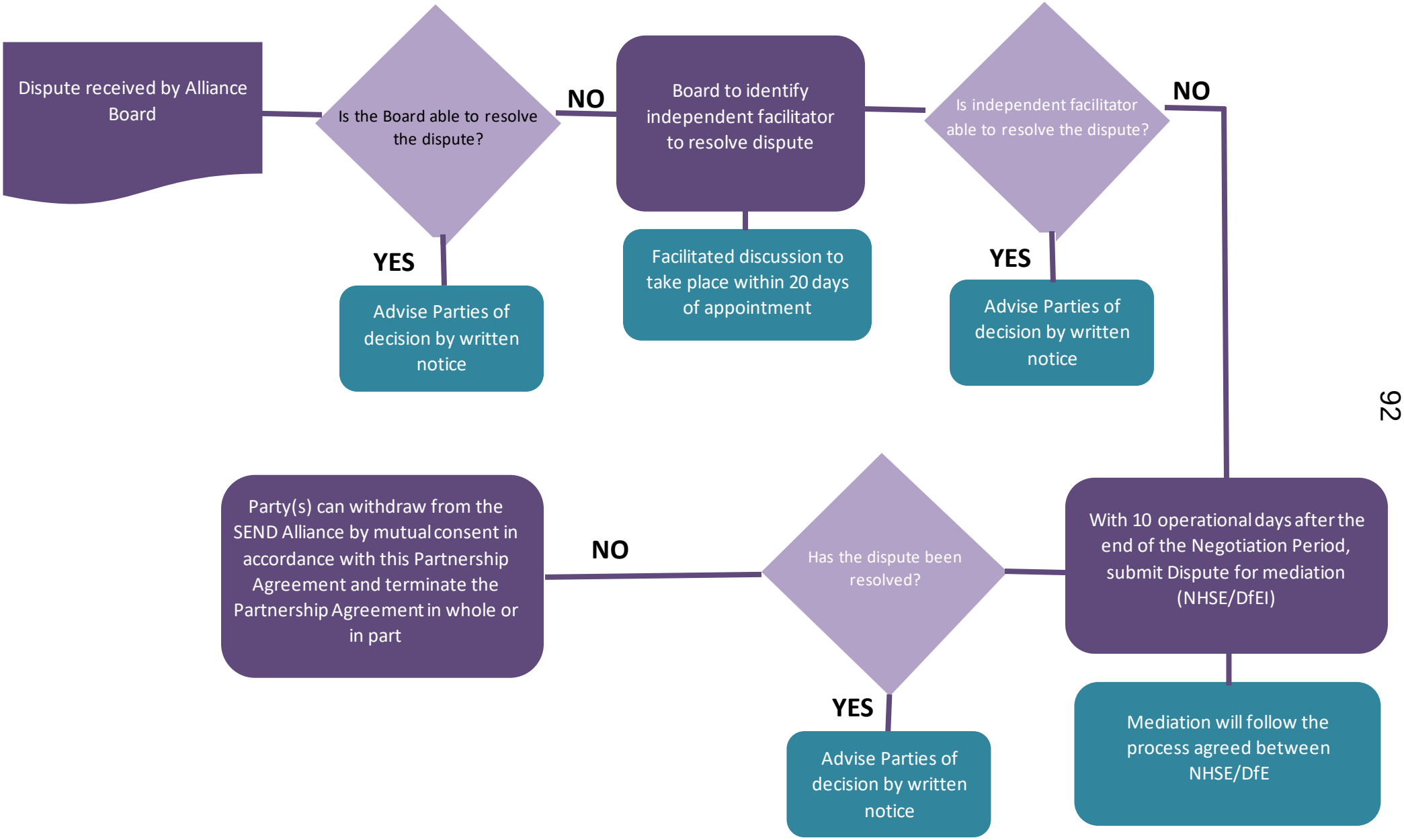
1.7.3 If the independent facilitator cannot resolve the Dispute, the Parties must, within 10 Operational Days after the end of the Negotiation Period, submit the Dispute to mediation arranged jointly with NHSE/DfE.

1.7.4 If, after taking the steps in this procedure the Dispute cannot be resolved, the Parties may agree:

(i) that the Party(s) involved in the dispute can withdraw from the LLR SEND Alliance by mutual consent in accordance with this Partnership Agreement.

(ii) to terminate the Partnership Agreement in whole or in part.

DISPUTE RESOLUTION PROCESS FLOW



Appendix 3 – Signatories

Disclaimer
It should be noted that by signing this document or by participating in the LLR SEND & Inclusion Alliance, the partners are not committing to legally binding obligations. It is intended that the partners remain independent of each other and that their collaboration and use of the term 'partner' does not constitute the creation of a legal entity, nor authorise the entry into a commitment for or on behalf of each other.

Signed on behalf of Leicester City Council

Name:……..……..……..……..……..……..…… Position:..……..……..……..……...

Signature:…...……..……..……..…….. Date:..……..……..……..……..……..
.

Signed on behalf of Leicestershire County Council

Name:……..……..……..……..……..……..…… Position:..……..……..……..……...

Signature:…...……..……..……..……... Date:..……..……..……..……..……..

Signed on behalf of Rutland County Council

Name:……..……..……..……..……..……..…… Position:..……..……..……..……...

Signature:…...……..……..……..……... Date:..……..……..……..……..……..

Signed on behalf of LLR Integrated Care Board

Name:……..……..……..……..……..……..…… Position:..……..……..……..……...

Signature:…...……..……..……..……... Date:..……..……..……..……..……..

Signed on behalf of Leicestershire Partnership NHS Trust

Name:……..……..……..……..……..……..…… Position:..……..……..……..……...

Signature:…...……..……..……..……... Date:..……..……..……..……..……..

Signed on behalf of The School Development and Support Agency (SDSA)

Name:……..……..……..……..……..……..…… Position:..……..……..……..……...

Signature:…...……..……..……..……... Date:..……..……..……..……..……..

Signed on behalf of Leicester City Parent Carer Forum

Name:……..……..……..……..……..……..…… Position:..……..……..……..……...

Signature:…...……..……..……..……... Date:..……..……..……..……..……..

Signed on behalf of Leicestershire Parent Carer Forum (Leicestershire SEND Hub)

Name:……..……..……..……..……..……..…… Position:..……..……..……..……...

Signature:…...……..……..……..……... Date:..……..……..……..……..……..

Signed on behalf of Rutland Parent Carer Voice

Name:……..……..……..……..……..…… Position:..……..……..……..……...

Signature:…...……..……..……..……... Date:..……..……..……..……..……..

Agenda Item 11

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

HEALTH AND WELLBEING BOARD:

4th DECEMBER 2025

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

PANDEMIC PLANNING

Purpose of report

1. To provide an update to the Health and Wellbeing Board on pandemic preparedness across Leicester, Leicestershire and Rutland (LLR), summarising current planning activity, key learning from recent national and local exercises, and proposed next steps to strengthen multi-agency resilience ahead of future pandemic threats.

Recommendation

2. The Board is asked to:
   - Note the current status of pandemic planning across LLR, including governance, plans, capabilities and risks.
   - Endorse the proposed next steps to strengthen multi-agency coordination and preparedness.
   - Support the continued integration of pandemic planning with broader health protection, Local Resilience Forum (LRF) and Emergency Preparedness, Resilience and Response (EPRR) frameworks (including NHS Core Standards).

Policy Framework and Previous Decision

3. The Health and Social Care Act 2012 places duties on local authorities and Directors of Public Health to protect the health of their populations. Pandemic preparedness is delivered through multi-agency arrangements under the Civil Contingencies Act 2004 (CCA), with local authorities and NHS bodies as Category 1 Responders and LRFs providing coordination.

4. Relevant national frameworks and guidance are included in the appendix.

Background

5. A pandemic is defined as the spread of disease across whole countries, international boundaries or continents at the same time, usually driven by a novel pathogen (virus, bacteria, fungi or other organism) to which there is little or no population immunity[1].

6. The national risk register [2] outlines the most serious risks to the UK and identifies pandemics as an acute risk within the 'human, animal and plant health' theme. The most significant risk to materialise in the UK in recent years has been the COVID-19 pandemic. The most likely future pandemic is expected to be respiratory, but planning covers multiple transmission routes (respiratory, blood and body fluids, contact, ingestion and vectors) to cover a range of emerging infectious disease scenarios.

7. Each pandemic, by definition, is unique. Novel pathogens present different challenges to existing circulating biological agents, even where they closely resemble them. This may include extended duration of a pandemic (many months, even years), multiple waves of infection, vaccinations or specific treatments not currently or readily available, and wider or atypical population groups being at risk and affected.

8. The unequal risk and impact of a future pandemic will undoubtedly exacerbate existing health inequalities and cause new disparities for communities across the county.

9. Following detection of a pathogen with pandemic potential, the health system will need to respond to significant challenges, and will be required to:
   - Identify and isolate suspected cases;
   - Implement appropriate arrangements (such as scalable contact tracing, diagnostics, pharmaceutical and non-pharmaceutical countermeasures, management of excess deaths);
   - Recovery management;
   - Arrangements for effective national and global coordination.

10. Pandemic influenza remains one of the most well-characterised and historically recurring pandemic threats, offering a valuable framework for multi-agency preparedness planning. Pandemics such as the 2009 H1N1 outbreak have provided critical insights into surge capacity, planning, vaccine deployment logistics and the importance of timely public health communication. These lessons continue to shape our strategic approach across LLR.

11. Pandemic influenza emerges when a new flu virus is markedly different from recently circulating strains. Few - if any - people will have any immunity to this new virus thus allowing it to spread easily and to cause more serious illness. The conditions that allow a new virus to develop and spread continue to exist, and some features of modern society, such as air travel, could accelerate the rate of spread. Experts therefore agree that there is a high probability of a pandemic occurring, although the timing and impact

[1] Framework for managing the response to pandemic diseases https://www.england.nhs.uk/long-read/framework-for-managing-the-response-to-pandemic-diseases/

[2] National Risk Register 2025 - https://assets.publishing.service.gov.uk/media/67b5f85732b2aab18314bbe4/National_Risk_Register_2025.pdf

are impossible to predict. The H1N1(2009) pandemic does not lessen the probability of a further pandemic in the near future and should not be seen as representative of future pandemics.

12. The COVID-19 pandemic, caused by a novel coronavirus, began in 2019 and was an unprecedented global health crisis, affecting every aspect of life in Leicestershire as well as the wider UK and world. The pandemic required rapid, coordinated responses from health and care organisations, local authorities and communities, highlighting the importance of preparedness, resilience and learning for future threats.

13. COVID-19 is no longer classed as a global emergency, however, remains a notifiable infectious disease and continues to circulate at low levels in the community. Surveillance systems are in place locally and nationally to monitor for any increases in cases or the emergence of new variants. The NHS and public health partners remain vigilant with ongoing testing, vaccination and outbreak management protocols ready to be activated if required.

14. The UK Covid Inquiry was set up to examine the UK's response to and impact of the pandemic. Its first report was published on Resilience and Preparedness, noting the UK was not adequately prepared for a pandemic. The findings and recommendations are being incorporated locally to ensure future pandemic planning is robust, inclusive and informed by the lessons learned.

Current Position

Preparedness:

15. LLR partners have participated in major exercises (Tangra, Solaris, Pegasus) to test and improve pandemic response. These have led to better coordination, refined protocols, and stronger relationships. Plans are regularly reviewed and updated, with roles and responsibilities embedded in Local Resilience Forum structures. The exercises are detailed below:

- Exercise Tangra, April 2025 – ICB led exercise aimed to test and improve the preparedness and response capabilities of organisations in the event of a pandemic. This was a mainly health focussed exercise mandated by NHS England (NHSE) and the Department of Health and Social Care (DHSC).

- Exercise Solaris, May 2025 – LRF led exercise to gain insights into how different sectors, especially local authorities, and voluntary and community sectors would coordinate a pandemic response. This was also a pre-exercise for Exercise Pegasus.

- Exercise Pegasus, Sept, Oct, Nov 2025 – a national Tier 1 pandemic preparedness exercise. The UK Government committed to a National Exercising Programme to deliver annual national exercises on a range of risks to test real-world resilience. The aim is to test the UK's ability to respond to a pandemic arising from a novel infectious disease, involving all regions, bringing together the Cabinet and every UK government department. This is a multi-agency simulation involving NHS, local authority, emergency services and voluntary sector partners to test pandemic response protocols.

16. Pandemic planning is one element of wider LLR preparedness and links to a suite of plans that would be activated in a pandemic, listed in Appendix B. Roles and responsibilities are embedded within the Local Resilience Forum (LRF) structures and are defined in Appendix C.

Resources:

17. Pandemic response requires coordinated action across different organisations within and beyond the health and social care sector. Key elements of resource planning include:

    - Review of PPE stock levels and supply chains, and fit testing capacity, coordinated across health, social care and local authority partners.
    - Testing and vaccination capacity is exercised, with flexible plans to permit surge testing and vaccination delivery as necessary, adapting protocols based on risk assessments in line with national frameworks.

Workforce:

18. The workforce actions taking place are:

- Surge staffing protocols agreed with NHS and social care partners, including bank and agency staff, volunteers, redeployment and mutual aid options.
- IPC training is developed and shared with partners across the health and social care sector with national escalation as required.
- Staff wellbeing and resilience during periods of increased demand was considered within the planning

Communications:

19. Core communication principles have already been agreed across all LRF organisations:

    - Use of trusted voices and spokespersons to deliver messages.
    - Multi-channel engagement (e.g. websites, social media, newsletters, and community networks).
    - Transparent updates aligned with national guidance.
    - Proactive response to misinformation
    - Consistency across agencies to avoid mixed messages.
    - Accessibility and inclusion in all communications.
    - Scenario planning and pre-prepared messaging.
    - Community engagement and feedback mechanisms to adapt messaging.

20. The LRF Warning and Informing Cell would be stood up and have representation from all relevant agencies and a strategy in place to include:

- Reassurance through trusted platforms.
- Signposting to official websites and national messaging.
- Engagement with religious and community leaders.
- Outreach to local media contacts to promote accurate messaging from trusted spokespeople
- Coordination with national and regional campaigns.
- Sharing of local insights with national teams.

Command and Control

21. The LRF's command structures are utilised regularly across incidents and are embedded into emergency planning preparedness. There are clear triggers and thresholds in place to convene Tactical and Strategic Coordination Groups and all LRF organisations understand the process to convene these. During the initial stages of a pandemic, multiple command cells are activated as required (see appendix D), operating in line with Joint Emergency Services Interoperability Programme (JESIP) principles, and the Civil Contingencies Act 2004, ensuring key decisions and rationale is logged. Minutes, action logs, recordings and transcripts are created and stored. Multi-agency partnership working remains central to all emergency responses.

Risks and Challenges

22. A number of risks persist with pandemic planning:
    - Funding mechanisms for PPE, isolation support, accommodation support for homeless people, additional staffing and equipment.
    - Sustaining readiness during inter-pandemic periods to avoid capability erosion.
    - Workforce fatigue and retention in health and care sectors.
    - Building and sustaining public trust, particularly around vaccination
    - Addressing health inequalities and protecting vulnerable groups.
    - Food, medication and PPE supplies.
    - Legal requirements to support some interventions.

Key Developments Since Covid-19

23. Learning from COVID-19 has been incorporated into current pandemic planning leading to greater agility, better protection for staff and vulnerable groups, enhanced coordination, efficient use of resources, quicker response times and greater organisational resilience and ability to maintain critical services during disruption.

LRF:

- Adoption of virtual meetings enables quicker decision-making, and reduced travel demands on key personnel, whilst minimising transmission risk and protecting vulnerable groups.
- Specific operational cells (e.g. community support, care homes, pharmacy, education) were established and will be reactivated as needed.
- Flexible leadership for coordination groups.

- Strengthened data sharing, community engagement and scenario-based exercises.

Health:

- Single Points of Contact (SPOCs) with generic inboxes ensure resilience and consistency in operational response.
- Establishment of a Workforce Cell to support rapid set-up of testing and vaccination centres.
- Development of local escalation frameworks to manage surges in demand and prioritise essential services.
- Increased use of technology (e.g. MS Teams) for efficient, resilient meetings and rapid mobilisation.
- Implementation of Virtual Wards and virtual primary care appointments to support clinical practice.

Local Authority:

- Strengthened business continuity arrangements.
- Improved IT infrastructure to support remote and flexible working.
- Regular reviews and updates of LRF and organisational incident plans.

Proposals/Options

24. LRF organisations have identified actions to further enhance pandemic planning as part of the 3 exercises carried out this year. These include:
    - Strengthening data-sharing agreements and real-time surveillance capabilities.
    - Enhancing community resilience through targeted engagement with vulnerable populations and VCSE partners.
    - Proactively planning command and control and ensuring cell structures are maintained.
    - Continuation of multi-agency TCG and SCG immersive training to support and build on relationships with partners.
    - Ensure all organisations maintain and refresh plans regularly.
    - Review of current risk assessments and SOPs.
    - Ensuring all staff have access to secure IT and reliable internet that would allow them to work from home if required in a future pandemic.
    - Review IPC training and guidance.
    - Confirming availability and how to operationalise the PPE hub.

Consultation/Patient and Public Involvement

25. Input has been gathered from NHS partners, local authority emergency planners, and community representatives through operational delivery groups and planning exercises.

Resource Implications

26. Existing resources from partners involved in planning will support the initial development and implementation. Additional funding may be required for enhanced responses in the event of a pandemic.

Timetable for Decisions

27. There are no decisions to be made by the Health and Wellbeing Board, however, regular pandemic updates will be provided following receipt of the Pegasus post exercise report from UKHSA.

Conclusion

28. LLR partners have robust foundations for pandemic preparedness and clear proposals to strengthen system resilience further in 2025/26. Board endorsement will support continued collaboration and focus on equity, agility and whole-system readiness.

Background papers

• National Risk Register 2025: https://www.gov.uk/government/publications/national-risk-register-2025

• NHS England – Framework for managing the response to pandemic diseases (July 2024): https://www.england.nhs.uk/publication/framework-for-managing-the-response-to-pandemic-diseases/

• UKHSA – Communicable disease outbreak management guidance and toolkits (2025): https://www.gov.uk/government/publications/communicable-disease-outbreak-management-guidance

• NHS England – EPRR: Core Standards and 2025/26 Annual Assurance: https://www.england.nhs.uk/publication/emergency-preparedness-resilience-and-response-core-standards/

• Cabinet Office – UK Government Resilience Action Plan (2025): https://www.gov.uk/government/publications/uk-government-resilience-action-plan/uk-government-resilience-action-plan-html

• Civil Contingencies Act 2004 – duties of Category 1 Responders: https://www.gov.uk/guidance/preparation-and-planning-for-emergencies-responsibilities-of-responder-agencies-and-others

• Role of Local Resilience Forums – reference document: https://www.gov.uk/government/publications/the-role-of-local-resilience-forums-a-reference-document

• Exercise Pegasus – national Tier 1 pandemic preparedness exercise (2025): https://www.gov.uk/government/news/largest-ever-national-pandemic-response-exercise-to-strengthen-against-future-threats

• NHS England Board update – Pandemic preparedness & Exercise Pegasus (July 2025): https://www.england.nhs.uk/long-read/pandemic-preparedness-exercise-pegasus/

• WHO – Pandemic Influenza Risk Management (2017): https://www.who.int/publications/i/item/WHO-WHE-IHM-GIP-2017.1

• WHO – Clinical practice guidelines for influenza (2024): https://www.who.int/publications/i/item/9789240097759

Circulation under the Local Issues Alert Procedure

29. Not Applicable

Appendices

Appendix A: Roles and Responsibilities
Appendix B: Plans

Officer(s) to contact

Amita Chudasama, Head of EPRR, LLR Integrated Care Board
Telephone: 0777 554 1930

Email: amita.chudasama@nhs.net

Anuj Patel, Strategic Lead – Health Protection, Leicestershire County Council

Email: Anuj.Patel@leics.gov.uk

Relevant Impact Assessments

Equality Implications

30. Pandemics disproportionately affect some groups (e.g., older people, clinically vulnerable, people with disabilities, certain ethnic groups, and inclusion health populations). Due consideration has been given to the needs of diverse communities and groups of staff. This is borne in mind when considering roles and responsibilities of all agencies and staff involved, promoting fairness, equality and diversity in the delivery of the service

31. There are no equality implications arising from the recommendations in this report.

Human Rights Implications

32. There are no human rights implications arising from the recommendations in this report.

Partnership Working and associated issues

33. Pandemic preparedness is inherently multi-agency. This report and associated plans have been developed with partners across the system.

Appendix A:

National frameworks and guidance:

- Civil Contingencies Act 2004
- NHS EPRR Framework & Core Standards
- WHO Pandemic Influenza Risk Management Guidance
- UK Influenza Preparedness Strategy 2011
- UKHSA Outbreak Management Plan

Relevant local guidance and plans include:

- LRF CONOPS for the Management of Pandemics
- LRF Mass Treatment Plan
- LRF Communication Cell Emergency Plan
- LRF Major Incident Framework
- LLR Outbreak Management Framework
- Individual agency Pandemic Plans

Appendix B:

Plans that may be activated during a pandemic

LLR ICB Incident Response
Business Continuity
High Consequence Infectious Disease (HCID)
Media and Communications
Mass Treatment
Multi-agency Incident Response Framework

Appendix C- Pandemic Roles and responsibilities

Organisation / Role	Key responsibilities
NHS England	• Strategic leadership of NHS response • Convene and chair regional calls with ICBs • Oversee local management of Antiviral Collection Points (ACPs) • Oversee PPE storage/distribution • Manage pandemic vaccination campaigns • Collate situation reports (SitReps) • Coordinate communications to NHS, partners, public, media • Convene recovery team for return to normal business
LLR Integrated Care Board (ICB)	• Convene Local Pandemic Influenza Incident Response Team (L-PIIRT) • Chair/attend Strategic Coordination Group (SCG) meetings • Lead local coordination and surge capacity arrangements • Chair Health Economy Tactical Coordination Group (HETCG) • Maintain 24/7 on-call arrangements • Share communications with local providers • Enact business continuity arrangements • Maintain local data collection and reporting • Participate in multi-agency response
UKHSA	• Support Chief Medical Officer and SAGE • Provide expert clinical/scientific advice • Liaise with SCG and NHS • Detect and respond to outbreaks in schools, care homes, community • Advise on use of antivirals • Disseminate public health information • Reinforce hygiene and social distancing messages
Directors of Public Health	• Review population health, surveillance, prevention, control • Provide visible local leadership • Advise on activation of wider pandemic response • Ensure public health presence on SCG, TCG, Excess Death Cell, Info/Intelligence Cell • Advise on vulnerability/resilience of local community • Mobilise local public health resources
East Midlands Ambulance Service (EMAS)	• Gateway for patient access to healthcare • Emphasise initial assessment/treatment at home • Ensure business continuity and expand workforce • Attend SCG and response meetings
UHL	• Provide emergency / secondary care • Implement infection prevention/control • Cohort / isolate patients • Increase critical care capacity • Maintain essential services • Organise / distribute antivirals and PPE • Communicate with staff, patients, public • Provide vaccination to staff/patients

Appendix D

Command structures that may be stood up during a pandemic:

LRF

- Strategic Coordinating Group (SCG)
- Tactical Coordinating Group (TCG)
- Media and Communications Cell
- Voluntary Sector Support Cell
- Humanitarian Assistance Cell
- Multi-Agency Information Cell (MAIC)
- Science and Technical Advisory Cell (STAC)
- PPE Cell (initial scoping stage)

Local Authority

- Support the recommendations of the LRF.
- Establish internal response groups to begin planning and coordination

Health

- Health Tactical Coordinating Groups (TCGs) to deliver the strategy set by the Health SCG.
- Activate related cells as required.
- Individual agencies hold their own organisational command meetings.
- Establish a health “battle rhythm” led by the Integrated Care Board (ICB)

Police

- Stand up a Gold Group to coordinate police response.

HEALTH AND WELLBEING BOARD: 4 DECEMBER 2025

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

JOINT LOCAL HEALTH & WELLBEING STRATEGY 2022-2032 REVIEW

Purpose of report

1. The purpose of this report is to seek approval of the final version of the Joint Local Health and Wellbeing Strategy 2022-2032 (Reviewed and revised 2025).

Recommendation

2. The HWB is recommended to:

   - Approve the final version of the Joint Local Health and Wellbeing Strategy 2022-2032 (Reviewed and revised 2025).

Policy Framework

3. Health and Wellbeing Boards (HWBs) were established under the Health and Social Care Act (2012) and were operational within each local authority from 1st April 2013. HWBs are responsible for a number of statutory duties, which includes the development and publication of a Joint Local Health and Wellbeing Strategy (JLHWS).

4. The 10-year JLHWS for Leicestershire was approved by the Health and Wellbeing Board in February 2022.

Background and Previous Decisions

5. The JLHWS sets out the vision, priorities and actions agreed by the HWB to meet the needs identified within the Joint Strategic Needs Assessment (JSNA) to improve the health, care and wellbeing of local communities and reduce health inequalities.

6. The 10-year JLHWS was approved by the HWB in February 2022 with the view that a review will take place every 3 years to ensure that the priorities and commitments remain relevant.

7. It was agreed by HWB members at a development session in July 2023 that the life course approach was the right approach. Therefore, the aim of the review

was to focus on the JLHWS commitments within each strategic life course priority as opposed to the life course priorities and sub-priorities themselves.

8. The approach to the review was agreed at the meeting of the HWB on 5 December 2024 with the work commencing in February 2025.

9. The recommended changes to the JLHWS 2022-32 were approved by the HWB at its meeting on 25 September 2025. The HWB also approved the approach to the next phase (Phase 2) of the review which focuses on:

- Strategy rewrite and redesign;
- Review of governance;
- Development of a communication, engagement and implementation plan;
- Development of delivery plans;
- Development of reporting templates including performance dashboards.

10. Considerable collaboration and partnership efforts have driven the review of the JLHWS. Governance for the review has been agile, with HWB providing strategic oversight and retaining responsibility for approving and signing off the final strategy. The process has been led by a Steering Group made up of diverse representation across system, place, neighbourhood, and the voluntary sector.

11. The table below outlines the strategic priorities, sub-priorities and revised commitments.

Best Start for Life
First 1001 critical days • We will help families feel confident in managing minor health issues, by making it easier to find trusted advice and local support. • We will support women to find and use local services that will help them understand how to care for their health and wellbeing before and during pregnancy, and after birth. • We will support families to find and use local services that will help them understand how to care for their baby's health and support their child's early development. • We will ensure the right health and wellbeing services are available locally and in a joined-up way, so families can get the support they need, when they need it. *School readiness* • We will help families to build the foundations for school readiness, emotional wellbeing and good health by making it easier to find trusted advice and local support. • We will support families to find and use local services to support healthy development and wellbeing. • We will ensure the right health and wellbeing services are available locally and in a joined-up way, so families can get the support they need, when they need it. *Preparing for life* • We will help young people (with support from their families, carers and professionals) to take charge of their own health and wellbeing, by giving them the confidence, knowledge and encouragement to make healthy choices, look after their own health and wellbeing and support life-long health and resilience.

- We will work together with young people, families, schools and other professionals to make sure young people can find and use local health and wellbeing services to meet their needs.
- We will ensure the right health and wellbeing services are available locally and in a joined-up way, so young people can get the support they need, when they need it, particularly as they move into adulthood. These services will support all young people, including those with disabilities, to stay healthy, build resilience, and feel part of their community.
-

Staying Healthy, Safe & Well

Building strong foundations

- Health and equity in all policies: We will prioritise a health & equity in all policies approach to all we do
- Healthy placemaking: We will work together to shape healthy places and create strong, connected and resilient communities where everyone can thrive.
- Healthy workplaces and local economy: We will work with employers and local organisations to create fair, inclusive and healthy workplaces, helping more people to get into work and thrive in their jobs.
- Healthy homes: We will work together to make sure homes are affordable, safe, warm and of suitable quality and type, to support lifelong health and wellbeing.
- Healthy & safe communities: We will work together to build communities where people feel connected, supported and able to live healthy and well.

Enabling healthy choices

- Supporting healthy choices and behaviours: We will offer support, information and opportunities that create conditions that make it easier for people to make healthy choices and reduce behaviours that cause harm to health.
- Healthy weight, food & nutrition: We will work together to create healthier food environments and promote good nutrition.

Living & Supported Well

Upscaling prevention and self-care

- Empowering self-care - We will work together to support people to manage their long-term health conditions in ways that work best for them. This includes offering different types of local support to meet different needs.
- Access to care services - We will make the best use of our resources to improve access to health and care services to ensure people get the support they need, when they need it.
- Supporting independence - We will support people with disabilities and long-term health conditions to live independently. This includes making sure they can access suitable housing, care, equipment, adaptations, technology and personalised support that meet their needs.
- Falls prevention & management - We will strengthen support to reduce the impact of falls and reduce their impact, particularly on hospital admissions, to help people stay safe and well.
- Support for carers - We will support carers to ensure they are included in decisions about the person they care for and can find the information they need, when they need it.

Effective management of frailty and complex care

- Early identification of need - We will build on the local population health management framework to create a proactive care model that identifies people's needs earlier, helping to prevent crises before they happen.
- Supporting independent living - We will provide joined up health and care services that help people, and their carers live independently for as long as possible in the place they call home. This will be supported by a joined-up workforce that will make sure people get the right support at the right time.
- Care in the community - We will develop community-based health and care models that proactively support people to manage their long-term health conditions. These models will build on local strengths and work closely with voluntary and community organisations wherever possible.

Dying Well

Effective end of life planning and transitions

- Making end of life conversations a normal part of life - We will work with people, health and care staff, and community groups to make conversations on care at the end of life easier and more common. By encouraging open and honest discussions, we can help people make choices that are right for them and ensure they are treated with dignity and respect.
- Understanding what matters at the end of life - We will use data and insights to better understand what matters most to people at the end of life. This will help shape how care and support are planned and delivered, making sure people's needs are recognised and met with compassion.
- Access to information - We will make sure that people, families, carers and professionals have the right information and support to make clear and confident decisions on end of life care to ensure smoother transitions and better experiences for everyone involved.
- Support with end of life planning - We will make end of life planning a key part of personalised care and ensure that professionals/staff feel informed, confident, and supported to have open and compassionate conversations, making planning a natural part of life.
- Bereavement support for carers - We will make sure carers receive timely and compassionate support during bereavement. This support will recognise the emotional impact of losing a caring role and help carers through the transition.

Improved mental health

- Levelling up mental health - We will make sure mental health is treated as equally important as physical health in how we plan, invest in, and deliver services, recognising that mental health plays a vital role in overall health and wellbeing.
- Mental health promotion & prevention – We will promote good mental health and prevent difficulties before they start by making sure mental health is considered in all parts of our local services.
- Reducing suicide – We will work together to reduce suicide and save lives by making it easier for people to get help early and by linking work with national and local plans.
- Improving access to services - We will make it easier for people of all ages to get support for their mental health and emotional wellbeing by working together across services so that help is joined-up, person-centred, and there when people need it most.
- Children and young people's mental health - We will work together to make it easier for children and young people to get support for their mental health and emotional wellbeing, while also working to improve how services connect with each other so that young people have a smoother and more joined-up experience, particularly as they move to adult mental health services.
- Dementia - We will support the mental health and wellbeing of people living with or affected by dementia by spotting problems early, preventing them where we can, and making sure support is joined-up.

Reducing health inequalities

- We will provide a universal offer of health and care services to all, with justifiable variation in response to differences in need between groups of people.

Health protection & emergency preparedness

- We will work collaboratively to ensure our health protection approach and response is proactive, equitable and resilient.

12. In conclusion, aligned with the evidence and identified need, the majority of the strategy remains relevant and fit for purpose. However, refinement was required to enhance clarity, coherence and effectiveness. While the strategy has been updated, every effort has been made to maintain continuity and familiarity with the original version. This approach ensures the document remains consistent with review requirements rather than representing a full refresh.

Consultation/Patient and Public Involvement

13. A comprehensive public consultation was carried out when the strategy was first developed three years ago, therefore it was approved by HWB at its meeting on 5 December 2024 that it was not considered necessary to repeat the process as the current programme of work was a review rather than a full refresh. Instead, the review drew on existing insights from a co-ordinated approach between Healthwatch Leicestershire and Voluntary Action Leicestershire.

14. The Health Overview and Scrutiny Committee reviewed proposed changes to the Joint Local Health and Wellbeing Strategy (JLHWS) at a meeting on 3 September 2025 and the points raised were incorporated into the strategic development including the incorporation of healthy aging and sedentary lifestyles. These were approved by the HWB at its meeting on 25 September 2025.

Resource Implications

15. The refinement of the strategy will have several important implications for the next phase of work. These include:

- Time and resource across the partnership to present the strategy in an accessible format.
- Effective communication of the updated strategy to ensure a shared understanding and ownership across partners. Communication is not solely about launching the refreshed strategy but about supporting its implementation across partnerships to bring the strategy to life. A comprehensive communication, engagement and implementation plan will underpin this work to ensure shared ownership and sustained impact.
- Continued development of a delivery plan to ensure the revised commitments are translated into measurable actions.
- Updating of reporting templates and performance dashboards across all governance levels that provide timely information and demonstrate impact of initiatives.
- Continued review of existing governance arrangements to ensure they remain fit for purpose and are capable of supporting effective delivery and oversight of strategy.
- Developing a JSNA programme of work to align with the strategy.

Timetable for Decisions

16. To achieve the requirements set out in paragraph 21, a set of workstreams will be initiated to deliver the products below:

- Publication of the strategy and development of easy read versions
- JLHWS Delivery Plan
- Communication, engagement and implementation deliverables;
- Highlight report template
- JLHWS dashboard reports
- JSNA programme of work
- Governance review and associated documentation;

17. An Easy Read version of the Joint Local Health and Wellbeing Strategy 2022-2032 (Review & Revisions), the JLHWS delivery plan and dashboard reports and a proposed JSNA programme of work will be presented to the Health and Wellbeing Board on 27 February 2026.

Conclusion

18. The purpose of this report is to approve the final version of the Joint Local Health and Wellbeing Strategy 2022-2032 (Review & revision 2025). This will enable commencement of the workstreams described in paragraph 23.

Background papers

Joint Health and Wellbeing Strategy 2022-2032: https://www.leicestershire.gov.uk/sites/default/files/2024-04/JointHealthandWellbeing-Strategy-2022-2032.pdf

Appendices

Appendix 1 – Joint Local Health & Wellbeing Strategy 2022-2032 (Reviewed & Revised 2025)
Appendix 2 - EHRIA

Officers to contact

Mike Sandys, Director of Public Health

Email: Mike.sandys@leics.gov.uk

Joshna Mavji, Assistant Director of Public Health

Email: Joshna.mavji@leics.gov.uk

Relevant Impact Assessments

Equality Implications

19. An Equality Impact Assessment was undertaken in 2022 at the time the Strategy was developed and remains valid (Current EHRIA can be viewed in **Appendix 2**). At this stage, only a light touch update is considered necessary to ensure alignment with the current strategic context. Over time, as individual initiatives are designed and implemented through the associated action plans, each will be subject to its own comprehensive EHRIA to assess and mitigate any potential impacts.

Human Rights Implications

20. There are no human rights implications arising from the recommendations in this report.

Partnership Working and associated issues

21. The JLHWS review focuses on the commitment from partners in delivering the strategic objectives to improve the health and wellbeing of Leicestershire residents.

22. Partnership working will be fundamental to the success of the next phase of the strategy review. Building on the strong collaborations already established, continued collaboration will ensure the successful progression of priorities and collective ownership of delivery. By working together, partners can draw on their combined skills, insights and resources to drive the work forward and achieve better outcomes for our residents.

Risk Assessment

23. A full risk assessment has been managed as part of the project

This page is intentionally left blank

APPENDIX 1

LEICESTERSHIRE Health & Wellbeing Board

Leicestershire Joint Health and Wellbeing Strategy 2022–2032

Reviewed and revised in 2025

Glossary

The following abbreviations and expressions have the meanings given below when used in this document:

LTCs – Long term conditions

HWB – Health and Wellbeing Board

HLE – Healthy Life Expectancy

MMR – Measles Mumps and Rubella

RSV – Respiratory Syncytial Virus

1. Introduction

1.1 Background

Established under the Health and Social Care Act 2012, the Health and Wellbeing Board is a statutory function that brings together key leaders from across the local health and care system to improve health and wellbeing outcomes of residents and reduce health inequalities. The Health and Wellbeing Board has several statutory responsibilities that form its overall approach in achieving this. One of these requirements is to prepare and publish a Joint Local Health and Wellbeing Strategy so that work carried out to meet the health and care needs of local residents is done in a coordinated and measurable way. Additional requirements relevant to the Joint Local Health and Wellbeing Strategy include:

- Publishing and refreshing the **Leicestershire Joint Strategic Needs Assessment (JSNA)** - an assessment of current and future health and care needs in the local population.
- Approving and monitoring the **Better Care Fund (BCF) Plan** – a programme that supports local systems to successfully deliver the integration of health, housing and social care.

1.2 National and local context

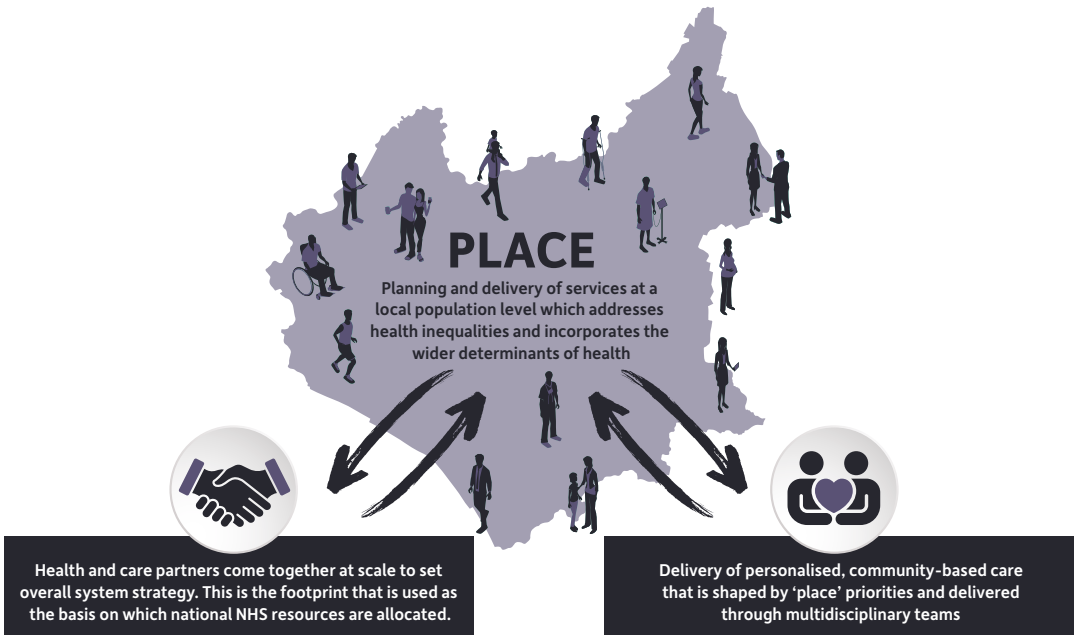
In July 2025, the 'Fit for the future: 10 year health plan for England' was published. The plan sets out three big shifts to how health and care will work:

- **From hospital to community** – providing better care closer to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care.
- **From analogue to digital** – greater use of digital technology and solutions to improve care.
- **From sickness to prevention** – helping people stay well by making healthy choices the easy choice and supporting people earlier to avoid deterioration in their health.

Since 2015, one of the ways that key agencies work together is through the Better Care Fund (BCF) which provides a pooled budget for delivering health, social care and housing functions through an integrated approach. This budget is spent in accordance with a joint local plan to deliver services that delay or prevent people from needing hospital care, reduce the length of time spent in hospital or that improves outcomes for people being discharged from hospital. These plans and this work continue in Leicestershire but become part of the wider strategy for health and wellbeing.

Leicestershire as a 'place' is the heart of our local health and care system. While system-wide strategies provide direction, and neighbourhood initiatives offer local insight, the place (Leicestershire) level is the key link between system and neighbourhood (figure 1), enabling two-way alignment and coordinated delivery that reflects the priorities and needs of our communities.

Figure 1 Relationship between place & system, and place & neighbourhood



This strategy was originally published in 2022 as a 10-year plan to improve health and wellbeing across Leicestershire. In line with our commitment to review the strategy every three years, a comprehensive review was undertaken in 2025 to ensure that the priorities and commitments remain relevant and responsive to current and emerging needs. As a result, some sections of the strategy have been updated to reflect new evidence and evolving national and local context.

While the overall vision and structure of the strategy remains unchanged, updates to specific content areas have been made to ensure the strategy continues to guide effective action across the life course. In particular, the original strategy was written under the shadow of the COVID-19 pandemic with a strong emphasis on recovery from its wide-ranging impacts. Whilst the impacts have not gone away, this work has now become embedded in our daily work. As such, the section that previously focused on COVID-19 recovery has been broadened to reflect a wider focus on health protection and emergency preparedness. Further detail is provided in Section 4.3. Another change to the strategy is that the revised commitments are intentionally broad to provide flexibility, enabling the strategy to remain relevant and responsive throughout its duration.

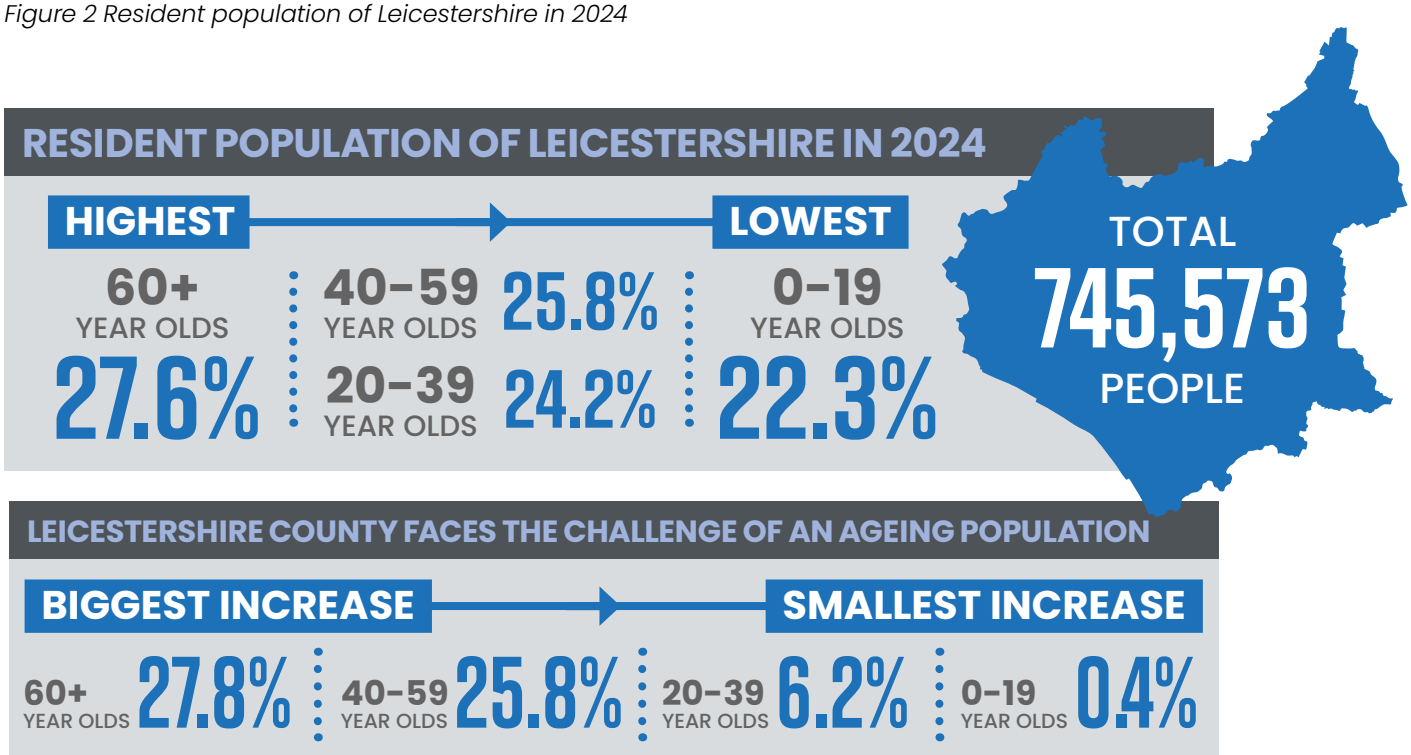
The strategy does not attempt to address every factor that influences health and wellbeing. Instead, it focuses on a set of priorities that will have the greatest impact on improving the health and wellbeing of Leicestershire residents. These priorities have been selected not only for their potential to make the biggest difference, but also because they require a collaborative approach to deliver meaningful and sustainable change. It is therefore important to note that the selection of these priorities does not diminish the value or importance of the work being undertaken by individual Health and Wellbeing Board member organisations. Many other areas of work remain vital to improving the health and wellbeing of Leicestershire residents, and this strategy should be seen as complementary to those efforts.

1.3 Leicestershire's current health and wellbeing

Leicestershire is a predominantly rural county and comprises of seven local authority districts. 67.4% of the population of Leicestershire live in areas classed as Urban, while 20.4% live in larger rural areas and the remaining 12.2% live in areas classed as smaller Rural.

Leicestershire faces the challenge of an ageing population. The population is expected to grow by **16.0%** between **2025** and **2047**, figure 2 provides further detail on this.

Figure 2 Resident population of Leicestershire in 2024



As the population ages, it is important to assess and implement plans that address future health and care requirements over time, with attention to preventable health conditions, especially among working-age adults. Health needs are likely to increase with age due to the increased risk of developing multiple chronic conditions. Therefore, without significant preventative interventions, there will be more older people with complex needs who will require input from all parts of the health and social care system.

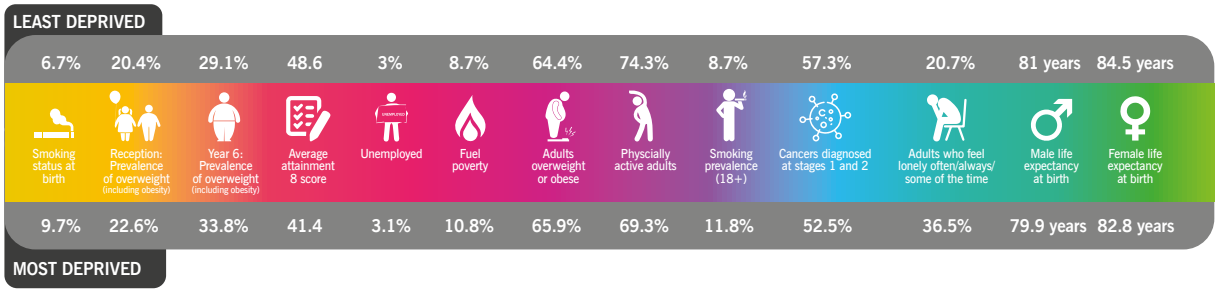
Even though Leicestershire is a relatively affluent county, pockets of significant deprivation exist, with some neighbourhoods in Loughborough and Coalville falling into the 10% most deprived neighbourhoods in England. The Education, Skills and Training deprivation domain and Barriers to Housing and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

According to the Leicestershire County Council Community Insight Survey (2017-2021), 82.7% of respondents reported being in good/very good health, whilst 3.5% reported being in bad/very bad health.

Life expectancy at birth in Leicestershire has remained significantly better than the England average since 2001-03. Healthy life expectancy (HLE) at birth in Leicestershire for males (63.5 years) and females (63.6 years) is similar to the national average. For males, HLE has decreased since 2015-17 and for females, HLE has decreased since 2014-16. There is an eight-year difference in life expectancy at birth between males in the most deprived decile and least deprived decile of the population. The equivalent figure for females is 5.4 years.

Figure 3 below shows the difference in health inequalities that exist between the most and least deprived districts within Leicestershire over the life course. In order to reduce this inequality, more focus needs to be toward those in greatest need and working together to reduce any factors that may have a negative influence on their health. Figure 4 presents some health and wellbeing indicators for Leicestershire.

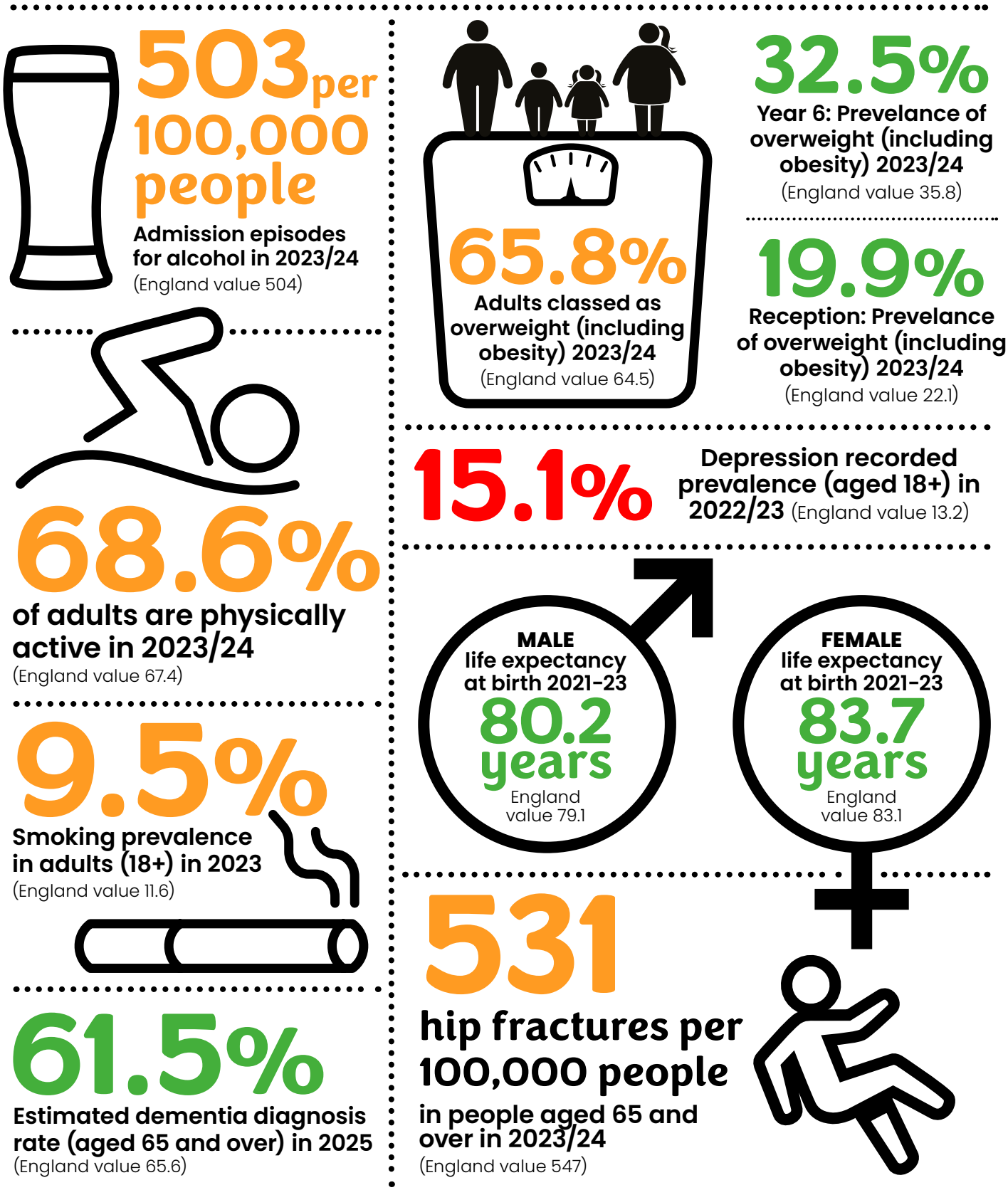
Figure 3: Health Inequalities across Leicestershire



Source: Office for Health Improvement and Disparities, Fingertips, 2025.

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

Figure 4: Overview of health and wellbeing in Leicestershire



For further information and evidence for priorities in the Joint Health and Wellbeing Strategy 2022-2032, view the Joint Strategic Needs Assessment Chapters here:

www.lsr-online.org/leicestershire-2022-2025-jsna

2. Vision and approach

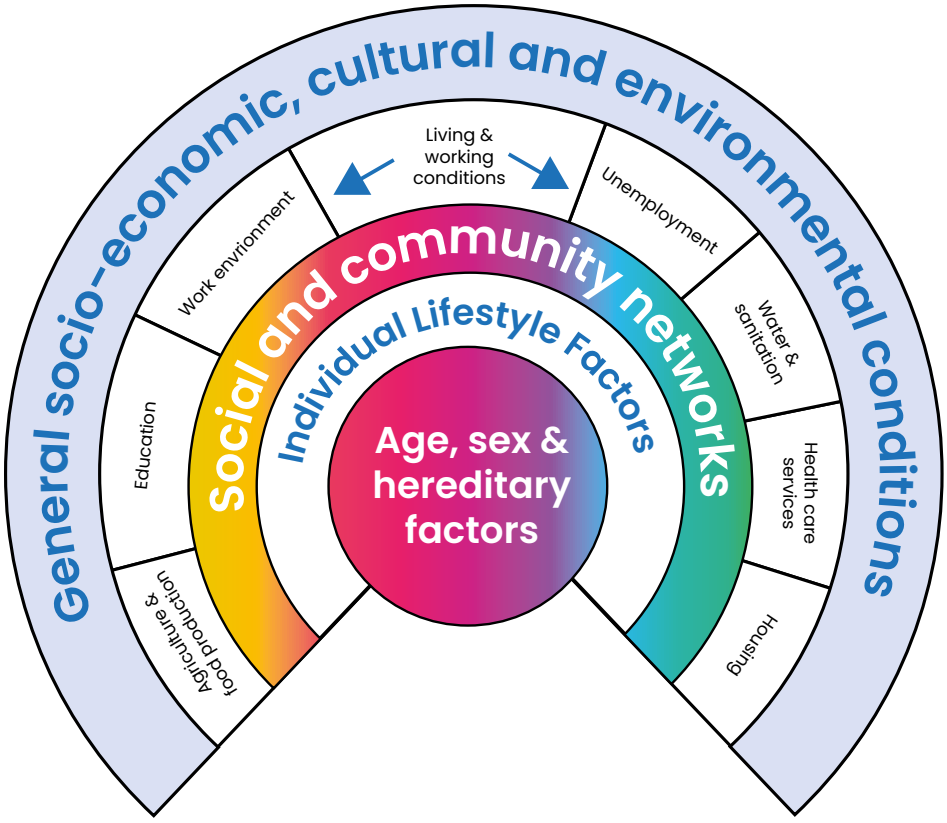
'Giving everyone in Leicestershire the opportunity to thrive and live happy, healthy lives."

Health can be defined as: "a state of wellbeing with physical, cultural, psychosocial, economic and spiritual attributes, not simply the absence of illness" (Marks, 2005).

This recognises the social model of health (as defined by Dahlgren and Whitehead) and identifies all but age, sex and hereditary factors as modifiable to change and therefore lying within the scope of this strategy, particularly in relation to primary prevention.

Figure 5 summarises this model and highlights the wider determinants of health including social, economic and environmental factors which influence people's mental and physical health. Systematic variation in these factors constitutes social inequality, an important driver of health disparities. Therefore, on a population level, improving the wider determinants of health (the "causes of the causes") will have a much greater effect on reducing inequities in health compared to healthcare interventions alone. Hence this strategy will embed the social model of health and include priorities across the wider Health and Wellbeing Board partnership which include the wider determinants of health.

Figure 5: A social model of health, Dahlgren & Whitehead (2006)



2.1 Life course approach

We want to ensure the communities of Leicestershire have the opportunity to have the best health and wellbeing they can across the life course. We want to embed a strengths-based approach to allow individuals, families and communities to support each other, aim high and thrive.

A life course approach has been used to identify high level strategic, multi-organisational priorities for the next 10 years and provide clear accountability to the Leicestershire Health and Wellbeing Board. These are summarised in figure 6 below. Further detail on the commitments under each priority are discussed in section 3.

Figure 6: Summary of the Joint Health and Wellbeing Strategy

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

2.2 Strategic principles

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

Person centred and holistic approach

We will take a holistic approach to supporting individuals, recognising the whole person, their strengths, circumstances, and aspirations and recognising that health and wellbeing are shaped by a wide range of factors.

Embedding prevention in all that we do

We will embed prevention across all aspects of our health and care system, tailoring preventative support to different stages of life and ensuring that prevention is a shared responsibility across organisations, services and communities.

Strategic alignment

We will work collaboratively to ensure that associated new and existing strategies are strategically aligned with our shared health and wellbeing priorities, avoid duplication, reinforce one another, and that our collective efforts maximise impact, add value and promote coherence across the system.

Resilience and sustainability

We will work to strengthen the resilience of our individuals, communities and services enabling them to adapt, recover and thrive whilst supporting sustainability of health and wellbeing services.

Trauma informed approach

We will work to embed a trauma informed approach throughout the life course, recognising that trauma can have long-term impacts on health and wellbeing.

2.3 Strategic enablers

There are a number of enablers that will support progressing the work.

Partnership & collaboration

We will work together across organisations and communities to share knowledge and resources in areas where we can add value, drive innovation and reduce duplication, recognising that improving health and wellbeing is a collective effort.

A skilled and informed workforce

We will support our collective workforce to be skilled, informed and united in delivering our shared priorities and understanding their vital role in improving health and wellbeing for everyone.

Leveraging technology

We will harness technology innovatively and responsibly to enhance health and wellbeing, improve access to services, support informed decision making, increase efficiency and empower our workforce to work smarter and more collaboratively.

Effective communication & engagement

We will foster open communication and meaningful engagement to ensure our strategy is widely understood by organisations and communities, empowering us to work together to shape and drive our shared health and wellbeing priorities.

Evidence based data and insights

By using a shared understanding of local health and wellbeing needs, we will apply evidence-based data and insights to understand what works, learn from experience and target collective efforts where they can make the greatest difference to people's health and wellbeing.

3. Strategic priorities across the life course

3.1 Best start for life

We want to give our children the best start for a happy, healthy, long life. We want them to fulfil their potential, allowing them to:

- thrive, meeting key development milestones and positive educational attainment.
- build positive relationships and strong emotional wellbeing and resilience.
- develop life skills.
- contribute to their community and society.

The families, communities, and environments we are born into and grow up in play a crucial role in shaping our health and wellbeing throughout life. This influence is especially profound during the first 1001 critical days (from conception to age two), when rapid neurological development occurs, laying the foundation for a child's life chances and outcomes.

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

3.1.1 First 1001 critical days

We know the building blocks for lifelong emotional health and wellbeing are developed in the first 1001 critical days i.e. from conception to the age of two. The human brain is not fully developed at birth and becomes hard wired by early childhood experiences including those in pregnancy, which impact across the life course. Ensuring families understand the first 1001 critical days will support good development.

We know children with secure attachment to their parents and carers develop into resilient adults, build strong relationships at home and work, and are better equipped to raise their own children. This is due to early social and emotional experiences that build a baby's brain.

On the flip side of this, people who lack nurture from one or more caring adults in the first 1001 days of their lives achieve less in education and in the workplace; are more likely to behave anti-socially, and are less healthy, physically and mentally, than individuals who were given a better start. Furthermore, the harm done to them is likely to be perpetuated in an inter-generational cycle when they have children of their own.

We therefore aim to develop Leicestershire as a place where every baby and family is nurtured to fulfil their potential. Developing this foundation for good physical and emotional health not only supports an individual's wellbeing but also results in wider financial implications through better employment opportunities and reduced reliance on the health and care system.

> The families, communities and environments we are born into and grow up in play a crucial role in shaping our health and wellbeing throughout life.

Where are we now?

- A&E attendances for 0-4 yrs has improved, going from significantly worse than the national average in 2018/19 to significantly better in 2022/23.
- Obesity in early pregnancy has worsened going from performing similarly to the national average in 2018/19 and now performing worse than the national in 2023/24.
- The caesarean section rate remains significantly worse than the national average.
- Proportion of new birth visits within 14 days has gone from significantly worse than the national average in 2019/20 to significantly better than the national average in 2023/24.
- Hospital admissions of babies under 14 days has improved, going from similar to the national average in 2018/19 to significantly better than the national average in 2022/23.
- Proportion of mothers initiating breastfeeding has fallen in 2022/23 compared with 2021/22.
- The childhood immunisation schedule includes several vaccines that are given within the first 2 years of age. Leicestershire's vaccination coverage in this age group is showing a worsening trend.
- Percentage of children achieving a good level of development at 2-2½ years is significantly worse than the national average.

Our commitments

- We will help families feel confident in managing minor health issues, by making it easier to find trusted advice and local support.
- We will support women to find and use local services that will help them understand how to care for their health and wellbeing before and during pregnancy, and after birth.
- We will support families to find and use local services that will help them understand how to care for their baby's health and support their child's early development.
- We will ensure the right health and wellbeing services are available locally and in a joined-up way, so families can get the support they need, when they need it.

What does success look like?

- Sustained reduction in A&E attendances for 0-4 yrs.
- Reduction in maternal obesity.
- Reduction in the proportion of caesarean section births.
- Sustained improvement in the proportion of new birth visits within 14 days.
- Sustained reduction in hospital admissions of babies under 14 days old.
- Improvement in initiation of breastfeeding.
- Improvement in vaccination coverage at 1 and 2 years.
- Improvement in the percentage of children achieving a good level of development at 2-2½ years.

3.1.2 School readiness

Preparing our children for school is an important transition in their lives, to allow them to have a positive start to their formal educational journey. We want the pre-school children of Leicestershire to be equipped with the skills they need so that all children develop well, learn to communicate, build relationships, manage their emotions, and develop their fine and gross motor skills through play. A child's ability to achieve these skills is influenced by their health and wellbeing. By maximising this, we are supporting them to be ready to learn and flourish as they enter their foundation year at school.

Where are we now?

- The demand for EHCPs (Education, Health and Care Plans) is continuing to rise.
- The percentage of children achieving a good level of development at the end of reception has gone from similar to the national average in 2018/19 to significantly better than the national average in 2023/24.
- The percentage of physically active children and young people has reduced in 2023/24 compared with 2022/23.
- The prevalence of underweight reception children has gone from significantly worse than the national average in 2019/20 to significantly better than the national average in 2023/24.
- While the prevalence of overweight reception and Year 6 children is significantly better than the national average, the prevalence has increased in 2023/24 compared with the previous year.

Our commitments

- We will help families to build the foundations for school readiness, emotional wellbeing and good health by making it easier to find trusted advice and local support.
- We will support families to find and use local services to support healthy development and wellbeing.
- We will ensure the right health and wellbeing services are available locally and in a joined-up way, so families can get the support they need, when they need it.

What does success look like?

- Sustained improvement in the percentage of children achieving a good level of development at the end of reception.
- Improvement in the percentage of physically active children and young people.
- Reduction in the prevalence of overweight in reception children.
- Reduction in the prevalence of overweight in Year 6 children.

3.1.3 Preparing for life

Children today are our adults of the future. We need to ensure they are equipped to navigate and thrive in society. This may be through good education, employment and training,

understanding how to live independently, stay safe, and maintain good health and emotional wellbeing. The good health and wellbeing of our children and adults are not only outcomes we want to see in their own right but are also vital for underpinning and promoting all the other elements needed for navigating and thriving in society. We therefore want to support our young people to transition seamlessly from children into young and prosperous adults.

Where are we now?

- HPV (Human papillomavirus) vaccination coverage is better than England for both males and females but not achieving the benchmark of >90%.
- Hospital admissions due to substance use in those aged 15 to 24 is similar to the national average.
- The proportion of females aged 15 to 24 screened for chlamydia has fallen year on year since 2022.
- The percentage of teenage pregnancies has worsened going from significantly better than the national average in 2019/20 to being similar to national average in 2022/23.

Our commitments

- We will help young people (with support from their families, carers and professionals) to take charge of their own health and wellbeing, by giving them the confidence, knowledge and encouragement to make healthy choices, look after their own health and wellbeing and support life-long health and resilience.
- We will work together with young people, families, schools and other professionals to make sure young people can find and use local health and wellbeing services to meet their needs.
- We will ensure the right health and wellbeing services are available locally and in a joined-up way, so young people can get the support they need, when they need it, particularly as they move into adulthood. These services will support all young people, including those with disabilities, to stay healthy, build resilience, and feel part of their community.

What does success look like?

- Improvement in the uptake of HPV (Human papillomavirus) vaccination in males and females.
- Sustained reduction in hospital admissions due to substance use.
- Improvement in levels of chlamydia testing.
- Reduction in teenage pregnancies.
- Increased proportion of young people successfully transitioning from children's to adult health and wellbeing services.

3.2 Staying healthy, safe and well

Prevention is always better than cure, and good health and wellbeing is an asset to individuals, communities and the wider population. It improves health and care outcomes and saves money across the whole system.

We want to give everyone in Leicestershire the opportunity to live happy, healthy, long lives and helping people stay well and free from illness or disease for as long as possible thereby promoting healthy aging. However, to achieve this we must consider the social model of health (Figure 5) which confirms the importance of strong communities, health behaviour and the wider determinants of health (including housing, work, education and skills, built and natural environment, income and transport).

Evidence shows us that clinical care only contributes towards 20% of health outcomes (Figure 7), therefore improving the wider determinants of health (the "causes of the causes") will have a much greater effect on improving health outcomes and reducing inequities in health compared to healthcare interventions alone.

Modifying these risk factors will take time to evolve and improve, however having a 10-year strategy allows Leicestershire to be bold in ambition and make true, sustainable action to improve the 'causes of the causes', which will transform the population's health and help break cycles of intergenerational inequality.

Figure 7: Contributors to health outcomes

Contributors to health outcomes

Health Behaviours 30%	Socio-economic Factors 40%	Clinical Care 20%	Built Environment 10%
Smoking 10%	Education 10%	Access to Care 10%	Environmental Quality 5%
Diet/Exercise 10%	Employment 10%	Quality of Care 10%	Built Environment 5%
Alcohol use 5%	Income 10%		
Poor sexual health 5%	Family/Social Support 5%		
	Community Safety 5%		

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

> Prevention is always better than cure, and good health and wellbeing is an asset to individuals, communities and the wider population.

3.2.1 Building strong foundations

We recognise that environmental factors can impact people's health and wellbeing. We want to develop a strengths-based approach by building social capital and community resilience and working with our community on areas that are important to help them flourish. We know this is dependent on having secure building blocks such as good work and economic growth, financial stability, good homes, accessible transport and a safe and healthy environment.

Where are we now?

- The Leicestershire population is expected to grow by 16.0% between 2025 and 2047, with the biggest increase expected in the 60+ age group which is expected to increase by 27.8%.
- At least around 48,500 additional homes are expected to be built by 2036.
- Bus services and community transport perform badly against other counties.
- The percentage of adults regularly walking for travel is significantly worse than the national average.
- Air pollution: fine particulate matter has worsened; previously performing in the middle quintile nationally in 2019 and now performing within the 2nd worst quintile nationally in 2023.
- The employment rate is better than the national average with diverse employment industries. The largest sector is Manufacturing (12.0%), followed by Professional, Scientific & Technical (11.4%), Transport and storage (11.1%) and Education (8.5%).
- Percentage of working days lost to sickness absences has improved. Previously performing significantly worse than the national average in 2017-19 to now performing similarly to the national average in 2020-22.
- Fuel poverty has worsened going from the 2nd best quintile nationally in 2018 to the middle quintile nationally in 2022.

Our commitments

- **Health and equity in all policies**: We will prioritise a health & equity in all policies approach to all we do.
- **Healthy placemaking**: We will work together to shape healthy places and create strong, connected and resilient communities where everyone can thrive.
- **Healthy workplaces and local economy**: We will work with employers and local organisations to create fair, inclusive and healthy workplaces, helping more people to get into work and thrive in their jobs.
- **Healthy homes**: We will work together to make sure homes are affordable, safe, warm and of suitable quality and type, to support lifelong health and wellbeing.
- **Healthy & safe communities**: We will work together to build communities where people feel connected, supported and able to live healthy and well.

What does success look like?

- Health and Equity in all policies approach successfully embedded across the Leicestershire Health and Wellbeing Board member organisations.
- Evidence that appropriate, equitable infrastructure (including health services) is in place for the planned housing growth addressing health inequality through design and use of health impact assessments.
- Routine use of health impact assessments in planning, transport and development.
- Collaboration with planners & licensing officers to influence the local environment, including limiting clustering of fast food, alcohol and gambling outlets, and assessing their potential impacts on the local community.
- Increased access to and availability of green community assets & green spaces.
- Expansion and/or improvement of active travel infrastructure with increased uptake of walking, cycling and sustainable transport.
- Reduction in air pollution and its impact on health.
- Sustained improvement in the employment rate.
- Sustained improvement in the percentage of working days lost to sickness absence and improved employee wellbeing.
- Reduction in fuel poverty and fewer households living in cold or energy inefficient homes (affordable warmth).
- Stronger community cohesion with increased local participation.

3.2.2 Enabling healthy choices

Every day we make choices that have an impact on our health and wellbeing, with poor health behaviours including smoking, poor diet, physical inactivity, alcohol use or poor sexual health contributing towards 30% of our health outcomes. There is growing recognition that prolonged sedentary behaviour is a major health concern with it being linked to musculoskeletal problems, poor mental health, and increased risk of chronic diseases such as diabetes and heart disease.

Making healthy choices is not straightforward and is heavily influenced by our social connections and the environment that we live in. We want to encourage and enable people and communities to make healthier choices, creating an environment to empower them to do so, ultimately resulting in the healthy choice becoming the easiest choice.

Where are we now?

- The percentage of adults who are overweight is similar to the national average.
- The percentage of active adults has improved. Previously performing similar to the national average to now performing significantly better than the national average.
- Percentage of inactive adults has improved. Previously performing similarly to the national average to now performing significantly better than the national average.
- Hospital admissions for alcohol related conditions has worsened. Previously performing significantly better than the national average in 2018/19 and now performing similarly to the national average in 2023/24.
- Smoking prevalence is significantly better than the national average.
- While the rate of abortions is significantly better than the national rate, it has increased (got worse) year on year since 2014.
- The percentage of adults meeting the '5 a day' fruit and vegetable consumption recommendation is similar to the national average.

Our commitments

- **Supporting healthy choices and behaviours**: We will offer support, information and opportunities that create conditions that make it easier for people to make healthy choices and reduce behaviours that cause harm to health.
- **Healthy weight, food & nutrition**: We will work together to create healthier food environments and promote good nutrition.

What does success look like?

- Implementation of Making Every Contract Count (MECC) training across the network with frontline staff equipped to have health promoting conversations.
- Reduction in the percentage of adults who are overweight.
- Sustained improvement in the percentage of active adults.
- Sustained reduction in the percentage of inactive adults.
- Reduction in alcohol related hospital admissions.
- Sustained reduction in smoking prevalence.
- Reduction in the rate of abortions.
- Achievement of the Sustainable Food Places Gold Standard Award.
- Improvement in the percentage of adults meeting the '5 a day' fruit and vegetable consumption recommendation.

3.3 Living and supported well

As people age, become unwell or develop one or more long term conditions (LTCs), it is important that they are supported to live as independently as possible, for as long as possible while maximising their quality of life.

We know the more LTCs people have (rather than age), the greater amount of health and social care support they will need, and that this can be progressive. With a targeted population health management approach, we can focus on supporting those with disabilities and multiple LTCs (at any age), to help them live as well as possible for as long as possible and prevent or slow further decline into ill health.

3.3.1 Upscaling prevention and self-care

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

We recognise that individuals know their own condition(s) best. Approaches that help people learn new skills and gain confidence to manage their condition(s) better have been shown to increase feelings of support, confidence and control, while improving health outcomes and quality of life. As more and more people have access to technology at home and the market continues to grow, we want to utilise new ways of helping people to stay independent and well for longer. Whilst support in person will always be important, it will also be crucial to ensure that we use developing technologies to assist with prevention, self-care, and independence.

Universal services such as social prescribing, Local Area Coordination and First Contact Plus deliver a range of support that can play a role in preventing or delaying people's progress to more resource-intensive care arrangements. The appropriate identification and commissioning of services within available resources will ensure that our universal services are used to their full effect.

Unpaid carers contribute a substantial amount of support every year, which has a significant positive impact on demand experienced across the health and social care sector. It is crucial that we support and recognise carers' contributions to the health and social care sector, and the vital role they play in the quality of life experienced by those they care for.

> It is important that people are supported to live as independently as possible, for as long as possible, to maximise their quality of life.

Where are we now?

- Feedback from individuals suggests that having access to appropriate information, advice and guidance, is an area for improvement across all channels.
- Permanent admissions to residential and nursing homes is performing at the national average.
- Emergency hospital admissions due to falls in people aged 65 and over is significantly better than the national average.
- Hip fractures in those aged 65 and over has reduced, performing similarly to the national average.
- There are over 61,300 unpaid carers across Leicestershire.
- The percentage of adult carers who have as much social contact as they would like has worsened, now performing significantly worse than the national average.

Our commitments

- **Empowering self-care** - We will work together to support people to manage their long-term health conditions in ways that work best for them. This includes offering different types of local support to meet different needs.
- **Access to care services** - We will make the best use of our resources to improve access to health and care services to ensure people get the support they need, when they need it.
- **Supporting independence** - We will support people with disabilities and long-term health conditions to live independently. This includes making sure they can access suitable housing, care, equipment, adaptations, technology and personalised support that meet their needs.
- **Falls prevention & management** - We will strengthen support to reduce the impact of falls and reduce their impact, particularly on hospital admissions, to help people stay safe and well.
- **Support for carers** - We will support carers to ensure they are included in decisions about the person they care for and can find the information they need, when they need it.

What does success look like?

- Producing care plans for people with multi co-morbidities to reduce the need for urgent or emergency care.
- Reduction in permanent admissions to residential and nursing homes.
- Increase in the use of technology to support people to live independently.
- Sustained reduction in the rate of admissions due to falls for people aged 65+.
- Sustained reduction in the rate of hip fractures.
- Reduction in the percentage of adult carers reporting loneliness or social isolation.

3.3.2 Effective management of frailty & complex care

We know that people with poorer health and multiple LTCs are the biggest users of health and social care resources. People with 5 LTCs will, on average, use 7 times more elective care than those with 1 chronic condition; for those with 8 LTCs, this will increase to an average of 14 times the amount of secondary care activity. If we can utilise a Population Health Management approach to identify those at greatest risk of hospitalisation and deterioration of their health, we will be more able to introduce care planning and interventions early, which will help prevent or minimise episodes of acute health and social care required. This will include work to understand barriers to those with multiple LTCs self-managing their conditions.

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

Where are we now?

- Over the last five years, GP practices' Quality & Outcomes Framework disease registers show prevalence for diabetes and stroke is significantly increasing.
- There are 51,101 people who have 5 or more LTCs and 15,802 people with 8 or more.
- The average days from Discharge Ready Date to date of discharge (inc 0 day delays) is 0.73.
- The average days from Discharge Ready Date to date of discharge (exc 0 day delays) is 3.91. This indicates that while most individuals are discharged on the same day they are ready, a smaller number of individuals experience longer delays.
- 81% of individuals are discharged on the same day as their Discharge Ready Date.

Our commitments

- **Early identification of need** - We will build on the local population health management framework to create a proactive care model that identifies people's needs earlier, helping to prevent crises before they happen.
- **Supporting independent living** - We will provide joined up health and care services that help people, and their carers live independently for as long as possible in the place they call home. This will be supported by a joined-up workforce that will make sure people get the right support at the right time.
- **Care in the community** - We will develop community-based health and care models that proactively support people to manage their long-term health conditions. These models will build on local strengths and work closely with voluntary and community organisations wherever possible.

What does success look like?

- Early identification of individuals at high risk of hospitalisation and social care needs using a Population Health Management approach and delivering outcomes within a neighbourhood care model.
- Reduction in emergency admissions for those aged 65+.
- Reduction in emergency bed day usage for those with 5 or more Long Term Conditions.
- Improved timeliness of discharges across all pathways.
- Increased utilisation of reablement.
- 95% of people identified as vulnerable have a co-produced care plan, which takes into account their wider needs e.g., multiple LTCs, social/psychological elements and carer arrangements.
- Improvement in the percentage of patients aged 65+ discharged back to their Usual Place of Residence.
- Reduction in long-term admissions to residential care homes and nursing homes for people aged 65+.
- Improvement in the number of people aged 65+ still at home 91 days after discharge into rehabilitation/reablement services.
- Improved patient satisfaction in the complex care pathway, especially for those with multimorbidity (5+ chronic conditions).
- Improved identification of people with moderate or severe frailty as a result of proactive action and care planning to support maintaining to live at home.
- Reduction in unplanned admissions for those with ambulatory care conditions.

3.4 Dying well

Our goal is to enable people to choose their care with dignity, through a personalised and compassionate approach that respects the wishes, values, and needs of each individual, their family, and those important to them.

3.4.1 Effective end of life planning and transitions

End of life is an inevitable part of the life course, yet we know that it remains a difficult topic for many people to acknowledge and discuss openly. People in Leicestershire have told us that they want more support to understand what good end of life care looks like and to feel confident about the choices available to them.

We want to support people to understand, plan for, and feel empowered during this stage of life, ensuring that everyone has the opportunity to make informed decisions about their care and treatment, and that loved ones and carers are supported throughout and beyond this time.

It is vital that we understand the types of support people require at this stage, whether that's practical advice on financial and legal matters, access to timely bereavement and emotional support for families, or guidance and encouragement to develop advance care plans. By listening to our population and working with organisations across health, social care, and the voluntary sector, we can ensure that people receive the right information, at the right time, and in the right place.

For many, the transition from living with one or multiple long term conditions into end of life care is gradual. We are keen to understand and respond to the needs of people, carers, and families through this final phase of life with the aims of informing how we can provide coordinated, proactive, and equitable support so that everyone in Leicestershire can experience a dignified and well supported end of life, wherever they choose to be.

Where are we now?

- Many people make this transition in an informed way, but we know that not all people have this experience.
- Percentage of people dying in hospitals is significantly decreasing.
- Percentage of people dying at home is significantly increasing.
- The majority of vulnerable people in Leicestershire have a care plan in place, but we know there are some that do not. This is a similar position for ReSPECT plans (a document that outlines a person's personalised recommendations for their care when they are unable to make their own decisions).
- Informal carers have indicated that advice and support available to them requires improvement.

> Our goal is to enable people to choose their care with dignity, through a personalised and compassionate approach.

Our commitments

- **Joined-up support** - We will improve how health and care services work together at the end of life, making support more joined-up, easier to navigate, and better tailored to people's needs.
- **Making end of life conversations a normal part of life** - We will work with people, health and care staff, and community groups to make conversations on care at the end of life easier and more common. By encouraging open and honest discussions, we can help people make choices that are right for them and ensure they are treated with dignity and respect.
- **Understanding what matters at the end of life** - We will use data and insights to better understand what matters most to people at the end of life. This will help shape how care and support are planned and delivered, making sure people's needs are recognised and met with compassion.
- **Access to information** - We will make sure that people, families, carers and professionals have the right information and support to make clear and confident decisions on end of life care to ensure smoother transitions and better experiences for everyone involved.
- **Support with end of life planning** - We will make end of life planning a key part of personalised care and ensure that professionals/staff feel informed, confident, and supported to have open and compassionate conversations, making planning a natural part of life.
- **Bereavement support for carers** - We will make sure carers receive timely and compassionate support during bereavement. This support will recognise the emotional impact of losing a caring role and help carers through the transition.

What does success look like?

- Increased proportion of people planning for late stages and end of life at a time when they are still able.
- Increase in the number of people dying in their place of choice.
- Care plans offered to all people that may benefit from having one. This should include a ReSPECT plan.
- Increased take up of care plans/ReSPECT plans with people specifically opting out of having a plan in place rather than being missed from the offer of one.

4. Cross-cutting priorities

In addition to the four life course stages, a number of cross cutting priorities have been highlighted as additional areas of need: Improved Mental Health, Reducing Health Inequalities and Health Protection & Emergency Preparedness.

4.1 Improved mental health

Good mental health is an important part of our overall health and wellbeing. It is linked to and affected by a number of factors including income, deprivation, domestic abuse, self-harm, physical illnesses, drug and alcohol use, smoking, obesity and homelessness. The impacts of poor mental health are wide reaching including lower employment, reduced social contributions, reduced life expectancy and reduced healthy life expectancy.

There is a renewed commitment to achieve parity of esteem to meet mental health needs in comparison to physical health needs, with a more targeted approach to enhance offers to support mental health needs.

The vision for mental health of both children and adults across the system is ***'We will deliver the right care to meet the needs of individual patients at the right time. We will integrate with health and social care partners to care for people when they feel they have mental health needs.'***

In Leicestershire, we are keen to support this system work whilst being clear on the mental health and wellbeing needs of those living in Leicestershire. This will be to ensure we champion individual needs and support delivery of high-quality prevention, care and treatment that improves their outcomes and experiences.

Where are we now?

- Leicestershire performs similarly to England for percentage of school pupils with social, emotional and mental health needs, however, over the last five years the trend has worsened.
- Hospital admissions as a result of self-harm in those aged 10 to 24 is significantly worse than the national average having previously performed significantly better.
- Leicestershire performs significantly worse than the benchmark for estimated dementia diagnosis rate.
- Benchmarking shows that the Adult Social Care team in Leicestershire supports more working age people with mental ill health than other authorities, but maintains more people to live at home without escalation to complex care arrangements.

> Good mental health is an important part of our overall health and wellbeing.

Our commitments

- **Levelling up mental health** - We will make sure mental health is treated as equally important as physical health in how we plan, invest in, and deliver services, recognising that mental health plays a vital role in overall health and wellbeing.
- **Mental health promotion & prevention** – We will promote good mental health by making sure that prevention is considered in all aspects of our work and that early help is provided where needed.
- **Reducing suicide** – We will work together to reduce suicide and save lives by making it easier for people to get help early and by linking work with national and local plans.
- **Improving access to services** - We will make it easier for people of all ages to get support for their mental health and emotional wellbeing by working together across services so that help is joined-up, person-centred, and there when people need it most.
- **Children and young people's mental health** - We will work together to make it easier for children and young people to get support for their mental health and emotional wellbeing, while also working to improve how services connect with each other, so that young people have a smoother and more joined-up experience, particularly as they move to adult mental health services.
- **Dementia** - We will support people living with or affected by dementia, through prevention, timely help and joined up support.

What does success look like?

- Increased proportion of individuals experiencing good mental health and wellbeing.
- Qualitative feedback that good emotional health and wellbeing is actively promoted and supported across the county including for carers, and that services are joined up and meeting people's needs at the right time and place.
- Reduction in the proportion of people with mental health challenges that need intensive and specialist offers.
- Sustained reduction in suicide rates below national average.
- Improvement in dementia diagnosis rate.
- Reduction in emergency hospital admissions for Intentional Self-Harm.
- Reduction in the proportion of school children with emotional and mental health needs.
- Sustained improvement in the number of children and young people accessing support by NHS funded community services and NHS funded mental health services.

4.2 Reducing health inequalities

"Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies".

As already described, health inequalities are underpinned by social determinants of health, or the circumstances in which people are born, live, work and grow. Overall Leicestershire is an affluent county, that generally performs well in terms of health and wellbeing. However, not everyone enjoys the same prospects or opportunities for good health and wellbeing.

Evidence suggests that those living in the most deprived areas of the county often have poorer health outcomes, as do some ethnic minority groups and vulnerable/socially excluded people. This applies across the entire life course. In addition, the most disadvantaged are not only more likely to get ill and more likely to live with more than one long-term illness or health issue, but they are less also likely to access services when they are unwell, and services are less accessible to them. This is known as the inverse care law.

Within our approach we will incorporate, where appropriate, Core20PLUS5 to ensure everyone has an equitable opportunity to support their health and wellbeing. Core20PLUS5 is a national approach to inform action to reduce healthcare inequalities. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

This cross cutting priority has been intentionally designed with breadth and flexibility to ensure relevance across all life course areas. This approach empowers each sub-group leading on each of the priorities to tailor their focus to the specific population groups most affected by health inequalities within their remit.

Where are we now?

- Inequality in life expectancy is estimated using a summary measure called the slope index of inequality (SII). The higher the value of the SII, the greater the inequality within an area. Nationally, the inequality in life expectancy at birth is 9.7 years in males and 7.9 years in females in 2018-20. The SII for males and female life expectancy in Leicestershire in 2018-20 was 6.0 years and 4.9 years respectively. From 2017-19 to 2018-209, the slope index of inequality decreased by 0.4 years for males and decreased by 0.1 for females.
- In males, life expectancy in the least deprived decile has increased from 82.2 years in 2011-13 to 82.4 years in 2021-23. For the same time period, in the most deprived decile, life expectancy at birth in males has decreased from 76.3 to 75.6 years.

> Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals.

- In females, life expectancy in the least deprived decile has increased from 84.9 years in 2011-13 to 86.1 years in 2021-23. In the same time period in the most deprived decile life expectancy at birth in females has decreased from 80.4 years to 80.0 years.
- The percentage of children with free school meal status achieving a good level of development at the end of reception is significantly worse than the national average.
- The number of looked after children having a health check has worsened as has their levels of emotional health.
- The proportion of children in care who are up to date with their routine vaccinations is significantly lower than England and has a decreasing trend.
- The National School Census for 2023/24 states that in Leicestershire schools, 17.8% of pupils have special educational needs and 4.8% have an Education and Health Care Plan. Children and young people with a learning disability are more likely to be either underweight or overweight, have epilepsy and experience significantly higher mental health issues.
- The gap in the employment rate for those who are in contact with secondary mental health services and the overall employment rate is still significantly worse than the national average.

Our commitments

- We will provide a universal offer of health and care services to all, with justifiable variation in response to differences in need between groups of people.

What does success look like?

- Reduction in the slope index of inequality or 'levelling up' of the social gradient.
- A greater rate of improvement in life expectancy and healthy life expectancy in the most deprived communities and vulnerable groups across Leicestershire.
- Improvement in the percentage of children with free school meal status achieving a good level of development at the end of reception.
- Improvement in the number of looked after children having a health check.
- Improvement in the proportion of children in care who are up to date with their routine vaccinations.
- Improvement in emotional wellbeing of looked after children.
- Improvement in health outcomes of children and young people with learning disabilities.
- Improvement in the percentage of adult carers who have as much social contact as they would like.
- Narrowing of the gap in the employment rate for those who are in contact with secondary mental health services and the overall employment rate.

4.3 Health protection & emergency preparedness

Health protection spans prevention, preparedness, surveillance and response to infectious diseases, environmental hazards and other public health threats. In Leicestershire, our focus is on a sustainable approach, ensuring our communities are resilient, prepared, and protected against a wide range of risks.

This cross cutting priority recognises that health protection is not just about crisis response, but about building robust systems and partnerships that safeguard health and wellbeing across the life course. Our approach is proactive, equitable, and tailored to the unique needs of Leicestershire's diverse communities, including rural areas and those facing barriers to accessing services.

Immunisation programmes and national screening programmes are cornerstones of health protection, preventing disease and enabling early detection to improve outcomes. Ensuring equitable access and uptake is essential to reduce avoidable illness and premature mortality.

Vaccination programmes are essential to public health and provide essential protection against infectious diseases that can otherwise cause serious harm. Vaccinations have saved more lives and prevented more serious diseases than any other advancement in recent medical history. Examples include MMR (measles, mumps, rubella), influenza and RSV (Respiratory syncytial virus). Suboptimal coverage leaves us vulnerable to transmission of infectious diseases, particularly in school, early years and communities with lower uptake. Sustained and targeted action is needed to improve coverage and reduce inequity.

The health protection system identifies infectious disease incidents and outbreaks, but also focuses on detecting diseases, such as cancer, at an early stage to enable early treatment and improve survival rates. Screening spans the life course, beginning with antenatal screening and pregnancy screening all the way up to cancer and non-cancer screening programmes. However, these programmes are not equally accessed by all, creating inequalities in early detection and health outcomes.

Emergency planning considers rural isolation and access to services, and close working with the Local Resilience Forum maintains a health focus on planning. Engagement with communities is vital to build trust and improve uptake of preventative measures. More frequent heatwaves, periods of cold weather and reduced air quality amplify risks for older adults, people with long term conditions and those in isolated settings. There is a need to focus on protecting those most vulnerable.

Leicestershire's health protection system benefits from strong partnership arrangements, through the Leicester, Leicestershire and Rutland (LLR) Health Protection Board, co-chaired by the Directors of Public Health. The Board provides strategic oversight, challenge and assurance to the respective Health and Wellbeing Boards on all health protection functions, including prevention, surveillance, planning, and response, drawing together programmes across partners into a single assurance function, and the delivery of an annual assurance report.

> Our focus is on a sustainable approach, ensuring our communities are resilient, prepared, and protected against a wide range of risks.

Where are we now?

- In 2023/24, only 91.7% of children in Leicestershire had received both doses of the MMR vaccine by age five, the lowest level since 2011/12. Coverage in Leicestershire is greater than the national average but has followed a downward trend.
- Flu vaccination coverage in those aged 65 and over has improved. Previously performing significantly worse than the benchmark of 75% in 2019/20 to performing significantly better than the benchmark in 2023/24.
- Cervical screening coverage across Leicestershire for individuals aged 25-29 years old has gradually reduced from 80.2% in 2010, to 72.6% in 2024. For individuals aged 50-64 years old, 2024 saw the lowest uptake of 77.9%, from 84.3% in 2010.
- Uptake of bowel screening has increased since 2015.
- Percentage of cancer diagnoses at stages 1 and 2 has improved. Previously performing significantly worse than the national average and now performing similarly to the national average.
- Preparedness for extreme weather events is becoming increasingly important, particularly for rural and isolated communities. Health inequalities persist, with vulnerable populations more likely to be adversely affected during emergencies.

Our commitments

- We will work collaboratively to ensure our health protection approach and response is proactive, equitable and resilient.

What does success look like?

- Proactive identification of vulnerable populations as part of preparedness for extreme weather events and other similar emergencies.
- Improvement in MMR uptake.
- Sustained improvement in flu vaccination coverage.
- Improvement in RSV vaccination coverage.
- Improvement in occupational vaccination rates across the health and social care workforce.
- Improvement in cervical screening uptake with reduced variation by age, deprivation and ethnicity.
- Sustained improvement in uptake of bowel screening.
- Sustained improvement in cancer diagnoses at stages 1 and 2 (early stages).

5. Moving Forwards

5.1 How we will know we've made a difference

The key to getting things right is embedded in leadership, partnership working and accountability.

The best way of knowing if this strategy has made a difference is to ensure effective and regular monitoring of the actions and the associated success measures that address the identified priorities and to highlight any gaps. The success measures outlined in this strategy are not exhaustive. They serve as a starting point to monitor progress and impact, but we recognise that additional indicators may emerge over time.

This strategy also commits to seeking insights directly from individuals and communities to understand whether progress is being made in ways that matter to them.

Delivery of this strategy will be overseen by Leicestershire's Health and Wellbeing Board (chaired by the Lead Member for Health) through a clear and collaborative framework that ensures all activity aligns with agreed priorities and principles.

The subgroups of the HWB will lead delivery of each priority area, supported by working groups that will develop detailed delivery plans. Delivery plans will set out the actions that will be taken to achieve specified changes.

Subgroups will also lead engagement and consultation with organisations, stakeholders and the public where appropriate, ensuring that actions reflect local needs. Equality Impact Assessments will be completed where required to ensure equitable delivery.

Progress will be monitored through highlight reports for each priority area from lead officers to their respective subgroups. Each subgroup will provide an annual update (as a minimum) to Health and Wellbeing Board and these updates will include:

- A performance dashboard showing the latest data evidencing impact.
- A written report summarising progress, outcomes, challenges and forward plans, including case studies where appropriate.
- A verbal update to accompany the report describing highlights from the report and answering any questions from HWB members.

Subgroups will contribute to the HWB's annual report, demonstrating collective achievements and the impact of initiatives.

A full review of the strategy will be undertaken prior to its conclusion in 2032, allowing sufficient time to assess progress, incorporate learning, and inform future planning. The timing of this review will be determined based on operational feasibility.

Through this approach, the HWB will ensure the strategy is delivered in partnership, with transparency, accountability and clear focus on improving health outcomes for Leicestershire residents.

This strategy commits to seeking insights directly from individuals and communities to understand whether progress is being made in ways that matter to them.

LEICESTERSHIRE Health & Wellbeing Board

Membership of the Leicestershire HWB include:

Leicestershire County Council

healthwatch Leicestershire

Leicestershire Police
Protecting our communities

POLICE & CRIME COMMISSIONER for Leicestershire

NHS

NHS University Hospitals of Leicester NHS Trust

NHS Leicestershire Partnership NHS Trust

Leicestershire District and Borough Councils

Z0413

This page is intentionally left blank

Leicestershire Joint Health and Wellbeing Strategy 2022-2032

APPENDIX 1

LEICESTERSHIRE Health & Wellbeing Board

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

Taking a life course approach - 4 strategic priorities

Best start for life
1. First 1001 critical days
2. School readiness
3. Preparing for life

Staying healthy, safe and well
4. Building strong foundations
5. Enabling healthy choices

Living and supported well
6. Upscaling prevention & self-care
7. Effective management of frailty & complex care

Dying well
8. Effective end of life planning and transitions

3 Cross-cutting strategic priorities

- Improved mental health
- Reducing health inequalities
- Health protection & emergency preparedness

Strategic principles

- Person-centered and holistic approach
- Embedding prevention in all we do
- Strategic alignment
- Resilience & sustainability
- Trauma informed approach

Strategic enablers

- Partnership & collaboration
- Skilled & informed workforce
- Leveraging technology
- Effective comms & engagement
- Evidence-based data & insights

10 Year Strategy 2022-2032

This page is intentionally left blank

APPENDIX 2

Equality & Human Rights Impact Assessment (EHRIA)

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

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

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

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

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

Date EHRIA assessment completed:	

Section 1: Defining the policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.

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

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

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

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

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

Section 2
D: Decision

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

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

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

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

Section 2: Completion of EHRIA Screening

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

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

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

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

Section 3: Equality and Human Rights Impact Assessment Report

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

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

Section 3
A: Research and Consultation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 3:
F: Equality and human rights improvement plan

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

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

Section 4: Sign off and scrutiny

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

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

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

Section 4
A: Sign Off and Scrutiny

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

Equality and Human Rights Assessment Screening ☐

Equality and Human Rights Assessment Report ☐

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

Date: ……

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

Date: 3rd February 2022……